

Seizing the Future Public Meeting
Teesdale District Council
Teesdale House, Barnard Castle
Tuesday 4th November

Representing the NHS:

David Gallagher, Director of Corporate Strategy, Services & Relations - NHS County Durham

Steven Eames, Chief Executive - County Durham and Darlington NHS Foundation Trust

Annie Dolphin, Non-executive Director - NHS County Durham

Brian Key, Non-executive Director - NHS County Durham

Bob Aitken, Executive Medical Director - County Durham and Darlington NHS Foundation Trust

Andrew Cottrell, Consultant Paediatrician - County Durham and Darlington NHS Foundation Trust

Neil Munroe, Consultant Physician and Clinical Director for Medicine - County Durham and Darlington NHS Foundation Trust

DG: OK? Yes. OK. I'd just like to welcome everybody to this which is the second meeting that we've had as part of this consultation on Seizing the Future. My name is David Gallagher. I'm one of the Directors at NHS County Durham, formerly known as County Durham PCT. I've got a couple of colleagues with me to the left here I'll ask to introduce themselves from the PCT.

AD: Yes, I'm Annie Dolphin. I'm a non-executive director of NHS County Durham and I actually live in Teesdale as well so I have a particular interest with the ...

BK: Good evening, my name's Brian Key, I'm one of the directors (inaudible) by County Durham PCT. Thank you.

DG: Thank you. We've also got colleagues from the Foundation Trust here. I'll ask Steven Eames to actually introduce as they come round as part of the presentation if that makes sense. I don't know if you want to say hello to people Steven?

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

BA: Good evening ladies and gentlemen. My name's Bob Aitken and I'm the Trust medical director.

AC: And good evening, I'm Andrew Cottrell. I'm a consultant paediatrician at Bishop Auckland.

NM: Hi. I'm Neil Munroe. I'm clinics director for medicine for the Trust as well. Thanks.

DG: Thank you gentlemen. We've also got scattered around the room a number of members of staff from the Foundation Trust and from the PCT as well and we've got Mr Tony Waites who's the Chairman of the Foundation Trust with us as well this evening. What I'm going to do is just run quickly through the process for this evening, explain a little bit about what the roles are and then we'll get into a presentation and then some actual work that we'll ask you to do and ask some questions really.

To start with our role within the PCT. We're here today really because we're actually running the consultation, we're leading on the consultation. We don't actually provide the services, this is something fairly new to us, we actually spend our time actually commissioning or buying health services and healthcare services for all the people of County Durham and Darlington, and as part of this process our role is to run the consultation with

assistance from some colleagues from Proportion who will help us later on and to make sure that there's a fair process, everybody has a chance to have their say, it's robust, and then to make sure that all of that is taken into account when the FT, the Foundation Trust, come back to us with some final proposals linked in with the consultation. I'll say more about that towards the end of the evening when I actually explain the next steps.

County Durham and Darlington FT obviously here, they are the people who actually provide the acute hospital services and the discussion we're going to have this evening and this consultation period is about three of their what we call acute hospitals, so it's the three big hospital sites that they've got. They have other hospital sites, nothing will change with the other hospital sites, nothing will change with the community services other than, as a PCT, we're looking to actually commission more services closer to home, and that particularly means making better use and making greater use of community hospitals, primary care centres, health centres etc. The consultation discussion tonight is very much about the three main acute hospitals in County Durham and Darlington and the presentation will explain what that's about.

We've also got colleagues as I say from Proportion who are with us. They are playing a key role, they're helping to facilitate the whole thing. Vaughan's hiding behind the flipchart in the corner. They are playing a key role in terms of actually helping us manage the process. One of the reasons that we've got microphones strewn about the place is because it's a formal consultation and we need to capture all of the views that people have we're actually recording all of the session as we go through it. We're also going to record everything on flipcharts and when we do some table work we'll actually record the work that you're doing on the tables as well, so everything that you say will be recorded, will be fed into this formal consultation process.

The aims of the meeting tonight are there and the key bit that I really need to stress is that this is about two-way communication and that means there's a chance initially for the Foundation Trust to put their case if you like, and we need to listen to that and understand it. There are then two opportunities which I'll explain in a moment where you can actually give your views back to us in terms of clarifying some issues but also your views on what is being proposed and then we'll explain to you at the end of the evening what we're actually going to be doing with this work and the information that we glean from you to take it forward.

