

**Seizing the Future Public Meeting
Darlington Arts Centre
Vane Terrace, Darlington
Thursday 13th November**

Representing the NHS

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Diane Murphy, Director of Nursing and Project Manager for Seizing the Future - County Durham
and Darlington NHS Foundation Trust**

**Bob Aitken, Executive Medical Director - County Durham and Darlington NHS Foundation Trust
Dr Katherine Noble, GP and Clinical Representative for Seizing the Future NHS County Durham
Sue Jacques, Deputy Chief Executive and Finance Director - County Durham and Darlington NHS
Foundation Trust**

**June Tulley, Director - County Durham and Darlington NHS Foundation Trust
Dr Robin Mitchell, Divisional Clinical Director for Support Services - County Durham and
Darlington NHS Foundation Trust**

**Achmed Darli, Consultant Obstetrician Gynaecologist and Clinical Director for Women,
Children and Sexual Health Division - NHS County Durham.**

DG: Can we make a start please, it's 6 o'clock, we are trying to start promptly, if people can find a seat please. Thank you, just a quick introduction then I have got a question to ask, my name is David Gallagher, I am one of the Director's at NHS County Durham, the PCT, we have got a colleague who has come along today who is able to offer a signing service for people, can I just check and see if anybody actually needs to use the signing service just so I can get people in the right place? No, oh well, thank you. I am assuming everybody can hear OK because of the rather loud PA system that we have got. OK, thank you for coming along tonight, it's not the best of evenings outside so we do appreciate you being here, as I said I am from NHS County Durham. This is a really important meeting, it is one of a series of meetings we are having as part of a consultation process which I will explain a little about in a moment but just to get cracking I'll just ask some colleagues from the panel here to introduce themselves and say who they are. So we will start with June please.

JT: Good evening, I am June Tulley and I am one of the directors at County Durham PCT.

CN: Hello, I am Dr Katherine Noble, I am an urgent care GP in County Durham and I am here as a clinician advising the PCT in Seizing the Future.

SJ: Hi I'm Sue Jacques, I am the Deputy Chief Executive and Finance Director at the hospital.

BA: Evening everybody my name is Bob Aitken, I am the Trust Executive Medical Director and in a previous life I was a consultant obstetrician and gynaecologist in the Memorial Hospital.

DM: Hello, my name is Diane Murphy, I am an Associate Director of Nursing and Project Manager for the Seizing the Future project.

DG: Thank you I will just explain, other than the obvious of you being able to hear by using the microphone and PA system because this is a formal consultation we are actually recording all of the preliminary discussion that goes on tonight so the microphone has got a dual purpose and I'll say a little bit about that later on. Just a few quick sort of housekeeping things, could I ask people if they have got mobile phones to either switch them off or switch them to silent please, just checked mine before I said that just so I don't get embarrassed. And we are not expecting a fire bell this evening so if there is a fire alarm it is the real thing, it is not a drill or anything, staff will actually escort people out of the building to the muster points should that arise, hopefully it won't. As I said this is an important evening really, an important set of meetings that we are having, I just want to explain a little bit about the consultation process which is very much about acute hospital services, so that is the bigger hospital services provided by colleagues in County Durham and Darlington Foundation Trust. As a PCT we actually providing funding for, we buy, purchase, commission, however you want to describe it, services from a whole range of providers across the county and across Darlington, and actually outside of the county as well for a range of services

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including community services, GP's, dentists, mental health services but also hospital services. And this discussion is really about hospital services provided by County Durham and Darlington Foundation Trust.

One of the things I want to do is just explain some of the roles we have got in the actual process that we have got this evening. As a PCT we are here really to actually lead the consultation process and ensure that everybody has a fair chance to have their say in the consultation process to make sure it is robust and it actually is listened to at the end of the day and I will say something about that as we wrap the session up. As part of that one of the things that we are really keen to do is to make sure that we try and focus people on two things, first of all this is about seizing the future and it is very much about the future direction and future configuration of hospital services. There is a lot of past history that we all know and we all understand but really if we can focus on what is being proposed for the consultation this evening that would be really helpful please.

The other bit is that we are having a series of these events across County Durham and Darlington and what we want to try and do is make sure everybody has their fair say. And that is very much about getting Darlington views and views of other people tonight and we need to make sure we try and get that as we move through proceedings. Having said all of that I will just explain quickly the process we are going into, I am going to ask colleagues from the Foundation Trust to actually do a presentation for about half an hour which is really setting out the proposals and giving some more information for people to discuss and then we will actually move you into some group sessions which will be facilitated by a number of colleagues that we have got from both the Foundation Trust and the PCT who are sat amongst you at the tables, that is a chance to do two things, one to actually answer some of the consultation questions that we have got to feed into the formal consultation process, it is also a chance to actually formulate some questions that we will ask the facilitators on the table to actually feed into the panel at the last section of it.

The last thing we will do is then open that up to sort of plenary discussions so we will have some open questions to the floor. This is very much about a two way communication process and what I would ask is that we can give a chance for colleagues to have their say and actually put the case forward and then it is a chance for us to listen to your views and to feedback on some of those, it is really important that we do that. I mentioned two players there, ourselves and the Foundation Trust, we have also got colleagues here from a company called Proportion who are helping us actually manage the process, they are doing a recording for us tonight, they will also make sure that everything we say is actually captured either written or via electronic means so that we have got a record of proceedings. Having said all of that I am going to hand you over to Sue Jacques who will actually start the presentation for us. Thank you Sue.

SJ: Thank you, I am just going to go through a little bit of the background in terms of how we have got to where we are today and some of it David has eluded to but I am going to give most of the time over to the Medical Director and Diane who is one of our nurses so they can take you through the clinical arguments because I think in this consultation it is those that are the strong arguments and it is those arguments that I am sure you will be very interested in hearing. If I can just get the technology to work! So really Seizing the Future is about ensuring that the hospital services that we provide right across our patch are fit for purpose and indeed excellent in the future. We have excellent hospital services now but we as a board have been convinced by our clinicians, the clinicians that you will hear from shortly, that to stay excellent we need to make some change and Bob will take you through the arguments that surround that case for change and also describe to you how by making that change we can actually really improve services for all of our population. In terms of some of the key messages I mean these are just some of the things that we know have been circulating, some of which are quite frankly not true, and I thought it was helpful to just knock those on the head sort of very early on. This review and Seizing the Future as hopefully you have all been able to glean from the documentation you have got is not about closing hospitals, we have no intention to close any of our hospitals, nor do we have any intention to make any of our staff redundant. The Seizing the Future is about strengthening our services, about providing a better working environment for our staff and about strengthening the services that you will enjoy as patients living in the local area. As well as that we have five main hospitals, three

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acute and two community and we are also looking to absolutely maximise the amount of activity and the quality of the activity that happens on each of these sites, so we see a really strong future for each of those five hospitals. We want to provide services as locally as we can, we know from a lot of the survey work that is being done both locally and nationally that patients want to be seen as close as they can to their own home, that is one of the government's main agendas and we believe that our network of hospitals helps us to do that, but also our services reach out further than our hospitals into patients homes, into GP surgeries and we see that as being really important in terms of moving forward and making our services accessible to you all.

There are some areas where we do need to centralise and need to centralise because we need to make care safe and we need to be able to meet and exceed the more and more exacting medical standards that are coming out of the Royal Colleges and I won't go into that any further because I know Bob is going to cover that in his presentation. And really everything we do ever in the organisation is aimed at providing you with the best possible treatment that is at the heart of every single decision that we make and it is absolutely at the heart of this consultation and we are really keen to hear, as David said before, in this session this evening some of your responses to what you have been able to read and what you will hear tonight. In terms of the clinical model that is proposed there are two options in the consultation document and both options revolve around having two acute sites, those sites being at Darlington Memorial Hospital here in Darlington and University Hospital in Durham.

At Bishop Auckland the plans include planned elective care centre and some rehab facilities, some enhanced rehab facilities, the likes of which we don't think really exist in the whole of the north east of England and again Bob will go onto to describe just how good we think they will be. We have two community hospitals that we own, they are Chester-le-Street hospital up in the north and Shotley Bridge and our plans would see an enhancement in terms of their position in their communities and some additional day case work in Shotley Bridge hospital in Consett.

