Response to

Healthy Weston Consultation Document of February 2019

(Including the Pre-Consultation Business Case)

From

Save Weston A&E

and

Protect our NHS North Somerset

Contents

1. Opening Statement — Page 3
2. Executive Summary — Page 4
3. Weston General Hospital – What Population does it serve? — Page 6
4. Staffing and Vacancy Rates — Page 10
5. Calculating Patient Numbers — Page 12
6. Travel Issues for A&E Patients and their Families — Page 15
7. The Proposed Changes to A&E in Weston General Hospital — Page 19
8. Expanding WGH to Meet the Needs of an Expanding Community — Page 22
9. Conclusions — Page 24
10. Appendices — Page 29
    - Appendix A: GP Practices within North Somerset and North Sedgemoor
    - Appendix B: Catchment Population of WGH
    - Appendix C: Patient Travel – Private Car Distance / Time
    - Appendix D: Questions Arising from the Healthy Weston Pre-Consultation Business Case
11. Glossary of Abbreviations — Page 40

Opening Statement

The Healthy Weston Consultation is currently not fit for purpose. Nowhere near enough hospital doctors, GPs and nurses are being recruited to ensure that the new model is ready to start in October 2019 and the proposed merger with University Hospitals Bristol Trust has now been put back by six months. Until this merger takes place we do not see how the recruitment issues will be resolved. The process should, therefore, be put on hold and proper public consultation should only start when the project is capable of being realised.

Save Weston A&E
Protect our NHS (North Somerset)

10th June 2019

1. Executive Summary

The Office for National Statistics has just reported that North Somerset's population could rise to 228,370 within five years and 237,767 within ten years. A total of 25,000 new homes have been earmarked for the North Somerset Spatial Plan by 2036. Further to this, in summer Weston-super-Mare's population increases with an influx of holidaymakers - both day-trippers and longer stay visitors - whose numbers exceed 8 million each year.

A town and county of this size both require a fully operational hospital at its heart. Indeed even The Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group ("BNSSG CCG" or "CCG") claims in its Consultation that:

> *"There is an overwhelming case for changing health services in Weston, Worle and the surrounding areas to enhance and improve the care available to local people, improve health and well-being and recovery from illness, and make best use of our resources. Developing a stronger and more focused Weston Hospital at the heart of the local community is key to our vision of a healthier future."*

With this statement of intent we entirely agree, but our agreement with the principle in no way means that we support or endorse the proposals laid out by the CCG in its Consultation. Our vision for the future of Weston General Hospital ("WGH") is one that recognises the reality of population growth, of increased population aging and the continuance of a healthy tourist economy set alongside the success of further education in Weston in bringing young people into the town.

The constant refrain within the Healthy Weston Consultation ("HWC") that primary and community care will fill in the gaps left by WGH's downgrading seems to us to reach the level of fantasy. The King's Fund, in a 2018 paper (*Reimagining Community Service*) emphasises the need for major development of primary care and community health services. But the article asks commissioners to recognise:

> *… that it is not realistic to release resources from acute hospitals to invest in services in the community when hospitals are working under intense pressure. It also means identifying the funding and staffing needed to make a reality of new models of care and creating time and support for this to happen.*

Healthy Weston will determine the shape of our healthcare here in North Somerset for at least the next 10 years. It is, therefore, vital to put in place services that will deliver proper care in the real world. It may embarrass or irritate BNSSG CCG to have to re-think their entire approach as part of this consultation period and to admit that their model and methodology is flawed, but it would be a lot less embarrassing than the consequences of an NHS that fails to cater for the elderly, for the next generation and for those unfortunate enough to require emergency treatment.

Our response to the HWC is designed to address some of the statistical anomalies we have noted in the document, to counter its vision of downgrading Weston's hospital and

to propose a new vision that meets the needs of our future. We accept that our work is not as detailed as that coming from the CCG, but we would point out that we have not been able to spend a total of £418,779.66 on consultants and legal advice on top of the salaried staff whose job it has been to produce the HWC. On the contrary our volunteer campaigners have given up many hours of their own time to attend Weston Area Health Trust ("WAHT") board meetings, HWC public events and further, seemingly endless hours going through the many hundreds of pages of BNSSG CCG documents and their appendices.

We have been supporters of the vision for WGH's A&E that had been originated and developed by the Consultants who work at the Emergency Department ("ED"), but we now know that WGH's Clinical Design and Delivery Group has met with the consultants and their proposal is being "evaluated" after the conclusion of this public consultation.

In brief:

1. We believe that this consultation should be put on hold until the issues surrounding the proposed merger with the United Hospitals Bristol Trust (BRI) – now slated for April 2020 - are determined, as the staffing problems that are at the heart of this Healthy Weston Consultation could be resolved once the merger is in place.

2. We dispute the population statistics presented by the CCG. We believe that the greater part of North Somerset looks towards Weston General and that many GP practices within the county and the area refer patients there.

3. We dispute the figures regarding the lack of nurses at the hospital and wish to understand why the staffing requirements for A&E increased between 2017 and 2019.

4. We look forward to a full and publicly shared and evaluated understanding of why the Consultants' proposal for A&E was rejected.

5. Targets for the new model for Weston General are being missed – e.g. GP recruitment and the delay in the merger with UHBT. This invalidates the HWC process, which should be consulted on once all the correct details are fully in place.

6. The Consultation process has been handled with little genuine attention paid to ensuring information is shared with all members of the public in the area – not just with the handful of people who are able to attend meetings or read the Mercury (circulation 9,000).

2. Weston General – What Population Does it Serve?

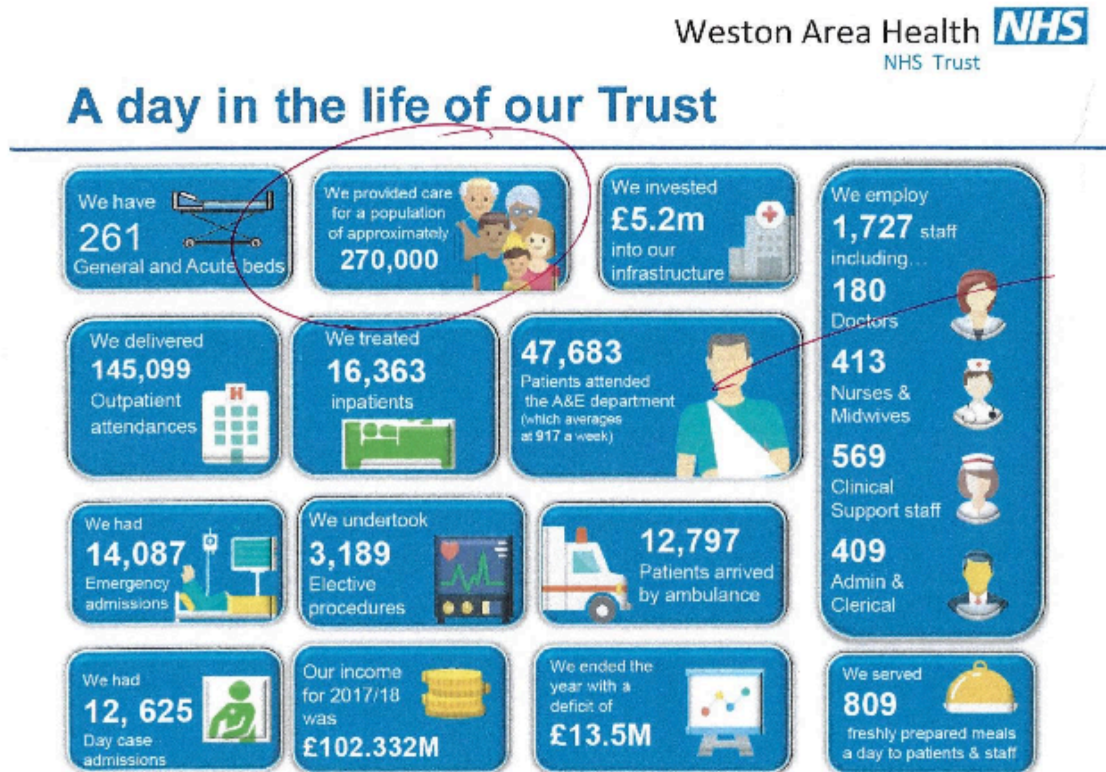
Our analysis of the report has led us to raise points about its methodology and the accuracy of its statistics. Our first point relates to the following statement in the document:

> *When we talk about the 'Weston area' we are referring to Weston-super-Mare, Worle, Winscombe and the surrounding areas including north Sedgemoor.*

The document goes on to state:

> *The number of people registered with a GP in this area is around 152,000 and this number is expected to grow to over 161,000 by 2025.*

However, from a Trust board report of November 2018[1] we learn that during the period April 2017 to March 2018 the trust "provided care" for a population of 270,000.



This has since been qualified in a response to an FOI request by our campaign to the claim that:

[1] WAHT Annual General Meeting of 01.11.2018. Presentation. Slide 34.

This is the maximum population the hospital could serve and not a representation of the population it actually serves.[2]

So we have a hospital capable of serving a population of 270,000, but which they define as only actually serving a population of 152,000.

And where does the 152,000 figure come from? As we know, according to the CCG, their estimate of the catchment population is based on the total registered patient numbers of 16 *local* GP practices in Weston and its immediate environs. This is clearly a considerable underestimate. There are some 36 GP practices in North Somerset and North Sedgemoor *(see below in Appendix A, Table 1)*. The CCG informs us that the registered patients of those shown in blue in Table 1 form the catchment population of WGH and those shown in red do not. However all GP practices shown in Table 1 can and do refer patients to WGH and we know that triages for orthopaedic referrals from Nailsea and Portishead use WGH and acute admissions from Clevedon will also go there.

