

**Seizing the Future Public Meeting  
Bishop Auckland  
Friday 9<sup>th</sup> January 2009**

**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  
Diane Murphy, Director of Nursing and Project Manager for Seizing the Future - County Durham and Darlington NHS Foundation Trust  
Bob Aitken, Executive Medical Director - County Durham and Darlington NHS Foundation Trust  
Professor Sir George Alberti, National Director for Emergency Access and Clinical Director for Service Reconfiguration**

DG: OK. Thank you ladies and gentlemen. Can we make a start? We've allowed a few minutes ... sorry, it sounds very loud ... we've allowed a few minutes to allow extra people to come in, there are more people coming in, I'll just let you come in and sit down before we start.

OK. Thank you. I'd like to welcome everybody to this wonderful college, it's a wonderful building this, it's nice to be here. The reason for this meeting is a follow on from some of the consultation meetings that we've had. I'll just introduce myself, I'm David Gallagher, I'm one of the directors at NHS County Durham, the PCT, we're the people that actually commission services. I've got with me a panel, we've got moving from your left to right, we've got Stephen Eames who's the Chief Executive at County Durham and Darlington Foundation Trust, we've got Professor Sir George Alberti who's the national lead for acute care, from the Department of Health, we've got Bob Aitken who's the Medical Director of County Durham and Darlington Foundation Trust and we've got Diane Murphy who is the Project Manager for Seizing the Future at the Foundation Trust. What we wanted to do this afternoon is, we had a meeting, we had a series of public meetings and the last one that we had in this locality, which was actually at Auckland Castle, we had hoped that we'd actually have Professor Alberti come along and give his view for this because a lot of the work that's been in the consultation is around and has been critiqued by, if you like, Professor Alberti, and he wrote a report on that, so we thought it would be really useful for him to come along and listen to your views, but equally for you to actually listen to his views on this. That was obviously kyboshed by the bad weather that we had so we did try to actually fit something in, and luckily, and we're very lucky to actually have Sir George here this afternoon to help us with this, he managed to fit us in the schedule, so what we're going to do is rather than the consultation process that we've had before with the group discussion and the presentations we thought it might be really useful if Sir George could actually give us his view of life and this and how it fits in, how it fits in with the national picture and his view of what's being proposed by the Foundation Trust and then an opportunity for you to ask him and the rest of the panel questions, so you can hopefully get a wider appreciation of some of the issues that we've got and it's a chance again for us to listen to some of your views. So we're going to kick off with that now, we need to finish at 5.30 because the College actually wants us out so we need to move fairly quickly through this, so a little bit of conversation from Sir George and then an opportunity for you to ask questions and have your questions answered. So I'll hand over to Sir George. Thank you.

GA: Well I'm just going to perch up at the front here, I hate standing but I don't like talking from an entirely sitting position behind a desk either. Anyway good afternoon to everyone. Some of you have heard me say some of this before and you can check for consistency. I'm sorry if you get bored by a part of it, but I thought I'd kick off by saying, you know, where I come from all this, in all this, and why I've been involved at all. My history is that I grew up on the River Tyne in Gateshead and spent the first 18 years of my life trying to get out of it and then worked subsequently in Newcastle where I still have an office. I also spend whatever time I can in rural Cumbria, and I make that point because I am acutely aware, being 32 miles from our nearest DGH in Cumbria, about travel and people's concerns about travel as well. For the last five or six years I've been working in the Department of Health in London on a part time basis, but very much as a clinician because I've grown up as a clinician and I'm in there as a clinician, and I'm the National Director for Emergency Care but more recently also for reconfiguration of services, and have been working with different health communities around the country. Now one thing I persuaded our last but one Secretary of State, Patricia Hewitt, was

**Seizing the Future Public Meeting**  
**Bishop Auckland**  
**Friday 9<sup>th</sup> January 2009**

that when it comes to things like reconfigurations unless they make clinical sense then you shouldn't be doing them, and a lot of them in the old days were done more on a financial basis perhaps than on a pure clinical basis, and what we've done is establish a team called the National Clinical Advisory Team and we are obliged to go anywhere where there's a public consultation and to give clinical views on the plans, and when I say clinical views, what we look for, we don't look at the pounds, shillings and pence, that's someone else's problem, but we look at are these plans going to give high quality care? Are they going to deliver safe care compared with ... or safer care compared with what we've got at the minute? Are they sustainable? You can always parachute in 20 people and have a short term solution but are these sustainable and do they provide reasonable access which I know is a bone of contention here ... do they provide reasonable access for people? And what does all this mean? Well it means us giving the level of staff, the level of care, the experience of staff to deliver the care that is needed by each individual person, and I'll come back to that in a moment.

The other thing which I'm deeply committed to is delivering care as close to where people live as safely possible, and that came out in one of the very few sensible White Papers we've had from the Department of Health, Our Health, Our Care, Our Say, which was now three years ago, where it basically said that ... let's deliver whatever we can for people locally, and it's against that backdrop we should be considering any of this, because to me that's a sine qua non\*, have we got good community services, and in particular are we using our community hospitals as well as we should, and it's reasonably straightforward to work out, OK, if you've got a less serious injury or illness then good qualified experienced nurses can deliver a very good standard of care. We have that in my local hospital in Keswick for example and that can be done in our community settings, saving a lot of people a lot of hassle trying to get to a hospital, so that's part of the backdrop. Have we got the right care for older people? Two thirds of our emergencies that come to hospital in fact are older people. I feel very committed to this at the moment as I have entered that category some little while ago and, you know, are we doing the best for older people? In many places, we're not. When I started in my current job we had this awful situation of older people coming to A&E, spending 18 hours on a trolley, no dignity, no cups of tea, no nothing, and it was awful, and we're getting around that but there are more things we can do as well.

Now when we talk about high quality, safe care, what you're all concerned about, I know, is closing A&E, or downgrading A&E, and a lot of people equate this with closing the hospital. I'll come back to that particular point in a moment. But what do we need for safe, high quality emergency care? First of all we need experienced people in A&E around the clock. No point having them there 9 to 5, Monday to Friday, people fall ill at any time of day or night and it's arguable in fact that the most seriously ill people come through in the middle of the night because they're the ones that really can't say oh well I'll contact the doctor in the morning or what have you, and that means having an experienced team in A&E. To do that properly and we're aiming for this, I've got a meeting about it on Monday again, aiming for this, all around the country, you need a minimum in the end of eight consultants in A&E who can actually do that and be on the shop floor, looking after the seriously ill people, but that's not enough. You have a lovely A&E but you need all the X-ray facilities open around the clock, you need your laboratories functioning around the clock, you need the same number of acute physicians, consultant physicians or very experienced specialist registrars around the clock, so that when you get to the hospital you don't have the system that I grew up under where you would arrive there, three in the morning, you would see a junior doctor who may have only been in the job for three days, or even three weeks, who just didn't have the experience or the know-how to deal with you properly, so that is what we're aiming for around the country. Now it's going to take a while to get that everywhere but we are a long way from it particularly at the moment in Bishop Auckland, we just haven't got it, we can't sustain it. You also need intensive care, you need a surgeon available quickly to give a surgical opinion and intensive care, again, needs senior experienced staff. So all of that you need.

*\*Latin meaning "without which not" commonly referred to as "given" or an essential element or condition*

**Seizing the Future Public Meeting**  
**Bishop Auckland**  
**Friday 9<sup>th</sup> January 2009**

Now I can hear people ... because they've said it to me before, I can hear them thinking well why don't we just do this in all three hospitals? First of all, we couldn't recruit enough people to do it. Secondly, the numbers of people actually involved are relatively small and I know you're all concerned about this but we are talking at the moment about 10-15 medical admissions per 24 hours. Now can you ... even if that was more, and I don't think it is ... you can't actually recruit and sustain and give people enough experience to produce the service you need for that and my feeling is that those people, and that's what I've said in my report, would be safer going to one of the other two centres and they would get more specialist care. We're specialising and sub-specialising all the time and the days when, you know, you saw a general physician or a general surgeon, that isn't good enough any more because we can do so much more if you see the right specialist and to me travelling a bit further, yes, it is very worrying, but if you travel a bit further and get to see immediately the right experienced specialist you're doing a lot better than being admitted to somewhere closer to home where you maybe have to wait 12 hours for the right specialist to come in from somewhere else and that is I think fundamental to our thinking.

