Seizing the Future Public Meeting
Shildon Town Council
Shildon Civic Hall, Main Street, Shildon
Wednesday 19th November

Representing the NHS:

David Gallagher, Director of Corporate Strategy, Services & Relations - NHS County Durham
Annie Dolphin, Non-executive director - NHS County Durham
Pat Taylor, Director of Investment Planning - NHS County Durham.
Steven Eames, Chief Executive of County Durham and Darlington NHS Foundation Trust
Alan McCulloch, Consultant Physician and Associate Medical Director - County Durham and Darlington NHS Foundation Trust
Andrew Cottrell, Consultant Paediatrician - 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
Mark Cotton, Head of Communications – North East Ambulance Service

DG: That's probably it actually, I think everybody's in and hopefully seated fairly comfortably. My name's David Gallagher, I'm one of the directors at NHS County Durham or County Durham Primary Care Trust. Welcome to this important meeting this evening. We're keen very much to hear your views. Before we kick off I'll just ask a number of colleagues from the PCT and from the Foundation Trust just to introduce themselves, just so that you know who everybody is, then I'll explain what we're going to be doing this evening.

AD: Good evening everybody, my name's Annie Dolphin, I'm a non-executive director of NHS County Durham or County Durham PCT if you prefer, so I sit on the Board of NHS County Durham.

PT: Hi everybody. My name's Pat Taylor and I'm the Director of Investment Planning at NHS County Durham.

BA: Evening everybody. I know some people are straining to see. My name's Bob Aitken. I'm the Trust Executive Medical Director and previous to that I was a consultant obstetrician and gynaecologist in the Memorial Hospital in Darlington.

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

AMc: I'm Alan McCulloch. I'm a consultant physician at Bishop Auckland and Associate Medical Director.

AC: Good evening. I'm Andrew Cottrell, consultant paediatrician at Bishop Auckland for the last 24 years.

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

DG: OK. Thank you for that. As I say, this is a very important evening, it's one of a series of public meetings that we've got as part of a public consultation and I just want to explain sort of what it's about and explain the format for this evening. As NHS County Durham we actually spend just short of or just around a billion pounds, I've got the Director … the lady who looks after the money there so she's just saying yes … a billion pounds of money on your behalf and on behalf of all the people in County Durham and Darlington, and that's to buy, to purchase, commission, however you want to describe it, health and healthcare services. Now that includes a whole range of things which include dentistry, it includes GPs, it includes mental health services and the hospital services from a range of providers. This piece of work that we're talking about tonight and we're asking your views and your opinion on is about a part of that, a significant part of it, but not all of it, and that's about the services provided by colleagues at County Durham & Darlington Foundation Trust, and in a moment I'll ask them to give a presentation to explain what their proposals are about and how that fits in.

We've got an Agenda as you can see on the screen there. We're going to go into a presentation from the Foundation Trust, we're then going to go into a series of round table discussions and we'll ask

some of the staff from the Foundation Trust and the PCT to actually facilitate that and to guide people through it, and then there'll be an opportunity to actually ask questions from the groups to the panel in terms of any issues of clarification or anything about the presentation and the consultation and then latterly we'll wrap the evening up. I'll actually explain what the next steps with this are and how we'll actually take your views into account.

I just want to start, before we get into the presentation, explaining sort of roles and responsibilities on two accounts really, on the first account, I've explained what the PCT, what NHS County Durham does, in terms of its day to day business if you like, and that's commissioning health services and healthcare services on your behalf. Obviously colleagues at the Foundation Trust provide a specific part of those healthcare services which you'll hear them talk about in a moment. In terms of the actual roles and responsibilities for this evening, we in the PCT at NHS County Durham are very much leading the consultation process and that's really important and I'll explain towards the back end of the evening how that process works and what our role will be at the end of the process, but it's up to us really and we've got colleagues here from the PCT to make sure that there is a fair and robust process to observe and to make sure that your views are reflected properly in the consultation process.

County Durham/Darlington have made their proposals for their case for change if you like and what those proposals are about and we've also got a third player in this, we've got colleagues from Proportion who are here helping us actually manage the consultation process. The wider process which involves using the Internet and the mail drops that people have had through the doors, but specifically for these meetings they're here to do a number of things, the key one is to actually record everything that is said and done. Now we'll do that in a number of ways, we're using the microphones (a) so you can here, but more importantly so we can actually record everything that's being said and we actually get a transcript back of all of the discussion that's gone on this evening. We'll also capture round the table discussion, we'll capture on the charts that the staff will have, the issues on there, and as we come to the plenary questions we'll capture on the flipchart the questions that are raised as well, so we are taking account of everything that's actually taking part, and that's important because we need to hear your views as part of this process.

The aims of the meeting this evening, just before I hand over to colleagues for the presentation, it's really about two-way communication and what I mean by that is it's an opportunity for you to hear what the issues are and what the proposals are that the Foundation Trust are bringing forward to address those issues and then it's your opportunity in two parts of the evening to actually have some say into that, some input, and to actually question them and get some answers back in terms of what's being proposed and the consultation.

As I've said we're recording your views and we're … crucially we'll tell you at the back end of the evening exactly what will happen next and how this will feed into that consultation process. So without further ado I'm going to hand over to Steven and his team and ask them to make a presentation.

SE: Can I use that or …? Hi. Good evening everybody again. Could I just before I start introduce Mr Ian Baine, who's a colo-rectal surgeon with the Foundation Trust and also our Director or Surgery. Well thanks for coming here tonight to hear our consultation proposals. I'm just going to kick off with a few introductory slides and I'm going to hand over to Bob Aitken who's going to talk about the clinical case for change and then Bob will hand on to Diane who's going to talk about some of the specific issues associated with emergency care and the issues associated with travel and access that we've been looking at, and then back to me just to summarise before we move into the next section of the evening.

So Seizing the Future, just to make one very clear point here. Seizing the Future, the programme that's behind this consultation, is about clinical care and it's essentially about the quality of care that we're looking to provide in the future and about, we believe very passionately, improving the outcomes of care, the people who use our services, our patients. So that's what this whole programme is about. And I just want to make, at the outset, some things very plain, very clear, about this whole process because obviously there's been a lot of interest, understandably and a lot of commentary on what we're

proposing and the first message that I want to give is we're not proposing any hospital closures, we're not proposing any service reductions. We are proposing changes in services and changes in the places that we might provide services from but no closures, no service reductions and actually no redundancies either because there has been some commentary that this will affect our staff negatively, quite to the contrary, as far as we're all concerned the proposals that we're making for our professionals and indeed for our other staff provides tremendous opportunities in the future. Secondly, one of, I suppose, the good things from our point of view is that although we operate services from five different sites and that adds to the complexity of the organisation it means all those sites are locally orientated and these plans are about maximising the use of all of our hospitals, every single one of them, we want to make the best use in the local setting. What we want to do behind that, and these next two points really reflect the way in which health services are developing nationally … nationally incidentally driven by clinicians not by managers like myself, firstly it's about providing as much care as possible nearer to patients, nearer their homes and actually in some cases in their homes, so what we've been thinking about in developing these proposals is how do we work both within the services that we provide and with our partners in health and social care to make that happen.

The second Agenda is … and Bob will talk about this in a bit more detail, is that we have a duty, a responsibility professionally to make sure that the services that we provide are safe and that they're high quality and we're concerned that if we're unable to make some of the changes that we propose we cannot maintain that in the future and we've got particularly fragile services in relation to intensive care, emergency care and children's services, and you'll hear about that more in a moment.

