

Representing the NHS:

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DM: ... Director of Nursing and Project Manager for Seizing the Future.

DG: Thank you for that. We've also got members of staff from both the Foundation Trust and NHS County Durham who are around the room and will be actually helping with some of the discussions later on. We'll introduce them as we come to them. What I want to do is just welcome you first of all to what is a very important series of meetings, actually looking at some proposed changes from our colleagues at the Foundation Trust, which is under the banner of Seizing the Future. It's a formal consultation process and it's very much about the future use of their three main acute hospitals. While it looks at those hospitals it's making an assumption that other things will not change so that future use of the community hospitals will remain the same, community services will remain the same, other than from a commissioning point of view which is our role in all of this, we're very keen to actually develop more services out in the community, making better use of health centres, making better use of community centres and also of the community hospitals. It's really important that you're here today, it's really important that people have the chance to have their say and have input into the process and our key role in this is to make sure that that's actually what happens so while Ann and myself are here from the Primary Care Trust from NHS County Durham, our role is very much about the process and making sure that we can see that there's a robust process, people have their chance to have their input and those things are actually picked up as part of the process. I don't know if we can have the next slide up please Diane. Thank you.

In terms of roles and responsibilities, our role in NHS County Durham is very much about actually commissioning or buying services, so as the slide says there, there are different roles and responsibilities depending on which organisation we're looking at. Our key thing is that we want to improve health, we want to reduce health inequalities and, crucially for the discussion that we're having this afternoon, to make sure that the services that we buy on your behalf in County Durham and Darlington are safe, sound and sustainable and it's because of that role that we've got that we're actually leading this consultation process. Obviously County Durham and Darlington FT actually provide the hospital services that we're taking about in amongst a range of other providers who provide lots of different services but this consultation is specific to the hospitals and the services that they run for us.

The other sort of player in this is we've got a partner organisation called Proportion. Proportion are the people who are actually managing these events, they're running them for us, they're making sure that we record the parts of the events, they're working the PA and all sorts of things like that and they'll actually get involved with some of the discussion towards the end of the afternoon.

In terms of what we're trying to achieve this afternoon, the aims are up on the slide there, but it's very much about two way communication and that two way communication's important because when I put the Agenda up you'll see the different chances there are to have different parts of input into this, but the two way means that really it's a chance to have a listen to the presentation that's going to be made by my colleagues in the Foundation Trust, to understand the issues that they're grappling with and their proposals for solutions, it's then also a chance for us to listen very much to your views on those proposals and have we got them right. Are there things that need to be changed or whatever, so at the end of the day we come up with a good solution and I'll talk a little bit about that towards the end of the afternoon.

We need to be careful obviously that we need to listen to your views. We're recording the input as I said. When we come to ask questions and use the microphone, we'll ask you to actually identify yourself when you respond or when you give the question just so that we can have a record of who's actually said what in the meeting. And as the last part on the slide there says, when we come to the end we'll actually tell you what's going to happen next in terms of this process.

?: The speaker's working there now.

DG: It's working, good, OK. If anybody can't hear at any point if you just make some sort of appropriate signal we'll try and do something about that. OK. There are three parts to the Agenda really. I'm going to ask colleagues to make a presentation for half an hour, there's then an opportunity to have open questions from the floor and we'll co-ordinate that so hopefully everybody has a fair chance to have their say and put questions to the panel particularly about the presentation and the proposals that are being made, and then the latter part of the afternoon we'll actually break into probably two, maybe three groups and actually have some discussion around the tables which we'll facilitate ... and again there's a chance for you to have your say, but also to feed into the formal consultation process, and we'll guide you through that as we go, but I think at this point I'll actually hand over to Steven now and ask him to actually make a presentation for 30 minutes, just explaining what the Trust is proposing. Thank you Steven.

SE: Thank you David, and good afternoon everybody and thanks very much for giving us the time to come here and talk to you. I'm just going to set the presentation up with a few key messages and I'm going to hand over to Diane who, as you heard in the introduction, is one of the most senior nurses in the organisation and who has also been handling this project since its inception some 9 or 10 months ago. And then on to Bob, both of whom will cover key issues associated with the consultation, particularly the key clinical issues, so if I can just explain that's what we're going to do. If I could have my first slide? I see it's up there now.

Seizing the Future is a piece of work that's been going on for nearly a year now, a significant piece of work looking at the future predominantly of acute hospital services across County Durham and Darlington, but of course within that we're looking at the relationships between acute services and other health and social care services as well. The point I want to make right up front here is this whole programme of change that's being proposed in consultation is about improving quality of care and improving outcomes for our patients, that's specifically what this set of proposals is about and I hope we can set that out for you in some detail as we go through. Can I have the next slide please?

A few key messages from me. First of all, in support of what I've just been saying, the work that has been done has been led by our clinical staff, our doctors, our nurses, our therapists, and they've worked closely with our Governors and our members. As the Foundation Trust we have, as I'm sure you know, representatives of our local communities working with us so there's been a significant amount of work done over the last year, bringing us to the proposals that we want to outline here today. Secondly, we are driven by some national considerations. National considerations about how best to organise clinical services that, on the one hand, are focused on centralising where it's necessary to do so, centralising services where it's necessary to do so to ensure safe patient care but, on the other hand, delivering as much as we can in a local setting for all of our communities and therefore that moves me on to the next point which is, again, I think to get across, very importantly, that we offer services from five sites across County Durham and Darlington and these proposals are about developing services at each of those sites. Yes, we're proposing some changes about how things are organised, but we're looking to develop services and use and maximise the use of our facilities in these plans moving forward. And then I'd like to underline underneath that that therefore there are no hospital closures. There has been some coverage in the media that has suggested that, but there are no hospital closures at all. Quite the reverse, we're looking at developing and building our hospitals for the future. And finally, again, because I think some of this has been picked up in some of the commentary thus far, there are no redundancies. In fact we see these proposals as presenting significant opportunities for our staff in order to ... in working in new ways, in different ways, working between hospital and community in delivering healthcare services to the local population. Next slide please.

So the proposal in summary is ... is looking first at the three acute hospitals, we're looking to concentrate our main acute service at University Hospital North Durham and at Darlington and redevelop Bishop Auckland hospital as a centre of excellence for planned care. We also offer services from Shotley Bridge and here in Chester-le-Street and we see ... there are no changes proposed here other than we would expect, some growth, particularly through the commissioning plans that we're aware of from our Primary Care Trust colleagues in outpatients and diagnostic services as opportunities for that develop over the next year or two, so if I can just make that point about the two community hospitals. So the proposals really concentrate on how we organise our acute care across the three hospitals I mentioned.

How did we select the sites? Well I've mentioned that we've had this whole process going on for a year and underneath what we're talking about today there's a huge amount of detail and a huge amount of analysis, looking at all aspects from how activity might grow, the demographics, where those changes might be over the next few years, looking at other public health indicators, looking at the financial dynamics, looking at how the activity might flow in relation to what we propose, and I might just add, because we picked this up in earlier consultations, that whilst we can't cover all that detail in the presentation today, it is all available and a lot of it is on the Seizing the Future website and we're also quite happy to provide any of that information to anybody if they wish to see the detail. There's been a huge amount of analysis behind the clinical model that I've outlined. And what that told us is essentially it made sense to organise it in the way that I've described. If you look at it from the point of view of the clinical arguments to start with, we've had some external input, primarily from Professor Sir George Alberti, who as you may know is the national Tsar for emergency care and has been involved in many of these sorts of changes across the country and he felt very strongly that there was a clear logic to the way in which we're proposing our services from a clinical point of view. In addition we looked at the possibility of identifying Durham hospital or Darlington hospital as the centre for planned care, and what that told us if you just look at some of the financial analysis for example, that to do that at Durham would mean an investment of around about £120 million. To do that at Darlington would mean an investment of around £90 million. To do that under the proposals that we're making is in the order of around £7 million. So there's a significant financial case underpinning this, but I don't want to labour the finances. I come back to my point at the start of this consultation, this is about quality of care for the future. We also looked at the impact of these changes in terms of movement of the workforce, what that would mean and indeed movement of patients between sites in alternative configurations, and it's clear from that analysis that the choice and the geographic location of Bishop Auckland makes a lot of sense in that context as well.

