

Seizing the Future Public Meeting
Sedgefield Parish Hall
Front Street, Sedgefield
Monday 3rd November

Representing the NHS:

David Gallagher, Director of Corporate Strategy, Services & Relations - NHS County Durham

Steven Eames, Chief Executive - County Durham and Darlington NHS Foundation Trust

Amanda Hume, Director of Workforce and Corporate Development - NHS County Durham

Bob Aitken, Executive Medical Director - County Durham and Darlington NHS Foundation Trust

Neil Munroe, Consultant Physician and Clinical Director for Medicine - County Durham and Darlington NHS Foundation Trust

DG: OK ladies and gentlemen, can we start proceedings please? First of all, I'd just like to welcome everybody to this the first of a series of public meetings that we're having about Seizing the Future, which we'll explain a little bit about. My name's David Gallagher, I'm Director of Corporate Strategy Services & Relations at NHS County Durham, or County Durham PCT might be the way that you've known the organisation in the past. We'll do a series of introductions for people who are sat alongside me to start with and then I'll just go through a little bit about the Agenda and the process for this afternoon, and then we'll take it from there, so I'll ask Steven to introduce himself first.

SE: Hi, good afternoon everybody, I'm Steven Eames, Chief Executive of County Durham and Darlington Foundation Trust.

AH: Hi, good afternoon, I'm Amanda Hume, I'm a director at the NHS County Durham along with Dave Gallagher.

BA: Good afternoon everybody. My name's Bob Aitken, I'm the Trust Medical Director.

NM: And I'm Neil Munroe, Consultant Physician and Clinical Director for Medicine across the organisation.

DG: OK. Thank you. We've also got a number of staff from both the NHS Foundation Trust and also the NHS County Durham who are sat amongst you in the audience, and we've got some colleagues from an organisation called Proportion who are also here to actually help us with the process and I'll explain a little bit about that as we go on.

Just before we get into the discussion properly really, I just want to ask people if they could actually switch their mobiles off, or certainly switch them to silent please, this is where people go scurrying to their handbags and their pockets to sort that out, I hope desperately I've done that already. We're not expecting any fire alarms or any fire bells, so if the fire alarm does go off, it's the genuine thing as far as we're aware, in that instance if we make our way to the back end of the room there and then turn left, we're back into the car park. If anybody needs to use the toilets, the facilities, they're at the far end, if you go out the doors and beyond there the toilets are to your right as you go through there.

My job really is to try and keep things to time and to get us to really have an opportunity here for people to have their say in this first discussion about a really important piece of work that we're leading on in NHS County Durham but it's very much the work and the day to day business of Country Durham & Darlington Foundation Trust and we'll here a little bit about that in the presentation as we go on. The Agenda you can see before you, you should actually have Agendas on your table. We'll start with this welcome introduction session, I'll then ask the Foundation Trust to actually give a presentation and a number of colleagues will go through that for about half an hour. We'll then have a session where we've actually got some

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open questions from the floor and we'll do that so people have the chance to ask questions in relation to the presentation itself and after that we'll have what we call round table discussions. We're probably going to ask John, our colleague from Proportion, who will actually facilitate that in the room, because we've got a fairly small group this afternoon, to actually get some discussion and answer some key questions that we have for you in terms of the consultation, but it's also another chance around the room to actually get some feedback in and to actually get some questions to the panel.

At the end of that session we'll have a bit of feedback with that and then we'll close by explaining what the next steps are as part of the consultation.

I want to start though just by explaining on the next side there, really the roles and responsibilities, in essence our roles of Amanda and my roles sat here from NHS County Durham ... we as an organisation are charged with actually commissioning or buying services on behalf of the people of County Durham and Darlington. We spend in total about a billion pounds worth a year which is a staggering amount of money and what that goes towards is not just hospital services, it goes to mental health services, community services, dental services, health promotion, health improvement, so it's much bigger than the piece of work that we're talking about today but nonetheless this piece of work is really important because it's about the acute hospitals, the three main hospitals that actually provide services for local people in County Durham and Darlington.

In essence we've got a number of things that we need to do, we need to improve health, we need to reduce health inequalities and crucially, and this is where it links in with this piece of work, we need to make sure that the services that we commission or we buy on behalf of local people are safe, are sound and sustainable, and that's really important because we need to make sure that the services are there to last and to make sure that they actually deliver what they need to do.

The consultation as I say is about three specific hospitals and the future use and reconfiguration of those hospitals. It's not necessarily about the whole system, though inevitably a lot of it links in with the whole system and certainly one of the things we're not talking about today are the use of the community hospitals or community services, although as far as we're concerned they aren't going to change other than they may actually be enhanced and improved and in particular the use of the community hospitals as time goes on to actually balance some of the work that we're talking about today and maybe that will come out in the discussion later on.

In terms of the roles and responsibilities for the process today, we're chairing this, we're sort of leading the process, colleagues from the Foundation Trust are going to actually present their case and be part of the discussion and just as importantly colleagues from Proportion who are around the room have a role to play in actually making sure that we actually capture everything that's said or done in the meetings. That's really important because it's feeding into a formal consultation process and there are a number of ways that we're doing that. We'll be capturing via the sheets on your tables, with flipcharts, but also ... and this is the scary bit I guess for people ... we're actually recording the proceedings as well, so one of the reasons we've got the microphones is to actually record the responses and we'll take all this as evidence as part of the consultation, so rest assured, if you think we haven't captured anything it's there and we're trying to get absolutely everything that's said as part of the process.

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In terms of the meeting it's really important that we see this as being a two-way communication process. It's very important that we give opportunity to the Foundation Trust and other colleagues to actually have their say and explain why we're suggesting what we're doing, equally we need to listen to your views and take account of those and what I would ask of people is because we've actually got it set into those key parts of the Agenda that we actually let people get on and say their bit, there'll be a chance for people to have their say in the open plenary session, there'll then be the chance to have the discussion in the round table

sessions as we talked about, and then there's feedback, so there should be ample opportunity for everybody to have their say, and please I don't want anybody to leave the room feeling they haven't had the opportunity to have their say and get things off their chest if that's what they want to do.

All of this feedback that we capture as part of this will actually be assimilated and taken into the consultation process and I'll say a little bit about that towards the end of the afternoon once we've actually been through some of the business. So if we can get on with the Agenda now really. I'll ask Steven to actually take ... he'll introduce colleagues as he gets into the presentation. Steven.