Now does that apply to everyone? No, it doesn't and I'd say immediately that, you know, anyone who threatens closing or further downgrading Bishop Auckland does that over my dead body, because I think the potential for Bishop Auckland is phenomenal, of doing things that can be done safely here. We've been talking about, you know, 10, 15, maybe 20 patients a day, hundreds of people get treated here every day. I want to see that number expanding. I want to see other services expanding here and one of the things that I've suggested building on the plan that was put to me originally was, for example, having effectively an emergency clinic seven days a week, 10 hours a day, run by a consultant or an experienced doctor, generally a consultant, so that if your GP sees you and says well I'm not quite sure and to me the biggest problems we have in diagnosis are, you know, just looking around the room, the age category that some of us belong to, because it's rarely just one thing wrong, you know, you have a fever and we had this condition when I was an admitting physician at Freeman called OTL, it's off their legs. Old person who suddenly goes off their legs. Now you want to know why and the odds are it's an infection, but you need some investigations, you need to check whether kidneys are working properly, whether it's been a silent problem with the heart, whether it's a chest problem or what, and what I want to do is for, you know, any older person who is not actually at death's door to come to the assessment clinic, have a proper work up, get the investigations that are needed, and I would then guarantee and we've tried this out in one or two places now, that 70% or 50% minimum, probably closer to 70%, will be able to go back home after that. After being assessed properly and a treatment plan put together, because acute hospitals are dangerous places and if you can avoid an older person being admitted I think that's very good, providing the right support is there and we come back to the community end of this and good district nursing, community nursing, etc. So an old person's assessment service.

The same thing for children. I mean sick kids scare the hell out of me and that's why I became an adult physician and not a paediatrician, but only probably one out of 40 who turn up actually need admitting and you need a good person to do that assessment. Senior nurses are very good at this, consultant paediatricians are good at it and I think you can avoid a lot of travel for people, and I am aware of the problems there, you know, and I set something up in South Bristol this way where there was an urgent care centre but they had no paediatric training, so 25% of the people who turned up with a sick kid be it a bandaged, you know, an infected finger or a serious infection, were sent away. We got well trained nurses in who had proper paediatric training and they dealt with far the majority on the spot and that saved mums going from a slightly remote housing estate on three bus rides with three other children off to the big city, so I think there are things we can do to make this user friendly and a really effective local service, and that's not all. I mean a lot of other things we can and should do on the spot here and I see there are plans to have this as a major rehabilitation centre. I mean just to go sideways for a moment, I'm a great believer in people only being in the acute hospital so long as they need the facilities and expertise of that hospital. In the second phase of illness, that's generally the first 36, 48 hours for many people ... second phase, if they need continued nursing and an eye keeping on them, then come back locally, and I see us using our community hospitals but also Bishop Auckland so that anyone who's been banished to the outer darkness or Durham or Darlington, you know, as soon as that acute bed is over, comes back here and I think that makes it all much nicer for the patient and of course for the family too.

**Seizing the Future Public Meeting  
Bishop Auckland  
Friday 9<sup>th</sup> January 2009**

The other thing I would say is with medicine having got much more specialised, already people are going from here to South Tees for example, because that's where you will get the best treatment for your heart attack. If they are in the north end of the patch, it may be to the Freeman because they can do the instant angioplasty which we know gives better results. We will be focussing care for strokes because we can now clot bust ... in inverted commas, clot bust people who have had a stroke, but you need a CT scan done any time of day and night, you then need intensive round the clock care for the first 48 hours but then you need continuing rehab, all of that continuing rehab will be done here and I think for many other parts of the County as well, and day surgery, I mean there are a whole host of things I've suggested to the Acute Trust they should be, you know, re-examining the whole range of outpatient services that are delivered and making sure that we have local outpatient services where there is a need, and I think that is important and one of the things I've said to my clinical colleagues, with support from this young Scot here, is that you do not serve a hospital, you serve a population, and I spent my whole working life working in two or more hospitals and other settings, and we need to move round as consultants to where we're actually needed, and that ethos is beginning to come back and I would see people, you know, having one primary base but going where they're needed to do their clinics so that, you know, we may be saying, OK, Shotley Bridge, we need to have a new clinic in this, Bishop we need a new clinic in this, and making sure we do it. Now all of that depends on getting the staffing right, we are even saying we'll have two acute hospitals, we still are short of consultant staff, and I'd say this to my colleagues in the PCT, they're going to have to dig and dig deep to make sure that we have the right sort of expertise of staff to provide the service that the people of Bishop Auckland want.

I think it's come to the point where I've probably talked for long enough, but I just want to wrap that up by saying I have a deep commitment to good clinical care, to the people who are worried about the travel and, you know, as I say, living in rural Cumbria I know what that means, but there are two things there now, one is that our paramedics are better and better trained, it's no longer a question of scoop or run, scoop and run, I mean they used to put a blue light on their heads and off they'd go. They start treatment from the time they see the patient. I know there are major concerns amongst some of you about the level and reliability of the Ambulance Service. I've talked to the Chief Executive of the Ambulance Service for this patch, whom I know quite well, I will talk to him again, because that is a key part of this whole equation. It requires funding of course but that to me is sine qua non and we can't do all this without good well trained paramedics getting to where they are needed quickly and reliably and that I think is something that has to be dealt with, and I think that's important. I see people shaking their heads, well it's one of those things which ...

???: *(inaudible) your problem, you're going to do this in two months and we're already short of (inaudible) It's unbelievable doing these things.*

???: *You haven't got ambulances, you haven't enough. You're just talking out of your head.*

GA: That is the sort of good blunt comment I appreciate in this part of the world. Don't get that in the south at all!

(Laughter)

GA: No, they're much ruder but much more subtly. I ... what I'm saying is what I have said, I have recommended, and which are the plans that need to be put into place. I'm doing everything I can to help get that implemented because without each part of this equation it doesn't work and we've got to make sure ...

???: *Does that include the British Red Cross, knocked at my door the other night looking for donations and when I asked them what they were looking for, why were they looking for it? Because they're short of ambulances, because they're short of ... they haven't got transport to take people to hospital. Do you want to do a First Aid course while you're at the door? Now listen to this ... nonsense!*

GA: OK. Well you have your views, I'm giving my view as ...

**Seizing the Future Public Meeting  
Bishop Auckland  
Friday 9<sup>th</sup> January 2009**

?: *It's not a view, they actually knocked at the door (inaudible)*

GA: Yes. No, you know, I obviously don't know ... yes. Anyway, I think we've got into the discussion period now and I'll do my best with my colleagues to answer questions.

DG: OK. Thank you. What we want to do is give you an opportunity, I think we've started some of it, an opportunity to actually ask the panel some questions. Just to explain ... we're using the microphones, one, so you can hear but we're also actually recording the proceedings so we've got a record of this which will help in terms of feeding into the consultation, so I'd like ... we've got a roving mic that John's waving there, if somebody's got a question if they can raise their hand, and that lady's probably the first one, give John some exercise ... if you can raise your hand, once you get the mic can you say who you are first please just for the record and then can I ask two things, one, for the questions to be fairly succinct because we haven't got a lot of time to get through some questions, we have till half five, but then secondly if we can ask the panel to be succinct with their answers as well so we can get as many questions through as possible please? OK.

PJ: *Yes, my name's Patricia Jopling and I'm a County Councillor and a District Councillor. The question I wanted to ask was the figures that are quoted for some of the reasoning behind this, and it's the admissions of the 15 people per day, I believe you said, to Bishop Auckland, is that correct? Figures can say anything and one wonders when you're doing these figures, did you count, well were they counted, the figures that had gone to Darlington and Durham for people that live in this catchment area, in other words farming out work that should have gone to Bishop Auckland, ambulances driving past Bishop Auckland, not taking the patients to that hospital. As far as I'm concerned this has come about by stealth. This has been going on for several years and we now are going to stand up and have our say and try and stop this because we've got to this situation now, it's the British Rail situation, where no money's put in, it's useless, let's privatise it. This is what's happened to our hospital.*

DG: OK. Thank you. Can I ...

(Applause)

DG: ... ask Stephen to respond to that?

SE: Thank you and I really understand that sentiment, we've heard that view actually a lot during the consultation and I really appreciate the background to that. What we've been trying to do is to address the future, we can't address what's happened in the past and what I'm absolutely committed to is making full use of Bishop Auckland hospital and for some of the reasons that you've outlined and that's not the case today, and it's important to point out that should our proposals go ahead we'll use that hospital more. Now Bob and Diane may comment a little bit more on the figures but the general point you made about the ... there is a ... if you're talking about emergency care, just for the moment, you were talking about ambulances going past the hospital door. That has been the case for a ... quite a significant category of patient, for some time, particularly the surgical emergency ...