So what these proposals are about are giving you and giving our communities the best possible treatment across the hospitals and the services that we provide. Just to remind you what the proposal is, the clinical model, and the first point to make is that we're looking to concentrate our main acute services at Durham and at Darlington and then redevelop Bishop Auckland hospital and I emphasise the word redevelop … Bishop Auckland hospital, as a centre of excellence for planned care and for recovery and rehabilitation and so it's got to be a focal point of many of the activities that we undertake currently and indeed will do in the future. We also operate two community hospitals at Shotley Bridge and at Chester-le-Street, I guess not much of a relationship with the community here but just to make the point that we will continue to provide services from those sites in the future.

And just very quickly these next two slides are a bit busy and they're in the documentation but they just re-emphasise what I've just said in terms of how the services are distributed between the sites, so this slide is showing you what we'll be providing at Durham and at Darlington and you'll see that, highlighted in red there, we're talking about centralising acute medicine, emergency care, and children's services, and the next slide demonstrates what we're proposing as far as Bishop Auckland is concerned, and you can see there's a number of additional services being provided here, alongside the changes in relation to acute care that I just referred to, we are providing a range of emergency and urgent care services including medical rapid assessment and children … paediatric rapid assessment, from Bishop Auckland under these proposals. We are looking to develop a Trust-wide … that means County-wide service, day surgical service, utilising fully the facilities that we've got at Bishop and in addition to all of that we're looking to develop a centre of excellence as I said for specialist rehabilitation and intermediate care for the County and potentially for the wider north east as we hope these plans develop. So with that I'm going to hand over to Bob to take you into the next part of the presentation. Bob.

BA: Thanks very much Steven. Evening again everybody. Before I get onto the specific points on the slide I want to just make three points of introduction. The present configuration of our acute services is a direct result of a previous acute service review that was undertaken in 2002, early part of, by the then Professor Sir Ara Darzi who came up, he was professor of surgery in St. Mary's Hospital in London, and he's now the very same Lord Darzi who is leading the reconfiguration and the redevelopment of the NHS. Second point I'd like to make, again just to correct some inaccuracies that have been reported in the media recently, is that following … in fact slightly before Lord Darzi's work, it has to be made clear that there has not been a full A&E service at Bishop Auckland service, for about ten years now trauma cases, major road traffic accidents etc. have not gone into Bishop, they've been

redirected to Darlington and certainly for the best part of eight years now, acute surgical emergencies have not been taken into the surgical unit at Bishop, so there really has been a relatively … an A&E service but not a full blown service that we've had at Durham and Darlington and that's been for quite a while now.

??: *(inaudible)*

BA: I'm sorry … we'll try and answer questions later. Can we try and go through the presentation?

DG: Sorry, could I just ask please if people can listen to the presentation, there's a chance to ask questions at a later part of the evening, so if you can let my colleagues have their say for the moment please, and then we'll let you have your say later on.

BA: The last point of introduction really is that some of the stuff I'm going to be talking about is quite technical and you know I haven't got the time to sit and explain it, or stand and explain everything, but what I'd like to just … make two points before we go, on two technicalities that will help you better to understand that what I think are quite significant drivers for change. The first of these is the idea of 1, 2, 3 and the reason I say that is that if you look at the grading of patients that are treated in Accident & Emergency departments and also patients that are treated in intensive care units, they are graded 1, 2 and 3, 1 being the least sick, for example the walking wounded, who need a few stitches in an A&E department, going right up to 3, people who are rushed in by Blue Light ambulance and go straight to the resuscitation area and involve multi-member teams, you know, really intensive therapy to save their lives and grade 2 is a whole gamut of people in-between these. Intensive care is the same, 1 are the least sick people and level 3 are the most sick, and I'll go into those in slightly more detail about the staffing between 2 and 3 which is significant, you know, a driver for our changes going forward.

Right, so … oh and the other thing I should have spoken about is critical mass. I think it's important we try and understand this concept. The critical mass is the amount of activity that needs to be undertaken and it can be applied to individual specialists, so for example a cancer surgeon is now looked upon in his pay review by the centre to say are you doing enough of a particular type of cancer operation to continue to be regarded as a specialist in that field? That's to the individual surgeon for example. There are also the same critical mass ideas applying to teams in departments, so is there enough complex activity being managed by your department to allow you to continue to be accredited, for example as a full level 3 A&E department and to be recognised to provide the care, not only to provide the care, but to provide training for junior doctors, nurses, etc. etc. etc. So critical mass is a very important concept going forward.

So let's go on, why do we feel we need to change? There is a series of national drivers and these national drivers are modified locally by local pressures that we experience within County Durham. The local pressures really are about critical mass, that is we … have we enough activity in the County to support three acute hospitals, yes? But we also have had a difficulty over the last few years in recruiting and retaining certain types of doctor with the appropriate specialisms, specialist training and experience to support the services that we want to continue with within the County. National drivers, specialisation. Very briefly that's about the critical mass for individuals and for teams that we've already talked about, yes? So there's a drive to put the more specialist techniques as medicine gets more complex in the hands of fewer, more highly trained specialists, and there needs to be a level of activity that you are able to undertake in any given year to maintain that specialism. So that is a significant driver going forward, and that's not just here, that's in the region, that's nationally.

Doctors' working hours … comes in two forms as far as I'm concerned. The first is primary legislation, you might well have heard of the European Working Time Directive and that's been introduced in the UK to our junior doctors. Consultants can opt out of the European Working Time Directive and most of us have, but junior doctors can't, and it's been brought in in three phases. The third phase is about to be implemented in August of 2009 and at that point the juniors' hours come down from a maximum of 56 to 48 hours in the week. What that means to us as a Trust across the whole County is we lose the equivalent of 31.4 whole time equivalent junior doctors. That renders a

lot of our emergency on call rotas as non-compliant with the European Working Time Directive. When that happens there is a great danger that you will lose the recognition to be a training establishment for junior doctors, so it's very important that we deal with that issue. Now the teams are working on that, there are one or two things that you can try and do, but by far the most effective is to reduce the number of emergency on call rotas that you actually run, a major driver for what we're trying to achieve. One doctors' hours as well, there is a change in culture really over the past two decades in that young doctors, and I don't just mean trainees, I mean young consultants and young GPs are looking much more for a better, as we term it these days, work/life balance and I've done quite a lot of work with junior trainees or senior trainees, looking for consultants jobs because we have got trouble recruiting new consultants into Bishop Auckland and into Darlington, not so much to Durham, and one of the big problems is that our teams, compared nationally to other bigger units, are quite small and the on call is frequent, and that being the case the juniors find them much less attractive, so it does cause us recruitment problems. Added to that, and let's go on to the specifics, remember Lord Darzi made his recommendations in 2002, has anything changed since 2002? You bet it has! In the Accident & Emergency field there was a new college formed, the Royal College of Emergency Medicine, they initially published expected standards of what staffing levels there should be, how many consultants there should be in a full level 3 department, what support services there should be, etc. etc. etc., but more importantly they recommended a critical mass, particularly … amount of activity again … of level 3, the most seriously sick patients that you needed to be seeing to maintain a full A&E service. What that means for County Durham essentially is that we don't have enough critical mass to run three full A&E departments. As I say we don't run a full service at Bishop anyway. But we can't run three full services because of the critical mass.

Acute medicine, that is people coming in with medical conditions, chest problems, heart problems, etc. there's been major changes that have come out of the Royal College of Physicians. In 2003 they recommended that we recognise the formation of a new sub-specialty in medicine as well as gastroenterology, cardiology, neurology, we should be looking at acute medicine and recognise and plan the development of a new type of consultant called an acute care physician. They needed to be specially trained and the idea would be that they would deal with a broad spectrum of the sickest patients for the first 12, 24 – 48 hours of admission to hospital in special areas called medical admissions units. And the model of care that was recommended in 2004 was that patients who were admitted as emergencies into the medical assessment units be managed by acute care physicians, they said there should be three of these specialists in each receiving unit, for up to a maximum of 24-48 hours, and then if necessary pass them into the back shop to the base wards where the patients should be handed over to the appropriate sub-specialists, therefore the sub-specialists, like the gastroenterologists, the cardiologists, the respiratory physician, they should work in teams of at least two so that if one was on holiday the other could still be there so at all times you had the facility to have an acute care physician dealing with acute emergency, passing to the sub-specialist at the back, yes? Now we're able to provide that service in Durham … sorry?