SE: (*Off mic*) Good afternoon everybody, again. Can you hear me without using the microphone, is that OK? OK. I'm must going to introduce this presentation with a couple of slides and then I'm going to hand over to Bob Aitken and to Neil to take us through some of the clinical case and clinical background to our proposals, then I'll come back at the end to pick up a few slides before we finish and move on to the next stage as outlined by David. Just to remind you, Seizing the Future is a piece of work that's gone on for nearly a year now, it's a significant piece of work, obviously informing how we would propose to organise acute services across County Durham and Darlington, as David said of course there's an impact there with other related health and social care services as well, and the thing I wanted to highlight on this first slide is I guess the two words within that particular statement, we're looking to provide the best possible services that we can for our communities and for our patients, that means a striving for excellence consistently year in year out, and also we're looking to maximise the use of all of our hospitals whether they be predominantly acute or community health service.

Can we move on to the next slide please? I just want to set up the rest of the presentation with these five key messages. I've alluded to this already, this work has gone on over the last year and has been driven by our clinicians. We've talked about doctors, but actually therapists, nurses, other professionals along with our doctors have been fully involved in leading this work. This is the product of a significant amount of debate, thinking with our clinical staff, that's also gone on with the Governors of the Trust and with the Members of the Foundation Trust, so that ... those discussions have been informed by the views of the users of our services. That's the first point.

The second point is what we're trying to achieve here is what's set out very clearly as the fundamentals underpinning the national reform of the National Health Service which is for safety reasons, for improving the outcomes of the patients in terms of the services that they receive, there are some areas of care that we need to centralise, that we know that providing them as they are now and into the future means those services will be increasingly fragile and it will be very difficult to deliver excellence moving forward, but everything else, we want to localise services and that's why all of our hospitals which are neatly distributed across the communities they serve are very useful to us, they're really important in the context of where we're going in the future. Therefore we're maximising, as I've already said, all of our sites,

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albeit in different ways, it's about using those sites together with other professionals in health and social care to give the best possible care that we can in local settings to local people.

Just to dispel one or two I think of the perhaps understandable messages that got into the media, first of all, there are no closures whatsoever. Yes, there are changes in services, but there are no closures, and we would contend there are no reductions in services, there's a different way of delivering those services but no reductions in service. And finally before I

hand over to Bob, there are no redundancies either. We regard these proposals as providing an exciting environment for our employees to work in the future, responding to the national modernisation agenda across the National Health Service and it puts in place I think a real platform for growth in our workforce, so we're not talking about redundancies at all. With that I'll hand over to Bob if I may to talk about the clinical case.

BA: (*Off mic*) Thanks very much Steven. Where best to stand? Can everybody hear me? Can you see the slides? Can everybody hear me OK? Yes? Steven already alluded to national driver, Lord Darzi's work, where, you know, he's (*inaudible*) moving into centralised services where appropriate but localising them where possible and obviously continue to deliver the highest possible care to the patients. I want to talk a little bit about specialisation and what I mean by that is where we really need to centralise certain of our services and there are a number of drivers in that direction. Over the past 10 to 15 years, almost in every specialty, across the whole gamut of clinical care, there's been increasing complexity of treatments we are expecting and are able and therefore (*inaudible*) which is the specialties in some (*inaudible*) and it makes it not cost effective to run it on a whole number of sites within a given organisation. There also is the ability of clinicians to actually use that special equipment or you know to be able to provide the increasingly complex procedures that are becoming increasingly available. So there's only a few (*inaudible*) the most complex. Then there's also, I'm going to use an expression called critical mass, and that's a thing we use fairly frequently when we're talking about (*inaudible*) developing services, and that is where the experts tell us the amount of activity we need under any individual to be providing these fairly complex changes for example to maintain a level of expertise that will be recognised nationally as recognising that individual or that team as being expert in delivering that particular form of care. So we're going to look at critical mass of certain types of activity that we provide in the organisation, and the reason we've been driven in that direction and I think a lot of it comes from my own background as the lead clinician for gynae cancer services where, almost a decade ago now, we got pushed with the national cancer plan to say we should be looking to centralise the (*inaudible*) with cancer surgery because there was lots of evidence from around the world, in America and Germany in particular, where if you put all of the say cervix cancer surgery in the hands of fewer individuals the outcome for patients was much better, and when we've gone in that direction and we've monitored the outcomes, there isn't any doubt now that the outcomes for patients significantly improve when you set up services that way.

Now if you listen to George Alberti and Roger Boyle who have looked at stroke care and heart attacks and trauma etc. the same has now been seen for acute emergency care, that it's actually often better for a patient to travel a bit further to be treated by the expert with a supporting team and you get better outcomes than to go to the local hospital that is staffed and equipped to a lower standard. So we've got to look at that within the organisation.

(*inaudible*) working ours is a thing that's been on our Agenda for quite a long time, it's about a thing called the European Working Time Directive. It's come in in three phases and the final phase of that is coming into force in August 2009 and at that point junior doctors,

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trainees in our terminology, will no longer be able to work any more than 48 hours in any given week. At the moment they can work 56 hours and when Robin and I were alive we could work up to about 120, 130-odd hours and that was OK. We provided what we thought was reasonable care but the number of times were off the planet really, when you look back now, were we delivering the best care to the patients? Those days are long gone, but when we look at the effect on our organisation of going from 56 to 48 hours it means that we lose the equivalent of 31.4 fulltime equivalent junior doctors from the organisation, and that is

(*inaudible*) we lose their presence on our on call rotas, in a whole number of areas in the organisation, that now will render our on call rotas non-EWTD compliant. Now it's a fancy term but that's pretty serious for us as an organisation because what happens when the specialist training committee comes round and looks at the training opportunities and the type of working environment you are providing for junior doctors, if your rotas are non-EWTD compliant there is a threat that training (*inaudible*). If you lose that, you lose the ability to employ junior trainee doctors. The jobs then become much less attractive for consultants to come and work in the organisation.

There are also .. what should have been on this slide, there should be another bullet point and certainly the effects of national recommendations on these services. The way we define them at the moment was actually following the advice of Lord Darzi when he was Professor, I can't remember if he was a Sir then or not, Professor Ara Darzi, who came and looked at our good services in County Durham in early 2002, so we are presently configured from his recommendations, but there's been a lot of changes in the recommendations since 2002 in a whole number of services. Let's take Accident & Emergency. In 2004 I think it was there was a charter given to the newly formed College of Emergency Medicine and they spent a whole load of time working on what standards they would recommend for Accident & Emergency Departments and I've actually said all along that emergency care should be delivered by a combination of Accident & Emergency departments, fully staffed, fully equipped, and a network of minor injuries units, a bit like what we've been providing for a number of years in Shotley Bridge. Now going back to the expression critical mass, the College does recommend the amount of activity that should be coming through an Accident & Emergency department, the types of services that should be provided in as it was the back shop, levels of different care, these levels 1, 2 and 3 will come up a couple of times with things that we talk about this afternoon and if you take ... the walking wounded being level 1 and your severe and multiple injury patients being level 3 and 2 being in-between, right? There are levels of staff and equipment provision that you need to deliver care to the different categories of patients. People in clinical care, there's level 1, 2 and 3, level 3 being the sickest patients who need more support and most expertise and support. So we've got to take cognisance of the recommendations going forward. If I tell you at this point in time that applying those recommendations that we don't have enough Accident & Emergency work in the County of Durham to have three fully fledged, equipped, manned Accident & Emergency department to satisfy the critical mass of activity criteria.

