

**Seizing the Future Public Meeting  
Auckland Castle  
Bishop Auckland  
Thursday 4<sup>th</sup> December 2008**

**Representing the NHS**

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Diane Murphy, Director of Nursing and Project Manager for Seizing the Future - County Durham and Darlington NHS Foundation Trust  
Neil Munroe, Consultant Physician and Clinical Director for Medicine and Emergency Care - County Durham and Darlington NHS Foundation Trust  
Iain Baine, Consultant General Surgeon and Divisional Director for Surgery- County Durham and Darlington NHS Foundation Trust  
Laura Robson, Director of Nursing - County Durham and Darlington NHS Foundation Trust  
Andrew Cottrell, Consultant Paediatrician - County Durham and Darlington NHS Foundation Trust  
Paul Liversidge, Director - North East Ambulance Service**

DG: ... seated there, are you OK at the back? OK. Thank you. My name's David Gallagher, I'm one of the directors at NHS County Durham, the PCT, the Primary Care Trust, and delighted to welcome you here this evening to one of a series of consultation meetings that we're having with colleagues from County Durham and Darlington Foundation Trust about some proposals they've got for the future of their hospitals. I'll just ask colleagues who are with me from the Foundation Trust to introduce themselves, then I'll explain a little bit about what we're about this evening and then we'll get into the proceedings.

SE: Thanks David. Good evening everybody, I'm Steven Eames, I'm the Chief Executive at the Foundation Trust.

DM: Hello. My name's Diane Murphy, I'm an Associate Director of Nursing and Project Manager for Seizing the Future.

NM: Good evening. My name's Dr Neil Munroe, I'm Consultant Physician, Clinical Director for Medicine and Emergency Care across the organisation.

IB: Hello, I'm Iain Baine, Consultant General Surgeon and Divisional Director for Surgery.

LR: Hello, my name's Laura Robson, I'm Director of Nursing of the Trust.

AC: Hello, I'm Andrew Cottrell, I'm Consultant Paediatrician based at Bishop Auckland.

DG: Thank you all. We had hoped this evening that we'd have also on the panel Sir George Alberti who's the Department of Health's lead for acute and urgent care. Unfortunately, because of the weather, which hopefully hasn't caused too many problems to us locally, but because of the weather George wasn't able to actually get out from London to come up to the North East this evening, which is unfortunate. If there's an appetite for having a discussion and actually having George come along and if we can manage it, we can look at arranging a future meeting. I guess it's not going to be this side of Christmas, it might into the New Year, it will depend on how quickly we could actually do that given that his diary is very busy but if there's an appetite to do that we'll certainly look and see if we can do that if people would be interested.

Having said all of that I think the key things that we want to have a discussion about the proposals for the hospital and all that Professor Alberti will be doing will be actually adding to that, giving a national perspective.

What we'd like to do, we've got an Agenda to run through this evening, which is the same format that we've used for a series of public meetings now. In a moment I'm going to ask colleagues from the Foundation Trust to actually present their case for change if you like and what their proposals are and

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then we're going to actually split ... have a brief session where we split into some discussions around the tables and get some of your views to feed into the consultation. We'll have some feedback from that and then there's be opportunity to ask some questions from the floor and what we'll do in the round table discussions is we'll get your views to feed into the consultation formally but we'll also have an opportunity then to actually formulate one or two key questions to start us off with the plenary session but then once we've exhausted those questions we'll have open questions from the floor to the panel. I'll then at the end explain briefly what the next steps are and how this fits into the rest of the consultation process as it goes forward.

?: *Point of order Mr Chairman can I just ask if we could consider dispensing with the round table discussions, having been to another one of these forums I know that they just are a waste of time and effectively gag discussion and only something like 5% of the (inaudible) something like 5% of the questions were asked, because people somehow with the tables discussing things without discussing them with the people at the end (inaudible)*

DG: OK. OK, I understand your point Sir, and it's certainly not an attempt to gag you. There are a number of people here who haven't been to any of the other meetings and ...

?: *(inaudible) by the end of this one, if you do the same that they've been gagged. (inaudible)*

*(Applause)*

?: *I can see the ones over there that are facing, they're the ones that are clapping, the others don't know (inaudible) it's a con. Let us have a normal public meeting. You tell us what's happening and we'll discuss it with you. It's a public meeting, not a gagging session.*

DG: Right. Excuse me Sir, it is a public meeting, but it's a formal consultation, we need to go through a fairly strict protocol for it, now what I would ask ... and I'll just move on to the next bit I was going to say, the key aims of this meeting is two-way communication ...

?: *So you're taking no notice of that then?*

DG: I've listened ...

?: *(inaudible)*

DG: No, I've listened to what you've said sir and if you'll give me the chance what we're going to do is, it's two-way communication, there are two opportunities for people to have their say. What I'd ask is that you'd actually give colleagues the opportunity to actually present their case and we'll do that fairly quickly, we'll move through the presentation very quickly, and then two thirds of the meeting are for a round table discussion which is a quick discussion and learning from previous events ....

?: *Two thirds of the meeting, quick discussion?*

DG: Two thirds of the meeting are your chance to have your say, and actually Sir if you ..

?: *It's doesn't work that way though does it? Of the round table discussion ... the questions that were posed, if you cut the (inaudible) one of the six was (inaudible), one of the five were not (inaudible) we spent a lot of time sitting round the table formulating questions which were ignored. It's better for us to just (inaudible) questions and stop wasting two thirds of the time with the round table, because that's what happened last time.*

DG: We're not wasting two thirds of the time and with due respect sir we can stand here and you can throw points back at me and I can explain the process till the cows come home that's not going to be moving us forwards.

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?: *According to you (inaudible) consultation (inaudible) and you need to start again if you want any sort of (inaudible) in the process. You're trying to consult that people, the local people, this is the first meeting you've had in an area where people are really affected, you've had them over in Easington, you've had them all over, you didn't even want to have one in the Dales did you, but you were forced to do that, they are the people who are affected, we're the people who (inaudible) are the ones affected, not the ones in Easington (inaudible)*

DG: Right. Excuse me, look, I'm sorry, but we want to run this in an orderly fashion, I understand your points, we will run this as quickly as we can, we need to get some input into the consultation process, there will be ample opportunity for people to put their questions towards the end.

?: *Like last time!*

DG: At the last meeting that we had, which a number of the people from the room were here, we did actually have more time for questions. There's ample opportunity for questions and actually the longer that we stand here debating this the less time there will be, so I suggest we move on and if you bear with us we'll get to your chance to ask the questions ...

?: *(inaudible)*

DG: I'll tell you what Sir, there are two choices here, we can do it the way we're suggesting or we can just say right let's forget the meeting. And I think people round the table ...

?: *(inaudible) public meeting (inaudible) but all I'm saying people notice the way we're being manipulated. You'll see afterwards how it's been done.*

DG: OK Sir, I think we'll just proceed with the presentation, we'll get then very quickly onto the discussion and we'll get the questions and answers and hopefully by the end of that people will be satisfied that they've had the chance to have their say. I'll hand over to colleagues for the presentation and could I ask, in the spirit of moving things on and getting at the chance to ask your questions that we hold any questions until after we've been through the presentation please.

SE: Thank you David, and just in relation to that point, we're all here this evening and we're happy to answer any questions at all from anybody in the room that comes up after the round table discussion, and I would remind you also that we've run this format in every single meeting bar the first one so we have to have a consistent approach so I'd ask you Sir to respect the process whilst we go through the presentation, there will be ample time to ask your questions.

Now can I just move on to the presentation that we would like to do here this evening. First of all, I just want to set out some key messages at the beginning, then I'm going to ask Dr Munroe to talk through the clinical case for change and then Diane Murphy will talk through some of the supporting issues particularly around transport.

Seizing the Future is about two things, it's about improving the quality of care to the people that we serve in all of our communities across County Durham and Darlington and it's about improving the outcomes from that care as well, which means in simple terms that we would want to organise services that allow us to make sure that the care is better in the future than it is now. So that's what this is all about and I should also say that in getting to this point of public consultation we've had nine to ten months of work, development work, which has been developed by clinicians across the organisation together with our Governors who represent the public as part of our Foundation and this ... what you're hearing here is the culmination of all of that work over that period of time. Now the key messages I want to give, and it's important I think to get these messages across, because of some of the coverage that this set of issues under these proposals has had. First of all, we're not proposing any closures, we're not proposing any reductions in services, we're proposing changes in the way that we provide and organise those services. Nor are we proposing any redundancies, in fact we would see these proposals over time, should they be implemented, would be better for our staff, would provide our staff with greater opportunities and more critically enable us to attract high quality people, professionals,

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doctors, nurses and therapists, to our hospitals. What these proposals are about also is using all of our sites, we operate services from five sites across the County and Darlington and we want to maximise the use of all of those sites and what's driving these proposals in terms of the clinical perspective are two things, first of all, providing services locally wherever we can safely and what that means increasingly over the next five years is more and more services being provided in local communities. On the other hand, we've got some serious concerns about the long term, or medium term, safety of some critical services and they are fragile now, critical care, Accident & Emergency and children's services, and you'll hear more about that shortly. So what we're all here to do is set out our proposals for what we believe very passionately is the best way to take our services forward in the future.

Now very quickly to just outline what we're proposing ... we're proposing to organise our acute services at Darlington and at Durham and in doing so we'll concentrate Accident & Emergency, critical care and acute care for children on those sites. We're planning to redevelop Bishop Auckland hospital as a centre of excellence for planned care, for outpatients and diagnostics, for day surgery, for rehabilitation and for recovery, and I would just point out ... this slide makes the point, and I think it's really important to get this across, if we're able to put these proposals in place, we'll be using ... remember that point I made about maximising our hospitals ... using more floor space in the hospital than we've ever done before. So there will be more space used in the hospital and more activity in the hospital in the future and we'll continue to provide services as we do now from Shotley Bridge Hospital and from Chester-le-Street. So with that I'm going to hand over to Neil who's going to take us into the clinical case. Neil.

NM: Thank you very much ladies and gentlemen. I'd just like to emphasise the point that Steven made there a second ago. These are not proposals that were handed down from somewhere on high, they've not been thought up out of the blue, they've been worked through with real clinicians, real doctors, real nurses, real therapists and lay representatives, patient Governors who take ... ordinary members of the public there to represent the people who actually use our hospital services and work through with their co-operation with their input and enthusiasm for ensuring that we do the best for our hospital services.