Furthermore, the CCG's estimate of the catchment population *(Appendix B Table 2)* ignores the fact that WsM is a major seaside town. Indeed the CCG appears to be confused by its own population data. They commissioned a report from consultants *GE Healthcare Finnamore*[3] that not only cost £200,000, but contained the following statement (page 9).

In addition to the local population, Weston-super-Mare attracts seasonal visitors. It is estimated that there are approximately 3.3 million day trippers and 375,000 staying visitors each year. In peak season, up to 10% of ED attendance are out of area tourists.[4]

However in the CCG's initial release on the Healthy Weston project[5] it stated on page 16:

In addition to the local population, WsM attracts 8 million day trippers and circa 500,000 staying visitors each year and in peak season up to 10% of emergency department attendances are by out-of-area tourists.

The reference the CCG quotes[6] shows year on year visitor number's increasing from 5.31m in 2004 to 8.56m in 2014. These figures were generated by an independent company, Global Tourism Solutions (UK) Ltd, which would suggest that after paying GE

---

2 *Response from WAHT FOI Request on the 10th November 2018 Ref 3573*

3 North Somerset System Sustainability. The Case for Change. V2.1 April 2016. D. Grayson.

4 GEHCF analysis of Taunton acquisition EY 2013/14 slam data.

5 NHS BNSSG CCG. Healthy Weston: Joining up services for better care in the Weston area. A Commissioning Context for North Somerset 2017/18 to 2020/2021. October 2017. J. Ross & Dr M. Backhouse.

6 North Somerset Council. Visitor Economic Impact Figures 2004 – 2014

Finnamore £200,000 the CCG doubted the data they provided and went with data used by North Somerset Council.

It is imperative to understand what this means for patient numbers attending WGH's A&E. Both the above sources state that out-of-area tourist numbers attending the ED tops out at 10%. But this is not the case according to the CCG themselves. On page 30, Appendix 14 of [7] there is a bar chart entitled:

> *WAHT (Weston Area Health Trust) sees an increase in the proportion of out-of-town A&E attendances during the summer months.*

The chart shows local and out-of-town A&E attendance for the period April 2016 to March 2017 peaking at 16% in August with a 5% minimum in January. So the statement referring to a peak of 10% is incorrect and should be quoted as 16%. Given as month-on-month numbers of local and out-of-town attendees we find local attendance of 48,400 p.a. and an out-of-town figure of 4,800 giving an annual total of 53,200 giving an average of 9%. Their figure of 10% is, therefore, not the peak but 1% above the true average. We assume that attendance at A&E will roughly go in line with the increased tourist figures, but that the percentage would stay the same.

At WAHT's April 2019 board meeting it was stated that daily attendance at A&E during March 2019 was 133, or 4,123 for the month. This compares to a March 2017 figure of 4,400 when the overnight closure had not been implemented. The question that needs to be asked is, does this imply a 10% (plus) drop in attendance or a 10% (plus) transfer to other A&E departments?

Coming back to the 16% peak out-of-town attendance figure: local attendees are classified as residents within the Bristol, North Somerset and South Gloucestershire CCG area. The catchment population, the population defined by the CCG to use the hospital, is identified as the registered patients of 16 local GP practices (page 72 & 73 of Appendix 14 of the PCBC. footnote 5). This obviously does not include residents of Bristol or South Gloucestershire. The figure of 16% should, therefore, be much higher bearing in mind the fact that we know many more GP practices refer patients to WGH than is claimed together with the additional issues of the proposed expansion of Bristol Airport and the contractors being brought in to build Hinkley Point.

If we then return to the Pre-consultation Business Case (Appendix 14**. F**ootnote 5) we find that annual A&E Attendance throughout the BNSSG area is broken down as follows:

- BRI (UHBT) = 129,000
- Southmead (NBT) = 85,000
- Musgrove Park (T&S) = 62,000
- WGH (WAHT) = 54,000

---

7 Healthy Weston Pre-Consultation Business Case. 29th January 2019.

Total for all 4 hospitals = 330,000

Or in percentage terms:

- BRI (UHBT) = 39.0%
- Southmead (NBT) = 25.8%
- Musgrove Park (T&S) = 18.8%
- WGH (WAHT) = 16.4%

Finally we cannot tell if an updated figure for the future will include the population impact of the proposed expansion of Bristol Airport in the north of the county and the number of contractors being brought in to build Hinkley Point C Power Station. To say that A&E at WGH is small and should, therefore, be downgraded – and eventually disposed of – is neither accurate nor in any way a sensible approach to a valuable and valued resource.

Questions to BNSSG CCG

1. Please confirm which population number that you have been using for WGH's catchment area?

2. Please explain why you think it is acceptable to refer to only 16 GP practices as referring to WGH when there are 36 practices in the area many of which we know from enquiry refer patients directly to WGH?

3. Please confirm whether the 10% drop in A&E attendance at A&E is simply a 10% transfer to other hospitals?

3. Staffing and Vacancy Rates

There is a national staff shortage in the NHS.[8] This, obviously, includes nurses. [9]

> *"Our analysis shows a 40,000 (11%) shortfall [in the number of nurses needed in England] in 2018-19 which widens to 68,500 (16%) by 2023-24 without intervention, as demand for nurses grows faster than supply."*

The question we have to ask if whether the situation is any worse at WGH than across the country. According to The Healthy Weston Consultation document it is, as it states on Page 20:

> *In February 2019 there was a 23% consultant vacancy rate, with particular challenges staffing A&E and general medicine, which means there is a reliance on locum, temporary staff. There is also a nursing vacancy rate of around 25%. These vacancy rates are significantly higher than at neighbouring hospitals.*
>
> *In January 2018 alone, over 800 nursing shifts were covered by agency nursing staff, with 60% of these due to job vacancies (as opposed to staff holidays or illness).*

So 60% of the 800 nursing shifts (480 shifts) covered by agency nursing staff within A&E in January 2018 were caused by job vacancies. We also know that the number of funded (commissioned by the CCG) positions of Band 5 nurses within A&E is approximately 30 (the actual figure is 29.93, see below). Also there is a 25% nursing vacancy rate within A&E, representing 7.5 Whole Time Equivalent ("WTE") nurses. So 480 shifts required to be covered by 7.5 WTE nurses equates to 64 shifts each in January 2018. There are 31 days in January, so this requires each nurse to work just over two shifts a day. A nursing shift is 12 hours which includes breaks and shift change overs at the start and finish. Therefore each nurse is required to work just over 24 hours a day, each day of January, without a day off. Obviously this cannot be the case we request an explanation from the CCG as to the basis on which they have made these statements relating to nurse vacancies and agency shifts required due to staff vacancies?

With regard to the employment of consultants and nursing staff our analysis reveals the following:

July 2017

- Consultants: 5 in place against a requirement of 6
- Middle grade: 2.4 in place against a requirement of 8
- Band 5 nurses: 20.56 in place against a requirement of 26.56.

---

[8] https://www.theguardian.com/society/2018/feb/21/nhs-england-has-one-in-11-posts-unfilled

[9] http://campaign.r20.constantcontact.com/render?m=1102665899193&ca=b99a655e-da38-4d50-aa72-18d05c8f43f0

May 2019

- Consultants: 5.7 in place against a requirement of 8
- Middle grade: 7.23 in place against a requirement of 11
- Band 5 nurses: 21.54 in place against a requirement of 29.93.

So from these numbers it can be seen that staffing levels have improved, if only by a small amount, for consultants and nurses. However the requirements have also increased!

Taking just the consultant requirements. We know that the Royal College of Emergency Medicine state that for a Type 1 ED (consultant led 24/7) a compliment of 10 ED consultants is required. When challenged on this requirement the Medical Director stated that they had compensation to reduce this to 8.

Why, therefore, in July 2017, was the requirement quoted as 6?

Was this the number of places the CCG funded and if so was this a contributory factor to the Temporary Overnight Closure being implemented?

Whatever the answers to these questions we have to emphasise yet again that the new model is not a guarantee of increased or safe staffing levels. Indeed, on page 9 of the Pre Consultation Business Case they, themselves state that their:

> *... proposal does not solve on-going issues with staff recruitment and retention*

Questions to BNSSG CCG

1. Please explain the nursing shift calculations referred to on page 20 of the HWC.
2. Why did the A&E staffing requirement increase between July 2017 and May 2019?

4. Calculating Patient Numbers

The impact of the preferred option, the model presently under consultation, is predicted in Table 13 shown on page 89 of the Pre-Consultation Business Case (PCBC) document. This table shows the number of patients affected annually by the proposals:

Table 13: Predicted impact of preferred option on activity at Weston General Hospital

			2018/19			Preferred Option			
	Activity	Units	Predicted	Impact of temporary overnight closure	Normalised to commissioned Model	Retained at WAHT	Impact of Frailty	Provided Elsewhere (TONC)	Provided Elsewhere
1	A&E major	Attendances	7,700	1,766	9,466	5,599	464	3,657	1,637
2	A&E standard	Attendances	21,923	5,028	26,951	21,127	795		0
3	A&E minor	Attendances	16,439	3,770	20,209	16,166	273		0
	A&E Total	***Attendances***	***46,062***	***10,564***	***56,626***	***42,893***	***1,533***	***3,657***	***1,637***
4	Acute medicine	Spells	10,336		10,336	8,965	1,286		86
5	Emergency surgery	Spells	3,266		3,266	2,393	310		562
							0		
							0		
6	Elective medicine	Attendances	283		283	250	0		33
7	Daycase medicine	Attendances	8,518		8,518	8,518	0		0
8	Critical Care	Bed days	1,784		1,784	815	0		969
9	Elective surgery	Spells	1,255		1,255	1,176	0		79
10	Daycase surgery	Spells	4,828		4,828	4,828	0		0
	Total Planned Surgery	***Spells***	***6,083***		***6,083***	***6,004***	***0***		***79***
11	Outpatient	Attendances	108,171		108,171	108,171			0
12	Paediatrics	Spells	827		827	1,241			(414)
	Total Patient Contacts		**185,330**	**10,564**	**195,894**	**179,249**	**3,128**	**3,657**	**2,952**

- Services currently provided by WGH with the temporary overnight closure of A&E in place are shown under the column '*Predicted*'.