?: *(inaudible)*

SE: Excuse me, would you let me speak and respect my views and I'll respect yours. If we come back to the point I was making, if you had a surgical emergency then those cases have gone traditionally for some considerable time to Durham and to Darlington. More recently as Professor Alberti pointed out people with heart attacks from all over County Durham and Darlington actually go to none of the local hospitals, they're stabilised by paramedics and they go to where they can get the best treatment and the recovery is proven to be better, so there is quite a lot of traffic past the hospital anyway. The only other point I would make is one of the issues about Bishop is that if you look at the numbers of emergency cases that attend that hospital, and we're talking about around about 10,000 people a year moving from the current arrangements at Bishop into the arrangements we would put in place at Durham and Darlington, quite a significant proportion already of that 10,000 would attend Bishop, be stabilised and then referred on into Durham or Darlington for specialist treatment, that's what happens now, and we

**Seizing the Future Public Meeting  
Bishop Auckland  
Friday 9<sup>th</sup> January 2009**

estimate that's around 4,000 people a year out of that 10,000. Now I don't know whether Bob and, very briefly, Diane want to add anything to those comments.

BA: Well just very briefly about the numbers when we did the analysis, the 15 relate to medical patients admitted. Now I don't off the top of my head, I must admit, have details of postcodes for all the admissions across the organisation but I do concur with what Sir George has actually said already and what Stephen has said. There are some categories of patients where we don't have the back up facilities at Bishop to support them, so they do go past, but overall for the number of admissions into the organisation I don't have the detailed postcode analysis. The one thing I would add though and Professor Alberti alluded to it, and I've been using the term critical mass, he was talking about the amount of activity, they're the same thing really, in that because of the nature of ... to provide 21<sup>st</sup> Century quality care, I mean I think we've proved with the analysis that we don't have enough critical mass of activity across the whole County to run three full acute services, and that's why we're recommending that we move to two.

DG: OK. I think actually the gentleman at the back ... I will take you in order, there's a gentleman at the back there and then the gentleman to the right.

?: *Yes, thank you gentlemen, I think we have spoken to you before. One question I would like to ask is can you guarantee a decent ambulance service from the outskirts, well, from Weardale through to Darlington, I mean quite honestly historically it's been bad, it's never been that good, so therefore I cannot see, I'm not convinced that you're going to get a good enough ambulance service to say that well there's no need for a decent A&E service in Bishop Auckland. So therefore ... as I said historically there's not been a good ambulance service, so therefore all of a sudden you say you can guarantee it, I don't see it.*

DG: OK.

SE: If I can comment briefly, I think your concerns about the Ambulance Service are well understood as I think Professor Alberti said and I know that the Primary Care Trust have listened very carefully over recent months to those issues as well in a separate consultation. There is an investment going in of £600,000 and that investment is in additional ambulances and additional paramedics and that's specifically targeted at the area that you're talking about. The other thing I would say from the experience of the consultation, which was interesting for me because I'm very new on the patch here, is when you talk about the area that you're expressing concerns about, actually quite a lot of people travel by ambulance not just to Bishop Auckland but from parts of the Dale to Darlington and to Durham at the moment and what we're focussing on is those areas where that's not the case, and those areas where the access is particularly difficult. Diane, I don't know, did you want to add anything to the issues around ambulance transport?

DM: Just to say that, I mean, there is the additional investment that's been agreed by the Primary Care Trust for ambulances services, but in addition to that the Ambulance Trust, key members of the Ambulance Trust, have been involved in the development of the options and are involved in the groups that would actually develop the pathways of care for patients and by doing that what we would get from them, as the detailed pathways are developed we would get a better understanding of any resource issues that would be required within the Ambulance Trust and if, you know, an estimate of need by community in terms of travelling distances.

GA: Could I add one other point there and that is that quite a lot of people who come in by ambulance to hospital today could have been dealt with adequately and well and possibly even better at home or closer to home. That requires us making sure the community services are improved and one of the things we have discovered with our advanced paramedics, certainly in several parts of the country, and that includes parts of the country up here, is that the better their training the fewer people they actually end up taking to hospital, they deal with problems on the spot. That then frees up time, travel time, for the people who really need to travel, and that is something we are trying to work on, you know, all over the place as well as here and I would hope that would happen but it does underline the importance of

**Seizing the Future Public Meeting  
Bishop Auckland  
Friday 9<sup>th</sup> January 2009**

making sure that, you know, our community services are really up to scratch to deal with a lot of problems either at home or closer to home.

??: *We just want to add just one thing and that is that other parts of the country have been using outside agencies as far as ambulances are concerned and they have been horrendous.*

GA: We have ... I'm hardly aware of that happening, most of the ambulance services are NHS Trust working around the country and they have had a major impact over this last five years particularly in improving care for people by being better trained and not just being transport services. There may have been some privatisation of the actual, you know, taking people to outpatients and back again, but when we're talking about emergencies there is very little private work going on there, that is NHS Trust work and we monitor them, we stimulate them, we prod them, we provoke them and they have improved quite a lot.

DG: Gentleman in the leather jacket and then the gentleman there and then we'll come down to you sir and then back up there.

SZ: *Thank you. Sam Zair, District and County Councillor for Bishop Auckland. I have met you Professor back in November.*

GA: Yes, it was a great pleasure then, I hope it will be one today.

(Laughter)

SZ: *Try very hard not to. My question is ... this document which has got your name from back to front, why has it been written from the clinician's perspective and not from the community's view? The document talks about what is good for the clinicians, but what about the community they serve and how it will affect them? This is not the same as a public consultation. The public will be affected by this shift, but how that will affect them and what it means for the areas of severe health deprivation as well as rural isolation which is not considered. Why do we assume what is good for the physician has to be good for the patient? Now this was brought up back in November as well and your comment was, from this document, it's not as I would have wrote it. Could you explain that? And another thing as well ....*

GA: I certainly don't recall saying but I'll certainly answer your question.

SZ: *I think there are one or two Councillors in this room at the time, I think can back me up on that, it's not as I would have wrote it.*

GA: Which document are you talking about? Are you talking about my ...

SZ: *Seizing the Future.*

GA: ... my report? Are you talking about ...

SZ: *The Seizing the Future ...*

DG: The consultation document.

GA: Ah, the consultation document.

SZ: *Yes.*

GA: Ah yes. I didn't write that.

SZ: *And another question as well, a couple of weeks ago, in the Northern Echo, the hospital plans that will increase bed totals, I'm a wee bit confused. You've got proposals under the new scheme, if it goes ahead, medical beds 77 proposed, and then underneath it you've got this includes 77 rehabilitation*

**Seizing the Future Public Meeting  
Bishop Auckland  
Friday 9<sup>th</sup> January 2009**

*beds. Now are they medical beds, are they rehabilitation beds, because as I see it you cannot cross contaminate both of them due to infections. Now ...*

DG: Sorry, can we get round to the questions ...

SZ: *Yes, I'll get to it now straight away, sorry David. If you take away the 77 rehabilitation beds away from these numbers we are in fact 49 beds less if this goes ahead than what we are now and I would like some answers on both of those questions please and another thing as well, one last thing, honest, I have been told on good authority that the Chief Exec, Stephen, that you've already been round to the two medical wards and said that you are closing. Well I'm sorry while this is under consultation I would have thought respect would have been given.*

DG: OK. Can we ask the panel to respond please?

(Applause)

SE: I think perhaps if George can answer your main question in a moment and I'll ask Diane in a moment to answer the question about the beds. Absolutely right, I've spent a lot of time at Bishop Auckland talking to all of the staff because they're clearly very concerned about the future. I've been to the medical wards at Bishop Auckland three times during the consultation in a planned way, I'll be back again next week, and we have ... they ... the truth of what you're asking me is they've been asking about what will happen next, and what we've talked about is what the steps would be in terms of changes in the future should these proposals go ahead. We haven't talked about closing facilities. We've talked specifically about what will happen as far as those individuals are concerned, and I might add that many of those individuals actually are very keen, as we are, to stay working at Bishop Auckland because they're very committed to the hospital and the community and they have the skills that we need to deliver the services that are outlined in our proposals, and that's the discussion that we've been having. I'm sorry if that's fed back in the way that it has to you Sam. Diane do you want to carry on?

SZ: *I have it on good authority what has been said and how it's been said.*

SE: Yes.

SZ: *And what the staff at Bishop Auckland feel.*

DG: OK.

SE: Well I'm quite happy to have that discussion with the staff concerned and yourself if you wanted to do that.

SZ: *I would like that very much.*

SE: That's fine.

SZ: *With the staff, yourself and myself. Everyone together.*

SE: Very happy to have a discussion with you and our staff Sam.

DG: OK. There's an offer being made there so I think we'll make sure that's taken up. Thank you. Do you want to respond to the rest of the ...

SE: Diane I think is going to respond.

