

**Seizing the Future Public Meeting
Ferryhill Leisure Centre
Clevesferye Suite, Ferryhill Leisure Centre, Ferryhill
Tuesday 2nd December 2008**

Representing the NHS

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

DG: OK. We've got an exclusive audience which is fine and what we'll do ... we'll not go through all the rigmarole we've been through before because I know most of you have seen the presentation. Any of you that haven't, what I'm going to do is ask colleagues to actually go through the presentation, and I think we'll pick up questions as we go through, but then we'll come back and there'll be a chance to ask questions at the end of it as well and we'll ...

?: (inaudible) our colleagues in the (inaudible) thought you were a member of the public.

DG: Come and act as one Laura!

?: (inaudible)

DG: OK. So we're going to ...

?: (inaudible)

DG: We're going to keep it as ...

?: (inaudible) attendees.

DG: Yes, swell the numbers. We're going to keep this as informal as possible but when we come to actually ask the questions though, because we're recording it because it's a public meeting, we'll give you microphones to ask the questions. Just so we've got a record. I think that's important, especially for people who haven't come, because they might query actually what went on, so we'll do it that way. So I'll not do all the blurb to start as you've heard it before and I'll hand straight over to Steven and his colleagues to go through (inaudible) stuff.

SE: Hi. I'm Steven Eames. We've met now. I'll ask Bob to introduce himself. We don't need to record this I don't think.

BA: Yes, my name's Bob Aitken. I'm the Trust Executive Medical Director. Prior to that I was consultant obstetrician and gynaecologist at the Memorial Hospital in Darlington.

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

SE: OK. Picking up on what David said then, I'm just going to sort of introduce the presentation and I'll stop after that and we'll take any questions and then I'll ask Bob to cover his part of the presentation, maybe around the issues associated with the clinical case for change, and we'll stop again. Then to Diane and ... is that somebody else arriving? It says 'Push to open' so the invisible man has just left. Anyway ...

?: (inaudible)

SE: Alright. OK. Then back to Diane who again will do the same and pick up on the transport issues and we'll stop there for questions and as you say David any further questions after that.

Seizing the Future Public Meeting
Ferryhill Leisure Centre
Clevesferye Suite, Ferryhill Leisure Centre, Ferryhill
Tuesday 2nd December 2008

So Seizing the Future if I just rush on is a major programme of change mainly about how we would like to see local hospitals organised in the future and our main focus in that respect is on making sure that we can provide high quality services and make sure also that we're improving the outcomes of care for the people that use our hospital services.

A few key messages, we're not proposing, contrary to what you might have heard here and there, any hospital closures whatsoever, or indeed any staff redundancies. We are proposing changes, no reductions in services but certainly proposing changes in the way that we organise our services and what we want to try and do with these changes is make sure that we maximise the use of all of our hospitals because they're all critical to how we want to deliver services in the future and we do recognise that we're providing to a diverse community across the County and in Darlington.

The two main things which Bob will say a bit more about in a moment that are driving these changes, first of all, we want to provide as much as we can locally, so in other words where we can provide services safely locally we're going to do that and that does mean that in many cases more services will be accessible to people in their local communities, but we do have some services which are quite fragile, emergency, intensive care, children's services, and in order to ensure safety and the fact we can meet standards in the future we do need to organise those differently and concentrate those services on less number of sites. So our clinical model is to concentrate the services I've just referred to briefly at Darlington and at Durham and that we want to redevelop ... and we think this is an exciting proposal ... redevelop Bishop Auckland hospital, or use more floor space in doing so, in terms of providing additional day surgery, a cataract centre, a centre of excellence for rehabilitation and recovery, the full range of outpatients, diagnostics services that we do now, and an urgent care centre that will still deliver services to a significant number, two thirds of the people who currently attend the emergency services at the moment, and also we'll continue to provide services at Chester-le-Street and Shotley Bridge as we do now, and in fact we'd expect a bit of expansion around outpatients and diagnostic services there. So these next two slides, I won't labour them, because I've covered it very briefly in what I've said, actually show what the changes are at Darlington and Durham in this first case, so centralising A&E services, focussing our acute stroke services at those two sites, centralising our acute paediatric services. And at Bishop Auckland, I won't repeat what I've said but you can see here what we've got now and some of those services in blue highlighted there you'll notice will be moving in the other direction, but on the right hand side are all the things that we're proposing will either stay at the site or indeed be developed as new services there, actually making those services much more accessible to people who live in Bishop Auckland and Weardale. So I'll stop at that point and perhaps as a first point to ask any questions and then we'll move onto Bob.

CC: *I'm rather pleased that the urgent care centre ... sorry...*

DG: Can you ... we have to record ...

CC: *It's, yes, Councillor Cath Conroy, lead member for community health. I'm pleased to see the urgent care centre will still be there because I think that's a very important service for the local people.*

SE: Yes.

CC: *The thing that worries me at the moment is parking in ... Darlington Memorial is the worst hospital I know ... well, all hospitals are bad, I mean the RVI's just the same, Newcastle, but Darlington in particular to put more services into there and not do anything else with the infrastructure, I would think was madness.*

SE: Yes. Yes. I think that's a very ... can I answer that now? I think that's a good question, it's a concern that we also have. I guess at Durham too in terms of some of the changes that we're making, but I guess as you'll hear briefly as we go through the presentation the way that we're organising services first means that some of the ... the plan of the more routine activity at Durham and Darlington will happen at Bishop Auckland so that will reduce some of the pressure on the site. We also have plans that we've developed, currently at risk obviously because they're in consultation, that will see us be

Seizing the Future Public Meeting
Ferryhill Leisure Centre
Clevesferye Suite, Ferryhill Leisure Centre, Ferryhill
Tuesday 2nd December 2008

able to increase the parking spaces particularly at Darlington where we've got probably the greatest pressure and as you will hear in a moment, the transport arrangements that we're working with the County Council on are about trying to make sure there are other ways of bringing people into the site rather than ... not just patients, but staff and visitors rather than use their cars. The other thing I would say is that for emergency care, because this came up a bit earlier on, of course for emergency care that's not so much an issue because for emergency care you get straight there in an ambulance, seen straight away, this is about all the visiting as I think you suggest for routine treatments. So you know we have very much in mind the concerns that you mentioned.

