

**Seizing the Future Public Meeting  
St. Catherine's Community Centre, Crook  
Thursday 11<sup>th</sup> December 2008**

**Representing the NHS**

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Jenny Flynn, Non executive director – NHS County Durham  
Anna Lynch, Director of Public Health - County Durham and Darlington NHS Foundation Trust  
Roy Westhead, Project Facilitator - County Durham and Darlington NHS Foundation Trust**

DG: OK. Good evening ladies and gentlemen. Welcome to one of a series of public meetings that we're actually holding under the banner of Seizing the Future, which is looking at the future of, or proposals for the future of some hospitals within County Durham and Darlington. My name's David Gallagher, I'm one of the directors at NHS County Durham, the PCT, our job is to actually commission services, so that's why we've got an interest in running the consultation process. I've got some colleagues here from the PCT and from County Durham & Darlington FT, so I'll ask them just to introduce themselves, if we can start with Jenny please?

JF: I'm Jenny Flynn, I'm one of the non-executive directors, but I also live in Tow Law, so I'm local.

AL: I'm Anna Lynch, I'm Director of Public Health for County Durham.

DM: And I'm Diane Murphy, Associate Director of Nursing and Project Manager for the Seizing the Future project.

SE: Hello, I'm Stephen Eames, Chief Executive, County Durham & Darlington Foundation Trust.

RW: Hiya, my name's Roy Westhead and I'm a nurse by background and up until recently was working in the IT department in the hospital and I'm working on the Seizing the Future project as a Project Facilitator.

DG: OK. Thank you all. As I said this is a very important meeting, it's part of a process, I'll explain a little bit about what we're going to do this evening and what our roles and responsibilities are in the process and then towards the end of the evening I'll explain how this fits in and what we're actually going to be doing, how we're taking this into account. We're going to go through an Agenda, which is up before you there. We'll start off in a moment, I'm going to ask colleagues from the Foundation Trust to actually present their proposals for change. They'll go through that and then there are two opportunities for people to feed into the process. The first one is we'll have some discussion around the tables which will help us actually capture some issues for the formal consultation but we'll also hopefully help you formulate some questions for the last session which will be actual open questions to the panel and what we'll do is we'll have some people facilitate that round table discussion and I'll explain that as we come to it. At the end of it I'll just explain what the next steps are and where we're going with this now. Can I have the next slide please Roy?

Just in terms of roles and responsibilities, obviously there are three of us here from NHS County Durham, the Primary Care Trust. In everyday life, if you like, our role is to make sure that we actually spend your tax payers' money wisely, so we spend about £1 billion worth of tax payers' money across Darlington and Durham and that's actually to do a lot of things, it's to look at GP services, health improvement, dentists, hospital services whether that's mental health hospitals, whether it's acute hospitals as you'll listen to tonight, and that last bit's from a range of providers so a part of the money that we spend, a significant ... but not all of it .. a part of it actually goes towards the services provided by County Durham and Darlington Foundation Trust and that's why they've come to us with some proposals for change. County Durham and Darlington obviously provide the services and you'll hear about the hospitals that we're talking about as part of the consultation process, but as far as the process

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goes, it's our role at the PCT to make sure that the process is fair, open, people have a chance to have their say, and then we'll actually wait until we've actually had some amended proposals back from the Foundation Trust in light of consultation and then we'll take a view of how this ...does it proceed at all, and I'll talk a little bit about that towards the end.

We've also got colleagues from Proportion who are with us. Proportion are a company that are actually helping us run the consultation process. They're helping us record everything that we say tonight which is why we're using the microphones, it's not just so people can hear us hopefully, it's so we can actually get an audible record of that which we'll have written up. They are also here to record on the flipchart as we do when we do the feedback session, to make sure we have a record of everything that's said and done as part of this formal consultation process.

The aims of the meeting really, it's very much about two-way communication and that's an opportunity for you to listen to the proposals for change and why they're being proposed and then, as I said before, two opportunities to feed into that and feed back your comments and ask questions to get some clarification so you can have an informed view into the consultation process, so we'll be listening to your views, we'll be recording the input in various means as I've described and then the key bit at the end is we'll actually explain how this fits into the consultation process and what happens next. Having said all of that I'm going to hand over to Stephen and his team and they'll take you through the presentation and then we'll get into your part of actually asking questions and feeding into it.

SE: Thank you David. Good evening everybody, thank you for coming to this evening's meeting. I just want to pick up a couple of slides first around the overview on our proposals Seizing the Future and I'm going to hand over to Diane who's going to take you through the clinical case and then Roy will finish on transport issues and what we're planning in that respect.

Seizing the Future is about ensuring we provide high quality and safe care to all of the communities that we serve and our proposals have been developed over the last nine months primarily by our clinical staff in concert with the Governors who work with us as a Foundation Trust, there's a lot of work gone into these proposals that you're going to hear about. Can I have the next slide please?

A few key messages at the outset. First of all, to be absolutely clear, there are no hospital closures proposed, in fact our plans are to make the best use and increased use where we can of all of our hospitals. Nor are there any redundancies proposed. There are no changes planned in terms of laying staff off, in fact our proposals, we believe, mean greater opportunities for our staff in the future. We're being driven by two major considerations, which is driving all acute healthcare services up and down the country. First of all, in order to make sure that we can provide safe, high quality care, we need to centralise some services, and the key services as you will hear in that respect are paediatric services, critical care and accident and emergency services. On the other hand, the whole thrust of national policy, in fact what ordinary people want, is services as local as possible, so our plans are also all about providing services from our five hospitals across the County and in Darlington as near to patients as possible, and that's all about giving people the best possible treatment that we can and importantly making sure that we can continue to do that into the future. The next slide ...

The clinical model, if I can just briefly describe this, what we're proposing in our consultation is to concentrate acute services, particularly our critical care, children's and accident and emergency services, at Durham and at Darlington. We're planning to redevelop Bishop Auckland hospital and you'll note from the slide we're talking about using more space, more activity, providing more services locally in that setting, by turning the hospital into a major centre of excellence for planned care, for rehabilitation, recovery, for a whole range of new day surgery including a cataract centre, and we will continue to provide services as we do now from our other two community hospitals at Shotley Bridge and Chester-le-Street. So with that I'm going to hand over to Diane who'll take us into the clinical case. Diane.

DM: Thank you Stephen. Just to say that apologies from our medical staff who were going to be here tonight, there's ... the colleagues have been called away to an emergency so they're dealing with that, so if you'll put up with me ... I'm a nurse by background so I can give you quite a lot of the detail

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around this. So our issues around why we actually need to change the way we run our services and the reasons for our proposals. The first one to pick up is around specialisation. As you'll all probably understand, you become a specialist at anything by doing something more frequently, you need to do something regularly enough to be a specialist and this applies as much to doctors as it does to anybody else, but increasingly so it applies to doctors, and being a specialist means that you've got to see enough of a particular condition and that means around seeing enough patients in a population. By being a specialist it means that our patients actually get better outcomes of care. Once upon a time if you came into hospital you would see a general physician or a general surgeon and it would be kind of somebody who just dealt with the whole realms of conditions, whereas nowadays we've got a set of new specialties which are described in national standards built up through good evidence of kind of why that kind of improved standards of care and the areas that we kind of see new special interests are in general medicine, in surgical specialties.

Doctors' working hours as you'll all know that we're providing services through 24 hours, and to do that we've got to sustain rotas of doctors through 24 hours and they are kind of underpinned by a tier of junior doctors who are critical to the functioning of our organisations and the junior doctors are important to us not just in terms of running the rotas but that's us contributing to the training of new consultants, and by having our facilities as training facilities that in itself enables us to drive up our standards. Because of legislation through the European Working Time Directive they've been working steadily to bring down the number of hours that junior doctors work. Once upon a time, they worked sometimes 100 hours a week or more and that isn't good. It's not good for you if you're seeing a doctor who is exhausted after a whole weekend on call. By August of 2009 the junior doctors will all be required through this legislation to work no more than 48 hours a week. The net impact of that on us as hospital providers is that we lose the equivalent of 31 junior doctors across all of our sites. That is a major impact on how we sustain rotas, and something that we need to find solutions to. The Royal Colleges, Royal Colleges of Surgeons, Physicians, Paediatricians, Accident & Emergency and they are bodies of those particular specialists who look at researched evidence and come up with recommendations to how they should, as a specialised group, provide services, and it's by them coming up with those recommendations that standards are developed and standards are actually driven higher and higher. Those professional bodies have made a series of recommendations, which we need to be able to take account of. For Accident & Emergency for example we need to increase the numbers of Accident & Emergency consultants that we have, we currently don't meet those recommendations on all of our sites and we need to be able to address that. For acute medicine there is particular issues around a new consultant specialism called ... relatively new ... called Emergency Care Physician, which is somebody who will look after your care, if you come in as an emergency, for the first 24 or 48 hours of care, but what's required through these standards is that you see these new consultants but they then pass you over at the end of that period to somebody who is a specialist in a particular condition, such as somebody who specialises in diabetes or heart disease or something like that. We need to ensure that we've got enough of those specialists for diabetes, respiratory medicine and heart disease and what have you, to actually ensure that when there are holiday periods we've got sufficient of them to cover every day of the year so that you get, after you've seen the emergency care physician, you get referred to the right specialist, that means you get on the right drugs, you probably have a shorter length of stay, you're less likely to have complications and you're more likely to have a safe discharge home, and it is again about driving up standards of care.