So the last point I want to make before I hand over to Diane is it's important I think to recognise in the consultation that this is about the future of all of our services. We passionately believe that we need to make the changes that are being proposed so that we can sustain and develop all of our services in all of our hospitals and make them sustainable for the future, and with that I'll hand over to Diane to take us on to the next stage of the presentation.

DM: Thank you Steven. Just a quick run through really of the services that we're going to make changes to. This slide will ... tries to describe to you the changes that we're making at Bishop Auckland hospital, that are in our proposals, and we're talking really about Option B because we've said in the document that Option B is our preferred option. The Accident & Emergency department at Bishop Auckland currently is not what we would describe as a full Accident & Emergency department. It doesn't provide the same services as that that we provide at both Darlington and Durham currently. What it does take currently are medical emergencies, so that is patients with conditions such as heart attacks, chronic or acute respiratory problems, that type of thing, and it also takes minor injuries. It hasn't for quite some years now taken patients with acute surgical problems or trauma, major trauma, and probably a lot of you already know that. What we're proposing to do is to change that service to a 24-hour urgent care centre that's integrated with the services that the current GP services provide, working together. The net effect of that is that acute medical admissions would go to Darlington or Durham and something like two thirds of the patients that are currently treated at Bishop Auckland would continue to be treated there. There are 29,000 patients a year currently that are treated at Bishop Auckland and

in the proposals 20,000 of those would continue to be treated there. The types of things that they would continue to be treated for in a minor injuries unit are things like fractures of the lower limb, cuts and bruises including sort of severe cuts that need ... tendon injuries that need suturing, that kind of thing, we would be able to actually diagnose using X-ray facilities, but things like major head injuries, acute medical admissions, things that require the Blue Light ambulance, would actually go to one of the other two sites.

A service that we would add in is the medical rapid assessment service. Now we've talked about shifting acute medicine, what would happen here is that for patients who the GP has seen, many who are acutely ill obviously see their GP first, the GP would assess them and if they didn't think they necessarily needed an ambulance and an acute admission, then they could ask and refer the patient to go straight over to the Bishop Auckland site to be assessed by a senior member of the medical team that would be either a consultant or the consultant's registrar and they would be assessed within the space of a few hours by a senior member of the consultant team. They would be given a range of investigations, say X-rays, scanning, that type of thing, a diagnosis and a treatment plan and discharged to an appropriate service, whether that's back to the GP in the community or if necessary a transfer to an acute bed.

We have a midwifery led unit at Bishop Auckland, very well received by the ladies that use it, it has a very good reputation, no plans to change that. If anything we would want to extend the use of that and get more ladies from around the County going to that and experiencing the type of care that we provide there.

Acute paediatrics currently is provided on limited hours at Bishop Auckland, it's something like 9 o'clock in the morning till 9 o'clock in the evening as a consultant-led service. Overnight there is a facility to keep children overnight but not if they need medical intervention, only if the child can be managed by nurses. Increasingly there are very few children using the paediatric services, inpatient services at Bishop Auckland and the plan is to actually move acute paediatrics again to Darlington and Durham and put in a rapid assessment clinic similar to that that we would do for medical admissions but for children and that would be led by consultant paediatricians. All of the paediatrics, outpatients, and all that kind of thing would continue on the Bishop Auckland site.

There is currently some planned surgery happens at Bishop Auckland and the proposal is that we extend the amount of planned surgery that is done there. It would be the centre for day case surgery across the County, so a centre for day case surgery would include our hip and knee surgery unit which is again well established at Bishop Auckland, has a very good reputation, gives a very good patient experience. We have a colo-rectal screening centre at Bishop Auckland which is a Trust-wide service, that will stay there and I've already mentioned diagnostics and outpatients, a full range of diagnostics, that includes things like MRI scanning, CT scanning, ultrasounds, a full range of X-rays and diagnostics there, that will continue, and patients who don't need admission but just need the diagnostics would still be able to have all of those at their local hospital.

We have a critical care, kind of the other word for that is intensive care, and there is an intensive care unit on that site. Level 2 ... basically means ... there are three levels of intensive care, 1, 2 and 3, 3 being the highest level of care, so the most seriously ill, patients who need to be on a ventilator, yes, sort of artificial breathing, that kind of thing. Currently for the most seriously ill patients, the level 3 patients, they aren't managed on that site now, and those patients already are transferred to either Darlington or Bishop Auckland ... and that's for reasons, which Bob will pick up later on, but that's to do with our ability to provide appropriate levels of medical cover for those patients.

New services that we want to develop are a centre of rehabilitation excellence. I mean many of you will know that there are a large number of patients for, after conditions such as a stroke or elderly people who've had their hip replacement, that type of thing, there is a period of care where they need very very acute care, they need, you know, lots of medical intervention, lots of nursing intervention, but following on from that they actually don't need, you know, that kind of acute environment. They need to be rehabilitated over a period of time, the care they need is about giving them the time and the

space and the therapists to actually enable them to get over their disabilities, to get to a level of functioning where they can go home safely and actually go back to their own homes rather than actually go out with a level of disability which might mean that they have to go to some kind of supported care. So our idea is that we will create this centre of rehabilitation excellence with seven day service, with lots of therapy support, specialist nursing support and that will without any shadow of a doubt improve the quality of care for those patients, reduce the length of time they spend in hospital, reduce the level of disability and give them a better chance to get back to their own homes.

Linking into that we would also include some intermediate care in that. That's where people still need some rehabilitation, it's not quite as intensive as if, you know, post-stroke or something like that, but there is still the need for care in a kind of supportive environment but not on an acute ward. And the other thing that we're proposing to develop is a Trust-wide ... a Countywide cataract centre, centralising all cataract surgery there. Next slide.

Darlington and Durham, the changes there really kind of pick up from the changes proposed at Bishop Auckland and we would have a centralised Accident & Emergency department, the effect of that is a little bit of ... the split of patients would be something like an additional 4,000 patients into Durham and 5,000 into Darlington. So you know kind of ... we have to develop our facilities to a small extent to actually take on that additional activity there.

Acute medicine will be centralised but acute stroke would also follow that. We need to manage patients in the acute phase of a stroke alongside where we've got an acute medical department and intensive care services. You know, nowadays a stroke is managed, it's very much like a heart attack is managed. Once upon a time it wasn't really an acute condition, you know, you just kind of went and you had some kind of palliative type of care. Nowadays you know you go in, it's a medical emergency, you need very rapid diagnostics, scanning, you know, some patients get a particular type of treatment which significantly improves their recovery and all of that needs to happen with the back up of all of the kind of intensive services that you can provide on an acute site.

The only other thing that changes is that we would have centralised acute paediatrics. In terms of the numbers that that affects, it's actually quite small.

We've put this in because we're in the north end of the County and we thought people would be interested in understanding what the impact of this is on our North Durham sites, OK? Shotley Bridge, Chester-le-Street and Durham. I think Steven's already alluded to the fact that we don't anticipate any changes to services at Chester-le-Street, that will remain unchanged. I've got to say that there are no proposals to change anything but I've got to say is if we developing a centre of rehabilitation excellence in one part of our Trust there will be some benefits for hospitals like Chester-le-Street who provide some rehabilitation now, because the level of expertise we develop at Bishop Auckland will be shared, yes? And there will be a natural kind of increase in the quality of services across the whole of the Trust so there is a benefit, there's no planned changes to the service but there are definite benefits. At Shotley Bridge we know from our modelling that there will be an increase in day surgery that we currently provide at Shotley Bridge and that's around about 1,500 additional cases in any year to start off with. At Durham we would obviously have a rise in the number of medical beds that we use and we've modelled that and a kind of planning ... or have kind of put into our models and our plans how we would cope with that. There would be a reduction in the amount of day surgery that is done at Durham and that is because we're creating the day surgery centre at Bishop Auckland so people who are going to have day surgery, almost all of them, there are very few where there is a bit of specialist equipment needed, almost all of them would go to Bishop Auckland and I've already mentioned the increase in A&E admissions.

