

**Representing the NHS**

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DG: OK. Good morning ladies and gentlemen. Welcome to quite a chilly Newton Aycliffe Leather ... Leisure Centre ... or Leather Centre even! This is one of a series of ... yes, thank you, thanks, we'll try and get warmed up a bit so we can shed some overcoats and scarves and gloves and things. My name's David Gallagher, I'm one of the directors at NHS County Durham, the PCT. I'd like to welcome you all here this morning to this meeting which is one of a series of public discussion meetings, public meetings, about some proposals from colleagues in the local Foundation Trust about the future of some of their hospitals. I'll just ... I've introduced myself, I'll just ask Stephen and Diane to introduce themselves.

SE: Hi, good morning everybody, I'm Stephen Eames, the Chief Executive of County Durham and Darlington Foundation Trust.

DM: Good morning, I'm Diane Murphy.

SE: Am I not loud enough? I am not on?

DG: Yes.

SE: Oh I am on, sorry ... Stephen Eames, Chief Executive, County Durham and Darlington Foundation Trust.

DG: That should be OK now Stephen. Ok, thank you. What we'd like to do this morning, we've got an Agenda to go through and I know some of you might have been to some of the previous meetings. Oh sorry .... Diane, I beg your pardon!

SE: (inaudible)

DG: We have, yes. Automatic pilot. Diane, would you like to introduce yourself please?

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

DG: Thank you. Apologies for that. We've got an Agenda to go through this morning, we're going to have a presentation from colleagues at the Foundation Trust in a moment which will explain their proposals that they're putting forward and then there are two opportunities for people to actually question the proposals and actually feed into the consultation process itself, partly around some ... I know we said round the table discussions, we'll actually do some focus group discussions and we'll organise that once we've finished the presentation, but then there's an opportunity to ask the group open questions from the floor and we'll actually ask some of the members of the panel to actually sit at the front when we come to do that, we'll introduce them as we start that. We'll finish off the morning by a wrap up from yourself and

just some comments on how this actually goes forward, how this feeds into the consultation process and basically what happens after the process is finished.

Just very quickly really, just a bit of clarification around the roles and responsibilities. I'm obviously here and we've got some colleagues here from the PCT. Our role in life is to make sure that we actually buy, purchase, commission, however you want to describe it, services for health and healthcare for the people of County Durham and Darlington. We spend about a billion pounds doing that. That covers a whole range of things from actually, interesting, I noticed when I was elsewhere in the Leisure Centre this morning there are some notices up about subsidised swimming and free swimming for people, we put money into that, we use the funds for that in terms of improving health, we also fund GP services, mental health services whether it's in the hospital or in the community, community services, dentists, etc. and part of the discussion we're having today about the acute hospitals which are sort of the physical illness services, the main hospitals. We get that from a range of providers, largely from colleagues at the Foundation Trust in County Durham and Darlington but we do actually get that care from other places like Sunderland and North Tees and Hartlepool, Newcastle etc. But the discussion today is really about County Durham and Darlington Foundation Trust and the hospitals that they run, the acute hospitals that they run, and obviously that's why they're there.

In terms of the consultation process, colleagues from the Foundation Trust are making some proposals. As a Board at County Durham and Darlington we've listened to those proposals and have agreed that there's a need for some change but what the consultation process is about is actually understanding what that change might be and how it might be implemented, so the only decision we've made so far is actually to embark on this process of trying to listen to local people and listen to the proposal and to get to a point where we can sit in judgement, if that's the right way to describe it, in terms of do the proposals go ahead and if they do in what shape or form. I'll give a little bit more detail of that towards the end of the morning.

What we're trying to do in terms of the meeting is ... we've got colleagues here from Proportion who are going to record on the flipchart when we come to the question and answer session, but we're also recording with the sound and the microphone all of the proceedings because that is actually fed into the consultation process and Proportion will actually write up the whole process and the outcomes from it and feed it back to us once it's finished. What we want to do is make sure this is a two-way communication process so there's an opportunity to listen to the proposals and the issues around them, and then as I said earlier it's your chance to actually feed into the consultation and to ask questions of the panel, hopefully to help you understand the issues so you can then feed into the consultation process via a range of means that I'll describe towards the end. So we'll listen to your views, we'll tell you what's going to happen next, but for the moment I'm going to hand over to Stephen and colleagues and they'll go through their presentation. Thank you Stephen.

SE: Thanks David. Morning again. I'll just put that ... like that. So our proposals Seizing the Future, they have been developed over the last nine months or so principally by clinical colleagues but also our Governors and members who represent different parts of the communities that we serve across Durham and in Darlington, and these proposals, I want to emphasise, are about the quality of care and the safety of care in the future. Now just a few key messages to start with because obviously there's been a lot of coverage around these issues in the local media ... the first message is there are no hospital closures and the second message is there are no staff redundancies, in fact what we're planning to do is maximise the use of all of our hospitals, the five hospitals that we provide services from, but because of a

variety of reasons, particularly clinical reasons, we need to reorganise our services, we need to provide them in the future in a different way, and what's driving those changes are two major forces really. One is the need to centralise some of our services and therefore stop operating them in three different locations for considerations of quality and considerations of safety. I'll explain that a bit more in a moment, and the particular services that are affected in that regard are Accident & Emergency, critical care and children's services. At the same time the whole thrust of what people want and what the Department of Health and Government reforms are about is taking more and more care into local communities, so nearer people's homes, nearer their local GP surgeries, so we're also looking in these plans to develop as many services locally as possible so we can give you the best treatment that we can in future.

Just briefly, therefore, the clinical model, the way that we're looking to organise, we're looking to concentrate our acute critical care services at Durham and at Darlington and that means that we'll be making changes to the Accident & Emergency services at Bishop Auckland and the critical care services and children's services ... emergency care children's services at Bishop Auckland. At the same time we're looking to redevelop Bishop Auckland hospital as a major centre of excellence for surgical activity and rehabilitation and recovery and there's a little note under there as you'll see on the slide, what that note is basically saying is if we're able to take these proposals forward following consultation there will be more activity at Bishop Auckland, we'll be using more of the floor space in that hospital than we do at the moment. We'll also continue to provide services at our two community hospitals at Shotley Bridge and at Chester-le-Street as we do now. Just going to hop over those two slides here.