Let's take acute medicine. That is people coming acutely into hospital with a medical condition as opposed to a surgical or a trauma type condition, it might be related to (*inaudible*) etc. In 2004 the Royal College of Physicians recommended a significant change in the way we offered care to these very sick patients and they came up with a new type of doctor called an Acute Care Physician and these are doctors who are specially trained on a number of areas to deal specifically with the sickest patients for the first 12-24 hours after they present at the hospital. Thereafter we should look to pass the patient on if they're not ready to go home by that time to the appropriate 'ologist' in the 'back shop' as Neil describes it, on the best wards where there are respiratory physicians for people with chest problems,

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cardiologists for heart problems, etc. etc. etc. And we should be trying to deliver that model of care as soon as we can.

Now if I tell you that presently at Durham we have that model of care, we have got acute care physicians on the ground, two, not three which is the national recommendation ...

SE: We believe passionately these proposals are about securing a long-term future for all of our services and therefore a long-term role for all of our hospitals in delivering those services. We're proposing a series of changes here that also ensure in the long term safe and secure services for our patients and we also believe that by making these changes that creates an environment in the future that sustains a strong and vibrant position for our staff. David.

DG: Thank you Steven. Thank you gentlemen and thank you to everybody for bearing with us and actually listening to the presentation. I said at the start this is very much a two-way communication process. This is now the part of the afternoon we're getting into different sections where you have your opportunity to have your say. The first section we're going to move into now is an opportunity to ask some open questions from the floor to members of the panel and to colleagues from the Foundation Trust. If you could limit those for the moment please to questions about the consultation, about the presentation that you've heard, there'll then be an opportunity which we'll ask John to facilitate later on where we actually have a chance to ask you some questions about that as well, so having said that I'll open up to the floor. Would anyone like to start with the first question please? Rosemary at the back please.

R: *(inaudible)*

DG: Sorry ... because we're recording this, we need people to talk into the microphone.

R: *I've listened to what you've got to say and I don't want to be insulting to anybody but the gentleman who was speaking first when I came in, there was a lot of the things you said that a lay person won't understand, a lot of jargonistic things, which in ... as you go round with your consultation, and I agree, I'm fully aware of what's going on within the changes and the evolving health service around the Darzi report. I've done, as a PPA, a forum member, we've done surveys in your urgent care centre in Bishop, reports are at the PCT, we have had concerns in the past about elderly clients having to wait for ambulances in states of undress etc. They are things that concern me. I did wonder if after you've gone to urgent care at Bishop would there be a rise in 999 calls because people are saying we've got no A&E, we'll dial 999. That was another thing that went through my head. And the one thing that as a psychiatric nurse I've noticed you haven't said is how you will provide for someone with mental ill health problems who may be in an acute state and present themselves at your urgent care, will you have A&E liaison staff, will you have crisis resolution staff, these people are in distress just as someone in a medical or a surgical emergency, and they're my concerns.*

DG: OK. Thank you. I mean the first point on jargon is a really helpful one and I think that's something we'll challenge ourselves to make sure that we don't lapse into that. The two questions about A&E, possible increases in 999 calls and mental health issues ...

SE: Just to ... regarding people phoning 999, I mean there's a lot of people do anyway and for a variety of conditions, some of which are appropriate and some of which aren't. Of course, paramedic staff are now increasingly trained to make decisions rather than just pick somebody up and take them to hospital and that then allows them to make decisions whether the patient

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does need to come to an emergency department, if so, what sort, or whether they can reasonably stay at home and be given appropriate advice regarding ongoing care.

With regard to mental health, yes, there are a proportion of people who attend any emergency department who do have mental health problems. We've not ... this is not done in isolation in this whole process and the Mental Health Trust are well aware of these proposals, but to say

that we've got specific proposals in answer to your question, I don't have any slides that show those at the present time. But your points are well made.

R?: Yes, the point on the crisis resolution, etc. I've sat personally for three hours in urgent care at Bishop with a relative waiting for a crisis resolution team. It's not good enough.

BA: Once more the Mental Health Trust is separate from our own, and we do liaise with them.

R?: Yes, I know but I would have thought that this consultation you were ensuring that people who were in a mental health crisis, you had the right provision in place from Tees, Eske and Wear Valley.

SE: Could we just say that I think we ...

DG: I think Diane might have an answer from behind you there Rosemary.

DM: I'm Diane Murphy, Project Manager for Seizing the Future. Just to say that I have had conversations and discussions with Tees Eske and Wear Valley Trust about the proposals obviously and they will be responding on the proposals, but specifically in relation to exactly what you're talking about, crisis resolution, how A&E are supported when people with mental health problems present at A&E and the difference for them obviously would be that they have to provide a service to two sites rather than ... to two A&Es rather than three A&Es, and they are looking at that and to how they would reconfigure their services to do that but that actually would enable them to provide possibly a more responsive service on two sites over and above three sites, and in terms of the service on the Bishop Auckland site, we've got nurse practitioners in post at Shotley Bridge hospital who deal with patients if they present like that. Generally they're not presenting at Shotley Bridge, but if they did present we would have nurse practitioners who were skilled and actually would arrange for the appropriate transfer of those patients to the right A&E department.

DG: OK. Thank you. We've got a next question, this gentleman?

??: Thanks for the presentation. I found it quite convincing. Just one point, I think if you're going to sell it you're going to really have to get to the public, I don't think we really are the public, I think somehow you're going to have to engage with them out there, apart from people booking in somehow, and you've got to engage also in the media I think because that would be used against you. But just a question, the hours of doctors working, 48 hours, does this also debar them from working in private hospital doing private work outside the 48 hours, or doing overtime at the weekend outside the 48 hours?

BA: Doctors tend not to do private work out of hours, but certainly it should preclude them from doing anything that takes them beyond 48 hours in a given week.