This slide is a little bit busy but I think if I can just talk around it, these two slides are designed to show you where services are now and where they are moving to, and I have kind of just touched on that but if we can just take a little look. At the minute we have an A&E service, a restricted A&E service at Bishop Auckland and again Bob will take you through exactly what that means and we have acute medical services at Bishop Auckland and under the proposals those services would both be moved to Darlington and University Hospitals North Durham, and at Bishop we would see the introduction of more sophisticated rehabilitation services than we currently have. Paediatric services and again they exist currently on all three sites will be focussed and majored on the two main acute sites, that is Durham and Darlington but there will still be provision for outpatient care for paediatrics at Bishop Auckland and as I said before Bob can take you through that in a little bit more detail.

This really just shows the same sort of shift in services but from the Bishop Auckland perspective so we are seeing a concentration of our acute facilities on two main sites, those sites being Darlington and Durham and we believe by concentrating our resources the clinical facilities that we will be able to provide and the clinical outcomes that patients will get as a result will be improved from the current position and that there is a very important and healthy future for the services in the third site, Bishop Auckland, which will see rehab service introduced that will be able to get people into a more fit and Diane will talk to you about this from a nursing perspective in a second in a lot more detail, but get people rehabilitated quicker so that people can get back to their own homes as quickly as possible because we know that is what you, the patients and population say that you want. We need to change, and I'll hand over to Bob so he can take you through the case for change.

BA: Good evening again ladies and gentlemen, I am going to try and talk you through why I feel there is a very strong case for changing the way we are configured. And before we get into the details of the slide I just want to make sort of three points of introduction really I think are quite important to set the basis of one of which you know the rest of the argument goes on. The present acute configuration in County Durham is based directly on acute service with you that was

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undertaken by Professor Sir Ara Darzi in 2002, that is the same guy who is now Lord Darzi who is a Junior Minister at the Department of Health and who is basically leading the re-organisation of the whole health service. Now following that review and I think again you know Sue has alluded to one or two mis-conceptions that have been fired around, they have been in the local press, and I've heard them on the local radio, is that at present there is not a full A&E service at Bishop Auckland hospital. For the best part of ten years, in fact trauma cases, that is patients who are injured following road traffic accidents, they have not been taken to Bishop Auckland and in fact for about seven or eight years now, emergency surgery cases, people with ruptured appendix and that sort of stuff have not gone into the Bishop Auckland site and these have all been centred on Darlington. Bishop at the moment receives an unrestricted medical admission state, that is people who have got chest problems or medical problems, or heart problems that need investigation, and they will be blue light emergencies into Bishop, all other blue lights go into Darlington or Durham depending on what is the nearest site and the consultant present for the A&E service in the south of the county is actually based out of hours in Darlington so there is a restricted service at Bishop and that has been there for quite a long time. What I am going try and explain to you at times is quite technical and it is actually almost impossible not to be technical but I just want to try and explain at this point, two terms that I am going to use relatively frequently, it is to help you to try and understand but if there is anything you don't please make a note and I will try if you want, during the question and answer session and the facilitators during the group discussions will try and explain things better for you if that is required.

The first technicality and I just want you to remember one, two, three, yeah, and what I mean by that is if you take accident and emergency medicine and critical care emergency intensive care, for different reasons patients are actually classified into groups, a level one, a level two and a level three of care being required and thank goodness they did it this way as the level one are the least sick patients and level three are the most sick patients, yeah and that is significant as we go forward, just remember one, two, three and there are certain levels of care that we need to provide to support certain things going forward and these things have changed since 2002 which is one of the big drivers for change.

The second technicality is a term that I will use frequently as well called critical mass, now critical mass in two forms, one is if you are a specialist who is doing some highly specialised for instance, cancer surgery, there have now been recommendations made about the critical mass, that is the number of patients that a specialist needs to be treating in a year for example, to be allowed to be still be recognised and accredited as a recognised specialist in that field by the national bodies like Royal Colleges and things like that. But also there is a critical mass of activity, of overall activity, that is recommended for a team or a service, for example an A&E service or a critical care unit, to be seen in any given year, not only to allow that service to be accredited and therefore that we recognise to get enough experience to maintain their expertise but it is also there is enough going through to be recognised as a unit to be allowed to train junior doctors or new nurses or blah, blah, blah, blah. So that is quite important both from an individual point of view and from a service point of view.

So why do we need to change, let's get onto the slide, there have been since 2002 a number of national drivers for change that have come in and have been driven by the Department of Health or by specific Royal Colleges that have made us think about the way we are configured and are we meeting 21st century standards? These national drivers also modified to a degree by local pressures that we face within County Durham, now one of the big local pressures is that over the past ten years or so the kind of national recommendation, ball park figures here, is that a catchment area for a district general hospital providing full services was about a quarter of a million people, more recently that figure is getting nearer half a million, four hundred thousand, five hundred, for a good big district fully equipped, fully serviced general hospital should be looking at that sort of catchment area to get the level of expertise or the more specialist type of services that provide the specialist services to patients and because our population is very dispersed across a wide geographic area that actually gives us quite a lot of pressure that we have got to address to try and deliver the highest quality to patients to everybody as near as they possibly can and it is almost a physical impossibility to actually deliver it in all of our sites.

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Also the other local driver is there has been, we have had quite a bit of trouble and I will come onto it a bit later on is about recruitment and retention of suitable specialists and to certain of our services going forward so there is the amount of activity that we need to generate to keep the specialist experience going but also some of our rotas are quite small, small teams working and it is quite difficult to attract particularly new consultants into some of our hospitals. So specialisation can be in two forms, in the complexity of techniques that is there are certain techniques now have become very, very reliant on very sophisticated pieces of equipment, very expensive pieces of equipment, one of these would be for example, the modern management of heart attacks and that would be a good you know example to give you to show how services can change quite quickly. About sort of ten years ago the standard treatment for a heart attack would be to be shipped into a coronary care unit to be assessed properly in your local hospital and then be given the clot busting drug or for the technical term being thrombolysis, then it was realised well we don't really need to be a real specialist to deliver this care, we can train the paramedics and we can try and deliver that care nearer home, so at the roadside, at your home, paramedics come and get you, you do an electro-cardiogram, send it electronically to the CCU, Coronary Care Unit, they say give the clot busting drug and a paramedic does it and then low and behold we thought we are trying to get the treatment nearer the patient, and then low and behold some wizard develops a technique where they can with using special tubes and little wires and stuff, can actually through an artery either in your groin or in your arm, can go up through your circulation directly into the artery in your heart and take the clots out and put little things called stents in that actually is a much more efficient treatment for your initial heart attack but that is highly, highly specialised so in apart from actually going to the local hospital to have the treatment, having the treatment nearer home but now having to be shipped much further into very, very specialised centres in appropriate cases to get the best possible care. Critical mass activity is also very important for specialisation to maintain that level of expertise you can't just be doing one a month you have got to be doing one, two, three a week, yeah, and that really is one of the national directions to travel.

Now does it benefit patients, I have a bit of personal experience in this sort of thing, not so much on emergency care, but I was a gynaecologist as I said earlier in Darlington Memorial Hospital and my specialist interest was gynae-cancer, and that has been a lot of cancer surgery and then the national recommendation came out that it was in the patient's best interest for all the cancer surgery to be centralised in our area in Middlesbrough now I had already transferred some of my surgery across there because I felt personally I wasn't seeing enough particularly in cancer of the cervix, but I thought I was doing a lot of other surgery for example for cancer of the ovary and the patients were doing well, so with reluctance I went with the national direction of travel. I am now totally convinced because the figures show in the last eight years, ten years or so that the outcomes for patients who have their treatment centralised, now it would be an over simplification just saying it's about specialist surgery, it's about multi-disciplinary team working as well working with all the different specialists, but there is no doubt that specialisation centralising of care and highly specialised units is improving significantly the outcome for cancer patients in this country. There used to be quite a wide gap between our outcomes and those in Scandinavia and Germany and North America, now we are getting, every year we are getting closer and closer to being as good as the best. It certainly is in cancer direction of travel. George Alberti the emergency care czar for the Department of Health is actually convinced as well that there is lots of evidence now internationally and nationally that that same direction of travel should be adopted for emergency care, that we should be staffing our hospitals with multi-disciplinary, highly specialised teams and if needs be stabilise a patient by paramedic intervention at their home or on the roadside, get them in the back of an ambulance and get them quickly to a fully staffed, fully equipped accident and emergency department or even bigger than that a trauma centre nationally, because then even if they have got to travel a few miles further the outcomes for the patients are better. So better to travel a few miles further than go to the local hospital if you can get an appropriate care when you get there.

