

**Seizing the Future Public Meeting
Spennymoor Leisure Centre
High Street, Spennymoor
Tuesday 2nd December 2008**

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

DG: OK. Good afternoon ladies and gentlemen. We're just having a bit of a problem with the IT at the moment but we'll actually start and what we'll do is if we haven't managed to get the computer talking to the laptop we'll just actually talk through the presentation rather than use the slides, because they're there as a guide only. My name's David Gallagher, I'm one of the directors at NHS County Durham, the local PCT, and I'm pleased to invite you this afternoon to this important consultation meeting, it's part of a wider public consultation and a series of meetings and other ways to actually consult on the piece of work that colleagues in County Durham & Darlington Foundation Trust are undertaking which is looking at the future of their hospitals. I'll just say a little bit about the introduction and then we'll pass on for the presentation and I'll explain what we're actually going to be doing this afternoon.

As a PCT, as a Primary Care Trust, our role in life is to actually spend your money, tax payers' money, on health and healthcare services and we spend about a billion pounds a year for County Durham and Darlington which is an inordinate amount of money and that goes towards lots of things, some of that is for GPs, some of it's for dentists, some of it is for community services, for mental health services but a significant, but not the only piece of that goes towards hospital services for physical illnesses if you like, so the big acute hospitals which we're going to hear about this afternoon. Again, some of the money we give goes to hospitals that are actually outside of the patch, so North Tees and Hartlepool, and also to Sunderland because they actually provide services for people in County Durham and Darlington, as well as South Tees and as well as Newcastle.

The discussion this afternoon is really about a particular group of hospitals, it's the group of hospitals run by County Durham & Darlington NHS Foundation Trust and what we'll do in a moment is we'll ask them to actually give a presentation which is their proposals on some changes that they want to make, the reasons for making the changes and how they're taking that forward. It's in three parts really this afternoon, and our role at the PCT is to actually listen to the proposals but actually listen to your views as part of this consultation, that's why it's really important that you are heard and it's really important that we listen to what you're saying because ultimately we'll make the final decision as to whether these proposals can go ahead or not. I'll talk a little bit about that towards the end of the afternoon. The key thing for now though is that the first part, for about half an hour, I'll ask colleagues to actually talk through their proposals and explain what the proposals are about, and then there's two opportunities for you to actually feed back and feed into the consultation process, which is a formal consultation process and it's really important, this is a formal mechanism which is why it's the 14 weeks that we're looking at. Now once we've done that, we'll do it in two sections, we'll have a section where we actually split you into a couple of groups and we'll ask you some specific questions linked to the consultation, to actually feed into the process and also give you an opportunity to actually formulate some questions for the floor and then the last part of the afternoon we'll actually have some questions from the floor to the panel, and then I'll wrap up by quickly saying actually what we're going to do next, what the next steps are and how the consultation process works from hereon in.

One of the things, I've just been reminded to ask you, because it is a formal consultation process, there are two things really ... one, it's really important that we record everybody who's here, so if you haven't managed to do so already, if we can catch you before you leave and actually, to sign, just to say that you've been here. The second one is, I'm just thinking have I done it myself, is ... can you please turn your mobile phones at least to silent so that we're not disturbed by some embarrassing ring tones which you might get out of my pocket for example. And the last bit is, and it's the reason for actually standing here with the microphone, because this is a formal process, as well as hopefully helping you hear what we're saying, we're using the microphones today because we're actually recording all the proceedings and what we do is we actually get all of this written up, there's a transcript of the whole meeting written up and that actually goes on the website and it's there as a record of the meeting and

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all the issues that have been raised and discussed, so when we come to asking for questions I'll ask people to actually identify themselves just so we've got a record of who they are and who is asking the question.

Without further ado I'll pass on to Steven who'll introduce his colleagues and actually take us through their presentation. Thank you Steven.

SE: Hi, good afternoon everybody. I'm Steven Eames. I'm the Chief Executive of County Durham & Darlington NHS Foundation Trust. I'll just ask my colleagues who are joining the presentation to introduce themselves.

BA: Good afternoon everybody, my name is Bob Aitken, I'm the Trust Executive Medical Director and previously I was a consultant obstetrician and gynaecologist based at the Memorial Hospital in Darlington.

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

SE: Thank you. I apologise. The technology's not working but hopefully we can get our messages across by talking to you with the microphone and if you're not clear about anything please do say as we present. I'm just going to kick off this presentation with a few main points to give an overview to the presentation about the consultation. Then I'm going to hand over to Bob Aitken who's going to take you through the clinical issues, the challenges that we face in that regard. Then Diane will talk through some other aspects of our consultation, including issues around transport and then we'll move on to the next stage as David described.

Now Seizing the Future, our proposals for change, there are two big messages I'd like to give at the outset. These proposals are about ensuring that we provide high quality care into the future and we've developed ... the second point I want to make, we've developed these plans with clinical colleagues, with the people who represent local communities, our Governors who are part of our Foundation Trust organisation, and these plans have been developed over the last nine to ten months, so what you're hearing about today is the summation of a whole range of work that's been done during that time. Four or five things I'd like to make clear at the outset. First of all, our proposals are about change, they're not about hospital closures, they're not about making any of our staff redundant, in fact we feel quite strongly that these changes will improve the quality of care that we provide to the people that we serve and provide greater opportunities for our staff as we move forward over the next few years. We're also very clear that our plans are about making the best use of all of our hospitals, we provide services from five different sites, and our plans are about making the best use of all of those sites, and what we're trying to do is to provide services wherever we can as locally as we can and I guess the way I'd characterise that is wherever it's safe to provide a service locally that's what we're going to do. However we are facing some significant pressures. We have fragility in two or three key services, in intensive care, in Accident & Emergency, and children's services. And also driven by considerations of safety and quality of care, it's important that we concentrate those services in a lesser number of sites than we do at the moment and, again, that's about quality of care, it's about making sure that we've got the right people, the right doctors, the right nurses, the right therapists available at the right time to make sure that the quality of care that we give to our patients and to the local public will meet the standards of today and in the future.

If I can just briefly remind you what the proposals are about in terms of our hospital sites. What the proposals say is that we would ... because of the reasons I've outlined, wish to concentrate our main critical care, emergency care and paediatric services at Durham and at Darlington, and that will mean some change in the services that we currently provide at Bishop Auckland hospital, but to compliment those changes we're proposing to utilise Bishop Auckland hospital fully, using more floor space, undertaking more activity than we do at the moment, for planned surgery and for rehabilitation care, for a whole range of diagnostics and outpatient services and we'll still be providing an urgent care centre there that will operate a service ... excuse me one second, I'll finish this line and then I'll come

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to you ... will operate a service for 20,000 people. Now at the moment 30,000 people attend the emergency care services at that site. A third of those will travel in the new arrangement to Darlington and to Durham but I would point out that for 20,000 of the current attenders, they'll continue to go to this site. We also intend to continue to provide services at Shotley Bridge and at Chester le Street in the way that we do now.

Sir, you wanted to clarify something.

?: *(inaudible)*

SE: Well can I say we'll come back to that question when we get on to the questions shortly?

?: *Yes.*

SE: But, you know, I'll let my other colleagues respond to that at that point, we're not making any cuts, that's the point I'm making, there are no cuts proposed whatsoever, just changes. Just changes to the way services are organised, so if you give us the benefit of ...

?: *(inaudible) end of story, end of conversation.*

SE: OK. If ... OK ... yes ... Thank you for your comment. If you'd just let my colleagues now go on to explain ...

?: *(inaudible)*

SE: That's fine. OK. OK.

?: *(inaudible)*

SE: That's alright, yes, yes. OK.

?: *I warned them just over a year ago.*

SE: OK. Well there are no cuts.

?: *(inaudible) I sent you an email the other week, and I'm still waiting for a reply.*

SE: OK. We'll take your comments. OK, we'll take your comments when we've finished the presentation. I'm going to hand over to Bob who's going to talk a bit more about the clinical case for change. Bob.

BA: Steven. Thanks very much. Ladies and gentlemen, before I go on to try and explain why I feel quite strongly, and my clinical teams in the hospitals feel strongly that we need to change the way we're configured, I'd like to make two points by way of introduction really, to try and establish one or two facts. The present configuration of acute services within County Durham is a direct result of an acute service review that was carried out by Professor Sir Ara Darzi in 2002, now Lord Darzi who is reorganising the whole of the health service. And the second point I'd like to make, that for the best part of ten years there has not been a full A&E service at Bishop Auckland. Eight years ago the trauma cases stopped going into Bishop, like you know badly injured people from road traffic accidents, for example, compound fractures, that is broken legs where the bones are sticking out through the leg etc., they have gone to Darlington for at least eight years. In 2002 following Lord Darzi's review, all emergency surgery was moved out of Bishop, so there's been no emergency surgical service in Bishop Auckland since 2002, and indeed since the beginning of ... I think it was last year ... two years now .. all of the major surgery, elective surgery, planned surgery, has actually been done in the Darlington site, and so there really has been a limited amount of A&E activity and acute medicine has gone in, so it's acute medical cases, not acute surgical or orthopaedic cases that have continued to go into Bishop. Now that was an OK situation in 2002, but a lot has changed since then, and I'll go through the

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changes really that are driving me to say to the Trust Board we need to change the way we're configured.

So what's happened since 2002? There's been a whole raft of national drivers for change, but also these national drivers have actually been modified locally because of certain local pressures that we face, yes? And I'll try and talk you through these as we go forwards. So let's look at some of the national drivers. Specialisation. This has been a direction of travel really for as long as I can remember, you know, since coming to Darlington in early 1993, it's actually affected my clinical practice, when the centralisation of gynae-cancer surgery towards the cancer services, I did a lot of gynae-cancer surgery in Darlington, but the direction of travel was that it should all be centred on Middlesbrough. I thought at the time we were doing OK, you know, is this really for the benefit of patients. I have no doubt now, when you look at the outcome data for treatment of gynaecological cancers that the centralisation and the specialisation and a smaller number of highly trained ... not just highly trained, there is a kind of technical term that I'm going to try and introduce at this point, and it's a concept of what we call in the medical profession, critical mass. You know, the critical mass concept can apply to individual specialists, but it also can apply to teams and what it essentially means is that the number of patients you're seeing with any given condition, or the number of operations of a particular complex type that you would do in a year, and there's an increase in tendency, and I think correctly so, where the Royal Colleges and the Department of Health and various other learned bodies are actually saying that to continue to be recognised as a specialist in that field you've got to be achieving a critical mass of activity, number of patients you see, number of operations that you do, and we regularly review that by benchmarking against other hospitals within our own organisation, in all fields of surgery and in medicine, yes? Now there's a lot of evidence to show that there is ... if you look at the critical mass, that equally applies to teams, so a critical care unit or an Accident & Emergency unit, that the more highly complex patients that they're seeing, then the more expertise they develop, but also they maintain that expertise, and there's been a number of recommendations on specific specialties which I'll come to, where critical mass is actually all important. I'll come to that later.