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?: If an employer for example, in a private hospital, knows that they've done 48 hours already for the NHS and takes them on, they are as equally culpable as the doctor themselves, but that's ...

?: *It will be monitored will it?*

BA: Well I have no way of knowing whether my junior staff are moonlighting, but equally it's a risk that particularly a private employer would be unlikely to take.

SE: We do take action, occasionally we are ... it is brought to our attention and we do take action to ensure that they don't do it again.

DG: OK. Thank you. I don't know if people are aware about it but actually the European Working Time Directive applies to most people anyway, most members of staff, it's just that actually the doctors and junior doctors particularly are just catching up in the process.

BA: I like the situation with consultants, you can still opt out as a consultant and do work more than 48 hours. But that may change in the not too distant future.

DG: OK. Thank you. We've got a gentleman in the back corner there.

?: *Yes, thank you. In the course of the presentation you mentioned two key factors about the future of Bishop Auckland General, that was recruitment and retention of critical care staff and the Working Times Directive and its impact on staffing the units. How much of these two factors have stimulated this reconfiguration of service? Would you have put it off for a little longer?*

EG: Yes, I think I'll ask Steven to respond to that one please?

SE: Yes, other colleagues may wish to comment on the specifics. We've mentioned those obviously as key reasons why we need to change, but what I want to emphasise actually is this is about all our hospitals, it's not just about Bishop Auckland. The sorts of pressures we're talking about here apply to all of our services and the key point is that if we can't make the sorts of changes that Neil and Bob are outlining in particular then this will affect Durham and Darlington just the same over time, because the sorts of rotas for example that we current have that are creating the pressures now, once the European Working Time Directive begins to bite next year, in a legal setting as you've heard, we'll have the same problem elsewhere, so it isn't just about those two things, and therefore we think ... we think this is why we wanted to move so quickly through the consultation ... we ... we actually know that in a year's time, if we were still struggling in this way we would be in some considerable difficulty, not just at Bishop but elsewhere as well, so there's no room for delay as far as we see it from a professional point of view.

BA: I'll add a bit from the acute care point of view, the one thing I've experienced as Medical Director and I think I alluded to it during the presentation, is that the .. more by accident now than by design, the merger of the medical teams of Shotley Bridge and Durham has made Durham a bigger unit than Bishop or Darlington, but because of that and, you know, because of acute care ... it's much more robust, you know, to changes. Steven did allude to it. We added ... to have a really serious problem pending with about three weeks to go of the change of medical rotas for the on call rota at Darlington, not at Bishop, so both Darlington and Bishop are prone to little changes, you know, two doctors deciding they've gotten a job as Medical Registrars in Darlington decide they're going to go to Australia and you've got three

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weeks, can't you find anybody else to take the rotas and if it's not European compliant you're in real trouble if you can't find locums, and locums because of the changes in medical training are becoming fewer and fewer, you know, they're not growing on trees, let's put it that way.

SE: And if I could just add one other brief point which I think is quite important in relation to your question, is there isn't a surfeit of doctors out there. It's a very competitive market and it's partly because the Government have made changes in terms of overseas recruitment of doctors in recent times, and also because the number of trainees coming through the system

aren't ... they aren't of the same order, therefore young doctors coming into training positions will be looking for jobs that give them adequate training, 48 hour working week, opportunities to pursue whichever branch of medicine that they're in and some of the ways in which we're structured it's just very unattractive in that context, and you would see that repeat partly across the whole of the north east where these sorts of changes are taking place in different ways in different places. There's a real worry that even in the new recruitment that's coming up next February a 16% vacancy rate, and that doesn't sound very high but actually it's in some very significant areas like anaesthetics where if you can't recruit people you can't actually run the service, so that's the backdrop to all of this.

DG: OK. Thank you. We've got a gentleman at the front here I think, and then I'll come to you next sir. This is where you need to be on roller skates and move round quickly don't you?

CO: *Good afternoon. My name is Clive Ord and I am spokesperson for Save Our Hospital campaign group at Bishop Auckland. I am a dedicated independent person, I am not affiliated to any political party and our activities in the future are going to be based on care for the community and particularly I feel at the moment and I think a lot of our committee feel is that the preservation of life which is a basic right for everyone has been overlooked here, and I think this is all about money, you're taking services away, you're not replacing them with ... a few doctors for God's sake to run an A&E. I know it sounds minor to you, it's massive to us, but I think the people of Bishop Auckland surrounding area deserve to have the facility for basic healthcare. We all accept that if you have a major problem such as the cancer, or the heart, we have to travel to get quality, we all accept that, but to get basic healthcare I think you're taking it away from them, and I think it's scandalous, I do really and really, gentlemen, ladies, have a think about this, have a think, speak to the people. I've spoken to people over this weekend who work for the NHS. Do you know, they're terrified to talk, they're terrified to talk about what's going on within the NHS. You know, that frightens me. And the reason why they're frightened to talk is because if this do talk and they are identified, they'll be sacked, that is shameful. That these people, it's not one, it's not two, there's been three or four people this weekend and I had to offer them total anonymity if they want to talk to me privately about what's going on in there. It is shocking and we feel very very very disappointed and let down. I am, as I say, independent, I'm not on a bandwagon or anything like that, I'm not in it for any other reason apart from helping the local people of surrounding areas of Bishop Auckland to have basic healthcare folks. You're taking that away. You can't take it away from them. You can take the major stuff away, we all agree with that. You cannot take away basic healthcare and preserve life, and the preservation of life is to get to a hospital quickly and get looked after straightaway. Never mind travelling to Darlington and Durham and all over the place and congesting all the roads with ambulances and fleets of cars and transport and that, give them what they need. Gosh! I mean you're spending millions and millions. Tell me? Who can answer this? You're going to redevelop Bishop Auckland ... how much is that going to cost? Anybody know? The redevelopment? Nobody knows.*

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SE: Well we do.

CO: *Well tell me, how much is it going to cost?*

SE: If I just may say this, in response to that question, but I think there's loads of important things you've said there that we need to respond to. We're going to be spending in these proposals around about £7m OK? And the other point to make about Bishop Auckland hospital, it's not fully utilised currently.

CO: *Yes. And ...*

SE: And our plan, which I think just to come back to something ... our plan is about utilising the hospital more. More.. Not just for the residents of Bishop Auckland ...

CO: *I don't accept that. I don't accept that Steven. You're not utilising it more, you're utilising it less. That's what you're doing.*

SE: Can you let me respond? Can you let me answer, you've had to air time, just let me just respond to your question which is we are intending to use Bishop Auckland more than we do at the moment and indeed not just for Bishop Auckland residents, it's not just about that community, it's about all the communities that we serve. I think there are some other important points that you made that others may wish to respond to, I wasn't sure whether you'd completed what you wanted to ...

