

Seizing the Future Public Meeting
Dales Centre
Stanhope
Thursday 27th November

Representing the NHS:

David Gallagher, Director of Corporate Strategy, Services & Relations - NHS County Durham
Steven Eames, Chief Executive of County Durham and Darlington NHS Foundation Trust
Roy Westhead, Clinical analyst - County Durham and Darlington NHS Foundation Trust
Bob Aitken, Executive Medical Director - County Durham and Darlington NHS Foundation Trust
Neil Munroe, Clinical Director for Medicine - County Durham and Darlington NHS Foundation Trust

DG: OK. Can I just explain what we're going to do now folks. Verna's obviously had the discussion with you and you've answered some of the questions. I don't know if Verna's going to ask some questions on your behalf to start with? Yes? Just to explain why the microphone's here, obviously it's not here so you can hear us because hopefully you can. Because this is a formal consultation process what we need to do is make sure we actually record all the questions and answers, so what I'll do is once Verna's finished asking questions on your behalf and feeding back on your behalf, if you've still got some questions you want to ask as individuals which you're very welcome to do could you just ... if you talk towards the microphone it'll pick you up, but I'll just ask you to identify who you are please before you ask the question if that's OK, and what we'll do is we'll record all of this and we're actually going to write .. we'll get the transcript written up so we see word for word what's been said as part of the discussion. OK? I just want to check you understand that. Yes, so ... to start we'll put the microphone over to Verna and I think Verna if you could just give us a couple of feedback points just to reflect what the group's said please?

VF: *Yes, absolutely.*

DG: And then we'll ask you to ask the questions.

VF: *Yes, sure. In principle do you accept the case for change, it was a very definite no, not from what people have heard obviously so far. In terms of how important was it that it was led by clinicians, well actually there was a perception that perhaps clinicians didn't fully understand the distances involved when they're suggesting that some people have to travel further, in terms of places like Lane Head which is miles out. Whether the consultation process is robust, there was questions over that as well. They felt that this meeting in particular had been poorly advertised. They didn't think that anything or very little had been put out locally, just one advert which they'd seen in the Northern Echo and that didn't mention registration either, and that was perceived as resulting in this very poor turnout. And in terms of the preferred option, well actually neither of the options were preferable because of the changes that would mean to Bishop.*

Overall there was a really strong view that this is more a PR exercise as opposed to a consultation in that things, the decision has been made and the proposals would go ahead irrespective, a feeling that Bishop Auckland services have been run down gradually. Pretty similar also ... or the parallel was drawn with Shotley Bridge hospital up in Derwentside, how that was run down.

And some questions that we have ... do you want me to pick up those questions?

DG: OK. If you could please ... can I just ... I mean I usually say towards the end but I'll just comment on the bit about this is a PR exercise. I mean as a PCT we're leading the consultation process and we're doing it because we have to do it, we have to do a formal consultation but actually we want to do it, it's really important that, you know, we do listen to people's views and that's across the whole of County Durham and Darlington, and I think I overheard as part of your discussion somebody saying that, you know, it was a waste of time or words to that effect and will it make a difference. It certainly will because when I describe at the end what the next steps are with this work, one of the key bits of evidence we listen to as a PCT, as the commissioners, the people who buy the services, is what was said in the consultation and how, you know, the proposals change in light of what's been said so ... I think I overheard a lady saying, you know, we'll see ... well yes, I guess ... judge us by our actions rather than our words is probably what I would say, but I will reassure you of that and I'll explain what

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the process is before we wrap up in a few minutes after some questions and answers, so having said that Verna if you'd like to ...

VF: *Yes. I mean the group questions ... one related particularly to the Golden Hour in relation to treatment and what this can mean for your care and how will that work in terms of the extra travelling that will be involved?*

DG: OK. Is that one for you Neil to answer please?

NM: Thank you very much. Yes, it's important to start treatment for any condition as soon as possible and as has already been alluded to by I think Roy in his part of the presentation ambulance services, paramedic services, now have the ability to start treatment at the point of arrival with the patient. They are no longer a service that simply scoops you up, puts you in the back of the ambulance and rushes to the hospital. As I mentioned in my presentation they may take heart tracings to establish if you've had a heart attack, they can beam that down through radio waves to the hospital so that the hospital knows what's coming, they can start oxygen and what's called nitrates, drugs under your tongue to open up the heart arteries, start aspirin therapy, so the Golden Hour is important, the initial time to start treatment is important but one of the key things is having the right people to start the treatment and just on that example you see where paramedics can actually start treatment in the Golden Minutes after arrival and not just in that first hour.