Next big one is doctors working hours and that takes two forms, one is primary legislation that is the law, European working time directive and mark parlance if you have heard of that. For junior

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hospital doctors in this country it has been brought in in three phases, the final phase of that comes in in August 2009 when the maximum number of hours junior doctors can work goes down from 56 to 48. For our organisation across the county it means we lose the equivalent of 31.4 whole time equivalent junior doctors. So that means that these guys are not available to man our on-call rotas out of hours. Now there are a number of ways you can actually do that you can have different members of staff, nurses working extended roles and stuff but there is no doubt that the most efficient way to do it and one of the best ways to do it is to reduce the number of emergency on-call rotas you have got and we need to look at that within the organisation.

There are other reasons that we will come to that makes a very strong clinical argument for reducing the number of acute sites but that is a very strong one. Second one and it relates more to recruitment and retention of particularly new consultants, is that young doctors these days aren't like the old codgers, like Robin and I who qualified more years ago than we care to remember, but the youngsters now and even the young consultants look more for, a thought and expression called work life balance, you know, particularly because a lot of the medical students now are ladies and ladies do what ladies do eventually and have families usually and then work becomes very secondary generally to the career and that does cause additional pressures when we are trying to staff hospitals. But even the young men looking now for much more leisure time that they can do rather than just being tied to the job all the time, so that is an issue that really does present us with sometimes recruitment retention problems because particularly in Darlington and Bishop Auckland our on-call rotas for the busiest services acute medicine are very small compared to say Durham or other hospitals within the region. Added to that there have been specific recommendations on a number of services and accident and emergency since 2002 what has happened, a new college, the Royal College of Emergency Medicine was formed in 2003/04, by the end of 2005 beginning of 2006 they were making specific recommendations about what staff should be available in a full A&E Department and what support services in the hospital should be there, what level of critical care support, what medicine, surgery, da, da, da, da, da. But more importantly they also recommended a critical mass of activity, the term I mentioned earlier, that you required to really be able to sustain an acute, a full acute A&E service. Within County Durham we do not have enough, particularly at level 3, the sickest patients, the badly injured patients who need, major initial major resuscitation when they arrive at hospital. We don't have enough critical mass in the county to warrant staffing three full level 3 full accident and emergency departments.

Acute medicine, that is, what do we mean by that, I mean patients who are rushed into hospital like the patients that I described who are going into Bishop Auckland now, with acute respiratory problems, the chest pains, do they have heart attacks, da, da, da, da, da, and there has been recommendation in the Royal College and generally in 2002 the acute medical tech was covered by general physicians who may be had a special interest in cardiology or what not. In 2003 the Royal College recommended recognition of a new sub speciality called Acute Care Medicine and we should recognise a new type of consultant called an Acute Care Physician who are specially trained to deal with acute medical problems across the whole gamut of medical conditions, not surgical ones, for the first 12 to 24 hours of their hospital stay. The model of care that was actually recommended in 2004 by the Royal College is that each acute site should have three of these acute care physicians and in the back shop when the patients were stabilised and had their 12 to 24 hours treatment in the medical admissions unit, should be passed back into a ward to a team of at least two ologists in the other sub specialities. That therefore allowed you restrictive leave so that no two, two sub, two cardiologists for example couldn't go on holiday at the same time. You always had a model of care where you had an acute care physician at the front end, 12 to 24 hours, they were passed onto the ward to the appropriate ward to an appropriate sub specialist because there was evidence that that care although the care of general physicians wasn't unsafe, there was a quality element to the care of seeing an appropriate sub specialist that was actually measurable.

In the county we are actually able to deliver that model of care in Durham and that is because we have got a big team of physicians in Durham but the situation in Durham is as a result of a merger of the acute medical units in Shotley Bridge and the old Dryburn hospital, so we have got more physicians there. We have also been able to attract acute care physicians on the ground and in the

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service of the county although we have got a few less physicians added together than in the north but because the two units are kept apart the teams in Bishop and in Darlington are very small and we have got a significant number of single handed ologists so when that lady or gentleman go on holiday we are left with no sub specialist in safer respiratory medicine, or cardiology in one of the sites. So we are really not delivering the 21st century model of care. Another issue is that in 2002 the critical care, the intensive care recommended support that was required for medical admissions, acute medical admissions was at level two, yeah, the recommendation now is that we should be, any hospital that is taking emergency care of any sort must have a full 24/7 level three service. Now the difference between level two and level three essentially is that we need to have, in a level three service, you need to have doctors that at night live in the unit, sleep in the unit, now we have not been able to deliver that model of care in Bishop Auckland. We do deliver that model of care in Darlington and in Durham. The Trust gave me a lot of money to prove this isn't about saving money, they gave me a load of money 18 months ago to find doctors to live in the unit in Bishop and we have advertised these posts about four times now and we have had one applicant who was appointable but he happened to replace somebody else that retired and we still have not been able to get to deliver the resident care that we require at Bishop Auckland, the resident level of staff. To the extent that for the best part of a year now we have had to transfer some of the sickest patients out of Bishop Auckland to Darlington or Durham to provide the level of care that would be expected in this day and age now that is not to say the staff at Bishop Auckland are not excellent from a nursing point of view and that are not excellent when required from a medical point of view but the pattern of care that we are delivering doesn't fit modern standards.

Critical care, I have already just briefly mentioned there, that the intensive care society made these recommendations in 1997, we have never been able to deliver them at Bishop Auckland but we were OK because the middle grade tier lived across the road from the hospital. These guys are now beginning to retire and we have got a serious recruitment problem to try and get the appropriate doctors into that area. We cannot deliver level three care and therefore if the recommendation is to take acute medicine in we in level three, it really is questionable whether we can continue to deliver a full acute service on three sites and incidentally the critical care was reviewed in Wales a couple of years ago and for the first time a recommendation was made on the critical mass that you were required to have a full level three service that was sustainable going forward and surprise, surprise based on those recommendations we don't have enough level three activity across County Durham to be able to support three level three units, so really one would have to say that the clinical case is very, very strong indeed for us moving to deliver acute care on two sites and not three as we have been trying to do up until now.

Children's care, paediatrics is a special case really and I feel a bit sorry for the paediatricians at Bishop Auckland because they, ten years ago, the model of care that they provided which was mainly consultants and very junior doctors and nurses, experienced nurses, was recommended as the gold standard of care across the NHS. It wasn't really universally implemented because there were issues, alright not all consultants really wanted to work in that way. Because of the issue about the way the culture is changing doctors and because we are losing people, retiring and moving on, we are finding it impossible to recruit a significant number of consultants to do these jobs to continue the model of care and the consultants themselves feel that we need to change that model. But it is not just us, if you look at European working time directive again, paediatrics generally is a shortage speciality for both junior trainees and for consultants and the ball park figure is that come next year if we don't make plans fairly radically now about 60% of the on-call rotas nationally will be none European working time directive compliant, so that will cause problems with junior doctors training. Not only that if the European working time directive applied to consultants, it actually does but consultants can choose to opt out of the European working time directive, but if it did apply to consultants about 25% of all the acute paediatric units in the country would have to close so it's not a problem we are just facing here, but it is a national problem, but it really is it's a nettle we have got to grasp going forward to deliver quality care.