CO: *No, I haven't, no, no. You tell me that actually the A&E at Bishop Auckland has been demonised for 10 years, it's been gone for 10 years, is that right? We didn't know that, the people don't know that. Someone here has just said*

SE: But I suppose basic healthcare in the context of ... if I understand what you're saying ...

CO: *Yes. Never mind level 3, but ...*

SE: Just on that point it would be about making sure the full range of emergency care services are available to everybody and I think the point that Bob was making was that that hasn't been the case for some considerable time at Bishop Auckland.

CO: *Why not?*

BA: Because ...

CO: *Why has the services not been there at Bishop Auckland, why?*

BA: Because it was felt that the medical staffing wasn't up to an appropriate standard...

CO: *Oh I don't ... oh come on! Are you criticising the dedication of the nurses and staff at Bishop Auckland?*

BA: No, I'm not. I'm sorry but I'm not ...

CO: *I think you are.*

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BA: I'm not. I actually said during my presentation that the staff are continuing to work really hard and providing excellent results under very difficult circumstances.

CO: *That's easy words, but what you're saying now Bob ...*

BA: Can you let us please finish?

CO: *Go on, carry on then.*

BA: I've had to listen to you go on.

CO: *Carry on.*

BA: Yes, and that College has come round to look at training requirements, critical mass of activity, support for junior medical staff to allow them to be properly trained, yes? Anaesthetic training was removed from Bishop ... about 12 years ago Robin? More than that?

R: *(inaudible)*

BA: Yes. Yes? So I mean that was because of the level of support that was being provided for the most junior doctors, it was felt by the College ... and especially training committees that it was not appropriate. It was the same for trauma.

CO: *So in actual fact what you've just said there is that the staff at Bishop Auckland are not up to the game? Is that what you're saying?*

BA: No that's not the case.

CO: *You didn't say that, did you not?*

BA: No I didn't, no.

CO: *Well we'll play it back and just .. we'll have it repeated what you've just said there because I think you were having a slant at the quality of staff at Bishop Auckland which I don't really agree with you know ...*

BA: No, I'm sorry ...

CO: *We'll move on from that ... we'll move on front that ... so the services are going to be removed from Bishop Auckland.*

SE: Can I just respond to one of your earlier questions?

CO: *Certainly yes.*

SE: I'm very concerned if there's a feeling that staff in the NHS feel they can't actually be part of this process and actually feed into it. Now obviously it's not within my organisation, I'm another part of the NHS, but any member of staff, any member of the public should feel well able to actually come forward and put their views forward as part of this, generally there will not be any recourse to them and actually from what I've seen from the work the Trust's been

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doing, they've involved their staff to a high degree in this. They could always do more, I'd agree with that, but we do need to be careful that people should not worry or be concerned about any recourse because of things they may say.

CO: *OK, can you accept from me I would not come here and say things which are not true.*

SE: Yes.

CO: *OK.*

SE: I think we'd accept that but I think as the accountable officer for the staff who work at Bishop Auckland I have made it my personal responsibility because ... endorsing Bob's point these are people who are working really hard in some cases in very difficult circumstances, providing a service to the local community. I've made it my personal responsibility to talk to them all and I've been into the departments talking to them all, and naturally some of those people are concerned about the future. So would anybody be when a change is being discussed. None of them have felt that they couldn't talk to me. None of them have felt that they couldn't say what they wanted to say. None of them are being sacked, just to really emphasise that point that you made earlier on. If somebody's saying that please point them towards my office and I will reassure them personally that they won't be sacked. I've said that staff already everywhere. This is about opportunity for our staff in the future, not about taking away their jobs, especially in the climate where it's very difficult for people on ... which many of our staff are in Bishop Auckland incidentally, on low wages. These people are concerned about do I have to travel somewhere else? Will I have to buy a car? Will I be able to feed my family? Now, we are responsible employers. We're taking all of that into account and I'd like you to take that message back to those people and please get them to come and talk to me personally if that's their concern.

CO: *Well maybe they'll be very frightened to identify themselves because of what they've said, but having said that I think it's fair to say that the staff at Bishop Auckland, it was renowned for excellent staff, where they all are now I don't know. I know a lot have been shipped away to Darlington and what have you, which you're doing anyway, but having said that ...*

SE: (inaudible)

CO: *Please accept, if you'd just give me a second, please accept that we will be fighting you very hard against your proposals. We feel obligated to do that on behalf of the general public and the people, it's nothing personal here at all, nothing personal for any of us. It's a sad state of affairs when we have to do this folks, but ultimately we'll be back in touch with you, we need to speak to Alberti, we need to speak to all the top people who are making these decisions and let's get it out and let's see what we're doing because folks, the groundswell of opinion is massive in and around the areas but thanks for the opportunity anyway, thank you.*

DG: No more questions from yourself, no? OK. What I'll do when we come to the end of this is I'll explain the process because I think that will actually clarify how people can feed into this and that needs to fit within that formal consultation process. I've got a question from the gentleman over there and then I've got a question from the gentleman in the blue at the back and then we'll come to you sir. Oh, or possibly not in that order.

?: *I think mine will be short and sweet. You're on about catchment areas and postcodes earlier on. Sedgefield's a TS postcode and at present we're generally referred to Teesside hospitals. Will these proposals have any bearing on that?*

DG: I'll answer that one shall I? From a commissioning point of view we buy services for all the people in County Durham and Darlington, that doesn't matter whether it's a hospital in County Durham and Darlington, whether it's in Sunderland or North Tees or Hartlepool or indeed Bournemouth because people can choose where they go to, so this will not force people to go into any of the hospitals, this is really about the services within those hospitals, and if you sir normally go to another hospital you'd have a choice to go to hospitals in County Durham, but equally you have the choice to continue to go to the hospitals you would normally do, so not a bearing from that point of view.

?: OK. Fine.

DG: OK. As you are over there, do you want to ... ?