The next key thing after that as I mentioned in my presentation is getting to the most appropriate place first time, to see the most appropriate specialist team first time and we need to be able to deliver that, not just the guy at the front door, but all the back up of the hospital service behind him, whether that's surgical services, orthopaedic services, intensive care units, we need to provide the whole gamut and be able to provide that for whoever comes to the door every time. Now if we have a situation where we can provide a bit of it, but not quite all of it, at some point somebody's going to say I wasted my Golden Hour getting to a place that couldn't deliver the right service first time.

?: *(inaudible)*

NM: I absolutely agree with that.

?: *(inaudible)*

NM: Yes, I'm aware that there are concerns with ambulance services, those are not part of these proposals and David may have something to say on that particularly, but we recognise the need for good ambulance services because they support what we do in hospitals and vice versa.

DG: Yes, I mean I'll just comment very quickly on the ambulance, I think Neil's right, it's not part of these proposals but obviously it has an impact on them. One of the things that we've done, the PCTs have actually put investment of £625,000 investment into providing extra ambulance services in the Dales and that £625,000 is for the Dales alone, that's not spread across the County, it's just for the Dales. Obviously when we hear the final proposals coming from this we'll need to take all of that information into account, you know, as we look at the proposals and whether we support them or not.

NM: *(inaudible)* one further point about understanding the distances travelled. I started my consultant career at Shotley Bridge hospital, I still go to Shotley Bridge hospital at least twice a week to undertake clinics and other services there. I know how far it is from Durham to Shotley Bridge and beyond that into Castleside and up to Wakerley or down to Rowlands Gill and all that sort of thing. I know where things like Billy Row and what have you are, because those are where my patients come from and I make it my business to know where they come from and how far they've had to travel to get there, and I would argue that I'm not alone in that. Many of my other consultant colleagues who do clinics at hospitals other than where their main site is know an awful lot about the area in which they work. Many of them have visited people at home in the area. Not everybody has been everywhere, but many have.

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DG: OK. Thank you. Have you another question Verna please?

VF: *Yes. This was quite a specific one ... apparently there's currently a medical ward in Bishop Auckland and we think it's used for emergency admissions, will that be moved to Darlington and University Hospital and, if so, what will happen to that ward?*

DG: That's another one for Neil.

NM: You're hearing a lot of me. The answer is that acute medical admissions will go to Darlington or Durham so that people coming in acutely with medical problems will no longer be admitted directly to Bishop Auckland, and those are for the various reasons that have already been discussed at this meeting this evening.

What we will be able to do is ensure that people, once they're over the acute illness, as we talked about the rehabilitation service and coupled with that if you read the options in the papers, as an intermediate care or step down service, is encourage people to move back to closer to their homes if they're going to be in hospital more than a small number of days, and just to use the analogy of Shotley Bridge once more, we do still have medical beds at Shotley Bridge hospital, we're currently running between 20 and 30 medical beds at Shotley Bridge hospital and if I have somebody on my ward who is getting better but isn't quite at the point of getting home and lives in Consett, just a couple of miles from Shotley Bridge hospital, we will use those beds as a stepping stone to getting them home, and this is very popular with patients and their families because it means they don't have to travel as far.

We have the advantage with other hospitals, community hospitals run by the PCT as well which we can also use as a stepping-stone to getting people home. Chester-le-Street's another example of that. So yes, acute medical services will move, that includes coronary care, it includes acute medical admissions, but the reasons for that we've already been through in terms of specialisation and getting the best possible care at the first time you come in the door.

BA: Can I just add a wee bit there? I do stress that the main driver at the minute for the move of the emergency service is the lack of critical care support. There is a very strong recommendation nationally that if you're taking acute medical admissions into the hospital you should have a level 3 ... remember the 1, 2, 3 levels ... of intensive care available to support and we're not able to supply three level 3 units in the County.

We've only ever been able to supply level 2 at Bishop. Now for the last year there's been a relatively unsatisfactory situation from our point of view where the sickest patients in the medical unit at Bishop, on the medical ward, who then go to the high dependency unit or the intensive care unit, are having to be transferred to Darlington or Durham to get the necessary level of support that they require.