Very briefly now I know I am rabbiting on a bit. Doing nothing is not an option and I have put that in inverted commas because I did mention a chap called Professor Sir George Alberti earlier

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on and George until recently was a Professor of Medicine in Newcastle University but now he is the emergency care czar for the Department of Health and he heads a thing called the National Clinical Assessment Team and once we had done all the work and came up with a model of care that we felt was appropriate going forward we invited George to come and review the work that we had done and have a look at the way we are configured across the county. His conclusion was that doing nothing isn't an option, we have to change the way we are delivering acute services. What happens if we don't get to make the changes, well the emergency contingency plans I say will not be new, it won't be something that I will be doing going forward, it is a thing that I've been doing for almost month on month for the past year, year and a half. Almost on a monthly basis I am faced with an impending crisis in paediatrics or critical care or in medicine, and don't get the idea that this is all about Bishop Auckland it is not, we face problems in Darlington particularly in the medical middle grade rota but most of the problems are in the south because in general in the north because of previous mergers, as I said earlier, the teams are bigger. No doubt in my mind that if we do not move and we cannot recruit there will be a decline in quality and the care that we are able to provide based on 21st century recommended standards and eventually if we are not recruiting and people start to retire that will impact on patient safety eventually. We talk about trying to reduce health inequalities, there is no doubt that if the second bullet point happens the third one will have a negative effect on health and equality, because our services will fold and people will have to travel further for the necessary care.

And finally, and this is the big thing for us, is that you might have heard of a thing called the Healthcare Commission, well that changes in April next year to the Care Quality Commission and the Care Quality Commission will be headed by a lady called Baroness Barbara Young, who I understand is a lovely lady I have never met her, but when it comes to deciding whether hospitals are providing high enough quality care she is a bit of a barbarian and we understand we will get about a year's dispensation but by 2010 if we are not meeting the national recommended standards our commissioners, PCT colleagues, will be told that the services are not fit to commission, they are not safe, they are not fit for the population. We face major problems if we don't implement these changes. That is all I have got to say, Di is going to....

DM: Be really quick....

BA: Be really quick....

DM: Because I think we have got about two minutes left OK. Just very quickly OK, why we really believe that what we are proposing is better for you. Sue touched on it right at the beginning, she said is what we're about is providing high quality care, every decision we make is about high quality care and we are trying to just sort of demonstrate here what it is about what we are doing which will actually really kind of improve the care we are giving. By reconfiguring the way in which we are proposing you will get better access to a specialist, that includes not just doctors actually, it includes nurses, OK, it includes therapists and all of the support staff that look after you. It isn't just the doctors who specialise in certain conditions, it's the rest of us as well and we are as important in your care. By actually reconfiguring being able to ensure you get to see a specialist doctor that will improve your outcomes in care, potentially reduces the length of time you spend in hospital but more importantly it means you get a better outcome of care, you are discharged in a better condition, less likely to be re-admitted because of problems and less likely or more likely to be better managed in the community, by the community staff, the community matrons and the GP's. Being on the right ward is about separating our acute patients, those who are kind of ill in a bit of an emergency or a crisis from our planned care, by separating that and doing much of our planned care on the Bishop Auckland site we can protect the beds for people who are acutely ill, we can make sure that if you are coming in for planned surgery there is less risk of your operation being cancelled because of that bed being taken up by an acute patient. We can better manage our beds OK. Better rehabilitation after being ill, mentioned about developing a specialist rehabilitation centre at Bishop Auckland, there isn't one in this area, rehabilitation is a large part of the care for many patients, it currently happens within acute wards but what happens in reality, you do get rehabilitated but if there is an acutely ill patient next to somebody who has been rehabilitated and that acutely ill patient needs care and attention, their needs quite rightly take

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priority over the person who is being rehabilitated. So there is something about, you know, making sure we have got people who are specialists in rehabilitation that is therapists, nurses, OK, it is a different kind of culture of care, it is allowing the space and time for people to be allowed to develop the skills to be discharged more often back to their own home, less people discharged into community support services and that might actually also include residential care or nursing care so returning more people back to their own usual place of residence with less disability and with less likelihood of being returned to hospital within a short period of time. MRSA a huge issue for you as members of the public, a big issue for us as well as a Trust, it's not just the MRSA there are other hospital acquired infections as well. By separating our planned care, OK, so if you are coming into hospital on a planned basis from our acute care and screening all of the patients that come in for planned care, we can ensure that if you are hosting an MRSA infection you can be treated and that means when you come into hospital we have got areas where everybody has been screened, those that were hosting infection are being treated and much less risk of you actually contracting an MRSA infection.

Quickly on travel and access, big issue for everybody, been raised right from the beginning, every public sort of discussion we have had, all our staff have raised it, our Boards have discussed it and we accept that this is a concern for people. The premise on all, with it underpinning all of our proposals is you will travel only where essential, so you will only travel to get to specialist care, OK, where you are actually needed to be in a centre that is supported by critical care and all of the back-up that provides. You will get your out-patients appointments, before and after surgery, before and after discharge at your local hospital, you will get your x-rays, your tests and all of your diagnostic procedures at your local hospital so travel on the basis only where absolutely necessary. Just quickly mention the role of paramedics, just to remember if you have been admitted to hospital in an emergency, your care doesn't start when you get to hospital, your care starts when the paramedic turns up at your door. Bob mentioned that in the context of managing sort of heart conditions, you know they are highly skilled people.

And lastly, in order to ensure that people can actually get around our site, patients, visitors importantly, and our staff, we are working with the integrated transport unit in Durham and we will be, we are kind of currently analysing which communities by household actually, will not be able to access our services within a kind of appropriate time frame and we will be investing in new services linked into the ambulance services as well. OK, thanks very much.

DG: OK, thank you. You have an opportunity to listen to the members of the panel from the Foundation Trust actually put their case forward, what we would like to do is move into probably the most important part of the evening which is a chance for you to have your say and your input into the consultation process. Two ways of doing that, the first way we are going to get into now is we would like to arrange you into groups around tables and have a discussion so one, we can answer some...you can feed in some questions and some answers into the consultation process but secondly, so we can actually ask the facilitators to get you to formulate some questions for the plenary session that we will move into after this. We have got a number of staff around the room, I will ask them to actually arrange you into the like sort of groups. We have got just over half an hour to do this piece of work and then we'll get some feedback from the facilitators, so if I can hand it over the team to actually arrange people suitably for this, thank you.

MEETING MOVES INTO ROUND TABLE DISCUSSION GROUPS

(General talking as people move around the room)

FEEDBACK FROM ROUND TABLE GROUPS

OK, thank you, thank you everybody, could I ask you to just draw your conversations to a conclusion please and we will do a bit of feedback and a bit of question and answers now.

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OK thank you ladies and gentlemen, I have just been asked, we have actually got two new members of the panel from the Foundation Trust, can I just ask you to introduce yourselves please.

RM: Yes, hello everyone, I am Dr Robin Mitchell, I am Divisional Clinical Director for Support Services for the Foundation Trust.

AD: Hello, I am Achmed Darli, Consultant Obstetrician Gynaecologist and Clinical Director for Women, Children and Sexual Health Division, County Durham.

DG: OK thank you. What I want to do is I am going to ask the facilitators from the tables to give me two key points from the discussion first, so it is more sort of feedback before getting the questions. Please rest assured though that everything that is being said, all the discussions being captured by the members of the staff on the table so we will take all that into account. What I don't want to do is get into death by feedback and if we do two quick points from each table we will then get around to the questions that you have been preparing. So I will start with the table here and Mark if you have got a couple of points to feed back please.

M: *Yes, the first point is well there was a lot of comment about after care and if you know if Bishop Auckland is going to work, the comment is that after care nearer to home and getting people out quickly and providing things close to home is very important. There was also another comment about parking fees on sites which are just too much. Another comment I suppose is about having a bit more, wanting a bit more detail about when surgery will go to Bishop Auckland and when it will go elsewhere.*

DG: OK, thank you, we will touch on may be some of that when we come to the round up. Can we go to Verna at the back please, sorry Amanda I know you are desperate to get hold of the microphone. Just a couple of key points in the discussion then we will come back for questions in a second.