I think being a nurse and I might not look like a nurse today, but I am a nurse, and I kind of really passionately believe that everything we do has to sort of have a benefit for patients and you know that's at the root of what I believe and always will believe as a nurse. The benefits for patients are better access to a specialist OK? The situation we currently have is that at Darlington and Bishop Auckland we've got medical services, for example, where we have specialists, for example diabetologists, yes?

... who are single-handed on each of those sites. Now if you go into hospital with an acute condition you need to see a specialist in your type of condition as soon as possible and the reason you need to see that person is because you will get the best care from a specialist and we know that and we know that that improves the outcomes of care because we know by the way that cancer services have been structured over the last sort of five, ten years, how that actually increases the outcomes for patients. It reduces deaths, it improves the level of functioning for patients, so by actually putting those services together we would actually be able to ensure that when you came into hospital, you would be seen by somebody at the front door, an acute physician who would get you your first 24 hours care, but if you had a particular condition, a respiratory condition or diabetes or something like that there would always be a specialist who would be able to see you and pick up the very specialist bits of your care, get you on to the right medicines, the right treatment and the right care plan and get you out of hospital quicker but get you out of hospital quicker with a better outcome. That enables us to do that.

Being on the right ward is linked to seeing the right specialist, because it isn't just about specialist doctors that improves your care, it's actually nurses who know about your condition as well and sometimes we can't always put the patients, for example with medical conditions on a medical ward, sometimes we have to move them because, you know, there's pressure on those services and they get moved to another ward where the nurses don't ... they can provide you with good care but they don't have the specialist knowledge. By actually separating our elective surgery from our acute conditions we can ensure you get on the right ward with the right nurses, the right therapists and the right specialist doctor. There's less risk of cancelled operations by separating our elective work onto one site. It means that if you've got a booking to come for your surgery, you know, there's much less chance of you getting a call the day of surgery saying well I'm very sorry but we've had a lot of acute admissions and, you know, we'll have to put your surgery off today. Better rehabilitation after being ill. I've already mentioned rehabilitation. I mean we are really excited about this prospect, about being able to provide this specialist rehabilitation, it's something that, you know, isn't widely available, certainly not available in this County and, you know, our kind of nurses, our therapists, and our medical staff are really excited at the ability to do ... the prospect of being able to do this.

MRSA, a huge issue for us as a Trust, bigger issue probably for the public, you know, what they read about it. By separating elective and acute care we can reduce the risk of MRSA and we can do that because elective patients will all be screened before they come into hospital, so as part of your plans to come into hospital you'll have a simple swab taken that will tell us whether or not you've got an MRSA infection, whether you're hosting an infection, we would treat that and when you come into hospital we can make sure that's an MRSA ... you know, certainly significantly reduce risk of contracting MRSA in hospital, and quicker tests and diagnoses. I mean I've already mentioned that in respect of access to medical assessment, rapid access clinics and that kind of thing.

Bob, I think it might be ... oh travel and access. Right throughout this project we've had Governor involvement and our members, Foundation Trust members' involvement, right throughout the process and when I mean Governors I mean Foundation Trust Governors who are drawn from the membership ... the public membership of the Trust and elected, and we've had them involved right throughout the process in all of the groups that have been developing these proposals, and at every meeting that we've had the issue of travel and access has cropped up, quite rightly, and it's something that, you know, we really have to take account of and we believe that we have done that through the proposals. Underpinning everything that we're proposing is the notion that wherever possible we will provide care locally OK? That means your outpatient appointments, your diagnostics, all of your tests, your follow up outpatient clinics, that type of thing, will all be done at your local site. That's the site nearest to you, so that kind of underpins everything. On the basis of that you travel only where it's absolutely essential OK? So only where it's essential to provide you with that safe, high quality care.

I think we've got to mention the paramedics' role in emergency care and it's important to recognise that because of the developments in the role of the paramedic over the last five and ten years, you know, they're not ambulance drivers any more, these are skilled members of the healthcare team. You know, your care doesn't start when you get to the hospital doors, when you land at A&E, your care starts actually when that paramedic arrives at your house, they start your assessment, they start your

treatment, they send details on to the hospital pre-warning people what's coming, there's some diagnosis made, everybody's prepared, so you know kind of once upon a time, you know, your care started sort of however long it took the ambulance to get from A to B to the front end of the hospital, that's not the case now, these are highly skilled technicians. The GPs often stand back when the paramedics come to let them begin their care and treatment.

Hospital link service is ... we've begun a piece of work with the County Council with their Integrated Transport Unit and they've set up a service in the east of the County called East Durham Link and we're working with them to put in place some additional transport services across the County and we're doing that by looking at existing public transport services, the volunteer drivers, patient transport service which is the part of the ambulance service which is about ambulance drivers really, kind of, you know, it's not about the acutely ill patient, and what would happen is that if somebody needed to get to hospital, OK? If you GP wanted to send you for an appointment, or you were going to visit a relative, there would be one single telephone number, you ring that telephone number, say you need to get to the hospital on this day or date and they would direct you to the most appropriate service. They would check if you were eligible for the PTS ambulance service and if you were book you on to that. If you weren't eligible for that but there was a good bus service that didn't require a significant walk and it ran regularly and it could get you to the hospital on time they would advise you on that existing transport route, and if that didn't exist there would be additional services commissioned and they would book you onto that and that would kind of pick you up near to your door within a 30 minute time band to get you to hospital, and that's not just for patients, that's for visitors and that's for staff as well, so we are actively in the process of working up those proposals and we're committed to be able to provide those to ensure that ... sorry, I've just been slightly distracted ... to ensure that your access was good. OK? I think we're handing over to Bob now. And I might have taken too long. I've taken too long, I'm sorry.

BA: She talks more than me! Good afternoon everybody. I think just very briefly before I go on to explain why we, in my opinion, we need to change. I think I should just try and cast folks memories back and tell you why we are configured the way we are. Our acute services were reviewed by Professor Sir Ara Darzi in 2002 and he made recommendations which we have implemented almost in full at this point in time. But since 2002 there have been significant changes in medical workforce patterns, in recommendations from a number of Royal Colleges and from the Department of Health about quality standards that we should be aiming to achieve in the 21st Century, and one of the big ones from the Department of Health is, you know, recommendations and a population base that actually should feed the District General Hospital and, you know, about 2000 that was about 250,000 people. Now that number is for a small DGH about 300,000 to 400,000, for a large DGH a minimum of 500,000 people, so that does put some significant pressures on County Durham because of the large geographic nature of our County and the way the population is divided up. So there are national drivers that I'll go into in a bit more detail but these are also modified by local pressures that we are experiencing over the past few years, certainly during the latter half of my spell as Medical Director and they mainly relate to recruitment and retention of suitably qualified hospital doctors, and I'll allude to that briefly as we go through the various things.

So let's talk a bit about specialisation. There has been a trend in the last decade or so within medicine for techniques to become much more specialised with pieces of equipment becoming much more sophisticated and with that unfortunately a hell of a lot more expensive and, people are finding it all round the country, it's not always possible to afford to put all of this really expensive gear in every hospital and there isn't the expertise to actually use it. So that's one thing going forward, but also there has been pressure to look at say cancer treatments and other specialised treatments such as vascular surgery, is to concentrate the operations that we perform on patients who suffer from these conditions in the hands of fewer specialist surgeons. Now I have personal experience of that because I was the Gynae Cancer lead in the south of the County and did quite a lot of Gynae Cancer surgery and really wondered about the evidence base when we were told as part of the National Cancer Strategy that all of our local cancer operations in the south of the County should be sent to Middlesbrough. Now I had already voluntarily sent some of ours across to my mate Derek Crookshank, but I was still doing a lot of that stuff in Darlington, so I was a bit doubtful whether it was really the right direction to travel. I

am now absolutely convinced because over the past eight years or so there have been significant improvements in cancer outcome data, survival data for patients, quality issues for patients, so there is no doubt that the concentration on a number of surgeons who are able to achieve a technical term really that we call critical mass of the amount of activity that they handle in a given year to maintain a level of expertise to allow them to be recognised nationally as a sub-specialist in that field and there's no doubt that benefit has shown ... enormous benefit in cancer, it's showing benefit now in primary treatment of heart attacks and I think internationally there's a lot of evidence that the same applies to acute care, to emergency care. George Alberti is absolutely convinced that it's actually for even a very sick patient to travel a bit further in the back of a Blue Light ambulance being treated by the paramedic to get to a fully equipped unit that's got all the specialist team that are appropriately qualified and are experienced in the amount of critical mass of activity to maintain that level of expertise.