?: *One of the reasons you said that was that you couldn't get staff.*

BA: That's correct. Yes.

?: *You said, you know, you advertised and you couldn't fill the posts. Why? Can you tell us why?*

BA: Well one of the main ...

?: *Are you not prepared to pay what another hospital pays?*

BA: We are prepared ...

?: *(inaudible)*

BA: I'm sorry ...

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?: (inaudible) salary levels.

BA: Well we like to not set precedents for pay but we can pay premiums. The problem you've got in Bishop Auckland for anaesthetics, because that's the ... it's the anaesthetists that provide the cover for the intensive care unit, is we do not have accreditation for the training of junior hospital doctors in anaesthetics. So you can't use trainees, so it's a special grade of doctor called a Trust doctor or a staff grade doctor that you need to apply. Now the way things have happened in junior doctor training and a reduction in the number of doctors that are coming in from overseas for example in the last few years, it means that the staff grade, Trust type doctor, there aren't nearly as many available. The Trust gave me a lot of money, I was told go find six doctors to provide that. Sorry?

?: (Inaudible)

BA: Well I mean the nursing staffing levels are not a problem. The nursing staff in the critical care unit at Bishop are alright. The medical staff are excellent but we need to provide an extra six doctors to provide that level of resident tier and we've not been able to find them. That has been the issue.

?: I say is there a specific reason that you can't ... (inaudible)

BA: No, it's just that they don't apply for the job. They don't apply for the job. Yes.

?: Because I thought it would be a good area to come to reside in.

BA: Yes.

?: (inaudible)

SE: On your specific question, it's not about money at all, we've got plenty of money to invest in additional medical staff. We can't get them because young doctors won't come and work in a situation where they could see within a year or so the service will be unsafe, how they won't be able to train properly, that's why they choose not to come because of the way, as Bob has said, we can't provide three centres for critical care. It's not possible, so that's why ... they're making a choice about their career and about the environment that they want to work in.

DG: OK thank you, Verna?

VF: Yes, and I guess this last question is probably linked to the discussion that we've just had. Bishop Auckland is seen as a really good building which is valued, not only by people in Bishop Auckland, but by people in a much broader area. Why are you going to change things and centralise them in Darlington and Durham as opposed to centralising it in Bishop Auckland?

DG: OK. I'll ask Steven to answer that first.

SE: Well not all of us ... couldn't agree more with that ... we ... it's a fantastic facility, it's actually the best hospital facility that we've got, and indeed you might know it's a private finance initiative hospital which means that we are paying, using tax payer's money, for that hospital for the next 25 years. We're not fully utilising the hospital now. I did mention in my very first slide I think that we'll use more floor space in the future should our proposals go ahead than we would otherwise, and I think ... I know we've talked a lot and understandably about your concerns around emergency care.

I'd just like to show you very quickly if I can find it here ... here it is ... this is what we're doing at Bishop Auckland and this is about some services being closer to you than they are now. This is the top floor and what this is showing you is that we're using the whole of that top floor for surgical activity. Much of that activity isn't happening now. This is new surgery, more orthopaedic care, eye surgery is going to be done here, which it isn't done here now, and it means therefore that older people, people I

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guess that you're representing here who often have cataract problems, it's usually because they get older, it's going to be near, that service is going to be nearer for people in this community than it is now. That's 16 miles rather than 30 miles, if I use that example, so I really would like you to at least appreciate from what we've said tonight, it's not all in one direction, we're talking about using the hospital as a really important part of what we do in the future, you know, and if you go through the floors, this is just describing what we've got there is largely remaining the same, on the floor below that. This is the ground floor. I mean Neil talked about what we're doing in terms of the emergency medical care, all of this is the outpatient and diagnostics on the right, everything that's there now stays there.

On the other side where the blue's highlighted here, this is, you know, a very significant investment in rehabilitation and recovery, therefore if you or your family need that you're not travelling to Durham or to Darlington or to Shotley Bridge or to Chester-le-Street for that, which actually you might do now in current circumstances, you'd be going to that facility there which we're aiming to be state of the art. And then if we go on to the lower ground floor that's where we'll have all our infrastructure around the urgent care centre that colleagues have been describing, so I think, you know, it's important to I guess acknowledge as well that while some things may be changing for the reasons that clinical colleagues have said, there's an awful lot coming back in the other direction.