It's a bit about why we need to change, going back to what I was saying at the beginning. I made the point about specialisation. These recommendations are coming from clinical colleagues nationally who have set out as part of Lord Darzi's report for the future who, he himself is a Minister but is also a doctor, have set out the need to specialise in a number of service areas and that's about having enough activity, enough volume, going through individual specialties to ensure that if you're having an operation, shall we say a gall bladder operation or something like that, then the person you see is doing that quite a number of times every month, every year, so you've got significant skills in place to ensure you get the best possible care. One of the other reasons around specialisation or critical mass, which is the sort of technical term that is used, is that we need to ensure that we've got enough doctors in place, not only to provide the care, but also to provide the rotas that are required 24/7, day in day out every year, and the really important education and training that we need to provide to our junior medical staff as well.

There's another big factor which is doctors' working hours and this relates to the European Working Time Directive that comes into play next year that limits the hours particularly that junior doctors would need to work. Now if we weren't able to make some of the changes that we're proposing it would mean the Trust would need to look to employ a further 31 medical staff just to maintain the rotas that we have at the moment. You might think well why don't you just do that then. The reality is that we won't be able to employ those doctors in the sort of rotas that we currently operate. They won't meet again the sort of standards that the national colleges, the Royal Colleges rather and the National Health Service require.

There are specific recommendations which, I won't go into the detail here but we can certainly outline in questions, in each of these areas, Accident & Emergency, emergency medicine, critical care and children's care, following that trend towards specialisation, so if you take Accident & Emergency care, what we're proposing as you've heard is to concentrate

the highly critical side of that activity at Darlington and at Durham. Now at the moment 30,000 people attend the Bishop Auckland site and these changes will mean that around about 10,000 of those people would get their service in the future from Darlington and from Durham. Two thirds of the people that go to Bishop Auckland at the moment would continue to attend there. Critical care services, we're particularly concerned about this because we've already had to make a number of changes in the past year around critical care, there are different levels, it's quite a technical issue, but there are different levels that determine the severity of critical care. Historically we had level 3 services at Bishop Auckland, for the last year we've been operating a level 2 service which is a lesser acuity and we're maintaining that service really through the goodwill of senior consultants, again operating in rotas which are very difficult to maintain in the future. Three of those consultants are retiring come next April and we won't be able to replace those doctors and so therefore for the reasons of safety and quality around specialisation but also for reasons again of medical staffing we're not able to maintain that service, so we would ... as I've said, we'd be looking to concentrate critical care at Durham and Darlington. And similar issues relate to the medicine changes and the children's services changes that we're proposing, so I won't repeat what I've said about those.

Finally from me, what would happen if we weren't able to move forward on this Agenda ... and you see the slides headed 'Doing Nothing is not an Option', that is a direct quote from Professor Sir George Alberti who before we started consultation reviewed our plans and that's what he made clear, from his professional opinion, having looked at issues like this up and down the country over the last three to four years. What would happen if we weren't able to move forward is we'd be constantly trying to patch up the services, emergency contingencies day to day trying to find doctors and specialist nurses to hold the service together and probably quite frequently as we get ... certainly if we got into the period where we were hitting the European Working Time Directive, having to temporarily close services and not knowing quite when that was going to happen, so that's not good quality care clearly and we're very concerned, clinical colleagues in particular are very concerned that that will lead to a decline in quality and safety. We also think that we're tackling, we're trying to tackle together with our colleagues in the PCT, the health inequalities agenda. We think that this will make those inequalities greater if these things stay as they are. And of course, ultimately, commissioners, our primary care colleagues, who buy our services are required to buy our services at a national minimum standard and if we can't meet that standard then they won't be able, because of the guidance and systems and procedures that they operate, to purchase those services and that's bad for the local community because they would be provided elsewhere. So on that note I'm going to hand over to Diane who'll take you through a little bit more of the detail around the clinical case for change.

DM: Thanks. Just to give you some information about the A&E proposals which have had a lot of coverage. The existing A&E at Bishop Auckland treats around about 30,000 patients a year and in our proposals 20,000 of the patients who would normally be seen at Bishop Auckland would continue to be treated there, types of patients that we will be treating there are people with sprains, cuts that need suturing, some fractures of limbs, I mean that includes obviously the X-rays that go along with that, so it is a range of conditions that will continue to be treated there. And just to say that we've actually got good experience of running a unit like that at Shotley Bridge hospital. We know from evidence that's been described through lots of recommendations, through Royal Colleges and through national evidence that patients benefit by travelling further for specialised care. The point is that what you need is not to be seen quickly, you need to be seen as quickly as possible but by the right team with the right specialist skills, that means you are more likely to be treated with the appropriate treatment and have a better outcome of care.

In the case of serious trauma which is people with major injuries, sort of following car accidents or things like that, that was centralised in Darlington in 2000, so that hasn't been treated at Bishop Auckland for quite some time. Patients actually go directly to Darlington, and in the case of patients with major head injuries we don't treat those in the County, they actually go out and go to James Cook hospital, again, where there are specialists with the right skills, and teams of specialists with the right skills who can make sure that people get the right care and outcomes. So just some kind of overall views of why this is better for you as users of our services as patients.

By reconfiguring the way that we're proposing we can ensure that you will, once you're admitted to hospital, you'll be seen at the front of the hospital by the right specialists, but after you've had that emergency care we will have the right numbers of specialists in things like diabetes, respiratory medicine, cardiology, in sufficient numbers that regardless of the day of the week, or you know the week of the year, regardless of whether people are on holiday that you will be able to be seen by a specialist who with the right skills, who can give you the right medicines, the right treatments, and again improve quality of care, and obviously meeting the standards that are required of us.

Specialist doctors actually work within teams. I kind of touched on that previously, and that means specialist nurses and it means specialist therapists, people who work together every day, build up expertise together, and they kind of generally are configured in wards, and we can, again, with these proposals, ensure that you go on the right ward, are seen by the right team of people with the right skills. There's less chance of you actually having to go to a ward, be moved to somewhere else with a team that don't understand to the same extent around your need.

By putting the ... most of our planned surgery on the Bishop Auckland site we will be able to reduce the risk of cancelled operations. We know how much effort it takes for people to organise their lives to get to hospitals on certain days at certain times and just the kind of emotional stress that that causes as well, and sometimes we have to cancel people at very short notice because there is a demand on an acute bed, somebody who is acutely ill needs that bed and we have to cancel operations, and we know that by separating our planned care from emergency care that we can reduce the number of cancelled operations and less disruption to you.