Doctors' working hours, otherwise known as the European Working Time Directive. A big driving force behind the previous review. It's been brought into this country in junior doctors' hours in three phases. The final phase hits us in August of 2009. What that means is all of our junior trainees, the maximum hours they can work drops from 56 hours in a week to 48. What does that mean to us on the shop floor, on our on call rotas across the County, it means that we lose 31.4 whole time equivalent junior doctors. It renders about 60% of our on call rotas non-European Working Time Directive compliant. When that happens you almost automatically have training recognition for the junior doctors withdrawn from the hospital. It's a very very serious situation and we're already planning for trying to deal with that even if we can't reconfigure and it's going to be very very difficult, so that's an issue that is really quite a significant driver for the changes that we need to make.

As well as that there have been specific recommendations on the specialties listed here. Accident & Emergency, and I do stress again as Di has already said, we do not have a full A&E department at Bishop Auckland. There is still an A&E sign about it but we haven't had trauma, we haven't had acute surgery go in for a long time. Di's alluded to the fact that in critical care you've got level 1, 2 and 3 with the increasing sickness of the patients. It's the same in A&E, there's 1, 2 and 3, 1 being walking wounded, 3 being patients who need immediate resuscitation with all the team looking after them when they get to A&E and 2 is the whole spectrum in between. The vast majority of A&E patients who have attended Bishop Auckland for a long time are level 1 plus a smattering of level 2. Major level 2 and level 3 patients haven't attended Bishop Auckland for almost a decade. Yes? The Royal College of Accident & Emergency Medicine was formed in 2004 and made recommendations about what facilities should be in a full A&E department and I think importantly the critical mass of activity, particularly of level 3 patients, that you required to be able to maintain the level of expertise. I'll say nothing more than County Durham doesn't have enough activity to allow us to have three full A&E services.

Acute medicine. When Ara Darzi made his recommendation in 2002, the level of critical care that was required or recommended to support an unrestricted medical admission take, that is all Blue Lights with medical patients, going in without having to filter them to another hospital was level 2 critical care. I won't bore you with the details of that but I'm quite happy to answer the question if somebody wants to clarify it later. What's happened since then is that the recommendation of the Academy of Medical Royal Colleges in 2007 has said for any emergency service to be taken into a hospital there must be 24/7 level 3 critical care activity, and when I talk about critical care I'll explain what that implication is for us. In the acute medicine though in 2004 the Royal College of Physicians recommended that we change the pattern of care that we deliver and that the very sickest patients who are coming in to be assessed on a medical admissions unit shouldn't really be seen where it was possible to deliver the service by a generalist, you should be seen by an acute care physician who was a new type of specialist. You should be managed by the acute care physician for 12 to 24 hours and then if you're required to be kept in hospital passed back into the back shop so to speak, into the best wards where you'll be looked after by sub-specialists, cardiologists, gastroenterologists, diabetologists, appropriate to the condition that you are suffering from, and therefore you .. the 'ologist' needed to work in teams of at least two, so that if they went on holiday at the same time you always had a sub-specialist in the back who could actually then take over the care of the patient. If I tell you that we were actually able to deliver that care in the University Hospital in North Durham, as I've said in the other meetings, more by accident than by design, and it was in my opinion the result of the merger of

Shotley Bridge and Dryburn hospitals about eleven years ago, and we've now got a bulk of consultants that we can actually deliver the model that's recommended by the Royal Colleges. We don't come close to that in Bishop Auckland or in Darlington because of the numbers that we've got, as Di's alluded to, we have got some single handed 'ologists' that cause us one or two issues when people are on holiday.

DG: Bob, you've got just a minute.

BA: OK. So this is an issue that we really need to address and by merging the two acute medical takes in the south of the County plus a little bit of investment in acute care physicians we can deliver that same model of care in the south of the County as we do in the north. The big issue is critical care. The recommendations for level 3 critical care is that we have resident medical staff on the shop floor in the critical care unit 24/7. We do not have that at Bishop Auckland. We have level 2 where people are available within ten minutes of call. I was given a lot of money by the Trust to find a resident tier of medical staff when this recommendation was made. We've advertised the jobs four times and we've had one applicant and I need six to provide a rota, so we're really having recruitment and retention problems there. So there is a need to address that issue. But again we go back to the critical mass and the critical care services in Wales were reviewed in 2006 and the Intensive Care Society came out for the first time with a recommended critical mass of activity, of level 3 activity, to maintain the expertise for a full level 3. Surprise, surprise, in County Durham we do not have enough level 3 activity to have three fully fledged level 3 critical care units, so if we need to have emergency care in a hospital we need level 3, we really can't have, continue to have, three acute take hospitals.

Children's' care, the paediatrics, is very simple. One minute David please ... it's more a recruitment and retention issue. I feel a bit sorry for the paediatricians in Bishop because ten years ago their service delivered mainly by consultants with very junior doctor support was the recommended gold standard of the Royal College of Paediatrics. Because of the way young doctors want to work now with much more emphasis on a work/life balance, is that we can't recruit to the post. Our consultant paediatricians are ... some of them are of a rather mature age profile and they're retiring in dribs and drabs and we're finding it very difficult to recruit and for two years the paediatricians have been wanting to rationalise the service onto the two acute sites in UHND and in Darlington.

Oh sorry ... what these basically changes give I think for the healthcare community, not just for us, is certainly about the future for all of the hospitals. I think it provides a key strategic role in the healthcare community for all of our hospitals and, OK, in Bishop quite a significant change to the way it's being used, but a very important role to play within the County and most importantly for me it allows us to provide strong, safe and sustainable local services within the County. Thanks very much.

DG: OK. Thank you. Really sorry about cutting you short but it is a requirement we give people a chance to have their say and their input which is what this process is all about.

BA: That's quite alright.

DG: We're going to move into a section now where there's an opportunity for people from the floor to actually question the panellists, ask any points of clarification in relation to the presentation or the proposals that are outlined in the presentation. What I'd ask is we've got a roving mic that we'll bring to you so if you can identify yourself by raising your hand if you've got a question, we'll bring the mic to you, if you can say who you are please and if I could please ask people in the interest of letting everybody have a say if you can keep your questions fairly concise and brief we'll try and get a chance to answer them all as we go through the session. So would anybody like to start with the first question? We've got a gentleman at the front there. Yes, can you just indicate yourself again sir? If you can use the roving mic it'll pick it up better for the PA system and the recording.

?: *OK. I'll do as you suggest.*

DG: Thank you.

?: *The point I really want to get to is the distinction between the NHS and the Foundation. You've got two different bodies apparently listed on the top of the headed paper here, the NHS itself and the Foundation Trust. Now I'm a member of both, as I understand it, but what does it mean in terms of what it's about.*

DG: I'll answer that one, that's a really good question, it's something we've talked about a lot over the last few months. What in essence we're doing is NHS County Durham, so the top line in the brown there, is very much what in the past we called the Primary Care Trust. The reason we've changed the name is that our role in the Primary Care Trust NHS County Durham has changed so that we now only commission, i.e. buy services, on behalf of local people. We don't ...

?: *Who are 'we'?*

DG: NHS County Durham. We don't provide any services, or what we do is actually buy services from colleagues like the Foundation Trust, from GPs, from dentists, from the Mental Health Trust, from other Foundation Trusts, so that's what we do. Our role in this is sort of ... in terms of managing the whole health system within County Durham and Darlington, then we have the provider organisations, the people who actually provide health services or healthcare services of which County Durham and Darlington Foundation Trust is probably the largest patch and covers most of the area and it's the services that they provide and that we've spoken about this afternoon that the consultation is about. NHS County Durham's role is actually to administer the consultation process but the issues and the outcomes and the final solutions are probably down to colleagues in the Foundation Trust. I hope that's helped.