DG: 14 minutes.

BA: Right. We're able to provide that service in Durham, yes? Because of the size of the team, we've got about 20-odd physicians up there. We've been unable to implement that plan in either Darlington or in Bishop Auckland because our team is small, yes? Another thing that's changed is, if we move on to critical care, is that in 2002 the recommendation for critical care or intensive care support for medical emergency units was to have a level 2 critical care unit. What that level 2 means is you've got one nurse on the ground for two patients in the unit and your doctors are on call and can be on call from outside the hospital. Level 3 unit is somebody who is a unit that's got one nurse for each patient, 24/7, and doctors are in the unit 24/7, so you've got people who are either living in the unit, sleeping in the unit itself, or very close to it so they can be immediately called to deal with problems. Now we have the level 3 model of care in both Durham and Darlington. We have not been able to provide that level of staffing in the Bishop Auckland unit. This isn't a matter of money or anything because the Trust gave me access to a load of funds, but I've been unable for reasons that I can't go into, if folk want to ask the question, we're unable to find the doctors to provide a resident level of care in Bishop. Now in 2007 the Academy of Medical Royal Colleges, has actually stated quite clearly that any hospital that is

receiving emergencies should be providing a level 3 critical care support, if you can't do it you shouldn't be taking in emergency care. Added to that, in Wales, they did some work for the first time, they came out with a critical mass of level 3 critical care activity to continue to have a unit. Same as A&E we don't have enough activity in County Durham to run three level 3 units. The case really is building up.

Children's care, paediatrics is a kind of special case and I feel a bit sorry for the paediatric unit at Bishop because ten years ago it was regarded as being the national gold standard, but since then things have changed significantly. What's happening now, it is a shortage specialty and Andrew can … you know, if you want to ask questions specifically, Andrew can give more detailed answers, but the number of trainees relative to the number of consultants who are retiring is actually going down, yes? When the European Working Time Directive comes in next year it is predicted that about 60% of the on call rotas will be non-EWTD compliant so we need to do something. But even more than that, I've mentioned that EWTD doesn't apply to consultants … if it did the projection is that in 2009 about 25% of the acute paediatric units in the country would need to close because we don't have enough consultants so we do have a problem with recruitment because some of our guys are of a mature age profile and it is giving us a problem going forward. The paediatricians have recommended that we move to the two acute sites and I think we have to support them.

Very briefly what happens if we don't make these changes. Emergency contingencies, don't think that that's a thing of the future … for the last 18 months or so, we're almost certain, and sometimes on a weekly basis but certainly on a monthly basis, I've been making emergency plans because we've come close to having services fall over, particularly in Darlington and Bishop Auckland. If that starts to happen there will be a decline in quality of the service that we can provide, and it will result to safety issues, the safety of our services will significantly reduce. That in itself will have a negative impact on health inequalities, if certain things fold altogether and people have to go out of the County, they have to travel further for care, and the result eventually in a service that's not fit for our patients, if it's not fit for our patients it won't be fit for our commissioners and they will have to look elsewhere for the service, so it's a really important time in our history, it's important I feel that we're allowed to make these changes. I'm going to hand you over to Diane now and she'll talk you through the rest of the presentation.

DM: Thanks Bob. I just want to say a few words about our proposals about the A&E service because that's something that is attracting quite a lot of attention. There is a lot of evidence around, and Bob's touched on the reasons why in terms of specialist care, that by travelling further for specialist care you will get better outcomes, the patients will benefit by travelling for more specialised care. We know from looking at our activity over the last few years that round about 30,000 patients a year are treated at Bishop Auckland hospital A&E department. Under the proposals that we're making at least 20,000 of those will continue to be treated at Bishop Auckland in the unit that we're proposing, so around about 9,000 actually, just over 9,000 patients would be expected to be transferred to Darlington A&E, that doesn't mean that they'll all be admitted, some will not be admitted, but some might be. In terms of trauma, Bob touched on the fact that Bishop Auckland for quite a number of years hasn't received trauma, that's people who have had major accidents, they haven't actually gone to Bishop Auckland for quite a lot of years, that was centralised at Darlington in 2000, and already if you have a major head injury, so if you need specialist care of neurosurgeons for example, then you would actually be transferred over to James Cook hospital in Middlesbrough, OK, so that isn't provided locally anyway so a proportion of patients are actually already transferred, and I think Bob's already touched on the fact that some patients for heart attacks for example now don't come into Darlington or Durham or Bishop Auckland because of new innovative treatments that have been pioneered in this area of the country, those patients are assessed in their own homes by specialist paramedics and actually transferred directly to James Cook hospital in Middlesbrough and the results of that is that they have a much better outcome and less risk of further problems from that heart attack.

So, in general, I mean I'm a nurse by background and I just want to sort of make the point really that better access to a specialist means better outcomes of care for you, OK? And we have lots of examples of that nationally, why that is the case, but access to a specialist doctor is only part of the story and as

you know from maybe some of yourselves have been in hospital or other people, doctors are part of a team and just as important in that team actually are the nurses and are the therapists and the occupational therapists and the wider team and those people specialise to, OK? So they actually develop their specialism along the lines of the medical specialties and by being … by separating our care and transferring people to specialist care in the acute sites and on the planned site having people who specialise in planned care what we can to a much greater extent guarantee is that you will have access to the whole of the specialist team, OK? That will equal better care for you. There will be less risk of cancelled operations. At the moment we have a number of people who plan to come into hospital for surgery, have a date, have to make all of the arrangements to come into hospital, and you know what they are, organising your home life and all the rest of it, and because of pressure on the acute beds where people, quite rightly, need a bed quite urgently, sometimes we have to cancel patients who are coming in for planned surgery. By separating that out and providing that care on the Bishop Auckland site then we will be able to reduce the risk of cancelled operations for patients. We're proposing this rehabilitation unit at Bishop Auckland, a specialist rehabilitation unit that again is about developing the skills of the team of staff to actually recover patients. By recovering them that means that we are better able to discharge them to the usual place where they live, less people being discharged to residential homes or to supported care. That means again, it means less disability for the people who go in there, better outcomes of care and more likelihood of being discharged back to the place you want to be discharged to.

Separating our planned and elective care means it gives us a much better ability to screen our patients who are coming in for planned care for MRSA before you come in, so in your outpatient appointment when the surgery is being planned you will be screened for an MRSA infection and if you have that infection and a lot of people are carrying that infection and hosting that infection, then you would be treated before you come into hospital. That reduces the risk of MRSA for those patients coming in to our planned sites.

