

**Seizing the Future Public Meeting
Derwentside District Council
Council Chamber, Civic Centre, Medomsley Road, Consett
Tuesday 11th November**

Representing the NHS

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Steven Eames, Chief Executive - County Durham and Darlington NHS Foundation Trust
Diane Murphy, Director of Nursing and Project Manager for Seizing the Future - County Durham and Darlington NHS Foundation Trust
Bob Aitken, Executive Medical Director - County Durham and Darlington NHS Foundation Trust**

DG: ... you all here today and hopefully have a useful discussion about the proposals that have been made by the County Durham and Darlington Foundation Trust. I'll just start with ... by asking colleagues to introduce themselves from the panel.

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

BA: Hello everybody, my name's Bob Aitken and I'm the Trust Executive Medical Director and I'm a consultant obstetrician and gynaecologist previously based at Darlington Memorial Hospital.

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

DG: OK. Thank you all. Just a few housekeeping things before we can get started properly. We're not expecting a fire drill today so if the fire alarms go off, then if you follow members of staff they'll actually find your way out. The muster point is actually at the Cenotaph but we'll help people actually get there. Could I ask if people have got mobile phones if they could either switch them off or if they can't switch them off if they can actually turn them to silent please, and I'm just hoping I've done the same myself. I'm sure I have but we'll soon find out. As I say, welcome, this is a really important meeting, it's one of a series of meetings that we're having as part of a public consultation. I'm just going to explain a bit about the roles and responsibilities of people within that consultation and then we'll get colleagues to actually go through the presentation they've got for us. What I'd like to stress before we start though is this consultation is very much about the future use of three of the acute, the main hospitals within County Durham & Darlington Foundation Trust's estate, if you like. It has an impact on other hospitals and I guess people locally will have a particular ... I know people locally have got a particular interest in Shotley Bridge hospital. This isn't specifically about Shotley Bridge or the community hospitals and one of the things that the presentation will probably say is that as part of this work there aren't any proposed changes to the community hospitals which include Shotley Bridge, although there are some knock on consequences which hopefully people will see as enhancements, but I'll leave colleagues to actually describe that as we move into it.

Just a little bit about what we're doing here this afternoon and some of the roles and responsibilities that we've got within this. As I say I'm from the PCT, from NHS County Durham. Our role in life in general is to make sure that we buy, purchase, commission, however you want to describe it, health and healthcare services for all of the people of County Durham & Darlington and we spend about a billion pounds actually doing that on your behalf and that includes healthcare services, mental health services. It includes services provided by GPs, by dentists, by opticians, a whole load of people, but this piece of work specifically from the Foundation Trust is looking at the services that their hospitals provide, so it's around the key hospitals which I'll explain or go into detail as part of the presentation.

As part of our role today we're actually leading on this consultation because of that role that we've got in actually buying services on your behalf and what's actually happened is the Foundation Trust have come to us with a range of issues and some proposals and we've deemed that it's right and proper that we actually have a public consultation discussion about those proposals which is why we're here today.

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This isn't the only way that people can contribute to the consultation. I'll explain a little bit more about that towards the end of the afternoon, but it's really ... two things we want to try and get out today, one is that we have two-way communication and that's very important, so there's an opportunity to listen to colleagues and listen to their proposals and why they're putting the proposals forward and what they mean, but then secondly, and probably more importantly in some respects is for you to actually have your say as members of the public and local stakeholders. We're going to do that in two different ways, first of all, once we've had the presentation, we're going to actually break people into groups and have some discussion around some key questions from the consultation and that will also allow people to have some facilitated discussion with other colleagues from the Foundation Trust and PCT to start to formulate some questions for a later session that we'll have, later in the afternoon, where we'll actually have a chance for people to ask questions from the floor. Once we've done all of that and we've had the questions from the floor, which is really about points of clarification, how to raise issues relating to the consultation, we'll then sort of explain the next steps and what happens hereon in, then I'll go through how people can continue to get involved with the consultation process. So very important that there are lots of people here, which is really good. Very important that you actually have your say and that's one of our roles to make sure that that happens and to start with I'm going to ask colleagues to actually take us through the presentation and then we'll split people into groups for that initial discussion, so if I can hand over to Steven and his colleagues ...

SE: Thank you David. I'm going to stand over here. If I do can you ... so I can see most of you or all of you. Can you see the presentation if I do that? OK. I'm Steven Eames, I'm the Chief Executive of the Trust and with me are Bob Aitken and Diane Murphy, and we're going to run through this presentation pretty swiftly so that we can get on to the discussion part of the event which is very important. I'm going to kick off with a few slides now, then I'm going to hand over to Bob who's going to say a little bit about the clinical background, the reasons why we believe we need to make some changes to our hospital services, and then Diane will talk about some of the other issues from a nursing perspective and pick up travel and access questions that have come up throughout the process of discussion and consultation. Then I'll come back and summarise the overall presentation and we're into discussion.

Seizing the Future is essentially about ensuring that we can provide the best quality services that we can in the future. We're doing very well at the moment but we're concerned that unless we're able to make some changes our ability to provide high quality care to all of our communities may be affected. So that's what Seizing the Future is about, it's not about the financial issues that affect the organisation, it's about the quality of care. Next slide please.

I just want to, on this slide, correct some things that you might have picked up, I'll probably come over here so that I can see it ... you might have picked up in some of the media coverage that there's been thus far which by the way hasn't really focused on this community so we're not going to do that either. We'll say a bit about this community here, but a lot of the focus has been around the emergency care services and there's been a suggestion for example that there may be hospital closures, there are no hospital closures at all. We are proposing some changes to the way we organise our hospital services but no reduction in those services and no closures, first important message.

Second one is, which again has been picked up I think incorrectly in some of the media, there are no redundancies, we're not making any of our staff redundant, in fact we passionately believe that these changes do provide big opportunities in the future for our staff. We're looking to make the best use of all of our hospitals and that particularly applies to Shotley Bridge hospital and Durham which are probably the local hospitals which you here relate to. No major changes in Shotley Bridge but we expect to see some development and some growth particularly in outpatient and diagnostic services on that site. And that's part of our agenda really which is reflecting the national programme for change in the National Health Service, of delivering care as close as we can to local communities, so your local hospital is crucial in relation to that. We like to see partnership with our colleagues in primary care, more services developed there as I say over time.

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The other big change that we're facing and Bob will say a bit more about this is for some of our services and this particularly in relation to emergency care and critical care, we can't continue we believe to keep providing these services in three locations and those three locations are Durham, Darlington and Bishop Auckland at the moment, and for a number of reasons which Bob will outline, in order to make sure that those services will be safe in terms of patient care in the future, we need to centralise them, we need to concentrate those services in a lesser number of sites. OK.

