

**Seizing the Future Public Meeting
District of Easington
Building 10, Council Offices, Seaside Lane, Easington
Monday 10th 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
Brian Key, Director of Commissioning - North East Offender Health
Dr Katherine Noble, GP and Clinical Representative for Seizing the Future NHS County Durham
Dr Robin Mitchell, Divisional Director of Clinical Support Services - County Durham and Darlington NHS Foundation Trust
Laura Robson, Director of Nursing - County Durham and Darlington NHS Foundation Trust**

DG: OK. Good afternoon ladies and gentlemen, conscious of the fact we've started five minutes late, we were due to start at 2 o'clock, now we've deliberately done that because we knew a few people were still getting parked and what have you. My name's David Gallagher, I'm one of the directors at NHS County Durham, or County Durham PCT as we used to be known. It's our role to actually chair events and explain the process but before we actually get into the proceedings if you like, I'll just ask a number of colleagues to introduce themselves. I'll start ... we've got some PCT representatives so I'll ask Brian to introduce himself first.

BK: Thanks very much. Good afternoon everyone. My name's Brian Key, I'm a Director of Commissioning for North East Offender Health.

DG: Thank you Brian. And to my right I've got Kat.

KN: Hello. My name's Dr Katherine Noble, I'm an urgent care GP and I'm going to be the PCT Clinical Representative for Seizing the Future.

DG: Thank you. We've also got a number of colleagues from County Durham and Darlington Foundation Trust. I'll ask Steven Eames, the Chief Executive to introduce himself and then the team to introduce themselves. Steven?

SE: Thank you David. Good afternoon everybody, I'm Steven Eames, I'm the Chief Executive of County Durham and Darlington NHS Foundation Trust.

BA: Good afternoon everyone, my name's Bob Aitken and I'm the Medical Director of the Acute Trust.

RM: Hello. Good afternoon everyone, I'm Dr Robin Mitchell. I'm the Divisional Director of Clinical Support Services for the Foundation Trust.

LR: Hello. I'm Laura Robson, Director of Nursing of the Acute Trust.

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

DG: OK. Thank you all. This is a really important meeting today; it's actually the fourth of a series of about 16 public meetings that we're holding, looking at this piece of work called Seizing the Future. I want to explain the different roles and responsibilities around the work that we're doing at the moment. As I said I'm from NHS County Durham. Our role in life if you like is to actually make sure that we buy, we purchase, commission services for the people of all of County Durham and all of Darlington, so that's health services from acute hospitals, the big hospitals, from community hospitals, community care, GPs, dentists and also from mental health hospitals. That's a big role and we spend about a billion pounds a year actually doing that. This piece of work is looking specifically at the hospitals that

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provide services from County Durham and Darlington Foundation Trust hence the array of colleagues that we've got with us and I'll ask them to explain what the process is about or what the proposals are about in a few moments. Our role and responsibility in terms of the meeting today and in terms of the consultation process is, as the commissioners or the people who buy those health services, it's our role to actually make sure that we run a fair and a robust and open consultation process and I'll say a little bit about what the next steps are towards the end of the proceedings this afternoon.

Obviously colleagues at County Durham and Darlington Foundation Trust, they actually provide the services and they're here today to explain the proposals that they've brought to us as commissioners. We've also got colleagues from a company called Proportion, they're here to help us with the whole consultation process and the public meetings are only one part of that process, there's a whole range of other ways that people can actually get involved which I'll come on to in a moment. But we've got a couple of colleagues here who are helping us with this and one of the reasons that we're using the microphones, apart from being able to be heard, is one of the things that we're trying to do is to actually record all of the proceedings, so when we get on to a later session where we come to some plenary questions I'll ask people if they're going to ask questions to introduce themselves so we've actually got that for the record, and then we'll get a transcript of the whole thing back over later on.

The aims of the meeting today and, as I say, the whole point of the consultation is that we're really keen that when we listen to the proposals that come from the Foundation Trust we take into account a whole array of evidence, some of which and an important part of it is what local people think and that's what this consultation process is about. There are other ways you can actually take part in the process, you can actually submit things in writing, via things that come through your door, some of the news sheets that have come, you can go on to the website and submit information on that and fill in the questionnaire, but this is one part of the process that we're in today. A key thing about the meeting is we need to make sure that this is very much two way communication and what I mean by that is it's an opportunity for colleagues from the Foundation Trust to put their case forward and explain what their proposals are and a similar opportunity for you to have your say, and I'll explain a little bit in a moment in terms of the structure of the Agenda for how we'll do that in two separate ways.

Obviously we need to listen to your views, we'll record the input as I've described and then the key thing towards the end of the proceedings and we will finish in time for 4 o'clock, is that we'll actually explain what's going to happen next and how you can continue to get involved in this process as it goes forward. But if we look at the Agenda for this afternoon, I'm going to ask colleagues from the Foundation Trust to make a presentation for about half an hour in a moment, we're then going to actually change the batting order around a little bit there, rather than have open questions from the floor, we're going to go and actually have some round the table discussions, and what we've got is we've got a series of colleagues from both the PCT and from the Foundation Trust who help facilitate that and help get your views into the consultation process and hopefully prepare for the second, last section there, which is actually about giving some open questions from the floor, some plenary discussion. We'll then take some feedback and then we'll close and actually explain what's happening next in terms of the process. So that's hopefully what people are expecting from the meeting, that's what it's all about. I'm going to hand over to Steven and colleagues now to actually go through their presentation.

SE: Well thank you David. I'll swivel the microphone round, can you all see the screen if I stand here? Great, thanks very much. Yes, I'm going to kick off with a few key messages and then I'm going to hand over to Diane who'll take you through some of the detail of the case and then finally to Bob Aitken who'll put forward our case for change and pick out some of the key clinical issues that we're facing. As you may know, Seizing the Future has been underway now for almost a year and the two big messages I want to get across first is that this is about improving our services and in particular improving the outcomes of care for the patients that we serve. We're aiming and we're very very passionate about delivering the best possible services that we can for all of our communities and this is what Seizing the Future is aiming to do. Next slide.

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So five key messages. Underneath all that work it's been led by our clinical colleagues, our doctors, our nurses, our therapists, over the last.. almost a year as I said, and they've been working very hard and looking at all of the different scenarios and options that could present themselves given the challenges that we face. I also would add they've been working very closely as that work's gone on with our Governors, as a Foundation Trust clearly we have Governor representatives representing our different communities, so they've been working closely as well with our Governors and our membership so throughout that discussion there has been a patient perspective being offered.