There are three main points on this slide that I'd like to emphasise. The first is the need for specialisation. In 2008, approaching 2009, it's never been more important that we ensure that patients see the correct doctor with the right speciality as early as possible, the right doctor, the right clinician first time. Many of our sites, particularly in Darlington and Bishop Auckland, do not have more than one specialist in a number of specialities, for example if you came into hospital to a site that has only one chest physician ... I'm a chest physician so I'm going to talk about that .. only one chest physician with an acute asthma attack, we know that if that chap was on holiday you will be dealt with competently by a general physician who can do the basics, but if you are seen by a chest physician you will get the best possible treatment, you will get the most appropriate treatment to go home with, you will stay for shorter times in hospital and you'll get the most appropriate follow up and that specialisation is important for patients and for their carers and across the whole spectrum of medical conditions.

There are Royal College recommendations on this and they would tell us that you need at least two, if not more, specialists in each of the major disciplines, such as chest medicine, diabetes, cardiology, to ensure that you get the best possible care whichever week of the year you come into hospital. The second point in this slide is doctors' working hours. There is a European Working Time Directive that states that nobody should work for more than 48 hours at a time. Now when I trained 25 years ago I worked for up to 124 hours in any given week. Currently our junior doctors work no more than 56 hours in any given week and that will fall to 48 hours by August of next year. That is the equivalent to us within our organisation of losing 30 medical staff, that spreads our staff even thinner across our hospitals and it's only by specialising and concentrating services that we can continue to offer that high quality care that we would wish to do. Third in this slide are further recommendations from Royal Colleges on vital services such as Accident & Emergency services. Now I'm sure that anybody in this room will know that at Bishop Auckland the Accident & Emergency service sees routine injuries, it sees patients with acute medical problems, but it does not see people with acute surgical problems such as appendicitis, those patients are admitted directly to Darlington or Durham. It does not see patients with major trauma, once more those patients are admitted to the other two sites. Now there are current

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College recommendations which have changed over the last six years since Bishop Auckland department was created as it is just now, say that you need an A&E department that is backed up with a full intensive care service that is able to provide maximum quality of care, maximum specialised care throughout the year, and we cannot provide that at the present time and we cannot go on pretending that we will be able to do so in the future. What's present there now is safe but it is not sustainable.

The second point under recommendations is that of acute medicine. One of the key points that we need to have appropriate acute doctors seeing patients with medical problems as they come in the door. Once more, if we spread our staff too thinly we cannot guarantee that the most appropriate senior doctor will see you first time, but perhaps most importantly of all is the critical care back up that's required for all these services. We need to provide highest level, level 3 critical care for patients coming into an Accident & Emergency department in under acute medical doctors, in under acute surgeons and all that ... all the other specialities, and we need to provide that 24 hours a day, seven days a week, 365 days a year, that's very important and, once more, we can provide a level of service at Bishop Auckland but that's not sustainable as things stand just now, and people say to me well why don't you just recruit more doctors, (a) there aren't the doctors out there and (b) the actual throughput through such a unit is insufficient to maintain the quality standards that is demanded of such a high intensity service.

Final point on that is children's care and we know that children's care at Bishop Auckland as with all our sites has been of high quality for a long time but once more we suffer with the same problem of services spread too thinly across the County. Being able to sustain services on three sites is becoming increasingly difficult.

Now if you read the consultation document, and I'm sure many of you have, and with the associated documentation from Professor Alberti he has quite clearly said within that that simply staying as we are, doing nothing, is not an option. Despite all our efforts to support intensive care and acute medicine and the emergency department we are having great difficulty in sustaining those things and if we slip we will have declining quality of care, we will have declining safety I would not wish on you or me or on any of our families or any of our friends and relations. Second of all that decline in quality will provide negative impact across the County because if we struggle on one site as an organisation that serves a whole County we will struggle on all our sites. If we cannot provide a quality of service our commissioners, the Primary Care organisations who buy, if you like, our services from the hospitals, not only will not wish to buy our services but will not be permitted to buy our services, and that means that they then have to buy hospital services from somewhere else, from Sunderland, from James Cook, from Stockton, from Gateshead and Newcastle and really that is not the way that I see healthcare in County Durham being best served.

One of the great myths that's come out of this consultation is that we will close the doors of the emergency department at Bishop Auckland. This is not the case. Two thirds of the patients that are currently seen at Bishop Auckland will continue to have the same treatment that they current receive at Bishop Auckland. In addition to that there will be a new service which is not running anywhere else in the County, in fact as far as I'm aware, nowhere else in the North East, of a rapid access clinic, accessed by general practitioners on the patients' behalf with urgent access to a senior doctor with urgent access to planned investigation to minimise the number of people that have to come into hospital, particularly the elderly and the infirm, and thirdly, that the department at Bishop Auckland with its close proximity to the general practitioner out of hours service is best placed to provide an integrated urgent care service that I would like to see not just at Bishop Auckland but across the County and this could provide an excellent blueprint for that service across the County.

We know that there is good evidence that if you need a specialist, travelling a little bit further to get that specialist care has been well recognised. Now one of the key parts to that is the ambulance service and the days of an ambulance being a service that simply scooped you up when you were poorly and dashed to the nearest hospital are over. Ambulance services start to provide care from the moment they pick you up, that may be appropriate treatment for your heart attack, with aspirin, with painkillers, with oxygen and indeed passing information down the line to the hospital so that we know what is coming

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and we can be best prepared for that. The same would apply to nebuliser therapy for people with chest disease and intravenous fluids for people who are shocked.

And there's good precedent for this. Already as I said before serious trauma has been centralised at Darlington for the south of the County, major head injuries travel to James Cook and to the Newcastle General Hospital because we know that that sort of specialist care is most appropriate for them, and just earlier this year, or from earlier this year, a proportion of people with heart attacks, possibly one of the most serious things to come into hospital with, have gone straight to the major cardiac centres and I hear nobody arguing against that length of travel for the most appropriate treatment. So for these reasons I think that the specialist services that can be offered by centralisation are vitally important. By specialising we can ensure that people are best served on the most appropriate ward when they come to hospital, for example a chest ward that is accustomed to dealing with chest patients rather than a more general ward, that by ensuring that we have more elective surgery at Bishop Auckland we stand less chance of having planned surgery disrupted by a flood of emergency admissions, and that with our dedicated rehabilitation proposals that we can ensure that people who have strokes, who have had fractures of hips or something like that, get the best possible rehabilitation, that we can then provide rehabilitation not just Monday to Friday, but seven days a week, so that these people stay in hospital for shorter periods of time, are functioning better when they do go home and are able to get back to normal lives sooner.

Finally, by separating out our emergency work from our elective work, this gives us the best opportunity to minimise hospital acquired infections such as MRSA, such as Clostridium difficile, you have heard of these things in the press, better specialisation allows us to concentrate our efforts on minimising those sort of problems. So with that I'm going to hand you over to Diane who's going to talk about travel and access.

DM: Travel and access for patients has been one of the biggest things that people have fed back to us, right throughout this process. Every public meeting that we've had, all of our Governors who've been involved and indeed our staff, have all flagged this as something that we must look at, so it's something that we have taken very seriously and continue to work on. Everything that we're proposing is based on the concept of travelling only when absolutely essential for care, so if we propose to specialise a service on a particular site, you will only travel for that service for the bit of specialised care that's based on that site, you would get any follow up appointments on your local hospital site and equally you would get all your diagnostic tests pre-operatively if you're coming into hospital at your local ... on your local site, so the basis is travel only where essential for specialist services.

Neil's already touched on the paramedic role in emergency care, you know, the care you get as an emergency starts as the paramedic arrives at your home, it isn't when you get to hospital and I think that's a really important concept to hold really.

In terms of looking at access, for people who have transport it isn't such a big issue but for people who rely on public transport there are some major issues in terms of getting to our sites. We've been working very closely with, and are continuing to work closely with, Durham Integrated Transport Unit which is a unit based in County Hall looking at the provision of transport across the County and we've been working with them to try and develop some additional services based on a service that has recently been implemented in the east of Durham to connect the hospitals that serve the patients in the Peterlee and Easington area. That was started a few months ago and already is evaluating very very well for the public. The kind of service that they've put in place is a single number, so if you need to come to hospital, and remember this is for patients who need to come in for planned care, not emergency care, emergency care you come by a Blue Light ambulance, you would ring a single number based at County Hall and if you were eligible for what we call a PTS ambulance, so it's not a Blue Light ambulance, you would be screened and you would be booked if you were eligible onto the ambulance, and if you weren't eligible for that but there was a good public transport route that currently existed they would direct you to that and give you information about that, and for the areas of the County where there are gaps in services for getting people to our sites, we would be commissioning some new and additional services to plug those gaps. We know exactly which parts of the County currently aren't served by good public transport links to our sites and what we also know is that

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actually our proposals don't worsen the situation for anybody. In fact, for this particular area, for this postcode, for access to public transport for elective care there is a significant advantage for this population because a lot of our planned care would be provided at Bishop Auckland, we've actually got the numbers on that. So there is a real commitment to actually plugging some of the gaps, to commissioning, providing some new and additional services to make sure that patients and their visitors and our staff if they need to use the services as well, are able to actually move around the County to the services that they need to move to.

SE: So finally, we're really passionate all of us here this evening and we represent all of the clinicians, all of the staff that work across our organisation. In putting forward proposals that we believe strongly secures a long term future for all of our hospitals, secures a great working environment for all of our staff and indeed will provide the environment of the future to attract people to come and work in County Durham and Darlington and most of all provides the best environment in the future for high quality care and better outcomes from that care. Thank you very much for listening.

DG: Thank you everybody and thank you ladies and gentlemen for listening to the presentation. I'd just like to thank the team for going through that very quickly so there's actually more time for questions when we get towards the end. What we'd like to do now is we need your input into some specific consultation questions and very quickly, and we'll do this ... I think we'll only take about 15-20 minutes to do this, we'll have some discussions around your table to answer some specific questions and to formulate one question per table that the facilitators will put to the panel when we get to the plenary session, after which everybody will have a chance to have their open questions and if we time it right we should have well over an hour for some questions from the floor. So if I can ask colleagues who are going to facilitate this next session to move onto the relevant tables ... I make it half six now, if we can finish this work by ten to please.