- Those services WGH are commissioned to provide by the CCG are shown under the column '*Normalised to Commissioned Model'*.

- If the proposals under the consultation are implemented then the change in patient numbers is shown under '*Preferred Option'*.

- The change in patient numbers presently attending WGH is shown under the column headed '*Retained at WAHT'*.

- The number of new patients WGH will treat due to the introduction of the proposed Integrated Frailty Service is shown under the column '*Impact of Frailty'*.

In all cases, with the exception of paediatrics, it can be seen that patient numbers drop or remain the same.

On page 90 of the PCBC the following statement is made:

> *"Clinically-led modelling suggests that around 80% of A&E visits for major issues, 99% of acute medicine and emergency surgical activity would continue to be*

managed at Weston General Hospital compared to currently commissioned services".

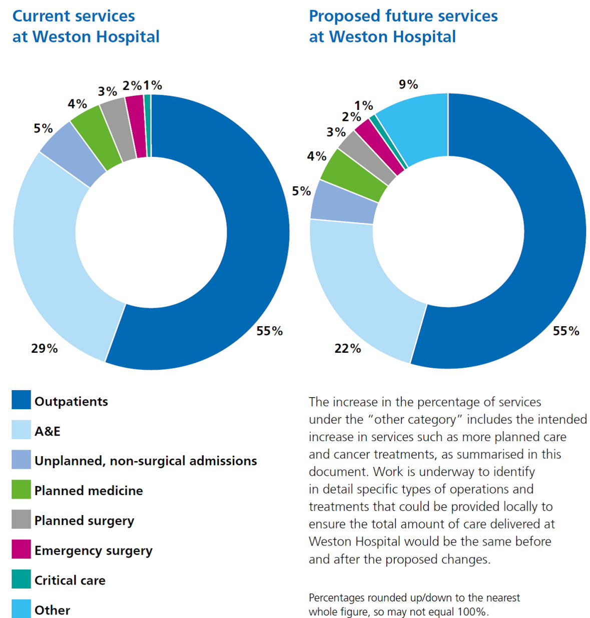
The above statement declares that 80% of A&E visits for major issues would continue to be managed at WGH. However from the above table it can be seen under *'A&E majors'* that actually only 59%, 5,599 / 9,466, of present commissioned numbers would be retained at WGH. If the number of new frailty patients is included then this percentage rises to 64% (5,599 + 464) / 9,466.

Considering acute medicine and emergency surgery then the number of retained patients would be 87% and 83% respectively. The percentages declared in the above statement are only achieved by the inclusion of new frailty patient numbers.

However these percentages hide the number of patients actually affected by the proposals. Consider again A&E majors. The number of patients affected annually would be 4,331 (9,466-5,599 + 464) which is equivalent to 56% of patients presently being treated (temporary overnight closure in place) or 46% of commissioned services.

Looking at the A&E in total then the current proposals would affect a predicted 15,266 patients, which is equivalent to 33% of patients presently being treated or 27% of commissioned services.

Within the HWC Document[10] (page 45) the changes to services at WGH due to the Consultation proposals are identified in the pie charts (inserted below). These changes to services relate to the patient numbers shown within Table 13, page 89 of the PCBC, shown above.



[10] https://bnssghealthiertogether.org.uk/healthyweston/healthy-weston-consultation-document/

The pie chart on the left is entitled '*Current Services'*. This would imply that this chart represents services with the current temporary overnight closure in place. This is not the case as this chart represents commissioned services, the services WAHT are commissioned by the CCG to provide.

With respect to the current commissioned services (left hand chart) the percentage of outpatients would be 55%, (108,171 / 195,894), as shown above. The percentage of A&E (total) would be 29%, (56,626 / 195,894), also as shown above.

Applying the same logic to the right hand pie chart, future services the percentage of outpatients would be 59%, 108,171 / (179,249+3,128) which includes the new frailty patients. The percentage of A&E (total) would be 24%, (42,892+1,532) / (179,249+3,128), which also includes the new frailty patient numbers. These percentages do not agree with the future services chart.

Whilst challenging the numbers presented may seem petty if, as we believe, the represented figures are erroneous then the information they attempt to convey loses its value.

Questions to BNSSG CCG

1. Please confirm how the chart labelled *Proposed Future Services at Weston Hospital* was generated?

5. Travel Issues for A&E Patients and their Families

We know that care for *some* life threatening conditions has been transformed in recent years. For some cardiac conditions, for strokes, and for major trauma, there is an evidence base that patient outcomes are better if patients access specialist care. (This is a minority of patients typically accessing Emergency Departments). For other conditions, access to emergency care is important, but specialist care much less so. For example, for haemorrhage, poisoning, anaphylactic shock, acute asthma attack, choking, or drowning, the key issue is speed, not specialism. This is an argument for bypassing the local A&E when a patient will benefit from specialist care, but it is a very poor justification for closing down A&Es.

A 2007 Sheffield University study[11] is the most important piece of UK research on the relationship between journey length and mortality. This large scale study looked at survival rates for patients with life threatening conditions, relating this to the straight-line distance between home and hospital. For patients travelling up to 10 km, the overall mortality rate was 5.8%. For those travelling 11 to 20 km, 7.7% died. For people travelling 21 km or more, 8.8% died. The 'absolute risk' of death increased by around 1% for each additional 10 km travelled, but relative risk shows the pattern more clearly. Overall, people who travelled more than 20 km to access treatment were 50% more likely to die than those living close to the hospital. Those with acute respiratory conditions fared even worse, and were around twice as likely to die if they had to travel the longer distance to access A&E.

The distances that Weston patients could have to travel for A&E treatment is included in *Appendix C Table 5* below.

More recent research confirms the pattern. A 2013 Japanese study[12] looked at distance to hospital for patients with acute heart attacks, strokes and pneumonia – a sub-set of the conditions examined by the Sheffield study. The study found a strong correlation between transport distance and mortality for acute heart attack and for ischaemic stroke; and a moderate correlation between distance and mortality for pneumonia and for subarachnoid haemorrhage.

A 2014 York University analysis[13] of Swedish data compared survival rates from myocardial infarction for people having to travel different distances to emergency care. The author concluded:

> *The results show a clear and gradually declining probability of surviving an acute myocardial infarction as residential distance from an emergency room increases*.

---

[11] Nicholl J, West J, Goodacre S, Turner J (2007). The relationship between distance to hospital and patient mortality in emergencies: an observational study. Emerg Med J. 2007 Sep;24(9):665-8. 2007

[12] Atsuhiko Murata, A; Matsuda, S (2013). Association Between Ambulance Distance to Hospitals and Mortality from Acute Diseases in Japan: National Database Analysis. J Public Health Mgt Practice, 2013, 19(5), E23-28. 2013

[13] https://www.york.ac.uk/media/economics/documents/hedg/workingpapers/1418.pdf

People travelling 50 to 60 km to emergency care were 15% less likely to survive than those living close to the hospital. Most of the excess deaths were of people dying on the way to hospital. The author also noted an inherent bias in much medical research, as studies typically look only at outcomes for people who arrive alive at hospital. Those who die on the way are excluded. Most research also takes place in urban areas, with little research on the impact on survival of people from rural areas and/or long journey distance. The few studies that do exist generally support the case that longer journeys to A&E result in higher rates of mortality.

There is evidence from the USA of Emergency Department closures[14] having a strong 'ripple effect', with mortality increasing by 5% for patients at neighbouring Emergency Departments that remained open. Existing facilities can easily be overwhelmed by increased demand. A strong and growing body of anecdotal UK evidence is of severe pressure on the A&Es that remain following the closure of a neighbouring unit.

Finally, another study by the University of Sheffield reviewing the closure of five Emergency Departments between 2009 and 2011 demonstrated that the case fatality ratio for emergency conditions increased by 2.3% in the areas affected by A&E closures or downgrades.[15] In the BMJ review of the study, one of the co-authors, Jon Nicholl, is quoted as saying:

> *We didn't find the better outcomes for patients that planners hoped to see from closing these small departments. This means it isn't clear that the disruption and anxiety that can be caused by closing emergency departments is worthwhile.*

Details of the distances to be travelled by patients in km from each of the 16 GP practices included in the CCG's statistics to each of the 4 hospitals – WGH, Southmead, the BRI and Musgrove Park – can be found below *Appendix C, Table 5*. These distances are included in order for patients to judge the impact on their mortality chances if they have to travel to a hospital other than WGH.

Appendix C Table 4 below challenges the CCG's statement that:

> *80% of the catchment population can currently access a hospital within 24 minutes at peak times and 21 minutes at off-peak times."*

---

14 Charles Liu, C; Srebotnjak, T; Hsia, R Y (2014). California Emergency Department Closures Are Associated With Increased Inpatient Mortality At Nearby Hospitals. Health Affairs, 33, no.8 (2014):1323-1329

15 Knowles. E et al. Closing five Emergency Departments in England between 2009 and 2011: the closED controlled interrupted time-series analysis. NIHR website. August 2018

By using 100% data we have shown the average time is actually 33 minutes. Furthermore we note that in a June 4th document published by the CCG[16] that:

The CCG commissioned South Western Ambulance Service NHS Foundation Trust (SWASFT) to undertake an audit of a sample of patients who were conveyed to UH Bristol from the Weston area overnight as a result of the temporary overnight closure of Weston General. The aim of the audit was to understand if the increased travel times impacted on clinical outcomes, and to review the clinical safety of travel times for the proposed Healthy Weston model, which proposes making the temporary overnight closure permanent. The audit was undertaken a SWASFT Paramedic and Clinical Lead and a Consultant in Emergency medicine.