The Agenda's there. Obviously the presentation from the Foundation Trust, there will then be an opportunity and if you can save your questions please until we get to the ... to after the presentation where we'll take open questions from the floor and they're really questions about the presentation that you've had and about the consultation. There's then a second bite at the cherry if you like to have a discussion and we're going to do this around the tables that you're sat with and we'll have staff there to facilitate those discussions, to actually get your views and to record some specific responses that we'll feed directly into the consultation. We'll have a quick bit of feedback towards the end of that session and then we'll have five minutes towards the end, leading up to about 8 o'clock, where I'll just actually wrap up and explain what we're going to do with the work that we've got and what the next steps are. So hopefully that's the sort of thing that people are expecting. What I would ask is that when you do ask questions towards the question session you actually identify yourselves so we've got a record of who's asking the questions, that would be really help. All of that said I'm going to hand over to Steven and that team and we're going to ask them to give their presentation, about thirty minutes for this and then we'll get into the series of open questions. Thank you Steven.

SE: Thanks David and good evening everybody again and thank you for being here to hear from us tonight on such a wet and horrible evening. I'm just going to set the presentation up with a few key messages and I'm going to hand over then to Bob and to Nel who'll take you through the clinical case that we're making in relation to the changes that we're proposing as part of Seizing the Future. Then I'll come back at the end with a couple of slides to finish up and then move into the next stage as David has outlined. Just to point out that this programme which has been running for ten months now is about two things specifically. It's about organising our clinical services in the future so that we can ensure that we provide high quality care and improve the outcomes for our patients. And secondly, therefore, to ensure that we continue to provide for all of our communities, for all the people that we serve, excellent services. That's what we're attempting to do by making the changes that we're proposing.

Five key messages that I want to get across right at the outset. First of all, this work which has gone on for some considerable time as I've said has been led by our clinicians, by our doctors, our nurses, our therapists. They've worked through in some detail together with many of their colleagues the proposals you're going to hear. We've also worked very closely as a Foundation Trust with our governors who represent our communities and indeed with our members with whom there's been a lot of interaction between our clinical staff and them in developing these proposals, so we've had a lot of engagement leading to this particular point.

What are behind these proposals are two principle changes that we're needing to respond to. One is the need to centralise and concentrate our services to ensure that they're safe and some of our services currently are facing some real challenges in that regard, particularly in emergency care and critical care as you will hear. On the other hand, what we're looking to do, along with the Primary Care Trust, is deliver as many services as we possibly can as close to the community as we can and in that sense that's why our hospitals are so important and as you probably know we operate services from five hospitals across County Durham and Darlington and I want to make it really really clear that what we're looking to do is maximise the use of all of those hospitals. Yes, we're looking to do things differently than how we do them today, but what we're looking to do is maximise the use of those hospitals and I want to emphasise very very strongly, you may have seen other messages contrary to this in the media, there are no hospital closures, there are no service closures, there are changes in services but no closures, and indeed there are no redundancies. We believe these proposals provide real and exciting opportunities for our staff in the future. So with that I'm going to hand over to Bob who will take you into the clinical case. Bob.

BA: Steven, thanks very much. Good evening again everybody. I'd like to say two things just to kick off, having had the first meeting last night, the first lady who asked a question said things seemed very technical and some of the expressions I'm going to use trying to explain the changes are a bit technical, but we haven't got a great deal of time for me to spend the whole event trying to explain them, so if you want anything clarified please make notes as I go on and I'm more than happy to have a go at the kind of question and answer session to try and explain things a bit better for you.

The second thing I think I would like to say at the outset, just to clarify certain things, is that the present configuration of our acute service, particularly in Country Durham, are a direct result of a previous service review that was carried out by Lord Darzi in the says when he was Professor Sir Ara Darzi, Professor of Surgery at St. Mary's Hospital in London, and I think to just clarify and correct one or two things that have appeared in local newspapers recently, that

for a long time now there hasn't been a full A&E service in Bishop Auckland. We haven't had any trauma cases going in, that is people who are badly injured from road traffic accidents or acute emergency cases, for the best part of ten years, so there is a limited service already, right? And we'll go on to try and explain in a bit more detail as to what the proposals are going forward.

So let's take why we need to change. I think there are a number of national drivers that I want to talk about. These national drivers are modified to a degree by some local pressures. Now if we could just address the local pressures first. They tend to be mainly around the recruitment and retention of suitably qualified medical staff and the recruitment and retention problem has got two parts to it, one is that in ... particularly the south of the County, there are some of our specialties, when you look at the ages of consultants, have got quite a mature profile, so we've got the potential for upwards in some specialties of 30% of our consultants retiring within three to five years. The newer generation of doctors are looking for a much better balance work life, a home lifestyle, and they're not prepared to work as long hours at the coal face as we were used to doing in our day and still as consultants, still do in lots of cases, and nobody can blame them for that really. I think part of the reason is for that, there's a lot of students going into medical schools now are ladies and there are certain times where about 80% of female doctors decide that they want to have families and the most important thing in their life changes from their job to their family and that's perfectly understandable, but it does .. does give pressures to when we're trying to find ... put teams together to man our acute services.