#### MEETING MOVES INTO ROUND TABLE DISCUSSION GROUPS

(General talking as people move around the room)

#### FEEDBACK FROM ROUND TABLE GROUPS

DG: OK ladies and gentlemen. Thank you. Thank you for .. I don't like doing this because there's lots of discussion going on ... can we ask you just to conclude your conversations please? OK. OK. What we're going to do now ladies and gentlemen is, you've had a chance to feed into the consultation ... I just want to assure you that everything you've actually said has been written down by the scribes on the table, all of that will be fed into the consultation. All I'm going to do now rather than get masses and masses of feedback from people is go quickly round the facilitators on each table to just have one key issue that was raised and then we'll come back round and get one question from each table, and that should give us a chance to have about an hour of questions and answers from the floor to the panel. Just before we actually start that I'll just introduce an extra member of the panel, we've got Paul Liversidge who's one of the Directors of North East Ambulance with us as well in case there are any issues around ambulance and the transport issues that Di touched on earlier on. So to start with we might as well start with the front table, so if we can have one key point, I'll just explain to people as well why we're doing this, we've got the microphones so that you can hear but equally we're actually recording all of the proceedings because we'll actually get a transcript which we'll put on the website so everybody can see everything that was said and done, so when we come to the questions we'll actually give you a microphone and ask you to identify yourself for the record if that's OK. So we'll start with this table please?

?: (inaudible)

DG: There's going to be one ... I've asked for one question from each table and then we'll open it up to free questions ...

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??: *We've got a list of questions, I'm just asking for information ... (inaudible) please can you tell us that?*

??: *He could ask them all.*

??: *Well actually I was going to ask, because I think there are two key points or two key questions from this table...*

DG: OK. Go on.

??: *... and I think ... that I thought was quite valid.*

??: *(inaudible)*

DG: The lady's going to give two key points from the group.

??: *(inaudible)*

DG: Well I did ask the facilitator to have one question from the table ...

??: *I know but how many is she not able to ask please?*

DG: Well if she doesn't ... I don't know ...

??: *You're not going to tell me are you?*

DG: We'll ask her but actually the whole point ... look Sir, will you please bear with us, the whole point of this is, there's one question per table, then all of the other questions that you've formulated and thought of we can put to the panel separately, but I just want to get a chance to go round each table to get one question from them. OK? And if we can proceed along that basis people will have ample chance to have their questions asked and answered. Thank you.

??: *Our first question was if there is a case for change why have we chosen Darlington and Durham and not Bishop Auckland and Durham, given that Darlington is the older building? The second big question from us was around the back up facilities, if emergency care is moving off, what back up facilities are there for elective patients on the Bishop Auckland site?*

DG: OK. I think we'll actually take the questions as they come round so Steven, so you want to start answering that people?

SE: Yes, some of my colleagues may wish to comment. If we pick up that first question around the choice of locations. First of all, referring back to Sir George Alberti's report, he points out because of the nature of the changes that have already happened it would be impossible to return to how things were on the Bishop Auckland site and if you were to look to try and put the services into the Bishop Auckland site to meet the standards that we were outlining in the presentation there isn't the space to do so, so that's the first point. The second point is if you look at the costs of developing, and of course during the consultation we looked at all of the options, we looked at whether Durham could be developed as the planned site or whether Darlington could be developed as the planned site, and if you look at the capital costs of that the figures as I recall them were in the order of costing around £120 million if we were looking to put the planned site at Durham, around about £80 million if you're putting the planned site at Darlington and of course the cost we're attributing to these proposals is in the order of £7 million. Having said all of that, I think the most important point about that choice is about providing services locally for local people. When you actually look at the way in which our services are currently organised and then compare with how they would be organised under the proposals as we have them, that's the best way to keep care locally across the range of all the specialties that we provide and in fact we believe by creating the elective centre that we're proposing at Bishop Auckland that in fact we'll be able to increase the level of activity, the numbers of people from

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our communities to come and have their treatment in County Durham and Darlington. If you did it any other way and we can give you the facts and figures, we have them available, if you did it any other way there would be significant movement of patients outside the County to other hospitals if you chose any of the other two hospitals as the planned site. Now I don't know if any other colleagues want to add to that?

NM: Can I pick up on the second point?

SE: Yes, Neil will pick up the second point.

NM: Can I just pick up on the second point about elective patients and if there are problems associated with them. Five issues around that. First of all, patient selection, our anaesthetic staff and their pre-assessment protocols are now becoming increasingly sophisticated at ensuring that patients ... risk stratifying patients prior to operation so that we can predict who will do well, who will require more intensive support after operation. Second point is under these proposals there will see be out of hours medical staff on site at the Bishop Auckland site for elective patients. Third point there will also be fully resuscitation trained staff, not just medical staff, at the Bishop Auckland site out of hours. Fourthly, there will be senior medical staff, consultants, who have no other responsibilities on the other sites, available to attend the hospital in the event of somebody requiring that sort of increased senior support, and finally, we know from the elective work that's currently done at Bishop Auckland for patients with orthopaedic procedures that it is very rare, because of the things that we've ... because of appropriate patient selection, it is very rare for somebody to require transfer out of hours.

DG: OK. Thank you. Can I just check ... we've turned the volume up, can you hear at the back now OK?

?: *Much better now*

DG: That's better, yes, OK. Sorry about that. OK. Thank you. If we move on to the next table, Amanda, it's your question please?

A?: *Sorry, do you want a general view and then...*

DG: A general point and then a question please.

A?: *Thank you. Strong views were expressed around the table about how Bishop Auckland is being downgraded and about it's proposed future. Recognition that change is needed but not the one proposed. There is a belief that Bishop Auckland could offer the opportunity to offer more capacity to Darlington. A question to the panel, how will they cope at Darlington when they are bursting at the seams with patients in A&E and acute care?*

DG: OK. Thank you. Panel?

SE: Neil will pick that point up.

NM: Yes. You're absolutely right and the changes that are proposed at the Bishop Auckland site are reflected in changes on the other two sites because this will affect not just Darlington but Durham as well. Firstly, with an increased elective activity ... an increased elective surgical activity at the Bishop Auckland site this will mean less elective surgical activity on the other two sites and hence space will be created around that. Secondly, some of the monies that Steven's already mentioned to facilitate this whole proposal will be used to ensure that particularly the emergency departments can cope with the changes in the numbers of patients attending across the three sites, so this is not just changes at Bishop, there will be changes on the other two sites to allow the whole process to happen. And it's like a stack of dominoes, you can't knock down one without knocking down them all. You have to change one thing so you can change other things.

DG: OK. Thank you. Has that answered your question fully there? Sorry Sir?

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?: (inaudible)

DG: The question is how many more doctors do you need?

NM: How many more doctors do we need for what Sir?

?: *To deal with the extra input into Darlington.*

NM: Well as we've already said our numbers of staff are currently spread across three sites, it will require fewer doctors in the Bishop Auckland site out of hours in particular to deal, to manage the patients that will be there, that will allow us to rearrange our staffing to ensure that we have adequate doctors on the other two sites.

?: *So you'll take staff out of Bishop Auckland, transfer them to Darlington, is that what you're saying?*

NM: We will ... we will be rearranging staff. We will be rearranging staff.

?: *So that's a yes.*

(Applause)

NM: I didn't say it was a yes.

SE: Can I just make a comment about that, yes, there will be a transfer of staff, but there'll be a transfer of staff in the other direction from Durham and Darlington to Bishop Auckland, and in fact the overall numbers of staff at Bishop Auckland under these proposals should they happen will be the same.

?: (inaudible)

DG: OK. Thank you. Can we go to Verna?

VF: *Yes, I mean I think one of the key points perhaps picks up on that last question, while the presentation opened with the reassurance that there would be no loss to services there is a perception here that actually there will be significant loss in the Bishop Auckland area, that was a very strong feeling here. And another point and perhaps a question as well was about where the proposals are said to be driven and the review led by clinicians, is this true or is it more target driven? But that was just a rhetorical question ...*

DG: I like your style Verna!

VF: *Just trying to capitalise here. But we thought that actually it would be a good opportunity I guess with Paul being here from the Ambulance Service, just to ask, we've heard a lot about paramedics and how your treatment starts when they get to you rather than when you get to the hospital, but there is an issue about ambulance target times and how often are they met and, you know, what is the average time it takes.*

DG: OK. So your question's more the ambulance bit that we'll put to Paul. Paul if you could please.

PL: Yes, I'll stand up for this one. OK. Yes, as far as obviously ambulance provision's concerned I think what I would like to say is just a general point starting off with is we are working towards having a paramedic on every single vehicle which is the first point I would like to make. In the past we haven't had sort of the skill levels on ambulances but we are working towards having a paramedic on every single vehicle, which will respond to 999 calls. I think certainly from a skills and knowledge perspective I think over the years more paramedics are working towards developing their own skills, what we're actually moving more towards is actually university-based training, so we'll end up doing a two years ... paramedics will end up doing a two years training course, so their skills and knowledge and they're armed now with a lot of ... in a lot of ways to be able to deal with any circumstance that

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may arise when they respond to incidents, and I think the term was mentioned earlier around this scoop and run, when it used to be the case where we travelled as fast as we possibly could, at 100 miles an hour, grabbed the first thing we could do, get them on the ambulance and dashed to hospital. I think we'll find now that a lot of paramedics obviously spend a lot longer on the scene stabilising patients prior to transferring and also deal with them moving to the scene. At the same time I'd also like to mention, I think on a number of occasions we've worked with a number of Trusts around the specialisation services and this is something that we would necessarily support in that respect, I think what I would be keen to see is instead of having a dilution of services across a number of sites I think we would much prefer to have, you know, a definitive sort of treatment in one site so that you get the best care possible and for an ambulance service we've got to cope with the transfer and transport of patients in that respect, and what I would say is without trying to interfere with the overall project from the Trust perspective is we need to then adapt ourselves and if necessary model the changes of transport and providing that we do not impact on existing targets and existing services whilst moving towards the changes that are being consulted upon, and we will work closely with the Trust to ensure that our targets are maintained in that way and that we deal with the circumstances of the impact in the right way and make sure that we're obviously dealing directly with the Trust in that respect

DG: OK. Thank you Paul. Can we go to, is it Katrina? Katrina's table?

KB: *Actually some of what's already been said was articulated on the table but there was concern actually around the level of communication that's taking place and the key words were it's been more hitty-missy than robust in terms of the some of the information that's got out and come to people locally.*

DG: OK.

KB: *In order for them to make an informed decision.*

DG: OK.