?: *Yes, the issue is ... (inaudible) .. the issue is as I see it, the distinction as it affects the patient, as it affects the person at the sharp end. Yes. Because it seems to me a lot of it is bureaucracy going through the system, but not affecting people that are going to be demanding services.*

DG: No. In terms of actually services that are provided, you know, it means the patient, the people I would come across are staff from the Foundation Trust or the GPs. Our role at NHS County Durham is actually to buy those services and make sure the service is in the right place at the right time and to get value for money for tax payers because we spend, you know, we spend all of our money as tax payers on those services. Understand what you're saying but hopefully that's the distinction between the two.

?: *Yes. I'm still not clear.*

DG: OK. We'll probably have a discussion when we've finished if you like, if that will help you sir. Yes? OK. We've got a gentleman at the back there, thank you.

MrF: *My name's Mr Flintoff. I'm using the University Hospital for myself and my wife so I'm quite involved. I like the plan. I think the doctors are going to do well out of it, they're nicely centralised and the thing is being much more centralised the nurses should be OK. I'm worried about the patients. I have a cataract developing. At the moment I can go half a mile down the road and get it seen to. In the future I'll have to go down to Bishop Auckland. I'll have to go by ambulance and I wonder, you know, is this going to increase the demand on paramedics, on ambulance staff, and another thing is the last time we were in hospital there's no ambulance provided after 5 o'clock at night to take people home. They'll bring you in but they won't take you out, so what you do is you either take a taxi, or there is one private ambulance for the whole of County Durham that will, if you wait long enough, until he's done the other runs, take you home. I've been ... I've suffered at that, and I just wondered if we're not looking too closely at the doctors, at the nurses, at the central organisation and not enough at the patient.*

DG: OK. Thank you for your question sir, I'll ask Steven to respond in the first instance please?

SE: OK. We're all going to have a go at what you've said, thank you very much for that question, it's a very good question too. But I would emphasise that, of course, your GP and you will still have a

choice and of course for patients who live in this part of the world, the choice is often made towards Sunderland for cataract operations, so that isn't going to change. You'll have that choice. What we're saying is that we're going to create a facility that doesn't exist in County Durham, at Bishop Auckland. You could choose to go there too should you so wish, so there is a choice about where you go, it's not forcing you to go a longer distance if there's an alternative, which there is in this particular case. But I'm going to hand over to Bob to say something about that too.

BA: I won't so much major on cataracts, I mean, because Steven's already explained that, but there are ... as well as having to specialise to maintain services in the County in acute care, we are very aware that with the catchment recommended for specialist surgical teams for instance of half a million people that we probably can't deliver all sorts of services on all of our sites, and it's certainly that when surgical teams are, you know, like developing special surgery for aortic aneurysm repair, that is a swollen major artery in your belly or a shoulder replacement operation that we've brought into the County in Darlington, the aortic aneurysm repairs in North Durham. We expect if we want to continue to deliver that service in the County patients to be prepared to travel. Now that was obviously concerning us. What was interesting when we did the travel analysis that Steven alluded to earlier on when we were trying to choose which site would be the planned centre for elective surgery and elective services is that there's quite a lot of travelling going on at the minute and people seemed to be prepared if we are able to provide high quality services, which we're confident we can, that patients are prepared to travel to get the best care. But again there is always the choice, you can choose North Durham or to travel to somewhere else, that is your right within the NHS.

MrF: *Do you have any comment on the after 5 o'clock situation?*

DM: Yes, just to try and pick up on that one. The success of us providing a specialist day surgery centre and a cataract centre will depend on getting patients in and out swiftly, yes? You can't run a day surgery centre if you actually can't get patients home so it would be as much of a problem for us as it would be for you and we are actually working with the ambulance service, they've been involved in the work that we're doing right from the very beginning and we actually, with them, are looking at how they would need to perhaps reshape their services, whether there are actually any changes to be made, for example, to be able to discharge, so we could discharge people from a day surgery centre which was centralised, so all of that is being taken account of and we would, combined with sort of an ambulance service but also the addition, you know, the Integrated Transport Service that we're looking at, be very hopeful, well we will be able to solve that problem because, yes, it's an essential part of the service. Yes.

SE: Just one final point if I may? Really in response to your question, just to remind everyone that we are ... we do provide day surgery services for a range, not cataract surgery, but for a range of other day surgical treatments at Shotley Bridge and we will continue to do that, in fact we expect that to grow, so that clearly, we're taking account in thinking that through in our planning of the population up here in the north of the County.

DG: Thank you. We've got a gentleman at the back there and then we'll come up front in a moment.

EM: *Thank you. I'm Mr Edward Murphy from Save Our Hospital group from Crook. Can I first of all ask, under this consultation, are you taking into account public opinion on a wider scale than at these meetings?*

DG: OK. Because we're running the consultation I'll answer that question. We are. I'll touch it when we actually get to the end of the session but this is one mechanism for people being actually able to feed into the process. We're also using a range of other mechanisms including response via a website, response via postal responses. We've actually put mail shots through I think just about every door in County Durham and Darlington, sort of a news sheet with the information on which you have the opportunity to respond to via Freepost on the back of that, so yes, we're trying to do as much as we can to get ... use as many different media as possible to get the public input into this.

- EM: Thank you. Are you aware then that County Council of Durham, Wear Valley District Council, Bishop Auckland Town Council, other town and parish councils in the Bishop Auckland area have voted for keeping the A&E in Bishop Auckland. Also, thousands of signatures and petitions have been collected against your plans at Bishop Auckland hospital. Therefore I put to you that your consultation has failed in the Bishop Auckland area. Thank you.*
- DG: Thank you for the question and the comment. We're aware of various discussions with each of the different Councils and indeed we're having separate meetings with the Councils as well on top of the consultation process and that will be taken into account as will any petitions or whatever that's fed in through the formal consultation process. The key bit is, because it is a formal consultation process, we need to route any comments in through this process which is why we're trying the various different media. We'll take account of petitions and the like, thank you. OK. I think the gentleman at the front ... and then I'll go to the gentleman at the back behind and then the gentleman to the right after that.
- RH: Thank you. Ralph Harrison, Chester-le-Street District Councillor. This one might be one for you David. We've had a lot of problems with NHS Dentistry. Fortunately we have a one which is not too far up the road here, at Pelton, but within the County there are so many dentists have gone private that people just can't get that treatment. What worries me is that we might find that people decide not to go and you end up with things which may involve Bob and his crew as mouth cancer and that sort of thing, so this is a problem, as a Primary Care Trust people, what are your views on that and what do you think you can do about that?*
- DG: OK. Because this is a consultation process about the proposals we very strictly need to keep to the proposals on offer, what I would say though very quickly is that we're actually putting a lot of time and effort into getting greater spread of dental facilities and particularly from the NHS so that the very problem you've described is being picked up. Unfortunately it's a separate issue so I don't think we should get into it around this, but ...
- RH: Private care is the point I'm making, the people with mouth cancer ...*
- DG: Yes, and that's what we're trying to do as a separate issue to this completely, to make sure that people have greater access to dental services. I think there's a gentleman at the back there.
- NH: Yes, thank you. Neil Harrison, Save Our Hospital Group resident at Bishop Auckland. No doubt these type of clinical proposals were undertaken nine or ten years ago before Bishop Auckland General hospital was given the go ahead to be rebuilt using vast amounts of tax payers' money in the process, nearly £70 million. Bearing this in mind, why and how could a brand new state of the art hospital lose its accreditation status within one year of it opening and which Trust and Board members have been dismissed for allowing this outrage to happen.*
- DG: OK. Steve or Bob?
- SE: Hello. I'll come on to Bob in a second, but I ... obviously I can't talk about ten years ago Councillor Harrison because I wasn't here and these proposals have been developed over the last 12 months in response to current pressures, and I think there's a lot of history which other colleagues could refer to in terms of those changes over time. I think Bob's got a comment on the accreditation point. I think what we were trying to get across in the presentation is partly response to your earlier question about the public opinion which obviously we clearly all want to listen to in the Foundation Trust and the Primary Care Trust. We're simply trying to outline as your ... as the people who steward your local health services, that's who we are, we're accountable in my view and increasingly so to you. All that we're saying is the arguments for setting out means that we don't think professionally, clinically, that we can provide high quality services unless we can make these changes. Now ultimately that's a choice through consultation that people will make and take a view on. My only plea about the views of the public is picking up your point that we're able to get to as many venues as we can to explain the reasons why we think these changes are important to make. Now I'm going to ask Bob to comment specifically on the point about the history and the accreditation I think you mentioned.