So that said, what are the national drivers for change? First one up here is specialisation. From that we mean ... I want to talk about the centralisation, the necessary centralisation that is being driven by quality issues and the complexity of medical treatments that we undertake these days, and the complexity takes two forms. There are certain procedures we're now performing that involve very highly specialised, very expensive pieces of equipment that rightly have to be centralised in regional centres and Neil will talk a wee bit more about that relating to heart attacks and things later on, but also the surgical procedures now are becoming much more highly complex and you have to be a very highly trained specialist to perform these. The second point I would make about that is an expression I'm going to use which I'll use a few times during this brief presentation, is critical mass, and what I mean by critical mass is the amount of activity, so the number for example, of highly complex operations of a certain type that a specialist would need to do to be continually, or continuing to be recognised as a specialist in that field, and that's very very important when you look at, for instance, in cancer surgery, you know, where there was a drive under the cancer agenda around 2000, the national cancer strategy, to centralise cancer operations in the hands of a fewer number of specialists rather than generalists and the experience nationally, as had been proven before internationally in particularly Germany and America, is that outcomes for patients when the surgery of that type is concentrated in the hands of fewer surgeons, the outcomes for patients improve. Now there is some evidence going forward now that in acute emergency care it is actually better to centralise services, it's actually better for even very acutely ill patients to be taken a bit further after being stabilised by paramedics and on a Blue Light ambulance and taken a bit further to an A&E department or an acute unit that is actually properly staffed and has the proper equipment to really give high quality 21st century care. The outcomes again are better in those cases.

Doctors' working hours is another national driver for change. By that I mean a piece of legislation called the European Working Time Directive. It's been introduced, particularly to junior doctors in this country, in three phases. Now the final phase which reduces junior

doctors' maximum working hours from 56 hours a week to 48 hours a week comes into force next August, in August of 2009. What that means for us as an organisation that if we take those doctors' hours out, it means that we lose the equivalent of 31.4 whole time equivalent junior doctors on the ground, the presence of, because they can work fewer hours. That has quite a significant effect on our emergency on call rotas. It renders a significant number of our on call rotas across the organisation what we call non-EWTD compliant, that is we cannot deliver it unless they break the 48 hour limit, so we can't make them work that way because when then the specialist training committees come round to visit, if we can't give these doctors working conditions that allow them to work less than 48 hours a week we lose recognition for training of junior doctors. That would be catastrophic for the organisation. So it's an issue that we can't continue to do. We've got to try and rationalise these rotas going forward.

There have been particular recommendations specific to certain specialties. In Accident & Emergency I've already alluded to the fact that there isn't a full A&E department in Bishop Auckland now, yes? But in 2004 there was a new Royal College formed called the Royal College of Emergency Medicine and in 2005 they made recommendations for what facilities should be available in a full A&E department and, again, the expression critical mass, how much activity that needed to be going through an A&E department, particularly of what you call Category 3, and I'll just explain this very briefly, applies to A&E and similarly to critical care, is that the patients are classified as Category 1, 2 or 3, the third being the most sick, the most in need of very high level care, the 1 in A&E terms being the walking wounded, yes? So the Royal College of Emergenc Medicine made recommendation for critical mass and what became very clear is that we didn't have a full A&E department in Bishop but we certainly didn't have the critical mass of activity in County Durham to have three full A&E departments. So there was a need really to rationalise how we were providing that care.

In acute medicine, that is people presenting with Blue Light ambulance, with medical conditions, chest problems, heart problems etc. etc. as opposed to surgical problems, the Royal College of Physicians made recommendation in 2003 that we should be having special type of doctors called acute care physicians who should be responsible for looking after these ... the sickest people while ... just after they present, for 12 to 24 hours, stabilise them, start their treatment, and then pass them into what Neil frequently terms the 'back shop' to teams of 'ologists' so sub-specialists, cardiologists, respiratory physicians, gastroenterologists, who will then continue to provide the more specialist care. The Royal College also made recommendation that an 'ologist' should always be available, so that means they had to work in teams of at least two so that if somebody's on holiday or study leave there's always at least one sub-specialist available. Now in the County, as I said yesterday in Sedgfield, more by accident than by design, we actually are able to deliver this model of care in Durham because of a previous merger of the acute medical services between Shotley Bridge and Dryburn hospitals, so the medical team is big. We are unable to deliver that model of care in either Bishop Auckland or in Darlington. There you are. And we haven't been able to do that for some time.