V: *Yeah, I mean I feel a bit guilty because we have got about nine questions here but I think the view on this table certainly was that they weren't convinced by the case for change. Accepting that, although accepting that if it has been truly clinician led and it hasn't been influenced by national government policy or financial reasons then that would be fair enough but they are actually not convinced of that. And if either of the proposals go ahead it is going to cause real problems for people who live in the Dales for example, and it might particularly effect elderly people who struggle to travel anywhere, so I think they were the two key points, and loads to pick up in the questions.*

DG: OK, thank you, Amanda you get your chance now.

A: *Thank you. Our group broadly supported the case for change and also thought the fact that the actual options and the development of the proposals was clinician led as being very important. Another piece of feedback that we had was that the actual consultation process and the communication and websites, some very positive feedback around that so that is something that we have appeared to have improved on and we also have a lot of questions.*

DG: OK, good it is now time to get over to the questions. I think if we can start with Mark's table, we will do it in the same order, what I'll do is if you give us the questions one at a time Mark and then I'll hand over to the panel and I think if I hand over to Sue she might say who the best person to answer is, yes. OK!

M: *The first question is around the plan about travelling and travelling for patients and visitors, it is good to hear that there is a plan in place but when is this due to start and what will it look like?*

DG: OK, is that one for Diane?

DM: Thanks. So when is there a plan in place was that essentially the question?

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M: No when will the plan begin...

DM: When will it begin to start?

M: When would it start, yes.

DM: OK right. What we are currently doing with the transport unit is actually what we call mapping and that really means looking at how individual areas including individual households in particular areas will be affected by travel and journeys, OK. Now by doing that we can actually look at how many people are affected and where we actually need to put additional services in place, all of that planning is happening now and actually we have had some information today from that unit which suggests there are actually far fewer people affected than we might have initially thought in terms of journeys. We won't be implementing anything until beyond consultation because we are in consultation and the purpose of that is to hear what people think about our plans, now there might be some changes to the plans in response to consultation and if there are changes we have to kind of mirror that and reflect that in the transport solutions that I put in place so transport solutions would be in place if and when we actually got to the stage of implementing the proposals OK, but not before.

DG: Bob do you want to add something quickly to that please.

BA: Just very quickly to pick up from the clinical point, when we were actually developing and I think I can assure people that Diane, Robin and Ahmed I am sure can confirm that the development of the options have been very much clinically led and that is you know doctors, nurses and therapists and everything so people shouldn't feel that that hasn't been the case. But you take the transport and particularly elderly and stuff and we did when we were actually developing the options for how we were going to put things together and then trying to put the overall picture, we did some very detailed analysis on travel times based on postcodes which one, surprised me a bit the amount of travelling that was going on already, but two, when we did the analysis and we did it based on each site being the planned site and how it would work out and we chose the one that would be, had least effect, detrimental effect on the travel. Then we did a special piece of analysis looking at, what was it, typically under represented, traditionally under represented groups, so it was the elderly, it was deprived areas, and in fact the analysis showed that these groups following the changes were not significantly adversely affected quite honestly so we were very comfortable that we were...and it is good news today when Di has been to overview in scrutiny where the transport unit at the council have confirmed that our findings in fact that the effects on transport and travel aren't nearly as great as what we initially might have feared.

DG: OK thank you. Mark have you got....

M: The next question was the group appreciated that Bishop Auckland would be a centre for sort of planned care and things like that and operations but planned care is also mentioned for Darlington Hospital and University Hospital and other community hospitals so what would be the criteria, what would be done at Bishop Auckland and what would be done elsewhere and how do you decide that?

DG: OK Robin.

RM: Yes we have put a lot of thought into this one because there is quite a lot of evidence now about the level of after care that is required after different kinds of surgery, it is not just about the type of surgery that is performed it is a lot about the general health of the patient and to make a decision about an appropriate environment to have a planned procedure you have to take into account not only the gravity of the operation but also the general health of the patient and the result you get is a combination of these two. Now there is quite a lot of president, both in this country and abroad for planned surgical hospitals where there is not the full as we have planned for the two acute sites, the planned site would have a lesser level of support but we have to be content that the safety

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aspects are well preserved and the key to that is good procedure selection and good patient selection and patients will travel to the acute sites only where there is a very strong case for benefit as to why they should have to be treated on the major site as opposed to the planned care site. In addition to that it is not as though the level of expertise that will be applied because the doctors and nurses who will be providing that care will not just be those who work there at the moment, there will be people working from the two major sites so that people who are accessing care locally at the Bishop Auckland planned care site will have access to a much broader range of specialists than they would otherwise have.

BA: There are systems available in this pre-operative assessment, you can actually assess a patient and you almost provide a risk, this computer programme works out a risk calculation and will actually tell you whether they think the patient would be best operated on so that can get quite sophisticated and there are systems like that in operation in other areas of the UK, so you plan it before the patient comes in.

DG: OK thank you, I tell you what Mark just so we get a fair mix of questions from the different tables, we have taken two from you if we go to the back and get two from Verna and then we'll get two from Amanda and work our way around that way please.

V: *OK, I am going to try and combine a couple here because these were around options because there was no, there was an agreement here that they didn't agree with either of the options to be honest and that was because there hadn't been anything said about why Bishop Auckland couldn't be an acute site as opposed to Darlington or University Hospital. But that also led onto the fact that apparently at a PCT Board meeting in September when the Foundation Trust gave a presentation no change was given as an option so we are wondering why that is now being taken off the table suddenly and I guess relating to that is just a question have Professor Darzi's recommendations from the previous reviews actually been implemented and there was a specific question around haematology services for example.*

DG: OK, one for Bob.

BA: I'll take the haematology service first, Professor Darzi if you read the document didn't actually state categorically that Bishop Auckland should be the site for haematology, what Professor Darzi actually said was that Bishop Auckland could be considered to be the site for haematology but taking into consideration its very close association with cancer and clinical oncology services that Darlington may well be the best site to site it, the in-patient haematology service, and we had it reviewed and yeah we had a plan to move it to Bishop and we agreed on that, and that was 18 months ago, but coming into the acute review it was quite obvious that the in-patient haematology service needed to sit with the acute medical unit and that is why we took a decision not to move it at that time because we needed to see what the result of the outcome of this was, so that's the haematology. What was the other one Verna?

V: *OK...*

BA: Why could Bishop....

V: *Why can't Bishop be considered as an acute site?*

BA: Yeah, yeah, well I think the clinical case is very strong that we should have two acute sites in the county and one support site and we did a lot of detailed analysis to try and work out which should be the planned site, now some people have said it was a forgone conclusion because we were winding Bishop down and we have to be honest and say if Newchurch who did a review in the mid 90's and the other reviews that have been done around emergency surgery and trauma are taken into consideration, if they did the type of analysis that we had done and populations hadn't changed very much then we would come up with the same conclusion. But the Board wouldn't accept that we had to go and do the analysis and we looked at it on three ways, one was the amount of travelling that needed to be done for the patient, we have already eluded to that you

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know looking round about that there were more patients needed to travel around if Darlington or Durham were the planned site than if Bishop was the planned site. The cost of actually developing Bishop as an acute site, if you take the build that would need to be put in, because Bishop is a smaller site, and if you made it one of the acute we needed to put additional ward blocks etc in and if you took the capital cost of actually taking say if Darlington was the third site and therefore Bishop was going to be one of the other sites, the cost was about £120 million. If UHND was a third site the cost was about £80 million to have met capacity but if Bishop was the third site the cost that we are proposing at the minute would be about £7 million to actually implement measures. But I think the most important one for me was as a Foundation Trust we need to look at our business and we have got to look at our sustainability going forward. Because our major conurbations Darlington and Durham are at extreme ends of the county, there is a danger that if you make one of them the planned site and take away the acute service from that if you analyse the postcode of patients and say then that brings neighbouring providers closer to that patients home so there is a risk that you will lose activity that we are presently providing. And when we did that analysis if Darlington was the third site there was a potential of losing, what we call spells of activity, that is patient episodes that come in that we actually generate our income from under a thing called payment by results, we would lose about 9,000 spells of activity, that would cause us potentially quite a significant financial pressure, right, and you know may be even threaten our sustainability going forward. If Durham was the third site we would lose on analysis potentially about 22,000 spells of activity now that might well render us unstable and non-viable going forward. When Bishop was actually analysed as being the third site, the potential was a small, I think it was about 300, 350 spells of activity so really that in itself, the travel, you know the business side, the cost, made it a very strong case that Bishop should be developed as a third site. We also looked at our own staff, you know the skill levels, whether we could redeploy and how many general numbers of staff that would be affected and if I say that if Darlington or Durham were the third planned site then it may well affect about a 1,000 members of staff on each of those sites so we would have to move to work in the acute side of Bishop and when you looked at it the other way around there is about 100 members of staff that we may well need to redeploy from Bishop to Darlington and Durham so on every count that we did, and we did lots of detailed analysis, it was pretty obvious that Bishop should be the planned site.