Travel and access has been an issue right from the start, from every member of the public we've talked to, patient representatives, our staff, our consultants, everybody's flagged it as an issue, and so we realise how important this is. Everything that we're proposing is based on travel only where essential so all of your outpatient care, your diagnostics care, that means X-rays, blood tests, all of those sorts of things, follow up appointments, everything will be done at your local hospital and you would only travel where absolutely essential to get that very specialist care, so it's about minimising the number of journeys. What we already know is a lot of people are already making a lot of journeys across County Durham to different hospitals for care so we're trying to minimise the number of journeys. I've already mentioned the paramedic role in relation to heart attacks, but if you're an emergency case I think it's important to remember that your care starts when the paramedic arrives, it isn't about when you get to hospital, the journey time is important but it's important in the context that the paramedics attend your home, they start the assessment, they initiate some treatments in certain circumstances and they are not just a transport facility, they are providing care and treatment. We're working with the Integrated Transport Unit at County Durham Council. They actually coordinate the transport across the whole of the County and they've actually got our … what we call our modelling … that's our kind of predictions about the numbers of patients that will be treated in different sites and they've actually run that information through their systems and the information they've given us is that eight patients a day would be affected in terms of being unable to access suitable transport to hospitals. Now we're committed to providing the solution for those people where there won't be good access to our hospitals under our proposals and the solution potentially runs along the lines of a service that is up and running now in East Durham, called the East Durham Link, and that actually provides transport for patients from that area of the County to the hospitals that they access and that's about three or four hospitals that they use, and that means in effect that if you need to get to one of our hospitals for an appointment or to visit somebody there would be a single number for you to ring and that gets you through to a central point, if you were eligible for an ambulance they would assess that eligibility through a few questions and if you were eligible they would book you onto the patient transport service. If there was a good transport route they would advise you what that public transport route was and if there isn't a public transport route that's the bit of the transport that we will actually be commissioning some additional services to provide and that would mean the likelihood that you would be picked up at your

door within a 30 minute timeframe to get you to the sites, and that is not just … you must remember that's not just for patients … that's for visitors as well, I mean that has been flagged to us as a major issue for people, you know, the importance of getting visitors to see patients. I think it's back to Steven …

SE: Very briefly, and thank you very much indeed for listening to the presentations so patiently. I just want to re-emphasise two or three points in closing. First of all, we believe that these proposals are better for our staff, provide better opportunities for our staff. Secondly, they guarantee in our perspective a long term future for all of our hospitals and, thirdly, and most importantly, we believe passionately, you've heard the clinical arguments and other colleagues will talk about that, that these changes will improve the quality of care and crucially the outcome from treatment for people that we serve. David.

DG: OK. Thank you Steven. Thank you for your patience in listening to the presentation ladies and gentlemen, very much appreciated. What we'd like to do now is move into two sessions where we can actually get your views back and the first part of that what we'd like to do is we've got some colleagues here who will facilitate this discussion and if Verna you could identify yourself at the back there, raising her hand, what we'd like to do is if we could arrange you into groups so we can answer some of the specific questions for the consultation, but also ask you to formulate some questions from the floor to the panel in the last section of the discussion that we have. Just thinking on that part, what I'd like to do and …

??: (inaudible)

DG: No, you can do that as well, there'll be time to do that at the end, so if you'd bear with us please sir, what I'd like to do though is .. and it probably picks up on an earlier point, these are very much proposals about the future and there are lots of issues I think people have about the past and what's gone on before about Bishop Auckland hospital and other hospitals, unfortunately or fortunately, that's where we are. This is looking at the future of the hospitals and if you try and keep your conversations and discussions and questions to the future of the hospitals and that will help us actually make sure we plan the right services for everybody. So if I can ask Verna and the team to actually try and arrange people around the groups and we'll have half an hour for this, we'll get this through quickly and then we'll have time to actually ask questions from the floor.

??: (inaudible)

MEETING MOVES INTO ROUND TABLE DISCUSSION GROUPS

(General talking as people move around the room)

FEEDBACK FROM ROUND TABLE GROUPS

DG: Rather than go through death by feedback what I'm going to ask the facilitators to do is just to feed back a couple of key points from the discussions and then one question from each table and then we'll open it to the floor for plenary questions to the panel. If I could just introduce a gentleman who's just joined us on the panel and wasn't able to make it for the start of the evening, but we've got Mark Cotton from North East Ambulance Services who's here who's actually joined the panel and be able to answer some questions from an ambulance point of view if necessary. OK? Can I … I think if we go to Verna first. Verna can we have just two key points from your table, then we'll come back to you for one question, then we'll open it into plenary after we've been round all of the tables.

V?: I think the absolute main point was that people accepted that in principle there was a case for change but not convinced that this is the change that should take place and felt that insufficient attention had been paid to possible other alternatives or indeed investigating solutions that might have kept existing services as they are. And the second key point I think was certainly not around the consultation

process per se but certainly around the format of the round table discussions and were we trying to gag people by asking facilitators to ask the questions.

DG: OK. Can we go … probably to Roy, we'll just go round the tables in order?

R?: On the table here the general consensus that people didn't accept the case for change, there were four No's, one Don't Know. Nobody felt it was important that the review had been led by clinicians and nobody felt the process of consultation was robust either, but the main kind of questions that came out were really concerns about travel. A couple of questions both relating to travel where, you know, how can you say these changes are safer when patients will have to travel more.

DG: OK Roy, can I … I'll just go round and take the comments now then we'll come back with those questions if that's OK. Over to Peter and Katrina in the … far end of the hall.

P?: Yes, the general consensus on this table was that the case for change was not accepted and that was a universal view. How important was it that it be led by clinicians, the view was that there was a cynicism about whether or not it was really led by clinicians and the extent to which there were political government and other influences in and around that. There was a general view that the process was robust and that was pretty overwhelming and .. which is your preferred option, none of those put forward was, you know, was a preferred option.

DG: OK thank you. And I think … moved over here ladies, just one … two key points then I'll come to you for the first question.

K?: I think the general consensus … OK (inaudible) … we were split on our table, it was 50/50 whether we accepted the case for change and there was a 50/50 split as well on the options, Option A and Option B. I think around our table again there was a bit of a cynicism that we'd left this too late and changes had gone on previously and why was this the first time that we brought it to people's attention … and again transport.

DG: OK. Thank you. Actually we'll just stay with the ladies, have you got one question from the tables to ask the panel?

K?: I don't think we've got a question, I think it's more of a comment and I think there were again concerns around transport and will we have the right infrastructure in place to support people moving around the County?

DG: OK. Does somebody want to respond to that, Diane?

DM: Yes, I'll respond. Can you hear me, yes? In terms of transport we are confident that we will have the infrastructure in place to support patients and visitors and our staff to move around the sites. There are … we've looked at exactly which communities, we've actually looked down to the level of postcode of people in terms of which communities will be affected and where people will not have, with current arrangements, good access to our hospitals then other services will be put in place prior to, you know, given … if these proposals were supported but prior to implementation services would be put in place to ensure that people could access, I mean that's really important, we understand how important that is and we have made a commitment to that.

DG: OK. Thank you. Can we go up to Verna now? One question from your table Verna please?

V?: OK. There was five questions but I think the one which most members would want me to ask if we've only got one bite of the cherry is this one, which is … is there any way in which other options could be looked at, could be exercised, or are we frankly wasting our time during this consultation because either A or B is going to be implemented.

DG: OK. IS that one for your Steven?

SE: Yes it is. Thank you. And if I could just say first of all we're willing to consider any alternatives that are put to us if people can offer a view about alternatives, we're clearly … we're quite clear that we would like to consider those, let's just make that point first. Secondly, I didn't mention it this evening but in fact we looked at in total 49 options in getting down to the two options that we have in the consultation and those options were driven, were led, developed by clinical colleagues and in fact had quite a significant input from our Governors who of course represent communities, are members of the public many of them, so we have looked at a whole series of options and on our website and behind all of this consultation is a huge amount of consultation that gives you lots of detail about how we got to where we got to, and the detail of the options that we looked at, and indeed if that's not available easily for people we can provide that information and if there are any detailed questions we can provide that.

??: (inaudible)

SE: I'm sorry?

??: (inaudible) independent review of (inaudible) somewhere along the way (inaudible) the status quo (inaudible) two options. It says here (inaudible) of which (inaudible) 49 options were produced. These were subject to hurdle criteria which included clinical safety and standards, efficiency, affordability, do-ability I think is a very important one, benefit criteria we also used which included integrated models of care and patient focus, access, workforce staffing and sustainability. In the end three options have been proposed, not two, three …

DM: (inaudible)

DG: Yes.

??: And the first of those was no change.

DG: OK.

??: I think that no change should be carefully defined actually.

DG: Yes, yes.

??: Because I think that means no change in the services provided not the (inaudible).

DG: OK. Can I ask Steven to respond to that?

