

**Seizing the Future Public Meeting
Durham County Council
County Hall, Durham
Tuesday 18th November**

Representing the NHS

David Gallagher, Director of Corporate Strategy, Services & Relations - NHS County Durham
Steven Eames, Chief Executive - County Durham and Darlington NHS Foundation Trust
Diane Murphy, Director of Nursing and Project Manager for Seizing the Future - County Durham and Darlington NHS Foundation Trust
Bob Aitken, Executive Medical Director - County Durham and Darlington NHS Foundation Trust
Dr Catherine Noble, GP - NHS County Durham
Mark Cook, non-executive director - NHS County Durham
Anna Lynch, Director for Public Health - NHS County Durham
Iain Bain, Divisional Director for Surgery - County Durham and Darlington NHS Foundation Trust
Neil Munroe, Clinical Director for Medicine - County Durham and Darlington NHS Foundation Trust

DG: I'll just ask them to go along the line and introduce themselves. I'll start at this end with Cath.

CN: Hello. My name's Dr Catherine Noble, I'm an urgent care GP for County Durham PCT and I'll be the clinician advising the PCT on Seizing the Future.

MC: Hello, it's Mark Cook, I'm a non-executive director for County Durham NHS. For anybody who doesn't know what a non-executive director is, we work part time, sit on the Board, so we're not full time executive directors.

AL: Hi everyone. I'm Anna Lynch, I'm the Director for Public Health for County Durham. I'm involved in this process as a member of the Board and I also advise on the health inequalities aspect.

IB: I'm Iain Bain, I'm a colo-rectal general surgeon at Durham and Divisional Director for Surgery across County Durham and Darlington Trust.

DM: Hello, I'm Diane Murphy, I'm an Associate Director of Nursing and the project manager for Seizing the Future.

SE: Good evening everybody. I'm Steven Eames, Chief Executive of County Durham and Darlington Foundation Trust.

NM: Hello, I'm Neil Munroe, I'm a consultant physician in Durham and Clinical Director for Medicine across the County.

BA: Good evening everybody. My name is Bob Aitken and I'm the Executive Medical Director for the Trust and in a previous life I was a consultant obstetrician and gynaecologist based at the Memorial Hospital in Darlington.

DG: OK. Thank you everybody. I just wanted to start by introducing what we're about and what we're going to try and do and I'll try and deal with the feedback here as well, apologies for that. This is really important as I say that we get your views as part of this process. We've got an agenda, which I'll go quickly through and explain that and then I'll explain to you very briefly what the roles of the different partner organisations are in this piece of work. So we've actually split the Agenda so that hopefully everybody has a chance for two-way communication and I'll talk a little bit about that in a moment, but there's an opportunity for you to have your say after you've listened to some presentations from colleagues at the Foundation Trust on their proposals and I'll say a little bit towards the end of the evening about how ... the next steps as far as this goes. Can I have the next slide there please?

In terms of roles and responsibilities our role at NHS County Durham is to make sure that we actually spend your money wisely and we make sure that we get the very best health and healthcare services on behalf of people in County Durham and Darlington. Colleagues from the Foundation Trust obviously provide specific hospital services and I need to stress that this piece of work is about the hospital

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service and the hospitals that they actually run. We commission services, or buy services, from mental health trusts, from the ambulance trust, from other hospital services and from other partners as well, but this specific piece of work is about the three main hospitals in County Durham and Darlington Foundation Trust and colleagues will actually explain what that's about as we move through. We're not here tonight to have a discussion about the community hospitals which ... there is a mixture of community hospitals that we've got across the patch, not to discuss those specifically today but there is an impact on some of those and I think the presentation will go into that particularly in terms of some of the North Durham hospitals. In terms of roles and responsibilities this evening, there are probably three partner organisations here. From the PCT's point of view it's very much our role to actually run the consultation process so we're running this process, it's our job to make sure that there's fair play if you like, to make sure that people have their fair say and input into this and generally then to actually accept the proposals that come back at the end of the process and we'll decide what will happen with them.

Obviously colleagues from the Foundation Trust are here this evening to put forward their case for change and the proposals that they're making and we're also supported by a third group of colleagues from a company called Proportion and they're here to actually record everything that we're saying, which is one of the reasons we've got the microphones because we're recording everything that's being said electronically. We're also going to have their assistance in actually recording some comments on the flipchart when we come to the open questions section.

One of the key things that I want to get across is that this meeting is about a two-way communication process and what I mean by that is it's an opportunity for you in the audience if you like to listen to the proposals that are being put forward and the case for change if you like that the Foundation Trust are putting forward, and then an opportunity on two counts to actually feed back into that and feed into this formal consultation process. The two ways of doing that is that once we've had the presentation we'll actually probably escort people out into the lobby area where we'll actually try and arrange some group discussion, partly to answer some questions that feed into the consultation formally but also to give you the opportunity with the help of some facilitators to actually formulate some comments and questions that you might want to put to the panel in the last session which is about open questions and we'll explain that as we come along to it.

It's very important that we listen to your views and as we go through we'll actually guide you through the process this evening. We'll explain what the next steps are and as I say towards the end we'll actually wrap up and say what happens next in the consultation process. So at this point I'm going to hand over to Steven and his colleagues and they'll actually take you through their presentation.

SE: Thanks David. I'm just going to pop this ... it's not attached to anything ... on here, so I can see it whilst I'm talking to you. Well, good evening again, I'm Steven Eames, Chief Executive of the County Durham & Darlington Foundation Trust. I just want to do a brief introduction and I'm going to hand over to Bob Aitken, our Medical Director, who'll talk a bit about the clinical issues associated with our case for change and then on to Neil Munroe who'll talk further about the need for specialisation and some of the issues behind that. Then on to Diane who will talk a little bit about travel and access and then back to me to finish up.

So Seizing the Future is about excellence. We're very proud to stand here tonight as an excellent provider as denoted by the Healthcare Commission of hospital services and we want to maintain that position and the whole of our Agenda as far as Seizing the Future's concerned is driven by considerations of quality and maintaining high quality services into the future.

Now I want to make four or five key points at the outset. Contrary to what people may have seen in some of the media, there are no proposed closures at all. We provide services from five hospitals and it's our intention to keep doing that. We are making proposals for change but there are no hospital closures, nor are there any redundancies either. We believe that these proposals give our staff some tremendous opportunities in the future and we intend to maximise use of all of our services in all of our sites over the coming years. We also want to provide in line with national policy, in line with the

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policy of the Primary Care Trust who commissions our services, provide as many services as we possibly can in a local setting and that's why operating services from five hospitals is so important, but we do know as you'll hear shortly that some of our services are quite fragile when we apply national standards and we need to centralise those services for safe care, so it's services in terms of intensive care, children's services and some aspects of our emergency care services are in that category, and it's all about giving you the public the best treatment that we can in the future.