So what we're proposing, very briefly, is to concentrate our main hospital services, our emergency care, our main surgical services supporting emergency care, at the University Hospital of Durham and at Darlington. Shotley Bridge and Chester-le-Street will remain as they are and we would like, as I've already said, we would want to look to provide more diagnostic and assessment and at Shotley Bridge incidentally more day surgery services in the future as part of these changes. Bishop Auckland we're looking to develop as a site that will provide a range of routine and planned care, so a lot of surgery for the County, a lot of day surgery going on there, complementing what will happen up here at Shotley, and we're also looking at Bishop Auckland to provide the same range of outpatient and diagnostic services that we do at the moment and create a centre of excellence for rehabilitation and for recovery from the acute phase of hospital care. That's not to say, if it's in anybody's mind, that we won't be providing that sort of service together with colleagues in community ... in other parts of our patch, what we're talking about is that for ... creating a highly specialised centre of excellence for rehabilitation and recovery for the whole of Durham & Darlington and indeed potentially for a wider group of patients across the North East, just to make that absolutely clear. So I hope you get from what I'm saying, there's a really exciting future here for all of our hospitals, although we are proposing a number of changes. Now I think at this point if we can hop through the next couple of slides because I think I've covered that in what I've said already, and I'm going to hand over to Bob to talk about the clinical case for change. Bob?

BA: Thanks very much Steven. I think it is best to stand here, if you stand over that other side I get in front of the screen. I'm going to major on the acute services which is the main driver I think for the changes going forward, these are services which at the moment are provided at Durham, Bishop Auckland and Darlington. I'll do it very quickly, behind this slide I could talk for about two to three hours on this alone, so I'm going to do it pretty quickly. A lot of it is kind of technical speak but what I want you to do if there's anything you want explained or me to put more detail on it, then please feel free to ask me in the question and answer session, this is your time, I should just try and get this brief message across as quickly as I can and let you ask the questions that you want, OK?

So two technicalities up front, is to explain certain terminology I'm going to use and the first one of these is 1, 2 and 3 – remember that. 1, 2 and 3 is in A&E services and in critical care services, the patients are graded, level 1, level 2, level 3 according to the severity of their illness, level 1 as you would expect being the least sick and level 3 being the most sick. Now that's significant when you look at national recommendations for how we should configure acute services. The second term is a term we use in medicine of critical mass, and critical mass is used to describe two things really, the level of activity that an individual doctor for example a surgeon doing cancer operations, there's a national recommendation on the number of these operations that an individual should be performing in a year for example, that allows him or her to maintain the level of expertise that allows them to continue to be recognised nationally as an expert in that field, but it also applies to services in teams, that is the level of activity that comes through for example in an Accident & Emergency department, not only to allow that team to maintain a level of expertise but to allow them to be recognised as a service and a centre for the training of young doctors and nurses and therapists, etc. etc. etc. So they're quite important definitions. There will be one or two others that I might confuse you with but they're not quite as important as these ones.

So we need to change really because of a series of national drivers that I won't go into but the national drivers are modified to an extent by local pressures that we face within County Durham, these local pressures mainly being some difficulty in some areas with the recruitment and retention of suitably qualified doctors but the critical mass of activity within the County does now in the 21st Century put us under severe pressure trying to deliver 21st Century quality standard of care on all of our acute sites. So

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what are the national drivers? There's an increasing drive towards specialisation, now that is seen on a number of fronts and as Steven's already alluded to, that in certain types of treatment there is a need to centralise in the hands of a few specialists some very highly technical modalities of care. A perfect example of that to give you an idea of how things are developing would be the initial care of heart attacks. You may well remember a few years ago that there were new clot busting drugs brought in that people were rushed into coronary care units and given, assessed and then where appropriate, given the clot busting drugs in coronary care. At the end people tried to take the care nearer to home, they trained up paramedics to go out to patients by the roadside or in their homes, send an ECG electronically into the coronary care unit and if given the OK, the paramedics would give the thrombolysis in the home or at the roadside or wherever and then take the patient into hospital. There was a feeling that there was more and more heart disease within the country so we set up programmes to train more and more cardiothoracic surgeons to deliver the services required. And then what happened? Some bright lad working in radiology developed a technique where they could put special little rods essentially and tubes into either an artery in your arm or an artery in your leg, your groin, and then go up through your circulation and take the clot out of your blood vessel in your heart and put in a little thing called a stent which essentially repaired the vessel from inside. So low and behold you needed then, and these were highly specialised people, so we went from being centralised in the local hospital in coronary care, to taking it local to thrombolysis in your own home, now to really centralising that service in Middlesbrough and in Newcastle for the North East of England, but very very highly successful treatment, so that's the way things go, swings and roundabouts, in modern care, so there is that drive towards a centralisation.

There's also this thing of critical mass comes in again. To maintain that expertise you've got to be treating enough patients in a year to make it ... you are able to maintain your expertise and to have a unit recognised for training. Now that's all well and good but does it benefit patients. We'll the Czar, George Alberti, the acute care Tsar, and Roger Boyle, the heart attack and the stroke Czar tell us that, and in fact there is lots of evidence in the literature now from abroad and from this country, that the centralisation in these cases does make a difference to patient outcomes. Now I've experienced that personally in my own service, I was the Gynae cancer lead for the South of Durham and I used to do a lot of gynae cancer surgery in Darlington and in the (inaudible) recommendations came out they said we should centralise all of that type of surgery in Middlesbrough and I really wondered whether that was going to benefit patients or not, but I have to say almost ten years later there is now plenty of evidence to show that the cancer outcomes data for the UK, having ten years ago been way back behind Germany and France and North America, is now really rapidly catching up. So the idea of centralisation and specialisation is well ... it's a strategy now that is well versed in the literature and the proof is there and it's a direction that we should be travelling in. Excuse me ...

To go back to emergency care, I think that is now even true in emergency situations where you would think well you've got to go to the nearest hospital if you're really really sick. Now there's lots of evidence to show that if the paramedics get to you, stabilise you, get you in the back of a good Blue Light ambulance, it is better to go a bit further to a fully equipped, suitably experienced team, the outcomes are better than going a shorter distance to a team that's less experienced and less well equipped and that is one of the national directions of travel.

Another big driver for us is doctors' hours and I think there are two facets to that. One is primary legislation, I'm thinking of the European Working Time Directive which some of you may have heard of, it applies to the junior hospital doctors in this country, comes in in three phase, third phase, final phase, is August of next year. That's when the maximum hours a junior doctor can work and that includes sleeping in the hospital whether they're working or not, from 56 to 48 hours. For our organisation that means the equivalent loss of 31.4 whole time equivalent junior doctors. It renders a lot of our on call rotas across our three acute hospitals non-European Working Time Directive compliant. That is a serious situation because the training ... the bodies that recognise training, the Royal Colleges, the specialist training committees, etc. if they come and visit the hospital and your rotas are non-compliant, you automatically lose training recognition. Losing training recognition for junior doctors is almost a death knell for a hospital, you need the juniors to be there to stimulate the

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consultants, to keep things going and make you really keep the standards high, and it's very very important that we keep that going.

Another aspect is almost a culture shift in the medical profession in that young doctors and by that I mean young consultants now have much more of an emphasis on, and rightly so I think to an extent, if you ask my wife anyway, is on work/life balance, and if somebody had asked me 30-odd years ago when I qualified about work/life balance I would have said what life are you talking about, you know? But now it's completely different and it makes some of our hospitals difficult to recruit new consultants to, you know, because we've got small groups, small teams, that means frequent on call and that makes the jobs less attractive.