And of course we could add at this point that the critical mass is important for recognition for training, you know, not only accreditation for a critical care service or an A&E service, but accreditation for training junior doctors and nurses etc. Very important for the future health and well-being of an organisation, a hospital.

Second big national driver really relates to doctors' hours, and to me that takes two forms really, one is pure primary legislation, European Working Time Directive you may know it better as, and in August of 2009 the junior doctors' maximum hours of work, trainees that is, comes down from 56 to 48 hours a week. Now when that happens next year the implication for us as an organisation is we lose the equivalent of 31.4 whole time equivalent junior doctors who at the present time staff our emergency on call rotas. Now I've got our teams looking at the present situation and we have got real serious pressures, a lot of our rotas become non-EWTD compliant and when that happens one of the first things that happens when the specialist training committees come round is they question your ability to do the training of the doctors because they mustn't be put under pressure to work beyond EWTD hours. There are different ways of actually trying to handle that, but the most efficient and the most effective is to reduce the number of on call rotas that you actually run. That's one of the big drivers going forward.

Another change that I've picked up, certainly in my time as medical director, is that the culture within young doctors, or among young doctors, has changed significantly. So in the days when I was a boy, newly qualified, and a trainee in obstetrics and gynaecology, and if folk asked me about work/life balance you would just have said well what life are you talking about, because you did work 100+ hours a week on call, but that was the expectation. Now it's different. Not only the trainees are controlled by the European Working Time Directive, but consultants are looking for much less onerous on call rotas, and they're voting with their feet. They want to work hard when they're there, still love their job, but they want ... they don't want to spend every other weekend, or one weekend in three, on call where they can't do things with their family. They want to do much less frequent on call, even if

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it's busier. So I did some work recently with a group of senior registrars and the biggest dissuader for applicants applying for a job was if you were expected to be on call any more frequently than 1 in 10. Now that does put Bishop Auckland and Darlington in a very unfavourable light and actually that's ... my experience as Medical Director on the ground. In some specialties we've had real serious problems trying to recruit new consultants to certain specialties in the South of County Durham. It's not a problem in the North of Durham, but in UHND the teams there is a result of the previous merger of Shotley Bridge and Dryburn so they've got much bigger teams, they can much more easily attract new consultants because their on call rotas are much less onerous. But added to that we've also had specific recommendations since 2002 on a number of specialties. Accident & Emergency, at the end of 2003 the Royal College of Medicine was formed, Royal College of A&E essentially, the boys changed their name, and what that College did within a year to 18 months is they made a recommendation not only for the staffing levels within A&E departments, but also the critical mass of activity, particularly the sicker patients, you talking about A&E patients are graded 1, 2 and 3, 1 being the walking wounded, 3 being people who are seriously ill or badly injured who need immediate resuscitation when they come off the ambulance, and particularly the recommendation on the level 3 activity required to maintain ... to continue to be recognised as a training centre. The big implication for us in the County although we don't have a full A&E department at Bishop is that we do not have enough activity in the whole County to have three full A&E departments.

Can I take your questions later? I'll just finish ...

?: (inaudible)

BA: Feel free to ask the question later. Can we get through the presentation?

?: *You said you haven't got enough to justify but that is only based on the one model that we are looking at and that model is based on half a million population etc. etc.*

DG: I'm sorry to interrupt. Can I just (inaudible) opportunity to ask questions when we get to the end of the presentation, unless we can get through, (inaudible) ample opportunity to ask (inaudible)

BA: Yes, I'm more than happy to deal with that later.

?: *Yes, well it is a key point and I'm not happy to stop for you there because I think you're wrong in your assumptions there because what you've done is you've just picked up on the one model...*

BA: No we haven't.

?: *...that the NHS is looking at.*

BA: No we haven't.

?: *...about specialities and about the size of population.*

DG: Can the gentleman please (inaudible) we need to insist please, we need to (inaudible) There is the opportunity to ask ...

?: *Well I will give way to you on this occasion.*

BA: Bring it up and I'm quite happy to answer the question during the question and answer session yes? And there are ways of actually dealing with it, you don't need to have just purely A&E departments, but we can talk about networks as well, which is the national recommendation going forward.

Second specialty is acute medicine.

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?: *Bearing in mind what you said can we just (inaudible) all the questions that you have ... more than happy to answer all of the questions ...*

DG: Yes, they will.

?: *... and if we get that out of the way then people are (inaudible)*

DG: Happy to do that.

?: *(Inaudible)*

(Applause)

DG: Yes, very happy to do that. The presentation might actually answer some of the questions and people might have some more questions so if we can get the rest of the presentation over that would help.

BA: I'll try and be quick to leave more time for questions but I think it's important that I try and explain what the issues are. Acute medicine. The way emergency medicine is actually provided, emergency medical services. In 2002 essentially it was general physicians and on any given night on a particular take, you might have a general physician with an interest in diabetes or an interest in chest medicine dah dah dah dah. And that was the model of care. You were brought in, you were looked after by a generalist essentially. In 2003 the Royal College of Physicians recommended the recognition of a new type of consultant physician called an acute care physician and by 2004 they had developed a new recommended model for the provision of emergency medical services, and that was essentially that every acute medical take unit should develop a thing called a Medical Admissions Unit, a special ward essentially, to bring in the acutely sick patients and they would be cared for by a team of three acute care physicians, for 12, 24 up to a maximum, the recommendation was, of 48 hours. Thereafter the patient should be stable enough either to go home or to be transferred into the 'back shop' or the base wards, where their care would be handed over to a specialist, cardiologist, a chest physician, a gastroenterologist, etc. etc. and what that essentially meant really was that for hospitals taking acute take you needed to be working in teams of a minimum of 13 to provide two 'ologists' in the 'back shops' so that there was always one available, you know, folk get holidays and study leave etc., and so it's been a bit of a challenge for us to try and deliver that model of care going forward. The challenge was to deliver the model by the middle of 2008. Now at the present time in the County we do deliver that model in Durham, although we've only got two acute care physicians, you know, because they are not growing on trees at the minute. But because of the numbers of physicians that we've got we have not been able to deliver that model in Darlington or in Bishop Auckland.

Now our proposals, if they're accepted, if we merge the two medical units in Bishop Auckland and Darlington, would allow us to provide that model of care in the South of the County. The big driver though for me as Medical Director has been in critical care, that is intensive care. Now in 2002 Lord Darzi made his recommendations, the recommended critical care support for an acute medical take was level 2, a minimum of level 2. Now if we go back to the 1, 2, 3 again, the same applies to critical care patients as it does for the A&E patients. Level 1, up to 2, up to 3, 3 being the sickest. Right? And there are differences in the way that HDU or level 2 ITU units are staffed, that is, the recommendation being one nurse to two patients 24/7 and doctors available within 10 to 15 minutes if called. Level 3 is one nurse to every patient 24/7 and a doctor immediately available and essentially what that means in Darlington and Durham where we have that level is doctors living in the unit. Now there was a further recommendation at the end of 2007 by the Academy of Medical Royal Colleges that actually said if you were taking emergency services of any kind you should be providing a 24/7 level 3 service. Now when we realised these recommendations were coming forward we didn't provide a level 3 unit in Bishop, we provided a level 2, the Trust gave me access to a lot of money to go and find six doctors that were required to provide a resident tier of anaesthetists to cover critical care in Bishop. We advertised four times, three or four times in a year to 15 months, and we got one applicant who was suitably qualified, he happened to replace somebody who retired, so we've got a real recruitment problem. We had to make a decision at the end of 2007 that if we could not meet the 21st Century

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standards of critical care then we needed to transfer the patients on clinical safety grounds and that's what we've been doing. Added to that, when critical care services in Wales was reviewed in 2006 for the first time there was a recommendation from the Intensive Care Society about the critical mass of activity required to maintain the expertise to run a full level 3 unit. Suffice it to say, that within the County of Durham we don't have enough level 3 activity for us to be able to run three level 3 critical care units, so in all the critical pressures are saying, you know, going back to the gentleman's point about, you know, catchment areas, I mean the catchment area for a district general hospital about 15/20 years ago was about 125,000 people, 10 years ago it was probably quarter of a million. Now the recommendation is about 500,000 to allow you to have a critical mass of activity to maintain the level of expertise to allow you to specialise, so we are faced as a County with some real pressures here, and we feel very strongly that the recommendations we are making is allowing us to continue to deliver services within the County to modern standards.

Very, very briefly about paediatrics. Yes. Paediatrics is a specific problem, it's a recruitment retention problem more than anything else and I feel a bit sorry for the unit at Bishop because 10 years ago it was the model of choice, the recommended Gold Standard, run by consultants with very little support from junior staff. Following the advent of the new consultant contract it's really fallen very much out of favour. It's a very difficult model to run, it's very labour intensive from a senior medical staff point of view and we have had recruitment problems into the service at Bishop, as I've said before the young doctors are looking for something different. We've actually had a couple of guys who have moved away, we're due more people to retire, and our paediatricians feel very strongly that they need to rationalise the service into UHND and the Darlington sites. That's why they have made that recommendation.

Very briefly, what if we don't? What if we don't make changes? Oh thanks, I didn't realise the slides were up. I mean the emergency contingencies I have to point out are not ... these are the emergency contingencies plans that as Medical Director I might have to make, this isn't stuff for the future, for the last year to 18 months almost on a monthly basis, not just at Bishop, but there's been problems at Darlington as well with staffing levels etc., but certainly in the South of the County, is I've faced crisis after crisis. What these changes will allow us to do is to stabilise the fragile services that we've got and continue to provide high quality care for all of the people of Durham. If we don't I have no doubt at all that with retirements and with difficulty in recruiting there will be an increasing decline in our ability to provide 21st Century quality care to people and even get to the stage where some of our services may well become unsafe. That will no doubt, if services start to fail, will have a negative impact on the health inequalities that we're actually trying to address. It will eventually result in a service that is not fit for our commissioners to commission from us but I would commend to you my feeling very strongly is that it's not a service that I feel is fit for the patients of County Durham. I'm going to hand you over to Di now who will talk you through some of the proposals in more detail and the travel.