A total of 50 attendances were reviewed, evenly distributed across varying lengths of stay. The review concluded that increased travel times as a result of the Temporary Overnight Closure did not have any adverse impact on clinical outcomes for any of the attendances reviewed. Where required, appropriate interventions were initiated by the attending Ambulance Clinicians, stabilising patients prior to further treatment in hospital.

We would point out that a study involving 50 journeys – out of what we assume to be an annual overnight total of 3,291 - plus additional conveyances (above commissioned model) due to preferred model of 1,637[17] - carries less statistical weight in comparison with the many thousands of journeys included in the studies quoted above. For instance the study referred to in Footnote 13 states that:

We undertook an observational cohort study of 10,315 cases transported with a potentially life-threatening condition (excluding cardiac arrests) by four English ambulance services to associated acute hospitals, to determine whether distance to hospital was associated with mortality, after adjustment for age, sex, clinical category and illness severity.

We conclude that the CCG is choosing to ignore the implications of the major surveys carried out across the world that have investigated the impact of the increased risk of mortality due to longer ambulance journey times.

Transport Costs Raised by the Proposed A&E Downgrade

People are rightly concerned about the implications for themselves or their loved ones if their access to life saving treatment is reduced. These concerns cannot be dismissed as emotional, and as not really affecting people much because it is just about ambulance journeys. We reject this. The fears are well founded, and there is an evidence base for them. And of course visitors play an important role in recovery, rehabilitation and

16 https://bnssgccg-media.ams3.cdn.digitaloceanspaces.com/attachments/govbody_4Jun19_Item6.5.pdf

17 Pre Consultation Business Case Page 92, Table 14

reassurance of family members or friends who are in hospital. Public transport is expensive, patchy, and sometimes simply not there at all.

We would point out, further, that many people living in Weston, particularly those in Central and South wards, are poor[18] with one part of South ward being in the top 1% areas of deprivation in the country[19]. This means those people will have a great deal of difficulty paying for taxis, buses or trains to visit their relatives in a Bristol or Taunton hospital, or, indeed, to get back to Weston late at night.

Weston itself has a disproportionately high number of people with learning disabilities, physical disabilities, mental health problems, drug and alcohol problems. These vulnerable groups will be particularly badly impacted by the HW proposals and again many of these people and their friends and relatives will not have the financial means to get a taxi back to Weston at 2 in the morning.

We note that these are serious equalities issues and their resolution should be central to any plans relating to the downgrading of our hospital or the closure of any of its key services.

We know that cost savings are paramount to the CCG, but in Table 14 (page 92) of the Pre-Consultation Business Case we find that due to the proposals under the present consultation there will be 4,928 A&E Major transfers annually compared to when the 24/7 A&E was in operation prior to the Temporary Overnight Closure (first row 1,637 + 3,291 = 4,928). (On page 91 the definition of an A&E major is defined as people with the most serious or life-threatening conditions).

Table 13 of the Pre-Consultation Business Case (page 89), shows for 2018 / 2019 A&E major patients (normalised to commissioned model) at a figure of 9,466. So Stage 1 of the BNSSG CCG proposals - which will come into effect in October 2019 - will see 52% (4,928 / 9,466) of A&E majors transferred and Stage 2 - when acute services are to be reduced to an urgent treatment centre - would see 100% being transferred. As the cost of an ambulance transfer is calculated at £450 per return journey,[20] the total cost of additional ambulance transfers in Stage 1 will amount to £1,800,000 per year for Stage One of the new model. The total damage to the environment is not mentioned!

The recent report in an article in The Bristol Post[21] of the closure of up to three Ambulance Stations in Bristol and the rumour of the Weston-super-Mare station also closing can only lead to greater concern about the safety of seriously ill patients from the county town who have to travel to neighbouring hospitals for emergency treatment.

---

18 https://www.thewestonmercury.co.uk/news/up-to-40-per-cent-live-in-poverty-in-weston-super-mare-1-4895568

19 https://quartetcf.org.uk/wp-content/uploads/2015/05/north-somerset-area-profile-final.pdf

20 Healthy Weston Travel Meeting (NHS Bristol, North Somerset and South Gloucestershire CCG), Thursday 14th March, Learning Space, Weston Museum

21 https://www.bristolpost.co.uk/news/bristol-news/shock-ambulance-station-closures-leave-2919612

Questions to BNSSG CCG

1. Please confirm that a full equalities analysis has been carried out in relation to the poverty issues facing many people in Central and South wards of Weston-super-Mare.

2. If such an analysis has been carried out then please confirm whether free transport will be available for patients and relatives having to travel to Bristol or Taunton and that such transport will be available without long delays and at all times of the day or night.

3. Is the CCG satisfied that a sample of 50 ambulance journeys is sufficiently robust on which to base their claim that increased travel times as a result of the Temporary Overnight Closure did not have any adverse impact on clinical outcomes?

4. Is the CCG able to confirm or deny the rumours about the possible closure of Weston's Ambulance Station?

5. Please confirm whether or not an environmental impact study has been carried out due to the increased ambulance journeys up and down the M5.

6. The Proposed Changes to A&E in WGH

Page 26 of the Healthy Weston Consultation addresses the document's key issues. Most important to us is this:

> **Description of the three specific changes we are proposing to the way that services are delivered in Weston Hospital.**

1 A&E and urgent care

There would continue to be urgent and emergency care provided locally 24-hours a day, seven days a week, but the services would be organised in a different way.

We are proposing to:

- Make the current temporary changes to A&E opening hours permanent. A&E at Weston Hospital would be open from 8am to 10pm, seven days a week.
- Add GPs to the A&E department team.
- Improve the process for GPs (and potentially paramedics) to be able to directly admit patients into a hospital bed when urgent and emergency care is required 24-hours a day.

From where, we would like to know, does the BNSSG CCG believe it is going to recruit GPs to carry out this work? In February 2019, the British Medical Journal carried an article entitled **GP Shortage Threatens Long Term Plan**. The article quotes *The Health Foundation Report* on staff shortages:

> *The number of GPs in England fell by 1.6% (450 full time equivalent staff) in the year to September 2018, the report said, despite ministers' pledge to recruit 5,000 extra by 2020.*
>
> *The report also highlighted the continuing decline in numbers of community nurses and health visitors, falling by 1.2% (540 FTE staff) in the year to July 2018. It noted slow progress in mental health recruitment. Psychiatrists saw the smallest percentage increase (0.6% or 50 FTE) among doctors, and numbers of mental health nurses rose by less than 0.5% (170 FTE) in the same period.*
>
> *The importance of international recruitment was being hampered by broader migration policies and Brexit uncertainties, the report said. Although the number of doctors from other EU countries had risen by 5.5% since 2016, recruitment of EU qualified nurses and midwives had fallen respectively by 8.5% and 3.1%.*

Shifting care out of hospitals and closer to people's homes was identified as a priority in the Long Term Plan, published in January. But Anita Charlesworth, a director at the Health Foundation, stated that:

> *"If [the NHS] can't recruit and retain more professionals in primary, mental health, and community care, this will continue to be an unrealised aspiration. There is no sign that the long term downward trend for key staff groups, most notably GPs, will be reversed."*[22]

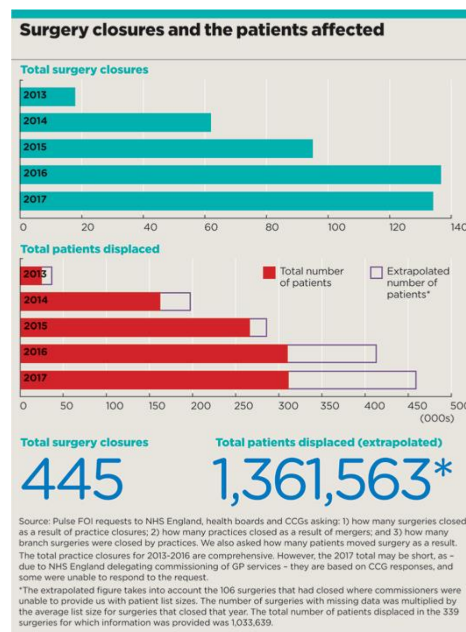
The same casual assumption that GPs could be found to support their model is made again and again on pages 27 and 29 of the HWC Consultation document.

> *It is sometimes difficult to recruit GPs, so we will have to ensure we make the opportunities to work in the Weston area as attractive as possible, and make it clear what the advantages and professional benefits are for GPs.*

Indeed, included in the response to our FOI request *(see Note 2 on page 6 above)* was the statement that:

> *50 per cent of [GP] job vacancies are unfilled after a year. Weston and Worle is also in danger of losing GPs to retirement as half the GPs in the locality are more than 55 years old.*

This has been emphasised with even greater clarity and urgency by the recent TV and newspaper headlines based on the story in the GP journal, Pulse,[23] on the acceleration of the closure of GP surgeries over the last five years.



---

[22] https://www.bmj.com/bmj/section-pdf/992037?path=/bmj/364/8187/This_Week.full.pdf

[23] http://www.pulsetoday.co.uk/news/hot-topics/stop-practice-closures/revealed-450-gp-surgeries-have-closed-in-the-last-five-years/20036793.article

It is our belief that the proposed merger with University Hospitals Trust, Bristol (UHBT), scheduled to take place in October 2019 and the installation of a proper system of medical staff rotation between the hospitals would mitigate the issues of recruiting junior doctors and other staff and make far more sense than trying to pretend that doctors who have chosen to become GPs would find "*advantages and professional benefits*" of working nights in a part time A&E department without proper support.