There have been specific recommendations nationally on these specific services. Accident & Emergency, the present configuration that we're in for acute services follows directly from Lord Darzi's review of acute services in County Durham in 2002. Since 2002 lots of things have changed. Accident & Emergency there was a new College of Emergency Medicine, Accident & Emergency Medicine formed in 2003/4. In 2005/6 they issued a document stated what quality standards we should expect as far as staffing, support services, behind A&E, like level 3 critical care, like orthopaedics, like general surgery, but also recommended a critical mass particularly of high end level 2 and level 3 activity, the most significantly injured or seriously ill patients coming in to maintain a level of expertise that allowed a full A&E service to be workable. Suffice it to say that when you apply these standards across County Durham, there isn't enough activity in A&E across the county to have three full A&E services. Now one thing I think Steven's already sort of suggested that he wanted to correct certain inaccuracies that have been reported in the local press, I think I should at this stage point out to people that there hasn't been for ten years a full A&E service at Bishop Auckland. Trauma cases have not gone into Bishop for almost a decade. Emergency surgery cases haven't gone in for about seven or eight years and the actual pure A&E patients are mostly level 1, the walking wounded, rather than the significantly injured. They have tended for the last nearly a decade as I say to have gone to Darlington, so some of the things you read in the Northern Echo aren't entirely accurate.

In acute medicine there's been a significant change in patients going in with emergency conditions, bad asthma, you know, chest pains query heart attacks, (inaudible) bleeding, gastrointestinal bleeding. Now in 2002 all of the emergency take tended to be done by generalists so there was a general physician with a special interest in diabetes which saw the emergencies that came in. In 2003 the Royal College of Physicians recognised a new sub-specialty of acute medicine and in 2004 recommended a model of care that said that all acutely ill patients presenting to medical assessment units, that was a new thing as well, go into a special ward in the hospital for the acutely ill patient and should be treated by acute care physicians who are specially trained in a different way from previously physicians had been trained. We look after these acutely ill patients for 12 to 24 hours generally, stabilise them, hopefully get them on the mend and then they did one of two things, one, if they were well enough could go home to the care of their general practitioner, or pass them into the base wards to the care of another sub-specialist and that would be a cardiologist for heart disease, a respiratory physician for chest disease, etc. etc. But also the recommendation was that these 'ologists' should work in teams that were strong enough and big enough that there was always one of these specialists available, so there needed to be a minimum of two, so that when somebody was on holiday or study leave or whatever, his mate was always there to pick up the emergencies that came in. Now that's been the model that was recommended in 2004 and we were told to try and apply that model and have it in place in our hospitals by the middle of 2008. We actually applied that model in Durham. We have got enough physicians on the ground there, we haven't quite got the three acute care physicians, but we've got two, and we've got enough 'ologists' that this model of care we're actually delivering in UHND. Both in Darlington and in Bishop Auckland we don't have enough physicians to actually deliver the model, we've got quite a few single handed sub-specialists and it does cause problems when these guys are on holiday, and because it's been difficult, because of the size of the teams to recruit doctors to both of these teams, I mean if I was trying to put that model into Darlington and into Bishop together I would need to probably take the number of physicians up from about 15 to nearly 30. Now we have trouble recruiting people to these small teams so that's not going to happen. So the sensible solution is

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to put the two teams together and if we put the two teams together and put a couple of acute care physicians on the ground we will deliver this model of care.

The big one though is critical care. That is intensive care that supports all of the emergencies that go into hospital. When Lord Darzi came, and this is where 1, 2, 3 becomes important again, when Lord Darzi came and recommended the set up that we've got in Bishop where you have emergency medicine going in but no emergency surgery, the recommendation nationally at that time was acute medical take should be supported by level 2 critical care. Now over the last few years that recommendation has risen to level 3. The big significance for level 3 is you've got to have doctors living in the unit out of hours so that they're immediately available. Now we recognise that as quite a significant problem, about two years ago, and the Trust gave me quite a lot of money to go and find critical care doctors, anaesthetists generally these days, to man that critical care unit at Bishop on a resident on call basis, and they're not there, can't find them, we advertised the jobs four times, we got one suitable applicant who happened to replace one of the guys who already worked there who retired. So it really is a significant problem for us to the extent that when there was a very strong recommendation came out from the Academy of Medical Royal Colleges in 2007 that any hospital accepting any kind of emergency care should be providing 24/7 level 3 critical care. We had to make changes. So what we've had to do about a year ago was start moving the most seriously ill patients from Bishop Auckland to either Darlington or Durham to get the level 3 care that the national standards are telling us we should be providing. It is an ongoing issue.

Another document was actually produced late 2006 where they looked at critical care in Wales and it was the first document that actually said, back to this expression, critical mass, right? It told us how much activity there should be going through any unit to maintain the level of expertise, and just like A&E, I have to tell you that the activity in County Durham is not enough to warrant three level 3 critical care units, so if we can't provide level 3 critical care in three units we can't provide, I would say, we cannot provide emergency care on three sites, there's a real strong case for changing and for rationalising and that rationalisation essentially should take place between Darlington and Bishop and move the acute care from Bishop to Darlington.

Children's care or paediatrics in my terminology is a national problem. It's a (inaudible) specialty, recruitment to the specialty is decreasing. The fact of the matter is that when the European Working Time Directive comes in next year, about 60% of all of the on call rotas in England will be non-compliant. Now there's ways you can deal with that but if you apply the European Working Time Directive to consultants, now we can opt out of the European Working Time Directive, there's not a lot ... many people can, but consultant doctors can, but if that applied to consultants, about 25% of the acute paediatric units in England would have to close because there aren't enough consultants to man the units to keep them open to apply the European Working Time Directive, so it is a real problem, and our consultants have been saying for a couple of years that they need to rationalise the acute services onto the two sites. Can I have the next slide please?

Very briefly, what does this mean? I quote doing nothing is not an option because after we developed the Clinical Pathway we asked Professor Sir George Alberti who's the Department of Health Acute Care Czar, ex-professor of medicine at the University of Newcastle, to come and see if he agreed with the work that we had done, and George did. So if we don't do it, what problems do we face? I was speaking in Darlington this morning and the emergency contingency plans, this isn't a thing of the future, if I tell you for the last year at last, even nearly 18 months, almost on a monthly basis I as Medical Director have faced many crises in critical care staffing levels, paediatric staff because of folk retiring or illness or ... medical rotas particularly at Darlington for the minimal grade tiers, so this is an ongoing problem, an ongoing problem, and it'll just get worse and worse. There is no doubt that once things start, they will start to crumble if we don't change and solidify and take the fragility out of our services. There will be declining quality in the services that we can provide and the big thing that worries me is the potential to become unsafe. We're not unsafe at the minute but we're a bit unstable, you know, month on month. If things do become unstable and start to flake off, there will be a negative impact on health inequalities because it will mean that some of our services we won't be able to provide in the County, people will have to ... they will be provided, the PCT will have to commission

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them from somewhere, but it might be from a lot further away, and eventually we'll be in a situation where potentially we're not providing services for our patients in our opinion, but also for our commissioners and with that the Healthcare Commission, some of you ... if you look at the standards of care we provide, is being replaced next year by the Care Quality Commission, led by a lady called Baroness Young who is really into quality in a big way. We might get a bit of dispensation in 2009 and given time to make changes to bring our services up to 21st Century standards, but by 2010 I'd be willing to bet that if we're not, if we haven't reached these standards, then my commissioning mate David here will be told by Baroness Young you've got to find the services somewhere else. So if we're not able to do this, I think there are significant consequences for healthcare delivery in the County. Thanks very much.