AA: *Thank you. Agnes Armstrong, I'm the Leader of Sedgfield Borough Council. Can I direct a question to Bob although he hasn't spoken yet?*

SE: OK. Of course you can.

AA: *They keep you in the wings like an egg head. I know from Option B which I voted for, to support, the midwifery led unit will continue as it does.*

BA: Yes.

AA: *My question is about resuscitation for infants who need resuscitation. Now midwife's are training in resuscitation but they are no substitute for trained paediatricians I would suggest.*

BA: Yes.

AA: *And I mean I am a midwife so you know I know my limitations as well. Can I ask about ... there'll be no out of hours anaesthetic cover under Seizing the Future.*

BA: No.

AA: *So what would happen in the case of a difficult to resuscitate infant or a collapsed mum? Can you answer that Bob please?*

BA: Oh yes, I can. I mean the plan would be if a mum collapsed and the midwives obviously need to be trained up to a level that would allow them to resuscitate ... the basic resuscitation of an infant, in fact the midwives within the midwifery led unit are ... are trained a bit further than the basic resuscitation. I mean 24/7 we would be having a doctor in the urgent care centre so we'd be looking for some support from them and from the people, you know, the nurse practitioners, emergency care practitioners. Also we would need to put in a situation where the paediatricians in the acute units would be made available. Now at the minute the actual call time, the response time for the MLU from the consultant paed is 30 minutes. That's the standard we're working towards, so we should still be able to deliver that standard even if the acute paediatrics is in Darlington and Durham.

AA: *Right. I mean I know I've spoken to Heather Smith about this and, you know, some of the paed at Bishop have concerns, so ... and some of my members on Sedgfield Borough Council ... midwifery is an extremely emotive issue.*

BA: Of course it is.

AA: *And it's one that people understand more than perhaps acute medicine and acute surgery, so we do get more questions and I, as the Leader of the Council, get these things. But you are reassuring me in a way aren't you Bob?*

BA: Yes, I am.

AA: *That it will almost be no worse than it is at the moment.*

**Seizing the Future Public Meeting
Ferryhill Leisure Centre
Clevesferye Suite, Ferryhill Leisure Centre, Ferryhill
Tuesday 2nd December 2008**

BA: It won't be any different, other than it will be some acute paediatrics, but the consultants are at home and we would have a cover by ... if required, paediatricians to go and collect the babies for example from the MLU.

AA: *It will be no different. OK. Thank you very much.*

DM: Can I just sort of ... can I just make a comment around resuscitation, just ... Agnes. Yes. Actually it's a shame we've let Paul Fish go. Paul Fish was here to actually support the meeting, but because there's not a lot of people here, he's gone, and he's our Head of Resuscitation, yes? And what we intend to do as part of developing the kind of detail around the pathways and the support that's needed, we're going to need to develop a resuscitation team for the Bishop Auckland site, OK? Which is skilled beyond ... led by nurses, supported by doctors, but skilled to a level beyond that of the nurses that are skilled on the two acute sites where they're supported by medics, and that'll need to run through 24 hours, yes? And it can support more than resuscitation actually because if a patient has a need at night, whereas normally we would call on a junior doctor, now clearly it's a different type of patient on that site, so it's not somebody ... it's somebody with an unexpected problem, but with some skills where they could go and they could do some clinical assessment and actually make a judgement, a safe judgement around whether or not we can manage that patient on that site or whether that patient would need to be transferred for more specialist care, but that's something that Paul and his team are very keen to do, very keen to get involved in. It's a bit of a resuscitation team and kind of a ... have you heard the Hospital at Night Teams? Yes? It's kind of, you know, extended skills for nurses essentially.

SE: So will have the range of cover and I think ...

BA: Yes, I think added to that Agnes is, you know, if you look at the Royal College of Emergency Medicine document about working in (inaudible) full A&E departments and then urgent care centres, minor injuries units, it actually states quite clearly that all of the staff who work in these place, just in case somebody does present with an anaphylactic reaction, I mean through the door, they have all to be trained up to a level where they can provide immediate resuscitation and stabilisation until such time as an ambulance gets there to transfer the patient, so we will be putting that in place.

AA: *So if you are moving patients post-op, the pressure on beds at Darlington sometimes, there may be pressure for young people perhaps slightly early to Bishop, you know where I'm coming from.*

BA: Yes, I know exactly and that's .. and that's an issue that we've got to monitor very very closely.

AA: *(inaudible)*

DM: You're right, yes.

BA: Yes.

DM: Yes, it's something that we have to be really careful about, we've got to have our processes in place and we've got to monitor it, we've got to monitor it almost on a daily basis through the clinical government systems and make sure that, you know, if we have any concerns or issues around that that they're actually tackled as and when they arise, but the critical thing is to have good, tight, safe protocols, everybody knows about before we actually move with implementation. It's about planning it really carefully.

SE: So Agnes are you happy that Bob goes on to his bit of presentation?

AA: *Of course, I'm very reassured anyway by those issues thank you.*

SE: OK. Thank you. Bob.

?: *(inaudible)*

Seizing the Future Public Meeting
Ferryhill Leisure Centre
Clevesferye Suite, Ferryhill Leisure Centre, Ferryhill
Tuesday 2nd December 2008

SE: Oh sorry ...