In terms of rehabilitation we currently provide that within acute wards and rehabilitation is a specialist skill in itself, it requires a completely different culture of care, it means that you stand back from the patients, you give them time and space, and you give them the skills to actually return to independence and function in a better state and all of that's supported by treatment from physiotherapists and speech and language therapists and people like that. By creating a specialist rehabilitation unit on the Bishop Auckland site for all of our patients this would be a unit that would first of its kind in the area and we think that we can actually provide something that people probably from out of the area would want to use as well. We can actually improve the outcomes of care for many of our patients. We might be about reduced length of stay, but more importantly it is about people returning to sort of fuller independence, fuller functionality, so that we can get people back to their own homes and less people into community services dependent on support and sometimes dependent on nursing homes or residential homes.

Separating planned and elective care also means we can actually screen all of our planned patients before they come in and in that way we can detect those patients who need treatment for MRSA before they come into hospital which is before they've had their operations and again this reduces the risk of a serious infection.

Travel and access has been raised as an issue right from the beginning of the work that we've been doing, so almost a year now, it's been raised by members of the public, by our staff, by our Governors, it's something that we have taken very seriously. Everything that we're planning is based on the principle of travelling only where essential which basically means that if we've got to centralise a service on a particular site you will travel for that specialist bit of the service but you'll have your follow up care at your local hospital. If there are any further diagnostic tests you need, that will happen at your local hospital. If you're coming in for planned surgery you'll have your pre-assessments either at your local hospital as an outpatient but some patients will actually have that done over the telephone, you won't even have to come to hospital, so we're doing everything we can to reduce the amount of travelling required for patients ... well not just patients actually, for the people who support patients as well, for their families and carers.

Just to note the paramedic role in emergency care, people have talked about the Golden Hour and once upon a time people talked about the Golden Hour and it was the hour that it took to get to hospital for treatment to start. Because of the changes in the way that the Ambulance Service run, the training and the skills that paramedic crews now have, that care and treatment starts when the paramedic arrives at your home or wherever they're picking you up, so that Golden Hour is not the same principle, it's about getting the paramedic to you and then getting you to the right hospital with the right teams with the specialist skills.

We've been working with the Integrated Transport Unit at Durham County Council, looking at transport services across the whole of the County and we've identified those communities that currently don't have good public transport access to hospitals and then we've looked at how those communities would be affected by our proposals and what that tells us is that actually we're not making the situation worse, but having said that there are still some communities who do not have good access to our hospitals and we need to address that and make sure that they are able to access our services. In East Durham, in the Easington area, a service has been set up called East Durham Transport Link, and by identifying the communities who don't have good access to public transport and working alongside existing transport providers including the Ambulance Service, voluntary drivers schemes, and putting that altogether and then commissioning some additional services, patients now, and carers and staff, can actually access public transport from all areas to get to all of the hospitals for appointments, for visiting times, to and from visiting times, that type of thing. We aim to provide a similar service. We don't actually think that we will have to commission many additional routes because of the mapping that we've done. We know the areas where we're probably going to have to do that and potentially increase voluntary drivers and schemes like that, we're talking to all of those people, so we've committed to doing that and we've also committed to investing in those services that are required to support that.

That's just a map of the County that kind of shows how people are affected. I've put up there DL5 which is the Aycliffe community and under our proposals, this is for public transport, this is based on activity last year, you know, nearly 600 people would see no change in how they accessed services by public transport, and there's a slight positive number in terms of the people who would be better off so 33 people would find it easier to access the services the

way that we're proposed to configure them and 29 would be worse off, but that's something that we're addressing.

DG: OK. Thank you. Thank you for listening ladies and gentlemen, what we'd like to do now is we need to get some of your views into the consultation so we can understand, when we assess the proposals, if they're the right things to go forward or not, so what I'd like to do, if I can ask Amanda and Katrina to arrange for you, we'll just do a quick focus group for about quarter of any hour, 20 minutes, however long it takes really, we've got some questions to ask you to feed into the consultation process, but there's also a chance to actually think about some questions to ask the panel once we've finished this piece of work, so I'll leave you in the capable hands of Amanda and Katrina for the moment.

#### MEETING MOVES INTO ROUND TABLE DISCUSSION GROUPS

(General talking as people move around the room)

#### FEEDBACK FROM ROUND TABLE GROUPS

DG: OK, thank you ladies and gentlemen. We're coming to the point now, I think we just had a discussion with you to see what you wanted, I think what we're going to do is Amanda will ask the questions that the group have ... that the group have actually come up with and then there'll be some time to ask some supplementary or additional questions that people thought of. We've got two more members of the Trust staff sitting on the panel ...

?: *(inaudible)*

DG: Yes.

CR: Carol Robinson, I'm Head of Physiotherapy and my work with Seizing the Future will be looking at the developments for rehabilitation.

DG: OK. Thank you.

SP: I'm Sarah Pearce, I'm a consultant physician. I also chair the Strategy Committee of the Governors, that is we examine carefully all the strategic proposals put ... we examine ... I chair the Strategy Committee of the Council of Governors and we have to examine carefully all the strategic proposals put forward by the management and nothing goes through without full discussion and we do have members on that Committee from all areas of the patch.

DG: OK. Thank you. Amanda, if you want to start with either key points or questions?

A?: *I'll start with questions.*

DG: OK. Thank you.

A?: *Thank you. The first question relates to maternity services. If you are in labour at Bishop Auckland with a seemingly uncomplicated pregnancy, or labour should I say, and suddenly complications start, what will happen then?*

DG: Diane?

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SE: Diane will answer that.

DM: Thank you. I'll take that. The midwifery led unit has been up and running for four years now and very successfully and it provides as you kind of comment really, it provides a service for women with uncomplicated pregnancies. Now by assessing those ladies through their pregnancies there are two key times in the pregnancies that the midwives make and assessment of those ladies and identify any risks that might preclude them from delivering safely in a unit where there aren't any consultant obstetricians. So there is a kind of ... before somebody delivers there is an assessment process to identify people who actually need to go to a unit with obstetricians. If however during the labour problems are encountered, at the first .. you know, there are kind of a range of protocols that midwives have to follow, and if the lady gets into some difficulties or the baby gets into some difficulties, and that is kind of a trigger on the protocols, then the immediate response to that is that the ladies are transferred to the Darlington Memorial unit by ambulance, a Blue Light, they are responded to as an emergency. It doesn't happen very often but when it does it has happened very successfully, the Ambulance Service provide a great service to that unit and we've never had a problem.

DG: OK. Thank you.

DM: Does that answer the question? You look a bit unsure.

A?: *(inaudible)*

?: *Well I'd just like to make a point ...*

DG: Sorry can you just say who you are as well please, just so we can record it?