We must emphasise that we support centralisation of specialist services **where this is evidence-based**; we oppose it when it is about organisational convenience and cost cutting, but will harm patients. We support, therefore, a future for our A&E, and for WGH to continue as a District General Hospital offering acute and planned care.

It is clear that the consultants at WGH had been so deeply concerned about the proposals included in the HWC that they had come up with their own plan that would ensure the maintenance of a 24/7 A&E at WGH. A meeting was held prior to local council elections, to which the CCG, Consultant doctors and the MP were invited. The aim was not only to discuss the consultants proposed model, but also to give the public the opportunity to ask questions about the current consultation. Whilst this was an informative meeting the CCG declined to attend at the last minute. Doctors confirmed that the CCG's long term plans would lead to closure of acute services at WGH leaving only an Urgent Treatment Centre. The plans would include the closure of 24 hour A&E services, the ending of emergency surgery as well as enhanced (intensive) care.

They stated that the downgrade of the hospital would impact plans for WGH to develop plans as a provider of planned elective surgery such as Hip and Knee replacements, similar to services provided by The Spire Hospital and Emerson's Green Hospital in Bristol. The Consultants confirmed that by not having enhanced care beds available in the event of post-operative complications there could be an impact on patient choice. The travel time to the nearest A&E department from Emerson's Green or The Spire Hospital, both of which are based in Bristol, is significantly quicker than patients needing to be transferred to acute care services from WGH.

They pointed out that around thirty small hospitals (non-trauma Centres) across the country are already struggling with the current, conventional ED model.

We recognise the historical difficulties faced by hospitals like WGH which include financial, staffing and safety issues, but however difficult the conventional approach may appear to be, the public wants, needs and deserves a 24/7 Emergency Department operating in our county town. Such an innovative approach, the consultants point out, could also be a trendsetter for other small trusts.

We note[24] that The Clinical Design and Delivery Group met in May 2019 to review the Consultants' Proposal. They stated that:

> *This clinical evaluation was an important step in the process ahead of receiving feedback from the public consultation. Final evaluation work will take place in July 2019 follow* [sic] *receipt of the independent report on the findings of the public consultation.*

They go on to say:

> *There were a number of elements of the Alternative Model that improve the Consultation Model – for example the integration of A&E front door team with medical, surgical and trauma & orthopaedic teams, which is not detailed in the consultation proposals.*

Questions to BNSSG CCG

1. Before the new model is finalised and agreed may we see the details as to why the Consultants' Proposal was rejected / amended?

2. How can the public consultation be completed without such a vitally important part of this process being included?

3. Are the CCG confident that under the circumstances referred to above by the consultants that patients would choose WGH over Bristol hospitals?

4. Please confirm the cost of the independent report into the findings of the public consultation and the make-up of the team carrying out the work.

[24] https://bnssgccg-media.ams3.cdn.digitaloceanspaces.com/attachments/govbody_4Jun19_Item6.5.pdf

7. Expanding Weston General Hospital to Meet the Needs of an Expanding Community

It is our opinion that this proposed (first-stage) reduction in clinical services will result eventually in WGH becoming a geriatric hospital or cottage hospital with only an Urgent Treatment Centre (UTC) for walk-in patients during daytime hours alongside some outpatient services. The proposed closures and relocation of other services will mean that the people of Weston, North Somerset and surrounding areas will increasingly have to travel either to Taunton or Bristol hospitals for treatments. This, as we have stated above, exacerbates the problems already faced by the other three hospitals.

The Bristol Royal Infirmary (UHBT) hospital site – the nearest hospital to Weston-super-Mare[25] - is already over developed. There is little room for future expansion and the entire hospital is on hilly terrain and in the centre of a very busy city. It is, of course, close to Bristol Bus Station (at the bottom of the hill) but is 1.6 miles from Bristol Temple Meads train station and although buses are regular, the heavy traffic, for which Bristol is infamous, makes this a slow journey. The motorway between Weston and Bristol is regularly closed by accidents, incidents and repairs and in rush hours and Friday afternoons / evenings is almost stationery. This, of course, leads to concomitant major congestion on roads like the A370 leading to Bristol. Neither of these facts is helpful for the elderly, infirm or injured negotiating hilly terrain nor for people travelling from Weston town and surrounding areas to the Bristol Royal Infirmary (BRI).

Further to the above, there is very limited parking at the BRI and once / if parked, steps and hilly terrain have to be negotiated to get into the hospital. Free hospital bus services are wholly inadequate and one of our campaign group recently witnessed an elderly wheelchair bound man in the BRI Oncology waiting room who had been waiting for six hours just to get hospital arranged transport home.

Weston General Hospital however has substantial virgin land surrounding its existing buildings. On the 20th March 2019 one of our campaigners checked with the Land Registry and through an FOI request to the WAHT was able to confirm that the land on which WGH is built and the virgin land to the north of the existing buildings, which is ripe for development, is known as Title Deeds AV211906. The additional land is the same profile size as the existing hospital buildings and it is clear that a new building the same size as the existing hospital could be built there. This would imply that WGH could easily expand by some 250 beds and provide more space for outpatient and other services. A significant advantage over the BRI is that all this land at Weston General is on flat terrain.

A threat to the realisation of such a proposal is the Naylor Review[26] published in March 2017 and welcomed by Theresa May's government as assisting in a solution to the future

[25] WGH to the BRI = 23.6 miles. WGH to Musgrove Park, Taunton = 27.8 miles. WGH to Southmead Hospital = 26.7 miles

[26] https://www.gov.uk/government/publications/nhs-property-and-estates-naylor-review

funding of the NHS. The Review proposes the sale of up to £5.7 billion-worth of NHS land and buildings. The government plans that property developers will handle sales – and share the receipts. As well as empty sites, the Government plans to sell 'inefficiently used' buildings. This will then rented back to the NHS. Although the Review appeared to concentrate most on London sites and GP practices there would, obviously, be a benefit to WAHT if they could sell the surplus land behind WGH.

We believe this would be a short sighted mistake.

WGH could be re-designated as a hospital suitable for future development and enlargement. It would be a hospital that would bring more clinical services, better services and therefore more medical staff to the town. This would cater for the rising population of North Somerset outlined above in Section 2.

Questions to BNSSG CCG

1. Does the CCG know of any proposals or plans to sell off the land adjacent to WGH?

8. Conclusions

Our campaign team is not inexperienced. It comprises business people, social work and NHS managers, doctors, engineers, journalists and union officers. Our first meeting was held in 2012 directly after the Lansley proposals were revealed and we have campaigned in North Somerset against threats to privatise or downgrade Weston General Hospital and to retain a fully operational A&E department in our County Town.

Our overall conclusion is that there are a series of unchallenged assumptions made throughout the Healthy Weston Consultation Document which are then addressed through previously accepted or already adopted and implemented answers. As a piece of evidence based research it is, therefore, flawed. Furthermore it ignores a key issue: that the NHS and Social Care have been massively underfunded for the last ten years. According to The King's Fund:

> *The Department of Health budget will grow by 1.2 per cent in real terms between 2009/10 and 2020/21. This is far below the long-term average increases in health spending of approximately 4 per cent a year (above inflation) since the NHS was established and the rate of increase needed based on projections by the Office of Budget Responsibility (4.3 per cent a year).*[27]

We neither intend nor need to say anything further on this subject as every independent authority has reached the same conclusion.

We recognise that questions of government funding fall outside the remit of the BNSSG CCG managers who have produced the HWC, but this in no way invalidates our conclusion that they are failing in their duty to the staff of the NHS, to its patients and to the public and is in breach of its duty of care to maintain the NHS as a body providing care for all, free at the point of need. The CCG appears to have forgotten that, in the words of Aneurin Bevan:

> *not only is it available to the whole population freely, but it is intended . . . to generalise the best health advice and treatment.*

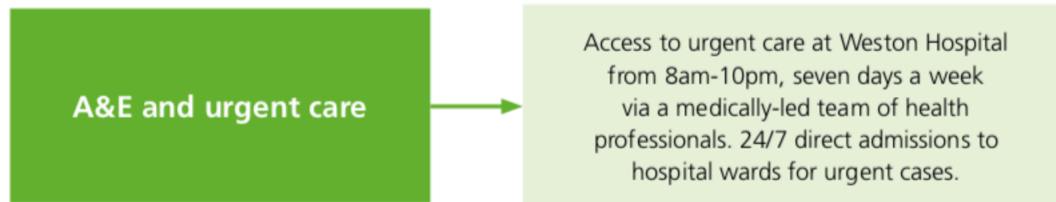
Given the data on population ageing and emergency admission rates for the over 85s, plus the general growth in population, we believe it is inconceivable that there will be a reduction in the deficit on current levels of funding. The fundamental lack of plausibility of this document is its attempt to demonstrate the feasibility of a deficit reduction despite consistent underfunding and its desire to make the figures fit this narrative.

BNSSG CCG's plans for Weston General Hospital are in two stages. Stage One, due to be implemented in October 2019, confirms what we all knew from the minute of the announcement and that is that the "temporary" overnight closure of A&E in WGH is now

[27] https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/nhs-budget

permanent. As one consultant at the hospital made clear in an e mail to us, he had not known of any "temporary" closure in the NHS ever being reversed.

Stage Two will look like this.[28]



Note the wording: *A&E and urgent care* in the left hand box becomes *urgent care* in the right hand box. And note the lack of guarantee as to what kind of leadership will be in place - it will be *via a medically-led team of health professionals* - what a relief to all those of us who had been expecting it to be run by a team of circus acrobats.

As we have seen in Sections 2 and 3 of this Response, the CCG's case contains what we believe to be statistical errors. It is not evidence based – viz the catchment area for the hospital being limited to 16 GP practices, and the recruitment of nurses and GPs - and will not save the kind of money that it claims will result from its changes.