SJ: And I think just to add to what Bob has said about the numbers which are true in the way that if Durham or Darlington were the third site we'd lose more activity, he is right we'd lose money but I think more importantly we'd lose the critical mass of patients that Bob is describing so actually the money aspect is a secondary aspect and what we would have is collapse of clinical services across the patch because we wouldn't be able to attract clinicians and we wouldn't have sufficient numbers for our clinicians to be skilled in dealing with the numbers that the Royal Colleges are recommending they deal with so it's actually very much wraps into the much more important aspect of clinical argument.

BA: It's interesting the Finance Director (inaudible)...

DG: I think there was also the question Verna, Verna was there also the question about doing nothing not being an option?

V: *The final part of that was apparently at a Board meeting in September no change was considered to be an option and now it's suddenly off the table as an option.*

BA: Quite honestly it was never really considered as an option going forward but we had a bit of a discussion and it's whether it should be put in the consultation document as this is where we are now and it was a comparison of the services going forward but certainly it was never put forward officially to the PCT as an option that we would favour going forward. It is, it is, it is, it is quite frankly not deliverable and George Alberti has actually confirmed that.

?? (Inaudible)

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DG: I think actually one of the....and it's a bit about the process that we have too date, the Foundation Trust have come to us in essence trying to convince us as commissioners that there is a need to do something as the case for change that we have talked about.

?: *The problem with that when people specifically and you have just said, you've just told a lie (inaudible)....*

DG: Can I finish sir I am just going to explain why you have probably got that view.

?: *Because I heard it.*

DG: Can I finish please. What we have then done, we have been convinced that there is a need to do something and as commissioners and the people who buy services on your behalf we would actually be negligent if we have been given a case for change that we, I think we understand there is a need to do something, the consultation is about what is done and therefore to actually say doing nothing is an option in the consultation would be unfair because we would actually be, it would be remiss of us because actually if we didn't do anything having listened to the weight of evidence that has come to us and then a year down the line, two years down the line services actually fell over because of that we'd be letting people down so that is the reason the consultation document says that it is not an option to do nothing. The key bit about the consultation is in light of that what actually needs to be done. I understand your views but can I come to Amanda's table first for questions from that table and I'll be coming back to this table in a moment.

A: *Thank you. The proposals talk of rehabilitation care, where will residents in Darlington receive their rehab care and can you tell us more about how these services will be provided?*

DG: Is that for Diane?

DM: Thank you. For a lot of patients actually their rehabilitation will be part of their stay on, you know on the acute site OK, so for a lot of people they will come into hospital, their immediate care will be managed and it could be a very short period of rehabilitation and discharge home, OK. For some people, for some groups of patients they actually need much longer periods of rehabilitation and specialist rehabilitation and that links back to the better outcomes, now the types of patients that we are talking about, they types of conditions that would be affected are patients who have suffered from strokes who as probably many of you will know sometimes require a number of weeks of rehabilitation, patients who have may be had an amputation, patients who have had a significant fracture in the elderly, so you know if you have kind of fractured your hip and major trauma patients, so it is people who need much longer periods of rehabilitation OK, so there is a front end, the short end, which is probably you know up to a week that could be provided in an acute site, but after that actually the type level of rehabilitation that can be provided in an acute site is actually very second rate rehabilitative service and as I have said before by moving people into a specialist centre for rehabilitation we will get significantly improved outcomes for patients. OK, thank you.

A: *OK thank you. Would you like me to.....*

DG: Yes next one please.

A: *Have trade unions been involved in discussions about how this may affect staff, specifically what have the staff used from Bishop Auckland general been on the proposals?*

DG: Thank you is that Bob?

BA: I haven't been directly involved with discussions with the trade unions but I know that the representatives have sat on the steering group for developing the models and the plans for seizing the future have been regularly discussed at the joint consultative committee which is where the management and the unions discuss these things. There have also been staff meetings where we

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have invited people to you know come along and share their views about how we are going forward and I have personally attended at least two of these in Bishop Auckland where there have been concerns and the concerns are understandable and you know we are trying to reassure people that there is a strong future for Bishop Auckland, that will be different you know in the shape of services provided but as Sue said in the first light there is no plan, and there was a worry that there was a plan to close things down, there isn't, you know the role of the hospital within, from a strategic point of view, within the Trust is extremely important going forward, it is a different role from what it has had in the past but nevertheless an extremely important one, but we understand there are concerns amongst the staff and we are trying to address that.

?: (Inaudible)

DG: Can I just ask you to use one of the mics please just so that we can get it recorded.

KH: *Hi, yeah, my name is Kevin Hull, I'm a Staff Governor and I represent the ancillary staff, porters, domestics, works department and people like that. We don't have many staff, I don't represent many staff at Bishop Auckland we only have got a few staff there but I have had queries and I do have people coming to me raising concerns about what the future holds for them and all I can say is I think the future looks better, I think these improvements, or what we intend to do, or should I say sorry about that, the changes are both good and a long time in coming. I think it is going to protect people's jobs, I think it is going to be more of an investment for services and basically that is what I tell people when they come and see me. I have people from Darlington come and see me all the time. Shotley Bridge, I have contacts with Shotley Bridge, I pass information onto them and I think things are looking good for Shotley Bridge and things are looking good for Bishop Auckland.*

?: *What about the general public Kevin, tell us about that?*

KH: *About the general public.*

DG: Sorry can we keep that as a question.

KH: *From an ancillary point of view I can't really discuss it because that is from a clinical area, I am speaking on behalf of the staff that I represent at Darlington Memorial Hospital, Bishop Auckland and Shotley Bridge.*

DG: OK thank you. The question on the public bit we'll come back to it when we come back to your table for a question. Can you...do you want to keep the microphone on this table and have you got any more questions on this table Mark?

M: *My question is that nothing has been said about children, are they going to be transferred to Bishop for treatment or will they have to go to Darlington Hospital?*

AD: Children service is a very difficult one, I think as Bob highlighted we cannot recruit, we have got about five or six consultants that are retiring over the next year or two and we cannot recruit. What will happen is that the acute service for children will be at Durham and Darlington, there will be a day service and urgent, type of urgent care for children that is referred by GP's that children want to be seen. There will be more expertise during the daytime but out of hours all the urgent care will be in Darlington and Durham.

DG: Thank you, is there another question from that table?

?: *Could I just make a point.*

DG: Can you speak into the microphone please, sorry.

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?: *I'd just like to make a point the gentleman at the back said there was an option one and in the newsround which I have got here there was an option one and it does say it was for comparison, you had to keep option one in there, and I think there were lots of options and then you discussed it and brought it down to two is that right?*

?: That's correct.

DG: OK, thank you, was there another question from the table?