DM: Can I just say that in terms of the beds, there is an increase overall in medical beds across the Trust with the proposals, and that's the particular specialty that is under the most pressure in terms of beds so we do increase the number of medical beds. Now in terms of whether they're medical beds or whether

**Seizing the Future Public Meeting  
Bishop Auckland  
Friday 9<sup>th</sup> January 2009**

they are rehabilitation beds, for many of those patients who would use the new rehabilitation unit, many of those patients would be drawn from existing medical services, some of them would actually be drawn from orthopaedics and surgery but probably the majority of them come from medicine, and actually rehabilitation is a sub-specialty of general medicine and that ... they will sit within general medicine. They will be within the overall specialty of medicine with a sub-specialty of rehabilitation so that is not an issue in terms of, you know, infections, I think that was the point you were making, around cross contamination, that's not an issue, they're actually with that cohort of patients now, so it's about creating this and developing this new specialty that sits within medicine. For some patients, for example, if you've had a fractured neck of femur, a broken hip, and you're going to go into the specialist rehabilitation unit, they will be transferred from a surgical speciality into the new, and more appropriate for that patient, rehabilitation facility which is part of an overall medical unit and a medical bed.

GA: I think this would also include people who, you know, say, go into Darlington acutely ill, 36 hours intensive work up, care, transferred back nearer to home, into a rehab bed for the continuation, you could almost call them acute care and middle grade care rather than just ... and they are all medicine. So I think when I checked the numbers they seemed to be appropriate for the clinical case. Now you did put a question to me and I got sort of thoroughly confused during it, the report that I actually wrote myself which I think you've had copies of, it's certainly been seen by quite a lot of people, was very much a clinical case for care and I did talk about transport there, I did talk about access, I did talk about community services, and it was a shortish report because I write shortish reports. The actual consultation document which was slightly different, you know, it's ... I may have said at the time that I would have written it slightly differently and I'm sure that's the case, because you know I've a different slant on things, but that's the one you've got, but you have got my report as well which does take into account the fact we are talking at the beginning, middle and end of all this about half a million people, about individual within that, and my concern is making sure that each individual gets the care they warrant, deserve and should get.

SZ: *It's just that this document, it's all one-sided, it's absolutely unbelievable. Can I sort of remind the Trust as well, Durham County Council, Wear Valley District Council has a policy in place that it does not support any reductions of services at Bishop Auckland General Hospital as we stand now, and I hope that's taken into consideration when you make your final decision on this report. And also the sixteen and a half thousand-name petition that went down to Downing Street.*

DG: OK. Thank you Sam, we've ... all of that will be taken into account as part of the consultation.

?: *(inaudible) lady spoke in the Northern Echo about the Trust, she said they will not be taken into consideration. This week.*

DG: Right, with all due respect and all fairness sir, the consultation is being run by the NHS County Durham and the PCT, the response will come back to us, we will take the weight of feeling of the march and everything else into consideration as part of the overall consultation.

?: *Well you've already said you won't take it into consideration, it's in the Northern Echo on Wednesday.*

DG: I am saying to you, standing here now, that as the lead director for the consultation process, we will take into account the feeling behind the march and ...

?: *You have been speaking to these two people here. She squawked to the whole of the Northern Echo and she's part of the Trust.*

DG: OK Sir, but I'm giving you assurances now ...

?: *Are you going to do anything about her?*

DG: Well ...

**Seizing the Future Public Meeting  
Bishop Auckland  
Friday 9<sup>th</sup> January 2009**

(Everyone talking at once)

DG: We can look to put something in the press to correct that, if that would help. We'll look to manage that.

SE: Actually I think it might be quite helpful, because if I could just say, on this issue, I haven't seen the piece that you're talking about and Barry's shaking his head and he's the Northern Echo reporter, so actually I think we just need to, first of all, see the piece and then we can respond appropriately to that question. If you've got it, we'll look at it now.

DG: Sir, we'll have a discussion at the end of the meeting.

?: (inaudible) I'll back you.

SE: That's fine, we'll do that at the end.

DG: We'll talk to one of the editors ... OK Sir. I've got a gentleman at the back in the ...

?: (inaudible) Can you hear us without the microphone?

DG: No, sir can you please just so we get a record of the questions please?

CH: (inaudible) My name is Colin Heads and I'm part of the group that wants to save our acute services at Bishop Auckland. I stress acute services because a lot of people, as you rightly say, are under the impression that Bishop Auckland hospital's closing, I know it's not closing. The acute part of the hospital is closing. So there's two questions that I want to ask Mr Aitken. Mr Aitken has been round the hospital on several occasions haven't you? I've seen you round the hospital, is it ...

SE: Are you talking to me?

CH: Oh sorry.

SE: Stephen Eames, yes.

CH: Stephen Eames. Sorry Stephen I got your name wrong.

SE: Yes, quite often, yes, that's right, yes.

CH: You've been round the hospital on several occasions and one of the things that you're saying to the people of Bishop Auckland and you're saying it at these meetings, that this is not a done deal, I stress that, so a consultation period means you're consulting. At the end of that consultation period you will come to a decision.

SE: Correct.

CH: Whether the things you intend to implement, you're going to, or whether you're not. My impression, because I'm also a porter at Bishop Auckland hospital so I see things on a daily basis, I see doctors' comments, nurses' comments, patients' comments, so one of the things is that you have said that this is a consultation period, yet I'm going on wards and hearing nurses, right? Not the press, not Councillors, not yourself, nurses passing comments that they're pencilling in next October, that no they won't lose their jobs, of course they won't lose their jobs, it's not Trust policy, the Trust is an anachronism that's very reluctant to make anybody redundant, so I don't think they're going to lose their jobs, but what they're not going to necessarily do is be in the same job, doing the same thing as a sister or a staff nurse or an auxiliary, so they'll find them jobs but the truth of the matter is, you're saying it's a consultation period, by my feeling on the Bishop Auckland site is it is a done deal.

SE: OK.

**Seizing the Future Public Meeting  
Bishop Auckland  
Friday 9<sup>th</sup> January 2009**

CH: *It's a done deal by the staff's ... what I hear from the staff telling me about them looking for alternative jobs, about finding alternative places for them, about coronary care and ITU going by October of next year or sooner, this is what you hear on the site. Now...*

SE: OK. Can I just respond to that one first. Consultation means consultation with the public and consultation with staff and obviously we've had a whole series of discussions with staff across the whole Trust and particularly at Bishop Auckland as part of the formalities of consultation, and they ask questions like if this goes ahead what will happen when. Now I can either sit there and say, or colleagues can sit there and say, well we don't know, or we can give them an indication of what we think will happen so I think what you're reflecting is what we think could happen should the consultation go ahead. Now I have to say I haven't seen you at one of the meetings that I've been at over the last few months at Bishop Auckland.

CH: *Yes.*

SE: And ...

CH: *Well I work for ISS Medical.*

SE: Well please come to the next one and you'll hear it from the horse's mouth because it's quite important to have ... in fact, what you're reflecting back is what people's interpretation are of what I might have said or what somebody else has said, but if you want to offer a view about it it would be helpful to get to one of those meetings and I would encourage you to do that.

CH: *Yes, well but what I'm saying is that the view is off a lot of the staff that this consultation period you're having ...*

SE: OK.

CH: *You're going to have it, fair enough, but it's still going ahead.*

SE: I can also give you another example that we've also been talking and colleagues will endorse that to our staff in Darlington and at Durham because for them there are also significant changes. Day surgery coming to Bishop Auckland, rehabilitation and recovery coming to Bishop Auckland, changes to the way in which we make our emergency care service. Now all those people are rightly concerned and want to know what does that mean to me then? Now I think it's my job to give them an indication and some reassurance that whilst we're making change, we're not closing anything, we're making change in the way that we organise services, that our staff have a clear understanding from me and my team about what we think that means for them, and I've made it clear in all of those meetings that clearly a consultation is going on and clearly none of this may come about depending on how the outcomes ... I think there's nothing else to be said on that.

CH: *I think that's a question I'm asking, so at the end of this consultation period what I'm really saying is that you're saying it's a consultation period, at the end of it, it may not happen, so you're still (inaudible)*

SE: I'm saying that the consultation decision doesn't reside with the Trust, it resides with the PCT.

CH: *Yes.*

DG: It might be worth just explaining that last piece because, yes, I understand people .... That ...