We believe that the proposed merger with University Hospitals Trust, Bristol (UHBT) - scheduled originally to take place in October 2019 and now delayed until April 2020 - and a proper system of medical staff rotation between the hospitals would mitigate the issues of recruiting junior doctors and other staff and make far more sense than trying to pretend that doctors who have chosen to become GPs would find "*advantages and professional benefits*" in working nights at a part time A&E department without proper support.

Finally and most importantly, we believe that Weston General should not be allowed to wither and die due to short sighted cost cutting measures. As we stated in Section 7, Weston-super-Mare is an ideal location for the expansion of hospital services. Unlike Bristol's BRI it has room (on level ground) to expand by a further 250 beds and provide clinical services fit for the future.

We have been underwhelmed by the Public Consultation carried out by the CCG. Evening meetings in different towns and advertisements in local papers are scarcely a proper way of interacting with the population of North Somerset. We believe that some of the money spent (wasted?) on consultancy could and should have been better spent on posting clear and simple information to residents' houses at key points in the consultation

[28] healthy_weston_consultation_document.pdf. Page 59.

period together with information regarding the response from residents to the proposed changes to our hospital.

During the 2 years the temporary overnight closure of A&E has been in force the demand for its services has increased year on year. The BRI, Southmead and Musgrove Park hospitals have also faced similar unprecedented demand. BNSSG hospitals have been unable to maintain the four-hour waiting time target imposed as a standard on the NHS and have dropped below the national average for this metric. There have also been increases in hospital admissions across all BNSSG hospitals. It was noted at the recent June board meeting of WAHT at WGH that a lot of work needs to take place to understand the reasons for these increases, which appeared to be different for each trust.

Also the number of patients being repatriated from other hospitals to WGH to complete their recovery closer to their home and families is still only in single figures each week. In June WAHT closed its 'overflow ward'. This needed to be opened again after only 12 hours as demand escalated. It was agreed at the board meeting that this was disruptive for staff, but they would nevertheless, attempt to close the ward whenever possible. As part of the HW program there are plans to create a pathway for health professionals to be able to admit patients directly into hospital without going via A&E. This is likely to increase admissions further.

The CCG's plans for implementing the Healthy Weston programme at WGH should by now have seen the recruitment of GPs to staff the proposed Consultant / GP led A&E. These GPs should by now be at the stage of being inducted into their new roles. The board confirmed at their meeting on 4th June 2019 that no GPs had been recruited and as yet there is no model in place to form the basis of any inductions. There is also an acknowledgement that during the 2 years the overnight closure has been in place there has been little to no feedback - from hospitals or the ambulance services - about patient experience. This is a gap in learning for the health service which could have provided valuable information for future modelling and impact assessments.

The Ambulance Service has recently announced significant changes to their organisation including the closure of several ambulance stations within BNSSG area. Weston-super-Mare station is rumoured to be on the list of closures. This further increases concerns for North Somerset residents about transparency and honesty within the consultation process. Was the CCG not aware of these plans? If not, why not? It doesn't build confidence in the need for close integrated services. How will this impact North Somerset residents?

It was stated at the start of the temporary overnight closure of the A&E that it was not about money, but solely about staffing issues and patient safety.

The consultation documents and public meetings have failed to inform the vast majority of the affected population by the CCG's proposals what they actually are. Putting articles in the local press is an inadequate means of informing the public when distribution is less than 10,000 copies. The two stage phased consultation process, of which the present consultation forms an initial temporary holding position before more drastic plans to cut

services are announced, seems bent on confusing people about the full plans to end acute care services. The document is not plain, neither is it transparent. It is more suited for medical and health professionals, and even then is contradictory in its data. It is too long and seems designed to discourage people from reading it.

The document notes that there are many recruitment challenges facing the Health Service across various professional roles. This is more than a challenge. It is a reality! Healthy Weston appears to be swapping one recruitment and safety issue for another - ED consultants for GPs.

What is clear is that the lengthy 2 phase consultation process creates uncertainty for experienced doctors and nurses in acute care in WGH and is counterproductive in any recruitment campaigns. Assurances from the CCG that 'no decisions have yet been made' are empty. It is clear to those that have persevered in reading the lengthy documentation fully, that without the full implementation of the phased changes to WGH acute services the hospital will fail to meet the financial targets set by the CCG.

The hospital continues to recruit nurses and doctors for A&E as at present this is what the CCG commissions WAHT to do. They have made good progress in meeting these requirements. However, what professional would apply to a hospital with an uncertain future in its acute service? A better approach would be to form a cross-hospital working site for professionals to maintain a fully functioning hospital in Weston, to build a sustainable service for the future. WAHT were close to ending the overnight closure early in the New Year and there is evidence that it is not impossible to recruit the required staff. *If, as they have stated, this is not about money then a secure future for WGH and its acute services would enable more progress with recruiting to acute services.*

It seems that many plans are still aspirational and that there is still much modelling to be done. There are more questions than answers in HWC.

Questions to BNSSG CCG

1. Please provide details of the public response to the Healthy Weston Consultation and provide evidence of the claim that 2,500 people who are supposed to have attended their public meetings?

2. How can the proposals in the HWC be taken seriously as the planning for the model is already missing its targets?

3. Why has the proposed merger with UHBT been delayed by six months?

4. Should not all the pieces be put in place for the new model before the consultation takes place as it impossible to tell, due to staffing issues, whether it is in any way feasible as stated in the HWC?

9. Appendices

Appendix A

GP Practices within North Somerset and North Sedgemoor

Shown below, are listed all the GP practices in the area of North Somerset and North Sedgemoor. Under a freedom of information request sent to WAHT the trust was asked which of the practices listed in Table 1 referred patients to WGH. Their reply was: "*All of the practices mentioned below can refer into WGH*".[29]

Table 1
GP Practices within North Somerset and North Sedgemoor

North Somerset

GP Surgery	Address	Locality	Postcode
Backwell And Nailsea Medical Group	15 West Town Road	Backwell	BS48 3HA
Banwell Surgery	Westfield Road	Banwell	BS24 6AD
Brockway Medical Centre	8 Brockway	Nailsea	BS48 1BZ
Care UK Clinical Services	Weston General Hospital, Grange Road	Weston-super-Mare	BS23 4TQ
Clarence Park Surgery	13 Clarence Road East	Weston-Super-Mare	BS23 4BP
Clevedon Riverside Group	Clevedon Medical Centre, Old Street	Clevedon	BS21 6DG
Graham Road Surgery	22 Graham Road	Weston-Super-Mare	BS23 1YA
Harbourside Family Practice	2 Haven View	Portishead	BS20 7QA
Heywood Family Practice	Lodway Gardens	Pill	BS20 0DL
Locality Health Centre	68 Lonsdale Avenue	Weston-super-Mare	BS23 3SJ
Locking Castle Medical Centre	Highlands Lane	Locking Castle	BS24 7DX
Locking Village Hall	The Village Hall	Locking	BS24 8AR
Long Ashton Surgery	55-57 Rayens Cross Road	Long Ashton	BS41 9DY
Longton Grove Surgery	168 Locking Road	Weston-super-Mare	BS23 3HQ
Nailsea Family Practice	Tower House Medical Centre, Stockway South	Nailsea	BS48 2XX
New Court Surgery	39 Boulevard	Weston-super-Mare	BS23 1PF
Portishead Medical Group	Victoria Square	Portishead	BS20 6AQ
Riverbank Medical Centre Δ	Walford Avenue	Worle	BS22 7YZ
St Georges Surgery Δ	135 Pastures Avenue	St Georges	BS22 7SB
Stafford Medical Group	4 Stafford Place	Weston-super-Mare	BS23 2QZ
Sunnyside Surgery	4 Sunnyside Road	Clevedon	BS21 7TA
The Cedars Surgery	87 New Bristol Road	Worle	BS22 6AJ
The Green Practice	Clevedon Medical Centre, Old Street	Clevedon	BS21 6DG
The Milton Surgery	232-234 Milton Road	Milton	BS22 8AG
The Village Surgery	Hill Road East	Worle	BS22 9HF
Tudor Lodge Surgery	3 Nithsdale Road	Weston-super-Mare	BS23 4JP
Winscombe and Banwell Family Practice	Hillyfields Way	Winscombe	BS25 1AF
Worle Health Centre	125 High Street	Worle	BS22 6HB
Wrington Vale Medical Practice Δ / **	Pudding Pie Lane Surgery	Langford	BS40 5EL
Yeo Vale Medical Practice Δ / **	155 Mendip Road	Yatton	BS49 4ER
Yeo Vale Medical Practice Δ / **	1 Station Road	Congresbury	BS49 5DY
North Sedgemoor			
Axbridhge and Wemore Medical Practice	The Surgery, Houlgate Way	Axbridge	BS26 2BJ
Brent Area Medical Centre, East Brent	Anvil House. Brent road	East Brent	TA9 4JD
Burnham and Berrow Medical Centre	Love Lane	Burnham-on-Sea	TA8 1EU
Cheddar Medical Centre	Roynon Way	Cheddar	BS27 3NZ
Highbridge Medical centre	Pepperall Rd	Highbridge	TA9 3YA

Δ These practices form part of the Mendip Vale Medical Group

** These practice (Congresbury, Langford and Yatton) form part of the Mendip Vale Medical Practice and appear as one practice in the catchment population data.