MrJ: *Mr Jones.*

DG: Thank you.

MrJ: *My daughter had a normal birth and she'd been for pre-med for Bishop Auckland all the time. Her birth was due in the middle of the night and they shipped her straight off to Darlington. Now that is not treating everyone with a normal birth at Bishop Auckland. They're picking and choosing.*

DM: No.

MrJ: *And as the lady said, if complications start in the middle of a birth you're going to ship them out another 10, 12 miles, I mean it's ridiculous to have to do that in the middle of a birth, there should be a full maternity service at Bishop Auckland, as there should be for A&E.*

DG: Right. OK. Diane do you just want to respond to that bit?

DM: Just to say that every woman is offered a choice of where they want to deliver their birth and...

MrJ: *No, she wasn't.*

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DM: Every woman is given a choice when they are going through their antenatal period, by the midwives. If there is an issue why they can't deliver at Bishop Auckland, so it might be an existing health issue, it could ... things like diabetes for example, if they've got a heart problem, but there are other factors as well, previous history, ante-natal history, then they would be advised that they couldn't deliver in a midwifery-only unit, but women are given a choice of all of our units.

MrJ: *Well my daughter was not.*

DG: Sir, can I suggest, if there was ... yes, OK.

SE: Could you give us the detail of your daughter, we'll follow that up and ask the question because she should have been.

MrJ: *Well I can't give you the full details.*

SE: Well, no, but at the end of the meeting we'll take your details and we'll follow it up.

DG: Is it linked to this?

?: *Well it's (inaudible)*

DG: OK. Go on.

?: *(inaudible) maternity services per se, but do you recall there was a case, not that long ago, I think it was probably about five or six years ago, a person of my acquaintance in fact, her child did die on the way because for some reason, there was something to do with transport and ambulance, and she went in a car with her husband, and she died ... well the baby died. Yes.*

SE: Yes. We can comment on that.

DG: Yes, it would be useful to get a comment on that possibly.

DM: Yes, it was ... and it was actually as the unit opened, and the lady did transfer in a car and it wasn't actually to do with the protocols. It's very difficult to talk about somebody's ... somebody's care ...

?: *You know, I didn't want to go into details but I mean (inaudible)*

DM: Yes, there was a significant investigation into that and there were reasons why that happened which actually are not about the transfers and the identifications of risks in pregnancy, and actually she wasn't actually delivering in the midwifery-led unit, that particular case, that lady was actually being assessed by ... in a ... I think it's an assessment unit rather than the midwifery-led unit, so it's a different kind of situation...

?: *No, I can understand that, but the thing is I think we have to (inaudible) be a little bit more ... to be honest I'm a doctor, and I do know that it doesn't matter how much you know prior to someone giving birth and you can look at all the risks and everything, but situations can change and the thing is why do we want to be in a situation where, you know, we're going to be in the headlines tonight, I know this has been going on for four years but just because*

*something has worked for four years doesn't mean to say it's going to continue. I myself personally chose to have my last child in Darlington, not because I wanted to, but because I wanted doctors to be present in case there was a problem, because...*

DG: And that's your choice.

??: *Yes, your pregnancy and your child are important.*

SE: OK. Doctor Pearce wants to make a comment.

SP: Yes, can I come in on that. My first job was in obstetrics so I have vivid memories of things going wrong at the last minute and all that sort of thing. The trouble is you have to have a certain volume of work going through a unit for everyone in that unit to have the right experience to deal with emergencies which can be very difficult and if you have three units, all small, none of them is going to have that expertise and we're not allowed to run like that.

??: *But then if you're going... sorry, if you're going according to your sort of ideas that specialisation... why haven't you moved all of maternity?*

SE: We have moved all of maternity, there is maternity led ... midwifery-led unit rather, sorry, which actually deals with something like 500 births a year, and what we're doing there is ... obviously that consultation was four or five years ago and those sorts of units do exist up and down the country and you're absolutely right, my wife has recently had a baby too, she wanted to go to a unit that had all of the back up and medical staffing and so on that you described, actually a lot of women though, one of her friends, wanted to have a baby in an environment which was entirely midwifery-led, it's a matter of choice, and we're offering that choice to our community.

DG: OK. Thank you.

KB: *Thank you. Are there going to be more ambulances and paramedics?*

SE: That's one for you David isn't it? And the answer is yes!

DG: Yes. I mean one of the things we're doing as commissioners because the hospitals don't actually buy the ambulance services, one of the things we're doing as commissioners particularly for the Dales is actually looking to put more investment in. At the moment there's one ambulance in each Dale, of the two Dales, Teesdale and Weardale, we're actually working with the Ambulance Trust and putting in ... sorry about the noises ... we're putting in £600,000 worth of investment so there's actually one ambulance in each Dale all of the time because we recognise, and I think we touched on earlier the role of paramedics, actually paramedics are key to all of this, because the ... I was going to say the guys, the guys and the girls who actually come in the ambulances are trained to actually look at stabilising people, in some cases actually treating them so they don't need to go into hospital, but we are putting more effort into the Ambulance Trust and more resource into them to make sure they're actually fulfilling the needs and to hit the target times that they've got.

KB: *Yes, OK. Is that OK? OK, next question. What was Bishop Auckland built for, for it now to be downgraded?*

SE: Sorry, what was it built for if it's now to be downgraded?

*KB: Yes, what was it built for for it now to be downgraded?*

*SE: It's not being downgraded. We're putting more services in, as I was saying in the presentation, to Bishop Auckland than there are there at the moment, that's the plan. We use more floor space, there'll be more activity, an awful lot more services will be more local to the people who live in Bishop Auckland than there are now. So I think ... we wouldn't be talking about downgrading, we're talking about providing a really exciting, vibrant future for that hospital as part of our group of hospitals in County Durham and Darlington.*

*??: (inaudible) somehow. Bishop Auckland is ... we're more concerned about the A&E services at Bishop Auckland and it is definitely being downgraded to just a ... I don't know what the word is, but it's just being downgraded to a nurse-led unit which will have no medical or clinical work done.*

*SE: That's incorrect.*

*??: The absolute simple A&E services that are going to be available to Bishop Auckland, everyone else is going to be shipped out.*