Critical care is intensive care and we need intensive care to support all of our emergency services. It's important, as you know, if somebody becomes very very ill that we've actually got the back up of those units which are run by anaesthetists. We currently provide critical care on three of our sites, Bishop Auckland, Durham and Darlington. The Bishop Auckland ... there are three levels of critical care, level 1 through to 3, 3 being the most seriously ill, people who require being on a ventilator, a life support machine, for a period of time and we currently only provide levels 1 and level 2 at Bishop Auckland, the reason we do that is because we have not been able to recruit the consultants with the specialism to manage these patients into that site and the reason we haven't been able to recruit, it's not about money, and it's not about us attempting or not attempting to recruit, it's because we don't see enough patients of the right numbers for those consultants to attract those people to maintain the specialist skills on that site, so there is an issue that's very pressing in fact around how we sustain critical care.

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Children's care ... I mean I'm sure you probably realise that over the years the way we deliver children's care has changed significantly, there's a much greater drive to actually care for children at home and in the community because that's where they get better quicker, and they only need to be in hospital really for the very very acute part of their care, for the essential part of their care, so the numbers of children in hospital have dropped but where they are in hospital they, the same as anybody, need to see the specialists. Now the numbers of patients that we have in the Bishop Auckland site are very small, not seeing enough people there, enough patients there, and there is a particular issue around paediatricians, nationally there is a problem around recruiting trained paediatricians, they're not there out in the system yet and a lot of our paediatricians are actually coming up to retirement age, so there's a very pressing issue around sustaining our rotas in paediatrics.

Doing nothing's not an option. We had a review by Professor Sir George Alberti who is part of the National Clinical Assessment Team. He is a doctor by background, a physician, and he came and reviewed our proposals and really tested them against what was considered to be national evidence and best practice, and his conclusion, he made a number of observations but he did say, doing nothing is not an option, we actually need to change the way that we organise our services in order to ensure that we're meeting modern standards of care into the future. If we don't do that we are ... we, as in the clinicians, the doctors and the nurses and the therapists, we are very mindful of the fact ... what we will see is, quite quickly in fact, a decline in the quality and safety of the services that we're able to provide, and what that then means is that the people of County Durham and Darlington are not getting the standard of care that we know they should be getting and that is expected of us to provide as part of a National Health Service and also as a service that a commissioner who buys services on behalf of you actually would want to purchase. They too have sets of quality standards that they have to demand of organisations when they're buying services, so overall we think this will have a negative impact on the health of County Durham and Darlington residents and certainly will not contribute to us being able to provide the best services as local as possible to you as residents of the County.

In terms of our A&E proposals, some quick headlines really ... the Bishop Auckland A&E department currently see almost 30,000 patients a year and under our proposals 20,000 of those would continue to be treated at Bishop Auckland hospital. 9,000 would be required to transfer to either the Durham or Darlington sites and those are the patients who require probably a Blue Light ambulance and need the support and infrastructure of acute physicians and intensive care back up. We know that patients benefit by travelling further for specialised care, there's evidence around that that is the case. That is really kind of underpinned by the fact that it's more important for somebody to travel a longer distance to actually get to the right place, to see the right specialist with the right skills and the right support set up around them. It's no good going somewhere that isn't able to provide that, where actually all you might get is a delay in your care prior to transfer somewhere else, a delay in care often means a detrimental effect on your care.

Serious trauma, serious injury, so people with kind of ... major car accidents for example, complex injuries, haven't been going to Bishop Auckland for some time, that was centralised at Darlington in around 2000, the year 2000, and major head injuries for all of our population, the major head injuries are actually treated for this part of the County at James Cook hospital for the north of the patch at Newcastle and we know that for certain specialised conditions our patients are already travelling outside of the County for significant benefit and that is particularly what we call primary angioplasty which is a new surgical procedure used to treat patients with a type of heart ... a particular heart attack, I mean there are different kinds of heart attacks, but patients who have had heart attacks can go, or do go, directly to James Cook hospital after being seen by the paramedic at their home or wherever they've been picked up and they do a heart tracing that's sent directly through using electronic images through to the units in James Cook and they go through there for their treatment and that is already showing significantly improved outcomes for patients.

So why overall this is better for you, well we can by providing the services the way that we're proposing we can actually ensure that we can provide specialists, more than one specialist, so reduce the number of single-handed specialists, and make sure you get to see a specialist and that will improve your outcomes. By separating our emergency work from our planned work we can ensure that you go

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onto the right ward and the point here is that it's not just doctors that specialise, it's nurses that specialise, it's therapists that specialise, it's the whole team, and being on the right ward with the right specialist team is as important as having the right doctor with the right skills, it's the team approach that improves the outcomes. We can also reduce your risk of cancelled operations, by having our planned care separate it will stop patients being called early on a morning, having the cancellation made at the last minute because there are pressures on the acute beds, we know that we can reduce that.

The proposal includes a specialist rehabilitation unit at Bishop Auckland. Rehabilitation currently happens within the existing acute episode of care. Rehabilitation is a specialty because it actually means people standing back and facilitating people to regain independence and regaining independence means you will get home ... you're more likely to be discharged home than discharged home with community support or discharged to nursing homes or residential care. By creating this specialist unit, putting some extra resources in with ... to enable us to provide seven day therapy support, rather than five days that they currently have, we can create a unit which is a centre of excellence, first of its kind in the area, and we believe it will be kind of something that people are actually seeking to access.

Less risk of infections. Our planned unit will be able to screen all the patients before they come into the planned care centre and by doing that we will be able to identify those patients who are hosting an MRSA infection and actually give them treatment before they come in so we can reduce the risk of MRSA infections. I think Roy's going to pick up now.

RW: Thank you. Thanks Diane. Right, I'd just like to talk for a few minutes about some of the work that we've done looking at the travel and transport implications of the proposals that we've made. I think, like I said at the beginning, I'm from a clinical background, I'm from a nursing background, I've worked in the NHS all of my career and I think all of us from a clinical background kind of obviously understand and support the clinical case for change, but as we've been through this public consultation process and you know spoke to lots of different people over the last few weeks, one of the things that's become very apparent, that we're being told from patients, people who use our hospitals, is that the one thing that concerns them is the impact on travel and transport, so I just want to talk for a few minutes about some of the work we've done, kind of, you know, looking at the impact on travel and transport.

The kind of first thing I'm going to say, and I think it's been mentioned already, is that all of the changes that we're proposing are basically underpinned by the principle that you will only have to travel more when it's absolutely necessary. If you look at, if you like, you know, the NHS as a whole, the whole NHS, and my PCT colleagues will kind of back me up on this, from a patients' point of view the commonest way you're going to come into contact with the NHS is through primary care, through seeing .. going to your GP and seeing your GP. The next kind of biggest area of contact you're going to have with the NHS is coming to an acute hospital and having an outpatients hospital and that's kind of the next, if you like, biggest area of activity. Now in all of the changes that we're proposing we're not planning on making any changes to the way our outpatient services are arranged so, if you have an outpatient appointment in ... if you go and see a doctor in Bishop Auckland or in Shotley Bridge or Chester-le-Street now, after we make these changes, if these changes are agreed, none of that will change. The changes really relate to patients who need acute care and with the changes we're proposing there is a small number of patients who will have to travel to get the specialised care that we want to deliver in the future.

I want to talk a little bit about emergency care. Now one thing that's changed significantly in the last few years in the NHS is the role of paramedic services. Certainly in the future and I can remember kind of in days gone by, really what the ambulance service, the service that the ambulance service were providing was simply transport of ill patients from the point of injury or accident to the hospital, to the hospital unit ... now that's changed dramatically in the last few years. The ambulance service now through the paramedic role provide very intensive specialised care, treatment and monitoring which includes direct contact with the hospital so they inform the hospitals of ill patients coming through and update them on their condition and the days when your care began when you arrived at the doors of the A&E department are very much a thing of the past. Paramedics now, like I say, are involved in very kind of intensive and involved lifesaving procedures and other treatments.

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In terms of the kind of more general transport issues, we've been working with the Durham Integrated Transport Unit, really looking at the type of services that are available at the minute. We're looking at where the gaps are and by working with them we're hoping to kind of introduce new services that will plug those gaps and make access to our hospitals a lot better. We've got a scheme running in the east of the County called the East Durham Hospital Link and we're looking at hopefully setting up a service very similar to that and those discussions are underway now. The way the East Durham Hospital Link works ... you have a single number to contact, you'll ring that number, they'll decide if you're appropriate ... if you're suitable for a patient transport service ambulance, the kind of normal patient transport ambulances, they'll book you into one of them. If you're not they'll give you advice on public transport if there's a kind of viable public transport service available where you live, and if that's not available they have dedicated transport buses that you can book onto that purely service the hospital, that will pick you up near your home and take you to the hospital and like I said those discussions are underway and you know they're very much a big part of these changes that we're proposing. And like I say the Trust is committed to invest in those new services and provide them where we can.