Secondly, what ... we're driven by two national agendas, first of all, to ensure that we provide safe services, some key areas require us to centralise those services rather than have them distributed across all of our hospital sites and that particularly affects some of our emergency care services. Secondly, what we're committed to doing in line with national programmes and change is to deliver as much as we possibly can in terms of our services locally and in ... at the heart of the communities that we serve. Next we're planning to maximise the use of all of our hospitals, you'll know we provide our main acute services from three hospitals but ... at Bishop Auckland, Darlington and at Durham, and we also provide community services from Chester-le-Street and Shotley Bridge, so we're looking to make the best use of all of those hospitals moving forward. And can I also make it absolutely clear because it may not be clear from some of the media coverage that we've had, there are no closures being proposed here, we are proposing changes to the way that we organise services but we're not proposing any closures whatsoever and in tune with that there's also been some commentary about the issues for our staff. We believe quite clearly that these proposals will improve and enhance the opportunities for our staff to develop their experience and their professional careers, so there are no redundancies associated either with these proposals if I can make that clear as well.

So the model we're proposing and I'm here focusing on three acute sites, is to concentrate our main acute services at Darlington and at Durham and to develop Bishop Auckland as a centre for planned care and what we would regard as you'll hear in a moment as a centre of excellence for planned care, and I've mentioned that we'll continue to provide services at Shotley Bridge and Chester-le-Street. In fact we'd expect the services to develop as the national agendas develop, particularly in relation to diagnostic and outpatient services. OK.

How did we select the sites, well Bishop Auckland is geographically well placed to develop in the way that I've described and indeed as many of you will know the quality of the facilities at Bishop are excellent, they're first class, so we see that as a great opportunity to provide planned and elective care at that site. During the course of the work that I refer to going on over the last few months, we have examined all of the scenarios as to how best to organise our services and taken into account the way that patients move between our sites, move into the hospitals from the different communities and we've looked at how those flows would ebb and change depending on how you configured the model. Clearly ... so we've looked at whether Durham could operate as the planned site, or whether Darlington could operate as the planned site and from every angle it's quite clear when you do the analysis that Bishop Auckland is the best place for us to move in that direction, and if I give you a couple of examples as to why we think that is so, when we looked at the cost of developing these proposals and we took into account the various models I've described. If we were to develop Durham as the planned site it would cost around £80million. If we were to develop Darlington as the planned site it would cost about £120million. Our proposals as you'll know from the documentation for the model we prefer indicates a cost of £7million. We also know that in organising our proposals that the least impact on our staff arises from organising in the way it's proposed here with Bishop being the planned site. And lastly, and probably most importantly, we had an independent review undertaken by Professor Sir George Alberti and he made it quite clear that looking at the way that we were currently constructed at this point in time, it made absolute sense to organise the clinical services in the way that we propose and identifying therefore Bishop as the planned site for the future. So with that I'm going to hand over now to Diane who'll take you through some of the detail around what we're actually proposing on each of the sites.

DM: Thank you Steven. This is a slide really just to try and show you what ... which services are going to change at Bishop Auckland. Currently at Bishop Auckland there's an Accident & Emergency

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department. That Accident & Emergency department isn't a full Accident & Emergency department in the way that you see an Emergency department at Durham or at Darlington or North Tees, those sorts of hospitals. What it does do at the moment, it takes minor injuries and it takes acute medical admissions so that is people with things like acute strokes, acute chest conditions, it doesn't take acute surgery and it doesn't take trauma and it hasn't done for quite some years. So it is a limited, as we might say, emergency department. What we're going to do there is create a 24-hour urgent care centre integrated with the services that the GPs currently provide. The net effect of that is that ... there are currently 29,000 patients a year treated in the Bishop Auckland A&E department, with our proposals 20,000 of them will still be treated within the A&E department, within the integrated urgent care department, so 20,000 will still be treated there. Another proportion of those will be treated in the service that we're calling Medical Rapid Assessment Service which is a service that will be run by consultant physicians, seeing, assessing and diagnosing and initiating very urgent investigations like scans and that kind of thing and that's for patients who don't necessarily need admitting to hospital, so GPs will be able to refer into that. So a large proportion of patients currently treated at Bishop Auckland will continue to be treated there in the 24-hour urgent care services. The difference with the minor injuries side of that is that that will be led by nurse practitioners, they already exist, we already have them there and we already know that they treat those patients very well and very effectively. We have a midwifery led unit, very well received by the public, that ... there's no changes to that, that will continue to be provided and I think if there are any changes what we really would like to see is that more people avail themselves of that unit and receive the high quality care that we know that that provides. Acute paediatrics is currently provided at Bishop Auckland, it is provided in limited hours, it's not a 24-hour service, consultant led service. Overnight there are no consultant support overnight, so acutely ill children who need care overnight are actually already transferred to the other sites at Darlington and Durham. That service will be centralised onto Durham and Darlington sites, but during the daytime there will be a paediatric rapid assessment clinic running similarly to that that will run for adults for medicine, so if a GP sees a child, doesn't think that child needs urgent admission to hospital, then the child will be able to be seen by a consultant paediatrician, rapid assessment, rapid access to diagnostics, and a treatment for the child's subsequent care.

Planned surgery, there's already a range of planned surgery happens on the Bishop Auckland site, that includes hip and knee surgery, that will continue but we will be doing more of it. We will use Bishop Auckland as a specialist centre for day surgery, so more patients will go there for planned surgery. The hip and knee unit similarly will continue there. We already have a Trust-wide colo-rectal screening centre, that is a specialist cancer screening centre that the Trust provides, that will continue, and I've already mentioned about rapid access for some groups of patients to diagnostics, that will continue, we will continue to provide a full range of diagnostic facilities on the Bishop Auckland site, that will include MRI scanning, CT scanning, all other X-rays, blood tests, that kind of thing and a full range of outpatients.

Where patients have to be treated at a centralised site for acute care, what will happen is that all their follow up in terms of diagnostics and outpatients will happen at the hospital most local to them, so we won't expect people to travel for diagnostics or for outpatients where the local hospital provides that.