Now just to briefly highlight what we are proposing and first of all to concentrate on our three main hospital sites. We are proposing that we centre all of our main acute services at Darlington Memorial and at the University Hospital of North Durham and that we redevelop, a really exciting proposal in terms of how we see it, we redevelop Bishop Auckland hospital as a centre for planned care and centre of excellence for day surgery activity and for rehabilitation. The two community hospitals that we provide services from at Chester-le-Street and Shotley Bridge will remain as they are although we would expect with the sort of commissioning plans we will see from our Primary Care Trust colleagues that services there, particularly outpatient and diagnostic services, will expand over the next few years.

And just very briefly, I won't go into this in detail, this slide shows those changes, so this first slide really identifies the point that I've already made about concentrating our main acute services at Darlington and at Durham, so centralising the Accident & Emergency services, focusing our acute stroke services and centralising our children's centres on those sites. And this slide just shows the changes we're proposing at Bishop Auckland. All the services that are currently provided aside of those I've just outlined will remain on the site but we'll also be introducing rapid assessment centres for medicine and for children's care, setting up a centre of excellence for planned surgery, including a cataract centre, and focusing on developing a County-wide and potentially region-wide specialist rehabilitation centre for rehabilitation recovery on that site, so as you can see some very specific proposals for development.

OK. I'm going to hand over to Bob now to talk to you about the case for change. Bob.

BA: Thanks very much Steven. Good evening again ladies and gentlemen. Yes, thanks Roy, there's my first slide. Before I go on to try and explain why I feel we need to change fairly urgently I want to make three points of ... by way of introduction. The present configuration across County Durham of our acute services ... or across, you know, University Hospital North Durham, Bishop Auckland General and Darlington Memorial, are a direct result of ... you may recall ... a review of our acute service configuration by the then Professor Sir Ara Darzi, Professor of Surgery at St. Mary's Hospital in London, now Lord Darzi who's advising the Department of Health and the Government about reorganising the whole of the health service. Now following that and I think this is where Steven's already alluded to some inaccurate reporting in the local media about closures of hospitals, and the one thing I'd like to clear up as well is that for about ten years now there has not been a full Accident & Emergency service at Bishop Auckland General hospital. Trauma cases have not gone in there, that is people badly injured in road traffic accidents, complicated fractures, etc. etc. and for about seven or eight years acute general surgical admissions, that is people who need emergency surgery have not gone into Bishop either, they have actually all been centralised on the Darlington site in the south of the County.

There has been an Accident & Emergency service but it's mostly been related to acute medical admissions and lower level A&E type work. And with that I want to just explain one or two brief technicalities. A lot of what I'm going to talk about will be pretty technical and it's difficult to avoid that, so if there are things that you don't understand please take note and ask me or ask one of the staff during the breakout sessions or ask me to explain things, or one of the team to explain things during the open question session. But the two things I would like to say to you before we start, is there are two technicalities we need to consider which are very important. The first one is 1, 2, 3 ... and it's as simple as that, but the 1, 2, 3 applies to patients that need to go to A&E and 1, 2, 3 also applies to patients who are treated in Intensive Care Units, level 1 being the least sick patients, that is in A&E parlance the walking wounded, that may need a few stitches in their hand and walk in and then leave and walk home, right? And the level 3 are the sickest patients, yes? So in A&E these are the people

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who are rushed to hospital by ambulance, go straight to the resuscitation bay and need very intensive therapy because of life threatening conditions, and level 2 are a whole gamut of things in-between the walking wounded and the really seriously ill. I'll explain a bit more about critical care when we get round to the specifics. But remember that, 1, 2, 3 ... same applies to each category.

The second thing that's very important is a term that I'll use pretty regularly during this brief presentation and that is critical mass and the critical mass of activity, that is the amount of work or patients with certain types of conditions are important on two fronts, one, as an individual specialist is now more and more coming under scrutiny by the Royal Colleges and the Department of Health to ensure that they are doing an appropriate number of any given procedure, that is they are seeing enough patients for that given condition to continue year on year to be regarded as a specialist in that field, so the critical mass applies to individuals, but at the same time a critical mass can also be applied to teams or to departments, that is a critical mass of activity for example of level 3 very serious activity in Accident & Emergency departments to allow these services to continually be recognised and accredited, not only for the quality of the service provision, but also for the training of junior doctors, nurses, etc. etc. etc., so it applies to individuals but it also applies to teams.

So why do we need to change? Two main fronts, there are a number of national drivers that are coming out of the Department of Health, some of these driven by Lord Darzi himself, and these national drivers are also modified to a degree by local pressures that we face. The local pressures tend to be related to the critical mass of activity that we have within the County, but also problems that we face in certain areas and certain specialties of recruitment and retention of doctors of suitable qualification. More of that later on.

So what do I mean by specialisation? Again, two main fronts, one is increasing complexity in certain procedures and I think to illustrate that I just wanted to talk briefly about the emergency treatment of people who have got heart attacks, certain types of heart attacks. About ten years ago, it might be slightly longer, there was a technique that was developed called thrombolysis or, you know, injection of clot busting drugs, you might better understand it by. Initially that started, was done, researched in coronary care units, so you needed to be taken to your local hospital to have that done and as we became more familiar with it eventually we were able to train paramedics to actually deliver that care and they could go out and see a patient by the side of the road or in their own bedroom, they could send over the wires an electro-cardiograph tracing to a coronary care unit in the hospital. The cardiologist would say OK, give the clot-busting drug and the paramedics would administer that locally, so that was an idea where initially it was very specialised in the hospital but we got more used to it and it was taken out into the community. But then what happened is that some chap, I think in America I'm right in saying, developed a technique where and showed that the best treatment for a heart attack, rather than the clot busting drugs in a lot of cases, was to put special tubes/wires into either an artery in your arm or an artery in your leg, go up through the circulation and actually take the offending clot out of the artery in your heart and put in a little thing called a stent which was really the most effective way of treating a heart attack in certain types of heart attack, that's called primary angioplasty. But obviously this is a highly specialised technique that's only performed by a relatively small number of practitioners across the country, but the results are so good that the recommendation nationally is that where appropriate in certain types of heart attack you should be shipped, if .. by helicopter if need be, to regional centres to have this treatment, it's so highly specialised. So in the North East of England there's a centre in Middlesbrough and there's one in Newcastle and they are the people who deliver this for the whole of the North East of England.

On the other hand there is a critical mass of activity that's involved in certain types of specialisation and that has affected my clinical practice over the years because I had a special interest in gynaecological cancer surgery and I did most of that in Darlington, but then at the end of the 90s there was a recommendation came that all of cancer surgery should be, in certain specialties, mine being one of them, should be centred in the hands of a small number of oncological surgeons, because there was evidence from elsewhere in the world that patients did better when that actually happened. I wasn't too convinced at the time but it was the national direction of travel so I went along with it and worked with colleagues in Middlesbrough and transferred all of the ladies I would normally operate on in Darlington

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into the care of the team at Middlesbrough and low and behold nationally the outcome measures have shown a significant improvement in these cancers. So there's no doubt in certain areas, cancer being one of them, that the concentration of the critical mass of activity that is needed to develop a level and maintain a level of expertise, the case has been proven.