*SE: Yes, OK. I think Dr Pearce may want to comment again on this in a moment, but if I could just say, absolutely, our proposals are about change in the way that we organise the service, but I think as we need to remind you ... I know you said there that .. I can't remember your exact words, but bear in mind that what we said in our presentation, that 20,000 people will still be getting an emergency, urgent care service from Bishop Auckland hospital which is the vast majority of what goes on there now. We're talking about the people who are critically ill, who require critical care support, and much as we would want to ... if you would just let me reply and listen to your question, much as we'd want to provide, you know, an emergency care service in every hospital that we operate from, we're unable to do that because there isn't enough work in each location for that to happen, and whilst in the past we have managed, the way in which the whole structure of the way our consultants and our junior medical staff have to work in the future, because of European and national changes, means that we can't do it any more, that's the reason, and nobody will suffer as a result, nobody's going to suffer, we're talking about providing a much much better service than we'll be able to do if we leave things as they are.*

*DG: Sarah wants to make a point?*

*SP: Part of the proposal is to have ... is to have an urgent care centre which will pick up a lot of the emergency type work that comes through an A&E department. Now many of the patients that come into hospital could go home very quickly if they're properly seen, tested, examined and treated on the spot. Now at the moment they tend to come into a ward and they usually end up staying overnight, but if the expertise is all there right at the front door of the hospital they can go home faster, so some aspects will definitely improve as a result of the proposed changes, and secondly, we're back to the same point that we were making about having babies and all that, is that you've got to have a big enough unit to generate the experience and expertise that really keeps patients safe and I am very worried that if we don't see these changes go through in the next year we are going to have an unsafe service.*

*??: But if you keep downsizing Bishop Auckland there is not going to be expertise as required at Bishop Auckland, you're taking them all away ...*

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DG: OK. I think Sir, if I may, you've made that point and I think it's been responded to in terms of ... there are specific issues around A&E which we'll record and we'll feed into the consultation.

?: *(inaudible) is maintaining certain services (inaudible) but it appears ...*

DG: No, I'm sorry Sir ...

?: *... that they're only wanting to maintain it at Durham and Darlington, they're not interested in maintaining it at Bishop Auckland, all they want to do is do away with it at Bishop Auckland.*

DG: OK. Can I just ...

SE: Just one final ... perhaps just one final point ... we're not doing away with anything, we have a responsibility to provide high quality care to the County of Durham and the people of Darlington. All we're saying is obviously we ... Bishop Auckland, Durham and Darlington are really important in that respect. In order for us to provide a high quality service to you in Bishop Auckland, to people in Darlington, to people in Durham, we have to make these changes and I should say that Darlington, at the moment, picking up on Dr Pearce's point, a year from now Darlington will be experiencing the same problems that Bishop Auckland is unless we're able to make a change, it's not just about Bishop Auckland.

DG: Can we move on to some more questions and then ... sorry, I didn't see your hand.

?: *You were just talking about staffing and the fact that, you know, you won't be able to get enough doctors to cover because of the Working Time Directive ... well the other issue is at what stage are health jobs at Bishop Auckland not going to be recognised because they're not going to have the input and the throughput?*

SE: They're not now.

?: *Are they not recognised? The house jobs are not recognised?*

SE: There is ...

DM: In some specialties...

SE: Sorry, I apologise, I thought you meant about in Accident & Emergency. In some specialties they are.

?: *Well in A&E you don't have house officers.*

SE: There's no training in the A&E department at Bishop Auckland.

?: *No, but the other point that earlier on you raised when you were doing your presentation, you said that you've got consultants retiring, and you can't replace them ... great comment, but there was no back up on that, why can't you replace them? Presumably money?*

SE: No, money's not an issue, we ... the Trust has currently a surplus of around about £10 million, if we could simply replace them by ... you know, recruiting those doctors and paying for them we would obviously do that, but the reason why we won't be able to recruit those doctors in the future is because doctors won't choose to work in a situation which is potentially ... not big enough to provide the experience that Dr Pearce was talking about and won't meet the standards that their own Royal Colleges recommend, so they won't ... when those doctors retire, the new consultants won't come to that environment to work.

?: *But don't you think we're ... I mean it's a problem of being created ... being created and therefore, you know, it's sort of ever decreasing circles in a way, I mean, you know, your ... it's cause and effect isn't it really? I mean why cannot we improve services, I mean ... I mean I value your intentions, I know that you've got good intentions and you want to do the best and everything and yet it just feels as if the services are being downgraded and, I mean, I'm disappointed by the turnout but obviously that's another issue, but people are very very keen on the fact they want good services and we have to be realistic, we've got an ageing population and an ageing and sicker population and in fact the younger people in our generation, in our society, are actually sicker than older people because of lifestyles, so we do need a better health service. I mean I don't understand where we're going, you know ...*

SE: Dr Pearce wishes to comment on that.

?: *Sure.*

SE: And I want to ask her to say something about (inaudible) services that you mentioned.

SP: Well I would certainly agree we all want a better health service, we're all working towards improving things, not making things worse, but again we're back to the fact that in order to develop a really good service you have to have quite a lot of patients going through it because if you've got a doctor who only sees a particular condition once every two years, he's not going to be experienced, he's not going to be able to deal with it expertly, so you can't really have all the services in all three hospitals. That is ... that is ... it's not about money, I don't think any of us doctors has talked about money in this, what we've talked about is can we recruit the staff and is there enough work going through each of these hospitals to provide all the staff, all the facilities and all the experience that is needed.

?: *(inaudible)*

SE: No, Dr Pearce is not telling you that, we're going to hand you over to Carol, but just to make a point also, going back to your point about money, we spent .. we spent over the course of this year nearly a million pounds on holding together, if I can just describe it that way, the service at Bishop Auckland, that's in relation to anaesthetists, because of the retirements that we've had. We won't be able to do that in future because the way that that service is being held together is by three consultants who are working with the additional resources that we've put in, some of them are actually working over 60 hours a week, which is not acceptable you would say in this day and age, they're all going to retire, we can't repeat that model in the future, but perhaps we could ask Carol to speak a little bit about the old people's services and the rehabilitation aspects.

CR: The older population that you refer to ... we're all very aware of the increase in the age bracket and the increase in the medical complexities of patients that are coming through our services and as an acute trust and as the rehab service we work closely with the Primary Care

Trust and mindful of all the data that comes from the Department of Health too, to know that in the future we need to develop our services to meet the demand. Rehabilitation's very key in that and we're all geared up to move to meet the rehabilitation needs of the increasing ageing population.

DG: I'll just add one bit to finish this point of conversation off, from a commissioning point of view, you mentioned about people being sicker and younger people being sicker, actually this is a discussion about health services ... there's a much wider discussion that we're having which is actually about putting more money into keeping people fit and healthy and helping them make the right lifestyle choices so they don't get ill in the first place, so it's part of a much broader agenda which isn't part of the remit of the consultation, it's a good point, and we're doing other work to try and address some of that.