CH: *(inaudible)*

DG: Yes, what I was going to say is, you know, there's a lot of feeling about ... we've had it lots in the meetings, that people ... yes, it's a done deal, that's the view, I can understand that, I think there's a lot of history around all of this and as Stephen said this is about looking forward, it's to the future, and we

**Seizing the Future Public Meeting  
Bishop Auckland  
Friday 9<sup>th</sup> January 2009**

can't undo history, you know, we are where we are, we need to make the best of the future. What we're doing very much here is a consultation process because no decisions will be made until 3<sup>rd</sup> March. Now the 3<sup>rd</sup> March the Trust will have listened to the issues coming from the consultation, they'll listen to issues from Overview and Scrutiny Committees and other information, they will decide what they want to do with ...

?: *Will it be open to the public?*

DG: Can I just explain this a minute sir? What will happen then is there'll be discussion then within the FT's Trust Board and they will decide what they do with their proposals, they may amend them, they may ... hopefully they'll listen to what's been said in the consultation, there is some evidence as they've gone along of actually changing things, the transport issue, they're doing a lot of work to try ... to put that together, so that when they actually come back to the County Durham PCT Trust Board in March, we'll listen to that evidence, we'll also listen to the evidence from the consultation, listen to the revised proposals and only at that point will we make any decision, and there was a comment made earlier on about this ... you know, this will be happening in two months time. That is just a decision for ... you know, whether the changes go ahead, or what the changes are. There will then be some detailed planning for the implementation of that which won't necessarily start from Day 1, so if you like the end of the consultation is the end of the beginning, there's lots of extra work that will need to take place to move that forward but it is not a done deal by any ....

?: *Alright. (inaudible)*

DG: And, yes, that meeting on 3<sup>rd</sup> March sir, where we take account of the issues and make a decision, will be held in public.

?: *Can I just raise the other question because obviously there's other people want to talk?*

DG: Yes.

?: *You talk about beds and you talk about Bishop Auckland not being an acute hospital. I have been on, you know, I've been on duty over the Christmas period, the New Year period, so I've seen the volume of patients that have come into Bishop Auckland hospital and I think on the 2<sup>nd</sup> of this month it was so horrendous in terms of the volume of patients that they had to go to the theatre to bring down trolleys, that was the (inaudible), so what I want to know is, yes, what I want to know is where are you going to put the volume of patients that are coming through Bishop Auckland, where you're going to put that volume of patients if this does go ahead.*

DG: OK.

SE: OK.

DG: Can I have a response from the panel please?

SE: I was going to say I think Bob probably could say a bit more about this in a moment. I would just comment that we're tremendously grateful to our staff at Bishop Auckland and the rest of the Trust over this last month in the way that they've dealt with what's been probably the most difficult winter period for some considerable time, and of course when that happens the sort of example that you described, it's all hands to the pump, and it's tremendous that that's the case and that's the spirit that we have in Bishop Auckland and in the Trust and that's what we want to preserve. In relation ... but of course that's about what's happening now and in the future we actually believe that the sorts of pressures you're describing ...

?: *(inaudible)*

SE: Well let me finish, the sorts of pressures that you've just been describing sometimes don't afford us the sort of quality of care we'd like to see for our patients. We believe our proposals will mean that they

**Seizing the Future Public Meeting**  
**Bishop Auckland**  
**Friday 9<sup>th</sup> January 2009**

will be better in future because we're going to organise and concentrate emergency care and resources differently to the way we do now and separate out some of the elective activity, so it will be easier to manage those pressures when they happen. Now we are planning to deal with the additional capacity and I was going to ask Bob to speak on that for a moment or two around what we're planning to do should the proposals go ahead.

GA: And I made the case and I'll make it over again, I'll say it to all of you too, that unless I'm convinced the capacity is there then it shouldn't go ahead. Simple as that. Bob, how are you going to prove this?

BA: Well essentially we've done the analysis of the type of patients that come in and, yes, I have to admit since the first week in December there's been unprecedented levels of patients being admitted to hospitals throughout the NHS, there have been pressures nationally that we haven't seen for probably ten years, so we've all been under pressure and I think, as Stephen said, certainly the staff, you thank them for the huge efforts they put in, that on our average activity analysis and the way that we are reconfiguring, taking elective surgery, dropping surgical beds, putting more medical beds onto the site, we are confident that we will cope with the level of activity that County Durham generally generates. To add to that, and I go back, and I was going to make a comment about it when Sam posed his question, because he implied that the document and the proposals had been developed because that's the way clinicians want to work to make it more comfortable for them, that isn't ... that couldn't be further from the truth. The teams, the Service Strategy Group, who developed the models of care, were actually given as one of their objectives to improve the quality and to be able to achieve 21<sup>st</sup> century standards which are improving all the time, and if my clinicians would have been a bit saddened to have heard that initial comment Sam, but we'll accept that at this stage. I do ...

SZ: *(inaudible)*

BA: I know that's your feeling and you and I have discussed it before. My feeling really quite strongly is, is that the proposals we're putting forward will dramatically improve the quality of the care that we're able to provide to all of the people in County Durham.

?: *(inaudible)*

BA: Well can I finish, sorry, can I finish.

DG: Can you let him finish please?

BA: Can I finish? Can I finish? What we've actually been having a meeting, we discussed at EDG yesterday, Executive Directors' Group yesterday, a plan to appoint new acute care physicians. We've a plan to increase the number of emergency department consultants.

?: *Can I ...*

BA: No, I'm sorry, we've listened to you ask all these questions, you know, let me finish what I'm saying. We're trying to, by doing this, we've done the analysis of the capacity, but also by attracting people to come and work in these better staff units, we're going to improve the quality of care that we deliver and I'm 100% confident about that.

?: *Can I just say (inaudible) is that I've seen this week Darlington and Durham that are full, on a regular basis, that happens, it doesn't just happen over the holiday period, it happens quite a lot, where Darlington's full, Durham's done so they're transferring patients from one hospital to another. So what the question I asked you is if that situation is arising now, where is it that you are going to find the beds to replace ...*

BA: By increasing the number of physicians that are able to process the patients, the acute care physicians that actually turn the patients round more quickly within an MAU, right, you will reduce the number of patients needing to be admitted. As Professor George actually has talked about the medical assessment unit, that should reduce the number of admissions that we put in, right? Listen, we've done all this

**Seizing the Future Public Meeting  
Bishop Auckland  
Friday 9<sup>th</sup> January 2009**

analysis, looking at the type ... we should reduce the number ... yes, there will be hot times, but we're confident that generally we will cope. There may well in the future be another ten-year surge where the whole organisation will suffer but we will find a way of actually managing a way through that crisis.

GA: OK. Let me just butt in for a moment. If you see, first of all, a nurse, then an inexperienced doctor, and you then wait to see an inexperienced doctor, you almost automatically add a day onto that admission for that patient and it's a very inefficient way of working. If you can have your round the clock rota of experienced people you will then first of all do what we all want to do which is treat each one of you quickly, promptly and appropriately and then you move through the system much more quickly and I think that is absolutely key to this and then you suddenly find, and places where this has happened have shown that the pressures diminish, they don't go away, but they diminish. I mean you can shake your head but do you want to lie around for 18 hours in ... you know, in an A&E department, waiting, hoping someone with appropriate expertise sees you? We want to get that flow through, and if you can guarantee your round the clock rotas of proper experienced staff then you move people through more quickly, it's been shown over and over again that you shorten admission times.

?: *But you're working on the theory of a quick turnover of patients. I've seen on many, many occasions that patients in Bishop Auckland, I can imagine (inaudible) at Durham, they've been sent out far too soon and two days later they've come back again.*

GA: Yes, we don't want that argument.

SE: No, we don't want that either but perhaps ... the last word on this is that we're talking here, and I mean I accept that some of the things that you're describing are part of what happens in the health service today when we're under pressure but our plans are about organising differently so we'll focus all that expertise in locations that are just simply dealing with that and we'll put people through more quickly, and we'll be dedicating resources for recovery, so that's the way ... we'll be working very very differently to the way that we are working today which is why I'm saying I passionately believe that these will be better services in the future than they are now.

DG: OK. Thank you. We've got a gentleman here who's been very patient. We'll move on to some more questions.

?: *Is that on?*

DG: Yes sir.

BA: Yes.