I think that's now becoming true, it's certainly true in certain types of trauma, in major trauma cases in certain types of emergency medicine there is now lots of evidence internationally and seen in this country where it's actually better to travel a bit further in the back of a Blue Light ambulance to a centre of excellence, to a properly staffed and equipped Accident & Emergency department for example, and there the outcome measures are actually seen to be better. So we're going in that direction. There is a real need for us to consider how best we deliver these services across the County.

Another big driver for us is doctors' working hours. That takes two forms really, one is primary legislation, there's a thing called the European Working Time Directive, now that's being brought in for junior doctors in three phases, the third phase is about to be introduced in August of 2009 and what that means for us in our organisation is when the junior doctors go down from working a maximum of 56 hours a week to a maximum of 48 hours and remember if a doctor is even sleeping in a hospital or on call that is regarded as direct working hours so that counts. What it means for us in County Durham is that we lose the equivalent of 31.4 whole time equivalent junior doctors on the ground, so therefore it makes it much more difficult for us to staff the number of emergency on call rotas we've got in various specialties across the County. Now that has got a huge implication because when trainees are in place you are visited by things called specialist training committees of the Royal Colleges and I can guarantee you that if your on call rotas are non-European Working Time Directive compliant then the first thing that will happen is that you will lose training recognition, so it really is ... and if you lose training recognition it's a disaster for the hospital. So it's very important for us that we address this issue going forward. Now the teams are working very hard on that, but one of the ways of actually doing it is actually reducing the number of on call rotas that you actually man.

The other thing on doctors' hours, it doesn't apply so much to junior doctors, it applies to young doctors generally, I suppose the modern expression would be work/life balance. Gone are the days when I was a lad, newly qualified, if anyone mentioned to me you know what do you think of your work/life balance I actually would have said well what life are you talking about, because it was 128 hours a week I worked in my medical house job, one in two on call, God I thought I was doing a great job but looking back ... hmmm, were we doing the best for the patients? I thought I did OK. But that's all gone now, you know, doctors are expecting to have a life, you know, they love their job, they want to commit to it, but they're really looking more for a life outside of medicine and therefore it does make it difficult when you're trying to work with small rotas, for example a group of doctors told me recently if you've been on call any more frequently than 1 in 10 in acute medicine, we're not interested. We've got two small rotas in Darlington and in Bishop Auckland so it makes it difficult for us to recruit into these posts. Interestingly enough, Durham's got a bigger rota and, you know, we don't have the same trouble recruiting people, so that's an issue, it causes recruitment and retention pressures.

Added to that there have been certain national recommendations since 2002 on Accident & Emergency, acute medicine and critical care. Paediatrics I'll talk about later on and this... mainly a local issue. So what's happened in Accident & Emergency since 2002? Well essentially there was a formation of a new Royal College, the Royal College of Emergency Medicine, they've even changed their name from Accident & Emergency to Emergency Medicine in 2003, beginning of 2004 maybe, and they came up with recommendations not only for the quality and the standards for staffing and, you know, what support services you should be around for critical care for example, surgery, orthopaedics, to have a full A&E, but even more interestingly for us is that they made recommendations about the critical mass ... that expression again ... the critical mass of activity that you needed to be coming through your A&E department, particularly at higher level 2 and level 3 to maintain that expertise. Enough to say that in County Durham we don't have enough activity as recommended by the Royal College to have three full A&E departments. We've got enough to have two, but not three. As it happens, as I said earlier on, Lord Darzi ... following Lord Darzi, we don't have a full A&E at Bishop, but I think we

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need to be a bit more honest with people and explain, you know, why we need probably to change the designation of that department and help people to understand better what the 21st Century standards are.

Acute medicine is very interesting in that the model, the recommended model of care ... in 2002 generally if there was an acute medical take, you could be ... most guys were general physicians with an interest in respiratory medicine or diabetes or something like that and so all the emergency admissions would come in and they would be seen by a general physician just on take that day. Now in 2003 the Royal College of Physicians actually recommended setting up a new specialty, so as well as cardiology, gastroenterology, respiratory medicine, they wanted us to recognise a specialty of acute medicine, that is emergency medicine, and recognise the development of a new breed of physician called an acute care physician who'd be specially trained to deal with a gamut of emergency cases for the first 12 to 24 hours of their presentation to hospital, following their presentation to hospital, and they would work on units called medical admission units, so they would be very geared up to high turnover investigations and dealing with the really ... the sickest patients. Once they were stabilised or even gotten better and go home, if they were stabilised and needed admission they'd be passed back in the model of care recommended in 2004 to teams of 'ologists', to the cardiologist, to the respiratory physician, to the gastroenterologist, and the recommendation was that these 'ologists' would work in teams of at least two, so that if you didn't go on holiday at the same time there was always at least one of the sub-specialists there to see you when you were passed back into the 'back shop' as Neil calls it from the acute care physician on the ground. Now the recommendation was that we deliver that model of care by the middle of 2008. I'm glad to say that we're doing that in Durham, we're one acute care physician short, the recommendation is that there should be three in each acute take care unit. We've got two in Durham but we've got a big team of 'ologists' and we do deliver the recommended model of care for the 21st Century. Unfortunately in Darlington and in Bishop Auckland, because of the number of physicians that we've got and the bits of problems, intermittent problems with the recruitment, is that we don't have enough physicians to deliver that model. So it is an issue that we need to address going forward.

There has also been a bit of a change in the critical care recommendations, so the intensive care support that should be available to allow an unrestricted medical, you know, acute medical take. In 2002 that was at level 2. Now level 2 is where you've got one nurse for every two patients and the resident staff, the medical staff don't need to be resident on the unit. Level 3 is where you have one nurse for every patient, 24/7, and you've got doctors who actually live in the unit out of hours, so they're immediately available should any problem arise. Now we deliver the level 3 in Darlington and Durham but we have, for reasons that I won't go into now, have been unable to deliver that model of care in Bishop Auckland.

DG: (inaudible)

BA: Ten minutes left, OK then David. So I mean the situation is we've got intensive care pressures at Bishop Auckland. What do we do? Do we try and staff it up? Well unfortunately there was another review of critical care done in Wales not so long ago and there was a national recommendation, again on this expression critical mass, there is a need to have a certain level of level 3 intensive care activity to have the ability to maintain the expertise and be recognised as an accredited unit going forward. Suffice to say, like A&E, we don't have enough activity in County Durham to actually warrant three level 3 critical care facilities. Yes? Added to that, last thing on the acute care, is the Academy of Medical Royal Colleges was asked by the Department of Health to look at acute care and how things should be configured across the country and they came out in November of 2007 and stated quite clearly that if you're taking an emergency service of any kind into your hospital you should be providing 24/7 level 3 critical care support, so that really does give us a problem with trying to deliver three emergency services across County Durham, and that's why I feel very strongly that we need to move in this direction and go to two.

Last thing is children's care. Paediatrics. Essentially this is a local pressure, we've got quite a unique model across the County, particularly in Bishop Auckland. We've accepted now that the difficulty with recruitment into the pattern or the way the consultants work will not be possible going into the

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future, and the paediatricians themselves have been recommending closing down the acute service at Bishop Auckland and centralising this in Durham and in Darlington. Can I have my next slide Roy please?