We currently provide critical care on the Bishop Auckland site, critical care is an intensive care unit. Now an intensive care unit is required because many of those services, like an A&E department and acute medical admissions, so your very sickest patients, you can only provide those services if you're able to provide the back up of an intensive care unit. That intensive care unit currently at Bishop Auckland provides care for two levels of patients. We categorise the types of patients as level 1, level 2 and level 3. Level 3 being the most sick patients and level 1 the least. For various reasons which Bob will pick up later on in his slides we currently are not able to provide level 3 care on the Bishop Auckland site, so that is for the most critically ill patients. Those patients have for some time now ... have been managed either at Durham or Darlington. We won't be continuing to provide that care at Bishop Auckland. Those patients will be transferred to the other two acute sites.

We will however be developing some new services on that site. We will be developing a centre of rehabilitation excellence. Just to sort of try and describe what that is, many of you will know that when

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you come into hospital the first few days of your care in hospital is kind of the most intensive part of your hospital stay where you require quite a lot of attention from doctors and from nurses and you probably at your sickest in those few days. Once you're over that kind of acute period, you actually move into a period of rehabilitation. Stroke is a good example of that. After a few days you actually move from being acutely ill to actually needing rehabilitation, needing much more support from therapists, from occupational therapists, physiotherapists and probably more from nursing staff and less from medical staff that you were requiring. What we want to do is actually create a centre where all of those services can be provided seven days a week to all patients to actually improve the outcomes of your care, to make you recover more quickly, and to actually reduce the length of time that you need to spend in hospital. We do believe that this will give significant benefits to patients, reducing the level of disability that you have at the end of your hospital stay, enabling more people to be discharged back to the place they were admitted from, so fewer people being discharged into supported care in the community, that might mean, you know, residential homes or nursing homes, so you know definite benefits for patients in that. We're also going to develop a Trust-wide cataract centre. That links into our day surgery proposals but a very specialist cataract centre, that's something not currently provided on the Durham site, so it will be available across the County for patients requiring cataract surgery.

At Darlington and Durham we centralise Accident & Emergency, we centralise acute medicine and acute stroke and the reason we centralise acute stroke is because to manage acute strokes we actually need the support of intensive care units and the anaesthetists to make sure the care is delivered safely. The only other thing that changes in that is acute paediatrics, again, that's moved onto the Darlington and Durham sites and again full range of diagnostics in outpatients.

Now benefits for patients. A number of benefits, the first one we'd like to talk about is better access to a specialist. Bob will touch on it in more detail in his presentation in terms of why this is critically important, but you know that, you know, to get the very best care you need to see a specialist in your type of condition, whether that's a chest condition or diabetes, you know, you need to see the person who is bang up to date, is dealing with that kind of patient all of the time, knows the latest treatments and, you know, by getting you swifter access to a specialist by centralising some aspects of that care, we again will make sure that you recover quicker and at less risk of your condition deteriorating later on.

Being on the right ward is really linked to access to a specialist, it means that by us separating planned care from our acute care we can better ensure that you go onto the ward where not just the specialist doctor is available but nurses and therapists who deal in that type of care and condition every day are available and are better in tune with your needs and are able to respond to that and, again, improve the outcomes of care for you.

Less risk of cancelled operations. You know that if you're planning to come into hospital, lots of arrangements go on at home just to kind of enable you to, you know, to get into hospital, and occasionally some people's operations are cancelled because we have demands on the acute beds and if somebody needs that bed acutely, if a patient needs that bed, we sometimes have to prioritise to that. By making the Bishop Auckland site a planned care centre those beds are going to be protected for those of you that need to come into hospital for your planned surgery, so you know you're much less likely to get that call to say that your operation's been cancelled.

Better rehabilitation after being ill, that links back to the comments I was making about a centre of rehabilitation excellence. You know, this is something that our therapists and some of our nursing staff that work in those kinds of areas where more rehabilitation takes place now, are very excited about that, we really think that will deliver you some significant benefits.

Risk of infections like MRSA. It's a great concern to the public, MRSA infection, it's a great concern to us, hospital acquired infections. By separating planned surgery what we can do is people who are going in for planned surgery will be screened for MRSA before they're admitted, and if you screen that means before you come into hospital we know whether or not you have an MRSA infection present and

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we can treat that and much less risk of you then coming into hospital and cross-contamination within the hospital.

And quicker tests and diagnoses and that links back to the way that we structure our services, again separating planned and elective care and access to specialists.

The impact on the North Durham sites, we were trying to sort of think what it means for your communities, I mean services at Chester-le-Street which some people might access, there are no plans to change any of those, they will all continue as they currently are. At Shotley Bridge similarly we haven't planned any changes in there but we do know from using day surgery the way we will, and planned surgery, there will be some additional surgical cases treated and managed at Shotley Bridge hospital and we think that that will increase over time. At Durham we will see an increased number of medical beds, so medical cases, acute medical cases going into the site and a reduction in day surgery on the site, there will still be a need for some people to have day surgery on that site and that will be people who have particular needs other than their specialist surgical needs, so it might be if you've got some pre-existing conditions that require that you have a kind of ... more support than other patients, and we will see an increase in A&E admissions.

Now travel and access is something that right from the very start we've had a lot of discussions about and the public have raised, at just about every meeting we've gone to, about the issues of travel and access. I've already mentioned we'll be having outpatients and diagnostics at all sites, so it's a principle of only travelling where necessary, so you only move to another site where it's absolutely necessary, so pre-hospital care, planning for surgery and follow up will all be done at local sites.

It's useful I think to mention the paramedic role in emergency care and just to kind of note that the days when your hospital care started as you went to, you know, the A&E department have gone. You know, paramedics now ... and these are relatively new roles developed over the last few years, but you know as soon as a paramedic gets to your home if you are acutely ill, that's when your care and treatment starts, you know, it's not when you get to the hospital doors. Significantly different to that, that it was probably even five years ago. We've been working with the Integrated Transport Unit at County Hall on developing a new transport service to serve the population. Now in this area you've got a fairly new service called the East Durham Hospital Link and this new service will be similar to that. It will bring together the patient transport service which is currently provided by the Ambulance Trust, voluntary driver schemes, public transport and also some additional services and what it essentially means is that if you need to get to one of our sites, whichever site it is for an appointment, you will ring one number and you will say I need to get to this hospital on this date at this time. You will be asked if you are eligible for Patient Transport Ambulance, so this is not a Blue Light ambulance, this is kind of the one that just sort of buses people around really, you'll be asked if you're eligible for that, asked some questions, and if you are you will be booked on to that Patient Transport Ambulance service. If you're not entitled to that then they will check whether there's an existing good public transport route, OK? So a good public transport route means it runs frequently enough, it doesn't require you to walk two miles from A to B to get to it, or from the other end to one of our hospitals, if there's a good public transport route you'll be advised of that, and if there isn't and where there are gaps in services there will be new services commissioned and you will be booked onto that service to pick you up near to your door within a 30 minute time slot to get you to hospital. Now it's not just about the patients, getting patients to hospital, it's also a service that will be available for relatives to use to get to and from hospital with patients or for visiting times and it's also a service our staff can use. I'm just going to hand over to Bob Aitken now, our Medical Director.