?: *Excuse me, you said the top floor is the theatres.*

SE: Yes.

?: *And you said there's no so much surgery done, because you've closed the surgical ward just a few months back.*

BA: (inaudible)

?: *It's been reduced hasn't it because I've been in as a patient a few times and it's ... you said there was less surgery, well there must be less surgery if you close the surgery ward.*

SE: No, no, no, but we're talking there about highly complex surgery. Currently something like 70% of all surgical activity is short stay day surgery and the likelihood over the next few years is there'll be more of that, so we're talking about the majority of surgical activity, that which is done on a day treatment basis. We're talking about the majority of that happening at Bishop Auckland. Now I'm sure Bob would say that for major complex surgery you need the critical care facilities alongside that and that's why we have to move in that direction and that's why that change was originally made, because we have to make sure that if you have a major surgical operation you get level 3 critical care should you need it.

?: *Right.*

DG: OK. Thank you. Thanks. Was that all the questions from the group Verna?

VF: (inaudible)

DG: OK. Thank you for reflecting that and hopefully Verna's reflected the issues that you had and your questions. There's an opportunity now if there's anything else that you want to ask and I think we started to get into that, anything you want to ask the panel and we'll get them to answer your questions now, and can I just say that before you actually ask your question just to identify who you are just so that we can record it please.

?: (inaudible) *Can I ask one?*

DG: You can, yes, yes.

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GB: *I'm Gwen Bright and I do the voluntary group.*

DG: OK. Yes.

GB: *I've done it for 16 year. Has any of you been to the top end of the Dale, (inaudible) up there? Do you know where the (inaudible) Council are?*

DG: Steven?

GB: *Do you know how far it is from (inaudible) to the top of the Dale? Because it's a lot further to go to Darlington.*

SE: I wonder if you might answer that question Roy, do you want to do that because (inaudible) travel implications are (inaudible)

RW: One thing that (inaudible) you know, I said we'd done quite a lot of work looking at the travel implications.

GB: Yes.

RW: We've got a few maps here now, they look a bit complicated actually, they're complicated to me actually, but ... what we've done is we've looked at all of the patients that came into our hospital as ... or hospitals ... as elective patients, so when you plan to come in for a planned operation, in the last full year we've got information for which is '06/'07 and we've kind of mapped that activity on these maps here, looking at what the implications of public transport would be, so I'll just point to the map actually, it's probably easier.

This is the map, there's Sunderland here, Durham here, Darlington down here, Bishop Auckland here and then obviously Weardale here, and Teesdale here, Stanhope's ... Stanhope's right there. On this map all of these areas highlighted in green are areas that you can currently access our hospitals in less than an hour on public transport, so obviously in an ideal world all the patients we treat would be able to get here within an hour but we realise, you know, people living in the kind of ... you know, the far reaches of the County, that's difficult for them, so these little black dots, all these up here in Weardale, are areas where people have to travel more than an hour on public transport.

If we flick on to the next slide ... the areas that have turned red are areas where if we make these changes we've pushed those patients into the group where they have to travel over an hour. Now what this map is showing us, if we go ahead with the changes we're planning in Bishop Auckland, these areas in red are people who have been, if you like, badly affected, they've been adversely affected and they've been pushed into the hour group, so you see, as you'd imagine, people living in Bishop Auckland are going to have to travel a bit further so that's why those areas have turned red. Obviously, you know, the areas that are wider out ... they've kind of remained more or less unchanged, but if we move on to the next slide ... these areas in red now, if we made the changes the other way round and kept Bishop as an acute site and, if you like, changed the services on the Durham site or the Darlington site, all of these households in red would be pushed into the hour group, so really what these maps are telling us is making the changes on the Bishop site makes a lot more sense because a lot less people are affected and this, like I say, is focusing on people who have to use public transport which are the people who are, you know, most likely to be negatively affected by the changes.

???: *So it makes no difference to (inaudible).*

RW: It makes no difference to the patients ... the people on the periphery right on the edge of Weardale and Teesdale.