BA: I mean just to try and clarify, there are a whole range of accreditations, almost every service that we provide is accredited for training for example, for the junior doctors, so there'll be a different accreditation for paediatrics, for general surgery, for orthopaedics, and it's an ongoing problem, for example, I mean we've lost anaesthetic accreditation training ... accreditation for anaesthetic training in Bishop Auckland about 20 years ago. Now we made, following the merger, really really, you know, big efforts, we got that training recognition back again, yes? But then what happens is because of surgical training recognition it was a recommendation that the emergency surgery moves is centralised to give a critical mass, that term again, for the acute take surgeons to be on call, so that's to maintain the accreditation for surgical training in the south of the County, but low and behold what happens is the next time the Anaesthetic College comes round, because there's not enough surgical activity at Bishop, you then lose that accreditation again, so it's an ongoing sort of, you know, flooring mechanism you've got to be one step ahead of the game all the time. The thing that ... one of the success stories is in orthopaedics. I mean one of the reasons for moving the acute trauma from Bishop to Darlington was to try and centralise and to try and get surgical orthopaedic training accreditation back into the south of the County because it was lost at both Darlington and at Bishop. We have now had that reinstated just over two years ago, so there are real success stories behind moving these services around and I know ... it's difficult, I wouldn't expect everybody to fully understand but by doing that we actually maintain a quality service in the area, but if we didn't do it then both services might well fold and you've had to travel much further for care.

SE: And if I may just come back on one point, you know, I really do agree with you, which we touched on separately, is Bishop Auckland hospital is not fully utilised and there's a lot of history that goes behind that that perhaps we can't do anything about now, but our plans are all about fully utilising the hospital, albeit in a different way, in the future, and I guess I'd argue if you look ten years ahead the whole thrust of care is about more being done closer to home and in the community and more being possible because of the way that drug technologies and diagnostics and assessment will work in the future, so we see, as I think Bob said in his presentation, that as central to providing a high quality service in County Durham and Darlington, so the ... what we're proposing to do is to actually build up services in Bishop Auckland, not take them away, albeit a different range of services.

DG: OK. Gentleman ... I'll come to you in a moment sir.

BM: *Thank you Chairman. My name's Brian Myers. I'm a member of the ... I'm proud to be a member of the Save Our Hospital Group at Bishop Auckland but also I'm the Chairman of the Greater Willington Town Council and also the Deputy Chairman of Durham County Council. What I want to say isn't a question, it's purely a statement from the Save Our Hospital Group and our message to the Trust is simply to abandon options that will result in the downgrading of vital lifesaving facilities at Bishop Auckland General hospital. A major ... this major consultation, public consultation is now underway and our group urges every one of those residents affected to reinforce their opposition to the life threatening plans by registering their formal protest before the end of the December deadline. Many people have already voiced their opinions under the consultation process and this public consultation scheme is our last chance to deliver a clear and concise message to those bureaucrats who seem hell bent on forging ahead with their centralisation proposals. This call is being backed by civic leaders, health workers, politicians of all persuasions and unions who are genuinely fearful of the controversial plans and our group's message is simple, we would rather save lives than save pounds. Thank you.*

DG: Thank you. I don't know if Bob wants to respond?

BA: I'll respond to that just to try and reassure people. I think Neil Munroe said it the other night in one of the public consultation meetings. I we honestly felt that what we were recommending was going to lead to patients unnecessarily losing their lives then none of us, because we're all clinicians, would even consider putting the proposals forward. We know, you know, that because of travel etc. that ... I had that when the local hospital closed in south west Scotland and I thought people would be dying in the backs of ambulances because it was 12 miles for them to travel to the hospital. It didn't happen. Neil Munroe was in Shotley Bridge when Shotley Bridge acute service closed down and moved it to

Durham. Have people been dying in the backs of ambulances? They haven't been. Yet we're trying to provide a high quality service. Can I make the offer I made at Sedgefield the other day David, it's very difficult to really talk through ... behind the slides that we've got there's probably another six slides for each slide, and there's almost, you know, three or four hours worth of work and me talking myself to death to try and help people better understand why we really need to do what we're actually trying to do ... and can I make the offer to come and speak with the Save the Hospital campaign group and try and help and present the more detailed data as to why we feel we need to make these recommendations, and if you feel that that would help in any way, then I'm more than prepared to put as much time into that as you would like.

DG: I think that's it, I think that offer has been made twice now, I think it would be worth taking that up and we'll try and sort that out. I don't know if Diane wants to comment on it?

DM: I just want to make a comment as a nurse. I definitely would not be sitting here if I felt what we were doing would in any way cause harm to patients and I am absolutely convinced, I've been in this project from the beginning and I can feel my heart racing now actually because I feel so passionate about it, OK. This will provide better care for patients, you know, I wouldn't be here, I wouldn't be doing this job, even if I'd started it, I would have actually walked away from this, I wouldn't be sitting in front of you now proposing what we're proposing if I really did not believe this would provide better care. My Dad's actually in Bishop Auckland today, he actually lives in Darlington and he's gone to Bishop Auckland today, he's travelled up to Bishop Auckland for his care and treatment today because I believe he'll get great care there and lots of other people will benefit from that care in the future.

DG: OK. Thank you. If the group wants to take that offer up then we'll arrange that. Gentleman at the back and then we'll come to the front.

CO: *Yes, good afternoon everybody, my name's Clive Ord and I'm from the same supportive group as the gentleman along here. As you can appreciate we're very very concerned about what's going on at Bishop Auckland and I personally think this is getting railroaded at pretty quick speed. I've got a little bit of data for you, I'm not going to spend too much time, but it is ratified. Did you know that in England and Wales there are 32,500 Council wards, OK? And in 2007 Bishop Auckland, I being the worst ward for health, Bishop Auckland was 56th worst ward for health, now this might be new to you but it is up to date data and the inequalities in healthcare at Bishop Auckland is going to get worse and therefore these people, this incident and this problem will not get any better, it will get worse. And just for the rest of the people who are here today I want to point out to you, apart from £67 million being spent on the hospital, Ward 9 surgical closed in 2007, Ward 3 medical and haematology closed in 2006, maternity downgraded to nurse-led facility now, children's ward downgraded to day time admissions, special care baby unit transferred to Darlington, downgrading of orthopaedics to knee and hips only, downgrading of surgeries, ITU downgraded, now proposed to downgrade further the Accident & Emergency, removal of the acute medicines, paediatrics downgraded again completely and stroke, one of the best in the world, headed by Mr Ali, I can't pronounce his surname, a very well respected man with a wonderful team working at Bishop Auckland, that's going as well ...*

DG: Can I ...

CO: *With respect please Mr Chairman, I just want to point out to people here that's it's already happened, you've already done it. We're not waiting for it to happen, you've done it already. Look at the list here, there's nothing left and you're going to take more away from us. Seriously you sitting there saying we've never known anybody die in an ambulance on the way to hospital ... quote, to a certain degree ... to a certain degree, right. Listen, please ... wait ... wait ...*

DG: Let the gentleman finish, Bob can you just let the gentleman finish?

CO: *Wait ... to a certain degree ... you talked about distances travelled and you haven't come across due to distances being travelled that anybody ... I'll rephrase that, due to distances being travelled you haven't heard of any fatalities. Well with due respect ...*

DG: Can I ask you sir ... well with due respect to everybody else in the audience sir have you got a question I can put to the panel because I'd like them to respond to what you've said so far?

?: *I think you should allow him to speak because he's making a point.*

CO: *I think with respect I don't want to be gagged again today, but I'm not here to criticise anyone in particular here, but what I will say is you have to listen, you must listen, we're all learning here, it's a big learning curve for all of us, but people are very passionate, especially when you live in the area we live in.*

?: *I can understand that.*

CO: *We want people to have basic healthcare. You're taking it away. We all agree that we have to look at places of excellence, we agree with that. We don't disagree if it's heart, if it's cancer, we will travel to these places of excellence. We're not asking for a place of excellence, we're talking and we're asking for a place to take our kids, our mams and dads, and people, to get seen to, and that's being denied. OK? We don't want a glorified care home on a £67 million site, we don't want that, we want basic healthcare for the people. Now then ... question...*

DG: Excuse me sir. Are you actually getting to a question. Put your question and then in fairness, it is about two-way communication, I'll ask the panel to respond.