There's also an issue around critical care, and the critical care is really fundamental to the delivery of acute care going forward. In 2002 when Professor Darzi reviewed the services, the recommendation at that time was that the critical care support that was required for an unrestricted medical admission, that is any person suffering any medical condition should be taken into a hospital, was that you should be able to treat level 2 patients, not necessarily the most sick level 3 patients. But since 2002 that recommendation has changed. Yes? And they've now upped that to say that if we're delivering 21st century care that we should be

delivering a level 3 critical care support. Now when you again look at the recommendations of the Intensive Care Society who are the specialists in critical care, they have actually come out in 2006 and made a recommendation, again, this word of critical mass of activity and they have stated the critical mass of level 3 activity that you need to maintain an expertise to have a fully fledged level 3 critical care unit and surprise, surprise, in County Durham we don't have enough overall critical mass to have three fully blown level 3 critical care units, so again, a really heavy driver for us to look at how we configure our services.

The children's care, the paediatric service, is mainly an issue around recruitment and retention. They are among one of the teams where our consultant body is of a rather mature age profile and we would have difficulty recruiting into the model of care, particularly that delivered at Bishop which is a bit sad because the one thing I would say about the team at Bishop, they have provided a brilliant service over many years and in fact ten years ago it was actually being recommended by their own Royal College of Paediatricians as being the gold standard of care that should be delivered across the country. That has changed, I think relating to the attitude of some junior doctors now and what they're looking for when they become consultants and that model is no longer now being recommended and our paediatricians feel that we need to rationalise the way that we deliver our care going forward.

So what are our recommendations? As Steven alluded to, we worked ... I chaired a thing called the Clinical Reference Group and below me there were three Service Strategy Groups, one of them led by Neil who you'll hear from shortly, and we came up with a recommendation eventually, after many months of working very closely together, of two acute sites for County Durham which would be fully fledged District General hospitals with a full A&E at Darlington Memorial Hospital and at University Hospital, North Durham. We felt very strongly that the acute services, really the emergency services, for the sickest medical patients should be removed from Bishop Auckland but we would still maintain, and I'll go into that in a bit more detail, an acute presence, and we would develop Bishop as a planned centre, for planned care for the County, and the two community hospitals, there's very little we'd change, although we're planning to try and increase the amount of activity that's going through these.

So what are basically the implications for the various sites? Down the left hand side we've got what's in Bishop at the minute, Accident & Emergency and the Blue Lights going in are almost entirely medical patients and minor injuries. The activity ... A&E activity at Bishop is mainly level 1, walking wounded, with a few level 2 patients. There are no level 3 patients or higher end level 2 patients going into Bishop, and haven't done for quite a long time. Acute medicine, including stroke, goes in there at the moment, but under the recommended changes they would then be redirected to ... 70% to Darlington and 30% to UHND. Midwifery led unit would stay as it is. Acute paediatrics at the moment is just for limited hours and there are recommendations that we would take forward. Neil will actually outline these bits in red during his part of the presentation. The planned surgery etc. will stay the same although we are recommending that Bishop as the planned care centre becomes the default centre for suitably ... clinically suitable patients for the whole of the south of the County and some of the north of the County, Shotley Bridge will take some of the northern clinically suitable patients, so the amount of day surgery for example being performed will actually increase.

The critical care we're delivering at Bishop is presently at level 2 and that will no longer be delivered, but we will be providing an intermediate care for the local population and under Option B we've got a really quite exciting plan to develop a centre of rehab excellence which Neil will talk a bit more about as well. We also have plans to open a standalone cataract

centre for the ophthalmology unit. These apply to both the acute sites, the Accident & Emergency, fully-fledged A&E departments at both sites. Acute medicine and the acute stroke that presently goes into Bishop will be divided as I say 70/30 between Darlington and UHND and the acute admissions for paediatrics will be taken to UHND and Darlington also. All three sites will have a full range of diagnostics and outpatient facilities as there is at the moment.

So why do we choose Bishop as the planned site? Because obviously we went through a whole process that considered the implications of any of the sites being the planned centre and the other two being the acute sites. Bishop obviously being more central seemed to us to be the best placed site for planned care. The facilities are excellent. Sir George Alberti was invited to come in as the leader of the National Clinical Assessment team and he agreed the thought that ... you know, Bishop really was the prime centre for being developed as the planned site. But we also did some much more detailed analysis. We looked at how long it would take to ... if for example Bishop became an acute site, we would need to build several more wards for it to be able to accommodate, so we looked at how long that would take and how much it would cost. We looked at how many members of our staff would be affected if either of the sites or any of the sites was the third site, and then we looked at the impact of patient flows and the main way we looked at that was if we moved an acute site from say Durham or from Darlington or from Bishop and we took the postcode of the patient's address, did it bring any neighbouring trusts nearer to that patient and therefore was their potential for losing that activity to outside the organisation which under the new NHS regime means that we lose income and therefore it makes us less viable as an organisation. On all of these counts, by a clear margin, that the analysis pointed to Bishop being the site that should be developed as the planned centre.