?: *Thank you. I used to be the Chairman of the Patients' Forum for the ambulance service and just before we were abolished about 18 months or so ago one of the things that we were made aware of was the beginning of a process of reviewing PTS services throughout the region and one of the things that we were aware of, some ... and I'm not saying your Trust, but some Foundation Trusts were looking at their use of PTS and deciding on cost grounds to commission taxi companies to take patients in and out of outpatients departments, and I was interested in what you said about further investment in the PTS service from the North East ambulance service. I would welcome that because one of the things that ... unfortunately because we were coming to the end of our time we weren't able to investigate it from a patient's perspective, but one of the fears that our group had was that if Trusts, whether they were Foundation Trusts or not, went down the route of using taxi services instead of the ambulance service PTS, the patient would receive a much poorer service because with the PTS transport it's not only a case of waiting outside the door and picking them up and taking them to hospital and bringing them back in, the staff, the crews, see them in the house, see them out of the house, see them in the hospital, outside and all the little extras and our fear was that by going to taxi services that would be lost and be a poorer service for patients.*

SE: Could I just respond to that? Well first to reassure you, we're not ... certainly not going to be moving towards taxi services and my understanding of the PTS service is of course that certain criteria area applied and if you meet those criteria then you're entitled to that transport and I'm not aware of any changes to those standards in our proposals. I think what I was alluding to when I was talking about investment in that direction was, obviously alongside all of this as I said, there's an awful lot of work going on about how patients move around, the patients move around as you rightly know from experience already but how will these changes affect that, and therefore we might need to make some adjustments to those services to reflect it, and I guess where our main investment is, it's more about complementing what the PTS does. Perhaps for those people who are a bit more mobile, but actually access is pretty poor, to certain locations, so that service that we're describing briefly here will be about filling the gap there and making sure that we can provide ... in some cases I think I'm right in saying a door to hospital service as well.

DG: OK. Thank you. We've got time for probably three more questions and then we'll move onto the next section. I think there were a couple of questions on this side, we'll come back to you in a moment sir. Go on, the gentleman over there.

?: *Hello I'm also from the Save Our Hospital campaign group from Bishop Auckland. Steven you used the phrase that you like to maximise the use of all sites within the Trust. I'm a wee bit confused. Would it be more value for money, taxpayers' money, to invest in a new site*

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rather than an old site which is 30, 40 years old? Because that's what you're doing. You're investing, you're putting all your eggs in one basket into an old building. Bishop Auckland has a brand new building, six years old, £67 million taxpayers' money, we'll be paying for this for the next 24 years.

Also Steven if you could answer this question as well. We have the state of the art path labs at Bishop Auckland. Why waste £1 million on a new path lab in an old crumbling building such as Darlington? Would it not be more wisely invested, that £1 million, into services at Bishop Auckland, rather than investing it and spending it in an old building?

Also haematology, haematology was recommended for Bishop Auckland, Darzi report. It didn't come. Our MP has fought and fought and asked questions why it hasn't come and I'm almost certain that she went to press last year, that finally haematology was coming to Bishop Auckland. We're still waiting. If haematology was promised to Bishop Auckland and it hasn't come, how can we believe the Trust, the Board, that this is the best move for Bishop Auckland? How can we believe you when haematology was promised and recommended, you did not deliver.

Another thing. Bob, I quote ... you said it's far better to go a little further, travel a little further, that's your opinion.

BA: No, that's the learned opinion.

?: *The land of opinion?*

BA: Learned opinion, internationally.

?: *Internationally?*

BA: Yes.

?: *Well I'd like to challenge that because if I was in an ambulance, with the blue light going, I would want to get to the hospital, the nearest hospital, every second counts.*

BA: Well that's the point we're making though, it's only ... the nearest hospital if the hospital is appropriately staffed and equipped.

?: *Midwifery unit. How long will it be before that closes?*

BA: There's no plans to close it.

?: *Sorry?*

BA: There's no plans to close it.

?: *There's no plans. Well we'll see further down the line.*

DG: Can I just ask if we actually respond to the questions as you ask them.

?: *OK sorry.*

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SE: Because I'm trying to write them all down. First of all, look, I can see from both what your colleague here has said and what you're saying and I've seen it elsewhere as well, as you know, in some of the meetings that we've been together in, the concern of the local community in Bishop Auckland, I think that's undoubted. I guess in terms of the question you ask about haematology, if I can just mention this, I'm going to pop that across the line to Bob in a moment and that precedes my particular time here on this patch, but you know what I come back to with all of this, as has been said by other colleagues, we believe this is the right thing to do for all of our communities, and I know that we're focusing in on Bishop Auckland but this is about all of our communities. Our hospitals don't work independently, they haven't done for a long time. They don't work independently. We tried to move them

into more collaborative and working together to meet some of the demands that have been raised here. You raised a point I think about investment and why would we invest in old buildings rather than new. Well we are investing, we're massively investing in Bishop Auckland, it's a massive investment as you rightly say for the next 26 years, and my concern, my clear concern which I think I've said to you before privately is that investment at the moment is not being made full use of. We can make more use of those facilities. Bob talked about day surgery. Fantastic facility, one of the best I've ever seen in the country anywhere, but we don't use it properly. What we're actually talking about doing is using that much much more, more patients than there are now going through that facility, a brand new cataract centre, a centre of excellence for rehabilitation care, meaning people will get better quicker in County Durham and Darlington than they do now. All of that's really really positive.

And on the point about taking things away, we're not taking anything away, we're changing the services round so that we can make sure that we provide, and I'm speaking on behalf of my clinical colleagues particularly, that we provide good safe care. We fear we won't be able to do that unless we make these changes.

DG: Bob did you want to comment? Sorry, can we just pick up the haematology bit and then ...

BA: Yes, the haematology bit was discussed at Board ... that we would plan to make the move but what happened was that the service review was called and there is no doubt that haematology who sometimes acute very sick patients needed to be where acute medicine was, so the move was put on hold until we got to the end of Seizing the Future deliberations just to see what was going to be the recommendation for acute sites and that was a decision that was taken by the clinical staff from both Darlington and Bishop Auckland sites, they felt it would be better to stay as they were until such times as the Seizing the Future was ... the work had been done.

DG: Yes, and Bob can I just ask you to comment on the midwifery comment or question that was made as well please?

BA: I'm not aware of any plan to close the midwifery led unit, it's been hugely successful, in fact one of the things that's been very pleasing for me, some of you may have seen me before on the platform, when I was Clinical Director in Obstetrics and Gynaecology and for European Working Time Directive reasons and one or two other things I felt that we needed to future-proof the services by joining the consultant units of Darlington and Bishop Auckland, and that caused quite a significant (inaudible) and I could fully understand that. The one thing I would say is that this time round, the maternity services haven't been affected at all, so we have managed to future-proof them to a certain extent, although Lord Darzi's chipping at our heels again, so going forward.

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DG: OK. Can I just ask, we've got time for one more question, then we want to ask you some questions.