SE: No, it does, and in that report those three options are referred to, but the No Change option as described there was the one we worked with all the way through as the one to measure all the other options that we developed against, but if you read on with that report, of course, Professor Sir George Alberti points out very clearly that the current scenario, the current status, the Option 3 as you're describing it in asking the question, is not sustainable for the reasons that have been outlined.

??: (inaudible)

SE: No, he didn't pass the do-ability test.

??: (inaudible)

SE: Do you want to comment Diane?

DG: OK. Could … Diane have you got a comment on that please?

DM: Just to say, I mean I think probably what would be helpful would be if we provided you with the process that we went through. The No Change option actually never passed the do-ability test, nor did it pass some of the other tests that we had around safety. But we kept it in all the way through because it was important always to have that as a benchmark, comparing what we were proposing to what we were currently providing and we did that on good advice and that was, you know, that was always in there for that reason. It didn't actually pass the do-ability test or the hurdle criteria …

??: So you're saying the Professor was given duff information then?

DM: No, that's not .. not that's absolutely not …

??: Because he says quite clearly here it passed the do-ability test, it's in black and white.

DG: Yes.

DM: (inaudible)

DG: Can Steven respond please?

SE: If I can just say I think we can provide the information they're asking for but I think what you're doing is drawing a sentence out of a five and a half page report which makes it absolutely clear if you were to read some of the later reports, if you read it very carefully, it would make it very clear that the current status is …you know, the current position is not an option and he says that extremely clearly in the report, so I think to just read one statement out and not, you know, clarify the rest of the report and what he clearly states, and we need to remember that Professor Sir George Alberti is the national Czar for emergency care in this country and he produced that report for us from the point of view of looking at whether the status quo as you put it was sustainable. He makes it quite clear that it's not.

DG: OK. Thank you. Can we move on to some more questions? Do you have a question from your table please?

??: It's kind of two questions rolled up into one really about transport. The first question is really how can we say these changes that are proposed are safer when patients will have to travel more and kind of linked to that really an example was given of a patient who had a heart attack up in Weardale and will the care that that patient receives in future be adequate and will the travel in that instance be an issue.

DG: OK. Thank you. Does that … Mark do you want to comment from the ambulance emergency side?

SE: And then Bob will comment.

MC: I'll be happy to comment on that from ambulance service point of view. The ambulance service works from the position that when we need to take a patient to hospital we want to take them to the hospital that can provide that patient with the best possible care and where there are certain conditions that (inaudible) the patient, there are certain centres where that patient can get the best possible care, but the example was given of a heart attack, there are certain types of heart attack which until recently the paramedics on board our ambulances were introducing clot busting drugs that would blow the clot out of the artery to allow recirculation for that particular patient and then we would take them into hospital. Now quite recently there has been a move within this region that has been adopted nationally now to move those particular types of patients to specialist centres whereby they then have a stent inserted into their artery and that provides a better outcome for the patient and for the ambulance service, for us, that's better for us to then take that patient to where they can have that particular type of operation done. Now we've been operating this system across the whole of the North East area now, since April and in the south part of the region, the James Cook hospital have been piloting the introduction of primary angioplasty for quite some time now and the success rate of that has been significantly marked compared with previous treatments. So we always favour taking patients to where they can get the best type of treatment and it shouldn't be … there's a bit of confusion sometimes that arises that overlooks

the longer journey. People assume that we're just a taxi service with a blue light on the top and we're not. The paramedic staff that work in our ambulances now, now need … now get accredited with a university degree education with the amount of drugs that they do and procedures that they carry out in terms of diagnosing and treating patients, it's far far more advanced than what it was even five or ten years ago, and that must be recognised in the sort of treatment that we can deliver whilst transporting a patient to hospital.

DG: OK. Thank you.

??: It's alright in the summer but what about in the winter? Instead of (inaudible) Weardale or even better in the ice and snow (inaudible) to the patients (inaudible)

MC: Well the drivers of ambulances are trained to the equivalent to the police Class 1 driver so the training that they need to go through in order to drive under Blue Light gives them an enormous amount of skill, as I say it's the same equivalent of a Class 1 driver within the police service. Now that sometimes means that if the road conditions are treacherous the journey can take longer, but we don't simply just have the use of our ambulances to call upon, where there's a real medical emergency and we need to transport a patient very quickly, particularly where the conditions call for immediate input or the location of that patient means that they are a very long way from help, then we've got the use of the Great North Air Ambulance that we can call upon to move patients.

??: But they're a charity (inaudible) so will you pay them for (inaudible)

DG: Yes. Can … sorry when people … I'm going to open it up to open questions in a moment, but when you speak can you actually speak through the microphone please just so that we record it.

??: I said with the Air Ambulance being a charity will you lot pay them to come and get someone from (inaudible) or Weardale to take them to where they've got to go?

MC: That's a question that needs to go to Government, it's national policy about how air ambulances are funded and …

??: (inaudible) charity all the time.

DG: No. I think, I can understand where you're coming from but I think it's a slightly separate issue, I think Mark's …

??: (inaudible)

SE: What are the numbers of emergencies (inaudible)

??: … to get people from A to B in an emergency, if there's no (inaudible) in Stanhope and the ambulance isn't vacant, then what?

DG: Ok. And I think Mark's actually described what happens at the moment which wouldn't actually change …

??: Yes, but you're going to have no ambulances on the road are you to take them to different hospitals.

DG: Yes, I understand the issue about the ambulance. We've logged it as part of the consultation. We've had a response, can we move on to some more questions please, we've got one last question from the tables and then I will open it up to the floor. From the far table if there's one from there, Peter and Katrina please?

P?: *Yes, we had four specific questions but I'll try to focus it on the one that draws out separate issues to those that have been discussed. It would be why has Bishop Auckland been selected as the non-acute site as opposed to Durham or Darlington?*

DG: OK. Is that … Steven do you want to start?

SE: Yes, I'll start that .. in response to that question. There are a number of reasons why that's the case. First and foremost, the location of the hospital is central to the County, it makes absolute sense in terms of how we organise our planned care in the way that we're proposing and our rehabilitative care to concentrate those services at that site, so that's one of the reasons. The second reason is as we've said in the presentation that for much of our routine and planned care the site is ideally designed, the facilities are superb, the day surgery facilities are superb and they are under-utilised, so as I said … we said in the presentation, we're looking to utilise the hospital more in that respect. If you look at the Alberti report that you referred to, George Alberti makes it clear that it would be very difficult given the current organisation of clinical services to reverse what's currently in place, he makes that point explicit in his report, and then if you look at some of the other issues like the implications for the workforce, if you were to make either Durham or Darlington the planned site that would have an impact, a significant impact of around about if I recollect the figures, about 1,000 people would be affected and we would be concerned in relation to that about some of the recruitment and retention issues that Bob raised in the presentation, in the context of Bishop Auckland being selected as the planned site it's around about 100 people. If you look at the capital spend that would need to be put in place to make either Durham or Darlington the planned site, at Durham I think the figure was, I just got it in front of me here, it was £80 million, in the financial analysis, for Darlington it was £120 million, and of course our proposals to create the model that we're proposing we're talking of the order of about £7 million, and then the last point I would make is that if you look at, and this is a critical point, if you look at … if you come back to my point at the beginning which is we want to utilise all of our hospitals to best effect for our community, then this organisation, this way of constructing the service is the best way to do that because if you were to make Durham or Darlington the planned site then there will be significant numbers of people who will be travelling outside the County, either north or south, and we can quote the figures are available here, that would mean that the amount of local service that could be provided for the County as a whole would be much reduced and then when you start to talk about the travel questions they become much more significant than the travel questions in relation to our proposals, so there's a whole series of reasons there as to why this choice has been made.