BG: *Right. Thank you very much. My name's Bob Gosling, I'm a local resident and a former employee of the NHS. I have two questions, one for the Trust/PCT and one specifically to Professor Alberti. Before I do though, I can't resist when I have the mic in my hand, on the last issue that's just been discussed, many of us in this room were involved in the so-called consultation which took place a few years ago about the removal from Bishop Auckland of the best consultant-led, most popular and most efficient consultant-led maternity unit in the region. At that time ... at that time we received similar assurances about capacity at the other end. Since then you just ask somebody that works there, I can assure you that my grandson was born in the corridor at Darlington, in the corridor, and that is not atypical. Now, on to my questions. I question the validity of your assurances about capacity in this context. I want to address in particular the A&E issue on my two questions. I received a copy of the latest expensive propaganda exercise that we're paying for from the Trust and I see that in that it says, and it has been said before, that the A&E department in Bishop Auckland currently accepts minor injuries and medical emergencies only and my question to the Trust and the PCT is ... when did that happen? When did you consult us about that? If there is to be a consultation it's coming back to this stealth business which I agree with entirely, what the lady said here about stealth, when did you consult us about that? You're chipping away, chipping away. You reduced, over the years, the size of our A&E to the point where, OK, there's difficulty obtaining staff, there's difficulty in all sorts of areas because*

**Seizing the Future Public Meeting  
Bishop Auckland  
Friday 9<sup>th</sup> January 2009**

*of a question of size, but you didn't consult us about it. How about consulting us in the first place not when the boat's already left the harbour. That's my first question and I want to know from the Trust and the PCT (a) did you consult us and (b) why not?*

*My second question is related particularly to Professor Alberti and I have in front of me a copy of his report, and with great respect Sir I ... there seems to be a contradiction in your report because at one point you highlight the fact that there were 39 options produced, sorry 49, did I say 39? And they were all subject to hurdle criteria, one of which was do-ability, and then you say three got through, but we're only being consulted about two. Now, you know, you said quite clearly that three got through the hurdle criteria, one of which was no change. Now I know people that didn't write the report have told me well that's because we wanted to compare like with like, we wanted to compare with the status quo, but no, you don't say that, you say quite clearly, was that a mistake, when you said that the present status quo, or no change as it says here, passed the do-ability procedure. You go on to give all sorts of reasons why it doesn't or why you think that should be changed, but it doesn't alter the fact that it passed the procedure and were it not for the historical situation we find ourselves in, which I referred to earlier, where we've had stealth and chipping away at our services, then I suggest to you that a lot of the reasons that you give in your report for discounting the no change option would not be valid anyway.*

DG: OK. Thank you.

BG: *And I would also suggest to you that no change is a rather negative expression. I don't think the third option should be no change, I think the third option should be make the present system work and I don't believe ...*

(Applause)

BG: *I don't believe that any serious attempt has been made by representatives of the Trust to make the present system work and you Professor have said it would work it's do-able.*

DG: Right.

(Applause)

DG: Can I ask for a response first on the last bit and then we'll pick up the bit ... the history bit I think we need to just explore.

SE: OK, we'll do it the other way round.

GA: OK. I did consider three options and one of which was not changing from the present. What I did not, or what I discounted, was moving to a level of staffing appropriate to make this a ... or to make Bishop Auckland a totally safe, acute hospital because I did not think that that was within the realms of feasibility of staffing that was needed for that, particularly ...

?: *Why say it was do-able then?*

GA: ... particularly ... particularly

?: *You said it was do-able.*

DG: Can you let Sir George just finish his response please?

GA: Particularly because ... you've made me lose my thread now ... because the experience that people would have because it is a relatively small intake by district in acute hospital standards, would not be adequate to sustain the rotations of specialists you would need, that was the reasoning behind that and why I then followed though with the other options.

**Seizing the Future Public Meeting  
Bishop Auckland  
Friday 9<sup>th</sup> January 2009**

?: *Because of the stealth.*

GA: Well I came ...

?: *This isn't the way to handle consultation.*

DG: OK.

GA: Excuse me. I came into this in July last year, I was not involved in the Good Lord's review of six years ago or whenever that was and was presented with the situation today and what could be done to generate a safe, high quality, good service for the people of Bishop Auckland and I drew the conclusions that I have drawn.

?: *Two wrongs don't make a right.*

SE: Just a brief comment on the first part and the general sentiment which I think others have expressed. I repeat what I said earlier, I mean, you know, I appreciate those concerns but similarly to Professor Alberti, I've been here a year, my main responsibility has been to address these issues in the way that we were discussing this evening and essentially what I would say about the comments that have been made are I don't expect you to trust me at the moment but I will be accountable should these go ahead for delivering what we've said and you can hold me to account if that doesn't happen. Now that's the assurance that I will give you. I cannot ... and neither can my colleagues, and either the PCT or the Trust, really talk ... the history is the history, other people were part of those consultations, we're dealing with the here and now and we're dealing with the future and I'm giving you an assurance that I am totally committed to moving these proposals forward and I'm happy to be held accountable by you and other members of the community for that, and I feel that should be ...

BG: *So do you wash your hands of what's happened before? If this consultation focuses, it's part of an ongoing process, and if ... and this consultation process is invalid if it follows on from an earlier decision where consultation wasn't made, particularly when the outcome of this consultation process is dependent upon the earlier decision about which we weren't consulted.*

SE: There have been previous consultations.

BG: *But you are ducking that by saying I wasn't here when it was made invalid, it's still invalid.*

SE: I'm not ducking it, Bob, thank you ... I'm not ducking it, I'm saying to you we cannot do anything about where we've got to today, I'm very ... I'm very clear about those ... I've been in charge for the last year, I'm very clear ... I'm very clear about the concerns, we're very very clear about that, what we're trying to do is put in place what we think is right for the future. What I'm saying to you is you can all hold me to account if these proposals go ahead. You will also hold me to account for what happens if they don't, I'm very happy with all of that and I think that should be the last word on that issue.

DG: OK. I think Sir ...

?: *I think you should be consulting us about the total picture, not just the bit that you want to consult upon there.*

DG: No, sorry Sir, sorry ...

?: *(inaudible) as to why we weren't consulted earlier...*

DG: Sorry sir, look, I need to stop, we need to move on from this because other people have got other questions, I think we've rehearsed quite well that bit about the past, we are where we are, for whatever reason we've got here, we're here, and we need to actually look forward and that's the piece of work that's being undertaken.

**Seizing the Future Public Meeting  
Bishop Auckland  
Friday 9<sup>th</sup> January 2009**

?: *Cover up, cover up.*

DG: You might think it's that sir, that's your view, but I think we do need to move on, I've got other people waiting for questions. I've got a gentleman at the back with the beard and then we'll come to Helen and then we'll come to you over there sir. OK?

?: *(inaudible)*

DG: No everybody...

?: *I've had my hand up for ...*

DG: OK. Sir, we'll come to you next then.

JL: *Thank you. My name is John Lethbridge, I'm County Councillor for Woodhouse Ward which is an area of multiple deprivation and we're standing on the edge of it here. If we look to the what we mean by multiple deprivation, there are various indices, one of which is longevity and the whole issue comes at me day after day, as it should, I'm their Councillor. Now I put that I'm down here but I'm equally concerned about the whole of Bishop Auckland and indeed the Dale, the thought of the travel that we have to do to get to the Dale, to get to the hospital, really does worry me and I'm not convinced by the arguments that you put to us concerning transport. Professor Alberti comes across as a very plausible gentleman, I think I've said this actually to his face when I saw him first at County Hall, and I would say it again, I do believe that you have a wonderful reassuring manner Professor Alberti, you're quite reassuring and you have a bedside manner which I would welcome.*

DG: I'm sorry sir, I don't ... I don't want to repeat it but because there are lots of people who've got questions could I ask you to ask your question to the panel?

JL: *No, I've been quite patient and ...*

DG: I know you have sir but other people have been patient as well.

JL: *And if you tell me how many minutes I have and I'll use those minutes. Let me say to you I spent part of this afternoon looking at ... I thought I'd just look at the history of our hospital here, it began as a workhouse in 1900, it is documented, and coming through to the 1930s when we had prefabricated buildings...*

DG: Sir, I'm really sorry but can I ask you to get to your point with the question please because we do need to get other people to ask their questions?

JL: *Well you've listened really quite extensively to many others and I find it difficult that I'm being put down here. What I'm saying to you is that the building of our new hospital, we had old buildings here, draughty, wet and so on, a tremendous amount of work was done in there, you know, we needed a new hospital. I've heard it said to me recently that Bishop Auckland shouldn't have had a new hospital, it didn't fit in somebody's management plans, well we have a new hospital, 2002 the apotheosis of what we were wanting we got, and yet from there on we seem to have gone over the hill, we started losing services in this wonderful hospital. Now that's the point that I was making, if that's OK with you. Now the questions that were put out were ... do you believe in change in terms of the consultation? Now I found that slightly offensive because it's so easy to lead into, anyone who said they don't believe in change are being silly, so that was the first question, let's put that one to one side. Should the change be led by clinicians? Well most sensible people would say well doctors are pretty bright people, sensible people, as I indeed say that you are, but Sir George I'll put to you that there are times when I do think we need to take cognisance of more than simply clinicians. When I am on the street collecting a few of 16,000 signatures who are totally against what is being proposed, brings to the fore this issue, should clinicians be the only people who are taking that, or should the people be taking that decision? Now clearly we need to be involved in both sides. We need both to be represented in this decision-*

**Seizing the Future Public Meeting  
Bishop Auckland  
Friday 9<sup>th</sup> January 2009**

*making. We don't need people who are nodding just in ... you know, I hesitate to say this, we don't need select few nodding to your thoughts, we need active discussion, active dialogue in order to reach a reasonable conclusion which is satisfactory to everyone. Now this may be very difficult to achieve, but we are not going through that at this moment in time. We have a Scrutiny Committee at County Hall who have backed you up and they received yesterday a fair amount of criticism and it was, I will put to you, it was a deserved criticism. My thought is this, and I'll come to it ...*

DG: OK. Thank you.