BA: Thanks very much. Good afternoon again everybody. Before we get on to why we need to change, I just want to make three brief points. Some of what I'm going to be saying is actually quite technical. If I just stick to one explanation at this point but if you want further explanation later on just take a note and I'll try and answer under the open questions session. Di's already alluded to the fact that in critical care patients are graded 1, 2 and 3 from the least to the most sick. It's a similar grading from 1 to 3 for A&E patients, 1 being walking wounded and 3 people who are coming off the back of ambulances who

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need immediate resuscitation or they would die, and 2 are almost everything in-between, and that's quite significant when I go on to explain one or two things.

The present configuration of acute services in County Durham is a direct result of another service review that was undertaken in the early part of 2002 by Professor Sir Ara Darzi at the time, now Lord Darzi, who is the Junior Health Minister, and again I would emphasise what Di has said as my third point, is that the A&E at Bishop is not a full A&E service and I'll come back to that a bit later on when we talk about the Accident & Emergency changes that have been recommended since 2002. So as I say we are configured the way we are based on Lord Darzi's recommendation of 2002. Since then lots and lots of things have changed in the health service. There's an increased level of specialisation in services, and the specialisation really takes almost two forms, one is the actual complexity of surgical operations, the complexity of pieces of equipment, very highly sophisticated, very expensive pieces of gear that you can't actually put in every local hospital and then a combination of the two. The expertise that you would need to actually be able to use these pieces of equipment and not all of these operations are suitable for every patient so you've got to have what we term a critical mass, and that's an important term as well. The critical mass of activity that a specialist will see in a year, for example, that will actually enable him or her to be recognised as a specialist in that field. Now that drive to specialisation has in fact led, as I say in the past eight to ten years, for the recommendation from the Department of Health for the catchment area for a District General hospital for example to go up from around a quarter of a million people to nowadays probably somewhere between 400,000 and 500,000. Alright? Now that's to allow you to have a critical mass of activity to allow you to sub-specialise, to be able to continue to deliver 21st Century care.

Now let's go on and talk specifically about some of these other things. Doctors' working hours is a piece of legislation otherwise known as the European Working Time Directive. Now that's been brought in for junior doctors over the last few years in three phases. In the third phase, the final phase, is implementing in August 2009, and that is when junior doctors' maximum number of hours work in a week reduce from 56 to 48. For our organisation that means, just by taking these hours out, we lose the equivalent of 31.4 whole time equivalent junior doctors, that is we've got fewer people who are available to staff emergency on call rotas, you know, among other things. Now that, in itself, if we just keep the same number of doctors, and there are problems I won't get into now, but I'm prepared to try and answer that under the questions session, is that that in itself with these reductions in doctors on the rotas means that about 60% of our on call rotas become EWTD compliant, that is we do not with the European legislation, or comply, sorry, with the European legislation. When that sort of situation happens and the various Colleges come round, and specialist training committees, to look at recognising or continuing our right to be a training establishment for junior doctors, if you're non-EWTD compliant you automatically get your training recognition withdrawn, so potentially it is a very serious situation for the organisation, and we've got to address that as a matter of some urgency, and all of our teams at the moment are producing plans to try and give us an idea at the centre of the organisation how we're going to comply with this legislation. One of the ways of doing it, in fact the best way to do it, is to reduce the number of emergency on call rotas that you are actually manning.

Specific services. Accident & Emergency, in 2002, there were no real concrete recommendations as to what an Accident & Emergency should entail. There were a whole gamut of different types of services. In 2003/4 the newly formed Royal College of Emergency Medicine, the new name for A&E, was given its charter and at the end of 2005, beginning of 2006, came out with recommendations for staffing levels in A&E departments and more importantly the recommendation for the critical mass of activity, particularly at the higher end level 2 and level 3 type of patients that you were treating, to be able to provide a full A&E service and if you did provide a full A&E service what support services should be there, trauma, critical care etc. etc. Suffice to say at this point that there isn't enough A&E activity in County Durham to warrant having three full A&E services. But we don't have three full A&E services anyway. The one at Bishop doesn't take trauma, it doesn't take acute surgery.

Acute medicine. New developments since 2002. In 2003 as well as having sub-specialties in gastroenterology, cardiology and respiratory medicine, the Royal College of Physicians recognised the sub-specialty of acute medicine or acute care and recommended that we develop a new breed of

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consultant called an acute care physician who was specially trained to treat the sickest patients when they come into hospital for the first 12 to 24 hours. The model of care recommended by the College in 2004 is any patient presenting with a medical emergency should be treated by an acute care physician in a medical admissions unit. Once they were stabilised they would either go home to primary care support or they're admitted to a base ward and put under the care of an 'ologist', cardiologist, respiratory... And one of the other recommendations was to ensure that there was always an appropriate specialist in the back shop that these guys should work in teams of at least two, yes? So that even if somebody was away on holiday, you know, even off sick, we could still have an appropriate specialist who would deal with the patient when they came in through the MEU. At the present time, probably more by accident than by design, in the University Hospital in North Durham, following the merger of Shotley Bridge and Dryburn, is that we have got enough physicians that we are actually able to deliver that model of care, we have got acute care physicians on the ground, not as many as I would like to be honest, but we're working on that, but we've got enough sub-specialists in the back shop to give that model of care and both Darlington and Bishop Auckland, we are not able to deliver that model of care, because we don't have enough physicians. But also in the south of the County because of the number of doctors, enough for the frequency of the on call rotas for general take, is that we've had difficulty recruiting physicians, young doctors don't want to come and work in small teams. We haven't had that problem in Durham, so there is something that we've got to learn from that, locate bigger teams, providing modern style of care, you can recruit people quite easily. When we're delivering an old fashioned type of system, not that it's unsafe, but it's not the way young doctors want to work and we do have recruitment problems there.