??: *So can I come in on that one? Tell me something …*

DG: Sorry, can you actually … I'm going to open questions to the floor now so this is probably a good time to do it. Can I ask three things of people, one, can you sort of raise your hand if you've got a question and we'll come round to you, two, when you get the microphone because we're recording can you say who you are please, and then thirdly because I know people have got a lot of questions to ask, can you keep the questions fairly succinct and equally can I ask the panel to keep their answers fairly succinct so that we can get through the questions in the time that we've got please? Sorry.

LZ: *I'm Leslie Zair, and when you talk … all you seem to be talking at the moment about money … so tell me how much are you going to have to spend to upgrade Darlington A&E. At the moment I mean we all know half the people here have probably either had to go in or something, my mum went in, we waited hours to be seen. That wouldn't have happened at a fracture clinic in Bishop Auckland because you can't cope with the amount of people you've got going into that fracture clinic at Darlington, you've got more people going in than you can cope with in a short time. My nephew a month ago spent four hours, four hours waiting for a triage. He was then seen at triage, he was then sent for an X-ray, another hour and a quarter. After that hour and a quarter …*

DG: OK. Can I ask the panel …

LZ: *No, hang on .. after that hour and a quarter he came back through to the A&E, the plaster room had then closed and he had to go all the way back from Darlington to Barnard Castle and come back the next day to have a plaster put on and we're talking money here.*

SE: Yes, well I think that's a dreadful service, I would absolutely agree with you and of course, well absolutely, and .. .well, but if you let me just answer the question, it is a dreadful service, I'm really sorry that that has happened in that case and really if you have any details then we'll investigate it, but the point I would make is you make the case for the change. Our change is all about …

LZ: *(inaudible)*

DG: Sorry, can you let Steven answer the question please?

LZ: *That's why you're struggling (inaudible)*

SE: Can I say I showed you some respect in listening to your question, would you show me some respect in listening to my answer? Now you made the case in many ways that we're making in a very powerful way, because what we're proposing to do is organise our services so that does not happen. That's the first important message to get across in relation to your question. Secondly we have accounted for how we would cope on the other sites, you remember what I think Diane said that … we need to remember here that of the 30,000 people that attend for emergency treatment at Bishop Auckland, 20,000 of those will still do so, so we're talking about the balance of people who will be treated at Durham and Darlington. Now we have accommodated in our financial planning for modifications to modernise the departments, actually both at Durham and at Darlington, to make sure of that, and of course the whole thrust of the proposals where Bishop Auckland is playing an absolutely central role in what we're trying to achieve in improving quality for people is we're going to concentrate much of our elective activity on that site, therefore that creates capacity to treat emergencies. Now the last point if I may, because I do feel that clinical colleagues here ought to comment on your point about money, this isn't about money, it's absolutely not about money, because it if was about money we'd spend it and not change anything, but I'd like … other colleagues to comment on that.

DG: Can we just have one comment from the clinicians then we'll come back to you for one last part, then we'll move on to another question.

AMc: Yes, can I comment. Just coming back, initially you asked whether it was clinically-led and the answer is yes, it was clinically-led, we're all clinicians involved, there were four groups, I was leading the surgery group, we came up with 49 options, there were all sorts of options including … we looked at orthopaedic … we talked about moving all of orthopaedics to Bishop Auckland, we looked at all sorts of options, came up with all sorts of ideas, one of them including knocking down all of the three hospitals and building a new hospital, so lots of options were explored in that thing … there is not a money issue, the thing is about quality of care and the fact that we, and as a clinician I agree entirely with George Alberti, I do not think looking forward that maintaining the three hospitals in an acute state as they are … is not sustainable, I do not for the quality of care.

DG: OK. Thank you. Could I …

LZ: *(inaudible)*

DG: I'm sorry, can we let somebody else ask another question please?

LZ: *No, I'm sorry I want to answer back to what he's said. The problem you have at the minute in A&E with your fracture clinic and the fact you've got too many people waiting, is because you've taken away the fracture clinic from Bishop Auckland so your need for change has already … that bit's already started and you're not coping with that need for change, otherwise a young man who'd broken his wrist and there were lots of other people, wouldn't have had to wait a full day and have to trail all*

the way back to Barnard Castle on a bus and then come back the next day for plaster, so I'm sorry but you blew the argument out of the water because you've already taken our (inaudible)

SE: Well I did say that I agreed with you about that, it's a terrible service, I think it is appalling and either or any of my colleagues would support that and we're trying to put that right. I would have to point out though that if you looked at the record of the Trust in relation to emergency care, even under the pressures that we're under, it is excellent compared to the rest of the country, so we are getting it right for lots of people but for, you know, one mistake is too many. One, two, is too many, and these proposals are about dealing with that.

DG: OK. Thank you. I want to move on because other people have questions to ask and we haven't got a lot of time left now but I do want to get more people to ask their questions so I think we'll start with Sam please.

SZ: Sam Zair. Bob?

BA: Sam.

SZ: You'd said that to have three acute hospitals in the Trust they would have to be at level 3 and Bishop Auckland's running at level 2, I'm a correct? How much of that …

BA: Can I just say, that's critical care, yes? We're talking about here?

SZ: Yes. How much of that is Government guidelines and targets have forced your arm to move the critical care away from Bishop Auckland to Darlington, and also you mentioned about Accident & Emergency has not been at Bishop Auckland for the last eight, ten years. Why have there been A&E signs all around Bishop Auckland leading to the hospital and if any of these options do flourish, to say the least, will the A&E signs be taken down or is that too much of a political hot potato to happen?

DG: OK. Thank you. I think there were three questions, I don't know …

BA: The critical care … can I take the critical care thing to start with? It's not so much, you know, a Government drive, what it is, as I've said, there's been a recommendation of what the standard of care should be that's being delivered. Now in 2002 the Royal College of Physicians were recommending unrestricted medical emergency take could be supported by a level 2 facility, yes? And I've told you what that was earlier on. But that has changed. Now they're saying that for any emergency … in fact according to the Academy of Royal Colleges which is all of them put together, has actually said in November of 2007 that the College of Physicians said earlier, is that for any emergency service to be provided, Blue Light service, provided for emergency (inaudible) you must be providing a 24/7 level 3 service, so that's a standard that we're expected to meet, yes? And I have to say the Healthcare Commission looks at these standards, looks at quality of care. The Healthcare Commission next April is actually changing to a thing called the Care Quality Commission led by a lady called Baroness Barbara Young. Now I understand, personally I've never met her, but she's a very nice lady, but when it comes to quality issues she is really strict on saying what quality should be and whatever, she will expect the 21st Century standards to be applied. Now we actually tried, when we realised we had to go to level 3, and this is where, you know, I really have to stress this isn't about money, the Trust gave me a lot of money to go and find six doctors that we needed to provide a resident tier of anaesthetists in the critical care unit at Bishop Auckland to raise it to a level 3 facility. Now because of rather complex issues around recognition of training for junior doctors and stuff, the type of people that I needed to find weren't there. We advertised four times I think it was in about 16 months and got one guy who was suitably qualified who happened to manage to replace somebody who retired, so we still didn't have that resident tier and we had to say we could not deliver the service. Now if we're actually being told, you know, that we can't actually do it since the end of 2007, to provide an emergency service, to me that's the big stumbling block, so it's a national standard rather than a Government target, it's …

DG: Thank you. I think there's another comment …

??: *I've spent 24 years of my life working at Bishop Auckland and I've seen the changes around, I've seen what's expected. The critical care service at Bishop has survived largely due to the unstinting efforts from a number of middle grade doctors who have given a huge amount of their time and effort to sustain the service but many of them are going to retire and as Bob has said attempts to replace them have been unsuccessful, so I think that is one of the key drivers that's taken this forward.*

DG: OK. Thank you. The gentleman there?

??: *What about the A&E signs?*

DG: Oh yes, sorry, there was a question about the A&E, I apologise for that.