PC: *Council Pauline Crathorne, Sedgfield Borough Council. My question again is to Bob and it's basically about you have planned day surgery, but I was asked a question by a young man down our Council offices about if his wife was in hospital having a baby and she had to have a Caesarean section, what were the plans for surgery in the hospital at that time. How would she get to Darlington hospital?*

BA: Well we've got lots of experience of that and what the midwives do is that there are certain protocols that they adhere to. Now the patients undergo quite a thorough as it were, pre-delivery, assessment at booking and then later on at 36 weeks and decide whether it's still appropriate for them, are they still in the low risk category. Even within low risk women there are things that can actually start happening in labour. Now at the earliest assessment where things aren't going plum normal then the lady would be transferred, right? Now it is very unusual for things, catastrophic events to happen, but they do happen on consultant labour wards. In the vast majority of cases where, you know, there is an emergency situation, we have an agreement with the North East Ambulance Service of setting them a very stringent target from a call to delivery time of the patient to the labour ward in Darlington of less than 25 minutes, and they have, you know, 100% of the time I've seen beat that target, so we haven't had any serious incidents where mothers have been, you know, compromised because we haven't been able to get them to Darlington quickly enough.

?: (inaudible)

SE: It won't make any difference.

BA: Option B won't effect the MLU service, it's still the same.

SE: It's exactly the same, exactly the same.

BA: Still the same.

SE: OK. Are you happy we move on to Bob now?

PC: Yes.

SE: OK. Bob.

BA: Yes. So I'm talking to the Council in the middle, yes? Just very briefly by way of introduction, the way we're configured at the moment as you may recall as the result of Lord Darzi's previous review of the acute services in County Durham in 2002. Now what's happened really since then, you know, and I should have put a point out at the minute because it seems to be a big thing for everybody, is that since 2000 we haven't had a full A&E service at Bishop Auckland. In 2000 the trauma ... you know, people with badly broken bones, or badly injured from road traffic accidents have actually bypassed Bishop to go to Darlington generally, sometimes Durham. Since 2002 following Lord Darzi's review, emergency surgery was removed from Bishop for training of junior surgeons reasons really and that was taken to Darlington. So really since 2002 we've had a very limited A&E service, we've a level 2 critical care unit which I'll come on to, we've had limited out of hours cover for pure A&E beds, but we have had an unrestricted take, that is only medical emergencies, as opposed to surgical or orthopaedic or gynaecological, people suffering from chest problems or potential heart problems, although that's changed recently, have all gone into Bishop with the support that was there, that was to the recommended standard of 2002. Yes? But what's happened since then, there's been a whole raft of national drivers for change within the health service. Lord Darzi started reviewing all the health service. The Royal Colleges have made recommendations on a number of fronts that we'll talk you through, and then there's the changes in the doctors' working hours.

Seizing the Future Public Meeting
Ferryhill Leisure Centre
Clevesferye Suite, Ferryhill Leisure Centre, Ferryhill
Tuesday 2nd December 2008

The big sort of general change here is on this slide, the move to specialisation, now that really has been going on for 10-15 years within medicine. If you think of historically the shape of the hospitals within County Durham, Shotley Bridge, Dryburn, Bishop Auckland and Darlington and they were staffed by consultants who were general consultants, so a surgeon would do a bit of breast work, a bit of urology, kidney work, do a bit of colo-rectal work, do a bit of upper GI, we used to operate a lot on stomachs, do a bit of chest work, and that was the way things were staffed and that's how historically the system's built up. What has been very clear over a number of years is that if you take, particularly the more complex operations, and you put them in the hands of a very small number of highly trained consultants, that the outcomes are better for patients, so there has been this move away from being very general to being a specialist in your field. This affected me a few years ago because I was a gynaecologist in Darlington but I had a special interest in the cancer work, but the Colman Hein recommendations came out to say we should centralise all of the gynae cancer surgery on a smaller number of sites, and for us that was in Middlesbrough. I felt we were doing quite well, but I went with the flow as being the lead cancer I thought it was appropriate that we did what seemed to be right and in the national direction of travel. I've no doubt now, seven, eight years later, that the outcomes for patients having surgery for gynaecological cancer by specially trained gynae oncologists in Middlesbrough, the outcomes are better than they were when we did it, although we actually did pretty well.

What there is now is there's more evidence in emergency care as well and George Alberti talks about that where it's actually better if you're actually travelling a bit further, particularly in the back of a Blue Light ambulance where the paramedics have already stabilised you, to travel 10 or 12 miles further to a team that's fully equipped, fully staffed, fully supported by a proper critical care, the outcomes for patients are better and in fact if you go to a local A&E that isn't fully staffed and fully equipped that can cause delays in care that actually leads to less good outcomes. So that has been an issue going forward. The thing I'd like to raise at this point in that is the concept of what we call critical mass in the medical profession, and what that means, it can apply to either individual specialists or it can apply to teams, and the critical mass is what the kind of calculated amount of work that you need to be doing, the number of fairly specialist operations or the number of a particular type of patient you need to be managing in a year, to enable you to say I am an accredited specialist in this field and to continue to allow you to be recognised by your own Royal College and therefore the Department of Health and the General Medical Council as a recognised specialist in that field. So that's for individuals, but equally teams, intensive care teams, A&E teams, surgical teams, have to have a similar critical mass of activity that they do to be able to be recognised as specialists, and that's a very very important concept because that's one of the things when you look at local pressures for us, trying to implement the national recommendations, is there are two things, we have difficulty recruiting consultants, particularly to the south of the County because we've got small medical teams, but also if you look at the critical mass of activity in certain areas across the whole of the County Durham, is that we don't have enough work to really allow us to have three acute centres. Now that's based on the main ... the service that I listed on the slide, I'll get to them eventually.