Critical care itself, there have been some issues for a number of years actually on the Bishop Auckland site particularly and we have ... because the middle grade doctors have lived near the hospital we've managed to get away with it, and essentially the Intensive Care Society recommended in 1997 that for level 3, that is to look after the sickest patients that come in to a critical care unit, you should have resident medical staff, that is the medical staff sleep in the unit overnight and they're immediately available to tend to patients who deteriorate etc. Now we've had that model in Darlington and UHND but we haven't had it in Bishop because the guys lived across the road, but these guys who have lived across the road for many many years are now beginning to retire, yes? And the number of people on that rota are reducing significantly, so that does cause me ... I know I've had recently when the Board decided we would go to resident staff, they gave me a lot of money to go and find people who would live in On Call, and we cannot find them. So we've had to take some difficult decisions in the past year about the sickest patients at Bishop Auckland and transfer them to the intensive care units at Darlington and Durham, so that was one issue, but Professor Darzi's recommendation in 2002 was that for just a medical take, you didn't have surgical patients, and you didn't have trauma patients, that supporting an unrestricted medical admissions unit with level 2 critical care was OK, but that recommendation has changed. In 2006 they reviewed critical care in Wales, the Intensive Care Society, and they not only made recommendations about acute take being supported by a level 3 unit but they also made recommendations for, again, this expression, critical mass, the amount of activity that you need to come through a unit to maintain the level of expertise that you needed to see, level of experience, to continue to operate a level 3 unit. In County Durham, surprise surprise, we don't have enough level 3 critical care activity to run three level 3 critical care units. At the end of 2007 the Academy of Medical Royal Colleges' final quote was they actually declared that under no circumstances should you be taking an emergency take of any form, medicine without surgery or the whole shooting match if you did not have a 24/7 level 3 critical care unit. So to me the case stands that if we can't provide level 3 across three units we cannot provide an emergency service across three units at that level, yes?

Children's care is a fairly simple one, it's a recruitment problem. The Bishop Auckland service has been excellent, the consultants are getting a bit long in the tooth, go back to saying the junior ... the younger doctors don't want to work the same way these guys have worked and our paediatricians have been saying for a couple of years that the present model can't continue. Yes. It's not moving. It's frozen. Ah. There are two slides still displayed. Yes.

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So what do these benefits ... sorry, what do these changes give to the healthcare community. I think it gives us, on the one point, certainty about the future of all of our hospitals, as Steven said at the beginning, there's no plan to close anything. All of our hospitals have got a very key strategic role in the future of our organisation, but mainly for me, it allows us to provide strong, safe and most importantly of all, sustainable services within the County of Durham. Thanks very much.

DG: OK Thank you. You've had an opportunity to have a listen to the proposals that are being put forward by the Foundation Trust. We'd like to give you now two opportunities to have your say on that, the first section of that we're going to move into now. What we'd like to do is actually arrange you into probably two groups, probably in either corner of the room if we could, and I'll ask colleagues from both the PCT and the Foundation Trust to facilitate that. What we want to do is to get you to answer a series of questions that we've got laid out as part of the consultation, but also to try and think about and formulate some questions that you might want to ask into the next session we go into after this which is about having some open questions from members of the panel. So if I can ask Verna and her team if you could actually arrange people into the groups. We'll do this until about 3.15, so we've got half an hour to have this discussion.

MEETING MOVES INTO ROUND TABLE DISCUSSION GROUPS

(General talking as people move around the room)

FEEDBACK FROM ROUND TABLE GROUPS

DG: OK. We're not going to take death by feedback from all of the groups. I'm just going to ask for a couple of key points from each group and then we'll give an opportunity for some open questions.

Thank you ladies and gentlemen. Thank you for participating. Although we're only going to go for some key points fed back by the two facilitators, please be assured that we have actually captured everything that you've said, it's all down on the sheets. Vaughan's going to capture the key points as we feed them back now, and obviously as people are talking we're recording this as we go along. Can I ask the group in the far corner to my left there, just a couple of key points please? Amanda it looks like it's you, you're poised with the microphone – either that or you're going to sing?

A?: *Thank you. Is it key points you want back and then questions David? Or altogether?*

DG: Yes, well key points and then we'll go into the open questions after that.

A?: *OK. The group has some discussion about understanding some of the services that we were actually talking about, trying to get our heads around what is planned in acute care and trying to get an understanding of what that would mean in practical realities. There was also some discussion about what services are where, so we were actually trying to understand Bishop ... what the actual changes of services at Bishop Auckland and for Durham and how that could impact on Easington. There was also some discussion about what the new build at Wynyard could mean for the long-term viability of some of the hospitals in the area. Key issue was transport and trying to actually get some tangible understanding around what measures could be put in place to actually support patients to access services in County Durham and I think those were the key issues in terms of what we discussed. Anything else? We've got some questions as well.*

DG: Yes, OK. I'll go across to the other group first and then we'll come back. Have you actually formulated some questions as a group? We'll come back to you to ask the questions then.

?: *You know from our group, again, a lot of what Amanda picked up there, transport came out as fundamental and including follow up appointments and how that was going to work and have an effect on accessing and using the different services. We had one person on our group who actually had personal experience of her husband having been to Bishop for surgery under choice and ultimately*

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said that they would choose to go back to Bishop Auckland if they ever needed to go to hospital again due to the excellent care, so I felt it was important to actually feed that back. The other point that was made was regardless of where people are in Easington, ultimately they're travelling anyway, they're travelling to Sunderland, they're travelling to Hartlepool, they're travelling to wherever, and it is about the quality of the care and there was a strong consensus on the table that this was a good proposal for change and basically it's about really looking at the transport issues in order for people to access quality and safe care.

DG: OK. Thank you. We'll come back to the other group now Amanda. Are you going to do the questions again? Or do individuals in the group want to ask the questions?

A: *(inaudible)*

DG: Go on then David, we'll come to you. Can I ask you, when you get the microphone if you can just identify who you are for the records please, for the recording?

DT: *David Taylor Goobrey, District of Easington. This is not to go in your official Minutes but if you want to get an enormous attendance at a meeting, why don't you fake a memo saying you're thinking about closing Durham hospital and leak it to the Northern Echo, and then I can guarantee that you will get more people than Barrack Obama, anyway ... that's not to go in the Minutes.*

DG: Thank you for that piece of advice!