KB: *And one of the key questions were the old South West Durham Health Authority covered a bigger population historically. Is this still the case considering the fact that Darlington population can access private hospitals like the Nuffield and that sort of thing, there's more around them, and for people who live in the Dales, they're now going to be travelling further.*

DG: OK. If anyone wants a stab at that one, but ... what I'll just say quickly from a commissioning point of view is in terms of accessing services, anybody wherever they are in the country has got access ... or can access services anywhere they want, so people have a choice and I mean I live in the north part of the patch here, I could actually go to, I don't know, Bournemouth to have a knee replacement should I choose to and the PCT would actually support that, so there is free choice. I'm not sure if anybody can pick up ... I think the issue is about the catchment area, is that the nub of the question?

KB: *(inaudible) Bishop Auckland and Darlington.*

DG: Right.

SE: Are sorry ...

DG: OK. That's helped thank you.

SE: Yes, I'm with you. The population size for Bishop Auckland and the Dales is about 100,000 isn't it? Just short of .. as far as I know. The population size for Darlington is around about 200,000, 250,000? 200,000...

DM: It's on the borderline (inaudible)

SE: You know the answer, I don't know the answer to that. We don't know the answer to that specific point.

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?: *(inaudible) traditionally dealt with for ... for Bishop Auckland hospital is around 120,000, for Darlington Memorial Hospital is was about 150,000, and for University Hospital of North Durham 250,000.*

SE: OK. Thanks. Does that answer the question?

KB: *They said yes, but they disagree with the figures that have been given.*

DG: Right, OK. OK. And you know if there's any doubt about any figures, we can try and get more detailed figures (inaudible). We'll go to the small but select group at the back?

?: *The kind of first point I'd make that came from his table was that the questions, both the questions that were asked here and the questions that are being asked more generally in the consultation document are biased and skewed in a particular way, and you know don't ... don't give respondents a chance to answer questions in the way they would like to, so that's the general point. The question that we've come up has I think already been asked, but essentially the question was why spend £30 million upgrading a kind of run down older hospital when we've got a brand new hospital with modern facilities up here in Bishop Auckland?*

SE: Well if I could answer that, I mean I think as we attempted to point out in the presentation, we see, because of the nature of the communities that we serve, that all of our hospitals are important irrespective of how we're going to organise services, if you take the specific point about Darlington, we would have to spend around about that amount of money simply to keep that hospital going into the future, so it wouldn't matter even if we weren't making these proposals we would need to address that question. I would also point out though, that ... we need to remember that we will be spending something very similar on Bishop Auckland, we're paying £6m to £7m in relation to the PFI arrangements that we have for the next 25 years and that's a significant investment too, and the point I'd like to make about that is as stewards of your local hospital services that hospital at the moment is under-utilised and it's not a great use of tax payers' money and our proposals are about making better use of tax payers' money with that facility, which is a tremendous one, for the sorts of services that we're proposing.

?: *Yes, but it's still under-utilised sorry, because you've already started systematically taking things to Darlington over a period of time.*

SE: Well these proposals are about the future and ...

?: *You're backtracking ... (inaudible)*

SE: I'm not backtracking, that's ... what's happened in the past, I fully acknowledge those changes have happened in the past and other colleagues here would acknowledge that too, but ...

?: *(inaudible)*

SE: Can I just answer the question? Give me the respect please to answer the question seeing as you've asked it? Our proposals are about the future, they're about what we can do now to make the best use of our hospitals and make sure there's a vibrant situation for all of them.

?: *Well as we paid as tax payers, about £67 million, I think we have a moral right to keep our hospital.*

DG: OK. And the point's well made ... can I actually ...

SE: We agree.

DG: Can I just make a general point to back up what Steven said? You know, whatever's happened in the past, whatever's been history has happened, right or wrong, like it or lump it, that's where we are and

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this is about looking forward to the future and the future of the hospitals so, you know, please bear that in mind, and some of it you might see as putting it right, I don't know, but we have to look to the future, not what's happened in the past. I know it's hard because we all get delved in the past but we need to look forwards.

???: *It's because of what's happened in the past we're here now, the problems with it...*

DG: Well that might be the case but what we need to do is look at trying to find the solutions.

???: *(inaudible)*

DG: Can I ... sorry, can I give a chance for other tables to have their questions?

???: *(inaudible) that's what's happened in the past, it's all here in black and white.*

DG: OK. Can we take some more questions then we'll open it generally.

???: *What are your reasons for changing (inaudible)*

DG: I'm sorry, listen, we need ... just as you couldn't hear us at the front .. when we come to the questions, we'll take one question from the back table and then we'll pass the microphone round and people can have their individual questions and you can talk to the microphone so everybody can hear and there'll be a chance to answer them, but ... I mean, I'm sorry, but I can't hear what you're saying at the moment. The microphone's at the back, can we have one question from that back table and then we'll move to the open questions.

???: *I can tell you this is one of four (inaudible)*

???: *The couple of points that you want us to make, there's a strong feeling on this table that the decision's already been made and you've already decided what's going to happen. Doctors have lost confidence in Bishop Auckland General, that's why they don't want to come here, and it's also felt that there's a third option for Bishop Auckland which is to make it somewhere that people will actually want to come and work, leave the services there and make it somewhere that people want to come and work. The specific question that's been asked is ... is acute medicine and coronary care going to be available at Bishop Auckland General Hospital in the future?*

DG: OK. So there's a question about ... specifically about coronary care beds.

SE: Thank you very much. Could I ask Iain to comment about ... on the point I think you made if I heard you correctly on doctors have lost confidence in Bishop Auckland, and I'll ask Neil to comment on the coronary care issue.

IB: Yes, I think as a clinician I can say that we haven't lost confidence in Bishop Auckland. You talk about cost cutting and this is all about providing a quality service going into the future and being able to continue to provide high quality services. We're trying to reconfigure as you know, use the services on all three sites and as leading surgery we're going to put in much more surgery into the elective centre to actually use the unit. In the past clinicians have been very keen, and as a clinician I was involved in bidding for the County Durham and Darlington colo-rectal cancer screening programme. We decided as clinicians the best place to put that was at Bishop Auckland, so patients who are screened, you all get your stool test and you mark it, if you're positive you go to Bishop Auckland, if you live in Durham or in Darlington you go to Bishop Auckland, and that was a clinical decision involved in the management two or three years ago which we drove through because we support the development of Bishop Auckland and the maintenance and providing a service. Clinicians through Seizing the Future have got all sorts of interesting ideas, what other extra services we can put into Bishop Auckland to use all of the facilities. As I said with the elective care centre there is going to be an excellent opportunity to do that.

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SE: Thank you Iain. Neil?

NM: I'd just add one point to what Iain said as well. I emphasise once more that there's no change in the outpatient services, the endoscopy services, all those things that currently take place which account for a very large proportion of the number of contacts that people have with the hospital will continue on the Bishop Auckland site. In terms of the acute medicine and coronary care, as Steven said right at the very beginning, acute services, acute admissions with medical problems, with heart attacks and with asthma and all those sort of things will be centred on the two sites at Durham and Darlington under these proposals.

DG: OK. Thank you. I was just going to say we'll now move into some open questions. The gentleman there has beaten me to it by putting his hand up. Can you ... if you just hang on a second Sir we'll bring the microphone to you. Could you just say who you are for the microphone and then if you can put your question to the panel? Can I ask at this point, because I know there are lots of questions from people, and this works both ways, if I can ask you to be fairly succinct and get to the point of the question and equally I'll ask the panel if they can be very succinct in their answers please, just so that we can get as many questions through as possible. It's all yours Sir.

*MrL: I'm Mr Loxford, I used to work in the NHS at Bishop General before it was developed. What I'm interested in is, you're saying that there's over 900 metres of space that you're not going to use, why are you not going to use it when you could do?*

SE: Well that's right, all of the space won't be used under the proposals but more space will be than it is at the moment and that's the point I was trying to get across, and obviously, picking up Iain's point, what we've planned here is for what we do now, how we organise services now and the numbers of people that we treat now. What we believe very very firmly is that if we organise our services, I come back to the example of planned surgery, elective surgery, and there are real opportunities to provide more care for people who live in Darlington ... Bishop by the way as well ... and Durham locally. At the moment quite a large number of people, a significant number actually in percentage terms, go outside our area for their routine treatment, so we would love to use more space, that's dependent on whether our services are attractive enough to bring those people back and we think the future proposals are bound to do that if we put that in place effectively.

*MrL: So you're going to develop it then, are you, further, later on?*

SE: Well on the basis that we can attract patients to the service, yes, because that's how the system works. Yes.

DG: OK. Thank you. There's ...

*??: Can I just add one point to that, is that under the rehabilitation proposals following the initial proposals that we put on the table to clinicians, yet another clinicians have come to me and said we could be part of that as well and build on that even further, so there's real enthusiasm as Iain said for surgery and within medicine as well to use more even than was originally written down in these proposals.*

DG: OK. Thank you. Sir, a question from you?

*NH: Yes, Neil Harrison, Leader of Wear Valley District Council. Two points, first how can you say we're living in the past, but the public have been lied to as little as six and seven years ago, so how can the public trust the Trust now when they've been lied to. Everybody in this area thought when that new hospital was built that there was a full trauma centre there, a full A&E, and even though I've been involved in this consultation a lot, I wasn't aware until recently that the hospital was built without that full service and I'm sure the vast majority of the public are unaware of that, so if that's the case you cannot really honestly expect the public to believe you now when so many lies have been told in the past. That's the first thing. Secondly, I asked for the figures to be given and they haven't been produced yet because, bearing in mind that up till two years ago, this hospital was a safe, successful*

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*hospital and is it not true that your targets have been moved that highly up by the Government that no hospital can attain it so it's an easy way of saying that the hospital is unsafe because the targets have increased so much, and I think the public have got a right to know what the figures were then and what the figures are now, and consequently let the public judge for themselves how the hospital is either safe or unsafe. Thank you very much.*

(Applause)

DG: Can we just put those two bits to the panel please?

SE: Yes, I'm just ... perhaps clinical colleagues can comment on the safety question. Do you want to say something more about that? But just about the general point first that you've made, and you've made that point very well before Neil in some of these meetings. In response to that where the targets were, or the standards were, because I think we're talking about clinical standards rather than targets, they are different now as Neil was outlining in the presentation to what they were even two years ago, and even three and five years ago, and that's driving some of these changes that we're talking about. Now whilst I think we would all acknowledge that those standards have been set, ultimately by Government, which is partly your point, they are derived by clinical colleagues like those around this table here and they're derived on the basis of what's seen as the best practice nationally for your care, actually if they're organised this way your care is better. Now rather than me give the example, I just wonder whether Neil you could just make the example in relation to heart attack treatment which you alluded to.