I'll hand over to Di, who's nurse (inaudible), she's always into the benefits for patients, the pink fluffy stuff.

DM: That's terrible! It's not pink fluffy stuff. This is why we're doing the project. The most important thing in this is that it will deliver benefits for patients and that's crucial, that's crucial to us as an organisation and to doctors and nurses. Some of these things have already been touched on so I'm not going to labour them, by addressing some of the issues that Bob's talked about, about you know enabling our consultants to work in teams that provide good specialists appropriate to the condition presenting to them. By us being able to do that, that means that you will get better quality care, you will get better outcomes of care, you will get better quicker and with less complications and less chance of you having to be very quickly referred back to us, it's a significant advantage. Similarly, it's not actually just about doctors providing healthcare as you know. Just as important are the nurses, the therapists and all of those people, the wider team, and nurses specialise too, you don't necessarily see that when you come into our hospitals, but they do. If you're a surgical patient, our surgical nurses know very specifically about your needs as do the medical nurses. Sometimes for operational reasons because we've got demand on our beds from acute patients we have to move patients from a medical ward for example into a surgical ward. You'll still get your needs attended to but actually the nurses looking after you don't have that very specialist knowledge and experience to be able to tune in very quickly to changes in your condition and to manage that, so we think by being able to separate our streams of care, so planned care from acute care we will be able to better provide the whole team of specialists and not just the doctors. Linked in to that is less risk of cancelled operations. We know how much effort you go to when you need an operation to just plan your lives to get into our hospitals on a certain day and a certain time. Too many people currently have those operations cancelled at last minute because of demands on acute beds. By doing what we're doing, separating the planned and acute care, we can significantly reduce the risk of you having your operation cancelled.

You'll be really interested ... I'm going to just move quickly to MRSA actually, and hospital acquired infections, because we know how important that is to the public and to us as well. Separating planned and elective care, we can actually ... when we know that you're coming into hospital, we have the ability then to screen you before you come in at your outpatient appointment for example, or at your pre-operative assessment, by screening you and treating you if you're hosting an MRSA infection we can actually then ensure on those departments and wards where we're just providing planned care, we can significantly reduce the impact and the risk of you getting an MRSA or a hospital acquired infection.

Better rehabilitation. Just to say that you probably all know that there's a ... the front end of your care, the first few days is very acute, you need all the interventions and lots of it from doctors and nurses. Over a few days you start to recover and the next part of your care is about good rehabilitation, that's currently provided within acute wards at the moment. That is actually not the best way to provide rehabilitation. The best way to do it is to have teams of people, doctors, nurses, but more importantly therapists. Therapists who can give you care over seven days a week, every day of the year. Currently on acute wards, the way we're configured, we can only provide that over five days a week. By centralising that we create an area of great specialism, significant benefits for patients, improved outcomes of care, less disability, more a chance of you being discharged or your families being

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discharged back to their usual place of residence, not needing to go home with supported packages of care, or into residential homes or nursing homes, so significant benefits there.

Travel and access, I know you're all sitting here thinking travel, how am I going to get to hospital, yes? It's an issue. It's been flagged with us right from the very beginning, from every member of the public we've talked to, but also our staff, also our Trust Board, everybody has raised this with us, so it's high on our Agenda. The principles underpinning our proposals are you will travel only when it's absolutely essential to do so. Bob's talked about specialising and centralising, but we will only centralise what has to be centralised, there's an awful lot of things that won't be centralised, your diagnostics, yes? So you're X-rays, your blood tests, all of those things will be done locally. Your outpatients appointments will be done locally, that is before you come into hospital, but also when you're followed up from hospital, so the principle is ... travel only for the very very specialist bit of care that you need to travel for.

Just to kind of mention, that ... Bob's touched on paramedics, really, and just to say that's really important because you hospital care doesn't start when you get into hospital, if you come in by a Blue Light ambulance, it starts when the paramedic picks you up, so ... I think you probably appreciate that living in this patch of the County already.

We are looking at providing some additional transport services to get people to hospital, having listened to what people have been talking to us about. We've set up a group working with the Integrated Transport Unit at the County Council and they've had some recent experience of implementing a bus link service, an integrated transport link in the East of Durham and we're looking to use that as a model for providing transport across the rest of the County to health services. The idea is that you would ring if you need to come to hospital, either as a patient or as a visitor, or as a member of staff, that you ring one number when you need to get to hospital. You ring that number and say when you need to get there. If you're entitled to an ambulance, what we call Patient Transport Ambulance, so it's not a Blue Light ambulance. If you're entitled to an ambulance they'll book your ambulance for you. If you're not entitled to an ambulance, but there's a good bus .. public transport link, they'll advise on that transport link, but we take into account that it's no good ... it's not a good public transport link if you've got to walk a mile to get on that bus and a mile when you get off it, yes? And you've got a chronic condition ... we understand that OK? So a good public transport link, you would be advised on that, and where links don't currently exist and the transport unit are currently looking at that, we will commission additional transport services and book you on to those and you would be booked on to those, it would be buses that would pick you up within a 30 minute timeframe to get you to hospital, either for your appointment or if you're a visitor to get you to visiting or from visiting. That does require investment. We have had discussions between ourselves and the Primary Care Trust. We all appreciate that and that is something that there is a commitment to providing. Thank you very much. I'll just hand back to Steven.

SE: OK. I'll be brief in summarising this. We've been talking a lot here about the wider changes, the impact on all of our hospitals, just to be absolutely clear about the impact for Derwentside which I guess would be a major concern to all of you here. We've touched on rehabilitation as we've discussed and we are looking to set up a specialist rehabilitation service and a centre which will be at Bishop Auckland but that's highly specialised and we'll explain more about that later but there still will be rehabilitation and recovery and intermediate care services in this locality and Shotley Bridge will play a role within that, just to make that absolutely clear.

The hospital has a long-term future at Shotley Bridge. It already is providing a vital set of services for us and will continue to do so and we expect, as I said earlier, more day surgery, more diagnostics and more outpatient activity on that site. Bob talked a bit about what was happening in the South, but we need to bear in mind that if these changes go ahead more emergency care will go into Durham hospital which I guess many of you and your families may choose to use. We are therefore making a number of changes in our plans that enable that to happen, to make sure that the emergency care service that we deliver is improved and remains at a high standard. So I just wanted to finish making those very key

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points about the impact locally and I'm going to hand back to David now to take us into the next stage. And thank you very much for listening to us.

DG: OK. Thank you Steven. Thank you team. It's now your opportunity as I said in two different ways to have your say and have some discussion. Just before we get into that though there's two things that I want to mention, certainly one I should have mentioned at the start. One of the reasons that we're ... well two reasons why we're using the microphones this afternoon, one is so that you can hear, which I guess is the obvious one. The other one is because this is a formal consultation we're actually recording all of the discussion in the plenary sessions so that when we come back to the open questions we will be actually asking people to identify themselves when they actually raise the questions. The other bit is just a comment really that we're going to get into some discussion groups now and there's a lot of history around the whole of the hospitals in County Durham and Darlington and a lot of anxieties and fears about things that have happened in the past. I just want to reassure people, this is about looking forward, it's called Seizing the Future, and what I'd ask you when you have your discussions and conversations and certainly when you get to the question side of things, if we can concentrate on looking forward to the future and the future of the hospitals and I think we've had a good description of what is planned and what's envisaged for the future and this is your chance to have a say in that.