?: *Thank you. What concrete evidence does the Trust have that they clinicians agree with the changes? Was there a vote?*

SE: We don't need to vote do we?

SP: We've never voted on any of these things because there has not been the need to vote. Clinicians have been involved on all the committees that have been working on this, and we've also involved members of the public from all parts of the area and they have had an equal voice with the clinicians on these committees. I think we have ... all the clinicians have spent many hours discussing these changes, both in committees and out of committees, so I can ensure you that we have been fully involved.

DG: OK. Thank you, Amanda.

A?: *OK. OK. How come the options have been dwindled to two which will both have a negative impact on Bishop Auckland General?*

SE: I've asked Diane to answer that.

DM: We actually, through the process of getting to these options, there were a number of groups set up as Sarah's mentioned and each of those groups led by doctors and mainly consisting of doctors and nurses and therapists ... and they actually, between them, at the beginning came up with 49 options for delivering our services. Now that was about looking at individual services and then we put them together into how that would fit into hospital services. Before we got to really getting any options on the table so to speak we developed a set of criteria, some things that we would evaluate each of the options against, and those criteria were around the safety of those services, the quality of the services, affordability and whether we could actually do it, you know, whether it was something that we could only achieve in sort of 10 or 15 years and therefore wouldn't be appropriate ... an appropriate solution, and then we also developed some benefit criteria. Now when we did that those criteria were developed with doctors and with the members of the public in the committees that we had, the groups that we had in the project, but then we also tested those criteria with stakeholders at two big events and in total that was something like between 250 and 300 people, actually we shared those criteria with and they validated those for us, so they agreed with that criteria. Then when the options were actually documented by the doctors, we actually tested each of those options against those criteria, but again using groups of people which included our elected Governors, our doctors, our nurses, staff representatives and that's how, using those criteria, we got down eventually to two and the two are the two that we believe are safe, are

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affordable, will deliver the quality of services that we want and ticked a range of boxes around the patient experience, including access and kind of the patient experience in terms of quality of services. So from a lot down to a few but through testing each one.

DG: OK. Thank you.

?: *But what we can't understand is why there should be just only two negative options which are detrimental to Bishop Auckland and not to either of the other hospitals. There should be a third option where Bishop Auckland is treated as an equal partner in regard to A&E which is the most vital service in any hospital.*

DG: OK. A quick response to that.

SE: I can just quickly respond. Amongst those 49 options that Diane mentioned we looked at whether we could make Darlington the planned centre, we looked at whether we could make Durham the planned centre as well as looking at Bishop Auckland as the planned centre, so you know we looked at all of that. Now if I could explain very clearly why we felt that Bishop Auckland was the right choice, having considered those ... let me answer your question ... and why it was the right choice in that respect is that if you were to attempt to create a planned facility at Durham you would be spending in the order of about £80 million on that change. If you were to be putting a planned facility into Darlington you would be spending in the order of £120 million on that change. The plan that we have we're spending around about £6 million, so there's a big difference there, but much more important than that, much much more important than that is that if you made Durham the planned centre as opposed to Bishop Auckland then something like, I think it was 20,000 episodes of care that would ... that happened for County Durham residents would happen elsewhere, outside the County, and if you did that at Darlington the figures which I just can't ... somebody has put them in front of me, you're talking about 6,000 people who are currently getting treated in Darlington who would be treated outside County Durham and Darlington. Putting the changes in place, focussing Bishop Auckland means there's a change in that respect for around about 300 people, so ... I apologise, 3,000, so there's a huge difference and the big point about that is first of all less care would be offered to people locally across the County and more importantly, of course, the resources, the money that we get from our commissioner follows the numbers of patients so if we lost that number of patients which collectively in any respect it would actually destabilise the Trust and we couldn't run the Trust effectively, so those are the reasons why we chose Bishop Auckland. Finally, it's a fantastic location and facility for planned care and rehabilitation, fantastic environment for people to come to to have their treatment and one that we couldn't provide in the other hospitals.

DG: OK. Thank you. Is it ...

?: *(inaudible)*

DG: Sorry ...

?: *One of your panel at Shildon stated ...*

DG: Sorry, can you just say your name Sir please, just for the record?

?: *(inaudible). One of your panel stated at Shildon that the A&E at Bishop Auckland is working under the ration approved by the Royal College of Physicians, this being done for the last*

*eight years. You have a surgeon here of 27 years at Bishop Auckland stating you are being ... the hospital is being kicked to pieces by your present panel. What are your comments on that?*

SE: He's a physician and actually if you read that piece he's talking about the history and I obviously understand the history, there's been a lot of change, but obviously we have to look at the future. He does talk about, in that piece, urgent care centres doesn't he? And he's supportive of that model, but the point he's making which a lot of people make and obviously I understand the history ... what I would say is my plan personally, you know, I'm new to this area so I don't have any of the history, is to put things back into Bishop Auckland, that's my plan because for tax payers it's a very poor investment at the moment.

?: *(inaudible)*

SE: Yes, but we are doing that.

?: *My daughter's a nurse. Occasionally she's been told to get to Darlington, they're short-staffed. Right? She goes to work at Darlington, all of a sudden Bishop Auckland's ... Darlington's overcrowded, it puts patients back to Bishop Auckland where the wards are being operated by less staff than should be.*

SE: Right. OK.

?: *And furthermore my ... talking about (inaudible), my daughter was given a choice eight years ago of going part time and registering for Darlington or applying for a new job after 25 years.*

SE: Well obviously I don't know the details of your daughter's case but we're happy to follow it up if you leave the details, but could I just say that all of our staff from time to time work at all of our hospitals depending on the pressures, that is not a one-way street.

DG: OK. Thank you.

?: *(inaudible) planned surgery. The planned surgery's an entirely different situation and department to the A&E.*

SE: Correct.

?: *And it's the A&E that we are most concerned about. They're talking about bringing planned surgery to Bishop Auckland, there'll still be planned surgery in the other two hospitals, so it's not going to be ... the main hospital for planned surgery but it's not the planned surgery that we're concerned about, it's the ... a full A&E that it should be as you've just suggested returned, reinstated at Bishop Auckland hospital, so that it's an equal partner to the other two.*

SE: But you see the basic flaw in that point, and I understand what you're saying, is we can't provide an A&E in three places, so if we did that then Durham or Darlington would have to be without an A&E. That's the situation and I must correct you and point out the facts about surgery, Bishop Auckland will be our main centre for day surgery and routine elective surgery that relates to that type of work, it's a very significant amount of change that's happening

which actually means that people who currently go to Durham and Darlington will go to Bishop Auckland.