Another big driver for us nationally is doctors' working hours. You might have heard of a thing called the European Working Time Directive. Now that applies to the junior doctors, the consultants are allowed to opt out of that, it would be interesting if we weren't allowed to opt out of it and I'll come to that when I talk about paediatrics, is ... but juniors ... this is being brought in in three phases, the third phase, August next year, the maximum number of hours a junior is allowed to work, and that includes sleeping in the hospital on call, comes down from 56 to 48. That for our organisation, the implication is that we lose the equivalent of 31.4 junior doctors on the ground, they're just not there long enough so there are times when they're missing, we've still got the same number of individuals but they're not allowed to cover the emergency rotas for as long. Now when I've got my teams doing a bit of analysis on that and it really does put us in a very difficult position come next August, a lot of our rotas, medicine, anaesthetics, surgery, there are certain things we can do, but all these rotas become non-EWTD compliant, and if that is the case and the Royal Colleges come round to visit, what is a very strong possibility is you're going to lose recognition for training junior doctors, and that is catastrophic for the hospital. You've got to maintain that because it keep refreshing the staff and it's good as consultant to be working with somebody who's just sitting their exam because it keeps you on your

Seizing the Future Public Meeting
Ferryhill Leisure Centre
Clevesferye Suite, Ferryhill Leisure Centre, Ferryhill
Tuesday 2nd December 2008

toes, you don't want them asking you questions that you can't answer. So it's very very important that we do that. The simplest way to deal with it, and the reason we don't have the problem to nearly the same extent in Durham, is 11 years ago the medical teams at Shotley Bridge and Dryburn merged. By merging the medical team in Bishop Auckland and Darlington it makes our ... both rotas at the moment if we stayed as we are, are non-compliant, put them together and we run one rota with the same number of patients coming through and the rota's compliant. You know? And that happens on a number of fronts, there are one or two issues, there are other things we need to deal with.

The other issue as well relates to work/life balance. Young doctors, and I'm talking about young consultants here as well, is that when I was a boy, you know, working 100 hours a week was commonplace, right? Now they're not interested, even though the European Working Time doesn't apply to them, they want to, you know, do much less on call, be busy when they're there, but do much less on call, and I've done some work with registrars and all I can say is at the end of that work ... is that Bishop Auckland and Darlington were very unpopular places to come and work as a young consultant, and we really do have recruitment problems going forward.

So what about the specific recommendations? Accident & Emergency ... there was a new College formed in 2003 for ... they made recommendations, not only about the standards for a full A&E service, but also this idea of critical mass, how much activity did you need to come through to maintain a full A&E service, and the implications of that for us is that we cannot have three full A&E services in County Durham, there just isn't enough work, we've already implied that we don't have a full service at Bishop anyway, right? But there are issues that I've got with the sign above the door, because the public think if there's an A&E sign above Durham, Darlington and Bishop, that there's the same thing behind the door, and there isn't and there hasn't been for a long time, we need to start being honest with people.

Acute medicine, that is looking after the people who come in with acute medical problems, the chest pains, the respiratory problems. In about 2004 the model changed and the Royal College of Physicians instead of ... let's go back to 2002 where it was a general physician, it was your turn on call, you looked after everyone that came in through the door, you might be a specialist in diabetes but you were on the general take. Now the recommendation is that you should have specially trained physicians, a different specialty called acute care physicians. You have a special ward in the hospital called the Medical Admissions Unit that they acutely ill people come in, they're looked after by the acute care specialists for 12, 24, 48 hours and then pass back to the specialist on the ward, so the sub-specialist, the respiratory physician, the cardiologist, the gastroenterologist, back on the base wards, so you look after the acute phase by the acute people, specially trained, and back into a team. The implication of that for us is that you needed a minimum of 13 consultant physicians to operate the modern standard of care in the proposed model. In the County we are able to deliver that model in Durham. We've got enough physicians on the team to actually deliver the care. In Darlington and Bishop Auckland because we don't have enough physicians and we've had difficulty recruiting, is that we do not deliver that model. To actually do it in the south of the County in both Darlington and Durham, sorry Darlington and Bishop, I would need to more than double the number of physicians on the ground on the site, and we're not going to recruit those people. Now put the two teams together and we can deliver that model of care with a little bit of investment and putting the teams together will allow us to recruit easier and we will be able to build that team up.

Critical care is the big one, intensive care. In the end, and if I could ... critical care is levels 1, 2 and 3. Level 2 was ... and that means one nurse for every two patients 24 hours a day, with doctors available to come within 15 minutes or so's notice, if the patient needed attending to. Level 3 is one nurse for every patient 24/7 and a doctor immediately available, so staying in the unit. Now level 3 is what we have delivered for some years in Darlington and some years in Durham, we've never been able to do it in Bishop. For technical reasons around the training of anaesthetists, but I do stress it's not a money thing. When we really ... this got pushed very very hard in 2006/2007 about the change in the support that was required for acute medicine from level 2 to level 3, the Board gave me access to a lot of money to pay for doctors to be resident on call at Bishop, and we couldn't find them, we advertised four times, we got ... I believe there were six people at each time and we got one applicant who

**Seizing the Future Public Meeting
Ferryhill Leisure Centre
Clevesferye Suite, Ferryhill Leisure Centre, Ferryhill
Tuesday 2nd December 2008**

replaced somebody who retired and it really is an issue. Now because it was an issue about a year go we took at decision onboard to transfer the sickest patients from Bishop to Darlington or Durham to provide the required level of support and that is a really really strong issue going forward. We're looking at four senior anaesthetists retiring within the Bishop Auckland team next spring and they are going to be well nigh impossible to replace so we've got to put some contingency plans in place to try and keep supporting the service, but I was speaking to anaesthetists this morning and actually that's going to be very very difficult. We put everything together and provide a proper level 3 then we have got a strong future for acute services. The critical mass comes in again in that if you look at the amount of activity you need to support a level 3 unit, we don't have enough in County Durham to have three level 3 units, so if we can't provide three level 3, we can't have three level 3 acute takes. Simple as that.

Children's care, paediatrics, is a special case. I've said frequently that I feel sorry for the unit at Bishop because ten years ago they were the national gold standard that was being recommended and then the new consultant contract came in and it blew that out of the water with the ... and the fact that the juniors now are looking for better work/life balance. Our team, Peter Jones and Andrew Cottrell, have realised for the time that when they start to go and think about retiring, they're going to be well nigh impossible to replace, and that's been our experience on the ground and they've been recommending that we move to two acute sites for about two years now, and just as an aside, I mean, 60% of the acute rotas for the European Working Time Directive for juniors in acute paediatric units in the country become non-compliant in August. Now if we revamp a little bit then we're going to be OK. But interestingly enough if the European Working Time Directive applied to consultants, 25% of the units in the UK would have to close, and paediatrics is a shortage specialty nationally, there are still trainees coming in but the rate that the consultants are retiring, the trainees being trained isn't keeping pace, so it is a real problem specialty going forward.