What I'd like to do now, if I can ask Verna probably and her colleagues to actually arrange people. We'll try and get you into a number of groups so that we can do two things, one to have a look at some specific questions to feed into the consultation formally and then just as importantly for you to have a chance to have a discussion, to start to formulate some questions that you might want to raise in the plenary session that we'll launch into in about half an hour's time or so. So if I can ask Verna and the team to organise people and we'll try and get round the logistics of the room as best we can.

MEETING MOVES INTO ROUND TABLE DISCUSSION GROUPS

(General talking as people move around the room)

FEEDBACK FROM ROUND TABLE GROUPS

OK ladies and gentlemen, can you draw your discussions to a conclusion and then if you can either make your way back into the room or make your way back round the table and we'll actually get some feedback and then there'll be a chance to have some open questions to the panel.

OK. Thank you, thank you everybody. OK. It's been really good, there's been a really good buzz around the room and lots of discussion going on in the groups. You'll be delighted to know that I'm not going to go for death by feedback and asking people to feed back on absolutely every point. Two reasons for that, one is we've recorded also .. the people who were actually facilitating the discussions have recorded all the comments and all the issues and we'll get that written up and colleagues then from Proportion will be doing that for us. The other reason is that we're going to ask the people who facilitated to actually feed back one or two key points and then one or two questions that have been formulated and then we'll actually throw it open to the audience to have their chance ... your chance to put any questions that you want to the panel. So I think I'll start with Verna possibly. Verna if we can ask you just for ... I think maybe two key points and then we'll come back round the facilitators for initial questions.

V?: *Yes, OK. I think the first key point was that whatever change takes place it should be patient-centred. It is worth travelling for specialist care but access has got to be taken into account and made as easy as possible. I think the other thing that might be interesting for us to note is that the question about how important is it to you that the review is being led by clinicians. That was felt to be perhaps a bit misleading because people assumed that it hadn't just been clinicians but there had been input by managers and administrators, and we talked a little bit about local governors also being involved, so maybe that's not a particularly helpful question. And that overall they felt the process for consultation had been good.*

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DG: OK. Thank you. If we can go possibly to Katrina and her group that's in the far corner there, just to make you run about (inaudible). We're about improving health and making people healthy and fit.

K?: Hi and thank you to the group, they really gave a consensus of opinion, particularly in principle about accepting the case for change which was unanimous, which was the first time I've had that in a group, so that's really good. There was some discussion around, I suppose, the timing of the meetings and needing more variety to fit in with say young mothers and that sort of thing in terms of the communication. Derwentside have had both of their meetings 2-4 and there's been a notice in the split in percentages that have been happening around the County, so there's a real need to have a little bit more variety in this area, particularly around consultations. The other part was other consultations of meetings like Friends of the Hospital and other meetings that are currently going on have led to a little bit of confusion in what people should be attending and showing up for. There was also ... the views locally were that although there has been a view of the past that, you know, things aren't going to change and people don't listen, there's also a view of the perception of local people are that they are currently travelling further and they need to understand about the services and more about care closer to home and what's actually on their doorstep and how that affects them.

DG: OK. Thank you. If you just pass the microphone on there, we'll do the group that was sat at the table here please?

?: Yes, hi. I've got I suppose two questions and one kind of very main clear point that came from my group. I think the first thing is to say that everybody in the group I was speaking to accepting the case for change, you know, understood the arguments around specialisation and everybody also agreed that it was important that the review is being led by clinical staff. The first question is ... people asked for reassurance really as to how the A&E department at University Hospital would cope with the extra activity, so that's the kind of first question. The second question is are there any plans for additional beds to be used at Shotley Bridge bearing in mind people are aware there's a ward there that's currently vacant. But really the ... so they're the two questions if that's OK. The kind of real strong point that came out from our table though is ... were issues around transport and difficulties that people in this area might have access and services if we move them. And the point was made that promises had been made in the past around transport changes when services have been reconfigured in the past and a feeling that maybe those promises haven't always been honoured so it was real, you know, concerns around transport.

DG: OK. I'll come to the questions in a moment, we'll come back to you. If we can just get some feedback first from the fourth, but by no means least, the last group?

M?: Yes, we had a good discussion basically, yes, the case for change seems very solid. That was partly due to the presentation and the bit about getting staff and clinicians. The group did feel that clinician ... the thing being clinician led was very important but it's very important that clinicians can see the patients' perspective as well within that. Another major point and we talked about it for quite some time was questions, really wanting more information, more detail, more clarity about the plans for rehab, the plans for surgery, how that will affect Shotley Bridge and how can you have, you know, when and where does rehab happen in Bishop Auckland and when does it happen in Shotley Bridge and it's about having more information around that to be able to formulate some more questions and get involved more. As a last point which I said I would feed in, there were some problems with ringing in for requesting information about today. There was an incident of an email not responded to and somebody said he has submitted some points and it would have been nice to get an acknowledgement as well, so that's a process ... a few points about process as well.

DG: OK. I'll pick up the points about the process as we close down. I think if we go back to Roy, do you want to just address those questions, there was question one which was about A&E to members of the panel?

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R?: The first question I suppose, yes, how will A&E at University Hospital cope with the additional activity that'll be going in there?

BA: Is this working, yes? Yes. Through the ... we did a lot of mapping and analysis of activities, you know, as part of the plan and one of the issues around the quality, which I didn't raise, in the national recommendations, is an increase in the number of A&E consultants on the ground. We'll be increasing staffing levels and we're confident that .. with again a split for the emergency work, we'll expect to go 70% towards Darlington and about 30% towards UHND, but with the mapping that we've done and the increased number of staff on the ground we're expecting that we will have more than enough capacity to cope.

DG: OK. And the second question?

R?: The other question was are there any plans for any additional beds to be used at Shotley Bridge?

SE: Shall I start of with that? Well there are no ... we're not proposing any plans for additional beds but we are making proposals for additional activity, and I'd just point towards the activity because if you look at the day surgery proposals that we have, that reflects what's going on nationally in day surgery, a lot of surgery that previously, I'm sure Bob and Di know more than I do, happened with an overnight stay or perhaps two or three days stay, is increasingly because of technology happening on a day to day basis, and of course all the surveys of patients will tell us that that's what people prefer. So it's not so much about the beds, it's about the activity that we're doing which means more day surgery activity, more diagnostic activity and more outpatient activity. Now that's not to say that there may be, if plans make sense and if things change, you know, you could use beds, there are some discussions in other parts of the patch around GPs, access and beds and so on, but that's not currently planned here, so they could be brought back into use for certain things, but our main focus is on the diagnostic, outpatient and day surgical activity.