DG: Thank you. Amanda? Any more questions?

A?: *That concludes the recorded questions thank you.*

DG: OK. Thank you. Can I just ... I was just going to ask actually if there were any more questions from the floor so you've ... sorry do you mind just speaking into the microphone, I know it's a chore but we need to record it.

?: *Sorry, I'm afraid I've forgotten the name of the lady who did the presentation ... Diane, yes.*

DM: Diane.

?: *Diane, when you did your presentation you ... part of it on the overheads, not overheads, the thing, was about reducing the risk of cancelled operations, I mean isn't that slightly misleading because it's not as if, you know, I mean surgery had already been downscaled at Bishop Auckland so why would ... why would, you know, your operation be cancelled anyway?*

DM: Well planned surgery currently happens on all three sites and day surgery happens on all three sites, so what we'd be doing is putting day surgery, creating a specialist day surgery unit on the Bishop Auckland site and almost all of the day surgery will happen on the Bishop Auckland site OK? Now alongside of that, the intermediate surgery would also move over there, there's already happening over there, it isn't a place where that isn't happening already, what we're planning to do is to put more in, there's already the arthroplasty unit, you know they're doing the hip and knee surgery over there and doing that very successfully. By actually having our services configured so that we've got a planned care centre separate from acute care, OK? When there's pressure, as you've probably experienced yourself, when there's pressure on acute beds as there are sometimes, OK, you actually cancel elective work to put your acute patient in. We can't put acute ... in our planned care centre we won't be putting the acute patients, OK, so those beds are protected for those planned ... for that planned surgery, therefore the operations won't be cancelled for reasons of acute pressures.

?: *No I perfectly understand that but again do you not think that the problems are partly of our own making because in order to maximise bed occupancy beds have been cut, not recently, but over the years, they have been cut, so obviously when you're getting acute emergencies in via A&E and they will take precedence and go into beds, I mean this is not something that's happening now I mean I've been involved in the industry for what 20 years now, from when I began my medical career, and I know that this is a situation that's happened ...*

SE: I mean I think it's a broader point than the consultation, but you're right, there are less beds in acute services than there were, something like ...

?: *And why? Purely to improve efficiency, yes.*

SE: Let me answer your question.

?: *Carry on.*

SE: It is to improve efficiency, yes, I was about to say there's something of the order of 40% less beds and 50% more cases going through. Now actually most people, I mean obviously reducing waiting times has been a national ambition of every Government since I've worked in the National Health Service and we have the best waiting times that we've ever had today, as a direct result of those plans and investment, so it's not actually a bad thing to reduce the number of beds, a lot of that's about people moving to shorter stay treatments, getting back home more quickly, coming into hospital for treatment for a day, all of which patients want.

?: *Absolutely, I perfectly agree with you and increased efficiency's a good thing, but not to the detriment of overall care of patients and unfortunately, again, I think we forget the fact that when patients come into hospital they may not be that acutely ill but it's not a static situation.*

SE: Dr Pearce, so you want to comment?

SP: I'm not quite sure what the question is actually, I'm just trying to tease out what ...

?: *Well I just felt slightly that we're being a little bit misled by that comment about how, oh, it's going to be wonderful because now there won't be a problem about your operation being cancelled because of lack of beds, and I think it sort of ...*

SP: I think we'll be able to offer people a guaranteed date for having an operation at Bishop Auckland which we can't at present in any of the hospitals. No, we can probably in the day unit, we can, but we will be able to offer people with even bigger operations, if they're having them at Bishop Auckland they will get a guaranteed date and that is a big help to an awful lot of people who need operations. Now as far as having fewer beds that is true, what's it's meant is that we have been able to save money in one area in order to spend it effectively in other areas and improve the service overall, that's why the Trust at the moment has such good ratings.

?: *Could I just ask a general scenario? If somebody's admitted into hospital, not particularly unwell and gets critically unwell, then they are going to be moved from Bishop Auckland elsewhere, I mean that is going to be the scenario.*

SP: Admitted for what, for a planned operation?

?: *No, no, no, not a planned operation, say, they're sort of medically unwell but not ...*

SP: They won't be admitted.

?: *They won't be admitted.*

SP: No, they will go to the urgent care centre, they will get a full assessment by an experienced person, they'll get X-rays, CTs if necessary, whatever's indicated and then if they're well enough they'll go home, if they're not well enough they'll get transferred to another hospital where there will be more doctors to look after them.

?: *So the consultants who are present are looking after say acute medically ill or whatever, so basically their jobs are just going to be ... what exactly, are they just going to be performing an outpatient service or ...?*

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SP: We will have an outpatient service at Bishop Auckland and inpatient service at one of the other two hospitals.

?: *And this improves service how exactly? I'm sorry, I must be from another planet I think.*

SE: If I can just add to what Dr Pearce is saying, we're not going to be cutting any medical staff jobs.

?: *But I think the quality of the staff is definitely going to go down.*

SE: Well ...

?: *They have to accept it.*

SE: They do.

?: *Right.*

SE: But it's not ... it won't affect the quality of their work. In addition to the changes that Sarah outlined we are putting in place at Bishop Auckland a rapid assessment centre staffed by consultants on a regular basis every week, day in day out, across the year and that will do exactly what Dr Pearce is saying. We've got the outpatient service and the rapid assessment service so if you go to see your GP on a Monday morning and the GP's not quite sure, you will be referred in to the rapid assessment unit, seen that day, everything that you need doing will be done on that day, now that's ... actually what happens a lot at the moment at Bishop Auckland is quite a lot of people go to Bishop Auckland and they don't see somebody on the same day, they're waiting a few days before they get into the system, that's a very big change, and already about 20% of the people that actually attend Bishop Auckland, particularly the A&E department, are assessed there and then transferred to other hospitals, that's what happens now.

SP: I think as you raised the question of what will the doctors think of it, to their quality of life and all the rest of it, there has been huge resistance around the Trust to try and combine services in this way but we have come round to the point of view that we have to accept the proposals that are put forward. So whereas there was huge resistance there is now huge support.

?: *Do you not mean huge resignation?*

SP: No, no. No, I think people accept that they've got to do it because of changes in the nature of medical care, because of the need for more expertise, the public expects it, you don't want to go to any of the three hospitals and feel you're getting a second or third rate service. If we're going to sustain a first rate service we have to make these changes.