SE: OK.

BA: So what do we do? I've put this in inverted commas, doing nothing is not an option, because we invited Professor Sir George Alberti in, and George is going to be at Bishop later this week, to look at our clinical model that we have developed. He is the emergency care Czar for the Department of Health and he also leads a thing called the National Clinical Assessment team who come in if we're recommended reconfiguration, they come and assess whether what we're doing is in the benefit of the local population and it meets all national standards, and he felt very strongly that the way we were configured could not stay the way it was, the services were unsustainable and did support strongly our recommendations. We're already making emergency plans, already spoken to you about potential, you know, problems in anaesthetics, if we don't manage to make the changes there will be a decline in quality in the services that we're able to provide and eventually in safety which is why we made the decision about critical care a year ago. It will have negative impacts on the population and lead to services that aren't fit, particularly for the patient, not just for the commissioners, and I feel very very strongly about it. If we make these changes we've got a very strong future, if we don't I think we might be in trouble.

SE: OK. So we're going to stop again there and pick up any questions about what Bob has said.

?: *Thank you Bob. I can see what you're saying about specialist care, having had a daughter, a granddaughter, with leukaemia for three and a half years, and attending the RVI at Bishop ... at Newcastle, I mean the travelling was horrendous but that ... she got specialist care and that was much appreciated, and I can see what you're saying about the level 3 at Newcastle General, there was one nurse on for every child that was in that unit and a doctor always available which gave comfort and reassurance to parents and the children, so that was good, so I can see what you're saying about that. I can ... in 2003 I had a heart attack and I was taken into Bishop Auckland hospital and treat immediately, you know, everything went fine. The only worry I can see is sort of getting to Bishop Auckland hospital, being diagnosed and, oh gosh, you know, we're going to have to send her to Darlington, we're going to have to send her to Durham, you know, the time that ...*

**Seizing the Future Public Meeting
Ferryhill Leisure Centre
Clevesferye Suite, Ferryhill Leisure Centre, Ferryhill
Tuesday 2nd December 2008**

BA: Can I ask you a question? Did you have the clot busting drugs when you came in?

?: *I did, yes, they gave me that straight away, it was fantastic.*

BA: Do you know what's happened since then?

?: *No.*

BA: There's been ... a new technique has been developed called primary coronary angioplasty. So they've realised ... I think developed by a radiologist in America ... and now they've realised that the best treatment for people with certain types of heart attack, and it sounds as if you had that very type, and what would happen to you now is the paramedics would drive past Bishop, they would drive past Darlington and they would take you to James Cook and in James Cook we've got ... in Middlesbrough, and in the Freeman I think it is in Newcastle, we've got two of the most advanced units for this technique, and they pioneered it and brought it in from the States, and pioneered it in the North East of England, and what they do is they then put a special tube into the ... either an artery in your arm or an artery in your groin, go right up into the blood vessel in your heart and under X-ray imaging remove the local clot and put in a little thing called a stent to keep the artery open, and that is much more successful than clot busters, fewer complications and it gives much less chance of the thing recurring, so that's how things change rapidly

?: *And a paramedic would diagnose that in the street?*

BA: The paramedics, what they do is they would come and, I mean, and shortly after you had yours probably, the paramedics could give thrombolysis in your own bedroom if need be, what they do is they do a cardiograph, they send it to the coronary care unit who read it electronically and then they say it's ST (inaudible) a 'stemmy', you know, ST elevation, (inaudible) infarction, you know, take this lady straight to James Cook, and then James Cook are waiting for you coming, their cardiac lab is ready for you, blah blah blah blah, and that's the way it works now.

SE: Diane wishes to say something about that.

BA: Yes.

DM: Just the other point on that is that a patient with chest pain would not, under the proposals, be taken to Bishop Auckland hospital by ambulance.

SE: You wouldn't go there.

DM: You would go ... you wouldn't even go there with a patient, you know, there would be categories of patients that could go to Bishop Auckland and would not go, and we know we can make that work because we've made that work in Shotley Bridge and it works very effectively, but if an ambulance ... if paramedics came to you and you had a chest pain, OK, a severe chest pain, you would be taken directly to either Darlington or Durham. If it was a heart attack as Bob's described ...

?: *Yes, which it was (inaudible)*

DM: You would go to James Cook, yes? Yes. But there are other reasons why you might have a severe chest pain.

?: *Yes.*

DM: And you wouldn't ... if you weren't eligible ... you know, if it wasn't that type of heart attack, and you weren't going to James Cook or Newcastle, you wouldn't go to Bishop Auckland, you would go to one of the acute sites straight away. Yes. So there wouldn't be that time delay, you'd still obviously get the paramedic ...

**Seizing the Future Public Meeting
Ferryhill Leisure Centre
Clevesferye Suite, Ferryhill Leisure Centre, Ferryhill
Tuesday 2nd December 2008**

?: *(inaudible) without a doubt, and I see what you're saying about the doctors as well, you know that they want to be at the bigger hospitals.*

BA: Yes, they do.

DM: Yes.

?: *Obviously, you know, it's more exciting for them, they see more, they train better and, yes, I can understand that.*

?: *Can I ask you a question Bob? Now that next year, next August, you're going to lose the equivalent of 31, probably 31 doctors ...*

BA: Yes.

?: *So ... if you merge the hospitals together, does that mean that you won't need to employ any more doctors or is there finances available to keep employing more doctors?*

BA: Well it depends what level of doctors you're talking about, in that we won't need any more ... well we might need a small handful of ... more junior doctors, we've already got the Trust ... a committee to provide that funding, but I think what my plans are ... we're going to need more doctors for County Durham but it's consultants that I want, who are fully trained and delivering the specialist care and we've got one or two plans that we'd like to take forward ... not specifically in this consultation but, no, the juniors, a small handful, we should be able to cover all the acute rotas that we would then be providing.