BA: If I can just come back there very briefly, going back to the A&E bed, I think ... if I can just give a fuller answer to that because a lot of the pressures that A&E departments experience, particularly with medical patients that come in, who sit waiting for long times, are not because of actual problems in the A&E and the A&E processes, but that's due to backlog pressures on the base wards where you know there are issues about how rapidly we can turn over patients, if we're providing rehab at weekends, etc. the whole package of the care that we're putting in is actually designed to make a patient's stay in hospital as short as we possibly can and get them back nearer home for rehab, recovery, dah, dah, dah, dah, dah. Now if we can actually make the average length of stay shorter within the acute unit that would take a lot of the pressure off A&E departments, yes? And another issue in there that we can do is to streamline patients, in other words take the 1, 2, 3 I talked about, because actually in some big A&E departments what they do is they take off the walking wounded, the level 1s, and have a completely different stream of care so they don't actually impinge on the care of the sicker patients and you can concentrate your staff on that. Middlesbrough is the perfect example of that where they've got a very very efficient system of dealing with that type of patient, so there are a number of things that we can do as well as (inaudible) staff.

DG: OK. Thank you. Katrina, were there any questions from your group please?

K?: Yes. There was one, one particular question, slightly similar, but ... how is the larger hospitals like Hartlepool, Newcastle, James Cook, neighbouring this Trust going to impact on their future services, activity and obviously with patient choice?

DG: OK. Is that one for you Steven?

SE: If I can say something, I mean just ... I guess now you could all make a choice to go to any of those hospitals, that's how the system works via your general practitioner. The short answer to part of your question is that choice is available now. We wouldn't want to pride ourselves and in the future continue to pride ourselves in providing a range of high quality local hospital services. We do provide

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some specialist care in plastic surgery and in dermatology for example which we will continue to do, but the vast majority of the services we provide are local services, local emergency services, local surgical services, and we're already working with Newcastle and with Middlesbrough for example, in .. yes, as Bob mentioned for example in cancer care, where the specialist skills and resources are concentrated, so we'd expect that to continue. I think the last thing I'd say about impact is I think we would be concerned that if weren't able to make the proposals .. or the changes associated with these proposals then it may be because we can't sustain the quality of care that Bob in particular talked about that some care that we provide locally may have to go somewhere else and the Commissioner, the Primary Care Trust, would have no choice in that because it has to operate to nationally agreed minimum standards for quality of care, so I think there's an impact which is not the one we want to see which those hospitals could take more activity from the local setting if we can't put these changes in place.

DG: Thank you. Bob did you want to add to that?

BA: Yes, I think ... I mean I know I majored on acute services and for me as Medical Director is the driver for trying to implement change to make our acute services available, but I think we can't not consider the elective services and you know that is for planned surgery etc. going forward. I think over the last ten years the direction of travel for the specialisation bit that I talked about has led to the kind of recommended catchment area for a district general hospital to be raised from, well, in historical days it must have been about 120,000 for Darlington (inaudible) but then about ten years ago it was about a quarter of a million, the latest is 400,000 to 500,000. Now we would say for national standards therefore we should be looking ... we should be able to provide a specialist elective service in one of our centres for the whole of County Durham and be able to deliver that to 21st century standards we talked about. Now if I tell you that we've got a colo-rectal service in Durham that is actually doing, in certain areas like (inaudible) nerve stimulation, far more highly specialist operations than Newcastle are. Right? We've probably got the leading, in certain aspects, of colo-rectal care, but the leading team in the North East of England. We deliver services now that we didn't ... and I can almost say the same in Darlington in shoulder replacement surgery, that, you know, three years ago people who were requiring that need to go out of the County to do it. We're actually now delivering haemofiltration, that is if people have renal failure in the critical care units we are now delivering that service in both Darlington and Durham, whereas previously up until 18 months ago, two years ago, patients had to go to Middlesbrough and Sunderland respectively, so we are actually beginning to punch our way, and talking about big hospitals, is you actually look at our Trust as an organisation and if we can get us all thinking together, opening the ... the song book, and the same sheet were singing from the same there, we're a big organisation that we've got because of the geographic, you know, diversity of our County and the dispersing of the population in big conurbations (inaudible) we have got some logistic difficulties. But then pulling together we can provide the population of County Durham with very high class services going forward, as good as anything around the place, working with our tertiary care colleagues. Certain things in Newcastle we will never provide and it would be inappropriate for us to try and provide, but very good quality secondary care services we can deliver very well for you.

DG: OK. Thank you. Can we just come back to Mark, you raised one issue earlier on about rehab and more information on that.

M?: *Yes, it was mostly about ... obviously there's been talk about more day surgery being in Shotley Bridge, it was a very simple question on one hand I suppose, if somebody has day surgery in Shotley Bridge, if they need any rehab or anything following that, would that be delivered at Shotley Bridge or would they have to go to Bishop Auckland?*

DM: OK. Just a quick comment about the day surgery, I think you might be interested in the numbers. Our initial kind of workings are that we expect around 1,500 additional day case surgery interventions on the Shotley Bridge site. In terms of rehabilitation after day surgery, we wouldn't expect day patients to require rehabilitation after day surgery. I mean day surgery is exactly what it is, you come in and you have your treatment on that day, there isn't a formal rehabilitation period, there is a kind of short, relatively short recovery period which happens in somebody's own home, it isn't really linked to

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rehabilitation. Where rehabilitation is important is where you have had a significant event and ... the types of things we would be talking about are people who've had a stroke, people who have had an amputation, people who have had a fracture of the hip, those sorts of things really, people with Parkinson's Disease, where there is significant rehabilitation requirements, requirements that go on over a period of weeks possibly. Now what we're looking at is actually developing the specialist centre at Bishop Auckland for some patients that ... again, by centralising that it would create an area of expertise. What it doesn't preclude is people getting some rehabilitation within their local community hospital. Some rehabilitation already exists in those community hospitals, it isn't a specialist team all brought together, it's not a service where you will get your therapists over seven days a week, to get that, and there will be a period of your recovery if you are one of those patients where actually that's the best way for you to get it, you know, for a couple of weeks to get very intensive rehabilitation at the early part of your period of rehabilitation, but you know you could then be transferred to your local community hospital to get a kind of slightly lower level of rehabilitation that'll actually prepare you for discharge home. Does that make sense to people?

BA: Yes, I think the only thing I would add to that is ... certainly I see it in my medical mind is that the unit of great expertise at Bishop will be for immediate post-acute inpatient care, all patients who are rehabilitated usually then reach the stage where they then can be transferred home and then attend the local hospital or go into the local hospital, so it's a kind of graded pathway of care so that the intensive stuff is delivered as an inpatient in Bishop Auckland and then when the patient's ready to transfer either to the local hospital or to home, attending the local hospital on an outpatient day.

SE: And I suppose if I may just add a comment to what Bob and Di have just said, that I think it's important to emphasise that what we're talking about in terms of the specialist rehabilitation facility is about that phase of care immediately after you've been as a patient acutely ill, and that currently happens alongside all of the emergency care and other things, what we've talked about is concentrating, it's the same argument really as there is around emergency care ... all our expertise in one place in order to speed up that process of recovery and all the evidence will demonstrate that the outcomes for patients are better if you do that and focus that resource in one place, so you're away from hospital very quickly, so this won't be for every single patient, it will be for patients who fit into that category and we'll be looking to support that with transport systems where that's relevant, to move patients between the recovery and rehabilitation service and home.

DG: OK. Thank you. Is that all the questions from your group Mark or ...?