NM: Yes, I mean I mentioned heart attack treatment earlier on, thank you Steven. You know, patients with heart attacks, it has been shown, do best if they go to a specialist centre and have a particular treatment called an angioplasty urgently and acutely. Now you could say well isn't that a way of trying to centralise all the care onto a very small number of sites, but if that provides the best possible outcome from your heart attack or my heart attack, who's going to argue with that?

SE: And Andrew, are you going to comment too?

AC: Yes. I am. I think from the paediatric point of view, again, I would particularly emphasise the safety aspect and the paediatric service admits a large number of children acutely, many of whom after a period of assessment turn out to have self-limiting illnesses which will get better rapidly, but the challenge is at the beginning of that process, identifying the few that will need very intensive and critical care. Any site which is going to see acutely ill children needs to have the facility to look after those few who do rapidly develop a serious illness and the standards that are expected for care of children, just as in adults, have increased. The difficulty in maintaining critical care services on each site has been outlined and it's only been maintained in recent years by goodwill of a small number of doctors who are nearing retirement. The question of the best service is not always the nearest service, but the service which can offer the full range of care to those children who need it and it is often better to travel a little further so that when you get there those few children who need really intensive care can get it and one of the challenges of paediatrics is the rapid change in children's conditions and predicting those few in advance who are going to need it.

DG: OK.

SE: Thank you Andrew. And just on your point about the numbers and the analysis and the comparison, we will get that for you, I think we can make some comparisons between standards now and then and what the impact has been on certain groups of patients because I think that's what you're asking.

NM: Can I just comment on some standards? We talk about cancer care and the Government ... it was a Labour Government who produced the cancer plan, because the cancer survival in our country is poorer than the whole of Europe and they drove through standards which include multi-disciplinary teams, consultants working together, discussing patients, things that were never done before, nurses being appointed, nurse specialists, and that has drive specialisation and smaller groups of people working. You can't work as an individual, you have to work as a team. Those standards are being driven by the Government and they are trying to drive standards of care up and it's quality of care, and it does

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unfortunately mean that there are changes in the way the Health Service is delivered, but they are driven because it's actually trying to improve the quality of care. I didn't necessarily believe in all of those standards but I've actually seen in cancer care cut by ... in my speciality, bowel cancer surgery, the differences that multi-disciplinary teams make.

DG: OK. Thank you.

SE: Just remind us what the first point was if you missed it.

NH: *The past ... (inaudible)*

DG: Oh yes, about the past.

SE: Well I could say what I said before, I mean, I ... I clearly understand the concern that's being expressed about what's happened in the past, but in my role as the ... I suppose the person, together with the Trust Board, who has responsibility for what's best to do in organising our services in the future, we have to look at the future and, you know, what we ... again, we really do believe very strongly and I hope this is getting across to you, is we really want a very very vibrant future for Bishop Auckland Hospital. We believe our proposals ensure that. We believe other alternatives will mean even more reductions in services in the future, that's what we believe. I can't do anything about the past Neil, I can only do something about the future.

DG: OK. Thank you. I think I had a lady in front there.

AG: *Yes, it's a personal ... sorry, it's quite personal for me and it happened last night. My name's Anne Golightly, I'm a town councillor and I'm also a grandmother. Last night my grandson took ill and had difficulty breathing and went to the urgent care which is fabulous. Unfortunately the doctor said that he needed to be admitted, so in the early hours of the morning he was transported at 11 months old to Darlington Hospital in a blizzard. My daughter had left her car at Bishop Auckland hospital and therefore when she got there she had no .. nothing with her, no money, no change of clothes, nothing and I find it very strange when you say quality of care, better care, giving best treatment, provide services locally and safely, that my 11 month old grandson was transported in a blizzard when we have the consultant for Bishop Auckland paediatrics with us, obviously, with no paediatric Board here, but it's just things like that that really get to me, so as far as I'm concerned, Bishop Auckland hospital is no more. It's Bishop Auckland care home because, well, not even care home, because it's all services, services, services, there is no care.*

*(Applause)*

DG: Thank you.

SE: I was going to ask Andrew to comment on that.

AC: Four years ago we ...

?: *That's in the past.*

AC: Yes. I'm trying to make the point that we learnt from previous experience and testing things out and seeing what works and what doesn't work well. Until four years ago we did have 24 hour paediatric services at each of the three sites in the County and four years ago because of working ... partly because of working time for doctors, we were unable to maintain three sites 24 hours but we did introduce what was effectively an experiment to admit children to Bishop Auckland during the day, retain those overnight who were safe to stay without junior doctors on .. present ... but those few children who need admitting overnight to concentrate those in the other two sites, Darlington and Durham. The outcome of that pattern of care is that many times of the year the overnight service is occupied by very few children and yet still requires a certain minimum number of staff to operate safely with ... wherever one lives there may have to be a variable amount of travelling depending on

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where the services are. Children with very serious and highly specialised conditions often need to travel from here to Newcastle and people do face the sort of difficulties you've mentioned to an even greater degree for that but they accept that for the quality and the specialised skill which they get when they reach there. Within the Trust we have decided ... we've concluded rather that in order to provide the necessary range of skills and safety and quality of care that it is going to be necessary to change again to move to all acute admissions being confined to the two sites, and that inevitably will lead to some more travelling. We are intending fully to maintain at Bishop Auckland the full range of outpatient and diagnostic services and wherever possible follow up after admission as nearer home as possible, but for the appropriate quality of care further ...you know, some travelling is going to be necessary.

DG: OK.

AC: Yes.

DG: OK. Thank you. We've got a gentleman at the back there and then I've got a lady there and then a gentleman over there. We'll get round to you all as quickly as we can. Sorry ... no go on, it was the other gentleman at the back, but carry on.

CO: *Well, good evening everybody, my name's Clive Ord and I am spokesperson for Save the Hospital campaign group. I'm pleased you all turned out tonight because it's time that these people were told a few home truths about what's going on. Now then we all appreciate that we have to have centres of excellence for serious illness, we're not arguing about travelling to Newcastle or James Cook, we're not arguing about that. What we're arguing about is that the people of Bishop Auckland and its surrounding areas deserve to have good healthcare in their town. What you're doing here, you're just decimating it. I could stand here and tell you everything that's gone already but it will not serve any purpose because it's gone already. The proposals are making it even worse for us all. Now then, I hear Anne telling us about an 11 month old child last night, that's not acceptable you know people, it's not acceptable at all. I had a person on the phone the other day, an observation please if you don't mind, they were telling me a relative, 23 year old, and he has cystic fibrosis and he wasn't very well on 8<sup>th</sup> November this year, not ten years ago, this year. He wasn't well this lad, he's 23, but he's managing his cystic fibrosis very well, but he wasn't well at all, so they took him to the hospital here and after five hours they couldn't do anything with him so they took him to Darlington where his mother was told we'll have a scan and we'll sort him. Four days later without a scan his mother was so concerned she got onto the RVI where he goes for his cystic fibrosis treatment and they rushed him up there and they fixed him.*

DG: OK.

CO: *Now this is what ...*

DG: Have you got a question Clive, sorry?

CO: *Yes, this is what's happening, this is what's happening. In Kidderminster they closed the hospital, they couldn't manage, the local hospitals couldn't manage, exactly what's going to happen with Darlington and Durham, they'll not be able to manage all this lot as well, and that's happened there, and they had to reopen the hospital. Now you're going down the line here where you're just taking all the services away from the people, there's 195 square miles of land out there with over 100,000 people that are going to be left without a hospital. That's all I have to say, thank you.*

SE: Thank you Clive and ...

*(Applause)*

SE: That's a very passionate but misleading statement, we're not closing the hospital, we're not taking services away, we're reorganising them so we can make sure we provide high quality care so that people don't have to experience further travel. Now if I ... in my own experience, with my own six month old son a little while ago, you know, we had a choice and we went to an urgent care centre like

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yourself in the middle of the night and it was fantastic treatment and, by the way, the people that provide the treatment at Bishop Auckland are absolutely first class individual professionals ... which we all support ...

*(Applause)*

SE: ... my son needed specialist treatment, we had to travel past four other hospitals to get it, but that was the right treatment. Now I would love to be able to provide specialist care, neurosciences, specialist care in liver care or whatever it might be, at Bishop Auckland. We can't do it, we don't have the critical mass as you've heard us say of staff to do that and the big issue about the point that you're making, I understand you're talking about Bishop Auckland but we have to be concerned about the services for the whole of the County and the difficulty that we will face in Darlington and in Durham in the future if we can't make these changes are the same sorts of difficulties, we're here to provide the best possible care for all of you. Now the point about travel, we accept that people will need to travel further for certain things. What I think you have to accept is that actually we're bringing quite a lot locally so a lot of people, actually probably more people requiring routine treatment, won't have to travel as far as they do now, and people from Durham and Darlington will be travelling in this direction so, you know, I think you have to have a balanced perspective when you make those statements.

DG: OK. Thank you. We've got a gentleman further to the back this time. Yes. Sorry Sir, I will come to you next, I know you had your hand up, we'll come to you next.

JL: *Hello. Thank you. My name is John Lethbridge, I'm County Councillor for Hanall and Woodhouse in Bishop Auckland. I was just jotting notes down here and I did actually think of a headline that was in the newspapers not so long ago and it was first and foremost my duty to represent my constituents that was said by Hazel Blaze, Cabinet Member, while she was standing outside a hospital protesting at the reduction of services there. I have the article in the newspaper cutting. Chair, I would suggest to you that ... and I said this to George Alberti on Friday afternoon, you may recall, that there is a gulf between us and you. There is a gulf in understanding. Now I know it doesn't sound ... well people get tired of anecdotes perhaps but I have to knock on doors to say will you vote for me, it's part of my work, and what can I do to help. I knocked on one door last election round and a gentleman came to the door and said he would never vote for me or anybody else. His wife was injured in a car accident and was driven past Bishop Auckland hospital and died on the way to Darlington. Now I felt so devastated myself, I honestly couldn't cope with that kind of response at a doorstep, but can I say to you put that aside for a moment if you can, can I say to you ...*

DG: I'm sorry Sir, can I press you, if you've got a question to the panel could you ask your question please so we can give other people a chance as well?