I put 'Doing nothing is not an option' in quotations here and this is a quotation from Professor Sir George Alberti who is the emergency care Czar for the Department of Health. We invited George to come in and look at our service and he has fully endorsed the clinical recommendation of direction of travel. What happens if we don't? The emergency contingencies are not things that I'd be looking to do going forward, contingency plans for what happens if things start to crumble, because they are a bit fragile. This has been going on for the last 18 months, almost on a monthly basis, and a weekly basis sometimes, but certainly on a monthly basis. I've been having emergency meetings with groups of staff to try and set things in place, find locums, so that the services don't actually start to fail, because if they start to fail there will be a decline in quality of the services that we deliver to the people of County Durham and that will involve decreasing levels of safety and as Steven's already said, that's what we're all about, providing the best service we can. There is no doubt if things start to fall over and we lose services in County Durham and people have to travel further for care there will be a negative impact on health inequalities within the County. We will then find ourselves in a situation where the services that we provide are not fit for the 21st Century and will not be fit for the commissioners. That fits with the advent, the Healthcare Commission is becoming the Care Quality Commission and will be led by Baroness Barbara Young from next April. She is a real stickler for quality. I understand that we might get a bit of dispensation for the first year but by April of 2010 if we're not delivering 21st Century standards then our commissioners almost certainly will not be allowed to commission our services, and that will be not at all good for the patients of County Durham. Thanks very much. I'll hand you over the Neil who is going to talk a wee bit more about the models of care.

NM: Thank you. David, I'll speak quickly. Ladies and gentlemen, thank you very much. The proposals that you've heard so far, a couple of points on those. These are not things that have been handed down to us from the Department of Health. These are things that have been put together by clinicians, nurses, doctors, therapists and members of the public, our lay Governors who represent you the members of the public within our organisation, who have worked with us to develop these proposals. So these are not dreamt up in an abstract form, they exist because they have been developed by people who work with and for whom this service is provided. One of the things that people, patients, their carers, their relatives, seek in modern hospital care is access to the most appropriate clinician the first time, better access to a specialist when you need a specialist, if you come into hospital with something that I deal with like asthma, you expect to see a chest physician at some point during your admission. We know that if you do that you get a shorter stay in hospital, you go home with the most appropriate treatment, you get the best follow up care and as a result of that the overall quality of the care that's given is better and our utilisation of all our services is also improved.

Now presently as Bob's already alluded to, we have a large critical mass of physicians at Durham but unfortunately at Bishop Auckland and Darlington with two small units we cannot always guarantee that people will see an appropriate specialist during their admission for their condition and one of the big advantages of the proposals that we've put forward are that you are more likely to see the right doctor, the right health professional at the right time. Coupled with that you are more likely to spend time on the most appropriate ward for your condition, because it's not just about me, I'm just a part of the process, there are the nurses, there are the therapists, there are everybody that contributes to making you as well as possible when you come into hospital with your acute condition. So better access to a specialist and better access to the most appropriate facility. By focusing our elective surgery, particularly the day case surgery, away from some of the acute medicine, you stand less chance of disrupting that elective surgery with emergency admissions coming in and pushing elective patients out of the way, simply because of the seriousness of their illness. If you can separate those two parts of our function then you improve once more the quality of care for everybody. So allowing us to develop an elective centre at Bishop Auckland, particularly for day case surgery, will improve the overall quality for a number of patients.

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Finally, or next to finally, better rehabilitation after being ill. One of the things that is key to getting the best possible outcome, for example after a stroke or after major surgery, is ensuring that you see the appropriate therapists to get you back on your feet again, functioning as well as possible. We would like to focus our rehabilitation facilities, not for every patient that comes in the door, but for those that need it most, at one site and that site we would like to make Bishop Auckland as a major rehabilitation centre, which may well attract people not just from within County Durham but from other surrounding districts as well. This would stand us in good stead to be a unique facility within the North East.

Finally, with few patients in the system at any one time, better division of urgent and elective care, we reduce the risk of hospital acquired infections like MRSA, like Clostridium difficile, things that you read about in the newspapers, we can better control those things.

I'd like to have just one final point, not on this slide, and this is a meeting in Durham itself. Can Durham itself cope? Can the hospital in Durham cope? Well I work there every day of the week it seems, and ... sometimes more than that ... these changes are not happening in isolation, there are other things that we're doing alongside these changes to improve how we manage, how we utilise best our hospital services, this may include better and slicker planned diagnostics and other facilities within the hospital, better changes to surgical activity so that we can be slicker in getting patients in and out of hospital, and better outreach services. In Durham we've pioneered within the North East an outreach service for people with bronchitis and emphysema to keep them out of hospital. It's those sort of things that we already do and will continue to build on that will allow us to make some of these changes and rest assured that we can cope with these changes of our acute service. Thank you for that, I'll pass you on to Diane.

DM: Thanks. Just a few words about travel and transport because that's obviously something that you've got issues with I'm sure. It's something that people have raised with us right from the very start of this process, and that includes our Governors raising that as an issue and members of the public and some interest from stakeholder groups. The first thing I need to say is that everything that we're proposing is based on the issue of travel only when absolutely essential, so you only have to travel to another site for care that you can't receive on the site closest to you, that means your outpatients appointments and your tests or X-rays, for blood tests and all those sorts of things will all happen at the site closest to you, so that's the basis on everything we're doing, so reducing the number of journeys to sites away from your local hospital. Just important to remember the paramedic role in healthcare is one, which has considerably changed the way that we deliver healthcare. It used to be that if you were an emergency patient, that your care did not start really until you'd got ... or your treatment didn't start until you actually got to our A&E departments. That's changed. We've got very specialised paramedics now manning ambulances, very specialist skills linked to the ability to use technology of diagnosing people at the site with, you know, heart tracings and things like that, and sending that information over to hospitals, so the care and the treatment starts when that paramedic gets to your door.

Now in terms of ... that's if you need a paramedic, obviously you're an emergency case, OK? So just put that to one side for a moment and just think about if you need to come into hospital for a planned journey, because you know that's a large volume of patients. We're working with the transport unit based in this building, Durham Integrated Transport Unit, on looking at how we can provide services to actually make sure patients can access all of our sites. Now there is a service being set up in the east of Durham which connects all of the hospitals to the communities in East Durham and that's about bringing together the Patient Transport Service, that's the ambulance service, voluntary driver schemes, public transport information, altogether under one roof, so if you need to get to the hospital for ... either as a patient or as a visitor, you would ring one number, ring that number, somebody at the end of the phone will assess whether or not you need an ambulance, not a Blue Light ambulance remember, this is just a public ... the patient transport service. If you need an ambulance they'll book you to that ambulance, and if you don't need an ambulance but there is a good public transport route that currently exists they will book you onto that public transport route. If there isn't a good public transport service

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and route then we will be commissioning additional services to get you to our sites for those appointments, but that's for you as a patient, that's for you as a visitor and that's also for our staff. Now the transport unit are working with us on that, they're leading a project which we will get some formal results from that very early in January in terms of the services that we would put in place, but I just think it's important to say that they've done some analysis of our data on the patients that we expect to be travelling between sites, because obviously we've looked at that, and their initial look at that is that it will affect around about eight patients a day, OK? This is people coming into hospital for a planned, you know, so it's eight people a day where we would have to provide transport over and above that that is currently available. OK? Much less than I think we all first anticipated, so they've mapped our proposals onto existing transport services, so I'll just leave you with that.