We're very conscious of the fact that all of the transport issue not only affects patients, it also affects our staff and it also affects relatives and carers visiting people in hospital and all of the kind of transport solutions that we've looked at will look at those groups of people as well. I think that's me about done, I'll hand you back to David.

DG: Thank you Roy. Thank you and thank you ladies and gentlemen for listening to the proposals that have been put before you. This is now getting into your chance in the two ways I described to actually feed into the consultation process and for starters what we'd like to do is if we can get you to convene into possibly two, three groups, possibly, if we get the facilitators to sort that out. We'd like to do two things with you, one is to feed into the formal consultation and and some specific questions to feed into the consultation and the second bit is to start to formulate some questions to put to the floor. Now ... can I just finish what I'm saying Sir and then I'll come to you? ... What we'll do then is we'll ask each of the groups to put two questions from the floor to the panel and then we'll open up after those two questions for general comments and questions from everybody around the floor. I think we can do this, we've probably got about 20 minutes for the discussion around the table and then the rest of the evening we've got until 8 o'clock for open questions from the floor. Do you have a comment Sir?

?: *I would just like to ask the people the people who are here in the audience whether they feel that the round table discussions are worthwhile or whether they would rather go straight into open questions and comments.*

?: *Just questions and comments as far as I'm concerned.*

DG: OK. I think actually a lot of people in the audience have actually been part of the round table discussion anyway so we've probably recorded your views as part of that. If those of you that haven't been part of this are comfortable with that ... ?

?: *(inaudible)*

DG: Yes, OK. We can do that, that's fine. What I'll ask is ... Vaughan will come and actually write up the questions as they come. As I explained because we need to record the whole process, very happy that ... you know, we'll pass the microphone round, we'll get people to pass comments. Can you please before you ask the question can you identify yourself just for the record and then we'll put it to the relevant person in the panel. I think we've probably got one more person from the team to be introduced ... yes, we've got a consultant paediatrician from the Trust here, John Furness, Clinical Director from Paediatrics, so he can answer any particular questions about the children's side as well, so if people are ready, if we've got a first question? OK. We've got a lady at the back. The microphone's on it's way, if you can just say who you are please and then put your question to the panel.

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*JW: I'm Jackie Wall and I'm secretary of Crook Community Partnership. My question isn't really a question, it's a comment that does actually require an answer. By definition, planned care, you plan round it, you plan your contingencies. I was actually in Darlington Memorial earlier on this year for a hysterectomy and we planned around it, annual leave etc. for my after stay care. Emergency care is what you need on your doorstep, not 20 miles away.*

DG: OK. I don't know who would like to respond to that please?

SE: Do you want us to comment on your statement?

*JW: Yes, the statement is ... planned care you plan around it, emergency you need on your doorstep.*

SE: Yes, OK. We also do quite a lot of planning around emergency care and what we've been describing very briefly is a way of organising so we can make sure that the care you get when you've got an emergency condition is better than it is ... it will be in the future unless we're able to change, but I'd like to ask perhaps Diane and maybe John if they wish to make a comment about what you've said. Diane, do you want to kick off?

DM: Yes, I mean I think if you look at the number of acute hospitals providing emergency care that we have in the North East, we actually have more per head of population than any other area in the country and it's only appropriate to provide that care if you can do so safely, that's the critical thing, that you provide the right standards of care with the right level of patient safety, and you know, everything that we're proposing is based on a review of how we currently provide services, the standards that we are required to meet and the gaps between the two, and how we can provide our services into the future safely. Safely means you come, you get your care with us, you get a good outcome of care, we don't have accidents, we don't miss standards in terms of, you know, poor ... you know, greater mortality for patients and that kind of thing, and it's rooted in evidence that has been used nationally, in the national reports on delivering high quality care.

SE: John?

JF: Thanks. Well, obviously my background is with children, but what I'm going to say holds across the age span and you saw from Diane presenting, talking about heart attacks and how the care has moved on an awful lot in the last five years, so that's an emergency that is actually best treated in some circumstances at one of two centres in the North East. The concept that I want to try and get across is that it's not as simple as the emergency department on your doorstep being able to give you the best care, there's a balance between the distance and the number of patients seen at that centre that is proportional to the expertise, the care given, and what's been shown in more and more conditions in children and all age groups is that if you have numbers that are too small then the expertise and the skill of the care that is given is not going to be as good as when the numbers are sufficient, and therefore it's not as simple as just the closer the emergency centre is to my house, the quicker and best care I'm going to get, and that's why the ambulance service has changed so that it can give good quality care literally on your doorstep. The ambulance drawing up to your door now is the same as 10 years ago, you going to the A&E department or the coronary care unit.

SE: Thank you John.

DG: Thank you. Have we got another question from somebody? I think there's a gentleman near the front here?

*JS: Yes, my name is Jim Smith, Greater Willington Town Council. I don't whether the members here watched the debate in the House of Lords on A&E and I feel that obviously there's someone not singing from the same song sheet. A question that was raised by Baroness Trumpington who lives in Cambridgeshire ... she expressed the view that people were travelling at least 12 miles to get to A&E and she wanted to make sure that in the review that was done on A&E, this was with the debate with the House of Lords, there would be better access and Baroness Thornton who was the Minister for the Health in the House of Lords replied that in the review people would be given a much better access to*

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*A&E, yet we're going to be faced in this particular area where people travel from in the Dales area 26 miles to Bishop Auckland and that's going to be extended, so where is the breakdown in communications? And this came as a debate in the House of Lords three weeks ago, which I listened to.*

DG: OK. Stephen?

SE: John may wish to comment again but if I can respond to the debate which I saw some of, and that debate was born partly out of the report that was also on the radio at the beginning of last week by the Royal College associated with Accident & Emergency service delivery nationally. Access, which is ... I mean I agree with you about the point that was made ... but the point about access isn't just about the distance travelled as John has just explained, it's about actually making sure that you get the right treatment of the right quality, that's all part of access, and that's what the Minister was talking about, and if you take the example, just for the ... just to re-emphasise about heart attacks, the care for heart attacks has changed dramatically in a very short space of time and there is evidence, reams of it, that would demonstrate that if you have a heart attack and you go to Middlesbrough or Newcastle, that your recovery will be better given the treatments that they can offer than the alternatives, that's a fact. It's an absolute fact. And that's what the debate is about. Now having said all of that it's very important when somebody has, you know, an urgent and critical experience wherever they are that, as John was saying, that there's an immediate response and that's the point about ... and that response is about stabilising you so that you can be taken to the best place for your condition. And John's going to just add to that.

JF: Unfortunately Mr Smith I didn't see the debate and so I was a bit lost on your point but I think your point was about, again, proximity to services, and all I can do is repeat what I said before, unfortunately the equation isn't as simple as that, it's not the quicker I get to a service the better care I get, it depends on the population around the area, the density of the population, how many people are treated at that centre, and all I can do is repeat what we said, that's it's not that simple an equation I'm afraid.

JS: *Can I just say one thing, it's totally confusing, planned surgery and serious acute problems which have to go automatically to either Newcastle or James Cook, planned surgery is planned for coming ... appointment ... what we are most concerned about is the A&E which is an immediate urgent service that we need at Bishop Auckland, not miles and miles away. Alright we agree the paramedics do a good job but they can only stabilise people till they get to hospital, they cannot treat them as such, so consequently the sooner they get to hospital the better because otherwise you are expecting the paramedics to take the responsibility of applying more medication in the way of drugs etc. to take them further to get to A&E which could be provided at a nearer hospital such as Bishop Auckland, and Bishop Auckland is the most central hospital to the whole of the Trust area.*

SE: Diane and John will respond.

DM: Just to pick up that we obviously talk to our colleagues in the ambulance service and actually they've been at some of our meetings and helpfully contributed. They do actually begin the treatment of some patients and they do carry drugs, and they carry drugs because the people who carry drugs are actually skilled to use those drugs appropriately so for instance if they come across somebody who's had a collapse and an allergic reaction they carry the right drugs, and they're life saving drugs, and they carry them and they administer those and they're trained and they're skilled to do that, so they do actually initiate some treatments but they also stabilise but we have to come back to the point that it is important that they do that and then get the patient to the right centre with the right skills where people have the skills and equipment to treat them.