?: *Sorry, could I ... one of my questions hasn't been answered, about the path lab. We've got a perfectly good path lab in Bishop Auckland, state of the arts, you've spent £1 million of taxpayers' money on a new one, built at Darlington.*

SE: If I can make a brief comment and then I'll pass over to Bob. I think this is another example of ... I'm not aware and if someone else can correct me if I'm wrong, we haven't spent a million, if we've spent a million pounds, in fact I think the Board has agreed to spend £3 million nearly, on pathology investments, that's not just about facilities, that's about information systems servicing the whole of the community and the thing about pathology services is that the national review, Lord Carter's review, and this is his second review of pathology services, which is about to be published I think early in the New Year, is talking about larger pathology services providing to large swathes of regional population, so if you applied that for example in County Durham and Darlington or rather the north east, you might well see, you know, one pathology service emerging over time for the whole south of the river. Now what we're planning to do which is all part of developing excellence locally is make sure our pathology services now are fit for purpose for responding to that challenge coming down the line. We're not taking anything away, we're investing more money, but Bob do you want to comment?

BA: Yes, I think a lot of it relates to the specialisation bit that I talked about and this time equipment, and now the analysers, the bio-chemists that we work with, are I mean amazing pieces of kit and they can do increasingly wide ranges of tests. The issue is though to make them cost efficient to run, right, you've got to have say one for the organisation on certain sites and then move the specimens around and have a run because you can then save some money and invest it in, you know, developing other services, so that's why the pathology strategy was developed for the County which was, you know, before Seizing the Future, the pathology strategy was drawn up about 18 months ago, so that's part of it, it relates to the specialisation of the equipment that they are now using.

DG: OK. Thank you.

?: *One final comment, it's not a question, but a comment that I want to make is that the Trust failed to deliver on haematology, how can we believe that this is the right move for Bishop Auckland because I've heard nothing yet, this afternoon, to convince me.*

SE: Just ... and I know David's keen to move on with the Agenda, but I didn't really respond to that Sam, I'm sorry, in relation to your first questions. I understand the point about the history and I understand the concerns that have been expressed, but I guess what we would have to say here is that we've got very clear plans, these plans are well developed, they're supported by all our clinicians, they're ready to run, the cataract centre could be up and running by next March/April, should we be able to move forward on that for example. Now clearly it wouldn't be right for us at this point in time to, in the middle of a public consultation, to be making any changes, I mean as David pointed out at the beginning, clearly these are our proposals, we have to listen as we are trying to do here today to your views and all the views we'll hear over the next few weeks and then we'll have to form a response to that, but I can assure you that should we be able to move forward following that process then you will see some evidence of that happening in the next 12 months.

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DG: OK. Thank you. One last question ... one last question from the table there. Thank you.
Thank you for being patient as well.

?: *Thank you gentlemen, I'm very understandable about your presentations, I've heard your presentations about three times now as you probably know ... yes, I'm part of the group for Save the Hospital in Bishop Auckland. You haven't convinced me on those presentations that the Bishop Auckland hospital will have the basic need of an A&E for ... outlying areas you're talking about 30, 40, 50 miles away, I think it's horrendous, especially for young children or elderly ... elderly patients having to travel so far. We always felt as part of the group of Save the Bishop Auckland Hospital, the fact that we want a full A&E department and medical support as well, but unfortunately it seems as though we're not going to get the medical support for a full A&E department.*

DG: OK.

?: *And it worries me and quite honestly I don't know how you're going to convince the people of Wear Valley or the County whether your actual projections of your proposals are going to work. I mean part of what you ... your presentation, there is sound ... to me there is sound sense for what you're doing, I'm not saying the whole thing is ... looks wrong to me, I think parts of it sounds good common sense in what you're doing, but there are things within the Bishop Auckland ... people are thinking oh well, we had a £67 million hospital and now they're just not bothering with us any more, we're just the third party, we're number three. We ain't going to be No.1 and No.2 ... we're going to be No.3, and people are beginning to feel that they're being pushed aside, certain services. Sam obviously mentioned like haematology and what have you. I think you're going to have a hard job to convince local people that they're safe in your hands if I'm to be honest gentlemen, and I hope within the next few weeks any actions that we take you may ... may make you look up and listen and think again. Thank you very much.*

DG: OK. Thank you for the comments. I mean the whole point of the consultation process is to get people's views like that and I think Steven's alluded to it so we can understand what the issues are and try and see how they can be fitted into the proposals. I don't know if ...

BA: I don't know if ... I'm interested in the three gents from the Save the Hospital campaign. I think ... and I take the point from the lady earlier on about using technicalities. From my part of the presentation I have to say on almost every slide that I was ... that I had the time to show, there's probably about another six slides behind that with the detail of why we've come up with the plan that we've got. I would certainly really welcome the opportunity ...

SE: Yes, I was going to say that...

BA: ... to come and speak and I'll speak in some detail, I will try and make it as, you know, untechnical as I can, but a lot of it will be technical stuff, to explain to you in words of one syllable why in each service we are making these proposals because I think sometimes because we're a bit short of time and what not, we just don't ... I mean I could speak for two hours myself on this and Neil could probably do another hour and a half on the emergency stuff, so I would really welcome the opportunity to try and help you understand it better, you know, and if we fail at that point then I hold my hands up and say, you know, OK.

DG: OK. I think that's a useful offer there, it might be something we pick up outside of the meeting and take it on. I do want to move the meeting on a little bit now, I deliberately let that section go on a little bit longer than we'd planned for and that's partly because we're

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actually going to collapse the next two bits into one. What I'm going to do, you've had the opportunity to have your say with some open questions. We've got a few questions for you and I'll ask my colleague John from Proportion to actually facilitate this, so I'll hand over to him. We've probably got about 20 minutes for this and then we'll explain where we go from here in terms of the process and wrap up in time for 4 o'clock as we'd planned. John, the floor's yours.

JP: OK. This is

MEETING MOVES INTO ROUND TABLE DISCUSSION GROUPS

(General talking as people move around the room)

FEEDBACK FROM ROUND TABLE GROUPS

(Break in recording)

?: ... were put to the table, in principle do you accept the case for change and the table decided all were in agreement and that was four for a yes. How important is it to you that the review has been led by clinicians? The table felt it was important but not very, but it was important. Do you think the process of this consultation is robust? We had three yes's and one no. Which is your preferred option? We had two for B and one for either A or B and one person decided not to choose. The additional comments were it's important there's a need for further information on specific details, some of the background information, it needs to be grounded, it needs to be in simpler format and language when it's being given to members of the public for them to be able to understand, clear and concise were the key words, and concerns over the amount of services about being bundled up into two site areas as opposed to three and what they would look like, and making ... basically about it being more clinically focused, that's the key, and we also had someone on the table who ultimately is in the catchment area, so not very near to either of the hospitals, and I suppose what was being discussed was the concern that if they had to go to A&E they wouldn't necessarily know which A&E they were going to and I suppose it's a clearer understanding of, in an emergency, where would they be going based on their catchment area. Is that fair comment? OK.