JL: *OK, you're cutting me down and I will try and cut it short. Can I put it to you that the people on the street from whom I take signatures, people who are protesting about what you're proposing, and this includes health workers, are those who you would describe as cynical. Perhaps. George Alberti referred to the cynicism of the south east. Well can I put it to you however good he is at presenting his case, and he is good, I'll give him that, he is not good enough to convince us that we should have a reduction in our services here, and that is the way we see it. Seizing the Future is not a good title for your presentation tonight, we are moving backwards, we are not going into the future.*

SE: Thanks for your comments.

*(Applause)*

DG: OK. We've now actually got the gentleman next to the gentleman, the gentleman standing up.

??: *Thank you. Thank you Mr Chair. I have two interrelated questions. Before I do I'd just like to say the documentation that has been produced in relation to this consultation exercise, I'd like to congratulate you on the standard of that. Very fine. I'd like to congratulate the management consultants that were involved in drawing this up, or helping you to draw this up, nice document. A very good exercise in*

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*managing facts and spinning situations because that's what it does, it doesn't actually give us the real facts, it gives us an impression of the facts, the impression that was required to be given. We're given only two options, two options. Well George Alberti, who has been mentioned several times tonight, but who's paperwork hasn't been on general circulation like everything else, made it quite clear that of the 49 options that were considered, most of them fell at the various hurdles, the hurdles were clinical safety and standards, efficiency and affordability, do-ability, do-ability I remind you. But three got through. Why are we only being told about two, three got through and you are hiding the third one. The third one was no change. Well surprise, surprise, that isn't an option given to us now, it's an option that's been hidden, and I know what you're going to say, George Alberti said in this document all the reasons why, all the negative reasons why, the lack of staffing, the lack of this and that, it's all laid out here, but I say to you if the money that had been spent on this expensive management exercise to try and con us had been spent on recruitment consultants and looking seriously about ... not the no change situation, but providing the service that we have now and doing it properly and try employing people like ... recruit ...*

DG: OK Sir.

??: *No, I haven't finished, like recruitment ...*

DG: Can you just get to your question? I think I know what your question is, but can you get to it please?

??: *Yes, I have asked one question, why have you hidden ... I said there were two related questions.*

DG: OK. Yes.

??: *The first question is why have you hidden the third option which passed all the criteria including the do-ability, don't tell me it can't be done, it passed the do-ability criteria.*

DG: OK Sir, we'll ask the panel in a moment.

??: *My second question which is interrelated is why didn't you, to make it do-able, instead of being negative and saying well George says the same as we say in our spin, that this can't be done, why didn't you spend money instead of on this, why didn't you spend money on recruitment consultants and people that would make the bloody situation work ... sorry about that word ladies and gentlemen, but we all know what you need is determination to do it and the determination's not there, but it's here among the people of Bishop Auckland.*

DG: OK. Can I just put those questions to the panel?

SE: Just very quickly just two or three quick points and then I think Neil wants to comment. First of all, George Alberti's report is available, it's on the website, Sir if you give your name to one of our staff we'll make sure you have it tomorrow, with your address.

??: *I've got it!*

SE: Fine, you've got it, that's fine. And anybody else who wishes to have that report, it is available for everyone. Secondly, there's nothing hidden, I mean the option you're referring to is the no change option, we have to measure, in fact we had 49 options before we got down to the two that are in the consultation document. On all of those options which were developed by a clinical college were measured against what we would call the status quo, what you're referring to there. And essentially the consultation document sets out very clearly what the status quo is, so ... and I think the key point about that option, of course we could, it is a serious option to do nothing, but of course it's do-able to do that, to use your phrase, but it's not viable in terms of the clinical services. That's the argument that we've been putting across.

??: *How about taking that one stage further though (inaudible) why not take (inaudible) existing services and make it work?*

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- DG: OK. Can ... Sir, you've put your question to the panel, can I ask them to respond please?
- SE: Could Neil just have ...
- DG: Yes, if Neil could just respond?
- NM: We have spent a lot of time, effort and manpower, putting money at it to preserve the existing service, but we are of the opinion ...
- ?: *(inaudible)*
- DG: Sir, can you let them answer the question please, if you give them the courtesy to do that.
- NM: We've put a lot of time, effort, manpower, all the capabilities of the organisation into preserving the status quo, but we realise, we understand that the status quo is not sustainable, we cannot continue to provide a high quality service with things as they are at the present time. No amount of management recruitment or bringing somebody else in from outside to have a look and see, nobody comes higher than George Alberti when it comes to looking at what you're doing and saying whether or not it's safe and sustainable, he's been ... this is his job, he travels round the country, to Kidderminster, to everywhere else, and says can you carry on doing this the way you're doing? Having known George Alberti for years, having watched him work for years, if he says to me, look, you can't carry on doing the way things are ... doing just now, no matter how hard you try, that is an opinion I have to pay attention to.
- ?: *(inaudible)*
- DG: Can we let the panel ... ?
- ?: *I've waited ...*
- DG: Yes, I think the panel are still responding Sir. If you wait until they've responded and then if you want any comeback we'll let you have that, but can you just let them answer first please?
- IB: Can I just agree with Neil about that? I personally totally believe that the option of no change is not viable in the future, you know the ... sorry ... the ... we're having, even ... there is increasing problems trying to get doctors and we've got shortages of doctors, we can't appoint junior orthopaedic surgeons even to Darlington, to get consultants to come and work at Bishop Auckland is increasingly difficult and the quality of those people working in small centres is very difficult to maintain. It isn't clinically viable and that's the decision and we've discussed it across all sorts of clinicians in the hospitals, we do not think that it is clinically viable.
- ?: *(inaudible) I agree no change isn't viable, it's just a question of what you're talking about, this gentleman was talking about no change to the situation, it's not working, it's breaking up, what I'm saying is there should be no change to the services provided and do something, I mean, if there's no expertise within the various operators involved (inaudible)*
- DG: OK. Well right ...
- SE: Can I just say ... I think it's a very important point to make actually about that, we have spent in the Trust ... I'm answering the question you asked about why can't we ... if I understood you correctly and forgive me if I haven't, but why can't we just improve on what's there now? Well in fact, that's what Neil was saying, we spent hundreds of thousands of pounds in the year I've been here, and certainly in the years before, on trying to provide a quality service, on real clinical consultants, providing a service at Bishop Auckland hospital. What clinical colleagues are saying and what I accept in my role is we can't continue to do that, not because we haven't got the money, we have a £10 million surplus, we

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could buy as many consultants as we would like tomorrow. We cannot get those people to come and work in the model of care that we provide. We can't ... they won't come and work in that setting.

???: *That's what I'm saying. Having failed to do it yourself, why don't you get specialists ...*

DG: I think actually Steven's answered that and they have tried to recruit and they've used specialists to try and recruit but they still haven't managed, not because it's at Bishop Auckland or anywhere else, but I think what they're saying is because of the model of care that exists at the moment it doesn't attract people. Can we come to .... I think there's a gentleman there and then I'll come to the lady who's been very patient there with the scarf on next.

WH: *Hello. I'm Wayne Hunter ...*

DG: ... before she gets impatient!

WH: *Can we go to paediatric cover for children? Obviously children's ward. I'm a parent, it's a major concern of mine. I'd like to ask the panel as to why Bishop was the actual model for this trial? Why was not Darlington or Durham chosen for a model of the trial?*

SE: I can't ...

DG: Sorry could you repeat the question please?

WH: *Children's care, as the children's ward at Bishop Auckland, obviously you had a trial and Bishop Auckland was closed on a night for admissions, why was not Darlington or Durham chosen for the model for this? Why was Bishop chosen?*

DG: Right. OK.

AC: Your main sites for acute admissions need to have the full range of supporting services that you might need. Now we've said that the previous changes, they may be questioned, but we're looking forward now. There isn't a realistic prospect that Bishop Auckland could again have a full range of surgical, orthopaedic, trauma support and particularly as we've said the critical care support for those children who have serious breathing difficulties, so we've, you know, considered the situation and trying to develop that full range of services in Bishop Auckland is not a viable option and we need to centralise the acute services where the other services are co-located.

WH: *That hasn't really answered the question. You still haven't answered the question.*

DG: Yes, I think ...

SE: Was your question why the service out of hours wasn't chosen to be provided at Durham or at Darlington in the past?

WH: *No, why was Bishop Auckland chosen, obviously as a test case, as a model ...*

SE: Yes, yes. Again, this is back if I may say to what's happened in the past, but the reason is that the full range of emergency care services for children and adults hasn't been provided at Bishop Auckland for the last decade, so there is only a partial ... it's true, so if you have a child ...

???: *(inaudible)*

DG: Can ...

???: *(inaudible)*

DG: I'm sorry Sir, can you please let the panel answer the question?

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SE: I think John Furness, who's in the table, who's one of our consultant paediatricians can answer your question.

JF: As the rest of the table know, I'm one of the consultant paediatricians at Bishop and Darlington. I think there's two reasons why Bishop did go that way, one is the support services as my colleague, Dr Cottrell, has been saying, were not there. The anaesthetics wasn't there because it wasn't there for the surgeons because the surgery was moved and that was because of critical masses of patients, and the second goes back to a point about the numbers and standards that may have moved. We've learnt in the last five years or so that acutely sick children presenting to the casualty departments, you need a critical number of around 15,000 a year for staff to maintain their skills and keep safe practice, and unfortunately at Bishop Auckland the number is just several thousand short of that, so it was those two reasons combined that led to the decision that Bishop Auckland would be the place that would have less overnight care.

DG: OK. Does that answer your question, yes?

WH: *Just.*

DG: OK. Thank you. We will come to this lady now and then ....

MW: *Thank you.*

DG: Sorry for the wait.

MW: *No, not a problem. My name's Marilyn Weerasinghe, I was a member of the PPI Forum. I am a member of LINK and a lay person on different medical research departments and for the Northern Academy for Post Graduate Surgery. As far as I'm concerned, we have to work together, you're a Foundation Trust and you're supposed to be working with the people that you serve. I would love to say, having listened to this tonight, that I have lots of confidence, but actually I don't, and I want to ask you one question. I don't want to go back into anything historical, but let's take for example your stroke unit at Bishop Auckland hospital. Absolutely first class and superb, the doctors, the nurses, the whole team. It was the first stroke unit in our Trust. We're talking about specialism, we're talking about critical mass. Bishop Auckland Stroke Unit was thrombolysing before James Cook hospital. Why then are you taking it away from Bishop Auckland and having stroke units at Durham and at Darlington? Why is Bishop Auckland not being used as the stroke unit, developing it? You're talking about rehabilitation. Stroke patients need rehabilitation. What's your argument? You're saying you want a vibrant future for Bishop Auckland hospital, you're not going to take services away. Why take a superb stroke unit, the first one in the Trust to Darlington?*

DG: OK. Thank you. Can ...