SE: Thank you Diane. Very quickly, finally from me, just to say something about the impact here in Durham and the north of the city. Services at Chester-le-Street, Shotley Bridge, remain the same. It's probably worth just pointing out that whilst we are making changes around day surgery, we would anticipate that there will be some continuing day surgery at Shotley Bridge and we expect that to increase, just to make that point very clear. And as you will see, and as you'll have heard, we intend to concentrate our acute services on the UHND site and develop that site significantly for acute services in the future. So if I could just say finally I hope ... thank you for listening ... I know we've bombarded you with a lot of different information here, but I hope we've been able to get across to you the reason why we're so passionate about the need to make these changes, so we can continue to provide a high quality and excellent service to our communities. David.

DG: OK. Thank you Steven. Thank you for being patient and for listening to that folks, it's now your opportunity in two different ways to actually have your say and feed into the consultation, but also as I said earlier, in this next bit, to actually formulate some questions for the panel which we'll pick up in a later session. Because it's awkward doing this in this room what we'd like to do is ask people to go out into the foyer and if I ask Verna ... Verna if you can identify yourself please? Verna and her team will sort of arrange people into groups in the foyer there and the two things we'd like you to do is feed into some specific answers to questions we've got for the consultation process, but secondly to talk with the facilitator and actually formulate some questions for the panel and there'll be time for some panel questions for when we come back into the room. We've got about half an hour or so for the group discussion and then we'll bring people back into here and go on to that final plenary session. Thank you.

MEETING MOVES INTO ROUND TABLE DISCUSSION GROUPS

(General talking as people move around the room)

FEEDBACK FROM ROUND TABLE GROUPS

DG: OK thank you everybody for your input into that session. What I'd like to do now is to, if I may, is to invite the three facilitators first of all just to feed back a couple of key points from the discussion and then I'll come back round to them and ask them if they can then start to put the questions that you've formulated to the panel so we can try and get some answers for you. So if I can start ... Mark's sat right in front of me. If we can start with Mark, from your group can you just give us a couple of key points please?

M?: *OK. Yes, certainly, the first one I suppose, it really relates to question 3 which was do you think the process of this consultation is robust? There was a distinct feeling in the group that ... well, yes, it's alright so far but it's a difficult question to answer even now ...*

DG: It's not the end.

M?: *It would even be easier in an hour, you know, once people have had time to ask questions.*

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DG: Fair point.

M?: *There was some general discussion about the quality of services and the load upon A&E currently and a bit of concern about that, obviously it's mostly questions I think.*

DG: OK.

M?: *We had a lot of discussion about the quality of the information and documents and website produced so far.*

DG: Was that that it was good quality or bad quality or ...?

M?: *It was mixed views really.*

DG: OK.

M?: *Some people felt, yes, yes, it was very good and then there was one or two that thought well not really and it wasn't very patient friendly, but then again to counterbalance that there was a view that it was good because there was a newsletter, there were some meetings and there was a high quality website.*

DG: OK.

M?: *There was a variety of options.*

DG: OK. That's good, thank you. If we can go back to the two ladies further back. Jill, if I can start with you please?

J?: *I think we, in our group, we certainly felt that the European Working Time Directive was a very powerful driving force for the proposals put before us. The need for specialisation, there was a general consensus that that was extremely important and a recognition that this would hopefully lead to improved clinical outcomes. In relation to the consultation there were certainly several members around the table who hadn't received information around the consultation process through the door and that's something that we'll follow up after the meeting.*

DG: OK. Yes, we'll do that thanks.

J?: *And then finally in relation to the options, there was a willingness to accept or to support Option B, but again very much contingent on adequate transport provision.*

DG: OK. Thank you. Last but not least ...

VF: *Some of the issues coming out of my group were issues around transport, parking and access ... came up, with some concerns about some of the changes affecting all of those things. There was ... the comments around the consultation was that there was a general feeling that it hadn't been robust enough and there was some ... a reluctance to make a decision about the options until people felt that they had some more information so they were able to do that fully informed and that they would welcome as clear and concise information about the need for the changes and then the impact on services so that that would facilitate some of the decision making process.*

DG: OK. Thank you. I'm not going to go into great detail in getting feedback on absolutely everything because we don't want to kill people off with feedback, but do rest assured that all the information that the facilitators captured will actually feed into the process and that will feed into part of the consultation work. In addition to that as you know there's ... Vaughan from Proportion is actually writing everything down as we go through this session as well as us recording it. Can I ... actually we might as well stay with you ... can we now get into ... what we'd like to do is ask you just to relate a

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couple of questions from each group which we'll get the panel to answer and we'll go round you, two questions each until we exhaust them all hopefully.

?: *A couple of questions ... I've got lots of questions.*

DG: That's OK. Yes.

?: *...from the group. One of the questions was what would be the impact on services if we didn't change at all and what would happen in five years time?*

DG: OK. We'll get the panel to answer that first ... is that for Bob?

SE: Start with Bob and then ... (inaudible) to make a comment.

BA: I think I'll let Neil talk about medicine, I think I'll major on the critical care support. I can't stress enough how much pressure that service has been under, particularly on the Bishop Auckland site, for nearly two years now, and we've tried very hard to recruit, it's not about money, the Trust have given me access to a large amount of money to try and recruit a resident tier of staff to be able to deliver level 3 level critical care activity, and we can't find the people because of changes in the way doctors are being trained, so really trying to deliver that model of care at Bishop Auckland I think is significantly time limited and it is highly likely in my opinion that that would be the first card to fall among the support services. That then really puts pressure on trying to deliver an acute medical service and what there is of an A&E service on the Bishop Auckland site. But I'll pass to Neil who will talk more about the acute care, the acute medicine more.

NM: Thank you. I go back once more, as Bob has done, to recruitment of clinicians. The division of medicine is both blessed and cursed, we have young physicians, we have middle aged physicians, and we have some more senior physicians who are approaching the end of their careers. That means that we have a good cohort of people coming through from ... who are newly appointed consultants, but equally we have some people who will retire in the next five years. Now as Bob already alluded to earlier in the presentation this evening, at Durham we've about 20 or so physicians on site, I can attract high quality applicants to posts. However at either of Darlington or Bishop Auckland sites with less than half of that number on each site, I've great difficulty recruiting the same number of high quality applicants. That of course has implications for the service on those two sites, but it also has implications for the service Trust-wide. Unscheduled pressures, unplanned increased pressures on the Durham site reduce the quality of care throughout the whole County for medicine in particular, so in terms of what will happen, yes we can limp along, but the quality of what we do will be impaired, the pressure on physicians and on other clinical staff as a result of that will be greater, and the risk of not being able to provide a service where and when you want to do it becomes greater still, and that will mean more people having to move around the County for medical care rather than less.