DM: Thank you. Steven's already alluded ...

?: (inaudible)

DM: Anybody know where the lights are? I'll just carry on whilst somebody's trying to do that for you, yes. Just quickly to go through the proposals for the A&E department at Bishop Auckland. Steven already mentioned earlier on that we've done analysis on the current patients who are being seen in the unit at Bishop Auckland and based on the analysis of that by the doctors and nurses who work in the A&E departments, we can say quite confidently that two thirds of those patients who are currently treated there will continue to be treated there, so that's 20,000 out of just short of 30,000 patients will still be treated at Bishop Auckland. We know there's lots of evidence around, lots of research papers and the evidence is being used at a national level, that patients do benefit by travelling for more specialised care. A quick example of that would be the care of patients who are having travel for cancer and by travelling further to receive specialised care for cancer we've seen much better outcomes for patients across all cancers. The point's already been made around the serious injury and trauma, this is around what currently goes to Bishop Auckland, that was centralised trauma, so patients who have had major injuries have been going to the Darlington site since 2000, OK? And of those patients, if you've got a

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major head injury you actually go further, you go to a specialised unit, for this part of the patch we go over to James Cook hospital for that, and for some patients, because of the introduction of really cutting edge new technologies for treatment of patients who have heart attacks, and this technology has been pioneered in the North East and has been kind of the first area to roll it out, that some patients already bypass all of our local hospitals in County Durham and go directly to a specialist unit at either James Cook hospital or the Freeman unit and actually have a minor surgical procedure which actually frees up the arteries and much better outcomes for patients as a result of that. That means better survival rates but it means less ongoing complications from those conditions. So that's just an example of where, you know, by introducing new technologies it means we have to change the way our services are delivered, we have to travel further for that specialised care, but it actually delivers real benefits for patients.

So overall, just to sort of try and kind of capture some key points of why we think the proposals are better for patients and kind of mentioned at the front really that I'm a nurse by background and I think one thing I want to point out is that Bob's talked a lot about specialisation of medical staff, but other staff who support the team also need to specialise and that's the nurses and that's the therapists and all of the support staff that it takes to look after patients, OK, it's a big team and we all specialise. So you know behind these doctors who need to specialise we create specialist multi-disciplinary teams of all of our staff, and by getting better access to a specialist and making sure that we separate our emergency care from our planned care, OK, so planned care is when you know the date you're coming in for your surgery and what have you, separating a lot of that into the Bishop Auckland site, we can better guarantee you'll be, not just seeing the specialist doctor, you'll be on the right ward where you've got the right specialist team and less movement of patients between wards to create the capacity to bring more emergency patients in. We call that boarding out, but we can much better guarantee that you'll be in the right ward. For the same point we can almost guarantee that there'll be much less risk of cancelled operations. We know the effort it takes for people to plan their lives to get into hospital on a certain date at a certain time, it's not just our planning, it's your planning as well. By actually having our elective patients, the planned patients separate on the Bishop Auckland site, again, we can protect those beds, we can reduce the risk of your operation being cancelled.

Better rehabilitation after being ill. One of our proposals is to have a specialist rehabilitation centre at Bishop Auckland. It's not something that currently exists in the County, in fact it doesn't exist around the patch really, sort of the borders of the County as well. Currently patients are rehabilitated in an acute ward, OK, so the whole of your stay takes place in a ward, but as you're getting better and need rehabilitation your care is less of a priority than the very acutely ill patients, and you will all understand that, if somebody becomes very very sick the nurses and doctors prioritise to them and the needs of the rehabilitation patient are actually about nurses and doctors standing back and enabling you to regain independence and supporting you, and it means about stepping back and giving you more time and giving you the skills to go out and live independently. By actually creating a specialist centre with additional investment in therapists so we can provide therapists over seven days a week instead of, as we currently do, over five days a week, we can again improve the outcomes of your care and by outcomes what we mean is that that will mean for a lot of patients, it will mean ... for some it's a shorter length of stay, for some it won't reduce the length of stay but it will mean more patients going back to their own home, fewer patients having to go home into supported community care or into nursing homes or into residential homes, and again by separating our planned activity from acute activity, from emergency activity, we can screen the patients that are coming in on a planned basis, so before they come into hospital we can screen them for MRSA, we can treat them for an MRSA infection before they come into hospital and reduce the risk of getting an infection.

Travel and access is a big issue. At every meeting we've been to, right throughout the whole of the programme, people, our staff, our Governors, our stakeholders, the public, everybody's said travel's a big issue for us and we agree with that. The principles of all our proposals are that you will only travel when it's absolutely essential, so you'll only travel when you actually need to travel for that specialist care provided by doctors that can only be provided on certain sites. Your pre-operative care, your outpatients appointments, before and after, will all be done at local hospitals, your diagnostic tests or your X-rays, your scans, blood tests, all of those sort of things, that will all be done at your local

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hospitals, OK? And wherever possible we'll be working with the community to actually do some of that work out in the community as well. So travel only where essential, OK? That's really important.

In terms of emergency care, just a note about paramedic care. Your care doesn't start when it gets into hospital, it starts when the paramedics arrive at your house. These are highly skilled technicians who come and start your treatment when they get to you, so that journey time to hospital, it is important, but it isn't important in the context that it was, you know, I don't know, five, ten years ago, paramedics are now, you know, trained to a graduate level, the training they have, and that's when the care starts, and they are critical in your care and really bring people to our services in a much better state than might have happened in the past.

We've been doing some analysis of transport, working with the Integrated Transport Unit at Durham and what we're proposing to do and are working closely with them is to actually set up some new services by integrating the current transport services, so that's the Patient Transport Service run by the ambulances, looking at public transport and where there are any gaps in current public transport service provision commissioning new services to actually ensure that patients, their relatives and our staff can travel between sites for appointments, for visiting times, and any other purpose they need to get to us.

Just a couple of ... there's just one slide, if I can just show you ... very quickly, this slide actually pulls out the postcodes for this area and I think it's Spennymoor and Ferrryhill that pulls out, and this is about access to public transport and this has been done by the Integrated Transport Unit at Durham based on the information we've given them about numbers of patients coming into our services and if you just look at the headline in that, in terms of access to transport and getting in to our services, nobody is worse off in terms of travelling to sites, OK? Significantly advantaged in terms of access to public transport to get to our sites over and above how it is currently.

On that note I'll just pass back to Steven to finish off.

SE: Very briefly, well thank you very much for taking the time to listen and I just want to finish by making it very clear to you as the stewards of your local health services, all of us here and the team behind us feel very passionately that these changes will improve the quality of care and improve patient outcomes and also secure a long term future for all of your hospitals. David.

DG: OK. Thank you. Thank you everybody for listening to that. What we want to do now, as I said, there are two opportunities for you to have your say. To start with what we're going to try and do is get you into maybe three groups, so we can actually do two things, one there's some specific questions we need to ask you to feed into the consultation process, which is part of the process this is. The second bit though is to give you an opportunity to actually formulate with the help of facilitators in the group I think two questions from each group which we'll put to the panel in the last plenary session and then we'll open it up for open questions and we'll try and get through as many questions as we can. I'll explain that when we get onto it but for the moment if I can ask the PPI team if they can actually facilitate, I think if we can try and stay in this room and maybe just rearrange the chairs and get people into three groups and we've got some space outside there as well. We'll do this for 20 minutes, which will give us time to get back and have some questions to the panel.

MEETING MOVES INTO ROUND TABLE DISCUSSION GROUPS

(General talking as people move around the room)

FEEDBACK FROM ROUND TABLE GROUPS

DG: OK folks, can we try and reconvene please? Thank you. What I'm going to do is I'm going to ask in a moment for the facilitators ... that sounds very loud from where I'm standing! I'm going to ask in a moment for the facilitators from the group to actually feed back some key points from the discussion

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and then we'll come back round and ask for two questions from each group and then we'll get into some open questions, but there are two other members of the panel who've joined us now so I'll just ask them to introduce themselves before we kick off with that.

CF: Hello, I'm Carol Fletcher, I'm one of the Matrons for the Trust, I'm also the Staff Governor.

AA: I'm Akmed Ali, Clinical Director for Women and Children in the Division.

DG: OK. Thank you both. I have to apologise as well, we've tried to turn the lights up, I think this is as light as they get unfortunately, so if you bear with us, I'm really sorry about that. If we can start ... which group wants to go first? If we start with Jill if you can ... we'll just get the microphone to you, it's just coming from behind you. Can you just give us a couple of points from the discussion and then we'll come back to you in a moment for some questions?

J: *Yes, in terms of points, I think there was a feeling among our small but select group that there was insufficient information and I think that'll come through in the question and answer session. The second point I think was around a real keenness to see investment and improvement at Bishop Auckland General Hospital and potentially using that as a training centre for junior doctors rather than a perceived downgrading of services.*

DG: OK. Thank you. Can we pass it on to Verna possibly from Verna's ... or Katrina, if you're going to go back, just behind you?

C: *In terms of the feedback from the group, ultimately there was a ... the process of the consultation they thought was robust but again, like Jill, it was more around the information. People would have found more value in having the documentation of, you know, Spennymoor, what have you, in the planned documentation that went out but they do appreciate there was additional and that was based on what they public were saying and wanting. Transport came through, again, very loud and clear and some issues specifically around people's needs being met when these changes are being undertaken and another point that was raised was around the moving of services from the Bishop Auckland hospital, people tended to be unaware that that had actually happened and taken place, so more consultation, more information around that when services are changing please.*

DG: OK. Thank you. And then, actually you can use this one Verna if you like?

V: *Certainly in our group there was a huge strength of feeling that neither of the options were acceptable and that really the only acceptable option would be to have Bishop Auckland hospital reinstated with full A&E as apparently it was in earlier times. And some really good points about the consultation in terms of ... full documentation was available on the internet but not everybody has access to the internet. Afternoon meetings are not always suitable particularly for people that work. There is ... and perhaps the fact that there aren't a lot of people here from Spennymoor is due to the perception that it's a done deal, that actually the consultation doesn't mean very much ... so that was ... and then lots of other points wish I've reassured people will be taken into account.*

DG: Do you want to keep the microphone Verna and we'll have two questions from your group please?

V: *Yes, sure. The first one was around Bishop Auckland staff and saying that have Bishop Auckland staff, because we had the discussion about how important is it that the review was led by clinicians, but have Bishop Auckland staff actually had a voice in that, because there was a bit of a perception that that hadn't ... they hadn't seen any staff from Bishop Auckland at our meetings.*

SE: OK. If I could just kick off. The short answer to your question is there has been full involvement from all staff at Bishop Auckland and Carol and Diane can say a bit more about that.