DT: *Now if you ... coming back .. seriously, if you ... first of all, thank you for your courtesy in organising this meeting because Easington doesn't always get consulted about things very well. There is an issue I think that in the long term that if we have the new hospital at Wynyard and Hartlepool no longer has an A&E service then the proportion of people who can't be catered for at urgent care centres and, again, thank you, you gave the figures today and I've been trying to find these figures out for some time, but it's about a third, isn't it, out of almost 30,000. 20,000 can be catered for in urgent care, so a third have to go in A&E. There will be probably more demand from this area for the services of Durham, I can see that coming. You know, if Hartlepool isn't operating and there are problems of getting to Wynyard, you know, I'm just guessing that, but there may well be. Now I actually did some survey work at the Durham A&E department when I worked for PPI and I'm afraid the service was not good. People were having to wait three or four hours and I actually saw this with my own eyes. I sat in there all night, so I think you have a big issue that you must expand the A&E service at Durham if it's going to cater for more people, you know, because people can't wait that long.*

DG: Yes, thank you. I'll ask *(inaudible)*

SE: David, yes, if I could make a comment first. I'm going to ask Robin to talk about your specific point there about the A&E department at Durham and the pressures. If I could just pick up your broader point about the new hospital and the impact and those sorts of issues. Of course it's some way off the new hospital and as I hope you got from what Bob was saying in particular, that the issues that we're facing at the moment are here and now and we feel very passionately they need resolving, you know, in the next 12 months, and indeed I would say without really, I suppose just an intelligent assessment of where we are in terms of the economic climate, new developments in the future may slip beyond current timetables. It seems to me if it's not under the control of the individual organisation I hasten to add in our case of course, the funding we would deploy would be from, you know, from the Trust's surplus effectively. So I think there's some uncertainty about time in terms of the new facilities and we have great pressures in the short term to resolve. Now you're absolutely right about the pressure on the department at Durham. One of the things I would say, the way in which we're planning to organise it eases that pressure first, because we're going to concentrate on emergency care and complex care on that site, and reduce in terms of diagnostics and planned care some of the pressure, but in addition there are other things that we'll need to do. I'm going to ask Robin to talk about that, that issue, if I may.

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RM: Yes thank you. I think the point's fairly well made and undoubtedly there has been, over a period of time, like a lot of very busy emergency departments some difficulty in matching the demanding but appropriate targets that there are. I mean there is, in terms of the highest level care, in terms of the critically ill or injured, where you need the full level 3 support, there are intrinsic things that we are looking very carefully at, our capacity, in terms of physical capacity, we have ... we're not making best use of all the space on the A&E floor on the moment and I know there is a draft proposal in fact which will increase the number of resuscitation spaces that we have on the UHND site. I think the other thing, looking at the other end of the spectrum, one of the big difficulties with emergency department management is the incredibly broad spectrum of case load that the department has to manage, and a fair chunk of the work that comes through the door of an emergency department is around ... is really urgent care work, it's because it's a very accessible service which, you know, you just walk in the door and present yourself and therefore it's highly demand led. There's no filtering before you get through the door and there's a lot of ... a similar proportion, you know, of the work that comes through the door of a major city emergency department is actually at the less heroic end of the spectrum, and I think what we've perhaps not been so clever at is making appropriate use of our resources in terms of how these patient streams are best handled and where there are streams of patients who have handled more and urgent care sort of area, I think we can look at appropriately putting staff or putting resources towards managing those patients in an appropriate way so they don't get in the way of the true emergency care patients. And I think this is something we're learning all the time and I think there's a lot of progress can still be made.

DG: OK. Thank you.

RM: And some of those ways may well be directly in the local setting, like in Easington in terms of the plans that we're developing for the future.

DG: OK. Thank you. Any more questions from that group? Are you going to take them Amanda if other people ...?

A?: *Thank you. One of the questions we got was actually answered in the group but I think it would be good to actually put it on the record because I think it might be quite a popular one. What will happen to the stroke unit at Bishop Auckland?*

DG: OK. Thank you. Can I get Bob to answer?

BA: We had a meeting of the stroke team on Monday evening and at the moment the agreed clinical pathway will be that ... the big thing that's hitting the papers at the minute is the clot busting drugs, or thrombolysis as it's known technically, and that very hyper-acute service will be delivered in Darlington and in Durham. The hub of the rehab service, you know, and I should stress that at this point in time that thrombolysis, that is the clot busting therapy, is appropriate in about 10% of stroke patients if you get them and diagnose them coming in with the timescale, at the moment it's three hours from the onset of symptoms, probably going to be extended fairly soon to four and a half hours. But there are certain criteria need to be factored into that. At the moment in the best cases in the UK, with thrombolysis, it's about 5% or 1 in 20 of patients who present with stroke, and if I say that the rehab part of it benefits all 100% of the stroke patients, so we did see going forward that the rehab hub, the highly specialist rehab hub will be based in Bishop Auckland but the acute service, the thrombolysis and the immediate acute care will be delivered in the acute centres at Darlington and Durham.

DG: OK. Has Steve maybe got a comment?

SE: Just to add to it really, first of all, can I just check, does that answer the question that was asked?

DG: Are people happy with that?

SE: Yes, OK. Right sorry.