What I'm going to do now is hand over to Neil Munroe, who's already introduced himself. Neil's the clinical chief for the medical division in the organisation and he led one of the ... the Medical Service Strategy Group below me and if we get the go ahead to implement the changes, he will lead the implementation group that will lead on the acute care agenda, so he's your man will all the inside knowledge of this sort of stuff.

NM: Thank you Bob, it's a bit of a build up but there we are. Thank you very much ladies and gentlemen and once more thanks for coming out on a wet and windy night. I'd like to just take a step back to something that Steven said earlier on when he mentioned that these proposals had been developed by clinically led groups and I'd just like to emphasise that these proposals were put together by doctors, yes, nurses, physiotherapists, and also members of the public, our Trust governors who are lay people like yourselves who have opted to become involved with the organisation. They live throughout the County, north, south, east and west and they've been represented on all the groups for both medical and emergency care and for elective care, for paediatrics, for obstetrics and for X-rays and all the sort of diagnostic tests, so these aren't something just handed down from central Government or the Strategic Health Authority, these are developed by real people who live and work in County Durham. I would put it to you that we wouldn't put something on the table that didn't make sense to us as people who live and work in County Durham and whose families live and work in County Durham, so these aren't just something handed down from above, they are part of the organisation, they're part of the community before we start.

Now one of the things that's already been touched on from what Bob said is that people expect and their relatives and carers expect that they get the most appropriate specialist care at the right time, when they come into hospital with a particular condition. As Bob's already

alluded to, if you come into hospital, I'm a chest consultant, if you come into hospital with asthma or bronchitis you would hope that you will see a chest consultant, a chest specialist, at some point during your admission to hospital, but if you have sites which are too small and only have say one chest consultant on that site and he or she happens to be away for a couple of weeks as some of us occasionally get away for a couple of weeks, it may be that you'll be looked after by a perfectly competent general physician who can do the basics of your care but can't add in that extra something, that extra tweaking of your medication to make it the best possible treatment, that can't arrange the same level of follow up to make sure that you get the best possible recovery and remain as well as possible from your chest problem into the future. Now there are at least two of our sites, Bishop and Darlington, both have single-handed specialists in one or more disciplines on each site and by amalgamating those two acute sites we can ensure to the best of our ability that we have a chest consultant, a diabetologist, a heart specialist, a gastroenterologist for your stomach problems, available to you no matter when you come into hospital. We know that patients need to be seen by the right staff at the right time and that's not just the doctors I've been talking about, but also the nursing staff who are accustomed to looking after patients with chest problems, gut problems, etc. so being on the correct ward by concentrating our resources, targeting our resources to where we need them, we can ensure that patients get on the right ward, get the best possible treatment throughout their stay.

By dividing up our services into a centre with greater emphasis on planned care we reduce the chance of those emergency admissions getting in the way of people who are planned to come into hospital to have an elective procedure, whether that's something for joint replacement, whether that's a day case procedure for ... to have your gall bladder taken out or a hernia repaired, those are the sort of things that often get put back or cancelled because of weight and flood of emergency admissions coming in and some of you may have experienced or had relatives who've experienced this. Now by dividing up our planned care from our emergency care we can better ensure that people get in when they need to come in for their planned surgery and also that as the turnover of patients is less on those wards we reduce the chance of people coming in with acute infections interrupting the care of those patients with planned care, so reduced hospital-based infections as a result of separating out those services.

Another point that Bob made earlier on was that we're planning to use Bishop Auckland as a centre of excellence for rehabilitation. Just yesterday evening we were having a discussion with the stroke doctors and nurses, the stroke team, from across the County, as to how best we could plan management of patients who come into hospital having had a stroke. Now already we have stroke units at Bishop Auckland and at University Hospital in Durham, and we've got a great team who provide a good acute care and excellent rehabilitation. But we're not satisfied with that, we want to do it better than that. We want to make sure that anybody who comes in with a stroke gets best possible treatment on a centre that can provide that 24 hours a day, seven days a week. That's the target. But we also want to make sure that they recover to the best of their abilities so they are more likely to get home and be able to function and do the things that they used to do before their stroke, and by targeting and centralising our rehabilitation services at the Bishop Auckland site, ensuring that they get maximum therapy input, physiotherapists, occupational therapists, speech therapists, to improve people to the best of their abilities, we can ensure that they get home in the best possible state, and that's not just going to be stroke, it's going to be people after operations for example orthopaedic operations, people after more general surgical operations, and maybe others who have had other acute medical illnesses, bronchitis as I said before, other things, may benefit from that rehabilitation. Not everybody will need to go there for rehabilitation but many will benefit from that.