CF: I'm actually based at Bishop and was Bishop based before we merged with Darlington. This time we've had a lot more involvement of the staff. I speak to the staff, the staff are invited to come to open

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meetings to discuss anything within the hospitals to see if they've got any concerns. I think the one good thing about this time when the changes have been ... there has been a lot of involvement of the staff and I would say that was a definite.

DM: Just quickly to support Carol in that. I think we've now done something like 12 or 16 open staff meetings, at least six of those have been at Bishop Auckland for the Bishop Auckland staff and held at different times of the day to facilitate staff getting there. We've sent newsletters out to staff every month. The groups that actually came up with the options and developed the options included staff from Bishop Auckland in those groups. I've spoken to all of the ward sisters across the whole of the Trust and that includes ward sisters from Bishop Auckland and we've actually ... the consultants were members of the working groups that came up with the options but over and above them being involved in that I think it was Bob and myself, certainly I went along and Alan McCulloch, one of the Associate Medical Directors, went along to Bishop Auckland and spoke to all of the consultants who are based at Bishop Auckland and had an individual meeting with them and, on top of that, Steven has actually had a series of breakfast meetings with consultants, including those at Bishop Auckland.

AA: And I as a clinician, I represent all my colleagues, the way ... I know all the medical and the clinicians either from Durham, that's myself, from Darlington originally, but the way we were appointed, it's an expression of interest, and people who came forward were appointed. When I sit here I'm representing 50 consultants in the Women & Children Division. Without them we can't do the change, so they are all involved, they are all with it, for all sorts of technical reasons that we can't go through really it is ... we represent all our colleagues because without them as a team we cannot make any changes.

DG: OK. Thank you. I'll take one more question from Verna. Just in the interests of time, there are a lot of questions, can I ask the panel to be fairly succinct in their responses please?

V: *Quite a big one this next one, but I think it's important enough to ask. Can an absolute guarantee be given that someone from Spennymoor needing critical care will not die by having to travel further?*

BA: When you say can I give 100% guarantee ... you can't really give 100% guarantee in anything if somebody, you know, is requiring ... what I would say is the experience that we've got at the moment of surgical patients or trauma patients, we haven't got an increased mortality rate in people who are having to travel to Darlington or Durham to the A&E departments there, right? So we haven't seen an increase in mortality since the changes were made around surgery. And certainly since we made the decision just over a year ago to move the level 3 patients from Bishop Auckland medical unit and intensive care unit to Darlington, one, we haven't had any untoward incidents during the transfer, and indeed there's been no increase in mortality at all. In fact the patients have actually done very well.

SE: I might just add if I may that the recent changes around heart attack treatment where people go to either Middlesbrough or Newcastle, the evidence both locally and nationally is that there is a reduction in mortality rate directly as a result of that change.

DG: OK. Thank you Verna. Can we have some questions from the other two groups please? I'll let you choose who goes first. Jill, thank you.

J: *The first question is a request for clarity around the 20,000 patients who will still be treated at Bishop Auckland A&E and the questions were specifically around are they true A&E patients, are the level 1, 2 or 3, is it doctor referral patients or is it self-referral?*

BA: Can I say the majority of the activity around A&E, if you look at the 30,000 patients that come in, virtually all of the Blue Light patients are medical emergencies and a lot of these patients, in fact most of them, other than just giving their details to the front desk, go straight through A&E and into the Medical Admissions Unit, right? The vast majority of patients who are seen and treated within the A&E service are, if you remember the levels 1, 2 and 3, are level 1 or low level 2s, you know, the sickest patients who are picked up by ambulance who are of a pure A&E nature tend to go to Darlington anyway, and that's particularly so out of hours, once you get beyond eight o'clock at night

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there is very little activity through A&E at Bishop and the vast vast vast majority of patients are level 1, walking wounded in other words. So we are comfortable that these patients will still be treated within the services we propose. In fact the proposals, other than changing the name of the unit, there's very little change in the service that is being provided.

???: *So are you saying then you can still walk into Bishop Auckland A&E department (inaudible)*

BA: Yes, indeed.

???: *I could ring them up could I and say I'm coming to see you and they would provide me a service?*

BA: They might ask you what the problem is, and may well advise you that for your particular condition ... I mean access as it is at the minute, if you were suffering from an ENT problem, for example, we don't have an ENT service at Bishop, so ENT emergency should all go to Darlington anyway, and there have been one or two little issues because people don't quite understand that and that is part of ... we should be educating people better, but yes, you can walk in.

???: *(inaudible)*

BA: Well if we go back to what we talked about before about model of care, if you read the A&E document from the College, emergency care is provided as a network and you have A&E departments and below that you've got urgent care centres and you've got minor injuries units, that all work linking to one another, so you've got different services provided in different places but they're all, you know, essentially and hopefully working to the same standards, even in this place, the staff would be trained, although we're putting nurse practitioners in or emergency care practitioners, they will all be trained to resuscitate somebody who comes in having had a severe anaphylactic reaction or who needs adrenalin for that sort of condition or severe asthma, there will be training given so that if people feel the need to get there or even if an ambulance brings them in, they will be able to be treated, stabilised and transferred. The staff are all trained to deal with that.

DG: OK. Can ...

???: *(inaudible) other 10,000 people that we're talking about (inaudible)*

BA: These are mainly the emergency medical patients that the ambulance pick up and at the moment we've got an unrestricted Medical Admissions Unit in Bishop, yes? Now, in 2002 the level recommended for critical care support to that unit would be level 2, on a high dependency unit essentially. Since 2007 the recommendation has been that we need a full level 3 to support unrestricted Medical Admissions.

???: *(inaudible)*

DG: Yes.

BA: Yes, but I mean we have trouble trying to deliver that sort of service.

DG: I think you've had your question answered. Can we move back to one more question from Jill's group and once we've had the questions from the groups we'll open it up to the floor.

J: *Yes, the second question is about transport. Not directly related to Spennymoor residents but relevant nonetheless. Does the analysis that's been presented around travelling times, does that take into account the home to hospital distance for people living in remote areas of the Dales?*

DM: It's actually based on households, so all of the travel analysis has actually been done by postcode of people who've attended our hospital so the maps that we've used, I mean I don't know whether I can just find them quickly ... all of those dots which actually kind of merge into red clusters and green clusters and black clusters there, each ... they're actually made up of individual households and they're

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the households of the patients who've attended our services, so it's actually been done at the individual patient level, and the transport analysis has been done based on travel from somebody's home to a hospital, so not from ... I don't know, Bishop Auckland town centre to Darlington or to Durham, if that makes ... does that answer the question?

J: I think it was specifically in relation to homes and residents in the Dales, so Weardale and Teesdale Diane.

DM: Yes. Basically Weardale and Teesdale are the black patches up on the left of that map. OK? So that's all the residents mapped in Teesdale and Weardale and that black ... those black patches don't change, that's how it currently is now, that's people who currently don't have good access to hospital services and that doesn't change, that picture doesn't change with our proposals, but what will change is that we will be putting some additional transport solutions in place to improve access for those residents of Weardale and Teesdale to our hospitals.

DG: OK. Thank you, if we take two questions from Katrina's group please?

C: Just staying with Diane ... transport came up. Specifically around those other transport solutions, there was a question around the needs, particularly for disabled users, but really a mechanism and means that the discussions that are going on around transport, that it is including weekends and evenings.

CF: Yes, it is.

DM: Yes, yes, it's seven days, it's over seven days, yes, for evenings, I mean evenings obviously because visiting times take place on evenings, and in terms of access for people with disabilities, I mean we have actually done some analysis around that just to try and make sure that we're not disadvantaging that group over and above any other group and we're satisfied that we're not, but whatever arrangements that we have agreed and in place should we be able to go ahead with our proposals they will take account of the needs of all groups, yes.

C: I think that's what they were looking for, some reassurance that it was going to cover weekends and evenings as well.

DM: Yes, absolutely.

C: And the last question, again, going back to the consultation process, but it was around the moving of the facilities, as services have been changing for Bishop Auckland, ultimately what was interesting for the group was to find out well how has that been communicated to the public at any given stage because people were very very unaware of, you know, the changes going on from there up to this point.

SE: Well it might be that other colleagues, particularly Bob who was here at the time, that my understanding just as a headline is on the major changes in the past there have been full public consultations. Whether they were ... effectively, you know, communicating some of the issues ... well, obviously I can't judge, but certainly there has been full consultation in the past. But Bob do you want to ... ?

BA: Yes, certainly the move of emergency surgery and of the major surgery move, it was contained within the Darzi report if I recollect, and I think probably what happened the move in maternity and child health services was so emotive at the time and that was the thing that seemed to be discussed at all of the meetings that ... so whether that just passed people by but I'm sure it was in the document. Edmund was at the health authority when it was actually done.

EL: I'm Edmund Lovell, I'm the Head of Corporate Affairs at the Foundation Trust and I was involved in the consultation in 2002 and there was full consultation on the previous set of changes that involved the centralisation of consultant-led obs, gynae and paed's at Darlington Memorial and some of the changes

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around emergency surgery and that's been the blueprint for services over the last few years and once that work was completed and after consultation a decision was made by Ministers on those proposals and once that was completed there was a door to door mail drop of a leaflet explaining the changes to obstetrics and gynaecology and to paediatrics, so it was fully consulted on and then great efforts were made to inform local people about that.

DG: OK. Thank you.

AA: And the move was actually in both directions, there is a lot of patients or ladies from Darlington that go to Bishop for certain services, particularly one-stop ...

DG: OK. I'm going to open it up for open questions but can I just, thinking about the last question, this is about looking forward, it's called Seizing the Future and I know people have got anxieties, concerns and cynicism about the past and what's happened in the past, but this is very much about proposals for the future and if we can focus the questions and the discussion around those please it would be helpful rather than get dragged into what's happened in the past, right or wrong, because you know we can't do anything about the past unfortunately. I've got a lady at the front who was first with her hand up. Can I ask you just to ... when you get the microphone, can you just identify yourself please for the record?