JS: *We're not arguing about the stabilisation of a patient, we're talking about the distance where there's no need to take them further than the local hospital. If Bishop Auckland was an equal partner in the Trust and they all had equal access to full A&E facilities in each of the three hospitals that treatment would be applied sooner rather than later, relying on drugs to take them the extra distance.*

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- SE: Well I think that's incorrect because, and I'm going to ask John to comment in a moment, because if you get run over anywhere in the street and have a serious head injury anywhere in County Durham and Darlington, you won't go to any of the local hospitals.
- JS: *Exactly, that is what I was saying.*
- SE: Yes, but my point .. hang on, let me ...
- JS: *Anything serious goes to James Cook or Newcastle.*
- SE: With respect ... with respect, let me answer...
- DG: Can you let Stephen finish please?
- SE: Let me answer your question please because you ... obviously we've listened very carefully to what you said ... I'm simply making the point that the services that are provided in this County do not provide everything that you might require an emergency treatment for, and you couldn't have equal access in every single hospital in every single community to every single emergency occurrence and that's the same in relation to the way we're looking to organise services locally because we want to make sure, for the reasons that John and Diane have explained, that you get the best care when you have an accident. John?
- JS: *We're not arguing about the serious ...*
- ?: *Everywhere is just as serious ...*
- JS: *Not arguing about the serious accidents going to James Cook, we know you've got to have specialised consultants to do that type of work, but we are concerned about the local A&E being available locally rather than having to take people further than you need.*
- DG: Actually can I suggest, would it be helpful if the panel can explain what would be available at Bishop Auckland under the proposals in terms of A&E, because I think that's the nub of the issue.
- SE: (inaudible) John is ...
- DG: Yes.
- JF: I was just going to get back to your first point actually, which you said that you thought we were mixing up elective, non-urgent work and urgent work and I'm not sure whether there's been a misunderstanding ... when we're talking about heart attacks and treatment at Freeman and James Cook, we're not talking about treatment after you've been ... after you've had your heart attack, we're talking about when you've had your chest pain, going straight there for a procedure.
- JS: *Exactly, we're not arguing about that.*
- JF: OK.
- DG: OK.
- SE: That's fine.
- JS: *We're arguing about local A&E services where Bishop Auckland is going to end up just looking at the patient and saying we can't do anything.*
- SE: No that's wrong.
- DG: If we get the panel ... can we get the panel to explain...

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SE: Let me respond...

JS: *... to have the same facilities as Durham and Darlington whereby there will be medical surgery, doctors, anaesthetists on an equal par to the other two hospitals.*

SE: OK.

DG: OK. I'll ask the panel to explain what will actually be there.

SE: Can I just say very quickly, 30,000 people attend the Accident & Emergency department at Bishop Auckland now. In the future, under these proposals, 20,000 still would, so two thirds of the people that currently go will still go, so we're talking about 10,000 ...

JS: *But it's the one third we're worried about.*

SE: Well of course it's the one third your worried about, I'm just getting the facts across so ... therefore this will affect those people ... the balance of people, the 10,000 people. Now what you're saying, if I've understood you correctly, is we want in every hospital in County Durham and Darlington ...

JS: *No not every ... the three main hospitals.*

SE: Well that's what I'm talking about, the three main hospitals, you want exactly the same services everywhere ... we cannot provide that for the reasons that we've said, so we could and we did look at making Bishop Auckland the fully fledged Accident & Emergency service as you have described, putting back the surgery that went away 10 years ago. If we do that then one of the other hospitals would have to change and become a planned centre. ... Just let me finish. That is absolutely the case, so either Bishop, Durham or Darlington, one of them has to be a planned centre for the future, we cannot run three fully fledged emergency care centres and we set out the rationale which I'll go on to answer if that's required, as to why it's right we think for Bishop Auckland to be the planned centre.

JS: *Well getting on to the planned part, bringing the planned surgery to Bishop Auckland, will the other two hospitals have no planned surgery? Or are we splitting hairs here, and still allowing planned surgery in the other two hospitals and then including Bishop Auckland as a sop to using A&E?*

DM: It absolutely isn't a sop to Bishop Auckland, I've got to say that first off. What we ... we can't ... we've got to do some planned surgery on the Darlington and Durham sites. All of the day surgery will go to the Bishop Auckland site, as will intermediate surgery .. now that ... it depends on the severity and the seriousness of the operation that's going to be done. The planned surgery that will have to be done on the acute sites is major surgery, some patients as you know come in for major planned surgery and when they have that surgery they actually need the back up of an intensive care unit and some of those units actually go into planned, on a planned basis, into intensive care or high dependency care. The types of operations would be major cancer surgery and I mean major reconstructive surgery, that type of thing, so some planned surgery, where again it's about the safety of us providing the service safely, making sure we've got the supporting arrangements there so that patients are actually managed well with good outcomes, that will have to be provided on the acute sites, and that's the right thing to do, that's what other organisations are doing, that's how they set up their services.

JS: *You're trying to give us the allusion that all planned care's coming to Bishop Auckland.*

DM: No, we're not.

JS: *... as a new service. By what you say, it isn't, it's going to be a divided service, in other words the other two hospitals are going to retain their planned surgery and you're going to give a little bit to Bishop Auckland.*

SE: No, I think we've just got to correct that ...

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DM: That's absolutely not true, that's not true.

SE: ... because that's factually incorrect. What we're saying is we were going to run day surgery activity at Bishop Auckland, the vast majority for County Durham and Darlington at Bishop Auckland, much more than we do today, facilities are terribly under-utilised, really badly under-utilised, and ... well, but look, if we go into the history, we have to talk about the future, in the future what I'm absolutely determined is we use the hospital more than it's used at the moment and as a tax payer you, like me, should be concerned, because you're paying.

JS: *We are!*

SE: Yes, well I'm just making the point, you should be concerned that the hospital is fully utilised and I hope you share that concern, but the point is that the other site where we used to do day surgery which we're already doing at the moment is at Shotley Bridge, for the community there in the North, we're going to leave that service there as it stands, but the vast majority of day surgery will happen at Bishop Auckland. Now if you have a serious illness or a serious accident or a serious medical condition it is possible that that may need, once the diagnosis, assessment and treatment happens, that you need surgery and that's why, as Diane has explained, we need to operate surgical activity on those sites as well.

DG: OK. Thank you. Can I come to a question from somebody else please?

?: *Yes, thank you. Talk about the 10,000 people that aren't going to be going to Bishop ... I've got some figures here, you might have some up to date figures, but these are relatively new I believe. You've reorganised the ambulance service in West Durham and your response times have dropped from 45 to 2%.*

SE: That's one for David.

?: *So, if those figures are correct, how can anybody out there have any confidence in the service that's going to have to travel further if the response times are so inadequate at the minute?*

DG: OK. I mean I'll pick that up from a commissioning point of view because obviously it's nothing to do with the FT really. We are reorganising the ambulance services in the Dales, what we're actually doing is putting extra resource in so there's an extra ambulance crew in the Dales to make sure that they actually get round some of the poor performance targets that have been there in the past. So we're looking ...

?: *But these are recent figures, these are just (inaudible) in the last few weeks.*

DG: Yes, and that's because we haven't actually put the investment in yet, we've agreed it tonight and we're going to be doing it, it takes time to recruit people, but there will actually be, rather than an ambulance in one Dale working between the two, there will actually be an ambulance in both Dales and I mean I'll get the figure wrong but it's around £600,000 per year that we're actually putting into that just for improving the ambulance service in Dales, so we are looking at that.

CO: *Clive Ord, Bishop Auckland. Last week members of the table there, I watched national news on the television, they spent five minutes on a story, which is very unusual for national news policy, on stroke, and the message that came through very loud and very clear was the reaction time from actually having the stroke to getting to hospital immediately when certain patients can be given certain procedures whereby if it's there quick enough they can walk out. Now then, the big question here is, the stroke unit is going to be removed from Bishop Auckland, people are going to have to travel, you're going to lose the impetus of early .. early attendance and early chances of a real decent or half decent recovery from a very serious and a very common position that a lot of people find themselves in nowadays. Now, this is a very serious sort of position to find yourself in with a stroke, I've had many years of experience of it and, you know, I would like to think that the stroke was dealt with a little bit*

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*more kindlier than you are going to deal with it now, because people are going to be in a worse state by travelling ... and it's all down to travel again ... but have a bit of think about the stroke unit, it's a superb unit at Bishop Auckland and I'm sure a lot of people around here will be absolutely over the moon to get early diagnosis and treatment. Can I leave that with you?*

DG: OK.

SE: OK. I'll answer that to start with and then perhaps John and Diane may wish to respond. I mean I saw the same news item, but you're missing a very important fact actually in what you've just said, because what the ...

CO: *(inaudible)*

SE: Well just let me reply ... what that item is about is a national stroke strategy and what the national stroke strategy is about is exactly what you're saying, and I absolutely agree with you, that's what we all want, we want much improved stroke care. Stroke care in the United Kingdom has been historically much worse than any other country, developed country, in Europe ... it's a scandal at one level, and therefore that review is about creating major stroke centres, based on population of about half a million. In the North East the proposal, which will be coming through in the commissioning plans next year, they're talking about three or four major stroke centres. We have three excellent stroke centres, at Bishop Auckland, at Durham, at Darlington, superb staff offering those services everywhere, and this is exactly the point that we're making. If we bid for the stroke centre at Bishop Auckland to be our centre of excellence it will not succeed. The population base is not big enough, therefore we have to ...

?: *(inaudible)*

SE: ... let me finish. Therefore we have to make a proposal based on our total population because if we do, with the fantastic staff that we've got providing these services, we will be successful, we'll have a major stroke centre in County Durham and Darlington and if we don't do that people like yourself and others will travel further for their stroke care. So let's just be absolutely clear about the background. The second point I want to make is the travel issue is not an issue in stroke care, you need to get that treatment in three hours, OK? Three hours, not half an hour, not an hour, within three hours ... but would like to comment more on that Diane?