SE: Neil's going to answer that one.

DG: Neils' going to answer that one?

*(Applause)*

NM: Thank you very much. I agree that it is a great unit at Bishop Auckland, it's a great stroke unit and Dr Mehrzad and his colleagues have done great work over very many years and they are not complemented by even more stroke doctors within the Trust than there have ever been in the past. I understand what you're saying about thrombolysis, that's clot busting of blood clots which may contribute to some people's strokes. That actually accounts for probably less than 5% of all the people presenting with a stroke who'll be suitable for clot busting drugs. The vast majority, 100% as close as makes no difference to people who have stroke, will benefit from appropriate rehabilitation and support once they're in hospital. That is the key to getting better for the vast majority, for not just the 5% who have had thrombolysis but for the other 95% for whom thrombolysis is not the most appropriate

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treatment. But acute stroke like any other acute condition such as heart attack, such as acute chest problems, needs the support of other services such as intensive care units, such as from time to time surgical problems crop up in other blood vessels, it needs that back up that you cannot have on a standalone unit, and in Bishop Auckland just now, as we've already discussed, there are issues around the whole acute medical support and whether it's safe and sustainable. Now if you move one, you can't just leave one bit behind. It's all part of the same whole and if you're going to have acute admissions coming to just one or two sites then all the acute admissions need to come to that, but the team Dr Mehrzad and his colleagues will still be part of that stroke unit and they will contribute to the very important part of the rehabilitation for that service.

DG: OK.

?: *Can I just have a quick question? How much is it going to cost of move the stroke unit from Bishop Auckland to Darlington?*

NM: The actual stroke unit ... the stroke unit is not bricks and mortar madam, it is people.

DG: It's a gentleman actually Neil.

NM: Sorry. Sorry. My apologies.

?: *What is it going to cost to move the service from Bishop Auckland to Darlington?*

DG: I think the question is what's it going to cost to move the stroke unit.

NM: It's part of moving acute medicine, so you know it is not ... it's the people that will change where they're working.

?: *No, I'm talking about the financial costs.*

NM: There's no specific financial cost associated with moving the stroke unit as such.

SE: Yes, I think there's again a point to be made here, it's quite an important point, which is you can only have in Bishop Auckland a high quality stroke service if we provide it for the whole County. The way in which the Government, it comes back to standards again, and the way in which the specialists who determine best care say we should organise is to organise on populations of around about half a million people. We can't have a stroke service independently in each hospital so what we're talking about here is using all of our hospitals to provide a nationally recommended best standard for stroke. That's what we're talking about. We can't do it by leaving things as they are at Bishop Auckland, or by leaving things as they are at Durham or at Darlington, and the vast majority of stroke care as you've heard from Neil is about recovery and rehabilitation, all of that in large part is going to be happening at Bishop Auckland.

DG: OK. Thank you. I don't know if the lady just wants to come back very quickly and then we'll move on to another question and then I've got two gentlemen on this table and a lady behind you.

MW: *Yes, just briefly. I know it's a very small number of people who are eligible for thrombolysis or where that's indicated, but I don't think you can dismiss it like that. I mean actually having witnessed it given and someone make a full recovery, it's a miracle, it is like witnessing a miracle. In the Trust we still don't have thrombolysis 24 hours a day, seven days a week. Now specialism, you know, it should have been and I said this years ago, at Bishop Auckland hospital when there were more resources there, why not focus it there, this is my question of confidence, you're talking about concentrating things for specialism but it hasn't happened and I'm not talking historically, I'm talking about now.*

DG: OK.

MW: *You know, and that's why I asked that question.*

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NM: As I've already said we've already built up the stroke team across the Trust in the last two to three years, there are more people working in the stroke team than there have ever worked in the stroke team, but I agree with you, I want to see availability of thrombolysis 24 hours a day, but we have to have the critical mass of doctors working together to achieve that. Dr Mehrzad on his own cannot do that.

DG: OK. Thank you. Yes. Can we move on to another question? I've got two gentlemen on this table, we'll start with Sam and then I'll come to the back, there are two ladies at the back we'll come to in a moment.

SZ: *Thank you Chair. Sam Zair, Bishop Auckland Town District and County Councillor. Would it be fair to say that people are now living longer? I think we agree? People are now living longer? Do we agree?*

SE: Yes.

SZ: *And is it fair to say that the admissions in this country are growing higher nationally? They are growing higher and especially in the north of England. The admissions rate.*

SE: It depends what you're looking at, but some rates of admission are higher, some are lower, depending on what ...

SZ: *Yes, especially in the north. Right. Also is it correct that the population of South West Durham is growing? I think it is, there has been a regional strategy and it's been proved that it is growing. Steven you were on about the future. I firmly agree with you, yes, we should be looking at the future, but surely these three statistics what I've just given you, we should not be here talking about taking away services, we should be here talking about how we can improve services and adding services to Bishop Auckland, not taking them away. We owe this to our children and our children's children.*

DG: OK.

*(Applause)*

DG: OK. Thank you. Sam, can we respond?

SE: We've obviously taken account of all of those statistics, clearly we're planning five years ahead, we have to account for growth, and you're right, the elderly population is growing nationally, the mental services are therefore greater, you're right that that represents itself in certain specialties, if you looked at some specialties you would see a different pattern, particularly surgical specialties, not all areas you know you can attribute growth to, but your general point is correct. Now we're not taking anything away. I keep coming back to this point. What do older people need once they've had their acute phase of treatment? And actually my colleague would probably say this much more eloquently than I. What they need is rapid recovery, rapid treatment so that they can get home more quickly and get back to their community more quickly, and I think we have to keep coming back on this point because it keeps being made by people in the room. We are moving some services from Bishop Auckland to Durham and Darlington. We're also moving services in the opposite direction and the focus of that ... if you said to me what's the most important thing for older people in the future about their healthcare, it's about do they get good recovery, good rehabilitation because that's the thing that's the difference between getting home and functioning fully and not. So we're putting at Bishop Auckland a centre of excellence that doesn't exist currently, that doesn't exist anywhere else in the North East, at this hospital.

DG: OK.

?: *(inaudible)*

SE: David, Laura wants to make a point.

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DG: Sorry, sorry Laura.

LR: Can I just ... Steven's quite right and you are quite right, the population is getting older. The north east of England has a much heavier reliance on hospital admissions than any other part of the country and that is something which the whole strategic health authority has been looking at. Why do we rely so much on hospital admission? The worst place for an elderly person to be is actually in hospital, so what we want to provide for them on all sites is rapid access to an expert opinion, so you can get an emergency appointment with a doctor, with a consultant like Neil Munroe, not waiting weeks, but waiting till tomorrow morning or later this afternoon, you'll get an appointment, you'll get an assessment and then if possible be sent back home with support from community services, because the worst place for an elderly person to actually go is into any hospital, not Bishop Auckland or Darlington or University Hospital of North Durham, you need to keep people at home if at all possible, so rapid access is a very important part of this proposal.

SE: Thanks Laura.

DG: OK. Thank you.

?: (*inaudible*)

DG: Sorry?

?: (*inaudible*)

DG: Can we try and keep ... can you answer that question very quickly, I'm conscious of the fact we've actually got people leaving who were waiting for questions to be asked.

?: (*inaudible*)

DM: Certainly. I mean David's probably the best person to answer that question because he is the person who commissions the service from the local PCT and the PCT are working very hard to deliver more services in the community. The whole strategy, the whole movement is to get people cared for closer to home in their home setting wherever possible with diagnostics, outpatients, other things delivered in local centres like Bishop Auckland, like Chester-le-Street, like Shotley Bridge, so that they don't have to travel to a big hospital to spend time there.

DG: Yes, and actually one of the things we're looking to commission in the future is very much that and also actually making better use of the community hospitals so in Weardale and the Richardson Chester-le-Street hospital, there's a whole range, actually a ring of community hospitals around the patch.

SZ: *Can I come back David please?*

DG: Can you be very quick Sam because I want to get some more questions in quickly?

SZ: *Steven you are taking services away, you are taking acute medicine away from Bishop Auckland, you are, that's what you're doing.*

SE: No, we're ...

SZ: *You're diversifying ... Darlington is full to the rafters...*

SE: Sam ... I'm ... we are proposing that acute medicine, clearly we're proposing that acute medical emergency and critical care services move to Durham and Darlington, but we're also proposing that other services that are currently provided at Durham and Darlington are coming to Bishop Auckland, and all I'm asking for when these questions are asked and when these points are made is that that's recognised, it isn't ... it's a two-way street, it's all part of the same service.

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- SZ: *Yes, but there's been a big mistake in Kidderminster which has been aired.*
- SE: We're not in Kidderminster.
- SZ: *Exactly, it's the same rural area. Now then, if this goes ahead Steven you're talking about going back, knocking Bishop Auckland hospital five to ten years back, well I forecast that if this goes ahead, what you're proposing, and the volume of people, the volume of patients that cannot access Darlington and Durham because they .. for over crowdedness, you're going to have to do exactly the same at Bishop Auckland which happened in Kidderminster, and that's reopening it again at the cost of the taxpayer.*
- SE: No. Kidderminster hospital has reopened an urgent care centre, like the one that we're proposing at Bishop Auckland.
- DG: Can I just plead with you basically, there's time for some more quick questions, but I really do need you to keep the questions quick otherwise other people won't have a chance. I'm going to ask this gentleman here and then I will come to the lady at the back who's waving at me, I'll come straight to you next madam. But can you be very quick and get to the point with your question sir?
- ?: *We hear of the vast increase in funding. There's been £900 million spent on stroke and I think it's heart, I'm not quite sure exactly what, but on stroke facilities, and they are now spread across the whole region in acute hospitals, so do you agree stroke services is a priority and if Bishop Auckland is reinstated as a full acute A&E hospital it does in fact widen the scope for Bishop Auckland to make an even greater contribution to local care due to the fact that his newspaper cutting tells us that the north east used to be ahead of the game in term of improved stroke services.*
- NM: It still is.
- ?: *But the region has now slipped a little as other areas have made rapid improvements.*
- DG: OK.
- ?: *There's scope for improvement everywhere, that is why virtually every Primary Care Trust in the country is now putting stroke as the No.1 priority.*
- DG: OK. Sir.
- ?: *And every acute hospital in England now has a stroke service. That is why I'm content that if Bishop Auckland was reinstated to a full acute A&E hospital it would automatically, in line with the others, have the stroke and other facilities ...*
- DG: OK Sir, I think we've got the gist of your question. I'll just comment firstly in terms of stroke being a priority, very much from a clinician point of view stroke is a priority. I'll ask colleagues to respond to that.
- SE: Well Neil will respond very briefly. The reasons why those proposals are being made is because in this country, compared to internationally, our recovery from stroke has been the worst in Europe, and why is it the worst in Europe, it's the worst in Europe because of the way that we're currently organised. Now ...
- ?: *(inaudible)*
- DG: Can you let him answer please?
- SE: Let me finish, because that's the reason why our recovery rate is much worse than every other country because of the way that we're organised. Actually at one level for a health professional like me it's scandalous, so therefore the proposals that we're making brings us into the same standards that are

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being operated for people in other European countries, that's what that policy's all about, but I'd like Neil just to comment ...