SE: It's a double whammy that because what that means is ... to keep things as they are we'd need to find 31 junior doctors, largely, and they're not there anyway, so we've got a really difficult double whammy there as I say. The national approach, which I think Bob's referring to there, is because juniors are going much more quickly through training and indeed I think junior doctors these days are not getting the same type of hands on experience on the way to that training that people like Bob used to get, that .. and because actually if you're driving for safe care, you really want more senior people making critical decisions, and therefore there's sort of a division if you like between the delivery of the service and training and we need to do both because we need to be a high quality trainer to deal with some of these problems of recruitment, but we want to provide high quality services, so when you say will we need more doctors, we will need more senior doctors but what we'll also need is ... as I think you were describing earlier Diane ... is actually more nurses with extended training, doing more things that doctors used to do as well, because if you go back to that example, frankly an experienced nurse practitioner running a resuscitation team, an out of hours service, is actually probably a much stronger team than you would necessarily get with junior doctors these days, so there's a whole mixture of things there.

BA: I mean one of the drivers for the acute care physician is that that came by trainees saying to the College, because it used to be that physicians were generalists with a bit of a special interest, now they're being trained as specialist with a bit of general medical experience and you find that a lot of the trainees in cardiology or gastroenterology or diabetes, when they come out at the end of their training, which as Steven said is much shorter than we used to go through, is that they don't feel confident to actually deliver an unrestricted medical take, on take physician, they want the acute people to be doing that, and so that's where you need to work in bigger teams where you've got more experienced guys supporting the younger ones and allowing them to develop and get more experience.

SE: So are you happy for us to move on to the next bit?

?: *Can I ...*

**Seizing the Future Public Meeting
Ferryhill Leisure Centre
Clevesferye Suite, Ferryhill Leisure Centre, Ferryhill
Tuesday 2nd December 2008**

SE: Oh sorry, OK.

?: *(inaudible) attendance at A&E, and ambulances taking patients to A&E, 50% of patients turn up to A&E under their own steam ...*

DM: Absolutely. No, absolutely.

?: *So you know there's a big education message here for the public...*

DM: Absolutely there is, yes.

?: *That's just a point I wanted to make*

DM: You're absolutely right, and the practitioners in the A&E would actually be able to perform the same sort of immediate assessment that the paramedics would be able to perform and actually divert that patient to actually give them the immediate care but then to be able to divert them to the right site if that's appropriate, and again that's something that we do experience at Shotley Bridge, not actually as often as you might imagine, I mean, speaking to them in Shotley Bridge, the practitioners there, they say something like 1 to 2 patients a month inappropriately attend ... now you would imagine it would be a lot more, but that's on the back of lots of education amongst the public, really strong messages, reinforced by practice, but good back up procedures to make sure that if somebody inappropriately turns up they are managed safely.

BA: Yes, I think from my reading of the situation it's liable, you know, this is from elsewhere when people have done this, it's what you'll find that we might not see as much activity as we know we can handle at Bishop because people will default if they think I've got to go and see ... they will go to one of the A&E departments, but as confidence grows in the system, like confidence grew in the midwifery legend after the disaster we had on day one, which was nothing to do with the MLU, but there we go ... it took us a while to get back from that, and I think people will eventually gain confidence and realise that although we're calling it something different, that the vast majority of patients who walked into A&E before can walk into the urgent care centre and be treated just the same.

SE: Just briefly on that question, having handled, you know, the implementation of consultations like this in the past, it's really as you say very important as you lead up to making the change, and if you take the example here, we will have a number of changes, it won't be all at once, they will happen in a sequenced way, but as you build up to that then it's really important to be communicating all the time, you know, then you do it and when you do it you don't put the whole thing in place at first, you put ... and you have the back up systems in place until, as Bob says, and I ... you know, the confidence has built up so ... I think you've got some experience here and also some experience from where this has happened elsewhere to make sure that happens and it's quite interesting that as long as you do that well the evidence is that the public learn pretty quickly, but you know the disasters happen if you don't support that sort of change.

Now shall we move on to the next ... can we move onto the next part and then maybe some other questions? Diane, are you going to take them through this?

DM: Yes, I mean much of this has been covered actually, so ... yes.

SE: We've covered all of that, yes.

DM: We've covered all of that, OK. Just, you know, why this is better for you. Bob has talked about specialisation and I think it's important to recognise and Bob does recognise that specialisation is more than something that doctors have to do, it's about the nurses, it's about the therapists, it's about the whole of the team, OK. We talk about multi-disciplinary teams and, you know, I mean there are some good researched examples of how kind of good teams, specialist teams actually improve outcomes of care. Stroke is your classic ...

..

**Seizing the Future Public Meeting
Ferryhill Leisure Centre
Clevesferye Suite, Ferryhill Leisure Centre, Ferryhill
Tuesday 2nd December 2008**

BA: Yes, cancer's one as well, it's not just about the surgeons, it's working in multi-disciplinary teams, it probably improves the outcome.

DM: Yes, nurses specialising is really important. Now you don't have to be called a nurse specialist to be a nurse with a specialism. A midwife is a nurse with a specialism and, you know, my background as a nurse in an acute hospital is both in medicine, I was a ward sister in a medicine unit and also in a surgical unit, and I kind of, you know, you develop your specialty in general medicine or in general surgery, and that's where patients with those conditions need to be nursed with the specialist doctors, developing the specialist nursing skills that go alongside supporting the care prescription as it were of the doctors, so that's really important. Now the way we plan to sort of separate care, so putting the emergency cases in Durham and Darlington and much of our planned activity in Bishop Auckland, that means that we can better provide and ensure that patients actually get the specialist care of the whole team and that ... the comment on there is being on the right ward. Currently you might get admitted for surgery for example, and there's pressure on beds at times for emergency admissions and we might have to move you to another area to actually put another emergency admission in that bed. We will not have to do that with anywhere like the kind of frequency. We want to move away from that completely, so you know separating those streams of care will enable us to better ensure that you're on the right ward with the right team and not just the right doctors, OK? Linked into that separation of planned and elective care is the issue around we can reduce the risk of cancelled operations, you know, we don't underestimate the effort it takes to get, you know, yourselves organised to get into hospital on a certain time and date, but you know too many patients have their operations cancelled at fairly short notice, again because of pressure on acute beds, and we have to cancel elective cases to get, you know, the emergency patients in. Separating them off, delivering the care in the way that we propose will reduce that risk.