SP: *Yes, I'm Shirley Prest, a resident of Spennymoor. In the recent year I have had need to visit Darlington and the hospital at Durham, I'm still going to call it Dryburn. I would beg of you, beg of you, in your consultations which I am 99% in agreement with, I have to be quite honest, please consider the people who are going as patients, who are going as visitors to those two hospitals. Over a period of four months I visited a relative in the Memorial Hospital, a very sick lady, she eventually died there, and I had to park on average one mile away to get into the Memorial Hospital, having battled with the traffic off the A1 and through Cockerton and then to be faced with that, I almost ended up weeping and coming home and going back again in the evening it was still quite a difficult. Last week we went to University Hospital in Durham, it took us 45 minutes to find a parking space. Now I know there are lots and lots of people who have cars, but I do think this should be a major point when you're planning this and thinking of it, is there room for more parking because it's of great concern to many people. Thank you very much.*

DG: OK. Thank you for the question. Can I just ask ...

SE: I could answer that very quickly. That's absolutely right, it is a significant issue in these plans moving forward. It links with what we were just describing ...

SP: *(inaudible)*

SE: Absolutely, on transport. We do anticipate that we need to make more accommodation for parking. The transport system will help. We're also looking at other ideas in the transport system such as Park & Ride which obviously helps to disperse the parking and also meet local planning regulations. All of that is in hand and we're quite aware that in order to make these proposals work we have to put those mechanisms in place. The other thing I would just mention though is that we also want to make sure, and our plans allow this in the way that we're organising our services, bear in mind that whilst we may be having activity moving into Durham and into Darlington, and you rightly reflect some of the cramped conditions ...

SP: *Bishop Auckland's the best place.*

SE: Well as I'm about to say, other services are moving from ... other services are moving out of those sites and can I emphasise into Bishop Auckland, and so that would also ease some of the pressures that we're finding at the moment.

SP: *(inaudible)*

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SE: So we certainly take those points fully onboard and appreciate what you're saying.

SP: *I have to be honest Bishop Auckland hospital was much more presentable in appearance sadly than the Memorial, the Memorial is overcrowded and is looking very very very shabby and to me it leads to problems with infections.*

DG: OK. Thank you. Gentleman ... I think the gentleman at the far end had his hand up first, then we'll come to you next sir. Or you can fight over it if you want ... ?

KT: *First of all, I'd just like to make a couple of comments. My name's Kevin Thompson, Durham County Councillor ... is that I thank the Primary Care for giving us the opportunity to consult on this. Secondly, any doubts about the support of Spennymoor, some four or five weeks ago I stood outside with a petition in Spennymoor, got hundreds of signatures and every person went out of their way to express concern, not just sign the petition, express concern, genuine concern. Now my question is I understand the critical mass situation, only so many types of operation take place in a given area in a given time, and for a surgeon to have the expertise to carry on doing those operations successfully he must have that practice, for want of a better word, to do those operations. But still coming down to the fact that people have to travel to Darlington, to Durham, to get that, are we still talking about a resource, I understand that you've advertised and taken up to 15 months to try and get people to come here, but yes we're just talking about County Durham, part of this must be a national problem and there must be an extra resource somewhere to try and make these people available so that we have enough to go round. You are trying to make the best of a bad job for the want of other terminology because you don't have the resource available, but I believe that there's a wider thing here where we must be investing more to make sure we have more people available. You are trying to do what you can with the resources you've got available, but there must be a better way than just cutting back, there must be a way to go forward and that's what I'd just like to say.*

DG: OK. Can we ask somebody to respond please?

SE: OK. I'm going to respond at first, I'm going to ask Bob and then Akmed to comment on what you've said, literally about resources and those key questions you asked. Could I just ask you a question? What was the question in the petition?

KT: *The question in the petition was, well your right, it was not quite the way you presented it, it was are you against losing Accident & Emergency from Bishop Auckland.*

SE: OK.

KT: *Now hearing what you said, then you may not agree with that ...*

SE: I just wanted to check what the question was.

DG: OK.

KT: *I didn't say that two thirds of the A&E admissions to Bishop Auckland would still be there, mine was a vague question.*

DG: OK. Can I ask the panel just to respond to the question please?

SE: Yes, I just wanted to clarify that, because it is part of my response to the Councillor's question, and I think you also mentioned, as other people have, about the concern of people having to travel further, which is true for those people requiring highly technical care for very serious conditions, and what the professionals are saying and what we're saying on their behalf is it's actually better if you travel further in those circumstances. I think what's important for any petition or discussion is we are putting more things into Bishop Auckland, for a lot of people on that map that Diane was presenting a few minutes earlier, it'll be nearer to go, the travel will be less for day surgery, for cataract surgery, for

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rehabilitation, for a whole range of outpatient treatments, for a whole range of diagnostic treatments, for a whole range of follow up treatments once you've had perhaps a heart problem or something very serious, so I think it's important that we get that message across, and as I said at the beginning we're using more floor space under these proposals should they go ahead at Bishop Auckland than we do today. So with that if I can ask Bob to comment on your other, I think, very genuine question about the resources and the issues about recruitment.

BA: Yes, can I take the recruitment first, I mean we have in a number of places, you know, a number of services in North and South of the County, we've been all over, and one of the acute care physicians we've got in Durham was brought in directly from India, we've got a Spanish cardiologist working in Bishop Auckland, we've got an anaesthetist from the Czech Republic working in Bishop Auckland who we recruited directly from there in international recruitment drives. We've actually sent people along sponsored by the Health Authority to go to the European Community to try and find appropriate specialists to deliver the services. I think that's one thing, trying to find the people to basically provide the service as it was modelled in 2002, but as I was trying to, you know, stress in my part of the presentation, is that this, you know, driver for change around the critical mass and the need to have enough activity to be specialists is actually a real issue going forward, but it works both ways. I mean we keep hearing this, we've heard it said several times today, we're running down services. Well if I tell you that we're doing much more specialised colo-rectal surgery within County Durham than we were five years ago, and in fact if you take a condition called, well (inaudible) a sacral nerve stimulation implant, is that we do far more than Newcastle and we're one of the leading units in the country. Three or four years ago if you needed a shoulder replacement operation you would have needed to go out of the County to have that done. Now we deliver that service for the whole County at Darlington. We got people in and because of the catchment area of half a million people where they are able to develop an expertise and we are developing specialist teams, we can't have a team in every hospital but we can have a team within the County but actually it means that our patients need to travel this far.

DG: OK. Bob. One quick point please.

AA: The training of manpower is very tricky actually, if you remember the level Government when they came they said they would open new medical schools and they were going to have 10,000 more doctors, the problem with that is by the time it comes there ... the European Working Time Directive has come in and we will need more doctors, also different levels, we have some doctors, junior doctors in this country who are unemployed, but senior doctors are not ready, that's the problem. The other thing, just very quickly, I would love to work at Bishop, I would love to take all my team and go and I've told Bob that a few years ago, I would love to because it's a nice new facility, the problem is it's not big enough to take all our services there as Women and Children, it just didn't work.

DG: OK. Thank you. Gentleman on the end, you've been very patient there.

A?: *Right, thank you. My name's Alan (inaudible), Durham County Council, I did request you at Durham County on Friday and you had the whole team there with the Professor there. I do think the NHS and the hospitals and the exercise you're carrying out is very important. I did mention last Friday about the downgrading of a very good, modern hospital, A5 hospital which is costing a lot of money, which is about £10 million per year over 25 years, and to actually transfer a lot of the work including two ward closures down to Darlington. What did come out of last Friday's session ... and you did bring this in today, that basically you could not attract the doctors, the correct people, and you did mention the European Directive which I do agree that basis, we don't want junior doctors working 80 hours a week, that was all wrong, but I do think that you're sending the wrong messages to the public, the wrong messages to the staff by closing wards and downgrading the Accident & Emergency services. As I said last week I had a person who had a trauma in Spennymoor and the existing service was far from perfect, I think what you should be doing is you should be upgrading the current service at Bishop Auckland, bring back the two wards what you closed, make sure that it's 100% cost effective and then march forward. I think you're going the wrong way, and basically speaking, if you're talking about Option A, B, I think you'll find the majority of people are against it. Thank you.*

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DG: OK. Thank you. I don't know if there's a response, I don't think there was a question there.

SE: No.

DG: Can I ... because I'm just checking the time there, because of the short time that we've got, we want to get all the questions out, can I ask, as I'll ask the panel to be succinct, if I can ask people just to ask a question and then we'll get that answered straight away. The lady at the front?

?: (inaudible)

DG: Yes, can you use the microphone please? Just so that we can record it.

PW: *Hello, I'm Pauline Wilson, first of all but most importantly, I'm a resident of Spennymoor. Secondly, I'm employed by Spennymoor Town Council as the Town Clerk. I've got a couple of questions, if I can ask you them quickly. First of all, it was mentioned that the ... I'm concerned, personally concerned, about the acute services, coronary care and intensive therapy, that's my personal concern. You mentioned that the level of acute services was reduced from 2 to level 3, sorry from 3 down to level 2, yes. When did that happen and what consultation occurred in relation to that?*

BA: We've never actually delivered a level 3 critical care service in Bishop Auckland.

PW: *Right, well in relation to that, my basis premise having had both parents and grandparents very well treated at Bishop Auckland General Hospital even in the old tin sheds, I would say I would rather have a level 2 service at Bishop Auckland General Hospital than run the risk of either of my parents having to travel for a level 3 service, because the care they've had has been first class. That's my personal question. I've got a second question if I can, that's actually been sent in to the Town Council by a staff member from the hospital, addressed to the Mayor who unfortunately couldn't remain here, and if I can I would like to clarify something on the petition in response to something that was said earlier, because you've inadvertently I'm sure, been given incorrect information about that. It's been ... the question that was put to us, Darlington Memorial Hospital's an old, run down hospital. Is it true that £40 million will need to be spent on Darlington Memorial Hospital to update it and when it actually costs in the region of £60 million to build Bishop Auckland General Hospital?*

DG: OK. Steven is that one for you?

SE: Yes. Let me take the last part of your question first. We obviously, in our plans, want to use all of our sites. Darlington Hospital does need a lot of attention paid to its infrastructure, you know, the utilities, the support systems around the hospital, and as somebody else was saying there's also quite a bit of refurbishment required, that's work that's been planned for the last two years and is starting now, so that's been going in the last year, and we would spend probably over the next five to seven years around about £30 million on our current estimates to address those issues. The point I would make is we would have to do that anyway, irrespective of these proposals, just to be clear about that. Perhaps on the question if you feel Bob around critical care you could perhaps give a response on that and did you want to come back on the petition? I'll ask Bob to just respond to your ...

BA: May I comment on critical care first?

SE: Yes.

BA: I don't think anybody should take away the impression at all that the staff at Bishop Auckland within the critical care, the CCU staff, are anything other than excellent.