IB: I would agree with what Neil said, I think really the clinicians feel that there is no option but to change. I don't think we can .. the option No Change in my view is unsustainable and in five years time all our services will be under huge strain. I think the key is quality of care. The reason to change is to improve quality of care and maintain quality of care. As the Chief Executive said, we've scored double excellent and we do provide ... I think as clinicians we do provide high quality care but to maintain it we do need to improve our services with the specialisation and those sort of things, I don't think we have a choice.

DG: OK. Thank you. One more question from your group, then we'll move on to another group.

?: *Another question particular to this group was what consultation information is available to people with sensory impairments?*

DG: OK. I was going to say do you want to answer that?

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?: (inaudible)

DG: No, go on, I'll let you.

DM: We've got, on our website we can provide an audio recording of all of the consultation information and we've also produced some Braille copies, so they are accessible at, you know, if people ring in and request that. We've already actually provided some people with Braille copies of the consultation document.

DG: OK. Thank you.

J?: *One of the first questions that came from our group was around a reference in some of the Seizing the Future documentation relating to Royal College of Surgeon guidance, around having one hospital for a catchment area, a population area of 500,000 and there were some concerns among the group, and this was a worry, given that County Durham was 500,000 population, and the question was very much around are these proposals a first step towards that and basically what's still to come?*

DG: I'll go to Steven first I think.

SE: Well the answer to the question is no, they're not a first step towards that, and yes, I think we're ... we are aware of that, that recommendation. I think the way that we're interpreting it is planning service for half a million people, and that's about the right size for many of the services that we operate, but we're not operating in a conurbation or in a city, we're operating in very much a rural setting, so we hold the view very strongly that operating as, I think we said in the presentation, across five sites is critical to maintaining services to that half a million. You've heard the arguments about two sites, but you know we think that that allows us to construct a robust service for the future and an example I would use if you just look at maternity services, if you think of the maternity services that we provide across County Durham and Darlington, there are about 6,300 births a year and growing. That's the most significant service outside Newcastle in the whole of the North East, so that's how we're planning, so the answer is an emphatic no!

J?: *Ok. Thank you.*

DG: Thank you. Bob ... sorry, Bob did you want to comment quickly on that?

BA: I thought Iain was going to comment actually being the surgeon. The one thing I would say just to add to what Steven said is that yes, there's a specialisation on the acute, the emergency care side, that when you're looking at a surgical team covering a population of 500,000, also to me as Medical Director, relates to specialisation on planned care and we've already got some things, we've got real excellent services provided by for example the team in Durham and Iain's team actually, the colo-rectal team, (inaudible) sacral nerve stimulators where we actually are one of the biggest providers of that service in the country, we're actually doing more than Newcastle do, and equally there are other services in say Darlington, the shoulder replacement surgery that we deliver, that sort of thing, for the whole County as well on one site because of the catchment area that the 500,000 allows us to do, so by operating that way it allows us to bring back some work that's been going elsewhere already, so there is specialisation even in the planned care.

DG: OK. Thank you. Do you have a second question for us at the moment?

J?: *Yes, absolutely. The question from our group was has anyone asked patients who are actually in the hospitals what they think of these proposals?*

DG: That one for Diane possibly?

DM: Well of course the patients who use our hospitals are also members of the public and they've had the consultation information widely distributed right across the County to all populations. Now we can't

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guarantee that absolutely every individual has received that but, you know, we've ... as best we can tried to ensure that all sort of areas and households get the information and of course we've got the website. We've also put some information on the consultation and how people can get more information about our proposals and the consultation in I think it's 70 GPs surgeries where we've got these screens, I can't remember what they're called, but screens with information that rolls across them, so there are 70 GP surgeries in County Durham that have that information scrolling across them, and we've also put the information on our Patientline screens, so in Durham, in Bishop Auckland and in Darlington where we've got Patientline, which is the TV screens at everybody's bed, we've not put information, the same as in the GP surgeries, as scrolling across the screens on the Patientline system.

DG: Thank you. Can we come down to Mark and a couple of questions from your group please Mark?

M?: *Yes, first of all, I mean the group understood about planned care potentially being in Bishop Auckland but it was a question about clarity and what's the criteria for having your planned care or day surgery or whatever in Bishop Auckland as opposed to elsewhere and linked to that is what if you have an existing underlying condition, you know, a heart problem or diabetes or pre-existing cancer condition?*

SE: That's one for the surgeon.

IB: I think it's ... the ... with all day care surgery we pre-assess patients carefully and make sure they're fit to travel to a day surgery unit. I think it's very important that the patients are fit and the majority of patients would go to either to Bishop Auckland or to Shotley Bridge. The patients who need major care with intensive care and back up facilities will have to be done on the main sites. As well as doing day care surgery we would hopefully be able to expand some of our elective, more minor surgery on to the Bishop Auckland planned elective site as well, but obviously we need to follow careful criteria and quality of care is essential for that.

BA: Speaking on behalf of the anaesthetists this time, Robin Mitchell usually does this bit but he's not here tonight unfortunately, is that we plan to put in quite a complex system of what's called pre-op assessment, so that takes account of people who have had previous heart attacks, who have got chest problems, and you can get quite sophisticated pieces of software that you get the pre-op nurses to assess the patients, you know, measure their blood pressure etc., take their history, you feed it in and the machine will actually tell you what is the appropriate site for that patient to be operated on, so we will be doing some of that as well on behalf of the anaesthetists.

DG: Thank you. Another question from your group Mark please?

M?: *Yes, it was about aftercare and once somebody has potentially gone to Bishop Auckland or one of the major sites, it was a question about where will the after care for that person be provided and there was some ... especially around bearing in mind if people are coming home after having had treatment or a stay in hospital or whatever, about the communication between health services and social services and home adaptations or whatever, but where will that be provided from and how quickly will people be moved back?*

DG: Neil, I think this is yours.

NM: I think the point was made earlier on that we will continue to provide outpatients and diagnostic facilities where we are currently doing it, so that if you have ... let's say you have a stroke and you have your acute care at one of the acute sites having been rushed there by ambulance, you're then suitable for intensive rehabilitation which may be most appropriately given at Bishop Auckland and you have a period of intensive rehabilitation there, but then you return to your home in Durham. The follow up for your care at outpatients will be in Durham, it'll not be back at Bishop Auckland and the links between the two hospitals are sound, we use the same information system so X-rays taken at Bishop Auckland are available in Durham and vice versa. We have the same results system so if you have a blood sample taken in Bishop Auckland or Durham it's available at the other hospital, and I know this works because I've moved between the hospitals and actually physically done it, so it does

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happen, and we have a single set of notes so you don't have a set of notes for one hospital and a separate set of notes for the other hospital, your case notes follow the patient, so you have continuity of that all the way through, and our discharge management teams .. we've recently brought them together under a single division so they are no longer hospital specific, they are Trust-wide and they have their own relationships with Social Services and Home Care facilities across the County, so where you live doesn't matter to them, they can liaise with your local provider.