The rehab unit that we're proposing at Bishop Auckland and I think some people describe this as kind of almost like a second rate service, and it isn't second rate rehab. Rehab is, you know, the biggest part of patients' care in many cases and it's the part that we probably don't pay sufficient attention to and it's currently, your rehabilitation is currently provided within an acute ward, and you'll know from being in hospital, you know, the first sort of 24/48 hours, you know, you get a lot of very intensive medical and nursing attention, but after that it's really about being given the space and the time to actually recover your confidence, recover your independence, and people stepping back from intervening all the time but allowing, you know, supporting you to kind of regain your independence. Now we can better do that by taking those people out of the acute care ward because then all the priorities are about doing that, about facilitating them to regain independence, yes? Rather than rushing them because they're actually on their way to deal with somebody who's acutely ill, I mean, I'm sure you kind of recognise that kind of scenario and I know it is ... having been a nurse on the wards, you know, how often you have to do that, so we think that's a really positive step. Our therapists are really up for this as are some of our nursing staff as well and we really think this will deliver better outcomes. It will mean more patients discharged to their own place, you know, to their own home where they've actually been admitted from, fewer people discharged into supported care. Separating the two streams of care also means we can screen patients prior to admission for planned care on the Bishop Auckland site and reduce the risk of infections so, MRSA in particular we're kind of stressing there.

Everything we're proposing is based on travel only where essential so you only travel for the specialist bit of care that we can only provide on a specialist site. Your outpatients appointments before and after, your diagnostic tests, X-rays, scans, blood tests, all of that, all happens at local hospitals or in the community or in community hospitals, you know, the premise is only deliver in hospital, in specialist units, what we have to deliver, so we're aiming to reduce the number of attendances, yes, unnecessary attendances. We've mentioned the paramedic role in emergency care already and you've obviously recognised that that's critical, you know, your care starts when they attend, not when you start hospital, when you get to hospital.

Working with the Integrated Transport Unit at Durham and Pauline's certainly seen some of the information that we've had there from the Transport Unit at Durham, we're working with them to try

**Seizing the Future Public Meeting
Ferryhill Leisure Centre
Clevesferye Suite, Ferryhill Leisure Centre, Ferryhill
Tuesday 2nd December 2008**

and ... well not to try, to identify the gaps where patients currently and within our proposals cannot access our services via public transport, because if you've got your own transport you can get there, so it's about public transport. So we've mapped the patients that currently attend. We've mapped that against current transport services, identifying the gaps, we're going to propose to integrate all of the current services so we're looking at the ambulance service, the patient transport service, volunteer driver schemes, public transport information ... put all that together so if you need to come to hospital or you're a relative or whatever, you ring a number, you're kind of sent to the right service, if it's an ambulance you'll get booked on it, if you've got good public transport routes you'll be advised of that, and if there's a gap in current service we'll be looking at commissioning new services to make sure that everybody can access, that's for patients, staff and visitors, and it's really important. I mean it's been stressed to us but we recognise that, we haven't needed persuading on that. You know, it's really important that visitors are able to get to visit the people who are in hospital as well, so ...

SE: OK. So I think that really concludes the presentation, but again questions about what Diane said and maybe, I guess David, any other questions you might have we can take them.

?: *I've listened to where we're going, where you want to be, and I was a nurse at Dryburn hospital in the early 70s and it seemed to me like we had that.*

SE: Yes.

?: *Am I wrong? We had the specialist wards, we had the doctors, we had first rate nursing and I've got to say after being in Bishop Auckland hospital we had first rate nursing in the 70s compared with what I saw at Bishop Auckland hospital, not a mattress was washed, not a locker was washed before the next patient went into that bed.*

SE: I think there's some truth in what you've said about things going ... but there's some truth about what you're saying in things going in circles, because in the ... in the 70s I can remember just back that far, in the 70s and then into the early 80s, there actually was a move away from community hospitals and so on and closing a lot of those down. Now one of the consequences of what we're talking about here, the sort of pressures Bob's talked about, of course it brings all of that back into play because if you're going to provide services more locally and you can do more of that locally then you're going to use those facilities much more. I think there's a big difference though between now and then in that, of course, the demands are greater, I'm not saying they're greater on the nursing staff, but the demands on healthcare are greater because we can do so much more, I mean every day we can do something else, and alongside that, because of the way in which we've been able to improve people's lives, then you know people are living longer. So Diane and her clinical colleagues will tell you that the people that we're treating these days are probably, there are probably more complex cases with, you know, a lot of different problems than there were then, so there are some differences and that of itself means it's pretty important for the critical end of the business that we can concentrate our resources to cope with that sort of demand, so you know there's a lot of similarities but there are some differences too.

BA: Can I just make two comments and I was smiling there because I was a Houseman in the mid 70s and I remember vividly trying to get past Sister if you'd a dirty white coat or dirty shoes on, getting on the ward was well nigh impossible, so ... (laughter) and the only other comment I would make is about the diagnostics, we do have ... we haven't formalised it yet but there's a possibility we'll have a plan where the Bishop may well be the centre for, you know, what's the word, fast tracking cancer patients for their diagnostics so that they're not sort of caught up in queues because of acute patients.

SE: Which is part of the national cancer plan isn't it Bob? Yes.

BA: So we may well be using the Bishop, you know, the CT scanners and MRIs and ...

SE: And it's a nice environment too.

BA: ... to fast track cancer patients through there.

**Seizing the Future Public Meeting
Ferryhill Leisure Centre
Clevesferye Suite, Ferryhill Leisure Centre, Ferryhill
Tuesday 2nd December 2008**

?: *Can I ask a question, another question? Regarding Bishop Auckland you were saying you were going to have like a ward where if your doctor needed a quick assessment of a patient ...*

BA: Yes.