PW: *That wasn't intended to be suggested.*

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BA: No, I know that, I wouldn't say that you were suggesting that, but people shouldn't think that we have moved the patients because we thought that the care being provided by staff wasn't of the highest order. But I did ask the immediate past president of the Intensive Care Society, a lad called Andy Cohen from Leeds, who heads critical care in Leeds, to come and review our critical care plans in 2005 and we had an Away Day and he wrote to me and said, look, your service at Bishop, the recommendation by then out of the Critical Care Society was that we should be trying to get to level 3, yes? And it was definitely only a level 2 service. Now we have gone on with that because we had no incidents, the staff were doing a great job, but the problem you've got in that sort of situation you rely on very experienced staff, the anaesthetists for example are, to put it politely, would be of a mature age profile. Now we're actually facing a situation where by next March four senior anaesthetists will have retired from the Bishop Auckland site. If you then try and recruit new people and you're asking them to come in and provide a level 2 critical care support to an unrestricted medical take, they will run a mile, quite honestly, we've had these discussions, and you know it is a sustainability problem, you know, the staff have been providing a great service but it's trying to sustain that into the future, you've got to be able to provide 21st Century standards on the ground to attract the young consultants to come and work in your hospital and we can't do that across the whole County because there isn't enough work.

DG: OK. Did you want to pick up the issue of the petition?

PW: *Yes, just on the issue of the petition, I should say that the Town Council actually made it publicly known that the petition was available to sign but the signatures were actually only actively collected on two short periods, no more than three hours at a time. Everybody who was involved in collecting the petition which didn't make specific reference to A&E services, was basically are you happy with these potential loss in services at Bishop Auckland General Hospital and it listed them all clearly so it wasn't a specific A&E issue.*

SE: No, could I just make a brief comment perhaps, I think we ... I guess we're a little disappointed that the Mayor didn't listen to the whole of the consultation presentation today because I'm sure we're making some changes that mean some services move from Bishop Auckland, but we're also making proposals for an awful lot of services moving in.

PW: *I think if I can just say the problem I've got, you know, and I've listened to what you've had to say, and as I say I'm speaking here from a personal point of view.*

DG: OK.

PW: *Right. You say there's no cuts, just changes. Now I consider what I've said in terms of you know losing a level 2 service of acute care at Bishop Auckland to actually be a cut, it doesn't matter how you dress that up, I don't think that's a change, I think that's a cut.*

DG: OK.

PW: *And the other thing ...*

DG: Sorry, have you got a question to answer, one quick comment and then we'll need to go to some more questions please.

SE: I know you want to move on but if I can just make one comment on that. But equally you could then say that providing a significantly additional number of day surgical operations at Bishop Auckland which had previously been provided at Durham and Darlington is also a cut if you use that approach, whereas what we're saying is we're not ... we're moving services around as Bob's been describing to make sure we deliver safe care. Seeing all of our facilities as part of a whole. And they have to be, they're all interdependent, it's not a cut, it's a change, but it is for the better from a clinical perspective.

DG: OK. Thank you.

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BA: It's a reconfiguration effectively.

DG: Yes, can I just ...

PW: *Sorry, I have just one further question.*

DG: Can you be very very quick please so we can give the opportunity to other people.

PW: *It's not my question, this has come from somebody that's actually written in. They're asking where are Darlington Memorial and the University of North Durham going to support all these patients from the extra workload. What they're saying is Bishop Auckland General Hospital is constantly full and on GP divert to admissions, both Darlington Memorial and the University of North Durham frequently have no beds available and this has been a constant problem throughout the year and they haven't even started yet with the winter bed pressures, that's a question from staff.*

DG: OK. Can we put that last question to the panel?

SE: I can deal with it very quickly. We do have those pressures on all of our hospitals from time to time, it's not constant, in fact we consistently deliver very good results in relation to our emergency care activity, but on certain times, at certain times of the year and on certain days we do get significant pressures and we work together to try and manage those. In relation to the capacity question we estimate that with ... talking about the emergency care changes you're talking about roughly 30 people a day being affected by those on a regular basis, and the changes that we're making that are freeing up space by putting more things into Bishop Auckland means that our ability to cope with that extra caseload, we'd split, and I won't bother you with the details now, between Durham and Darlington, is perfectly adequate, perfectly adequate.

DG: OK. Thank you. I think we've got a question from ... did you still have a question sir or was it ... ?

DT: *Thank you very much. David Taylor, I live in Newton Aycliffe which is right in the middle of the two hospitals, or three hospitals ... you talked about specialisation and I'm all in favour of specialisation, but you also talked about balance a little bit, and I think we do need to be careful that we do get the balance right and I think we're gradually tipping the wrong way because we're getting more a critical mass, we're getting bigger and bigger and bigger, now this is fine if you live in the south where there's lots and lots of people, but we can see that map up there and we can see how diverse County Durham is, so we need to be a little bit more clever and we need to think a little bit outside of the box don't we? Not just think one size fits all, because it doesn't, and it clearly doesn't fit in County Durham, so these pressures that are coming down from the NHS and they're making recommendations of half a million people etc. etc., they don't fit, they don't fit in this scenario, so you cannot apply it. You can have your specialisation to a degree....*

DG: Yes, I think Bob wants to comment on that.

SE: I would agree entirely with you, I think if we weren't in County Durham and in the middle of Manchester we'd go to one site. We'd go to one site.

DT: *Yes, not a problem.*

SE: But we're quite clear for the reasons that you've said, but we've got a diverse conurbation is probably the way to describe it so we have to serve all of those parts of our population as best we can, therefore ...

DT: *Not as best we can ... not as best we can, the NHS ... the Government has pumped billions and billions into the NHS...*

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SE: Hang on let me answer because the second part of my question ...

DT: *You can't say as best we can.*

SE: None of this ... you're saying this is coming centrally, this is coming from doctors, doctors who deal with heart disease, doctors that deal with brain problems, doctors that deal with stroke, nationally advised, groups of doctors drawn some of them from our hospitals, drawn from all over the country, we were saying from international and national experience, what's the best way to organise ... that's what the specialisation is, we're not being told to do this, I'm being told to do this by these people who are trying to run a quality service so we need to make it really clear, this is about what we think, what these people think is right for local care, and can I just say one further thing around your point about the balance on specialisation. Take stroke care, the evidence is for stroke care you need swift high tech treatment. Your chance of recovery is much much improved if that happens. Now that's a very small percentage of the total care pathway. What we're saying about Bishop Auckland if we can bring that back into focus is for the vast majority of care associated with stroke and recovery in other serious conditions, it's going to happen locally, so the balance actually is very much in favour of local care in that respect.

DT: *Yes, it's going to happen in Middlesbrough, it's going to happen in Newcastle isn't it, we haven't got the money, we haven't got the expertise, we haven't got the teams in County Durham have we?*

DG: Can I ask Bob just to respond to that and then we'll move on to another question?

BA: Can I challenge you, because I mean I think we do.

DT: *You might look at one or two specialisms and that's all we will look at, and that's fine, I've not a problem with that.*

BA: Can I comment on the clinical model? Right. If somebody had asked me 12 years ago, there's a blank piece of paper, or there's a map of County Durham and I want you to design your clinical services. Like everybody else I would have probably said let's have a big new hospital near Newton Aycliffe, just off the A1, and that will best serve everybody. I'm absolutely convinced now during my time as Medical Director and I was very closely involved with the last consultation but I was in Akmed's job then, I was the head of the Maternity Service, but this time I've been very very closely involved with the analysis in trying to put a template together that allows us to deliver 21st Century standards for the people of County Durham, and as Steven said we've got a problem, there are two big conurbations at extreme ends of the County. I am absolutely convinced now and I've talked briefly about the successes of sacral nerve stimulation, of shoulder replacement and one or two other things that we could wax eloquent about, is that this model gives us a really good model to make medical care within County Durham absolutely robust going forward. Now our stroke model is going to have to be different in that what we're doing is putting the very specialist rehab into Bishop Auckland which might be for the whole County, in fact if people need intensive rehab it will be for the whole County, but the two acute heads of the service, the thrombolysis, the clot busting drugs, will be delivered at Darlington and Durham, so we'll have a County-wide stroke unit but it will be on three sites, and that's the way we have to organise our services, and there are one or two other services that are organised that way. I'm convinced that this model of Bishop being an elective centre and your two acute centres is the best one for us going forward.

DT: *Thank you. Just one point I would say, Lord Darzi in his wisdom has made five pledges to change. I wonder if anybody knows what his first pledge was?*

BA: We all do.

?: Front door.

DT: *Pardon?*

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?: Front door service.

DT: *Well his first pledge was that ...*

SE: Local, clinically led for the benefit of patients.

DT: *Change would be for the benefit of patients. That's his first pledge.*

DG: Yes.

SE: Yes.

DT: *The benefit of patients which is ... I mean we've all got the potential to be patients haven't we unfortunately.*

DG: OK.

BA: So do we.

DG: I think sir it's a point really well made and when we come to actually look at what comes out of the consultation, the final proposals of the PCT, they are the areas we'll look at.

DT: *Well what I was going to say is we do have a reduction in services don't we? Whichever way you look at it, we have a slight reduction in the service.*

SE: We have a change in service.

BA: It's a reconfiguration of services, we'll actually be doing more work.

DG: OK. Can I ...

BA: There's not a reduction in services.

DG: Can I move on to another question please?

DT: *His first pledge isn't even matched is it?*

BA: There is no reduction in service (inaudible) there is no reduction in services.

DG: I think, we've got a question there, we've got a gentleman behind you, we've got a lady at the back and then I'll come back to the two gentlemen there because you actually had a chance. Can I ask you to pose a very succinct question please?