M?: *There's just one more quick one, it was about transport and it's been mentioned that planning for new transport provision has been looked at. Has that been looked at in a great deal of detail yet and if so when will that be communicated?*

DG: Diane?

DM: We have done quite a lot of detailed work already. Looking at all of the activity that the Trust provides and looking at where patients currently travel from, how long their current journeys take, how many patients are actually already moving around our sites and actually there's already a lot of movement of patients between sites, people choosing to go to not their local hospital actually, there are some people going from Darlington to Durham, Durham to Bishop Auckland, you know, all over the place really, so there's a lot of movement already happening. We've also looked at how the proposals would affect certain groups who might be thought to be more significantly affected, women with children for example, older people, yes, people in certain communities and what we've already seen is that our proposals wouldn't significantly disadvantage them over our existing configuration. In terms of the work that we're doing to come up with some proposals, the Transport Unit have actually already done a significant amount of work for us in terms of mapping existing services. Now they're working with ourselves, they're working with ... the team at Durham, they're working with the ambulance service and they're working with the voluntary sector, so we've got to put all of those kind of elements of transport together, so they're working together. We will have some firm proposals for us by the end of consultation, that's the kind of plan that we've got, that that links in to the end of consultation, so ...

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but we have a very ... you know, I mean I described what we wanted to deliver and that's what's currently being worked up.

DG: OK. Thank you. Verna, there were some questions from your group?

V?: *I'm afraid I didn't manage to get round to the question stage.*

DG: I'm disappointed in you Verna, it's not like you to ... (laughter)

V?: *No, but I'm sure, I mean the groups around here, I'm sure if there was any ...*

DG: Right. Well what I'll do, I'm going to open up questions to the floor now, as we said, useful to have the feedback and the questions from the group, if there's anything else, especially if anything's been sparked off from the discussion latterly there. What I'd ask if you can actually raise your hand if you want to ask a question and then once you get the microphone if you could actually identify who you are please for the record as I described earlier. We've got a lady dying to ask a question straight away.

AM: *Hello. I'm Anna Milburn, I'm part of the Community Reference Group at Stanley. We would like to know from Stanley why we haven't got a meeting set up in Stanley, we have no meeting at all in Stanley. Thank you very much.*

DG: OK. I'll respond to that because we're actually leading the consultation. What we're trying to do is to get ... well two things, one to get as many people to have input into the consultation as possible and the public meetings are one means of doing this, and actually as an illustration of why this is one important but fairly small part of the consultation, the vast majority of responses that we've had so far, given that the consultation only started last month, have been through either email via the web, or via people actually filling in the back of the stuff that came through people's letterboxes. Having said that, public meetings are important, we're trying to get a spread as best we can across the County and Darlington. Inevitably that means we can't get to everywhere and one of the good things is, you know, we've got a really good response here today, what we've said is if there's a need and we can demonstrate there's a need we'll look to put on other public meetings, but there's ... there's a balance between having lots of meetings with very few people there and bigger more meaningful meetings like this, so we'll have a look at that and see if it's possible to do it.

AM: *The thing is though there's three of us here from Stanley. There's three of us here from Stanley, right? Now then, I mean say we have been neglected for so long in the past, we've always been neglected, I mean to say we were trying to get diabetes off into the Agenda into Derwentside, we've tried hard and what's happened? Are we failing or what?*

SE: Can I ... sorry, just a suggestions, if it's helpful certainly it would be possible I'm sure if there was a group of people that you're representing here for us to come along and talk to you if you would find that helpful and we could certainly include that as part of our consultation process.

AM: *There's absolutely nothing.*

SE: But we're very happy to do that.

DG: OK. Can we link into that group if we need to. Thank you. We've got a question by the pillar. Can you ... we just have to wait for the microphone I'm afraid.

DL: *Thank you. My name's Dennis Lavin, I'm a Councillor here in Derwentside, from Anfield Plain, but on the subject the lady's raised about public meetings. I actually looked at the documentation that went out and I find that Derwentside has one public meeting, Sedgfield has two, but the interesting thing is that they had five or six areas all covering about 80,000 to 90,000 people, and there is a heck of a variation. There were initially a number of public meetings on the list, now a number have been added, I don't know whether these have been added for any specific reason or if they were asked. I have to*

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sympathise with the lady, my reaction was, yes, one in Derwentside is not on. What we now have, standing today, is that we have Sedgfield with two between 2 and 4, and three between 6 and 8, that's not bad, they've got five. I know that their population is 88,000, Derwentside's is 87, we've got one between 2 and 4. People with school children cannot attend, people who are at work cannot attend. It would be nice to please if you can consider another one. I'm sure that it would go down reasonably well for somewhere like The Lamplight in Stanley maybe?

DG: OK. Yes. Well the reason, just to clarify, the reason for actually putting those extra dates on is because people like yourselves have suggested there's a need for it. We'll take that away and have a look at it and if we can we'll put something on and we will bear in mind, you know, the time of day that we hold that, and The Lamplight might be a good venue to use, so we'll come back on something about that. Anybody else with a question for the panel? Yes, go on.

?: (inaudible)

?: I'm naturally quiet!

DG: He's on his best behaviour I reckon!

?: *I am. Someone mentioned A&E, will Durham UHND cope? I've no doubt that it will. But one thing that is a major problem with A&E, a lot of people turn up at an A&E department because when an event occurs, whether you've cut a finger, you chop off a toe, whatever it might be, it's not 9 till 5, you cannot see your own GP. When you do turn up, and if it is in the small hours of the morning it is absolutely infuriating that you turn up there, you know there's nothing happening if you like outside the hospital, other than at A&E, and at A&E the ambulance drivers are standing there ready for 24 hour call at all times, they're in and out all the time. You turn up with a patient and I've done this as a silly volunteer, you get there, there's nowhere to park your car, you can't get them from your car into A&E. You end up standing where the ambulance drivers are and they get a bit infuriated they do, understandably so, I would, if I was driving the ambulance I'd want to get in and out, I don't want every Joe, Tom, Dick and Harry parking where I am, but there should be some parking facility near A&E for drop off and pick up. At the moment there isn't one and I know that it's not part of the overall scheme of this, but I think it's something that should be said and taken into account please, if you're going to increase A&E numbers.*

DG: OK thank you. Do you want to respond?

SE: I've been thinking about that, that's a very helpful suggestion which we'll take back and I think your proposition about trying to identify an area for drop off and pick up is useful. I would just say that people do, even though they restrict access to the A&E department, if they happen to come by car with very sick occupants they do tend to drive up to the door and alert the nursing staff and others who of course help out straightaway, but we'll certainly take that suggestion back.

DG: Bob, did you want to add to that?

BA: I would just take issue with one thing the Councillor says, is the term silly volunteer.

(Laughter)

BA: I must say I had a great pleasure earlier on this year to be involved in the presentations of long service awards to a whole variety of volunteers, I happened to be doing the presentation at Darlington and Laura did Durham and somebody else did Bishop etc. and it is amazing the service that the volunteers give the hospital and its patients and the community and long may it continue, so please don't anybody think silly, it's actually a really really great thing to do, we're eternally grateful for everybody who does that.

DG: Well said. That's good. We've got a gentleman with a question at the back.