CO: *I totally agree, totally agree.*

DG: Thank you.

CO: *I've got loads of questions but I'm not going to bore you with them all, but we'll get through them eventually through this process I'm sure.*

DG: Well if you could keep yourself to one question because we have got other people waiting to ask questions.

CO: *I will do. So we have heard twice now that we are unable to get doctors to come to Bishop Auckland to see to the patients, now I doubt that, but however, under your proposals people are going to go to Bishop Auckland and see consultants now, readily available at Bishop Auckland, and you cannot get damn doctors there. So could you repeat that one please? Could you tell us how that's going to work?*

?: *(inaudible)*

(Applause)

DG: OK. Shall we respond, I'll ask Bob to answer please.

SE: I'd like to answer that specific question and, again, I'm very grateful that you've raised all those points because it's very important to get those into the consultation and obviously you made some of those similar points the other day when we were in Easington, but I hope also you're hearing the points ... in Sedgefield sorry ... yes, Easington next week. I hope you're hearing the points that we're making as well and you listed there things that have changed, but there are things that also have changed in the other direction that we mentioned in the presentation, for example, a centre for colo-rectal screening for the whole of the County at Bishop Auckland which in addition will be enhanced by the surgical services that we intend, Bob was outlining briefly in what he said earlier, behind those, providing a hugely increased number of day surgical activities down at the hospital and a centre of excellence for rehabilitation. These are all really important services. And they go a bit beyond the basic, I mean they are at one level basic services but of course most basic healthcare is provided in primary care and obviously the focus that we all have is improving the primary care infrastructure, that's what a lot of

Lord Darzi's report is about, and many of our proposals are about working together as we already do with general practitioners in that setting to improve basic care, so I think it's just important to make those points in response. You picked up something around health inequalities so I want Diane just to say a word about that and then I'm going to pass back to Bob around the issues that you raised in relation to him.

DM: Just to say that we are very aware of the health inequalities picture across the whole of the County as are the PCT and what the PCT do in terms of their commissioning actually takes full account of health inequalities, but we've taken account of it as well in the work that we have done and I think what I've got to say is that one of the biggest issues in healthcare and health inequalities is how people access services. Now access isn't about kind of the length of ... you know, the number of miles that you travel, what we have done is actually within the proposals, you know I was talking about making sure that we provide everything that we can as locally as possible to the patient, so the diagnostics, the outpatients appointments, the follow up appointments, yes, all that kind of stuff will be done as locally as possible. We only actually ask people to move where absolutely essential. I also mentioned on the travel and transport slide about our proposals to actually develop enhanced transport facilities for people over and above that that currently exists. This will not, regardless of our proposals, that will improve access to health services. Now the other thing in terms of health inequalities I must mention is that if we are not able to move forward with the proposals that are in our consultation what that will .. the net effect of that will be services will deteriorate, the quality of services will deteriorate and they will start deteriorating very quickly and they'll deteriorate because we can't provide the specialist care that we were talking about, we can't provide the right levels of cover of the specialist doctors. You will end up with a second rate service and a rapidly declining service and your health inequalities in County Durham will go down further ... that's my opinion.

DG: OK. Bob.

BA: Can I just pick up three points that Clive made? He always succeeds in winding me up, but never mind that. Stroke ... you're absolutely right, it's an excellent service that's provided at Bishop Auckland when the consultant who leads the service is there. When he's not there, or when he's not on call, there isn't a service provided. We've managed to upgrade that recently by working to try and pull together a team. What we're trying to do is develop a Countywide stroke service. We had a meeting with the stroke team on Monday evening and signed everybody up across the County to deliver a joined up service that we're going to develop going forward, so yes, the individual that you mentioned has provided an excellent service, but when he's not there, yes? And that, to me, that's not a service, that's somebody providing great care and he does, don't get me wrong, but you know if ... if Ali's not there, then the service is a bit flaky and we're trying to consolidate that and we've got to provide it for all of the people of County Durham all of the time, 24/7 is what we're aiming for, we haven't achieved that yet, but very few units in the country have done.

Midwifery-led unit. I think our midwives working at Bishop Auckland would be a bit upset if they felt that their service that they provide was looked upon as a downgrade. There is no doubt it is a superb service and I just wish more patients across the County would avail themselves of it. If you look at patient satisfaction through that service then it is exceptional. For reasons that, I won't bore you with the details now, in 2002 there was a need to preserve the sustainability of consultant services across the County, and we needed to centralise the consultant services in south Durham and that's why they consolidated, but to counter that we provide a superb midwifery-led service in Bishop Auckland.

Arthroplasty is another thing in Bishop Auckland that we developed. If you look at patient satisfaction through the primary arthroplasty unit at Bishop, we were victims of our own success, we got through patients so quickly that, you know, there were certain levels of (inaudible) that we could accept and some we couldn't, and we got through the patients very very quickly and it was like 100% absolutely excellent satisfaction rates, so we have developed excellent services within the Bishop Auckland environment in the last few years, but you were saying this is about a two way learning process, you know, I hope that, you know, by trying to outline and I'm prepared to come and see you again, I reiterate the offer, come and explain more in detail about what the drivers are for the acute

service and why we have to look at the quality of the service that we provide. I mean Healthcare Commission disappears and it becomes a Care Quality Commission in the Spring and Dame Barbara Young I think heads that up, and she will be looking very very closely at the quality of the services and the standards of the services that our commissioning colleagues have to look at and if we're not providing the recommended 21st century levels of service, then they will almost be coerced or forced into finding the service somewhere else, so we've got to make these changes.

DG: OK. I've got time for just one more question for the moment then.

?: (inaudible)

?: I think we've ...

DG: I think we'll have an opportunity to do that later on, but if we can just have one last question then we'll move onto the next section please.

BE: *Thank you Chair, my name's Brian Edmondson. I'm a resident of Chester-le-Street and I'm really concerned that at this meeting we do get some views of how this is seen from the Chester-le-Street perspective because I get the feeling that if there's any railroading going on it's not going on from your table but going on from a small group mainly behind me. Can I also say I was for 11 years an elected representative of Chester-le-Street on the County Council and I was very disappointed my colleagues decided to vote against these proposals before they'd been published and they could have seen them, and that really undermines the role that they should have in scrutinising these process ... I think they have a difficulty there in quite independently scrutinising these processes having already pre-judged the issue before the proposals were even published. However, I'm sorry if that's a bit provocative. I do agree with the colleague here that this is a learning process. This consultation should be a dialogue, an exchange of views in which we both learn from both sides, but I think those who've made up their minds before they even saw what the proposals were, that they were going to oppose them, are not exhibiting learning behaviour. However, can I come back to my view as a resident of Chester-le-Street. My concern and indeed my concern for residents of Chester-le-Street but also for all people in the County is that we are able to get the right treatment of the best quality at the place that's most appropriate and I really feel therefore that if we are being told, and I think it's right that actually the evidence for that should be scrutinised, that the quality of care cannot be delivered from three centres, as a resident of Chester-le-Street and for all residents of the County, I want to make sure that it's the right quality, it's safe, and it's available to us. In fact from Chester-le-Street we probably have a bit of an advantage here which will not benefit the rest, because if the quality is not available within County Durham and Darlington Foundation Trust we actually can quite easily opt and choose to go to Sunderland or Newcastle and of course if we opt out of that Trust they're going to have even more difficulty in maintaining the quality of their services.*

So I really think that, you know, from a Chester-le-Street perspective, but that is also one for all residents in the County, that what we want is the best quality services in a safe environment from the highest qualified people that we can get. I should have also said I am a ... and I've had an opportunity to have these conversations before, as a non-executive director of the Primary Care Trust, and clearly some of the things that have been said do impinge upon that role for me as well, but as a part of the Primary Care Trust, as a director, we have to commission the safest and the best possible services and we have a responsibility to do that so we should listen very carefully and look very carefully at the proposals that result. But the issue is all about health inequalities that were raised, I represent the Primary Care Trust along with the professional directors on the Health Improvement Partnership which is part of the County Durham Partnership which is led by the County Council and with the County Council our Trust has done a Joint Strategic Needs Assessment to try and address these health inequalities and we need the co-operation and we need the support from our County Council colleagues in actually addressing those inequalities which as I think one of my colleagues here said, rests primarily with the Primary ... at the primary care level, and particularly though on the issue of transport here, which again I've had my questions with these colleagues before, and I think there are serious issues there that we need to look at, but we are very dependent here on the co-operation of our

colleagues with the County Council who are the public transport authority to help us deal with those transport issues. I'm so ...