???: *The last slide's going to make a difference because that's where your population is in the urban areas isn't it?*

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RW: Yes, yes. Now this slide again ... is I think really interesting, this again looks at all the Durham postcodes, and what we've looked at in these columns here, we've actually said how many patients would be better off if we make the changes we're proposing, how many people will be worse off and how many people will be about the same, and again, this reflects .. relates to inpatients who are coming in electively. Now the overall figures are more people will be better off or about the same than would be negatively affected by these proposals, but what's interesting in this kind of top box here is, for people who live in DL13, and like I say this is based on the last year's activity and we can't say, you know, for ... the activity next year will be exactly the same but it's the best kind of ... it's the best information we've got that we can look at accurately. For people of DL13 we think ... again, related to the patients, the activity in the last year, 205 patients would be better off in terms of the amount of time they'll have to travel and just a small number, just under 30, would be worse off. The reason for that is if you're having, for example, a hernia repaired tomorrow, the likelihood is now you would have to travel to Darlington for that. After we've made these changes you'll just be travelling to Bishop Auckland so that's where these figures come from.

SE: Thanks Roy.

DG: OK thank you. Another question from you ladies and gentlemen?

?: *Yes. All these proposals are, for Bishop and all, you know, we've got a community hospital at Stanhope, will that be in any way ... will you be putting any services out to there or not?*

DG: I'll take this if you like. As I mentioned this doesn't affect directly those hospitals.

?: *No, I appreciate that.*

DG: One of the things that we're very keen to do as commissioners, again, the people who actually buy the services, to make sure we make as best use we can of all of those community hospitals and actually on the map that Roy's just had up, there's actually a ring of community hospitals around the main hospital sites that we're talking about. Now we're very keen that we actually make better use of the Weardale hospital here, the Richardson hospital, all of the community hospitals, Sedgfield, Peterlee Community hospital, Shotley Bridge has been mentioned, to make better use of those services so that people don't have to go into the big hospital sites unless there's a need to and it all links to the specialisation discussion that we've had so we're very keen to promote and support that and we'll be looking to do that and getting providers of services, the Acute Trust and community providers, to make sure that they actually do that for us.

SE: Can I just add to that David? Just adding to that, things have moved on even as we're discussing Seizing the Future, things that are not directly a part of it, but we have already ... my diabetes specialist colleagues are in discussion with general practitioners about holding diabetes clinics in the surgeries rather than in the hospital, just as we've said before, moving them closer to the patient when they don't absolutely have to be provided at the hospital, so we're piloting a project with general practitioners initially around the Bishop Auckland area, but there's no reason in the future why other communities such as Stanhope or anywhere else, if there are willing general practitioners who want to co-operate and have that sort of discussion with the PCT, we can look to providing services further out than we currently do. Now that's not part of the Seizing the Future proposals, it's part of other general improvement in the quality of our care that we're trying to provide.

?: *Yes, at one time you used to do this.*

SE: Indeed ...

?: *And it's stopped now.*

SE: Indeed, it was more common in the past, you're quite right.

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?: Yes.

SE: The intensity of medicine, changes, fashions and fads change, there's been a move away from that, and there's now a big move back towards that and, you know, consultants that I work with day in day out, particularly younger consultants as they're coming in, understand that close working with general practitioners and with patients out in the community is part of the way forward.

DG: Thanks. I think Pat would like to comment as well ... just to keep me fit!

P?: I just wanted to pick up on the point about the work that we're doing that Neil's raised in the practice in Bishop Auckland. That's been done under an initiative within the Primary Care Trust and it will be formally evaluated to then see whether or not we can roll it out, so that's one of the reasons why we've supported that initiative, was for it to be properly piloted and to be evaluated for us to get patients' views about the experience, whether or not they felt the service was as good, and we would then look to roll out that if the experience of patients has actually been beneficial.

DG: OK. Thank you. Any other questions? No? Sure? OK. First of all, I just want to thank you all for coming along tonight. It's actually quite nice having a small group, you can have hopefully a bit better of a conversation rather than having sort of a (inaudible) and more informal, and hopefully we can ...

?: *Can I ask a question?*

DG: You can, yes.

?: *What's the general feeling with the top consultants whether they want to keep it as it is, or change it, what's their opinions or are they keeping quiet?*

DG: OK. I'll ask one of the top consultants. Is that what you are?