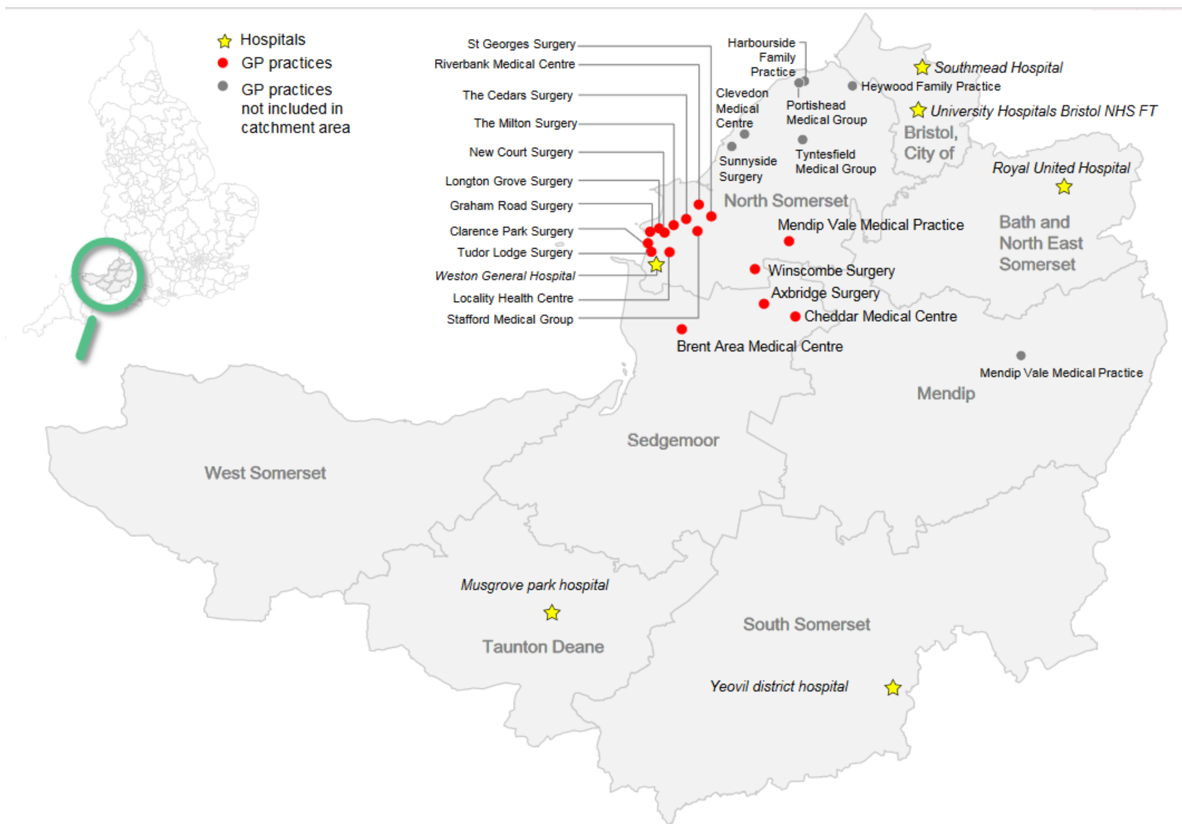
---

[29] WAHT FOI REF 3740 dated 07.03.19

Appendix B
Catchment Population of WGH

The CCG declares that the catchment population of WAHT is formed by the registered patients of 16 GP practices. These practices are shown on the diagram of Figure 1. In Table 2 the registered number of patients at each of the 16 GP practices are shown. The total number of patients from these 16 GP practices sum to approximately 152,000 (151,872).

Figure 1
Sixteen GP Practices the CCG Declare as forming the Catchment Population of WAHT



Shown above within Table 1 are all the GP practice in the area of North Somerset and North Sedgemoor. Those shown in blue form the catchment population of WGH as defined by the CCG. This identifies the people who actually use the hospital as being the patients registered at these practices. The GP practices shown in red are not included within the catchment population and as such their registered patients are deemed not to use WGH.

Table 2
Catchment Population of Weston General Hospital

	GP Practices	Number of patients
1	Mendip vale Medical Practice *	26095
2	The Cedars Sugery	15460
3	New Court Surgery	11934
4	Safford Medical Group	11600
5	Tudor Lodge Sugery	10174
6	Riverbank Medical Centre	9862
7	Winscombe Sugery	9470
8	The Milton Surgery	9052
9	Graham Road Surgery	8731
10	Axbridge Surgery	8724
11	Cheddar Medical Centre	7800
12	Longton Grove Surgery	7291
13	Locality Health Centre	5389
14	Clarance Park Surgery	4865
15	Brent Area Medical Centre	2781
16	St Georges Surgery	2644
	WGH Catchment Population =	**151872**

* Mendip Vale Medical Practice is made up of multiple sites - here St Georges Surgery and Riverbank Medicale Centre are shown separetly. However those of Langford (Wington Vale Medical Practice), Yatton and Congresbury (both called Yeo Vale Medical Practice) are shown together.

Page 73, Appendix 14[5]

The CCG's estimate of the catchment population ignores the following:

There are a total of 36 GP practices in the area known as North Somerset and North Sedgemoor, all of which can refer patients to WGH (WAHT FOI REF 3740 dated 07.03.19). The CCG only consider 16 of these and ignore patients referred by the remainder. (See above in Section 2, page 5)

As only the registered population of the above 16 GP practices are considered to from the catchment population of WGH this ignores '*out of town'* patients in the form of visitors and tourists.

Appendix C
Patient Travel – Private Car Distance / Time

An evaluation has been performed of the distance and time taken to travel by car from each of the 16 GP practices shown within Table 2 to each of the 4 hospitals of WGH, BRI, Southmead and Musgrove Park. The data is shown is point to point data based upon postcode.

It is assumed that the postcode of a GP practice forms the geographical centre of the registered patient catchment of the GP practice. Values are derived from *RAC Route Planner (https://www.rac.co.uk/route-planner / - based upon fastest route).*

These are average times and do not distinguish between 'peak' and 'off-peak' times.

Table 3. Private Car Travel Distance / Time

GP Surgery	Postcode	WGH BS23 4TQ		BRI BS2 8HW		Southmead BS10 5NB		Musgrove TA1 5DA	
		Milage miles	Time minutes	Milage miles	Time minutes	Milage miles	Time minutes	Milage miles	Time minutes
Clarence Park Surgery	**BS23 4BP**	1.60	5	23.68	43	26.42	39	28.94	44
Graham Road Surgery	**BS23 1YA**	2.41	6	23.35	42	26.09	38	29.73	45
Locality Health Centre	**BS23 3SJ**	2.06	6	23.12	43	25.86	39	29.38	45
Longton Grove Surgery	**BS23 3HQ**	2.47	8	22.34	40	25.07	36	29.81	46
New Court Surgery	**BS23 1PF**	2.59	8	23.11	42	25.85	38	29.90	47
Riverbank Medical Centre	**BS22 7YZ**	5.96	16	20.26	36	23.00	32	31.16	42
St Georges Surgery	**BS22 7SB**	5.44	14	19.74	35	22.48	31	30.64	41
Stafford Medical Group	**BS23 2QZ**	2.79	8	23.15	42	25.89	39	30.10	47
The Cedars Surgery	**BS22 6AJ**	4.19	11	20.30	36	23.04	32	31.20	42
The Milton Surgery	**BS22 8AG**	3.19	10	22.06	40	24.80	36	28.43	42
Tudor Lodge Surgery	**BS23 4JP**	1.11	3	23.75	44	26.49	40	28.43	42
Winscombe and Banwell Family Practice	**BS25 1AF**	6.97	16	17.35	37	27.10	40	29.47	45
Wrington Vale Medical Practice *	**BS40 5EL**	9.15	22	14.30	30	16.99	35	32.10	49
Axbridhge and Wemore Medical Practice	**BS26 2BJ**	11.04	18	19.14	39	21.83	44	27.92	41
Brent Area Medical Centre, East Brent	**TA9 4JD**	5.07	8	30.60	44	33.34	41	22.84	33
Cheddar Medical Centre	**BS27 3NZ**	13.61	24	19.43	41	22.12	46	30.49	47
	Average	**4.98**	**11.44**	**21.61**	**39.63**	**24.77**	**37.88**	**29.41**	**43.63**

* This Practice is also known as Mendip Vale Medical Practice and includes Congresbury and Yatton. Langford is chosen as it is the practice chossen by the CCG to represent this gropup of practices.

For each of the 4 hospitals the distances and times are shown as averages of all 16 practices at the bottom of Table 3. However these values are the normal averages of 16 separate journeys (one from each practice) to each of the 4 hospitals.

The GP practices all have differing numbers of registered patients as shown in Table 2. To account for this variation then weighted values are derived based upon the number of registered patients at each GP practices. This is achieved by factoring the values shown in Table 3 by the patient numbers shown in Table 2.

For each of the 4 hospitals the weighted values of the 16 GP practices are summed and then factored by the total catchment population (151872) to derive average weighted values for each hospital. This process is shown in Table 4. Note only times are shown for simplicity and that these are 100% values.

Table 4
Car Transport – GP Practices to Hospitals Average Weighted Travel Times

GP Surgery	Registered Patients	WGH	BRI	Southmead	Musgrove
		Time in minutes			
Clarence Park Surgery	4865	24325	209195	189735	214060
Graham Road Surgery	8731	52386	366702	331778	392895
Locality Health Centre	5389	32334	231727	210171	242505
Longton Grove Surgery	7291	58328	291640	262476	335386
New Court Surgery	11934	95472	501228	453492	560898
Riverbank Medical Centre	9862	157792	355032	315584	414204
St Georges Surgery	2644	37016	92540	81964	108404
Stafford Medical Group	11600	92800	487200	452400	545200
The Cedars Surgery	15460	170060	556560	494720	649320
The Milton Surgery	9052	90520	362080	325872	380184
Tudor Lodge Surgery	10174	30522	447656	406960	427308
Winscombe and Banwell Family Practice	9470	151520	350390	378800	426150
Wrington Vale Medical Practice	26095	574090	782850	913325	1278655
Axbridhge and Wemore Medical Practice	8724	157032	340236	383856	357684
Brent Area Medical Centre, East Brent	2781	22248	122364	114021	91773
Cheddar Medical Centre	7800	187200	319800	358800	366600
	Catchment Population	**Average Weighted time values**			
	151872	**12.7**	**38.3**	**37.4**	**44.7**

Table 4 shows the following average times taken for the catchment population to travel to:

WGH (Weston-super-Mare)	= 12.7 minutes
The BRI (Central Bristol)	= 38.3 minutes
Southmead (Filton, Bristol)	= 37.4 minutes
Musgrove Park (Taunton)	= 44.7 minutes
Average time to all four hospitals	**= 33.3 minutes**
Average time to BRI, Southmead and Musgrove Park	**= 40.1 minutes**

The above derived average travel times should be compared to the following statement made by the CCG (overnight closure of A&E applies between the hours of 2200 to 08:00).