DG: I'm sorry to cut your short, have you got a question for the panel?

BE: *I'm on my last point.*

DG: OK.

BE: *But I really look forward to our County Council colleagues being ... helping and co-operating and learning in this process.*

DG: OK. Thank you. I think we've probably reached the point now when it would be useful to move on to the next part of the discussion really which is ...

?: (inaudible)

DG: If it's very ... one point very very quickly sir.

CO: *Thank you. Getting back to the question of the children's ward downgraded to whatever, I have no axe to grind with any staff at Bishop Auckland General hospital. I rate them very very very highly and I support them very very highly. There was no intent there at all to have any slant on the quality or the type of staff there. But I want to finish with one little bit from here, it states the constitution, the NHS, belongs to the people.*

DG: Yes.

CO: *It is there to improve our health.*

DG: Yes. And ...

CO: *We are proposing a set of principles and values which should guide everything we do including commitment to providing a comprehensive service available to all without discrimination and based on clinical needs not ability to pay.*

DG: Yes, I get that.

CO: *Remember that please. Thank you.*

DG: Yes, comments are noted and appreciated, particularly the comments about the staff. I'd actually like just to move us on now. Sorry Steven. What we'd like to do now, this is another opportunity, a different type of opportunity for people to have their say and have input into this. What we'd like to do is actually to break you up into two groups, we've got members of staff who ... sorry, three groups, I hope they're saying three groups .. we're going to split into three groups, what we want to do is have a chance for people to have a discussion around the table with some key facilitators from various organisations. There are some specific questions that we'll ask you to answer as part of that but again it's a chance to have your say around the table and then we'll have a feedback session on that before we close. We've probably got 20 minutes for this so if I could ask the facilitators to organise you into the three table groups please and move on to this next section.

MEETING MOVES INTO ROUND TABLE DISCUSSION GROUPS

(General talking as people move around the room)

FEEDBACK FROM ROUND TABLE GROUPS

DG: We're also recording everything that's written down on the table and equally colleagues from Proportion are actually recording on a flipchart as you've seen. Because of that what I don't want to do is get into death by feedback. What I'd like to do actually is just ask the people who've been facilitating on the group just to give me two key points from the table just to give people a flavour of what's been discussed and then I'll explain what the next steps are. So if I could ask the table at my back left there, just for two key points from your discussion please?

?: *I think the first key point is that there is a general appreciation or I should say a majority, certainly not a unanimous appreciation, of the case for change and I think the second point is that there were some concerns raised about the robust nature of the consultation process, some concerns about whether ... and the silent majority was the phrase used ... would actually come out to meetings like this and actually submit the feedback forms.*

DG: OK. Yes, and that last bit's really useful because we can reflect on that and see how we might need to pull that back if that's the right phrase, so thank you for that. If I can go to the table to my right now? The microphone's on its way Katrina.

KB: *Thanks. Well our table basically, yes, the case for change was agreed but with some reservations and pertinent points of concern, particularly around communication between patients as members of the public and professionals to understand that, you know, to walk in the patients' shoes and see how it affects them as patients because when they're healthy it's fine, they can make those decisions, but actually when those changes take place and they're actually undergoing them and travelling and transport that's really when it really affects people. And I think we had an understanding on here that although there was a consensus that there is a need for change, that ultimately before decisions are made some people would like that more detail and certainly there's a member on this table who would like to take up that option for the Save Our Hospital, to get that detail before they could decide and make their decision. Thank you.*

DG: OK. Again, they're really helpful points, we'll certainly reflect on the first point and see what we can do. The latter bit about actually providing the greater detail, I'll say a little bit about that towards the end in a couple of minutes, but equally I think we'll actually arrange for that meeting so that we can get into the detail that inevitably you can't get into in a 30 minute presentation, so I think that would be very welcome from everybody's point of view. OK.

I'd just really like to wrap up now a little bit, can I have the next slide? What we've tried to do and, again, just to reiterate our role in NHS County Durham, it's to make sure that the process is robust and that's why some of the comments have been really helpful today, we'll reflect on that and see what we can do with it, but our role is to make sure that everybody has a chance to have their say, and that's across the County and across Darlington because we need to make sure that we actually get the views across the whole of the patch that we're trying to do and any of the views that you've got on how we can do that better we'll certainly listen to and try and entertain. Our role in this is very much the honest broker if you like. There is the consultation process there which this is part of, and as I say we've captured all of your views and all of your input today. The consultation runs until 12th January and I just want to make absolutely clear and it sort of resonates with the last point really, the only decision, and I'll stress, the only decision that has been made on this thus far is to actually embark on this consultation process which you've been part of today and will hopefully be part of until the end of January ...

?: *But you do have recommendations as well.*

DG: Sorry?

?: *You do have recommendations.*

DG: We have recommendations? There are some recommendations there ...

?: (inaudible) in some people's mind (inaudible)

DG: OK, well I'll just reassure people, and I'll explain what the process is, we haven't made any decision on what happens, the whole point of the consultation process and please judge us by our actions rather than my words on this, the whole point of the consultation process is so that the evidence and the information can be laid before people, with some recommendations because that's often useful, but we'll not make any decisions on the final outcome of that until probably February of next year. The reason for that is what we'll be doing is colleagues from the Foundation Trust Board will actually be considering their proposals in the light of the feedback that we've had from this process, they will then come back to NHS County Durham Board in our role as commissioners and they will actually suggest what they want to do with the proposals and only at that point will we actually agree or disagree with that. In doing that we'll take account of everything that's been discussed as part of the consultation process and all of the evidence before us and only then will a decision be made.

In terms of the process itself there are a number of ways that you can continue to get involved with this, obviously there are public meetings and we've put on extra public meetings to try and meet the demand and we will look to see if we need to do any more of that if we need to. People can fill in the public consultation response form that I mentioned earlier. You can actually log on to our website at NHS County Durham or the Seizing the Future website, the details of which are in the documentation but also on the slide there, or you can email comments, you can just email free comments to the email address that's there or indeed you can actually write to the Freepost address or send the documents that you've got with the consultation questions to that Freepost address. All of that will be taken into account by my colleagues from Proportion and they'll produce a report for us at the end of the day in terms of what the consultation has said. In terms of access to more information I think one of the learning points for us today is that we can actually provide a little bit more information for people actually at the venues when we have the meetings, but equally the website, particularly the Seizing the Future website has got all of the detail behind the presentation and the discussions and everything that's gone on with clinical colleagues and a range of people thus far, so a lot of the detail's there if people want it. If you find that is not accessible, if you get in touch with us at NHS County Durham, we'll try and get the information to you and make sure that you have got the chance because at the end of the day, when the decision is made, whatever the decision is, it needs to be made in the light of the evidence and people need to be fully conversant with and fully understand the issues and why decisions are going to be made and what the issues are, so all we can ask is, you know, if people are having trouble accessing the information, please get in touch and let us know.

Having said all of that I just want to thank you all for your input, both in terms of listening to colleagues from the Foundation Trust, your questions from the floor and particularly for your comments and discussion around the table, it's all very valuable and somebody made the comment earlier on about the NHS constitution actually belonging to the people, absolutely, and that's why we're going through this process, we're not going through it just for the sake of it, we do need to listen to your views, we need to take account of those and please rest assured, we'll do that. So thank you all for your time and your input and I hope you all have a safe journey home. Thank you.

(End of meeting)

Seizing the Future Public Meeting
Chester-le-Street District Council
Civic Centre, Newcastle Road, Chester-le-Street
Thursday 6th November