?: Oh sorry

(Laughter)

EL: I was miles away! I've nearly written a novel... I'm sorry because we failed at the first hurdle, I don't think I'm the best facilitator in the world. I mean I think in principle I mean we had three people here and the views were quite charged I think ... I think they'd all agree, but probably all the better for that, but I think on balance people appreciated that there was a case for change and they also felt that it was important that that was put by clinicians and you know from the point of view of the Save Our Hospital campaign it's very important that they talk to clinicians. Just ... we didn't get through 3 and 4 I'm afraid, but in terms of the general comments there was a feeling that there was a good case and we shouldn't be, you know, we shouldn't be worrying people about things that aren't going to happen and I think that was particularly around the idea of, you know, hospitals and services closing. A sense that even though it's, you know, no staff have ever been disciplined or dismissed for raising concerns that that's still perhaps a level, a concern that there is for staff at grass roots level. It's ... also a sort of sense that, you know, A&E is around basic care and I think that there's something

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about making clear what can be provided and what can't be provided at particular sites and why that is, I think there's a sort of understanding over some of the issues like cancer and heart disease and so on, but less of an understanding as to why that should be a driver in other areas such as respiratory medicine, and also a sense that, you know, people will potentially be spending more time in ambulances than in hospital beds so we need to do a little bit more work around explaining some of those issues. I think that those were the main things that we discussed.

DG: OK. Thank you everybody. I'd like to thank everybody for their input into that piece of work particularly, but for the whole of the meeting today. I just want to spend five minutes before we close just explaining the process now and probably reiterating a few points if I may. First of all, re. the role of NHS County Durham's part of this, why Amanda and I are sat here, we're, if you like, we're the honest broker and particularly where there are concerns raised about, you know, if you're concerned about staff or what might happen to staff, and if you're not reassured sufficiently by what Steven has said, and there's no reason not to be, but if you're not then by all means if you come to us as the honest broker we will actually take some of that on, we're quite happy to do that. Our role in this is very much making sure that everybody has had their chance to have their say and equally in fairness everybody has a

chance to listen and that's why I started by saying this two-way bit is really important and it's really important people have the chance to say whether that's ... colleagues putting proposals forward or actually you having your views and putting them back to people, and hopefully we've had an opportunity to do some of that.

We've captured all of the issues that we've taken today, either via the microphones and what have you or via the charts on the table and equally by the flipcharts that colleagues have taken, and all of this will be fed into this formal consultation that we're in, and I'd just like to remind you that this process actually goes on to 12th January so there's still an ongoing process. I said at the start this is the first public meeting that we've had as part of this. What will happen after that is that County Durham and Darlington FT will actually then sort of sit back and listen to the issues that have arisen. Hopefully they will be addressing some of those issues as we started to do today I think, as it goes through the process, and they'll actually bear that in mind and they will actually consider those proposals and I guess that your Board will consider that Steven, and then we'll come back to NHS County Durham with their views on how they want to take this forward. Our role therefore is then to say OK we've had a look at the process, we've been part of the process, we've made sure it's safe and sound, we've made sure people have had their say and it's been a robust process and we will then sit in judgement if you like in terms of how that's taken forward. I must stress the only decision that's been made thus far is the decision to actually start this process and come out and talk to you today, so that's all we've decided between the two Boards, we are very much of the mind that we will sit back, we will listen to all of the issues that are raised, if people aren't happy with the process then we'll listen to that as well and we'll try and put the process right, we will not do anything and certainly as a Board, as NHS County Durham, we will not make any decisions until the FT have come back to us in February to actually say this is what they're going to do in the light of the proposals, and then it is up to us as the people who buy the services to decide what actually happens with that.

So very important that you've had your chance to have your say today hopefully. There's lots of other ways that you can actually have an opportunity to get into this. You can actually fill in the public consultation response form, you can do that by logging in to our website, NHS County Durham, you can log into the Seizing the Future website where you can actually do that, or you can email your comments into the email address that hopefully is behind you

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there, comments at seizingthefuture.org.uk. You can also do that by actually writing in to the Freepost address. So what we're trying to do is try and have as many media as possible, as many ways as possible for you all to have your chance to have your say and then we will sit back in the light of the evidence from that in February probably and actually try and decide where we go with this, but I do want to reassure people that there's nothing will be decided, there are no done deals in this, it's in nobody's interests to do that, we need to have this debate and discussion and that's precisely why we're sat here today and we're trying to get this out into having a public discussion and an open debate. I don't know if Amanda or my colleagues want to add anything to that.

AH: I think just to reiterate and to reassure you that our role in this is really to be that independent partner if you like to ensure that you do have your views and that both parties if you like are able to present their thoughts, comments, views, ask questions and that we make sure that all of those points are aired and that responses are given, so it really is just our role to ensure that that happens.

DG: Good. Thank you. Katrina.

KB: *(inaudible)* request that if further details *(inaudible)* some of the presentation slides *(inaudible)*

DG: OK. There's actually a wealth of information on that Seizing the Future website and there's a lot of documentation that I guess fills in the gaps that Bob mentioned earlier on, sort of fills in the detail behind the slides. If people want to look at that directly they can. If they equally want to get in touch with either Verna Fee (?) at PCT at the back or with Edmund at the Trust, we'll actually provide the details for doing that but that login is the way to get into that Seizing the Future.

SE: *(inaudible)*

DG: Yes, and Steven's just reminded me that actually the offer I think from Bob to actually have a discussion with the Save Our Hospitals campaign and to go into the greater detail that inevitably you can't get into in a public meeting like this, if that's something you want to take up we'll make sure we do that and actually have that debate and discussion there, which I think would be useful for everybody, if only just to understand the issues.

CO: *(inaudible) repeat ourselves (inaudible)*

BA: So will I though!

DG: Well for that closed session, that's fine. As I say, our concern is we get the views across the whole of the County and I think the point was made earlier, you know, this isn't about any one hospital, it's about the whole series of hospitals and we need to make sure that happens. Having said that, I'd just like to thank everybody again for their input whether it's you as members of the public or whether it's any of the staff or colleagues that we've got here. I think we've had a useful starting discussion here, I'm sure the discussion will continue right the way through the consultation but it is important that you have your say and thank you all for coming along. I hope you have a safe journey home. Thank you.

(End of recording)

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