And finally by concentrating our services we allow ourselves to plan tests and diagnoses. I'm going to come to that in relation to the A&E proposals in the next slide, but by better planning our care we can better schedule tests so that they're done as soon as possible and the most appropriate test done well. None of this means that we're doing things badly just now. We've just scored very highly on a national rating, but nevertheless we believe we can do better still and get all these things done to the best of everybody's ability and to the greater satisfaction of our patients and indeed their carers.

Specifically with regard to A&E, this slide perhaps should read the other way round, so I'm going to start at the bottom and work up. Already a proportion of patients who attend any of our A&E departments, or who might attend any of our A&E departments, do not do so, they already ... we already move people directly to major centres, for example for heart attack treatment, a recent development just this year, to the Freeman Hospital or to the James Cook for what's called angioplasty, to open up their blood vessels. We already have people with major head injuries going to James Cook Hospital and Newcastle General Hospital for neurosurgical intervention, and as Bob's already said, for some years serious trauma and major surgical problems have not stopped at Bishop Auckland but have gone to Darlington or on occasion to Durham for the most appropriate treatment, so we're starting from a point where Bishop Auckland specifically but also other emergency departments for other conditions, already have other services centralised outside of our own hospitals. One of the myths that's been going around is that the patients ... sorry, the emergency department, the A&E department at Bishop Auckland will close. That is not going to be the case. We have analysed how many patients come along to Bishop Auckland Hospital, to the emergency department, each year and that falls at around 29,000 people a year come to the emergency department at Bishop. Of those, under these proposals, 20,000 of them will still have the same treatment that they're currently having at Bishop Auckland at Bishop Auckland. Of the remaining patients a proportion of them will go into the new services described in Bob's slide, the Medical Rapid Access Service, where general practitioners see patients and they're not quite sure whether or not they need to come into hospital but would like them seen by a specialist and perhaps have some tests done, we'll be able to arrange those patients to come down in a planned fashion, have the tests and on many occasions get to go home directly, perhaps coming back to a clinic at a later date for the results of investigations, rather than our current position where the general practitioner either sends somebody or they send a routine letter to the outpatient clinic or gets them admitted as an emergency to a hospital bed. Now I don't know how many of you have ever come into hospital not expecting to have to come into hospital, but having spent this last weekend on the emergency unit of the hospital in Durham, there's a significant proportion of people who came along saying I didn't think I was going to get admitted, I thought I was just going to come down and be seen. This service will actually cater exactly for that population which we estimate to be around 20-30% of patients can be turned around without spending a night in hospital. What we're trying to do is to avoid them even getting tucked up in bed.

Finally we know that patients from the top of the slide there do benefit by travelling for more specialised care and there's good published evidence to support this. I've been through all this once before because I started my consultant career 15 years ago at Shotley Bridge hospital and Shotley Bridge about three or four years after I started there, which had been planned before I started there, we amalgamated services at Dryburn hospital in Durham, and one of the fears was at that point, that extra 14 miles down the road on a wet night would lead to people becoming less well, arriving at hospital less able to get better. There's been no evidence to support that over the course of the last 12 years, 11 years sorry since we

amalgamated the services. There are no obvious increases in the number of people turning up who have perhaps deteriorated or died en route, that just hasn't happened over the course of the last 11 years. So I would like to reassure people that we can provide high quality care by centralising our emergency services and that we can give them more specialised care when they get there and that that can be done safely with the support of our ambulance colleagues, the paramedics, with the support of our critical care units backing up our emergency departments and the specialist on site. Thank you for your time. I'm going to hand back to Steven now.

SE: Thank you Neil, and I'll be brief now but one or two further important points. Many concerns have been raised throughout this process about access and transport and I'm sure some of you in this room hold the same concerns, particularly for more elderly people in the communities that we serve. I just wanted to reassure you that we're taking that into account. First of all, just building what Neil was just saying about emergency services. To support the changes in emergency care we're proposing there is greater investment in ambulance services and more critically in paramedics on those ambulances because the key thing is stabilising acutely sick people where they have their illness. Secondly, we would ... there is the patient transport service that will continue that provides a very important service and, thirdly, specifically we're looking to invest quite significantly in a transport service, a new transport service, that will move patients and their families and visitors around the communities to the hospitals. Now this is not something that we've just brought together without any research. We know a similar service currently operates in the north of the County. This will be bigger than that and we're currently planning a lot of detail as to how to put that in place if these proposals go ahead and that will provide a significantly improved transport network than the one we have at the moment.