BA: Yes, well following Lord Darzi's report A&E, you know, when Ara did the first review, A&Es were a variable (inaudible) but I did say the new Royal College of Emergency Medicine was formed late 2003, beginning of 2004, and then they issued their standards, you know, and they said that emergency care should be delivered by basically networks of, you know, trauma centres which are major things which eventually will come out and there'll be maybe a maximum of ten in the country for the really major work where you have all the major, you know, neurosurgery, cardio surgery, all in one place. A&E departments that are fully functioning and are able to cater for the level 3 patients that the paramedics bring in having started their treatment in their home, below that there would be a network of urgent care centres and minor injuries units, right? And depending on what service is delivered, staffing levels are slightly different, so the idea would be if our proposals get the go ahead, yes, the sign in Bishop Auckland would change because it would be a minor injuries unit from our point, but we would put GP presence on the ground so it would become an urgent care centre.

??: *(inaudible)*

BA: I would expect the A&E signs to come down because it wouldn't then be a fully fledged A&E department.

??: *I suspect it's six to eight weeks before a new A&E sign was put up.*

SE: But I think it's just worth making a comment about that, and I think Alan made the point in his comments. We have people providing an emergency care service at Bishop Auckland, it's not a full emergency care service but bearing in mind Bob's 1, 2, 3 analysis and it hasn't been a full service for many years. The service that is provided though is a very good service and the reason it's very good is because of the people who have been providing it. The point Alan is making is those people are not there any more. We can't get them. So if we're going to provide safe services we can't keep doing the same thing. And the point that we're making, you talk about the sign, what the sign will be saying is, this is an urgent care facility. Two thirds of the work that currently happens at Bishop Auckland is urgent care and of that definition, I keep making that point, two thirds of that work will continue.

DG: OK. Thank you. We're got a gentleman in the middle there.

GH: *Thank you Chairman. My name's Gary Huntingdon, I'm a town councillor, I'm also a borough councillor and I'm also a county councillor. It's very interesting, first of all I'd like to make a comment on some of the comments that were made around the tables, and it's obvious, call it cynicism if you like or whatever, but the view of the public and I meet them an awful lot in my job is that the don't accept what is being offered here, for whatever reason, with respect, and I must say this is one of the first meetings I've come to where someone's said that money is not the criteria, and that's refreshing. I find that, you know, quite flabbergasting, and it's raised a lot of questions from me.*

DG: Sorry, could I ask you to actually ask the question please?

GH: *Yes, I'll ask the question, the question is this. If it's not money and you mentioned earlier that there were reasons which you couldn't discuss, or words to that effect, or you couldn't mention, but I'll not go into that, we've been told it's a staffing problem, that we can't get staff to operate in the Bishop Auckland area. Now with respect you said that, the Health Service wouldn't have worked in '47 if we'd accepted that kind of talk, but why is it that we make a decision because we're told that this decision is being made because of advice, clinical advice, from the top people, and that's why we're arriving at this decision. It sounds to me like this decision's been made because of a failure to recruit for whatever reason the right people to come to our area and I don't think that's a good enough reason if that is the reason, why should we be making decisions that affect people's lives all over this town and …*

DG: OK Sir.

GH: *Now could you explain to me is that true or is it not true?*

DG: Right. Just before I ask the panel to answer the question can I just make a point, we're using the word decision here, there hasn't been any decision made, these are some proposals that are being put forward. I'm sorry sir, can I just ask …

GH: *There's a document there that makes the case (inaudible)*

DG: I'm sorry, can we ask the panel to answer the question because …

SE: I'm just going to ask Alan to make a comment about some of what you've said.

AMc: Just to quote again from Professor Alberti, if you've seen this document here, what he's saying is it's more and more accepted and expected by the public that if they're acutely ill with a serious condition they will need to be seen quickly by an experienced clinician, for some conditions such as stroke, heart attacks, major trauma, highly skilled teams with appropriate support are needed to provide round the clock immediate care and it suggests that these services should be concentrated on a smaller site. The point we're making is it's not just about difficulty recruiting, it's difficulty providing that sort of service on three sites.

SE: Yes, and if I may just add one comment because I know you're concentrating understandably because of who you represent on this community here, what George Alberti also says is if we aren't able to organise services for safety and for quality in the future exactly the same situation that we're facing here will happen in Darlington first and then potentially beyond that University Hospital of Durham. Those are the issues that we're facing as professionals and all we're trying to do is set out those to you, so it isn't just about the Bishop Auckland issues, it's also about the other hospitals as well and the services they provide, and it isn't about money because if it was about money, the money is not a problem, we have a surplus of nearly £10 million, we could spend that surplus on sustaining services, but we have the money to spend, it's not about the money, I just want to make that point again, it's about the quality of care and it's about making sure that when you need urgent specialist treatment you get the best possible care that you can by ensuring that we're concentrating those resources together for you.

DG: OK. Thank you. I've got a gentleman at the back in the red there with a question.

??: *Yes, just …*

DG: Sorry, can you say who you are please?

GP: *Yes, George Pennington.*

DG: Thank you.

GP: *Elton Parish Council. Just two points of information, quality of care, I understand that the people who have to go to Bishop for outpatients, their notes are kept at Darlington and have to be transferred from Darlington to Bishop for the people to look at. The other point is the urgent care on a weekend, the computer system doesn't give the doctors access to the individual patient's notes so they can't make really informed decisions on those individual patients. Is this correct or incorrect? Thank you.*

DG: Someone to respond to those two points please?

BA: The one about information I think what we were talking about, certainly all of our computer systems across the Trust, so in all of the A&E departments, they've got access to results and whatnot from all of our sites, where we have had a problem from an IT point of view is having access to GP records in the urgent care centres and linking them to the hospital, now that is actually being addressed as we speak and is about to .. in fact I think in October there was a system put in that dramatically improved that, you know, but I think that's the point you're raising and we're addressing that.

GP: *At the minute it's not good enough because people go there with urgent complaints on a weekend, having no access to their own GPs, and they go to the hospital and they give you a quick MOT and told to report to their own doctor on Monday.*

BA: Yes, well the link between us and primary care is an issue that .. you know, I think it's a really important issue, but it is part of what's called the National Care Record Service that is actually being addressed nationally and we are part of that system, so you know we're working as quickly as we can to put in systems that allow that thing to happen, but it is a national problem.

DG: OK. And there was a question about outpatients I think as well? Was that your first question sir? Oh it was the same issue was it?

GP: *The records that are transferred from Darlington to Bishop, I mean that's … doesn't make sense to me, bringing them by taxi or whatever and from Darlington to Bishop …*

SE: Can I just say it's not just … obviously case notes do travel around the whole of the healthcare system between Darlington, Bishop, Durham, into the community, back into the hospital, they do and they're paper records, and I would agree with you, I think it is quite inefficient and sometimes causes problems but of course the National Health Service is investing billions of pounds in a new information system that will mean that information, it's already happening as far as your diagnostic tests are concerned, we're going to be able to turn those round very very quickly, electronically, and that's not about Seizing the Future, that's just about the investments being made to modernise the information that we pass around diagnosis and clinical activity, so that's coming, it's coming less quickly than we would have liked, as I say it is a national programme, so I mean you have a point absolutely about some of those issues on occasions, it is a frustration for our staff as well.

DG: OK. Thank you. Got a question from the gentleman at the far side there? Just to give me some exercise …

??: *Thanks very much.*

DG: Can I ask if you can make it a quick question so that we can get a quick response as well please?

CO: *Yes, I will. My name is Clive Ord, I'm from the Save The Hospital campaign group from Bishop Auckland, as spokesperson. I'm interested in the guy from the ambulance service when you tell us that your drivers are qualified to the standard of a grade 1 or class 1 police driver, is that right? Can you tell me who does the training?*

MC: We do.

CO: You do your own. OK. Thank you.

DG: OK. Thank you, was that the question or …?