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- DT: (inaudible) was where (inaudible) service in Bishop Auckland and you had a full unit there (inaudible)
- SE: Yes, OK. I mean there's one point I would add about using stroke as an example, and it's understandable why we talk about individual hospitals, but what Bob's describing is the model of care that's actually ... our hospitals are inter-dependent and so the services, ... so if you look at that question we providing the acute phase, the smaller part but high tech part of the care in the main acute hospitals and the most significant proportion of care in our proposed centre of excellence for rehabilitation. That's the model of care we're proposing and again we believe that the outcome ... the outcome for patients is better by organising that way, all the evidence points towards that.
- DG: Bob has one ...
- BA: Just coming back with a final point, when you're talking about surgeon rather than physician David, I should probably have mentioned ...
- DT: (inaudible)
- BA: Part of a stroke service is I think a service that's set up to manage episodes called transient ischemic attacks, that is temporary strokes where patients present with stroke type symptoms and then they gradually get better. And we have a service in the organisation where special investigations are done on these patients within 24 hours of the onset of symptoms and some of them require surgery called carotid endarterectomy so you operate on the blood vessels in the neck to reduce narrowing and things and it drastically reduces the risk of them subsequently suffering a permanent stroke. That is such a specialist service that at the moment we only deliver it on the Durham site so there is, going back to this sub-specialisation of services, there potentially will be a need in the organisation if we can maintain that sort of service within the County, it will be based on one of our sites, not across all of them.
- SE: And we will finish on this last point, but it's a very important point. If you were our commissioners, if you were buying our services as indeed the PCT will and indeed general practitioners and our patients will have a big say in that, you would want to make sure if you looked at stroke that the service that was being bought delivered what Bob's just described. I think what we ... I have to make absolutely clear is we cannot do that, we will not be able to do that if we leave the services configured as they are. Now that doesn't mean to say you won't get the service, it simply means that the local hospital services won't provide it, it will be provided by others who can meet that model and I think commissioners I'm right in saying David will be guided by national standards and those national standards are out now, they're in the planning guidance now, we have to put them in place next year, so I mean I think it's a very very good example that underpins the difficulties that we face.
- DG: OK. Thank. Amanda, can we have one more question from your group for the moment?
- A?: *Yes, certainly, I think the main two other questions were actually sort of encapsulated in David's question but the final question from the group was how is information about transport publicised?*
- DG: Is that .. Diane to answer that one.
- DM: Well we're currently working with, as I mentioned in my presentation, working with the transport unit to actually model exactly what additional services we would need to provide should we be able to go ahead with our proposals, so that work is happening now in terms of looking at existing transport, looking at where the gaps are. We will have detailed proposals ready for the end of the consultation period and should we actually get the approval to go ahead, and implement our proposals, we would then have a period of planning to implement that service along with planning implementation of the changes to our services and we would make sure that there was a very significant publicity campaign so that people knew how to access this single number, you know, including sort of using your GP surgeries because a lot of people currently access their transport for ambulances through GP surgeries, so we would embark on a significant period of sort of sharing information publicly.

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DG: I'll just add to that .. sorry, Steven, I'll just add to that because I was conscious of the fact when Diane was talking about the East Durham hospital there were a few blank faces around, which is slightly worrying given where we're sat. One of the roles that we've got as commissioners at the PCT is to try and make sure that sort of information is available. It's something that's only started fairly recently in fairness, but I suppose that makes it even worse in some respects, we need to do a piece of work that actually highlights that and lets people know what it's about and how you access it and all those sorts of things. We'll do that East Durham bit, whatever comes out of these proposals will be part of that as well.

SE: I mean, and it would be helpful I think perhaps picking up the gist of that point, if we were able to make some of that information available David at our meeting, because it's a very good example, it's available, it's there, of what we're planning to do, so we'll try and do that, yes.

DG: Yes, that's good. Thank you. Amanda, do you have any more questions from that group? Now that they've taken the microphone away from you anyway ... OK. Can I ask ...

R?: *(Inaudible) I just want to make a general comment.*

DG: Can I ask you just to use the microphone just to say who you are please?

R?: *I welcome the opportunity for people to put their point of view here but obviously the way we access services at Easington is three ways. Obviously the people from Easington Village go to Sunderland, 200 yards down the road Easington Colliery they access theirs at Hartlepool, and obviously at the West of Durham they'll go to Durham. I'm not sure how many people access services from Bishop Auckland round this area, so probably you know you're not getting the feedback that you have been from other areas, it's just that probably Bishop Auckland isn't that important in the overall theme of things. I thought I'd just make that point.*

DG: It's a useful point Rick. One of the things that we're very keen to do as commissioners because we buy services for everybody in County Durham and Darlington is to make sure that everybody has a fair say in this consultation and equally because everybody has choice and you can choose whether you go to Sunderland, to Hartlepool, North Tees, to Durham, to Bournemouth if you wish to, we need to make sure that people have their say, so it is a bit of a different discussion here, absolutely right Rick.

R?: *So can I get my knee done in Barcelona?*

(Laughter)

DG: You have the right to have it done, yes!

SE: I'd worry about our European Working Time Directive rotas if that was the case!

DG: Take it to them directly, yes. Can I ask Katrina, or can you ask .. can I ask you to give any questions from your group please, and then I'll open it up to general discussion, comment after that.

K?: *I'll keep it short. There weren't that many questions, I think there was probably one based on the comment that I gave previously about follow up appointments being considered in conjunction with public transport. In terms of the consultation everybody, well there was quite a consensus, just about everybody on the table thought that the rehab situation and the additional services in Option B was really the way to go, and they would access those services. However it is about ... is there any work being done in consideration of public transport and thinking about the services that if people had to go for follow up or go for rehab that that's being taken into account and how is that happening, and that's basically the question.*

DG: OK.

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SE: Well could I just very briefly answer that two ways. One is it's important I think for us to highlight that what we're proposing around rehabilitation and intermediate recovery is one part of the whole care and treatment sequence because clearly there are lots of other facilities, community hospitals, in other localities, a lot of services provided by teams in different communities, so the first point I would make is we would look to make sure that those services are accessed as well, so it's not just a case of one location for recovery and rehab and I think if I just pick up a point that Di made I think a little earlier, that part of our research if you like in relation to how we set up our transport infrastructure, precisely about that. What do we think the movement will be and that's why we didn't want to be too precise at this point because we're picking up information as we go through the consultation and we're refining some of the analysis around patient movement that we've already undertaken so the short answer is it will be taken into account.

DG: OK. Thank you. Is that it Katrina? Any more questions from your group?

K?: *Can I just check with our group? Are there any other questions? No?*

DG: OK. I mean I'll open up generally now, the idea was actually the chance to actually formulate some questions from the group but if anybody ... any member of the audience has any questions they'd like to ask the panel I'm happy to take them now. Yes, there's a lady at the front there?

EC: *Edna Connor, District (inaudible) and Councillor for the North Ward of Horden, mine's on the role of the paramedics. What responsibilities have they got when they go out to someone with a suspected heart attack (a) to be treat at the doorstep or (b) you know, what powers have they to say you're going into hospital, and what powers have they got on these drugs what can be issued, the blood clotting factor. Thank you.*

DG: OK. It's not specifically about the consultation because obviously the paramedic service aren't provided by the FT, but we'll ask Laura as the Director of Nursing just to respond on that.