(Laughter)

BA: I was ... I was a top consultant. There is no doubt there is an overwhelming consultant opinion that the changes, particularly for the acute services we're talking about, the emergency services, need to be made to sustain the viability of services. As Neil already said though our teams realise that, you know, the way forward is to work closer with the general practitioners and where appropriate to try and bring services into communities, so actually deliver clinics in local community hospitals, etc. etc. etc. So only have people travelling to hospital when they really need to do that. I mean I'm a gynaecologist by trade and we did, after the last consultation, did provide a lot of services, you know, pre-operative assessment etc. and discharged ladies early from Darlington because there's where we centralised surgery, and then we'd a team that goes out to do the post-op care in the homes and stuff to make it more amenable, and that's been a very successful service, so you know there is overwhelming support from our consultants for the direction of travel, but with the understanding that we need to try and take community services closer to home.

?: *(inaudible) the change.*

DG: OK. Thank you. Just a little bit about what happens now basically. This is only part of the consultation process and I'll say a little bit about that in a moment but because we're using microphones we've captured all the issues today and hopefully you've had a chance to ask all the questions that you want to ask and hopefully it helps you understand issues a bit better. The consultation itself runs until 12th January and that's because there's a statutory period that we need to run for and we've actually added a couple of weeks to that because Christmas is in the middle of it. At the end of the consultation process Vaughan and my colleagues at Proportion will actually write up all of this for us and give a report to us at the PCT, but also to the Foundation Trust, and what they'll do is they'll sit down and look at the original proposals and as you can hear I think from some of the

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conversations tonight that they're sort of looking at the proposals and changing things and adding things in light of the discussion but they'll have some final proposals that they'll bring back to us at the PCT and our Board will then sit and listen to the evidence from the consultation, from Overview & Scrutiny committees who are part of this, from themselves in terms of proposals, and then we'll make a decision on whether, you know, they actually go ahead or not. The key bit about that is that no decisions will be made and I heard Verna talking about this earlier. The only decision to be made so far is to actually embark on the consultation process and that's purely because we think as a PCT that there is a need for change, but the whole process is about, you know, what should those changes be, what do local people think, how they feed into that, so we get the right answer for local people basically.

In February/March then we'll make a decision on that and obviously we'll let people know, we'll probably have a public Board meeting and it's looking as though that's going to be the beginning of March, where we'll actually consider all of these issues and then we'll make a decision on whether the Trust actually proceeds or not. As I said before, this is one part of the process, it is disappointing that not many people come to some public meetings and we're looking at that, we'll reflect on it, but actually the public meetings are a small part of the consultation, so people have had the information through the doors, there's a chance to actually go onto the websites, there's a website link there, www.seizingthefuture.org.uk, and on that website there's lots more information, so there's all the information in the leaflets and things that you've got here, plus some of the background information because you can't capture it all in those documents.

There's also the chance to go online and actually respond to the consultation so you can do it electronically and at the moment more people are actually responding electronically or via the post than are through the public meetings, and that's fine because there are different ways that people will actually respond to it. If people want to they can write, there's a Freepost address that's actually in the back of all the information, you can write in with comments and views, or they can email their comments and their views as sort of free text. So lots of ways of doing it. I want to thank you very much for coming along tonight, actually being part of this part of the consultation process. Hopefully you've got a better idea of some of the issues from it. We've actually learnt a lot from what you've said and we've got some of the views, you know, what your issues are and we'll make sure that they actually feed into the consultation process and we'll take account of that when we get to the position at the end of February/March. So thank you to the team for coming along and presenting. Thank you Verna and her colleagues for actually, you know, trying to articulate your views and comments, but thank you very much to yourselves for coming along and hopefully, however far your travelling home, you have a safe journey home.

?: *Just disappointed with the turnout.*

?: *Yes.*

DG: Yes, and we'll look at that and we'll reflect on it because we have tried to advertise this as widely as we can and we'll see and, you know, if there's a reason why, you know, people haven't been turning out tonight, we'll see if we can do something else to try and supplement the meeting. I really do want to thank you for coming along.

?: *A lot of people who don't maybe come to these meetings because they think it's cut and dried.*

DG: That's possible.

?: *That's maybe the attitude, you see.*

?: *Yes.*

?: *A waste of time.*

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DG: Yes. And hopefully, you know, as I mentioned earlier will judge us by our actions rather than our words and, you know, we'll try and engage people by different means, but ... thank you all very much. I do appreciate you being here.

?: *Yes, thank you.*

?: *Thank you.*

DG: I'll turn the microphones off

(End of meeting)