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Cllr S: Thanks. Councillor Stelling, sorry another Councillor, Durham and Derwentside. Transport I'm afraid gentlemen and ladies. A lot of ... if you pardon the pun ... the pain of this could be alleviated if Go Ahead North East, you know, could be more involved in the transport arrangements from throughout the County. They're going through their third different form of timetable in four years, it's just absolutely crazy and I would really have liked to have seen Go Ahead North East, because like I said in the rural parts of Durham and obviously you're in North West Durham today and you'll have similar things no doubt when you go to the Dales and other parts of the County, is that if Go Ahead North East could their head together with our Integrated team who are working very hard, this could be a lot less painful.

DG: Thank you. Di, do you want to ...

DM: Just to say that the Transport Unit have actually, in the group of people we've got actually doing that work, we have the providers of transport services as part of that so people like representatives from Go Ahead and I think it's Arriva is the other one, so yes, thank you very much, you're absolutely right but we have got them involved. Yes.

DG: OK. Thank you. Yes, I think that infuriates everybody, doesn't it? Changing the timetables. Any more questions from the floor?

?: *(inaudible) and the big two tend to (inaudible)*

DG: Yes.

?: *Maybe consultation with some of the smaller operators would be much more beneficial ...*

DG: Yes, and Diane's just ... I'll just repeat what Diane said, it is actually the small operators that we're working with and particularly the East Durham version that's been set up, that is working very much with small operators as well, so it's all providers of transport arrangements, but it's a good point, thank you. Any more questions? OK, if we come to the gentleman here and then the gentleman at the back.

KL: Thanks. I'm Keith Little, I'm the Hospital Support Group. One of the subjects which has cropped up regularly at our meetings has been this idea of choice where you can go to Shotley Bridge for appointments and we've been a little bit concerned that sometimes people haven't realised that they have the choice to go to Shotley Bridge and the GPs haven't been passing this choice on to them and I think that the services at Shotley Bridge would have shown to be a lot more in demand if people were a lot more aware that they could go to Shotley Bridge and I was just wondering if you were aware of the problem or, you know, the fact that people are deliberately being diverted elsewhere?

BA: Yes, they're certainly not being deliberately diverted elsewhere from our side, but what sometimes happens however, if we're ... you know if this 18 week outpatient target and if in certain services we look as if we're not going to meet that, sometimes the available slots in clinics can disappear off the computer system, that's a technicality that ... I'm a complete technophobe, I don't ... I never quite understand. But sometimes, it depends who your consultant or the GP wants to refer you to because in different services, for example, orthopaedics, different consultants will have different sub-specialist interests and some of them might not do clinics at Shotley Bridge, so it may well be that the (inaudible) who comes will be an expert in knees but you need to see somebody about your elbow or something like that and you have to go ... that might be the reason but if you're keen to be seen at Shotley Bridge you should say to your GP I want you to check if there's a clinic slot available for my problem in Shotley. It's perfected within your ... and we are prepared to look at that. But I accept that there may well sometimes be technical things on the system, on the screen, that your GP sees, that I don't fully understand. But I'll take that back anyway and we'll get the team to investigate.

DG: I know we're aware of an issue and it's part of their (inaudible) system that Bob was talking about, we're aware of some of the issues and we're trying to get those put right because as Bob says, if people

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want to go to Shotley Bridge and the service is delivered there, then you're perfectly within your rights to go to that. Thank you. There's a last ... time for one last question from the gentleman there?

?: *It's just an observation.*

DG: OK.

?: *I frequently find myself in this position, I wanted to give thanks to the panel for clarifying a lot of things that frankly I was personally suspicious about and I'm sure that may well be said by many of us here. If anybody would like to second that, in a sense, perhaps you should stick your hands up, if it's not being helpful keep them on the table!*

BA: Thanks very much indeed.

DG: I'm sorry ... there was one more question, I couldn't see because of the pillar.

DS: *Sorry. Hi, I'm Derek Snaith from Durham County Council. Hopefully it's a question that will help everybody, it's when and how is feedback going to be given on the results of the consultation. I guess you might have rounded with that (inaudible).*

DG: That's a wonderful link and the money's in the post, because what I'm going to do now that we've finished the questions is just explain the next steps for this, so thank you very much for that! Yes, this is very much part of a formal consultation as I described earlier and one of the things to make clear to people hopefully ... and I welcome the comments from the gentleman about the fact that it's been helpful. It's certainly been helpful for us because while we've captured things audibly through the microphones, we've captured things through Vaughan on the flipchart, we've also captured everything that's been said and discussed in your groups on the sheets that we've got. All of that will be fed into that formal consultation. The consultation ends on 12th January, it's of a statutory period that we're working with and what will happen then is colleagues in County Durham and Darlington Foundation Trust, the people who provide the service, the people who have been presenting to you today, will actually consider the issues raised from the consultation, all of which will be compiled by Vaughan and colleagues at Proportion. They'll look then and see if they need to make any changes to the proposals and I think from what we've heard there are some ongoing discussions about transport and about how that will work and how that would fit into it, and then when they've done that, that will then come to the PCT Board at NHS County Durham and we will listen to again the case for change which we've listened to already, we'll then listen to also the proposals and we'll have a discussion and at that point a decision will be made either way as to whether the proposals actually go ahead as suggested by the Foundation Trust, whether there are any changes to be made to it or whatever. One of the key things that I really need to ... I can't stress enough, I don't mean to labour it with you. The only decision that's been made so far as part of this work, the one single decision, is that we'll actually embark on this consultation process. The reason we've done that is because it's really important that we get sufficient evidence to come back to the PCT Board in February which is when we'll probably listen to this so we understand the issues, we understand from consultation, we understand from all the clinical issues that have been raised, what is actually happening, what needs to happen and then we can take a view on whether proposals actually fulfil the requirements and conditions that have been laid down, so no decisions will be made until at least February 2009 and I can't stress that enough.

Having said that this is part of a consultation process. There are a number of ways that you can also get involved with the process. People should have had through the doors, you've had some literature today, on the back of that there's a sheet where you can actually answer the consultation questions, you can send those in via the post and they'll be picked up as part of the process. Equally you can actually log into our website at NHS County Durham or there's a Seizing The Future website there www.seizingthefuture.co.uk. On that website there's a lot more information. There are all the documents that you'll have seen so far hopefully, there's a lot more background information that illustrates and demonstrates the discussions that have actually got to this point to making the proposals. Please feel free, you know, to get that information. If for any reason you're not getting the information

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or you're not getting a response, there's a comment earlier that people were not actually responding to information that was being sent in. If that's not happening, if you let us know, we'll try and get the information for you or we'll elicit a response for you because it really is important that you have the information and that you can make decisions and form a view on as much information as possible.

You can also email your comments in, the email address is there if people want to use email and lastly you can write to the Freepost address which is in all the literature. You can send your comments via that. All the comments that are made will be collated, they'll be put together in a report, and then we'll feed into the process that I described earlier.

As I said at the start our role in this as the PCT is to make sure that you do actually have a chance to have your say and that people have the chance to have their say across the whole of County Durham and Darlington and we'll look to see what we can do with any further meetings or any further ways of discussing the issues with people in Derwentside particularly. We need to make sure we do, if you think that's not working then please let us know, because it really is important that we hear your views. Colleagues in the Foundation Trust desperately want to hear your views as well so that we actually get the right answers through all of this because it's really important ...

(End of recording)