LR: We've just wrapped the Chief Executive up in a wire here! I can answer a bit, obviously we don't deliver paramedic services, but paramedics work very much under strict protocol so that when they go and see a patient, they will make a decision based upon their protocol as to what they give, but the paramedics have the ability from the back of an ambulance to send an ECG recording of a heart into our coronary care units, into all of the coronary care units around about, whichever one's closest, and then they can be in communication with the ambulance to say what type of heart attack this is and what drugs should be given. As you know the North East actually is the leading area for direct access to coronary interventions in both James Cook and Newcastle. Some patients now don't come to us in Durham and Darlington or Bishop Auckland, they go directly to James Cook or to Newcastle for intervention which happens very quickly and the North East is the leading part of the country for that intervention, and paramedics will make that decision at the doorstep in conjunction with the coronary care unit or with one of the acute services, so they are very well equipped to make those decisions. They're also, we've talked a little bit about stroke, and they've done an awful lot of work around stroke and recognising very quickly whether a patient's had a stroke or not using what they call the fast test and they can then take the patient directly, bypass all A&E departments, directly to a stroke unit, so the advances in those two areas are really significant and the paramedics have done a huge amount of work delivering that sort of service. Does that answer the question?

DG: I think Bob wants to add something to that as well.

BA: Just to add a very brief comment to that, I think the heart attack situation is a perfect example of how services have changed quite dramatically in the last few years and why there's this sub-specialisation or specialisation agenda going forward, because it wasn't that long ago, from patients being brought into local coronary care units, for example in Durham or Darlington or Bishop Auckland and having clot busting drugs for their heart attack, and then the first service developed that the paramedics were trained up and, as Laura has already alluded to, sending in the ECG trace to be looked at by a

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consultant and said, yes, OK, give the thrombolysis, and the paramedics gave the thrombolysis, either at the side of the road or at home or what not, to try and be as quick as they could and then a new service became available, the very high ... you know super-duper primary intervention of primary coronary angioplasty where now these people are shipped either from up the Dale by helicopter or by fast ambulance to James Cook or the RVI in Newcastle, and we've got very highly technical people who can, you know, put little things into the coronary arteries and put little stents in, so they don't need the clot busting drugs any more, so it's rapidly advancing services that need to be centralised to give you that .. one, the expertise to make it available but to keep the critical mass of activity to let the experts ... maintaining experts. It's a perfect example of how that's gone on in the last ten years.

DG: Has that answered your question? Yes? OK. Anyone else with any questions for the panel?

DT: (inaudible)

DG: Can you just use the microphone again please David, sorry.

DT: *David Taylor Goodrey again. I apologise to whoever went out, I actually searched downstairs to see if I could find any leaflets about this bus you see, I am aware that such leaflets exist and I did find a leaflet asking people to come to my PPI forum which is now defunct and that was interesting! But seriously, you've got to publicise this service. Now it is the County I know who runs it but whoever runs it, if people don't know about it, there's not much point in having it.*

DG: No, it's a really good point and as I say I was slightly surprised at the blank looks on people's faces, we'll actually take that back and we'll make sure that we get everybody well versed in what it is and how you access it, because it's really important, because otherwise it's not going to get used apart from anything else, so thank you. Any more questions for the panel? Stunned into silence! Ok, that's fine. I mean hopefully we've given you the opportunity this afternoon to listen to colleagues from the Foundation Trust and hopefully you also feel as though you've had the chance then to actually have your say into this and obviously we've recorded it as we've said as we've gone along.

I'm just going to say a little bit now about what happens next. It's part of a formal consultation process and again one of the reasons for recording all of this is so that we can actually feed that in formally into this statutory process that we work within. The process itself lasts until 12th January. I'll just explain a little bit about what will happen from that point onwards. As we've said, as the PCT, our role in this is actually making sure the process is fair and robust and the consultation process stands up to scrutiny. What colleagues from the Foundation Trust will be doing once we've actually had the end of the consultation, and our colleagues that are helping us from Proportion have actually written up a briefing, if you like, a report on the consultation and the outcomes of the issues raised in the consultation, and that will actually then be taken into account by the Foundation Trust Board. They will then decide whether they need to do anything else to their proposals, whether they want to change them, add to them, I think we've had some indication as we've gone on this afternoon that it's actually an iterative process this as it's going along and people raising points, then colleagues are trying to address those and trying to plan for those. What will happen then is that the Foundation Trust Board will actually bring, it might be revised proposals or the proposals back to NHS County Durham, the PCT, probably in February of next year, and only at that point will we actually decide in the light of the evidence from the consultation or the evidence that's there, will we actually decide what we're going to do and whether we actually I suppose allow, in inverted commas, the Foundation Trust to proceed along these routes. I want to stress at this point that the only thing ... the only thing that has been decided thus far, is to actually embark on this consultation process that you're actually part of today. There are no done deals in this. We need very much to listen to the views of local stakeholders, local people particularly and that's across County Durham and Darlington, I think we've alluded to the point that, you know, Bishop Auckland isn't really an issue for people here, but the rest of the services might be. We need to make sure we get people to have their fair say on all of the services as we go through the process.

There are a number of ways that you can continue to get involved with this. This is only one and the public meetings are probably a small part in terms of numbers of participation that people can

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participate. You can actually go onto the website, we've put the website link up there, www.seizingthefuture.org.uk, you can visit the site, in addition to the consultation documents including the full summary of the document here, there's a lot of supporting information on that website as well which people are very welcome to actually look at, to browse, and help understand the issues and the proposals that are being put forward and help formulate your views on what you think about the proposals. You can also log into it via our website at the PCT. Part of going on the website means you can actually respond to the consultation questions, you can fill that in online. You can also fill it in with some of the documents that we've got. Indeed you can actually send an email to comments@seizingthefuture.org.uk which will actually log the response there as well, so what we're trying to do with the Freepost address as well is to give people as many options as possible to actually feed in their views on this set of proposals so we can then sit back and between us we can get the right answer, the right reasons for the local people.

Having said all of that our role at the PCT is to make sure the process is fair. I hope you've had an opportunity to have your say today. I hope you've felt that you can get any questions across the panel and I hope it's increased your understanding of what's being proposed and I'd just like to thank yourselves really for your input and your time this afternoon for coming along and being part of this debate. Please get involved via as many means as you want to. We do need your views. We seriously do need your views, and lastly just to thank the members of staff who have helped facilitate, present or whatever, the proceedings this afternoon. Thank you to them. And may I wish you all a safe journey home. Thank you.

(End of meeting)