DM: Just to sort of confirm that really, the point is about getting somebody to a unit, a stroke patient has to be in a unit that is actually backed up by intensive care and the full range of specialists. Stroke care is a specialism in itself now, we need to make sure that we're configured so that when the stroke specialist isn't around, the way it's structured now is, you know, there's one person on the Bishop Auckland site, well if you're not ... if you arrive with your stroke and that person's not there then you won't, you know, in the future you wouldn't get that diagnosis and that treatment in the way that we need to provide it. By reconfiguring, enabling what we talked about before, about having specialists, having more than one specialist so if one isn't available there is another one available, we can make sure that all the stroke patients, through 24 hours a day, get their scans done, their diagnosis made and the treatment in the very small percentage of patients actually who are eligible for that treatment, and I think it's only something like 3 or 5% of all stroke patients ... 10% is it? 10%, who are actually eligible for that treatment. That 10% is really important, I totally agree with you, you know, it's a fantastic treatment, you know, for those patients we need to provide it through 24 hours with the specialist services that we talked about.

CO: *OK. I'll accept ... I'll accept what you're saying, but all of a sudden this very successful unit at Bishop Auckland is becoming an obsolete, out of date, totally unacceptable to everybody else, apart from you ... you don't seem to be listening to it all, I mean you must hear from people and from the hospital itself, it's a well run good unit, and you're going to decimate it, why don't you get people to come from Darlington and Durham to Bishop Auckland to use it instead of taking it away from Bishop Auckland. I'll leave it there.*

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SE: Well Clive, Clive, can I just ... can I just say that, again, you're misleading as usual with your comments. I'm sorry, let me finish, you've had your say, you're misleading ...

DG: Gentlemen, please can you just ...

SE: People from Durham and Darlington go to Bishop Auckland now.

CO: *Excuse me, but do not get personal please.*

SE: I'm not getting personal, I'm simply saying you're misleading people in the room with what you're saying, it's wrong.

CO: *Stephen you've been doing it for five weeks.*

DG: Right, OK, gentlemen ...

SE: OK, I'll just ... I'll just carry on making the comment.

DG: Can we just leave it at that point and have another question?

SE: ... I was about to make ... that what you're saying is not true. People from Durham and Darlington already come to the stroke unit in Bishop Auckland and people from Bishop Auckland go to the stroke units in Durham and Darlington, that's how it works, and we're not decimating the service, I was there this afternoon with all the staff, talking to them, they're very excited about being a major stroke centre, they're very excited about being a major stroke centre in the North East and bear in mind that the other 90% that Diane obviously talked about the 10%, the other 90%, most of those people benefit more in the future from high quality excellent recovery and rehabilitation, so when you make your comments it would be very helpful if you were able to reflect those things as well.

DG: OK. Can I ... I've got a question from the gentleman here and then I will come to Sam because I know he's been waiting for a while, but a question from you Sir?

JR: *It's not a question. There's various questions but there's also various comments.*

DG: Sorry could you just tell us who you are please?

JR: *I'm John Redmond, I'm a resident of Spennymoor and I work in Bishop Auckland in the school.*

DG: OK thank you.

JR: *So I work with children as well. There's various things that concern me about this. You make a great play of consultation but you don't seem to be listening. You also have provided online consultation and you've started sending stuff out to houses that asked only two questions: do you want Bishop Auckland to be downgraded to this or do you want it to be downgraded to that? And the second one being your preferred option. You don't give a third option. When we had the meeting at Bishop Auckland you said it's not a done deal, you also said that both Darlington and Durham are in the frame, but they don't seem to be. What's of great concern is that it seems to be that because it's Darlington and Durham Healthcare Trust, Bishop Auckland's just not in it anywhere in your plans apart from making it worse in certain respects. You also say you can't recruit, but what came first, the chicken or the egg? Did the recruitment problem start when you started to downgrade the hospital? Because people do not come to work in a sinking ship and the more you downgrade it the worse it gets. Yasmin Choudhry, Chief Executive of NHS Durham, was quoted as saying that the views of the local people on the proposals are extremely important. There were 800 people plus in the town square at Bishop Auckland who are against your proposals, 14,000 plus people have signed a petition against your proposals, are you listening? I don't think that you are. We're told that lives won't be at risk. You keep going on about travelling and it's not a problem and it's not far and so on. Have you ever tried to travel to Darlington or Durham and get to the hospital? You can get to the outskirts of both of them*

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*very quickly, the next bit is the difficult bit, going through the traffic lights at Nevilles Cross and getting to the hospital. Going through the traffic lights on the edge of Darlington and getting to the hospital. I can't see how a delay in care can be beneficial and this extra travelling time is not going to be beneficial, so I believe that lives will be at risk and I honestly don't think you're listening, and I do think it's time you did.*

DG: OK. There are various things to respond to. I'll pick up some of the bits in terms of the consultation and Yasmin said that, and absolutely right, and to be honest if we weren't listening, if we weren't interested in listening, we wouldn't be stood here tonight having this discussion. The bit about the travel I think links into the consultation because very much part of the journey that's gone, this consultation, it's about bringing the proposals to the people, getting the views, looking at what some of the issues are with that and travel was one of the key ones, and then looking to the people who are making the proposals to say, OK, in light of that what are you going to do to make that solution better before we actually make a decision on it, and one of the things I've observed is that the Trust are certainly listening to the transport issues, they're doing some work with people and they're trying to find solutions which are still part of the proposals and absolutely, Yasmin's absolutely right, we need to listen to your views, we're taking account of all of your views, we're using the consultation, we're aware of the depth of feeling in particular parts of the County and understand the issues, we'll take notice of all of that when we actually come to judge, if you like, on the proposals that come to us, but what we'll be looking for is that colleagues in the Foundation Trust have listened to the voices of the people, have made some changes to the proposals to actually get them right, and, again, that's the process of consultation, consultation for me is not about we'll tell you what we're going to do, we'll listen to you then we'll still tell you what we're going to do, we won't change, we'll be looking to actually see and to challenge the Trust to see in light of the bits and pieces that have been raised, and the concerns that have been raised, how you're changing these proposals, and only at that point will we actually make any decision, and at that point, yes Sir, then you can judge us and see whether we've listened or not.

JR: *I'll hold you to that.*

DG: That's fine. I haven't got a problem with that whatsoever. I don't know if colleagues want to comment on the other bits?

SE: Just a brief comment, I'm going to ask John to comment on something that you said then, just to re-emphasise from the Foundation Trust's point of view and the same for the PCT, we're required by the Government and indeed by the Department of Health in public consultation to obviously listen to all of what's been said, and consider three factors in that in making any recommendations. The first one is considerations of safety and quality, the second one is are the proposals that you're putting forward affordable and the third one is the weight of public opinion, so those three things are the three factors that are weighed up in the consultation process.

JR: *(inaudible)*

SE: Percentage? It isn't a percentage ... it's a judgement against those three things.

DG: No, there are no weightings for those. Yes.

JR: *(inaudible)*

SE: Yes, but the only point about public opinion is that I think, you know, when you talk about the petition and what the petition is asking, it isn't actually putting forward the proposals that we're making.

JR: *(inaudible) you did not put forward a third proposal and that's the thing ... I think the thing that concerns people most is that it's all about one hospital being made worse, and two hospitals being made ... getting all the business if you like.*

DG: Yes ...

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JR: *No, can I finish please? That's the concern. If there'd been a third option on the actual written consultation I wouldn't be saying this, but there isn't, there's only two options and they're both about doing something that we dislike about Bishop Auckland and also what really gets my goat is, you mention it yourself, Bishop Auckland cost £67 million and we're still paying for it, and you've taken and taken and taken things away from it over the last 10 years, and that's one of the reasons you can't recruit.*

DG: Can I just make a comment on ... and I understand fully and we've had this at lots of meetings and lots of discussions, and I really understand where it's coming from but, whatever's happened for the last 10, 15, 5 years, yes it's important to people, but actually what we're looking at here is actually proposals to take things forward and it's hard, and I know I struggle with it as well, but we need to almost forget what's happened in the past and look to what's being suggested in the future.

JR: *But we would like better suggestions, we would like to make Bishop Auckland a better hospital by having the stroke unit, by keeping the other things there.*

DG: OK. Can I ask colleagues to comment?

JF: All I would say is I have heard what you're saying, you're a very angry group of people who are very upset and worried about what's happening. This is not an easy decision and it's not a straightforward decision, and clearly I don't feel that the message that I've been trying to get across is being heard which is that it's not as simple as having an emergency department on your doorstep, it's what conditions are treated in that emergency department and how many people get treated in that place, which is an equally important part of the equation about delivering the best healthcare, and I was going to pass to Diane to answer your ... about the other options.

JR: *(inaudible)*

JF: Certainly.

?: *This is very simple, how many people do you need at an A&E?*

JF: I can only answer that for children.

?: *Right.*

JF: But for children basically to be ideal you need around about 15,000 coming in a year, and there's about 12, 13,000 coming to Bishop Auckland at the moment.

?: *So we just have to get 3,000 more accidents then we'd be sorted.*

JF: Well no, the accidents are already going to Darlington.

DG: OK.