CA: *Of course I will, of course I will. I'm not going to drag on, it's nice to hear other people contributing towards the consultation actually, but it was good of you to give ... by the way, I'm the spokesperson for Save the Hospital campaign group at Bishop Auckland. It was good to see that you were going to have us have two meetings on Thursday at Bishop Auckland. One at the technical college at 2 till 4, then at the Castle from 6 till 8. Now you've pulled the plug on the one in the afternoon, we're very concerned about that, that is the area where you really really should be consulting and now you're taking away a full afternoon of meeting. Now then I asked last week David if you remember if you could consider giving us an extra hour at the Castle in the evening, maybe a half an hour before that and half an hour after the two hours allocated to give the people of Bishop Auckland a chance, they're the people really, with respect to all of you people I've appreciated all the input that you've put in this afternoon, it's very constructive ...*

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- DG: Right. Can I just answer that quickly yes? There's a particular reason why we pulled that meeting as you described but actually what we're offering is that we're going to provide another meeting in the Bishop Auckland area if there's a need to and certainly as far as extending that meeting we're happy to do it, we can't extend the beginning of it but we can certainly look and see if we can extend it towards the back end of that meeting to allow longer questions.
- SE: Yes, that's fine, Clive, and I think the only thing I would just add very quickly is, in part that was .. and I think to your own question up in Shildon about being able to be exposed in some depth to Professor Sir George Alberti, and what we recognised was that in terms of registration there was very little registration at the afternoon meeting but clearly a lot of interest in the evening, so we felt that everybody ought to have the benefit of the Professor that evening, there's no problem in extending that nor indeed running a meeting later.
- DG: We can certainly run another meeting if we think there's a need for it.
- CA: *That's fine David and again I'll leave this one with you, we or me personally, have spoken to many people that work at Bishop Auckland hospital from that level to that level, none of them will talk to me. And I have it on excellent authority and I want to tell you this, none of them are prepared to talk, they are frightened to talk.*
- DG: OK.
- CA: *Now I know it's a point, but even at that level they're being told not to speak. OK, now I'll leave it.*
- SE: Well the short answer is ... the short answer is you want to meet with the staff at Bishop Auckland, we'll organise it. Talk to Edmund at the end of the meeting, we'll fix that up, but I'd like a member of staff from Bishop Auckland to say something.
- DM: I go ... I actually do bed management as well within Bishop Auckland, I'm going from this meeting to where I work on a Tuesday night, I go round every Tuesday night and speak to anybody that's there, if I'm there through the week I go out and say is there anything that you'd like me to say on your behalf when I go to these meetings or when I speak with any of the Exec. I'm surprised that they've said that because usually ...
- CA: *(inaudible)*
- DM: No, no, if you'll let me finish, I'm surprised that they haven't spoken to you, what I'm not surprised is that they feel a bit frightened about what they're saying and what's going to be repeated because as we repeat things it's repeated by somebody else, but they have the opportunity to come to plenty meetings to say to us, you know, what do you want to say, so they do have a voice, it may not be their voice, but if you ask anybody at Bishop and you say ... I'm very passionate about care, I'm very passionate about Bishop ...
- SE: But I think that has to be refuted, that is nonsense and I think what you have to do if you're going to stand up and say that Clive, take up on my offer, come and sit and talk to staff without me, without Bob, and hear what they have to say to you. With all due respect that's what you need to do.
- CA: *OK (inaudible)*
- DG: Sorry, can I just add to that ... Clive, sorry ...
- CA: *(inaudible)*
- DG: Right. OK.
- SE: Well then do that then.

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DG: The offer's been made, and the other offer that we made at the Sedgefield meeting when I had Amanda Hume with me, what we offered was because we're the honest broker in this as the PCT and we're not ... we haven't got any relation to the Foundation Trust, if there are issues about the way you think staff are genuinely frightened to come forward, they can come to us and we'll act as the honest broker, so I think there are two offers there to try and address that. OK?

DM: I would be more than happy to meet with you and work through it as well.

DG: OK. Thank you. Mr Ward, I think you had a question please?

MrW: *Yes, basically the general consensus here seems to be that most people are afraid because they think that what's actually happening at Bishop is clearly cut backs, regardless of what the panel says.*

DG: OK.

MrW: *Regardless of what the panel says.*

DG: OK. Do you have a question for the panel?

MrW: *And the whole point at the beginning of the meeting was this, the fact was you were saying that is not an option, that means, that sounds to me like you are dictating something. That is not an option. What the people want here is to have the choice and to be listened to. That is exactly what the people want, so you saying that is not an option, right ... this is supposed to be a democracy.*

DG: It is sir. Have you got a question to ask the panel please?

MrW: *Laughingly supposed to be a democracy. Sorry?*

DG: Have you got a question to ask the panel because we are running short of time and I want to give other people a chance to ask their questions?

MrW: *Right. If the people here today, if the consensus says we don't want the proposals you put forward, is the panel going to charge ahead and carry them out anyway regardless of anything that the people say?*

DG: OK. Because we're running the consultation, I'll respond to that. What we'll do is once the consultation period is over we will listen to all the evidence that we've got which includes evidence to the Overview & Scrutiny Committee ... can I finish please?

MrW: *Yes.*

DG: It includes all of the discussion from the consultation right the way across County Durham and Darlington, we'll listen to how those proposals have been adapted or changed by the Foundation Trust and then we'll take a view and that won't be until we get to February or March of next year, and I'll say a little bit as we close, but we will listen to what's been said and in light of all of the evidence we will make a decision.

MrW: *And could the likes of this gentleman be included?*

DG: The opportunity ... I mean this gentleman's actually had with his group the opportunity to be part of the Overview & Scrutiny Process and part of this consultation process.

MrW: *And so why are you not answering his questions then?*

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DG: We are answering his questions, I'm sorry, I think he's had ample opportunity and his colleagues have had the opportunity to be answered in part of the meeting. Now have we answered your question Sir, can we move on to the next one?

MrW: *No, you certainly haven't but I'll hand the mic ...*

BA: (Inaudible)

DG: Go on very quickly.

BA: I didn't realise when the slides were, actually I was talking to my notes, it's not me who's saying no change is not an option, I happen to believe that no change is not an option, but the actual head of the slide was in inverted commas, and that comes directly from the report that was written by Professor Sir George Alberti, who is actually coming to the Bishop Auckland meeting who is the previously Professor of Medicine in Newcastle.

?: *(inaudible) to Bishop Auckland.*

BA: He knows Bishop Auckland very very well. And he heads up the national Clinical Assessment Team and we invited them in to look at the clinical model to see if he thought it was appropriate. Now he did make certain recommendations to change things a bit, but he stated quite clearly that on a number of occasions in his report that we could not stay the way we are because it was very fragile and going forward it was not sustainable and could not meet the 2008 standards, and that's George Alberti, that's not just me. I happen to agree with him and we came up with the model before he came, but ...

DG: OK. Thank you. The lady here had a question. I'll come back to you in a moment madam.

BG: *Yes. Barbara Graham. I'm a member of the New Durham County Unitary Authority. We've heard a lot about what the general member of the public thinks. I haven't heard anything about the general practitioner and what their views are on this, I wonder if somebody could answer that please?*

DG: Bob is ...

BA: Yes, we have actually consulted with as many of the GPs as we could, the Durham Local Medical Committee which is a BMA group, we've also met with the various practice-based commissioning groups, and I'm going to have to say that there are a number of GPs within Bishop Auckland itself are a bit perturbed about the changes, but I have to say that of the GPs that I've spoken to, that's up the Dales and ... is that the actual acute model of care, they seem to be supportive of. They realise that we need to meet standards. What are their concerns is that will we actually deliver on our promises to actually bring services into Bishop Auckland, they want to see a robust future for Bishop Auckland as a hospital. We have to guarantee it because we need Bishop Auckland, we need to deliver the services that we've outlined to you to allow the other two units to function as the acute centres, so my experience has been that the GPs are very supportive.

DG: OK. Thank you. Lady at the back, sorry ... if you just talk to it, it's on, it should be OK.

LM: *Hello, I'm Councillor Liz Madison, I'm a Sedgefield Borough Councillor, also Spennymoor Town Council. I was involved in collecting signatures on behalf of the Town Council and I was surprised at the level of people who in fact were coming up asking to sign the petition so there is very much strength of feeling there. I did mention to the facilitator when we were in the group sessions that some of the concerns that I have is as has been muted previously with the transport system that's operating currently at Darlington, impossible to get a car parking space and logistically once inside impossible to find somebody who will actually deal with your enquiry, and then to be spending two or three hours waiting once you do get into a particular area, so I think the whole logistical thing needs to be resolved and listen to members of the public who are having these experiences. But also as regard to private transport, it has been said to me on occasions that by the use of taxis people are put into these taxis,*

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you know, they're all different shapes and sizes and some of them are having uncomfortable experiences, so once they then arrive at a destination to then have to spend three or four hours sometimes alone, you know, you have got some serious issues that you need to address. Thank you.

DG: OK. Thank you. I don't if there's a quick response to that?

SE: Very briefly on the issue about patient opinion and experience. Obviously every poor experience is one too many and we're very much focused on that irrespective of these proposals wherever we provide services. I would just say that of course we have the national survey every year of our patients and although we would want to do better in some of the areas, which I won't go through, the detail we can provide, in some of the areas you mentioned we score pretty highly compared to the rest of the country. It's not good enough, we want 100% but we're doing quite well. I think we're not quite sure about the taxis question, we do not use taxis for patients who have any form of disability or need to be taken home because they're recuperating from a hospital stay. And the third point I'd make ... the third point I would make is bear in mind that those people who are most ill, who need to get to hospital, are not using car parks, largely, they're using ambulances. For those people who do come into hospitals sometimes as they obviously do with a sick child and so on, they pull up outside the department, the staff come out and take the patient or the child in, that's what happens in practice, so there is absolutely no difficulty in terms of access for emergency care. But I do accept from the earlier point that you were making, absolutely, that experience around routine travel and so on is actually quite difficult and we're trying to address that.

DG: OK. Thank you. Gentleman with the tie on please?

MrJ: Yes, Mr Jackson, Aycliffe. There seems as though there's a lot of confusion and contradiction regarding the A&E at Bishop Auckland. Now the A&E has been a full A&E previously and has already been reduced. The proposals for A&E make it that, if I'm correct, it is not going to be an A&E. If you contend that it is, I'd like to know whether it will be doctor-led, and whether there'll be medical surgery available or will it just be nurse-led care?

DG: OK. Thank you.

BA: Yes. The model of care provided, we're talking about (inaudible) answering this gentleman's question earlier on, is that the model is, you know, you have a fully fledged A&E department and a fully fledged A&E department, I can't remember whether it's 50,000, 55,000 you know patients a year minimum, with co-located surgery, orthopaedics, level 3 critical care, right?

MrJ: I'm talking about the proposals that you have for Bishop Auckland.

BA: Yes.

MrJ: You keep denying that it's not going to change and it's still going to be an A&E, it isn't going to be an A&E if isn't doctor led.

BA: We're not saying it's not going to change.

DG: Can you just ... can you let ... Bob answer first please?

BA: Yes. What we will change it into is a thing called an urgent care centre and the proposal is that we put a GP ... or emergency acute service, and we merge it with a nurse-led or an emergency care practitioner-led minor injuries unit type of facility, which if you look at and analyse the activity, the pure A&E activity in Bishop, is that the vast majority of that is in fact of a minor injuries nature. So you will have a medical presence 24/7 but it will be a GP.