CO: No that's not the question. If this man Alberti seems to get mentioned a heck of a lot around here, when are you going to bring him to a forum?

SE: George Alberti will be with us on 4th December and I'm sure …

CO: Will he be present at the two … at Bishop Auckland?

SE: He will be at Bishop Auckland yes.

CO: Excellent. Thank you.

DG: OK. Thank you. I've got time for one last quick question because we are right out of time, I think the gentleman at the back just got his hand up before you madam. Sorry.

MS: Yes, Michael Stott, Shildon resident. You keep telling us that the decision to make this move or change hasn't been done yet. My father was in Darlington Memorial Hospital about three to four weeks ago, he was in there for a week, during that time there was boxes of files, filing cabinets in the corridors being moved around. He asked a member of the staff at Darlington Memorial what was going on and he was told we are getting ready for the services from Bishop Auckland. No, you can stand there and either call me a liar or my father a liar but that was the answer he was given, and I saw the files and the cabinets in that corridor as I was visiting then.

DG: OK Sir, I'll put the question to the panel.

SE: No, it's OK, what I would be .. very grateful actually if you could give us the details of your father, not now, not in public, but after the meeting.

MS: (inaudible)

SE: No, no. If you could just … because how can we follow that up unless you do that? And we will follow that up. Obviously on the hospital sites there are lots of different activity, with all sorts of things going on and where things might be moved about, I can make it absolutely clear that nothing's going on in terms of redeveloping any buildings in relation to Seizing the Future, what is going on and quite legitimately so if one looks at the guidance about public consultation is we are considering during the course of public consultation how these plans might be implemented, so the term would be planning of risk.

??: A dummy run!

SE: Well it's not a dummy run, but it's just a sensible piece of process that you would normally do in these circumstances, but that's different, that's different from actively, physically, doing things to facilities and buildings and I can give you an absolutely categoric personal assurance that's not happening and if a member of staff is saying that then we'll follow it up if you give us the details.

DG: OK. Can I …

??: (inaudible) yesterday right? Dr Cotterell knows my daughter very well and she goes to see the dietician every three months and the dietician said I don't know where she'll be weighed next time as the children's ward's closing. Is that closing Dr Cotterell?

DG: The microphone will pick you up, you're OK.

??: (inaudible) dietician and I don't know where she's going to get weighed next time (inaudible).

AC: Well first of all if I may say whatever happens the intention is not to change any of the outpatient facilities for children at Bishop Auckland or anywhere else. The discussion is around the acute service and if your child is seen by any of those clinicians, dieticians, etc. in Bishop Auckland today then I see no reason why they shouldn't attend the same clinic after changes have occurred.

??: But she always gets weighed on the children's ward doesn't she? And she said she doesn't know where she'll get weighed because (inaudible)

AC: Well that may be a … and that may be a convenience that has been employed hitherto but as you're well aware the vast majority of children who attend the clinics are weighed in the clinic area and if I can take the opportunity of having the microphone just to make …

DG: Very quickly if you don't mind.

AC: … a few points about the children's acute services. The changes that are proposed for children's services arise partly because of factors in other departments and partly because of factors within the children's service itself. Example of the changes which are proposed as a result of other areas are, as in medicine, the critical care issue. We talked about safety and assume that safety is achieved by being seen at the nearest possible hospital and in fact we're trying to make the point that safety is achieved by having all the services required and concentrated, available round the clock, 24 hours a day, and if your children particularly come into hospital, many of them come in with similar presentations, a few of them become very ill, the majority get better by themselves, but predicting those few that are going to need intensive care can be quite difficult and we don't want to continue to admit children as emergencies to a unit that doesn't have the facility to maintain them … to support them if the need arises prior to possibly transfer to a special facility in Newcastle. The factors from within the service … you will know that in 2004 we changed the paediatric service in Bishop Auckland so we continued to admit children during the day but at night we no longer did so because we did not have junior staff available to do that because of Working Time Directive issues. The overnight facility led by nurses, covered by consultants, has actually many times been seen to have perhaps two children in overnight, but … and they still need a full complement of nurses to look after them and that is an issue which we don't see as sensible or effective use of skills and the decision, the recommendation rather that's been made is that the overnight facility would not exist, we do intend to provide services for children as close as possible where it's appropriate and you saw on the presentation the proposal for a rapid access clinic, this means the children who don't actually need to be admitted to hospital but who have problems which are too urgent to wait for an outpatient appointment can be seen within a day or two's notice at the local hospital rather than all having to be admitted. Now I could expand on that but clearly time is …

DG: OK. Thank you.

AC: But those are just some illustrations about the process from the children's service perspective.

DG: Thank you. I did promise the lady in red one last very quick question and we'll get a quick answer and then we will need to wrap up. The lady at the back there, thank you.

DB: My name's Dawn Boddy, I'm a resident of Shildon but I do originally come from Bishop Auckland. In your statement, the lady with the glasses on, you did say this thing about transport, you know if people couldn't get too and from, depending on bus services etc. Would there be a charge for this? And also can I just add before you answer it, in Shildon some years ago we were called the Jewel in the Crown at Shildon Shops, I hope the jewel isn't taken out of the crown from Bishop Auckland.

(Applause)

DG: Thank you. Diane, do you want to answer the transport question?

DM: Thanks. In terms of the transport, there would be a service in place, the … if you are eligible for an ambulance then obviously that's free, if we were providing additional services, additional public transport services that would not be free, that would be at public transport rates but would be … the concessionary passes would be taken and applied to that, but the other point to make is that where people are eligible for free transport to hospital then obviously people do already claim that money back and will continue to be able to do so with the use of this service as well.

DG: OK. Thank you. Thank you. OK. We need to draw things to a close now. I want to thank you all for your input and just to explain a little bit about what the process is hereon in, as we mentioned this is part of an overall consultation as the slide says behind me there, that runs to 12th January. As well as the public meetings there are a lot of other ways that people can have input into consultation and I'll just say a little bit about that before we close. But what will happen is once we've actually closed the consultation and colleagues at Proportion have actually written up the report and handed it to the Foundation Trust, they'll assess the issues that have been raised in the consultation and actually they won't wait till the end because they're doing that, and the transport's a really good example, they're doing that as the work goes on, they'll actually assess what they've heard, what we've seen and then they'll decide whether they keep the proposals as they are, whether they change and amend them or whatever in light of the views that they've heard. That will then come to the Primary Care Trust NHS County Durham, probably in February and at that point we'll actually listen to all of the evidence from the consultation, from Overview & Scrutiny, from as many ranges of interest as we can and different pieces of information and at that point and not until that point will any decisions be made, I just want to reiterate what I said earlier, the only decision that we've made so far is to actually embark on this process that you're part of this evening, that's actually to look at the proposals, find a way forward and then make a final decision in February or into March of next year. I just want to reassure you about that. There are various ways you can also get involved. Obviously the public meeting is part of it but there are lots of other ways you can get involved. You can fill in the public consultation response form that's on the back of all of the literature that is available. You can go to our website and log on there and get access to it, equally you can go to the special website, www.seizingthefuture.org.uk, as well as being able to respond to the consultation on there there's a wealth of information so all of the consultation documents there and a lot of the background information that inevitably you can't get into in a session like this, but all that information's there. If you look at that and the information isn't there to help you, ie. you think there's something missing then please get in touch and we'll try and find and source that information for you. You can also email your comments to the email address that's there and is on the back of all the literature or you can actually write to the Freepost address and actually write into that and all of that will be fed into this formal consultation process.

I think the only thing left for me to say now is to thank everybody, thank you to the panel for answering the questions, thank you to the staff that facilitated, but particularly thank you to yourselves for listening to the presentation, for taking part in the discussion and actually fielding and asking the questions. Thank you very much and can I wish you all a safe journey home. Thank you. Goodnight.

(End of meeting)