JF: Because there's not enough other facilities for the trauma.

DG: OK. I think Diane was going to make a comment and then I'll come to Sam and then there's a gentleman at the back we'll come to and then we'll come to you Sir after that.

DM: Just to make a quick point about the options. We've got two options in the consultation document but just to say that, you know, we've been getting through the process and getting to this point for nearly a year now and, as I think we've stated very clearly, the options have been developed by our medical staff, they've been led by our medical staff and our nurses and therapists, OK? Now the two options ... just let me finish please? Yes, we did listen to you ... where we started off, there were four groups of doctors and nurses actually looked at the options, we started off with 49 options, then we actually

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applied some criteria that we developed with patients and with stakeholders about whether those options were safe, whether they were affordable, whether we could actually just deliver them into the future, and then we developed some other criteria around patient benefits, and by using those criteria and applying those criteria to those options we actually went down to something like 22 options and eventually we got down to the two options that we've gone to consultation on. The options we're consulting you on are the options that we felt met the criteria that were set by the clinicians and by the Governors, elected Governors who were part of the group, and by 150 stakeholders who came to a meeting in May and validated those criteria. The options that we are left with are the ones that could be provided safely, affordably and actually be delivered, we know we can deliver these. That's where we're at, so you know we've actually worked through a very lengthy process to get where we're at.

?: *May I just ask (inaudible) and why did it just come down to Bishop Auckland?*

SE: Diane answered the specific points but you see I think there is an issue here, which I think I understand very clearly, the focus you naturally have is on Bishop Auckland. Our focus is on all our services, and, you know, these issues we're talking about, the changes we're talking about have an impact at Durham and Darlington, there are big changes proposed in those places too around how services will be organised and how staff will need to work differently, so our ... what we're talking about is what we think is right for County Durham and for Darlington for the future. Do you want to say something about the specifics about the people (inaudible)

DM: Just in terms of I mean of the 150 people there were 60 consultants at that meeting and the rest ... there were about ... I can't say off the top of my head how many from Bishop Auckland, but I can remember quite clearly some of our very senior clinicians from Bishop Auckland being there. We had a number of nurses and we had our Governors, we had elected members from Scrutiny Committees at both ends of the patch, we had a wide range of people, we had voluntary groups, we had the British Heart Foundation, Stroke Association, Diabetes UK, we had a good range of people at those meetings. We've got all of that evidence if anybody actually wants to see.

SE: We could provide you specifically with the details, who came from Bishop Auckland and Wear Valley to those sessions.

DG: OK. Thank you. We've got a question, Sam, thank you for being patient, a question from you now.

SZ: *Thanks David. Sam Zair, Bishop Auckland Councillor. I feel as if we're just going over and over and over again over the same things over the past few weeks but I make no apologies for this. I think we all agreed at Bishop Auckland consultation at the Bishop's Castle that older people are living longer, the population in South West Durham is growing and is expected to grow, and not only that, the admissions rates in the country are growing, especially in the North and you talk about planning for the future. All this is the future, and once again, to make my point is that you're taking services away instead of planning more services at Bishop Auckland to cope with all these three criteria's which I've just given you. But one final thing that I want to say is that I've just found out just this week, and I quote, this if from the College of Emergency Medicine, that some patients could be at risk because they attend NHS urgent care centres instead of A&E departments, that's what the experts have said, and also expressed concern, concern saying that they were ill thought out and being imposed for financial reasons. Now you talk of quality healthcare, I'm very very disturbed at those quotes and could you explain?*

SE: I'm sure we can.

DM: Just in terms of that report that's come out from the British Association of Emergency Medicine, yes. What the ... the urgent care centres that they're referring to, they've put it into a particular context, it's emergency care centres that have been set up specifically to ... what's the word? ... to deflect patients away from A&E services, that is not ... no, that is not what we are proposing to provide, that's about primary care led new developed urgent care centres, what we're proposing is something quite different, this is about ... it is something different, it is about reorganising our current A&E services and actually providing treatments for fractures, providing treatments for, you know, if people need suturing, and a

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range of conditions that would not be seen in the kind of urgent care centres that that report is describing. So it's very specific, we have looked at that report.

SZ: *I'm sorry but that doesn't answer my question and the cause of my concerns are ... the concerns of the whole (inaudible)*

DM: I mean in relation to the point about long term conditions and numbers of older people, we have taken that into account actually in the development of our proposals, all of those are actually issues that were considered throughout the process, and also linked to that is not about ... it's taken account of the older population, the rise in long term condition, but also the need to provide much of that care in the community because, you know, older people don't always need to be in hospital, they need to be in hospital for certain things but we've got to also see a similar shape to actually provide more services in the community which is what the commissioners are looking at and which we tried to look at as well, and we've taken account of that when we've developed the proposals and modelled the proposals, but linking in specifically to older people, the services that we're proposing about rehabilitation, you know, and recovery and intermediate care are services that will predominantly affect to the better the services that we provide for older people.

SZ: *So people in Darlington and Durham that get their operations, their planned operations, who come to recover, will they move them into Bishop Auckland to ...*

DM: If they need specialist rehabilitation they will move to Bishop Auckland.

SZ: *Well I can't see the people of Darlington and Durham being happy with that, I mean after their operations, after a few days, then pack their bags ...*

SE: Well obviously we talked to the people that lived at Darlington and Durham about this.

SZ: *... (inaudible) to Bishop Auckland, so I think in the long run I think Bishop Auckland is going to lose out big time which it has been losing out since the (inaudible)*

SE: That's just a comment.

DG: OK. Yes. I've got a gentleman at the back, I've got a gentleman at the front and then the lady at the back.

?: *Thank you. Last time I spoke to you I felt you cut me down because you said please will you get to your question, so I've got to weave a question into ...*

DG: OK, I'd appreciate that. I'm sorry if you thought I cut you down.

?: *Well I think you did, but even so, let me speak. I spoke at the rally on Saturday morning, I enjoyed speaking very much, we were there with 800 plus people who were of one opinion, now they were from all ... right across the political spectrum and it's a great pleasure for me to be in here tonight with Sam Zair and others, Eddie Murphy and so on. I'm a Labour Councillor, it doesn't matter what my description is, I'm from Bishop Auckland and we want the best for Bishop Auckland. What I did say to the people on Saturday morning was that this is a policy which is being projected, I would put it to you, from Government. I listed the services which have been cut from Kendal hospital in recent times and I ... the more I look at it, there is a national thing going on here. Hazel Blears' ... the famous photograph in The Guardian in 2006, December, was protesting about the possible loss of the maternity unit at Salford, you know, this is a national thing and you ... with Professor George Alberti, you have a very eloquent and a very persuasive gentleman leading your team. It does disturb me greatly to think that this is going on, it's not just Bishop Auckland, and I did say this on Saturday morning, it's not just Bishop Auckland who are going to be suffering here overall. Darlington is overflowing. We can't get parked down there, if you can get parked the parking charges are scandalous and it is overflowing, so I do think you touched upon the fact that it's going to cost ... there's going to be some investment in Darlington in order to make it work. Well we do have a*

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*beautiful hospital, architecturally it's superb, we have a smashing hospital in Bishop Auckland, we want it to be upgraded. Now I know that you're not keen on that ... on that term, but if someone uses the term downgrade you equally, you don't like using ... that term being used.*

SE: We are upgrading Bishop Auckland.

?: *But if I may continue ... do cancel out anything that I'm saying but I shall finish quite quickly. It was put to me that ... and perhaps, I was going to say, should I say this or should I not? It was put to me by a doctor and I can't say who, but it was put to me by a doctor who is feeling himself a little disenchanted with our system that this whole system is being run by accountants and administrators, but especially accountants, and on Saturday morning a friend of mine Derek Jagel stood up and said to the people this is about people, it's people first and accountants should come down the list. I would put it to you, is this process being run by accountants? There's my question. Thank you.*

DG: OK. Thank you.

SE: John's going to comment, the short answer is no and in fact the whole National Health Service policy is being run by a surgeon who is a Minister in Government, but perhaps John you want to comment on that and I will say something about the access and parking in a moment.

JF: I'm extremely cynical, I may well have been one of those doctors saying one of those things to you about national policy, but I can assure you this process has been clinically driven and I've been pleasantly and refreshingly surprised about how clinically driven it's been.

SE: Thank you John. Just on your point, I mean I agree with you, access is a big issue on the Darlington site and in fact, you know, on all sites to greater or lesser extent, but of course where the change is happening is around emergency care and car parking is not an issue in that regard because obviously emergency cases are transported to hospital by ambulance and, indeed, we do have very occasionally people who don't use the ambulance, who may, you know, come to the hospital with their injured relative or friend, you know, in a car and what happens, they come straight to the front of the department and the staff in the department get out there straightaway and get them into the hospital when that happens, so the access ... the access issue on emergency care isn't one that we're concerned about. We do agree with you though about the issue about access more generally because of the way in which, you know, cars dominate our lives and we do know that we need to do something about parking one way or the other in all of the locations that we offer services and we do have plans to do that and finally the transport arrangements that Roy was outlining a little earlier, obviously part of that's about reducing traffic into the sites and we are going to be running those services directly routing between hospital sites to try and replace some of the traffic that we currently have.