BA: Just the only thing I would add to that is that Roy, the lad sitting at the back there, he's doing an excellent piece of work at the minute on electronic communication between our hospitals and primary care, and we're, you know, making that much more efficient going forward, we're putting really really stretching targets on ourselves to try and get really accurate and contemporaneous really communication. Now it would be a simple matter to, I think Roy will know more about that than me, to add Social Services in to these communications and I would say that if a patient needed to move we could be telling the GP (inaudible) than the ambulance moving from one part of the County to another.

DM: Just a couple of last points really is that ... for the overwhelming majority of our patients their length of stay in hospital is actually round about five days, five, six days, so for many people, you know, their discharge from home is ... it actually happens quite quick and there are a large number of patients who are in less than that, you know. For those that do require a longer length of stay well usually there's a specific need and that links to the need for us to provide better rehabilitation, so you know it is on the basis of need really that they would transfer to that. The other thing to say is that we have been talking to, obviously, to Social Services departments in both ends of the County because they need to support us in that discharge process, with the discharge management teams. They're very well aware of our proposals and what it means and they're looking at how they would better provide their services to us to support patients to ensure that that discharge into the community where people need ongoing care from community services is kind of timely and provided well.

DG: Ok. Thank you. Can we go back to the two ladies and have a couple of questions from each group please? Because we've got 10, 15 minutes, can I ask when we get the questions if we try and respond quite quickly please?

???: *We had a question around when Bishop Auckland hospital built why weren't these changes considered then and will there still be capacity in five years time?*

DG: OK, is that, perhaps that one's Steven's for starters?

SE: First part of your question, obviously then I don't suppose you could see what the situation is now in terms of some of the guidance and standards that we are required to meet and that's part of the reason in relation to that as far as I'm concerned. Secondly, in terms of capacity, I'm not sure I'm clear about the drift of your question but correct me if I'm wrong. Clearly one of the issues at Bishop Auckland at the moment if we focus there is that the capacity's under-utilised and our plans are all about utilising capacity, using it more, maximising what's an absolutely superb healthcare facility, so that's absolutely what we're trying to do. If anybody else has a comment on the history ... ?

DG: Bob.

BA: Normally I think I would say is that what I majored on in my part of the presentation is the national drivers that have come into being since 2002 when we are where we are. Now the hospital was built before that so, you know, year on year the quality standards that we're being measured against are becoming more stringent and I think the critical mass thing is a major driver to, you know, concentrate our emergency services on, on the two sites. Obviously that then potentially creates capacity issues at Durham and Darlington and Bishop really is the solution to provide the planned part of the care.

IB: Just making a point that in looking over the next few years Bishop Auckland is key as an elective care centre to the surgical plans. We're actually increasing the surgical throughput, patients treated in County Durham and Darlington Trust, over the last three years the PCT fortunately are paying us to

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provide that service. We're doing more and more day cases and as more elective surgery turns into day cases so people can get home quicker we're going ... an elective care centre where people's operations aren't cancelled because of emergency admissions is going to be key to it and I see the expansion of that service at Bishop Auckland rather than reduction.

DG: OK. Thank you. Another one from your group please?

?: *Yes, my second question was if the plans for A&E service provision aren't sufficient, do you have a contingency plan?*

DG: OK. That ... Neil?

NM: I'm not quite sure what you mean by not sufficient, I mean we have plans to change the infrastructure, the actual bricks and mortar of both A&E departments at Darlington and Durham to increase capacity there. We have good information about how many patients are currently attending all three sites and what the likely change in attendance at each of the sites would be after this, so that we can know in advance how many more patients, for example, may come to Durham and how we increase the capacity to manage those patients. I'd add to that closer working with the Primary Care Trust out of hours services which will then ensure that the patients, once more, coming back to the same things, seeing the right doctor first time. Working more closely with the Primary Care Trust to achieve that. So I think that we can create capacity on both the acute sites and finally a significant proportion, two thirds of the patients who currently go to the A&E department at Bishop Auckland will continue to do so under the current plans. This is not closing the emergency department at Bishop Auckland and all those patients going elsewhere, it's only ... no more than about one third of those patients being spread between the two other sites.

DG: OK. Thank you. Jill, a couple from yours?

J?: *Yes, the final ...*

DG: Oh the final one?

J?: *Final question, yes, final question from our group was how does the proposal for rehabilitation care at Bishop Auckland General Hospital fit with intermediate care that's already provided at the community hospitals, what's the relationship between those two?*

DG: That one for Diane?

DM: It is different. It is different. What we're not doing is providing the care that was currently provided in the community, the proposal is ... it's actually what we've done is looked at how we currently provide care for our patients, OK? So it's about looking at the same patient groups but providing what we currently provide differently, so taking the recovery and the rehabilitation part of their current stay in hospital and us providing that differently and I think we've ... you know, we've had some discussions with Social Services and we've used the words intermediate care in our document and intermediate care does mean different things to different people. Perhaps a different way of describing what we're going to provide is intermediate recovery and that kind of distinguishes it slightly from that that's currently provided in the community, so the answer is ... it's different, yes? It's what's currently provided in our hospitals but us providing it differently.

SE: I agree ... I mean it is different. The distinction can be difficult to describe.

DM: Yes.

SE: I think the ... there are two ways of looking at it, there are people who will benefit from intensive therapy services, from intensive physiotherapy, intensive speech therapy. There are people who simply need a bit longer in a caring environment to get better, they may need a little bit of doctoring, they may

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need quite a lot of nursing in order to improve, but they no longer need the intensive facilities available in an acute hospital bed. Those are patients for whom intermediate care is appropriate. There are some patients who will benefit from intensive physiotherapy to improve their mobility, to increase their stamina, to allow them to get back to functioning as well as they did before, where time alone will not be sufficient. Those patients will benefit from the centre of excellence of rehabilitation. Is that ... cleared the distinction ... or muddied the waters, I don't know?

DG: OK. Thank you. Mark? Have you got a ... a think a couple of quick questions from Mark's group and then we'll come back for the last couple from yours.

M?: *Yes, it's the last two questions. One, the first one is it looks ... somebody asked, from the plans it looks as though there'll be more medical beds at University Hospital, where will they come from, where will they be, is it beds that currently exist elsewhere?*

DM: (inaudible)

DG: OK.

BA: Of course this is not just about medicine, not just about A&E, it's about surgery as well, so with some change in surgical provision moving from Durham to the Bishop Auckland site, with improvements in our service provision as I mentioned earlier on about slicker diagnostic pathways, so that you spend less time sitting waiting for your tests, you have ... in a planned fashion, and can move through the system more quickly, by improved services at the front door where you see a senior doctor earlier, and for many cases that means you don't need to stay in hospital at all, rather than wait till the following morning to see the senior doctor, all those things will reduce our requirement for beds. There will however, our plans do include more medical beds on the Durham site than we currently provide and that will be largely initially through some rearrangement of surgical facilities to accommodate that, and the same applies to Darlington as well.