M: *It's just this is the last question, I know it has partly been answered about the rehab that will go on in Darlington on the ward but will there be specific rehab beds in Darlington or is it part of the recovery on the ward?*

DM: No there won't be specific rehabilitation beds in Darlington, it will be as it is now, it would be within current wards, current acute wards which is why it is not specialist, and the way to actually make it better is to make it specialist and you know what we will be doing, we are not just kind of moving it, or planning to move it over to Bishop Auckland it is actually move it, give the staff the opportunity to develop even further specialist skills and to invest in additional therapists so we actually move from services that are not just within a very specialist area but are currently only provided, you know so if you have had a stroke for example, or your sort of fractured femur you will get physiotherapy Monday to Friday, but over a weekend you won't get any physiotherapy or therapy services, we will be investing so we can provide the service over seven days, much more intensive, the whole kind of ethos of the ward is about enabling people to move towards self care, yeah, so it's a specialist service, we can only provide it once, it's resource intensive, it's the same principle as doctors specialise in, people have to be centred in one place, there is huge amounts of evidence, OK, researched evidence around quality of rehabilitation linked to kind of the development of specialist teams so again it kind of links back to the evidence and what is recommended.

DG: OK thank you. Verna if we come to your table do you want a couple more of your questions please?

V: *Yeah, I guess the next one we'll pick up on this issue of consultation and we have got a few here, first of all there is a perception that this was almost a paper exercise and it's been manipulated to suit us to be honest and then related to that is have GP's been consulted on this and are they in agreement and where is the evidence of that, can we see some evidence of that. Similarly, have all staff and clinicians in the Trust been consulted and again can we see some evidence that that is the case and where is it and the final one related to that is around how much consideration will be given to the views of people local to the Bishop Auckland Hospital who will probably have the most to say about it?*

DG: OK, I'll take the first and the last of those because they are about the process for the main consultation and I'll ask colleagues to talk from the FT's point of view. It is not a paper exercise, the only thing that has been decided thus far, and I stress the only thing that has been decided is to actually launch this consultation exercise. Nothing else has been decided, nothing will be decided and I'll say a little bit about the process when we wrap up towards 8 o'clock so I just want to reassure people of that. In terms of, what was the last bit again Verna sorry.

V: *Well there was this, oops....*

DG: It was the last point.

V: *The last point was about how much consideration will be given to the views of people local to Bishop Auckland.*

DG: OK, yeah, yeah. Consideration will be given to a whole range of things, one of the points of having a consultation is that we actually listen to views right the way across County Durham and

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Darlington, that includes all of the county because we need to do that. That is part of the evidence that we will listen to, we'll also listen to evidence from the Overview and Scrutiny Committee, we'll listen to national evidence as well. Ultimately when we get to make a final decision back into February, probably March of next year, I'll touch on that a little bit towards the end just in terms of next steps but if I can ask colleagues just to talk about the specific bits.

SJ: If I take the one about have all staff been consulted, staff have been consulted in a number of different ways from way before we started the consultation exercise but staff will also be listened to as part of the formal consultation. We have had meetings within the organisation at various locations, various times, so that staff in pre-consultation can come in and contribute and actually develop the options because these options have been developed by our clinical staff, they haven't just been dreamt up, so staff were very much at the very conception of the need to move forward which was back in February of 2008. We also have staff on all the clinical groups that have been working since February in developing the detail of the options and on the steering group that Bob chairs that looks at how we pull those options across the different clinical specialities together to make something sensible that will markedly improve healthcare provision for all of the area that we serve so I would say yes we have had staff heavily involved right from day one because this has been developed by the staff, we have had open meetings, we have had comments earlier about the accessibility of our website which is available to all staff, it is on our intranet and we continue to involve staff and continue to have staff involved and engaged in all the key committees that are associated with this exercise. And I will pass over to Bob because we have also been talking to GP's in pre-consultation and post but he can give you a bit more detail.

BA: I mean part of the process is that I have chaired the clinical reference group so we have been tasked with pulling together the various models of care that were being recommended by the four service strategy groups that were led by the guys and a couple of colleagues. On my group there was a GP representative of the local medical committee for County Durham so and he has been feeding back regularly to that committee. Diane and I went and talked about our proposals to the committee that have representatives from every practice, the site potentially in County Durham and our area of GP's and the vast majority were supportive of the direction of travel, there were one or two decentres I have to be honest and say that. We have also spoken to GP groups in Darlington and Durham Dales personally and in Durham and in general there seems to us, or what is coming across to me, is an overwhelming support for the direction of travel.

DG: OK thank you. Amanda were there some questions from your group, oh sorry, sorry.

AD: *I can speak for my division and we actually had lots of meetings in the build up other stuff and out of hours all different places, different times to make absolutely sure that all the staff are included and the queries answered. At the moment actually we all practice across the sites still, I mean we all as clinicians I would love to use the facilities at Bishop Auckland but Bishop Auckland is not big enough for all the services we need to give. The new stuff is very good and we have been going there, and the patients have been going there for a good few years now actually.*

DG: OK, thank you.

?: (Inaudible)

DG: Right I think Bob did mention, did mention Durham Dales GP's but....

BA: I did speak, we have been to see the Durham Dales GP's, we have visited Stuart Finlay, what's the....Bishop Gate Medical Practice twice to speak to groups there and yes there are one or two decentres on the way forward but the majority of people around the table, certainly when I've spoken to them, have been supportive of the planned changes.

DG: OK thank you, Amanda.

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- A: *Thank you. Will these changes save money or can you tell us about the extra investment which will be made in Darlington Memorial to ensure these services will be provided to a high quality and can you talk about staffing and facilities please?*
- DG: Is that one for the Director of Finance?
- SJ: The proposals we have got don't actually save any money, we believe that ultimately they will lead us to being able to provide efficient clinical services moving forward but it is really about reallocation on the kind of revenue side, the day-to-day money, and investing in some of the areas particularly around rehabilitation. In terms of the future of all of the hospitals what the proposals do is give a really strong future for each of our five hospitals and develop the centres of excellence and in doing that particularly referring to Darlington given that is kind of the basis of your question, Darlington does need some investment, it would need investment regardless of seizing the future in terms of some of the infrastructure but it will support and consolidate the need for hospital in the largest conurbation that we serve as was described in the opening presentation, and we are earmarking some money for investment in Darlington Memorial as a result. In terms of the...there will actually be investment on each of the three sites, in terms of the numbers the initial changes that we'll need if we are successful through the consultation will be about £6.6 million and that is split between Durham and Darlington with a small amount at Bishop Auckland but the infrastructure work at Darlington Memorial which is all the kind of stuff behind the scenes, the electrics and the water and things that just need upgrading would need to be done anyway and that will be on top so it's you know seizing the future consolidates the need for that hospital but actually the investment would be needed however the consultation transpires. Does that answer?
- A: *OK and probably linked to that is this proposal sustainable in the long term and not proved to be a waste of public money in the future?*
- DG: Who wants to take that? Can we keep it brief because I am conscious we have got a few more questions.
- SJ: From all the work that we have done we believe this is absolutely the right direction clinically, but also from a business perspective the analysis we have done we believe it is the strongest option for us moving forward.
- BA: I mean being brief on a question like that with the Darzi review of the health service and the north east having to prepare plans as to how we are going to take things forward with maternity services and acute children's services you know there is no guarantee that we are going to be able to stay the way we are proposed to be configured forever and we have got to constantly horizon the sky and look at what are the recommended national recommendations for standards, Baroness Young is going to make sure that we do precisely that, and I can't guarantee that we won't need to change again in the future but at the moment for the future, the next five to ten years of our organisation in maintaining a really sustainable strong future has to go this way, yeah, and I do stress this thing about money, if you just think of, even if we had enough money to put in the models of care, the number of acute care physicians, the number of ologists into both Darlington and Bishop Auckland then, and try to get care to level three, we don't have enough critical mass. The reason some of the services were moved before the trauma and the acute surgery was about training of junior doctors, it is only in medicine that we have training recognition and if we try and continue with not enough critical mass to train them we lose that recognition as well. So to sustain the training within County Durham we really need to consolidate our acute services.
- DG: OK, thank you, does that answer the question, Verna is there another question from your table? We have got about three or four minutes left so again if you can try and combine questions that would be helpful.
- V: *Yeah, well I think this next one was actually relating to the one that has just been asked because again it was about reassurance in terms of if these proposals are agreed just how sustainable are they, because just a few years ago Bishop Auckland was hailed as a flagship hospital and here we*

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have Darlington Memorial which is an old tired building, can we be reassured that in five, six years time we aren't going through this whole process again and swapping.....

DG: And has that been answered by the previous answer?