JL: *Sorry if I'm stressing you out.*

DG: I'd appreciate that and I think everybody else would.

JL: *I would put it to you, we need to change, we do need to change, we need to change our management of this issue. We need to look at this afresh, not in this present them and us situation which you may recall that I said we have, we need to be in some form of dialogue from which something is emerging, and that point that Sam made a short while ago was that ... virtually it should not be entirely in the hands of the clinicians, I think there were ... I'm paralleling the point that Sam Zair made when I say that. I would put it to you however good you are Sir George, you do need people here to be in discussion with you because as it stands this profession is going to a big wall. Thank you.*

(Applause)

DG: Yes, OK.

SE: Let's take some more questions.

DG: Yes.

SI: *Hello, my name is Stanley Ingham and I'm here purely on a personal basis, OK? I understand that you are to close the excellent stroke unit in Bishop Auckland and transfer it to Darlington. Three or four weeks ago one of the Health Ministers made an announcement on television that the drug thrombolysis would be available to every hospital in the country providing people got in within three hours. Now I find that the closure of this unit will be detrimental to the whole population, and I would like your comments on that please.*

SE: I can perhaps comment very briefly about our plans. Actually the stroke developments that we're talking about, irrespective of Seizing the Future, we'd have been talking about anyway because there is a national stroke programme.

SI: *I'm aware of that.*

SE: As you probably know, directed by the Department of Health.

SI: *I actually had a stroke six years ago (inaudible)*

SE: Sure, but what that programme is saying is that you need to design a stroke service that operates on the basis around about a half a million people so we have to look at how our hospitals as a whole, all of them, need to change to provide that service. Now when you say there's a proposition to close stroke services at Bishop Auckland, that's not right. There is a proposition to make changes about that initial period in which you require urgent and rapid assessment but the vast majority, as you probably know ...

SI: *But your proposals ...*

SE: Well if you'd let me finish, we haven't got any firm proposals, we're simply saying about ...

**Seizing the Future Public Meeting  
Bishop Auckland  
Friday 9<sup>th</sup> January 2009**

?: (inaudible)

SE: No, let me finish and you can understand what I'm about to say, which is actually quite important in relation to Bishop Auckland, that I'm sure you know if you had the experience yourself, 90% if not more of stroke care is about what happens after you've had the stroke, and that's all about therapy, recovery, swift intervention from the beginning, and that's got to be ... that's not provided by the high tech scanning and the specialist doctor intervention at the beginning, it's provided by nurses and therapists and all the research will tell you that's what you need to do. That, and stroke services in this country, are way behind those in the rest of Western Europe because we haven't been doing that. Bishop Auckland is going to be our centre of excellence for stroke as part of the recovery and rehab services. We're certainly not taking this away ...

SI: *But what about the initial diagnostics?*

SE: Let me finish, there will be more activity in stroke care at Bishop Auckland in the future than there is today, that's what we're proposing and it needs to be really clear that that's what we're proposing.

SI: *Well I contend that that just wouldn't be the case. You're still denying people this service, it's an excellent service at the moment.*

SE: OK. Well we'll wait and see what ...

SI: *Since years ago.*

BA: OK, can I just fill you in with part of the data because Clive and I have had this discussion about the stroke service. The thing I have as a Medical Director ... what we provide at the moment at Bishop Auckland is a limited hours service for thrombolysis when we have the expertise on the ground, we don't provide it 24/7.

SI: *Why? Why?*

BA: Because we don't have the expertise on the ground. We don't have the expertise on ...

SI: *Why?*

BA: Well I'm trying to answer ... you keep saying why and I'm trying to answer you and you won't let me finish.

DG: Can we let Bob answer please?

BA: Basically because we don't have an adequate number of specially trained clinicians, as Sir George was talking about earlier on, to actually deliver that on the ground. Now the plan is ... no we haven't, we don't provide thrombolysis at Darlington at all at the moment. Yes? What happens is the stroke patients from the Darlington catchment area, at present, come to Bishop Auckland. There is a level of support required for the first 48 hours post stroke, looking at HDU, potentially critical care facilities. Now what we have is a model of care, as Stephen alluded to, for catchment population of about half a million, but the clinical pathway that is being developed by our teams has a virtual County-wide service where there's thrombolysis and the initial assessment will be delivered on the acute sites, the thrombolysis delivered, a service provided 24/7, then once the patient is stabilised they will be transferred to Bishop Auckland from the County-wide catchment for rehabilitation. So it will be a Countywide service.

SI: *Yes, I understand that, it's the initial three hour period of ... you're denying to the whole population ...*

BA: No, that would be delivered in Darlington.

**Seizing the Future Public Meeting  
Bishop Auckland  
Friday 9<sup>th</sup> January 2009**

SE: Bob ... I wouldn't use the word, can I just say, I wouldn't use the word denying, we've not been able because of the way that we organise the services, to provide the service that we need to provide to ensure excellent care, not just for Bishop Auckland, for all of our population, and that plan that we're putting forward in terms of stroke means that we'll be able to do that in the future, that's the really key issue to really get across, wherever you go at the moment we're not organised well enough to meet those national standards and what Bob's describing is how we do that, and the pivotal role that Bishop Auckland plays in that.

BA: Yes.

DG: OK, sorry can we move on, we need to get through some more questions if we can please?

SI: Yes.

DG: We've got the gentleman here then I'll come to you Helen next.

NH: *Yes, thank you. Neil Harrison, Leader of Wear Valley Council and County Councillor for Bishop Auckland. You keep saying don't talk about the past, OK, let's talk about the future and let's talk about the new NHS constitution that's kicking in shortly which will allow patients the choice to go wherever they like to be treated. Well the people in Easington, Peterlee, Chester le Street, Stanley, have all said on these consultations large elements of the population that you serve they'll choose to go to the large hospitals run by other Trusts, not your Trust, they'll choose to go to Newcastle, to Sunderland, to Hartlepool, to Middlesbrough. You know you'll not be able to bring these promised extra services here because you'll lose revenue, people won't come here, you won't be able to afford it, consequently you can bring your reductions to service here now because you know that in the future you won't have the money to bring the extra services here because you won't have the revenue to do so and we'll be left with a mortgaged PFI cottage hospital and finally I would like to say that I wrote as the Leader of Wear Valley Council to Professor Alberti five weeks ago and I haven't even had the courtesy of a reply.*

(Applause)

GA: I will answer that question first. You will get a reply sir, but your letter was so rude that I needed a few weeks to cool down because I found it personally thoroughly offensive.

SE: Neil, we've had this conversation previously. Actually, in terms of your analysis, in a way you've described what I think will happen actually if we don't make these changes. I think we are talking about trying to provide more care against the standards that our commissioners will require of us for patients who live in County Durham and Darlington. Actually quite a lot of patients, as you rightly say, currently go to hospitals much further away for quite a lot of routine treatments, and if you take the example of what we're proposing around day surgery where we want to concentrate a lot of routine activity, using extra capacity again, at Bishop Auckland, we're very confident that we can actually bring some of that work back for some of those patients. What you described is what I think will happen if nothing happens in the next year or two.

DG: OK. Thank you. Helen, sorry.