DG: OK. Thank you.

M?: *And then finally one person felt there was a very good, and apparently successful, cataract centre already in Sunderland that appears to be providing good services. Is there a proven case for this new one, which will potentially be based at Bishop Auckland?*

DG: For Steven?

SE: Well that's true, and obviously people can choose to go there and some people may well do that from the northern part of the County and, you know, that's an option that any patient has. However we're quite clear that in the south of the patch, that is we organise in that way that we will (a) I think provide a swifter and more ... a slicker service for patients requiring cataracts, and I think also there's an opportunity there to develop that service beyond the south of the County as well with some of the changes that may be happening further south in North Yorkshire, so we think there's enough, to use Bob's terms, critical mass, to develop that, but essentially it's a quality improvement, we don't have that facility anywhere in the County at the moment and we'll be dedicating resources at Bishop Auckland to a specialist centre for cataract surgery.

DG: OK. Thank you. I think we've got one more question from ... from the third group?

?: *Just a final question was around the parking and access issue and Diane's already mentioned ongoing work around the transport issue. Does that include some work around parking and access, particularly disability access?*

DG: Is that one from Diane or ... ?

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SE: I'm going to talk about parking. Diane's going to talk about disability access. The short answer to your question is yes, I mean clearly in our thinking we've had to take account of parking and access issues. I would point out that the transport system that Diane outlined in the presentation will of course assist in parking we would hope because we would see that service not only providing, you know, an opportunity for people to travel between the sites, patients and their relatives, but it also enables staff to move across the sites as well, but we are making plans alongside these, should they go ahead, to review our car parking and respond accordingly.

DM: I don't perceive a huge problem with the proposals that we're making in terms of disability access, in terms of what we need to do for access. I think we kind of meet all of the current recommendations that are laid down for us. There might be an issue around additional disabled bays within our parking arrangements but we actually need to look at the parking arrangements on each site to ensure that, you know, that kind of thing is taken into account if we're able to go ahead. I mean in terms Many of the people who have disability access will actually access our services through patient transport services as well and through voluntary driver schemes and obviously they need to be assessed through that booking arrangement within that and taken account so, I mean, I think if there's anything more specific that you picked up from your group then I think we'd be kind of keen to hear that, if there's something that we haven't taken account of.

DG: Thank you. I think that's answered all the questions from the groups. We've probably got just literally two minutes if ... there's time for two more questions from the floor if anybody thinks they haven't had the opportunity to have their question ... gentleman at the front here. Can you just ... I'll need you to speak in the microphone, can you say who you are as well please sir?

GE: *George Edmond. There's one area of secondary care which hasn't been mentioned at all, it's a shambles at the moment, when I say what it is you'll probably say it's nothing to do with us Gov, well who is it to do with? When's it going to be sorted out? And unified with the other things, and I'm talking about psychiatric care.*

DG: OK. I'll answer that from the PCT commissioning point of view. I mean you're right, as I said at the start, this consultation is very much about the acute care, the hospital care for physical illness. As a PCT and as commissioners we are looking to actually do a lot more work with psychiatric care and mental health and perhaps we can have a discussion when we've finished if that would help, but it's not part of this consultation directly. One last question from the gentleman to my right there?

?: *It's not a question, it's an observation. You've been ... embark upon a consultation process and if I was sitting where you people are sitting I wouldn't be over-thrilled at the turnout you've had here this evening and I think that'll be true throughout the whole of the exercise. I don't have any quarrel with that because I firmly believe, because I've been involved in consultations in my previous existence, and at the end of the day the people who really matter are the folk who are sitting at the top table where you are and as far as being a regular attender at University Hospital Durham I have nothing but the highest praise for the work that you undertake and do on our behalf, so I'd just like to leave that thought with you, that your consultation hasn't fallen on deaf ears, it certainly has gone back to you by way of the passage of normal consultation. Personally I don't have a lot of faith in consultation but nevertheless it's got to be gone through in the democracy. You're doing it extremely well and you're also looking after your patients extremely well. Thank you sir.*

DG: OK. Thank you. I think that's led very nicely into next steps so I just want to explain now what the process is from here really. It is part of a formal consultation process. It's something that we have to do, but actually it's something we want to do, certainly as the commissioners and the PCT who buy the services, the only way we can do that and get it right is by listening to local people and listening to their views so it is really important and we have to do it. We've captured everything that you've said today. As we've said, we're doing it electronically and the facilitation groups have actually captured it, Vaughan's captured the points that were made there so there will be a record of the whole of the proceedings and that will be fed into the process as a whole.

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The process goes up to 12th January. One of the things I want to stress and it probably picks up on the gentleman's last point there, this is one part of the process, the public meetings. There are a whole range of other ways that I'll come on to in a moment, how you can actually participate in this consultation because it's not all about public meetings. It's one way of doing it. The process at the end of the consultation process is that the Foundation Trust, the colleagues who've made the presentation to you this evening, will sit back and reflect on the issues arising from the consultation and possibly amend/adapt their proposals for change in light of the consultation process. That will then come to our Board at NHS County Durham, the PCT, and we will then take a view on whether, in light of all of the evidence which will include the information coming from the consultation process, it'll include the information that colleagues have given us as part of the work, and lots of other evidence as well, and then we will decide if this is something we will actually support and fund and actually help take forward. I need to stress at this point that to date, and as part of this process, the only decision that we've made, the only single decision we've made, is to actually embark on this process, and that's the consultation process and I know there's potentially some cynics around who might say it's a done deal etc. I need to assure you that that's not the case and not until we get to that point in February at the earliest, February of next year, will a decision be made and at that point it will be in light of all the consultation.

I mentioned how you can get involved. A range of ways, obviously coming to public meetings is one way to do it, but as the slides say there, you can actually fill in the consultation response form and that's one the back of all the literature we've sent out, obviously you've had a chance to pick some of that up today, you can fill that in. You can log into either our website at the PCT, the Trust website, or you can actually visit the Seizing the Future website, the address is there, www.seizingthefuture.org.uk, you can respond via that and actually there's a lot more information in that website and a lot of the detail behind the presentation which of necessity, you know, colleagues can't get into as part of a process this evening. There's lots of information there. If there's anything you think isn't available that would help you understand the issues and help you form a view, then please get in touch with us and let us know and we'll try and provide that information for you, because it is important that you understand the issues and can have an informed view into the process.

You can also email comments in to the email address that's up there and is also in the documents. And lastly if you want to you can actually just write to the Freepost address and feed that into the consultation process. That will all be taken account of in the decision process that I described a couple of minutes earlier.

Having said all of that, I'd just like to thank you all for ... one, for being here tonight, for turning up, but most importantly for listening and taking part and your input into that which we will listen to when we come to actually here this as the NHS County Durham Board, so thank you for that time and input, thank you for hopefully getting involved in the other ways that we've described, I'd like to thank all the staff that have helped this evening and can I wish you all a safe journey home. Thank you.

(End of meeting)