?: *I'm sorry but I'm not talking about other countries. This news item states that it's the north east that has slipped...*

SE: .. against ...

?: *... against the rapid improvement in other parts of the country.*

DG: OK. Can I ask the panel, Neil, just to quickly respond and then I do need to get to that lady at the back to ask a question.

NM: Right.

?: *Well I've got another question here.*

DG: Well I'm sorry Sir, I need to get somebody else to ask a question.

NM: Just very quickly, as I've said already, we have never had more people working on stroke care as we have at the present time, and that is only set to rise. There are more things that we can do for strokes now than we've ever been able to do. I'm very pleased that the rest of the country is working hard to improve their services to bring them up to as good as the north east, the challenge for us is to get back ahead of the pack.

?: *That is why Bishop Auckland should be reinstated to a full A&E and then it would be able to ...*

DG: I think Sir you've made your point and it's noted.

?: *... as an equal partner.*

SE: But if we restored Bishop Auckland to a full A&E it wouldn't mean you'd have a high quality stroke service. And that's the point I think ...

?: *It applies to every acute hospital.*

SE: Every acute service providing to a population base of around about half a million people.

DG: OK. Can I suggest that we move on please? There's a lady at the back who's waiting. No, I'm sorry Sir, there's a ...

?: *The other question I wanted to ask is, you keep saying that ...*

DG: Are you going to ask your question rather than the lady there?

?: *Well no, but ...*

DG: Well can I ask the lady ... can the lady ask her question first please? Thank you. I am trying to make sure that everybody has a chance to ask a question.

?: *What I would like to ask is has the panel ever considered ...*

?: *We can't hear you.*

DG: That's better.

?: *Sorry.*

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DG: Yes, that's better. We can hear you now.

?: *Sorry. Has the panel ever considered that if the people in Bishop Auckland can't get the service locally that they will indeed bypass Darlington? There's very little difference between travelling from Bishop Auckland to Darlington and travelling from Bishop Auckland to Middlesbrough, and also if I can be allowed to pass a comment, this tonight does not seem to be to very much like a public consultation. I am just a lay person but it seems to me that the decision has been made and we're here tonight to be persuaded to agree to it.*

*(mobile phone rings in background)*

SE: Musical accompaniment!

*(Laughter)*

DG: That's just what I was going to say actually but ....

SE: How did you do that David?

DG: I'll ask the panel to respond and I'll say something about the consultation when we come to the end if that's OK, because I do want to explain the process and where we are with it.

SE: About people going past Bishop Auckland to Middlesbrough, a lot of people already go from Bishop Auckland to Darlington, a lot of people come to Bishop Auckland from Darlington for different services already and we'd expect to see that increase, so there's a lot of movement between our hospitals in the south at the present time. Some patients do go further for treatment as has been said earlier to both Middlesbrough and, depending on where you live, up into Newcastle, for highly specialised treatment. As I said before, we think that if we're able to organise as we propose then we'll be able to maintain the level of service that we currently provide for our local residents wherever they live and hopefully increase that for those that currently travel outside for local acute services.

DG: OK. Thank you. And I will pick up your point about the consultation when I make my closing remarks if that's OK madam. OK.

SE: David?

?: *Can I just comment that we actually now have patients coming in from outside our Trust to our area because they want the quality of the service. With regard to ... they said a new surgery for strokes, for TIAs, and we provide that service in Darlington and in Durham and we actually are one of the leaders in the country at providing that one time, because we do believe in stroke services and we're trying to provide the services as locally as possible to the high quality.*

DG: OK. I've got the lady next to Vaughan and then we'll come back to this table for the lady here.

NH: *Hello, my name's Nicola Hunter. I just out of interest, it's just a very quick question. How many of the panel and the people that you've got around the room actually live in Bishop Auckland?*

DG: Can people raise their hands if they live in Bishop Auckland?

SE: No, no, not the people in the audience, people on the panel.

NH: *Just the people on the panel.*

SE: Andrew does.

?: I'm sorry but could you say it again please, the question?

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NH: *I just said it was ... how many people on the panel actually live in Bishop Auckland? I'm just trying to get an idea of how many on the panel are actually affected by the changes that they're proposing?*

DM: Well we're all affected.

NH: *You're all affected?*

DM: We're all affected, we all live in the County.

NH: *So if the changes were the opposite way round you'd be sat there saying exactly the same?*

SE: There's one person here who lives in Bishop Auckland. I think many others around the table live in the County. These changes are about the whole County, so if you were to live in Durham at the moment, you may well be coming in the future to Bishop Auckland for one of your surgical operations. If you live in Darlington at the moment, under our proposals you would come to Bishop Auckland for a cataract operation, in a specialist cataract centre that we don't have at the moment, so these proposals are about the whole of the County, not just about Bishop Auckland.

NH: *So you can honestly say hand on heart that you would be as passionate about this if the changes were being the other way round and ...*

SE: Absolutely.

NH: *... it was going to be Darlington?*

NM: Absolutely, I mean I live in Durham, for the record, but I care for the patients within County Durham. I've done clinics in Bishop Auckland, I speak to my patients week in week out, I know what people think or what they tell me, no-one knows what they think but it's what they tell me. I wouldn't put something on the table that I wouldn't have a member of my family or any friend of mine take part in.

NH: *But it doesn't actually affect you or your family though does it?*

DG: I think you've asked your question and they've responded.

SE: David.

?: *It does actually affect us because we're asking patients to travel to Bishop Auckland, as I said about the cancer screening, two or three years ago when we said cancer screening would be based, the procedures would be based at Bishop Auckland, it means patients from Durham and Darlington have to go to Bishop Auckland to have that screening, you know, all patients will travel and then they have to travel one way or the other, it does have effects on everybody.*

DG: OK. A question from the lady here.

?: *Mine are just very quick questions. It would appear that you're creating a postcode lottery service here, and as your Nursing Director said, the postcode here, well I'm sorry but postcode doesn't come into it, we, the people, and you must have to live in an urban area to get the quality of service, i.e. Darlington or Durham. The second question is to the Ambulance Service. How long is it going to take you to put a paramedic on every ambulance, because you're saying you can do that, so if you're dragging people further away from a hospital, how long will it take you to do that? And finally the real consultation for everybody here is 11.00am Bishop Auckland Market Place on Saturday. Thank you.*

DG: Can ...

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SE: Very quickly our responsibility is to provide a high quality service to all of our residents wherever they're living in County Durham and Darlington, about your first question. Perhaps Paul you could say something about the second question?

PL: Yes. Actually the technicians that we have on at the moment, those staff are now being trained so it's as fast as we can get them through the training courses. I would expect within 18 months that we will have a paramedic on every single vehicle.

?: *So the service is going to be changing before the 18 months aren't they*

PL: Yes, I assume they are but at the end of the day it's not as though we haven't got ... we've got enough paramedics at the moment to serve obviously the Ambulance Service. The fact what I'm saying is that to get to 100% from where we are will take 18 months, but we're working towards that.

DG: I think all that depends on what I'll say in a few minutes about the closing part, about what happens with the consultation, because there's one thing to actually make a decision, it's then how it's implemented, if the proposals go ahead. I'm going to take one last question from the gentleman at the back because I'm conscious that people are wanting to go and we were supposed to be finished at 8 so we've given a little more time for questions.

BG: *Actually, I've had an awful lot to say, it's not a question, so I hope other people can ask questions. I just wanted to apologise, I'm the only one who didn't say who I was. My name's Bob Gosling, I'm an ex-NHS employee and I'm a resident of Bishop Auckland. I hope other people can ask questions as well.*

DG: OK. Well I think actually Sir what I'd like to do is draw it to a close because I know people are starting to wander away anyway. I'm conscious of the fact it's probably quite slippy outside now. What I would just do and hopefully I'll pick up the point from the lady about the consultation, this is part of the consultation, there's a series of meetings, I think we've got 15 or 16 public meetings that we're having across the County, a lot of them actually around this part of the world. It's not the only part, it's not the only way you can actually take part in the consultation though, I'll explain a little bit about that in a moment, but the consultation itself runs to 12<sup>th</sup> January, at that point all the consultation will be written up, it'll go to the FT Board, the Foundation Trust Board, and they will make a decision on what to do with their proposals, then they will come back to us as commissioners at NHS County Durham, the PCT, and we will take a view in light of the consultation, in light of the other evidence that we have, in the light of the Overview & Scrutiny Committee work, what we actually do, whether we actually let them go ahead with the proposals or not. The only decision that has been made so far is actually to embark on this consultation process and the only reason we've done that is because we've been convinced as commissioners that there's a need for some change and the proposals and the consultation process are about what that change might be. And very quickly, a number of ways you can respond, the vast majority of people are probably responding using the website, you can actually go onto the website and two things about that, the address is up there, you can go on and you can get more information on the proposals, all the detailed information. If you're not finding the information there that you want and we've had some examples tonight where people have asked for more information, let us know and we'll provide that information for you, we'll make it readily available. The other thing you can do is you can actually go online and actually fill in the consultation questionnaire which gets fed into the work that colleagues from Proportion are doing and will feed into the final process for us. You can also write or email using the addresses there, but the key thing I want to assure you of is we will listen to everything that's said in the consultation, we will take account of that when we look at the final proposals that come from the Foundation Trust.

On that note I want to thank you all for being here tonight, for coming along. There's obviously a lot of passion and a lot of concern here. It's good that you've had the chance to ask the questions, if you've got any more questions to ask, again, more information, you can come to us and we'll try and provide that information, but thank you for being here tonight, thank you for your participation and I hope you have a safe journey home.

*(End of meeting)*