?: *He can send them in there.*

BA: Yes.

?: *So does that mean therefore that you won't be sent to Darlington Memorial Ward 31 and 32, as it is now?*

BA: What we reckon, if you take the, you know, about 30 patients referred up a day to the Medical Admissions Unit, probably only just over half, about 18 patients a day need to be admitted. Now if we just took away the Acute Medical Assessment from Bishop altogether it would mean the 30 patients would be trekked off to Darlington and then processed and then nearly half of them would be sent back again. What we're proposing in both children's services and in medicine is that it won't be a kind of walk in thing, but your GP will see you and not really sure whether ... you know, some old ladies, particularly old ladies, tend to be very complex and they've got a few (inaudible) and the doctor's really not sure what's going on, but probably not ill enough to need Blue Lighted into hospital.

?: *Yes.*

BA: What there will be, the GP can write, and that's why the service starts at 10 in the morning, so that they will see the patients then they'll make an appointment, they'll be sent up, there'll be a consultant physician or a very senior registrar on the ground who will examine the patient, order investigations, they will be fast tracked, the investigations done, CTs or blood tests etc etc. and the patient will be assessed. We would hope to turn them all round, each individual round within two, three, four hours, and then a decision made as to whether the patient needs to be admitted to hospital therefore the admission will be to Darlington and Durham, to the appropriate specialist, whether in fact all they need is to stabilise now, but they need an early appointment in outpatient clinic in Bishop, seen by the appropriate specialist, or whether in fact they can go home with a care package put in place with primary care, you know, and we're hoping that ... if you're Dr Alan McCulloch who's a very senior consultant physician at Bishop, every time Alan does a weekend on call he sends me an email and he's analysed, his audits as patients come in, and he reckons that at least half don't need to be in hospital, that the default situation is at the minute you get in, you get tucked up in bed in the Medical Admissions Unit, and when you're tucked up, because the guys are busy doing other things, you know, you tend to run out of time and the old lady or gent stay in hospital because that's the kind of only option you've got at the minute. We're hoping with primary care colleagues to drive new options in care and how ...

?: *I'm pleased that's going to happen because when my husband was in Darlington Memorial, it was absolutely chronic, he was moved from one ward to the next, and then it was too full and they had to be transferred into Ear, Nose and Throat for the weekend, and then they were thrown out of that and sent him home Thursday (inaudible). It's horrendous.*

BA: I know and it's desperate. And the overall plan in the end as Diane was saying, if you look at the really, the modern way of going forward, Northumbria are going this way, is you separate the acute care from elective care and I just see us doing more of that as time goes on and the actual role that Bishop plays in our organisation gets stronger and stronger and it will do more and more elective surgery going forward and the other areas will concentrate on the acute care.

SE: It covers your point actually that it is often ... it is going on all the time that movement and it's not high quality care, so in terms of our aspiration to do that then this separation allows us to address that because sometimes you might have to move, but you really want to minimise that in a way that's

Seizing the Future Public Meeting
Ferryhill Leisure Centre
Clevesferye Suite, Ferryhill Leisure Centre, Ferryhill
Tuesday 2nd December 2008

planned rather than having to move because of the excess pressure on the system and all the evidence says that your recovery is much better if you're not moving about and there's a settled environment for your acute phase of care. Of course, and for the families, yes.

DM: And for the staff as well.

SE: And for the staff too. Yes.

DM: Yes, it's just not ... it's just not the right standard of care for anybody, not something that any of us want to do, or want to sort of, you know, continue into the future, but ...

SE: OK. So have we managed to answer all your questions or are there any further questions?

AA: *Just an observation really in a way ... I left midwifery and went into politics. (Laughter)*

SE: Well actually ...

BA: Wise woman or ...

(Laughter)

BA: Agnes, I left obstetrics and I'm beginning to think of going into politics!

AA: *Don't ... that's by the by, but you're going on and we're very grateful for your time this evening, all of us, and we'll spread the message where we can, because you have a good message to take out. But as I say I'm the leader of the Council and I listen to my members and I listen to the public, and in some instances the message isn't getting across.*

DM: No.

AA: *I don't know why in a way, I think it's two-fold. We're very grateful and I was always very grateful when I worked in the acute sector and in primary care for the loyalty of patients to their hospital, you can't buy it, when I worked at Dryburn if it hadn't been for fundraising we wouldn't have had any equipment on the Special Care Baby Unit, so come on, let's be right about this, so we don't want to discourage that loyalty and that commitment to Bishop hospital. On the other hand we've got to look at it as the best care for everybody in County Durham, not just the villages nearest. I think you need the GPs on board certainly, I think primary care, they've got to stop carping on the sidelines and get in there, because it's for their benefit as well, and I mean I raised it at the surgeries and things like this, so you know can I take this opportunity to thank you very much and to wish you well on behalf of Sedgfield Borough Council.*

DM: Thank you Agnes.

SE: That's very kind.

AA: *And we'll do what we can to help on the sidelines.*

SE: Well we'd appreciate that.

BA: Thanks very much indeed.

DM: Thank you.

SE: Thank you very much. OK.

**Seizing the Future Public Meeting
Ferryhill Leisure Centre
Clevesferye Suite, Ferryhill Leisure Centre, Ferryhill
Tuesday 2nd December 2008**

?: *The other thing about travel, what you said, is that ... at the Scrutiny Review we are going to go onto the public transport system and go from every area to different hospitals to give ... you know, so we know what patients can achieve getting to and from hospital.*

DM: Yes.

SE: OK.

DG: OK. Thank you.

SE: Thank you all very much.

DG: I'll just return those thanks actually, I know there's not many people here but actually it's been a really good conversation.

BA: This has been one of the best ones actually, it's nice, it's a bit more intimate you know, we weren't being abused!

(Laughter)

SE: Thank you very much.

?: *(inaudible)*

DG: Can I just ask you ladies if you haven't filled in one of the questionnaires please ...

(End of meeting)