?: *Can I just ask why ...*

DG: Sorry, can I just check ... no, sorry, can I just check does anybody else want to ask a question because what I really want to do is make sure that people have ... if anybody has a question they would like to ask?

?: *Yes, but let the ...*

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DG: No, I'll come back to you, I'm sorry we just need to make sure people have a fair say.

?: *No, it's breaking the flow of her questioning, just let her ... well again what I'm concerned about is ... I can't get used to the microphone!*

DG: They're a nuisance I admit.

?: *What I'm concerned about is they keep saying that the volume of throughput is very vital. The volume of throughput at Bishop Auckland is going to reduce because they've taken so many services away so you can't criticise Bishop Auckland for not having a volume throughput and also we keep hearing about closures ... there's still a threat of closing four theatres, 130 beds and 700 jobs being lost.*

SE: Well I think you're ... that's ... wherever you're hearing that from, it's nonsense.

DG: Can I just make a comment? As the commissioners and as people ...

?: *(inaudible)*

DG: Excuse me Sir, no, ...

?: *(inaudible) I've got to make one point. If it's nonsense it's your own Mr Saxby that's made that ...*

SE: Mr Saxby was the previous Chief Executive.

DG: No, can I just ... can I just say something Sir? Please, this is an important point I just want to make it. Actually, two important points. One, there are lots of things happened in the past and lots of the things that we've talked about today are consequences of the past, this is about moving forward. None of us here, whether we like it or not, can do anything about what's happened in the past, this is about looking to the future and making sure the services are safe, and that's why we're listening to the consultation.

?: *But two wrongs don't make a right.*

DG: I'm not ... Sir ...

?: *If it's happened in the past it's wants putting back.*

SE: Well can I just say that in the future we're going to put more theatres into Bishop Auckland OK? That's our plan. That's our plan. You have to accept that what I'm telling you is the truth, we're putting more theatres into Bishop Auckland if our plans go ahead.

?: *But that's for the planned surgery.*

SE: Well of course but ...

?: *But it's the A&E we're concerned about.*

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DG: Yes, I'm sorry, Sir, you've made a very ... you've made a very good point about the A&E on a number of occasions, it's been raised, we've captured it, that's something we'll listen to when we actually come to listen to the outcome of the consultation and I know .. I know it's a problem for you Sir but you know if you go on and on about it, it's not going to get us anywhere, all I'll say is we'll actually ... we will listen to that and we'll reflect on it when we get the results of the consultation.

SE: OK.

?: *(inaudible) these consultations are a waste of time, you've already planned it.*

DG: No, we haven't. Nothing ... the only planning that's been done is to actually get the proposals to the state they're at the moment and the Trust need to do that because they need to actually tell us what they want to do. The other key bit of the consultation process is it's a journey, starting off with coming up with some proposals, we need to make sure that actually what is being said by people like yourselves is taken into account and the final proposals take account of that and the only decision that will be made then is whether we actually support the proposals, we'll not do that until we've finished the consultation, we've listened to views across the County which we're trying to do in a whole range of fashions, not just these public meetings and ...

(Tannoy message interrupts)

DG: Sorry, I wasn't expecting that! And you know we'll not do anything until we've actually seen what the final proposals are and to make sure they reflect the issues that have been raised as part of the consultation. Sorry, do we have another question?

A?: *Did you have another question?*

DG: OK, any more questions from anybody from the floor?

?: *Can I just ask at what stage then does this all (inaudible)*

DG: OK, I'll come on to that now if we've finished with the questions. I mean first of all just to thank you for coming along, we are disappointed with the response to some of these events but ...

?: *(inaudible)*

DG: Well OK, we'll look to see if we can do that, what I will say though is it's not the only way to actually ... it's not the only way to get involved in the consultation. We've captured everything you've said today, you notice Vaughan's been making copious notes. I'd like to thank Katrina and Amanda for actually taking notes as part of the discussion you had around the .. not around the table, but around the group. We're also recording all of this. All of that will be fed along with the rest of the formal consultation into the process which closes 12<sup>th</sup> January. What will happen then, which I've alluded to already, is the Trust will then listen to the issues and the consultation, review their proposals and see what they want to do with them, they might want to change them, you know, that's up to them. It will then come back to us at the PCT and I think we've said February, it's actually probably going to be 3<sup>rd</sup> March, we actually listen as a Board to all the information that's been gleaned from the consultation, from other processes like the Overview & Scrutiny Committee processes, from our clinical

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advisors within the PCT who are separate from the Trust and the final proposals being made by the Trust and at that point and only at that point will any decision be made, and part of that discussion will be about, you know, if the proposals do go ahead, what's the implementation plan, how does that work. I guess issues about the transport which, you know, we need to see some of those transport things being put in place before anything does go ahead anyway so there's a whole series of other things to happen after the consultation. But I just want to stress, no decisions have been made other than to actually have this process that you're part of today.

Public meetings are only a very small part of the consultation and colleagues like Vaughan who actually run consultation processes for a living, that's their expertise which is why we've actually bought in their support for this, will tell us that there are lots of other ways of actually getting people's views. You can fill in the response form that's actually on the documentation that will have come through people's doors, it's available here today, it's available in public places as well. You can log onto our website at NHS County Durham, the address is there, or you can visit the [seizingthefuture.org.uk](http://seizingthefuture.org.uk) website, as well as actually using that to respond to the consultation and answer some of the questions that we've asked you today, you can also get lots more information behind the ... you know, the detail behind the stuff that's in the documents that you've seen and the presentation today. What I would say is if you're delving into that and you can't find what you want or you want some more information, then by all means come back to us and we'll try and get that information for you. From our point of view at the PCT we need to make sure that people have a chance to have a fair say, but equally that they understand the issues so they can have an informed input into the consultation process. You can also email in your comments or you can actually write to the Freepost address so you can just write into that rather than just filling in the consultation forms if you like. So lots of ways of doing it, it will be fed into, we will listen and we'll take that into account with all of the other evidence that we have when the proposals come back to us in March.

I'd like to thank the panel for their input, I'd like to thank the members of staff that have helped facilitate this, but I'd really like to thank yourselves for actually having ... taking the time to come along, talking to us, getting your views across, hopefully you've had a chance to ask all the questions that you wanted to ask and we'll see how that actually fits into the consultation as it comes out at the end of January. So thank you and have a safe journey home.

SE: Thank you.

*(End of meeting)*