Just to make one point about this slide ... Professor Sir George Alberti who you've heard about once or twice during the presentation made it very clear in his review because of the reasons that Bob and Neil have set out that no change is not an option and our concern professionally as the stewards of your health services locally is that if we can't make these changes then we will not be able to provide quality and patient outcomes will be affected. That's the key point on that slide.

So just to finish then ... this is not actually ... I don't know why this slide is called Benefits for the Trust, it's really benefits for the organisations but more particularly benefits for you and the communities that we serve. I mean I think it gives some clear certainty about the future for all of the services that we currently provide from all of our hospitals and moreover it gives certainty for all of those hospitals which I want to re-emphasise and I hope it's been outlined in the presentation, all play a key role in what we're trying to do in the future, and underpinning all that is strong safe sustainable local acute services for you all in the communities that we serve in the future. Thank you David.

DG: Thank you Steven. Thank you gentlemen and thank you to everybody for being patient and listening to that. We've now got two opportunities for you now to have some feedback into this and to ask some questions and I'm going to start with some 20 minutes or so when there's an opportunity for you to actually clarify anything about the presentation or about the consultation. Do you need to use this mic for that? Yes, OK. What we'll do is if you want to raise your hand if you've got a question, we'll get the mic to you and this is important because we're actually recording this. If you would indicate who you are please just for the record and then if you ask your question and if I could ask you really if you could stick to questions about what you've heard today or what you've read in the proposals. There's an

opportunity to have further discussion around the table after this session. So we've got 20 minutes of this now. Has anybody got a first question?

TC: Thank you. Tony Cook, Teesdale District Council. Whilst you've indicated that the three hospitals in Durham are going to operate, one of the problems you've indicated is that Teesdale has a problem getting to these. One of the other problems that hasn't been looked at is parking facilities when people make their own way there and if I can take Darlington Memorial, I need to go there at least an hour before my appointment. At 5 o'clock at night you can actually see the car park empty so the majority of the people parking in there are people who are working around the area. At Milton Keynes they're actually operating a system now where you get a ticket to park in the car park and a designated place for A&E or what have you. Can that system be operated at all in the north?

DG: OK. I'll ask Steven to respond to that please?

SE: Yes, thank you and thanks for that suggestion. I'm sure that suggestion and others we need to look at, particularly around car parking at Darlington Memorial because you're absolutely right, it's an issue. We do have some plans for change around car parking and the other thing I would say is the transport system I refer to ought to help minimise the use of car ... car traffic into the sites, and finally by organising the separation that Bob and Neil were talking about, we would see more of our routine care moving to Bishop Auckland where I think the car parking issues are ... you know, there's less pressure there. OK. But we'll take your suggestion on board, thank you.

DG: OK. Thank you Steven. Got a gentleman in the back corner there?

SH: Simon Hoods. I have a couple of questions, particularly in regards to Option B. This Trust doesn't look after the Richardson hospital or for that matter the one in Stanhope either which are community hospitals and are very important for the local people here. I wonder if there's been any kind of study in terms of the long term impact, demands etc. that some of the rehabilitation work which is my understanding, is something that the local hospital also does here, is there any impact or any danger to our local community hospital in terms of what you're proposing and have any studies been done with regard to this?

The second question I have ... are you ... I wasn't quite clear what the Chief Exec said there, whether he was committing as a result of these changes to make Darlington Memorial a level 3 A&E hospital .. is that the intention to achieve that?

DG: OK. Thank you. I'll answer the first part of the question about the community hospitals at large and hopefully, one of the things I said at the start of this was that one of the things that we're looking to do as commissioners of services is to get more services delivered closer to the home and that actually means probably providing more services from the likes of the Richardson hospital, from the hospital at Stanhope, from Shotley Bridge, from lots of other hospitals as well, that are around the periphery of the County but provide a really good service, we'll do an awful lot to provide more services from those. I think Neil wanted to add something to that in terms of how the proposals would affect them.

NM: Yes. I mean just to try and encourage that we're actually looking to move out of our sites. Just last week we approved as an executive director group a plan to move some diabetes clinics out into the community at the request of the general practitioners so that patients were receiving the same level of consultant care but not having to travel as far to do that. So we

have a commitment ... we've talked about our own main hospital sites, but we recognise that there are hospitals here that we want to aid the PCT in fully utilising.

SH: *Sorry, I wasn't quite clear. There will be no negative impact as a result of these changes on the community hospitals, that's what you're sure of?*

NM: Yes, we're assuring you of that. I was going to say no, but yes!