V: *Has that been....yeah we're OK with that one, yeah OK right.*

DG: Thank you.

V: *Yes, so perhaps the more important question is actually can these proposals be implemented and what are the timescales for the implementation if they are agreed?*

DG: OK is that Sue, Bob?

BA: If we get the go ahead straight through the consultation then I have been you know trying to look at how we would implement things and Diane and our team I have been working together. We would like to think that we could have all of the services reconfigured within a year to fifteen months from now so by Christmas time of next year we would like to think that we would be in a position to deliver.

DG: OK, I'll come back to Amanda for one more question from that table and then we'll come back to Verna for one, probably final question.

A: *Sorry guys I have to do eany meany on this one but we will put the questions and the actual feedback. Can you tell us a bit about the background to the development of these options, how long has this part of this process taken and how many options were considered originally?*

DG: OK, that's one for Diane, makes me walk again.

DM: How long do you want me to talk for, short David says. OK, well we have already heard that we started developing the options back in February through four clinical groups led by four of our doctors and each of those groups came up with, were given a blank sheet of paper and asked to kind of see how many options they could come up with to actually meet the needs of recommendations and to meet best practice. In total at the very first cut we had 49 options, 49 options, but they weren't joined up, you know with individual services coming up for how their service could deliver their option, now the options have to join up, services depend on each other so we short listed those, we used safety, do-ability, which was could we actually achieve it, would we actually be able to implement in a reasonable timescale and affordability. And on the basis mainly on the basis of safety we ruled out many of those options and got those down to 22 options and then we grouped them together into how it would look for services and we kind of just kept filtering through a series of criteria which initially were affordability, clinical safety which was probably our top one and do-ability but then at the end we actually used a series of benefit criteria which included a better patient experience, better patient outcomes, travel, impact of travel and things like that, to actually get down to our final two options. So 49 was the....

BA: Just to explain because I can see some eyebrows being raised in consternation. Why would a clinical team come up with an option that wasn't safe, I can see you asking yourself, and what it was, was the clinical teams were asked to say just you think inside, not outside your box, just inside your own box as how could you deliver. What my groups job was then to look at how these various services fitted together in the hospital because there are certain things that you would need to do, you know to deliver in critical care, so if you asked the surgical team to go and they could do this, this, and this and this, but I needed to ensure the anaesthetic team were coming up by putting the appropriate services next to that to support it so when you put the mosaic together it took a lot of the options out because there wasn't the appropriate co-located support service. So these 49 when we modelled them the first time it came to, if you looked at patterns of care across the whole county, there were only five options came out of that first when we put the 49 pieces together.

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DM: Sorry, can I make one point just to finish this response I think the other thing that is really important people know is that we have got 39 Governors, the majority of which are publicly elected and the represent the whole area that we cover and we have got 4,000 members, and the point that you know it is really important that we share is that when we were coming up with these criteria, this wasn't even just the clinicians, there were meetings and sort of days out with the members and Governors so we were listening to what other people, the people that we serve thought were the right criteria and we used that to develop this ranking and I think it is just an important point to make.

DG: Can I...does that answer the question for that table, yeah OK. I am afraid we are going to have to come for one last question from Verna's table.

V: *Right, OK, well one last question, but just to reassure people on the table the questions are recorded anyway so they will be included.*

DG: I was going to say something about how we will handle that towards the end.

V: *So don't worry, but this was an interesting one, apparently there has been some discussion about whether or not to delay the introduction of the final part of the European working time directive because of the global financial crisis and if that does happen does that mean these options could, might change?*

DG: That is a fantastic question, I'll be fascinated at the response.

BA: It is a fantastic question, it's a real good one because I haven't heard that I have to admit, I would say that the European working time directive is one of the drivers. Yeah, I think it is one of, if you look at the independent recommendations for different colleges it is one of many drivers, it is an important one but I would really feel that the quality standards that we are actually trying to deliver would mean that even if the European working time directive didn't come in there would be a very strong case still to move, right. There might not be the urgency because we have got teams working on that at the minute is what precisely do we do in August if we are trying to implement, if we get the go ahead I am talking about Christmas but, so there are issues we have got to deal with but I would think no matter whether it is implemented next year or not it will be implemented and we would be daft to delay.

DG: Thank you, thank you all for your comments and your input, Marianne is it going to be very, very quick please. OK yeah.

MS: *So everybody knows I am Marianne Swift, I chair Health Scrutiny for Darlington Borough Council. We have been consulted by Steven, Edmund and Diane for the last year, we have had monthly meetings with them. When the consultation started we had our first health scrutiny meeting, we listened to the proposals, the background of them, and the decision of the health scrutiny at that time was to wait to hear the views of the residents of Darlington and reconvene at the beginning of January when we had heard those views and concerns. We had a gathering of our local strategic partnership on Wednesday which was very successful around there.*

We are meeting, our full council meets on the 27th November when Seizing the Future is on the agenda and will be debated. The views I have had from members of the public, from meetings and fellow councillors who have been involved with the pre-consultation meetings is the proposals are sound and we would like to urge residents of Darlington to respond to the consultation in whatever way they feel fit to do so, either by letter, filling the form in or on the website and support option B, so through all these consultations there has been a major concern and I think Bob has actually eluded to it today, its definitions, I think there's a lot of confusion out there. In his presentation this evening he has used accident and emergency, urgent care, trauma, critical care, full accident emergency department and support, intensive care and emergency medicine, to members of the public out there it means absolutely nothing and I think what we have to get out

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there to the public is what these definitions all mean, so I do urge the residents of Darlington in this room to respond to the public consultation.

DG: OK thank you. I am conscious of the time, there are probably some more questions, I'll just say a little bit about the next steps and particularly what we will do with those questions. We have captured everything that has been said today, either on paper on the tables, audibly by the microphones and also John has been scribbling frantically on the flip chart there. I just want to reassure people, I know because you know we have actually run out of time, if there are other questions that haven't been answered we will find a way of actually responding to those as part of the process, and you know this is about making sure people have ample opportunity to have their say and to question where possible so we will find a way to do that. The consultation runs until 12th January and I just want to be again really clear with people about what the process is from that point on. Nothing will happen until the 12th January, at that point our colleagues from Proportion will actually write up a report on the whole of the consultation and that will go to colleagues in the Foundation Trust. They will then take account of the issues in the consultation, the issues raised and all of the discussion, all of the useful input we have had and I would echo your words there that we do really want everybody to have their input into this and have their say, it's really important. What they will do then is they will actually come back to us as commissioners with a proposal which might be change in light of the consultation and only at that point once we have had that, we have the views of both the overview and scrutiny committees, the one in Darlington, the one in Durham, will we then sort of sit down and listen to that and make a decision on what happens. Nothing will happen until that point and assuming that the proposals are taken forward, whatever the final proposals are, there will then be a process of actually getting a detailed work plan that will actually map out the timing for implementation, but I really do need to stress nothing will happen until we have had all that information, until the decision has been made in light of all of the evidence before us.

This is an important part of the consultation process, we have got a series of these meetings across County Durham and Darlington but it is not the only way to do it and actually it is only one small part of it in some respects. There are a number of ways that you can continue to be involved with this, you can actually fill in the public consultation response form by logging into our website at NHS County Durham. You can go to the Seizing the Future website, the address which is there and is in the documentation and actually that website has got a lot more information than we are able to get across this evening and a lot more information in the documents. There is all of the consultation documents, we have got a lot of the supporting information behind that and that again might answer some of the questions people have got. People can also e-mail, there is an e-mail address there that people can respond by e-mail and if people just want to actually write in there is a freepost address, they can write into that consultation process. All of the views as part of that formal process will be taken into account and as I said at the start the key role for us in the PCT is to make sure we listen to all of those views, we make sure that final proposals from the FT take account of those views and to make sure there is a robust and fair process for people to have their input into that. Having said all of that I want to thank you all very much for your input tonight, we have had a good discussion, there have been some really good questions and I would just like to wish you all a safe journey home, and to thank the staff that have actually presented, who have helped facilitate and just generally help with the evening, so thank you.

(End of meeting)