DG: OK. Thank you. Just say for the record I'm not an accountant. Gentlemen with a question there?

EM: *No, it's not a question. Councillor Murphy, Crook South Ward. I'm a member of the group of Save Bishop Auckland Hospital Services and all these people here are part of that. On behalf of the group I pass a vote of no confidence in County Durham and Darlington NHS Foundation Trust.*

?: *(inaudible)*

*(Group of people leave meeting)*

DG: OK. There's a lady at the back with a question?

?: *Well mine's actually irrelevant after what Mr Eames has just said, so I'm going to pass over to my husband.*

DG: OK.

?: *As everybody runs out, that's a good way to clear the room isn't it?*

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DG: You haven't said anything yet! But go on.

?: You know me too well!

DM: (inaudible) listening to the public...

AH: *Andrew Hall, Chairman of the Crook Community Partnership amongst other things and a long time member of the NHS but let's just keep that quiet. You mentioned about the Accident & Emergency services at Darlington, rubbish, right, I'm sorry but what you've just said was wrong, I'm very very upset about what you've said and the way you've said it, I did ... I was going to ask something about A&E and were you going to actually put investment into A&E at Durham and at Darlington and I think you haven't put that across very well at all. You've gone badly wrong with that, you're constantly indicating and making reference to Darlington, people who live in Durham, fine, use Durham, people who live in Crook also want to use Durham because it's quicker to get to. The problem is with your transport problem, you need to talk to the Council about getting the roads gritted because the other day there was no grit on the roads. I worked up at Eastgate for seven and a half years when Blue Circle was there, I know what the travelling is like. To contemplate the idea of taking anybody, and this is personal experience, who had an accident there to Darlington for surgery or assistance is wrong. I lost seven and a half layers of skin through an acid burn on my leg. The idea of going all that way with any means to Darlington is abhorrent.*

*We went to Bishop, we got sorted out, everything was fine, it wasn't as bad as thankfully it looked at the time, but anybody who lives at the Dales will probably want to go to Durham, you don't stress this enough, Durham is an awful lot easier for people in general to get to, it's quicker to get to than Darlington unless you're following an ambulance. I've experience of that when my father was rushed into hospital from outside of Tow Law, we got to Darlington in 15 minutes behind the ambulance with the lights on at 3 o'clock in the morning, and they did a great job, but if you don't mind just going back to Darlington .. my wife was in hospital earlier this year. She was kindly given a present she didn't want from Darlington Memorial Hospital which was unfortunately C. Diff. I had to take her down in the back of my car, she passed out twice on the way, because we were asked if we wanted an ambulance and we were told it was going to be about 45 minutes to an hour before they could get there, so I eventually thought it's quicker for me to go and take the risk. I arrive at Darlington, pull up outside the emergency centre. My wife almost passes out in the back of the car as I struggle to find a suitable wheelchair to put her in, ask somebody for a piece of help and he put his hands in his pocket and he was wearing a uniform and if I'd had the time afterwards I would have probably reported him on the spot, and he just said 'not my job' and then I had to leave her there whilst she was looked after by an ambulance driver for a couple of minutes, unbeknownst to me, because I had to leave her while I had to go and hunt to find a car park to come back and get her and then take her up to the ward. That's terrible service, no matter wherever you go.*

SE: I agree with you.

AH: *We did complain because a friend of ours happens to be on the Board at Darlington, part of it. I know people at Darlington, I didn't get in touch with any of them though. But I know that everybody I spoke to within the NHS thought it was absolutely horrendous and I've known people for 21 years from security ... this health authority down over and what you're thinking about doing, everybody knows there's got to be change, there's a lot of people don't accept it, but there has to be change, people who are in the business know that it's not an unending pot of money, but the way that you've done ... and if you don't mind me just commenting on this in general, with the whole consultation, you're so far up your own noses with the terms you're using, you've alienated the public, you've done it yourself. You haven't given them the correct options, you concentrate on Darlington, people who live here don't see themselves as related to Darlington, they see themselves as related to Durham. You've made a big boob with that.*

DG: OK. Thank you.

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AH: *I'm sorry if I went on a bit about that.*

DG: No, it's OK. And I think all of us would recognise ...

SE: I don't know if John wants to comment, I think that experience is terrible too and you know I wouldn't condone it and if, you know, if we knew who that member of staff was then they would be disciplined for that sort of behaviour, so I agree with that, absolutely, and we clearly wouldn't want to offer services of that type and I'm sorry that that happened to you and your relative. The only reason I guess we talk about Darlington is many of the people who unfortunately have now left talk about that all the time, so we're drawn to respond to that and I think your point is a very good point that you make about access to Durham, and I'm sorry that we weren't able to explain in the earlier conversation that we are going to invest in Durham in particular quite significantly to improve the Accident & Emergency service and critical care service and the facilities on that site for the reason that you say, but I would ask John to comment also on some of the things that you've said.

JF: Well I was basically going to say exactly what Stephen has said that, yes, I'm sorry for the poor care you've received, I'm sorry if it's come across that this is Darlington, Darlington, it may ... but very much I was expecting to come into Crook talking about Durham and Durham is very much where, as I understand the plans to be, is where we're investing in care and you will be going.

?: *(inaudible)*

DG: Yes.

?: *(inaudible) everybody says we've got choices, a lot of people now see what's happening and the way it's being handled and feel they haven't got any choice, because one minute your advertising nationally choice, choice, choice, and people generally don't feel (inaudible)*

DG: Yes, can I comment on the choice bit. You're absolutely right, yes, well no ... it's not a different thing, you're absolutely right, I mean people have got choice, in fact I live in County Durham, if I choose to I could have my knee replaced in ... I don't know, the Isle of Man or Bournemouth, or wherever.

?: *(Inaudible) taken to Darlington ... sorry, you're automatically taken to Darlington and for me who lives here in Crook, Durham is a much better option, you're never given that choice, I mean I know you say you want the quickest care you can possibly get and I understand that, but to be told if you're taking a relative into say Darlington and you know that it's actually better for you for visiting, for speed to get there and all the rest of it, I want my father in Durham, no we're taking you to Darlington, no I want him in Durham, because there's better buses, there's better ways of getting there.*

JF: You've caught us all looking a bit puzzled there, are you saying that if you call an ambulance in Crook you are taken to Darlington?

ALL: Yes.

DG: Right. OK, well I'll tell you what, as ...

?: *(inaudible)*

DG: Yes ...

SE: I'm not arguing with you, we just think it's odd.

DG: We're astounded as you can tell.

?: *You ought to be looking into it.*

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DG: As commissioners we'll take that away and we'll actually ask that question because I mean you can probably tell by the reaction that we're surprised that that would happen.

SE: We're not arguing with your experience, it's just that we think it's very strange that that's happened.

DG: Yes, but we'll talk with the people that actually manage the ambulance contract and just find out why that's happening, yes, it doesn't make sense.

?: (inaudible)

DG: Yes, OK.

?: *The treatment, I have to say, if it hadn't been for the fact he had the treatment he had down at Darlington at 3 or 4 o'clock in the morning when I'm standing in vomit because of the drugs, but that's another story ... if it hadn't been for the case of the treatment he'd had it would never have been discovered that he had a heart problem, it was ... it was stomach cancer and he ended up at John Cook and we're travelling and doing that from here, visiting every day, it's a joy when you're at work and come home and do that, but I mean I know that's specialist treatment, that was fine, there was no problem with that, and if you hadn't ... but we had no option other than from Toft Hill because they were up in a caravan, don't ask why, to go all the way through to Darlington. Now I work in Durham, fine. But if I live in Crook it's a quicker route to get to me, via a bus, my elderly parents who can't drive...*

SE: I agree with you.

DG: The best thing to do is, once we've finished, we'll have a conversation, if you give us the details and we'll just ask the questions to the Ambulance Trust because I ... on the face of it I don't understand why that's happened or is happening, so we'll look into that. Thank you. Thank you for raising it as well. We've got a lady there?

?: *Have you ever tried travelling from ...*

DG: Sorry, could you just say who you are please just for the ...?

Mrs?: *Mrs (inaudible), Tow Law.*

DG: OK. Thank you.

Mrs?: *Have you ever tried travelling from the top end of the Dale to Darlington as regards emergency care or anything? I have always been told the first hour of emergency is the vital one, it can take over an hour to Darlington and that is in good weather. You all know how narrow the roads are from the ...up the Dale until you get nearer to the likes of Crook. I don't think the Dale residents have been given a thought. Bishop is their nearest because Shotley was took away, so I think it's just been downgraded completely. The Dale is getting wrote off without a consideration.*

DG: OK. Is there a comment on the travel times?

SE: Diane will probably comment at first and then I will comment.

DM: Just to make the point about the hour, you know, the first hour being the most critical. That used to be the case, that's how kind of all the experts considered the best care would be provided previously that gets somebody to the nearest hospital and get their kind of treatment within the first hour. That's changed and that's changed because we now know through evidence that you need to get, not just to any hospital, you need to get to the right hospital with the right specialists and the right services so you then get the best care, and going back to the point we made about the ambulance service and the paramedic crews who are not just straightforward ambulance drivers, they've got additional skills, they've got a much higher level of training and skill, and they actually start your care and treatment the

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moment that they arrive to pick you up, so you know in a sense that first hour starts as the paramedic crew arrives with you.