MrJ: Yes.

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BA: So there is potential for us to support that with a few clinics from the A&E consultants but that will be probably relating to patients who are (inaudible)

MrJ: *What I'm asking is will it be doctor-led, with medical surgery available?*

BA: No, there won't be any emergency surgery.

MrJ: *So it won't be A&E?*

BA: No, that's right. It's not A&E.

MrJ: *Exactly, you keep saying that there's going to be no change, it's still going to be A&E.*

BA: There isn't any emergency surgery available at the moment.

MrJ: *That is because it's been taken away previously.*

SE: Sorry the answer to your question The answer to your question ...

MrJ: *The way I look at it, Bishop Auckland is the most central hospital for the whole of the Trust area and if you take it as the central corridor, it's nearer to eight towns than either of the other two hospitals.*

BA: Yes.

MrJ: *And consequently it stands in good stead for that hospital to be restored to full A&E and work in full partnership with the other two hospitals.*

BA: Well can I say we did a lot of analysis about this before and looked at where activity, whichever site was the elective site, and I think Di can, she's got some of the travel analysis we've done...

DM: Yes, basically this slide is actually showing how with the proposals ... the green are actually patients who can access the units at Durham and Darlington, OK? The grey ...

MrJ: *But they're further away than the Bishop Auckland site.*

DG: Just listen, can you let Diane finish first please?

DM: If our services switch to Bishop Auckland, OK? So that's based on services switching away from Bishop Auckland, if our services switch to Bishop Auckland that's the picture that you get, all of that red, OK, are kind of numbers of ... numbers of households sorry, that would then be affected by not being able to access...

?: (inaudible)

?: (inaudible)

?: (inaudible) on there.

DM: No we haven't, not in terms of ... no.

?: *Well there's Sunderland and Hartlepool (inaudible)*

DM: That's Seaham .. we serve, those are people that have actually used our services. That's from existing patient flows.

?: (inaudible)

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SE: Can I answer ...

BA: No, sorry sir, you're confusing ... can I just tell you ...

DG: One quick response to this please?

BA: Yes, we did analysis looking at emergency activity, this relates more to elective, when we were trying to put together and I was in charge of the group, there were four groups below me and I was trying to put together the master plan as to how we should go forward, and we looked at if we made Darlington the planned site, Bishop the planned site, Durham the planned site and how ... when we looked at emergency cases, for taking the postcode, if we moved an emergency site, they did bring another neighbouring Trust, Gateshead, Sunderland, Middlesbrough, North Tees, they didn't bring that service, that A&E service closer to that patient than any of our sites. Now if I tell you that if Darlington was a planned site we potentially were going to lose about 9,000 spells of activity, that is patient episodes in a year. If Durham was a planned site we would lose about 22,000 spells of activity. If Bishop was a planned site, and patients would still travel to the nearest emergency service, we would lose about 300, and that relates to the highly specialised stuff we're talking about, so really from the clinical model and in effect that's the answer I was trying to make this earlier on about the ideal model for us as a County, is the way it is, one hospital wouldn't work because you try to put in one, you would leak so much activity to the site, it then brings in critical mass of activity and it makes us almost non-viable as a clinical organisation going forward. That's why we're configured ...

MrJ: But people are not asking about the Bishop Auckland being the only site, all we're concerned about is the total cover for the whole of the Trust area.

DG: OK.

BA: Yes, and that's what we're talking about, yes.

MrJ: (inaudible) as a partnership (inaudible)

BA: Yes, that's precisely what we're talking about.

MrJ: But we're more concerned about the A&E and the effects of the removal of A&E from Bishop Auckland.

DG: OK sir. I think you've made the point, I mean the point's been picked up.

MrJ: (inaudible) it's the most central site and it stands it in good stead to work as an equal partner with the other two hospitals, not to be ...

SE: Yes, we're saying the same thing. Can I just very quickly answer your ...

DG: Very quickly.

SE: Your point about what the urgent care centre is. 30,000 people attend now. OK? 10,000 of those people who currently go to Bishop Auckland will go to either Darlington or Durham under the new proposals.

MrJ: (inaudible)

SE: Hang on ...

DG: Can you let Steven finish please?

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SE: Let me finish, just let me finish ...

DG: No, I'm sorry sir.

SE: That's about 30 ... just let me finish. That's about 30 people therefore a day on average. Of those 30 people a day, already roughly half of those go to Bishop Auckland, are stabilised and then moved on to Durham or Darlington so ...

MrJ: *(inaudible)*

SE: Hang on. So ...

MrJ: *That is why if Bishop Auckland was full A&E it wouldn't happen.*

BA: It's got nothing to do with A&E.

DG: OK. Can I just draw things to a conclusion, I think you've made your point sir, we've registered it, we've tried to respond. What I'd like to do is actually just to move us on a little bit now because I'm conscious of the time, I'm conscious of the fact that it seems to be getting even darker in here which I apologise for. I've tried to give everybody a chance to have their questions.

?: *(inaudible)*

DG: Have you got additional points that are different to the questions that we've got?

?: *Yes.*

DG: I'll come to the two of you and then we'll wrap up if we can. I don't know if ... have we got the microphone for the gentleman at the end please?

?: *(inaudible)*

DG: No, can you ... it's just so that we can record it.

?: *Right. Thanks very much. I'd like to thank you officers of the NHS for coming and giving us the presentation, I think everything that they've done has been fine, I think the literature's been fine, the literature does say at present there is Accident & Emergency facilities at Bishop Auckland, Option A, B, you withdraw them, so I recommend that like I've done that everybody else does likewise, we can't afford to lose them. Coming back to two points that was made at Durham on Friday, and has been made today, that Bishop Auckland you say is expanding, the services are expanding, the specific request is that you open up the two wards that you closed, if it's expanding let's use it 100%. We've said before let's bring the morale back to the staff, not by downgrading it, it was said at Durham all you're doing is your downgrading Bishop Auckland hospital. Thank you*

SE: Well I mean I think all I would say is we're not downgrading, you know, I think people keep using that phrase but actually the hospital is under-utilised, it's not fulfilling the tax payer's commitment to it, and we're talking about using the hospital more. That's not downgrading.

?: *(inaudible)*

SE: I'd agree to disagree.

DG: One more question from the gentleman there please.

?: *I can't get away from the point where you said we're reconfiguring and then you're saying you have the problems for instance with recruiting the anaesthetists who are going to retire. I've just got this*

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feeling that out of all this reconfiguration and you talk a good argument and I understand and believe a lot of what you say, but I still think out of this reconfiguration there's going to be less resource available for major care at Bishop Auckland, and I think we should be looking at moving forward in getting the extra resource, new technologies are being made available, we don't want to be looking at running down ... sorry, I know you don't agree with running down.

SE: Yes.

?: *You're going to take more floor space up and you're going to utilise the hospital more, but at a lower level is my belief, and I think we should be looking to get these people in that you need, you've probably been told you can't have because of financial, or because the training isn't developed to produce these people. Throughout this reconfiguration I still cannot get out of my head that somewhere down the line Bishop Auckland is going to have less available than it would have had before, and that's basically for you and Primary Care as well.*

SE: I think if I could just make a very brief comment about that. We could do what you say, you know, we could do and we've had ... Bob has talked about the analysis. We could actually put all our critical care services at Bishop Auckland and Darlington, but then Durham would have the difficulty or the other way round Darlington would have the difficulty, we can't do all these things in three locations and it isn't about the resources. The Trust is making a £10 million surplus this year. We plan to make an £8 million surplus next year, and the year after that. Money is no problem whatsoever in resolving this problem. We cannot get professionals, nurses, doctors, therapists, whether it was Durham, Darlington or Bishop Auckland, to come and work in a modern ...

?: *(inaudible)*

SE: Well but my point is that if you were looking at this as we have to do, and I would suggest as County Councillors have to do, as a wider question, how do we provide to you high quality services in the future? All we're describing is how we think is the best way to do it, we cannot give everything to Bishop, everything to Darlington, everything to Durham, we have to use every hospital to make sure we can deliver the care that you deserve.

DG: Yes, OK. Thank you. Before we move on any further I would just like to thank members of the panel for answering the questions and I'd like to thank you for your questions and your input into the afternoon. What we've done is we've recorded everything that's been said, so either via the microphones, you notice Vaughan's been diligently writing down all the questions and the points there, and your facilitators in the group work have actually written down everything that was discussed, and all of that will be fed into the consultation process. This process runs until 12th January and what will happen then, which I touched on earlier is the Foundation Trust .. the Financial Times I nearly said ... the Foundation Trust will actually prepare the final proposals in light of the consultation, they'll get a report back from colleagues at Proportion who are writing this up for us. They will then come back to us at NHS County Durham, the PCT, and our Board will actually assess all of the evidence that I've described before which includes the consultation information, and only at that point will we make any decisions and that's likely to be, it says February, it's likely to be the beginning of March when we actually make that final decision. The only decision that's been made so far, and I really wanted to get this message across to you, the only decision we've made thus far, is that we've agreed as the PCT that there's a need to do something and that's why we've agreed to launch this consultation, actually run this consultation, this is very much about picking all of your views, so your input to it has been excellent, it's been really helpful that we've had that input and we'll take account of all of that.

?: *May I say Mr Chairman I consider we're very lucky with the medical care that we receive in this County.*

DG OK. Thank you.

SE: Thank you very much.

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?: *In this area I think we are very very lucky.*

BA: Thank you very much.

DG: OK. That's noted. Just finally, this is only one part of the consultation process. Consultation isn't all about public meetings, public meetings are an important part of it and there's a range of public meetings that we're continuing to run, but you can also actually fill in the consultation response form, hopefully you've had it through your door in a wrap around in the local paper or you've had it as a separate insert in the local paper, you can log on to the website, it's there, our PCT website, you can get a link to the consultation website. There's a separate website seizingthefuture.org.uk. There's lots of information there so if you feel as if you haven't got enough information please go onto that website. If you still haven't got enough information and you want any more then please come back to us and we'll try and get you the information that you need. You can also email or you can actually write to the Freepost address and all of that will be part and parcel of that consultation process that will actually close at 12th January and then we'll see where we go from then.

Thank you again. I must apologise again for the lighting. I've deliberately let us run over by about 15 minutes because we had a bit of delay at the start and there were lots of questions, but thank you and hope you have a safe journey home.

SE: Thank you.

BA: Thank you very much.

(End of meeting)