HG: *I want to concentrate on two issues in particular, one is the issue of health inequalities and the other is the question of travel. Everybody in this room is agreed that the NHS is a service for everybody and that equal access is at the heart of that. In fact, everybody in this room also knows that there are big health inequalities in this County and improving equity of access is vital to tackling that, and that's not my words, that's the words that the local NHS have produced. However, there is a problem in the way the Seizing the Future proposals have been put forward in that they don't take account of these health inequalities. I have today had a letter from Stephen saying we do not hold information on health needs by postcodes. Lady (inaudible) sat here five minutes ago and told me we're talking about the future and I shouldn't talk about the past, you've all said the same. Another thing I asked for was a forecast of changes in health needs in this County, I was also told you haven't made such a forecast. Now, I*

**Seizing the Future Public Meeting  
Bishop Auckland  
Friday 9<sup>th</sup> January 2009**

*think those things do matter and I think if that analysis is not done we will not come up with the right answers. I have done a little piece of work, obviously I'm not resourced up to do a lot of work, but I have done a little piece of work and I can tell you that Wear Valley comes No.33 in the order of deprivation, whereas Darlington is No.95 and Durham is No.190, so in other words, this community is the most deprived community, but what you are doing is taking health resources away from this community and concentrating them in Durham and Darlington.*

(Applause)

*HG: And I do not wish to have head shaking from people at the table because the figures that you produced shortly before December show that in Bishop Auckland the number of beds is being cut almost in half from 141 to 77 and the letter that Stephen has sent me today shows that although the picture we were given initially was that you were taking A&E out but more elective care would come into Bishop, in fact the increase in elective work proposed is 123 cases a year, compared with the 3,000 to 5,000 cases which are going away, well if you are shaking your heads you're going to have to write me another letter.*

SE: Probably!

*HG: These are the numbers that you have given me.*

SE: OK. Well that's not right.

*HG: And that's what I am basing it on.*

SE: OK.

*HG: And that is a problem because you have the legal requirement to give me the information within 20 days and your time limit's up. However, I'll come on to the issue of travel. Repeatedly you have said to us this has been at the forefront of your concerns and this is a major issue for us.*

SE: Yes, it is.

*HG: Sorry, and I don't think for example this is Professor Alberti's fault, it probably isn't the fault of anybody in the room but the information on which you have been basing your analysis is quite wrong. You have sent to me and you have produced maps which show that it is possible by public transport to access Durham and Darlington within an hour from most of the area which this hospital serves. I have now had new information from the County Council that shows that that is very far from being the case, that if you live in Barnard Castle, Cockfield, Shildon, the journey is more than an hour and that's during the day as well as at night. And as John was saying, we're right next to one of the poorest parts of the community. In Woodhouse Close people are dependent on using public transport. 45% of the people who live in Woodhouse Close do not have access to a car, so I think the reason that you get a very negative response from the community here is that you make very general statements like we're very concerned about transport, but you don't bother to do the detailed work and actually find out what the situation is on the ground.*

DG: OK.

*HG: And finally, I'm surprised that Professor Alberti spoke to the Leader of Wear Valley District Council in the way he did. I wrote to Professor Alberti in July. My letter was certainly not impolite and I haven't received a response either.*

(Applause)

GA: You certainly received a response to your first correspondence ...

*HG: I didn't.*

**Seizing the Future Public Meeting  
Bishop Auckland  
Friday 9<sup>th</sup> January 2009**

GA: Yes, you did. Well you should look in your mail box because I certainly wrote to you Helen.

DG: OK. Can we ... agree to disagree on that one possibly?

GA: Let's not bicker about that. I mean I share your views completely about inequalities and the need to ensure that places with these high indices of inequalities are looked after properly. Now for far the majority of people they will have improved access. We're talking about ... no don't shake your head, just listen ... we will have, what did we reckon, about 20 people moving to other hospitals, there will be, and I made this a sine qua non, now what I said, that we have to improve services here for everything that can be done safely here, and that's an awful lot, so that with improved outpatient services which is where public transport becomes a major major problem, we should be able ... in fact I've been told we will be able ... to see many more people locally here. We will move, the professional whom you don't think ought to have a say in this, but we will .... No, you didn't, I was talking off left ... and we will deal with more people in the end here from the local population than are being dealt with at present, but people who require major specialist intervention and that is this smaller number of people will go where you can deliver that most safely, and OK, you may ... some of your colleagues may object to smooth talking clinicians, but you know as a clinician I do not want to be involved in producing a sub-standard service for people and that was based on what I wrote here, that was the best that I felt we could do to ensure good standards of service including the problem of transport which I do accept is a problem.

DG: OK. A quick comment from Stephen and then one last quick question because we are starting to run out of time.

SE: Yes, 30 seconds on the correspondence, it's certainly not 123, we're talking about literally thousands of additional activity at Bishop Auckland, we need to just actually clarify that, but not now. And certainly in relation to your point about transport, Diane might wish to add something to this but the figures we are working on are provided by County Durham and Darlington Transport Unit, County Durham County Council, rather, Transport Unit, so there's obviously some discrepancy there and we're quite happy to take account of any new information as we move our planning forward Helen, as I'm sure you know. The point is we're planning to invest in transport and we've now got a really good idea from consultation about where to focus that transport to make sure that those that are affected get a service. But I want to finish by just reading out, when people talk about inequalities and access, this is what will be at Bishop Auckland in the future should these plans go ahead – a cataract centre, doesn't exist at the moment anywhere in County Durham and Darlington, lots more day surgery, a centre of excellence for rehabilitation and recovery, expanding outpatients and diagnostics, the urgent care centre that we've talked about, some of these things by the way have emerged in the consultation, a GP ward which is being sponsored and proposed by local GPs, education ...

(Noise around the room)

DG: Sorry can you let Stephen finish please?

SE: Educational facilities, we're going to consider on the back of your own recommendations Helen whether we can think about me and my team basing ourselves at Bishop Auckland, now if that isn't commitment I don't know what is, so we're certainly going to take that seriously onboard. Midwifery-led services, a bowel screening centre and our surgeon ... those of you that have been around at the meetings will have heard our Divisional Lead for Surgery talking about a specialist focus for colorectal activity at Bishop Auckland, because a lot of that work is day orientated, an endoscopy centre, and actually one of the other things which is a really exciting proposition that's emerged from these discussions, currently we provide surgery for children in three locations, it doesn't meet any national standards, there's about to be a regional review, we don't have dedicated surgeons and anaesthetists, if we want to provide that service in County Durham and Darlington we have to put it all in one place. Where's the best place to do that? Bishop Auckland. And that ... all I'm saying to you is when you talk about inequalities and access, there's an awful lot there in what I've just read out to you that isn't there now and actually it's going to be nearer for some of these communities than it is now, so ... all

**Seizing the Future Public Meeting  
Bishop Auckland  
Friday 9<sup>th</sup> January 2009**

I'm asking for is when we have the debate that we have some balance in that debate. I understand all the other issues but there's a lot of developments here that we're proposing.

DG: OK.

?: *Can I make just one point? If you can get specialised people to do these specialised services that you're bringing to Bishop Auckland why can you not get the specialised people to keep it an acute hospital? What's the difference?*

?: *Absolutely.*

SE: Well ... because you have to see ... I'll answer that question ... because you have to see, which I know is very very difficult, it's difficult in Durham and it's difficult in Darlington and it's difficult here, you have to see your local hospital as part of a whole range of facilities providing a service to 500,000 people because that's what determines specialism. That's the answer to that question.

DG: OK. Thank you. Ladies and gentlemen, I'm sorry, Clive it will have to be very very quick.

CA: *It will be quick, yes it will be quick, I'll make a quick observation to you gentlemen. You keep using the word safe. I think you're making it totally unsafe.*

?: *Yes.*

(Applause)

CA: *Totally unsafe.*

DG: OK.

CA: *I'll explain the reason why David, I'll explain the reason why. You're going to have more people travelling longer distances in the back of an ambulance.*

SE: Incorrect.

CA: *Which is open to unsafe roads, unsafe weather and everything that goes with it. I'll leave that alone. Mr Alberti, one question, have you ...*

DG: It'll have to be quick Clive.

CA: *... in the past tried to close the A&E at Bishop Auckland? In the past, have you ever tried?*

GA: No.

CA: *Is that a definite no?*

(Pause)

CA: *He's been at it for the last 15 or 20 years, this man, he's been trying to close that A&E at Bishop Auckland for 15 to 20 years.*

GA: That's absolutely ...

CA: *You have!*

GA: Have you written evidence for that because I have not!

CA: *I'll get it, it's at County Hall now.*

**Seizing the Future Public Meeting  
Bishop Auckland  
Friday 9<sup>th</sup> January 2009**

DG: OK sir, I think we ...

GA: Rubbish!

DG: I think ladies and gentlemen it's probably time to draw things to a close, not least of which because ... not least of which because the College is expecting us to be out of the building fairly soon. I'd like to thank you all for coming along. This is part of a consultation. I do want to reassure people.

?: *Consultation (inaudible)*

DG: Excuse me, can I just finish speaking?

?: *In a minute (inaudible) described as (inaudible) in December but we told them to take patients to Bishop Auckland (inaudible)*

DG: OK. Can I thank you all for coming along, for your input, can I thank the panel for their responses and have a safe journey home. Thank you.

SE: Thank you.

*(End of meeting)*