???: *And how long does it take to get an ambulance?*

SE: Yes, John's going to ...

JF: I was just going to emphasise that, if I get knocked over in the car park after tonight, I don't want you to have a doctor looking after me, I want a paramedic looking after me, and it's because of the point you've exactly made, that it's impossible to get everywhere in the UK within an hour and therefore it's been the ... the ambulance service has upgraded to be much more of the Golden Hour delivery service and they're the people who are far better at it than me or anyone else sat in this room.

SE: Can I say, I mean you're right about ... about the communities in the Dales, about some of the difficulties you're talking about and we are concerned about that. We know that our proposals will mean for some people in the Dale, for some things, they would have to travel further as you're reflecting, but actually there's a lot of things coming back into Bishop Auckland that means there'll be less travel for those people than there has been hitherto, so there is a balance there. And on the point about emergency care, one of the things that we have to do with the Dale as we do all over the country, you know, where you've got relatives in remote communities, is we do use the air ambulance, the air ambulance was used I think three or four times last year, especially of course when the roads are inaccessible, so there is a service being provided, because you're absolutely right, on occasions, even for ambulances it's difficult to get where you need to get to quickly, so on those occasions the air ambulance is used. Now what tends to happen with the air ambulance is it tends to go to other hospitals than those in County Durham and Darlington because at the moment we can't facilitate, particularly Darlington, sorry to mention Darlington again ... but we can't facilitate the air ambulance landing, but of course the same principles apply that you will get immediate treatment on the ground from the crew on the air ambulance.

???: *Yes, but that is using someone outside, you're wanting the outside people to back the NHS up because they've cast the Dale off, oh well the air ambulance will make up.*

SE: No, no, I'm sorry that's not what we're doing, I think what we're saying is you have to have special arrangements sometimes for people living in communities like that Dale and it happens in other parts of the country, like in Cumbria, or in parts of the South West.

DG: Yes, colleagues are reminding me actually when I mentioned the extra investment that's gone into the ambulances for the Dales, that extra crew that's going in is actually in a four wheel drive vehicle. Now, alright, that won't always be able to get through the terrain because of the bad weather but it's about actually putting more safe services in there so people can actually get to you and give you the treatment.

???: *Yes, and what about these times when they're strangers and they don't know the Dale and get lost.*

DG: No, the whole point is, and one of the reasons it's taken a little while to recruit these people, is to actually get them so they actually have got that local knowledge, and actually what we want as commissioners is when they're not actually in the ambulance coming out and working as paramedics, they'll work from the community hospitals and work in community centres and they'll actually be stuck ... they'll be kept in the Dales, so they'll have that local knowledge.

???: *Yes, saying that, but you take someone all the way to Darlington, how does their relatives from up Wearhead, St. John's Chapel, get to Darlington and get back at night if they are not in possession of a car?*

SE: I was going to say ... the point we're making is that a lot of the care that you may have had to travel further for, you may have to travel further for now, particularly for older people, especially around rehabilitation, and actually for a lot of day surgery ... you know, most cataract surgery is for people

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who are older people. We're bringing that to Bishop Auckland, so it's nearer than it would be otherwise.

?: *I said what about the people you do take to Darlington though? To get relatives in to see them.*

SE: Well that's why we've looked at the transport services and we are looking to make sure that we improve that so it's easier to do that.

?: *Buses up the Dale, late at night. I don't think so.*

DM: Yes.

SE: Yes.

DG: Well, and in fairness, that's one of the things that I said earlier on, that what we'll be doing is actually listening to the issues coming from the consultation, we'll be using that to challenge the proposals when they come back to us and we'll be asking those very questions on your behalf. Got a gentleman at the back again.

?: *I think one of the things I hope you're going to look at is visiting times, I know it all links in with the transport system as well but I can understand why the lady mentions about trying to get down, depending on what ... a lot of wards in hospitals nowadays basically have a good open policy, obviously there's reasons for some why they can't.*

SE: Yes, that's right.

?: *And I think everybody understands that, you know, treatment times, meal times or ... well, I say meal times at Durham, but never mind ... or whatever it's going to work out at, you've got to have that sort of time when you come in and out and people know that, but it's always been I think a problem with anybody who's going to use the hospital outside, and see Durham as outside of our area, where if you go to Durham through the day to visit somebody who's been taken in as an Accident & Emergency person or whatever, you can go and visit, pop down the town, visit again, get your bus and travel up to Stanhope. That's not a problem. It's a different kettle of fish when you start talking about going to Darlington or Durham because the travelling would have to be very much integrated with visiting times to make it suitable for people.*

DM: Yes.

SE: You're absolutely right.

?: *And that I think is something again that probably because of the changes you're wishing to make and obviously you say there are going to be changes, that's something that's going to have to be seriously looked at as well, and I think if people knew they could jump on the 9 o'clock bus from Stanhope market place, get all the way down to Darlington, have time to go in and visit the person at the time that bus roughly arrives without having to sit around and try, you know, spend some money, then go in and see that person for a couple of hours, come out and be able to get on a bus and come home, then I think an awful lot of people would feel an awful lot more satisfied with what's happening, but I can understand why ... the transport situation, you're talking about Councils, you're talking about bus firms, all of that's going to have to be linked in and I think that to sell this you're going to have to have all of that there before you start to move with your changes, and if you don't sell that you are always going to have problems.*

DG: And actually that principle then, not just for transport, for a lot of it, some of the principles that we'll be looking at that actually you put the alternatives in place first, for that very reason, so people are reassured. I don't know if you want to comment?

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DM: It almost sort of makes me think that you're on the group that's looking at this ... because you're saying all the things that we are ....

?: (inaudible)

DM: No, I know you're not, but ...

?: (inaudible)

DM: No, the group ...

?: (inaudible) the average person ...

DG: And that's really helpful, thank you.

?: (inaudible)

(Laughter)

DG: It depends how small it is!

DM: All of the things you're saying are ... all the things that you're saying are things that we're looking at, we know that we need to do, it's the basis on which the East Durham Transport Link has been set up so that the services are actually linked into getting people to visiting times and back from visiting times, so you're absolutely right and that's what we're looking at.

?: And again people need to know (inaudible)

DM: Yes. Yes. Thank you.

DG: OK. Thank you. Any more questions?

?: Can I get some tea now?

(Laughter)

DG: I think you've earned it! Any last questions from anybody? No? OK. I'll just say a little bit about what happens now. First of all, thank you for your input, particularly those of you who actually stayed and asked some questions towards the end there. As I said earlier we've captured all of the issues that you've raised. Vaughan's been desperately scribbling them down as we've been talking, equally we've recorded all of this and we'll actually publish a transcript of the whole meeting, so everything that's been said will actually go onto the website so people can see absolutely everything that was said. The consultation process ends 12<sup>th</sup> January. What will happen then is the FT, Foundation Trust, will actually come back and they'll revisit their proposals in the light of the consultation and then they'll come back to us as commissioners at NHS County Durham, probably at a Board meeting at 3<sup>rd</sup> March we think it's going to be, and what they'll do at that point is actually present their case for change, present the proposals in light of the consultation and we'll then take ... you know, we'll listen to the proposals, we'll listen to all the issues from the consultation, we'll listen to what's come from the Overview & Scrutiny Committees and from some of the clinical groups and at that point we'll be in a position to make a decision as to whether the proposals go ahead or whether any changes are required or whatever, and I just want to stress that at this point the only decision that's been made and I know there's a lot of cynicism about but the only decision that's actually been made is to embark on this consultation process and that's only because our Board's been convinced that there's a need to do something and the consultation's about actually trying to understand what that something is, to get it right for local people, so your comments and input have been really helpful tonight.

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There are a number of ways you can get involved in the consultation other than the public meeting, and the public meetings are just a small part of the consultation ... there's a response form, some of the documentation that's there, there's a chance to actually fill the questions in and feed them into us, you can do that on the web, via the website, you can do a link from our website or from the Trust's website, there's also a specific website there, [www.seizingthefuture.org.uk](http://www.seizingthefuture.org.uk) ... there's lots more information on that website, more than we can actually get into the documentation there, so if you want to have a look there, have a browse, if there's something you think's not there, you need more information, let us know and we'll try and provide that for you. You can also fill in the questionnaire online as part of that. If you want to you can just write to the Freepost address and just write some free comments in. You can also email to the address that's there that we'll leave up for a little while, so there are lots of other ways of actually getting involved in the consultation. It is really important and, despite some of the cynicism and the comments that we've had earlier which I fully understand, but despite all of that, you know, we are listening, we need to listen to what you're saying, the whole process of consultation really as I said earlier is about some proposals for change and let's refine those proposals so we get the right answer at the end of it that meets everybody's needs.

Having said all that I just want to thank you again, I want to thank the panel and members of staff that have helped out this evening, thank you particularly for coming along, for putting your questions and for listening and just wish you a safe journey home. Thank you.

SE: Thank you very much.

DM: Thank you.

*(End of meeting)*