> *"80% of the catchment population can currently access a hospital within 24 minutes at peak times and 21 minutes at off-peak times."* [30]
>
> .

[17] Healthy Weston. Pre-Consultation Business Case. Appendix 21. Patient Travel. Page 6.

If we only consider the BRI, Southmead and Musgrove then the average travel time becomes 40.1 minutes ($^{\{38.3 + 37.4 + 44.7\}} / _3$). This should be compared to the following statement made by the CCG.

> *"If patients cannot be treated at Weston and care is provided elsewhere, this rises to 41 minutes at peak times and 35 minutes at off-peak times".*

Table 5
Travel Distances (Km) – GP Surgeries to Hospitals

GP Surgery Included North Somerset Surgeries	WGH	BRI	Southmead	Musgrove
Clarence Park Surgery	2.57	38.11	42.52	46.57
Graham Road Surgery	3.88	37.58	41.99	47.85
Locality Health Centre	3.32	37.21	41.62	47.28
Longton Grove Surgery	3.98	35.95	40.35	47.97
New Court Surgery	4.17	37.19	41.60	48.12
Riverbank Medical Centre	9.59	32.61	37.01	50.15
St Georges Surgery	8.75	31.77	36.18	49.31
Stafford Medical Group	4.49	37.26	41.67	48.44
The Cedars Surgery	6.74	32.67	37.08	50.21
The Milton Surgery	5.13	35.50	39.91	45.75
Tudor Lodge Surgery	1.79	38.22	42.63	45.75
Winscombe and Banwell Family Practice	11.22	27.92	43.61	47.43
Wrington Vale Medical Practice	14.73	23.01	27.34	51.66
Axbridhge and Wemore Medical Practice	17.77	30.80	35.13	44.93
Brent Area Medical Centre, East Brent	8.16	49.25	53.66	36.76
Cheddar Medical Centre	21.90	31.27	35.60	49.07

Shown in Table 5 are point to point distances, measured in Kilometres, from each of the CCG defined catchment population GP practices to the hospitals of WGH, the Bristol hospitals of the BRI and Southmead and the Taunton hospital of Musgrove Park.

The distances given in miles shown in Table 3 have been factored by 1.60934 to convert distances into kilometres (km) to form the above table. This has been done so comparisons between hospitals can be made referring to the data within Section 6. For example, Clarence Park GP surgery to:

- WGH is 2.57 km
- BRI is 38.11 km
- Southmead is 42.52 km
- Musgrove Park is 46.57 km

Whilst the above distances do not give point to point distances from the readers own home to the four hospitals it is felt it will gives sufficient information where an individual can have a reasonable idea of these distances would be.

These distances must be viewed in light of the following statement regarding patients with life threatening conditions:

> *The 'absolute risk' of death increased by around 1% for each additional 10 km travelled, but relative risk shows the pattern more clearly. Overall, people who travelled more than 20 km to access treatment were 50% more likely to die than those living close to the hospital. Those with acute respiratory conditions fared even worse, and were around twice as likely to die if they had to travel the longer distance to access A&E.*

Appendix D

Questions Arising From
The Healthy Weston Pre-Consultation Business Case

Page 3
If these proposals are a substantial variation, please confirm the process whereby they will be reported to the Health Oversight Scrutiny Panel of North Somerset Council and then to the Secretary of State?

Page 11
It is stated that the themes from the public consultation will be independently analysed. Please inform us who will be doing that?

Page 18
The document claims that by delivering a more stable model for key acute services at WGH there will be an increased opportunity to attract and retain staff to work at the hospital. It is our contention that by launching this consultation and the proposals to downgrade the hospital they have made recruitment and retention worse.

Page 25
This outlines why the CCG believes things need to change: population, variation in access to and continuity of care, variation in the standards of care provided, it is essential to ensure value for money. We have already challenged evidence for all of these because of the population figures (Section 2 Page 5 above) and we believe that the case for change is actually a case for expansion.

Page 27
This refers to health inequalities, but there is no mention here of the costs of transport to go to other hospitals for the people living in poverty in Weston Central and South wards.

Page 31
Refers to people with urgent and emergency care needs and states that evidence suggests 35% of them could be equally well treated by other services including GPs. The argument is that more work needs to be done on explaining to patients when they need to seek emergency care. However is it not more likely that other services such as ‘out of hour’ GPs and 111 are not functioning properly?

Page 36
Elective surgical services. This is posited as an opportunity for WGH – but will people choose to go there for elective surgery, particularly if it doesn’t have 24/7 A&E?

Page 38
Sustainability and value for money. The WGH financial deficit is expected to increase to £16.6 million by 2025 – but it is apparent that pretty much every hospital across the country is in deficit, indicating that all are being underfunded! Why is this never stated?

Page 39
The NHS Long Term Plan – Healthy Weston proposals are apparently in line with this, specifically the national proposal to develop a standard model of delivery in smaller acute hospitals that serve rural populations – what does this amount to? All the NHS Long Term plan says is:

> *"1.32. We will develop a standard model of delivery in smaller acute hospitals who serve rural populations. Smaller hospitals have significant challenges around a number of areas including workforce and many of the national standards and policies were not appropriately tailored to meet their needs. We will work with trusts to develop a new operating model for these sorts of organisations, and how they work more effectively with other parts of the local healthcare system"*

So what is this precisely and has it even been developed?

Page 41
Contains the claim that this new GP partnership, along with the prospect for GPs working in A&E, will make it easier to recruit GPs – what is the evidence for this?

Page 42
Intensive Support Scheme funding for GPs in Weston – project's deliverables were supposed to happen by March 2019. What have the results been?

Page 42
A £3.2 million grant has been established to create a primary care centre in the centre of Weston. What is happening with this? When will it be up and running?

Page 51
There is reference to the creation of a virtual citizens panel that will take part in the consultation. At the end of 2018 there were 380 members, including 86 from North Somerset – who are these people and how were they selected?

Page 86 onwards…
The preferred option will deliver £5.3 million improvement in net income and expenditure with a £5.2 million capital investment. But they admit that the preferred option will not fully close the financial gap – presumably that will be further closed by moving to option 27b – complete downgrading. Please inform us why finance directors think this option is risky?

Page 87 onwards…

Describes impacts of preferred option, including on page 88 that the preferred option still does not address all safety issues. Why not?
Page 91
This describes the impact on travel, but only describes times and makes no mention of costs or environmental impact. Why not?

Page 93
This states that the Ambulance service is supportive of the preferred option. In the light of the recent closures and threats of Weston closure of ambulance stations, is this still the case?

Page 94
Although there have been no reported incidents in patient harm due to the temporary overnight closure, additional funding was provided to the ambulance service – how much was this?

Page 96
Describes public transport travel – there is no mention of cost, or the poor bus and train services, particularly overnight. Why not?

Page 97
Travel Working group – what have been the results of the work of this group?

Page 98
Workforce: Health Education England have expressed concerns about the training of doctors within the preferred option. The CCG agree it is a risk and that is why they think preferred option is a short term option to stabilise WGH but unlikely to be sustainable in the future. Does this not mean that it will become inevitable that the hospital will be further downgraded.

Page 98
Refers to a workforce plan being developed which should be completed by April 2019 – has this been done and can we see it?

Although the thinking is that the preferred option is the best one for the workforce, the risks are around greater reliance on GPs, including GP recruitment issues. What is happening with GP recruitment?

Page 103
Describes the enablers such as technology and clinical informatics, a more robust model of primary, community and social care integrated with a new frailty service, clear transfer arrangements for patients, coordinating the frailty offer for Somerset residents, and new governance arrangements. Should not all of these be in place before implementation?

Page 107

The Equality Impact Assessment, includes on page 108 the claim that the currently commissioned model results in a -40 score, whereas the preferred option results in a +3 score, but there is no detail as to how these figures were arrived at. However if you look at the actual equality impact assessment in Appendix 24, the scores are different. The current model gets -32.5, whereas the proposed option is -10.5. Again there is no detail as to how scores are worked out, but why are the scores different?

10. Glossary of Abbreviations

A&E	Accident and Emergency
BMA	British Medical Association
BMJ	British Medical Journal
BNSSG	Bristol, North Somerset and South Gloucester
BRI	Bristol Royal Infirmary
CCG	Clinical Commissioning Group
ED	Emergency Department
EU	European Union
FOI	Freedom of Information (request)
FTE	Full Time Equivalent
GE	General Electric
GP	General Practitioner
HWC	Healthy Weston Consultation
IT	Information Technology
km	Kilometre
N.B.	nota bene
NBT	North Bristol Trust
NHS	National Health Service
p.a.	per annum
PCBC	Healthy Weston Pre Consultation Business Case
T&S	Taunton and Somerset NHS Foundation Trust
UHBT	University Hospital Bristol NHS Foundation Trust
UK	United Kingdom
USA	United States of America
UTC	Urgent Treatment Centre
WAHT	Weston Area Health NHS Trust
WGH	Weston General Hospital