DG: At the moment Darlington A&E is a full A&E department as would be expected in a District General hospital which takes level 3 activity. It shouldn't be confused however with the recommendations that came out last year for the centralisation of trauma services on a regional basis where people who have got serious head injuries and multiple traumas, they actually ... there's a national recommendation that there are perhaps say 10 of these in the country, so there will be a very major trauma centre somewhere in the north east but we would doubt very much whether it would be in County Durham, but we would still receive level 3 patients into Darlington and into Durham.

SH: *(inaudible) only University of Durham by chance was level 3 in terms of the staffing levels or the ...*

DG: That was in acute medicine yes.

SH: *Yes. That's right. So is the intent, again, to have that level ... achieve that level at Darlington Memorial?*

BA: Yes. Yes, that's what we were saying, if we ... as Neil alluded to, if we merge the two, if for example, as we say recruitment is a problem, to take ... to provide the model of care that we presently provide in Durham, if I remember my calculations, we would need to raise the number of consultant physicians from 15 to about 26 across the south of the County. If we actually put them together we can probably deliver that ... we can deliver that level of service with the 15 that we've got, perhaps going up to 17, which makes it much easier. Also the youngsters who are coming in as acute care physicians they're much more likely to apply for jobs where they're working with bigger teams with plenty of 'ology' support behind them, so I'm sure it will be a significant improvement.

DG: Thank you Bob. We've got a question here.

RB: *Thank you. Richard Bell, Councillor. There's been a lot of concern in Teesdale about poor emergency ambulance response times so naturally people are concerned when they hear that the A&E facility at Bishop is going to be sort of downgraded yet further. I think we all know people who have gone to Bishop to be told we can't treat you here with accidents of various sorts, so my question is really what exactly will the urgent care centre, the 24 hour one at Bishop treat, when you say two thirds of A&E patients will continue to be seen at Bishop? What exactly would it do? Because above all I think we need clarity on what Bishop Auckland can do. I hear of people who go there to be told they can't be treated. Equally I hear of people who don't bother going to Bishop in case they are told they can't be treated, so above all I think we need clarity, but what exactly will Bishop be able to do for A&E?*

DG: OK. Thank you. I'll hand you over to Neil.

NM: Thank you for that question. Many of the patients who come to the A&E department at the present time have relatively minor problems that can be easily dealt with. Those may be minor fractures, it may be cuts and things that can be stitched fairly readily by our experienced and trained nurse practitioners. These people already exist and deal with, as I say, round about 20,000 of the 29,000 patients that currently come along. All those things will still happen at Bishop Auckland. What I would hope is that patients, members of the public, ambulance staff will have clear guidance, depending on the outcome of this consultation process, of what the service on offer at Bishop Auckland will be. They will then be better able not to turn up not knowing whether or not they're going to get the appropriate treatment, but they will turn up, they will go ... immediately make their way to the most appropriate thing, most appropriate service. Obviously that will also apply to patients coming to us through NHS Direct whose supply or direct rather many of the ambulance services to the appropriate patients. So I think it would be difficult to go through a list of what will and what won't come along right at this present time, but you're right, there are patients, there are about two patients a day currently turn up to Bishop Auckland A&E department with orthopaedic or surgical problems who have to be redirected elsewhere and those are figures that are, you know, based on the last two or three months, they're right up to date as it were. So we hope that ... well, we would anticipate that we will have a public information campaign for members of the public, for general practitioners, ambulance crews, NHS Direct, that clearly set down what is most appropriate for each unit. Already we have patients who attend the minor injuries unit at Shotley Bridge. Now we would expect that this service will be a little more than that. I've already mentioned the medical rapid access service for patients with medical problems, so that not all medical problems will have to travel to Durham or Darlington. Indeed, if that service is successful, there's no particular reason why patients from Durham or Darlington shouldn't travel to Bishop Auckland to access that level of care. Paediatric problems, similarly, a proportion of people turn up at A&E who could reasonably be slotted in to an urgent paediatric clinic service and Andrew Cottrell I'm sure could comment further on that if you want to talk specifically about paediatrics. Has that answered your question? In a roundabout fashion?

RB: *(inaudible)*

NM: Yes, Yes. I think we're all queuing up. Mine was really only thank you for raising that, I just wonder whether it would be helpful for us to summarise as clearly as we can following on from tonight for anyone, for all of you, particularly for Councillors, a bit of detail behind your question, would you find that helpful, because I'm sure we can do that.

RB: *I think so because you've said that at the moment Bishop does level 1 and level 2 but no level 3, well I don't know what they are.*

NM: No, exactly and this is ...

RB: *(inaudible)*

NM: That's very helpful and we'll endeavour to do that and we'll get that out across colleagues.

SE: Can I just make a comment on that. I stood on the platform at the last, you know, public consultation and at that time I was the Head of Obstetrics and Gynaecology Services, but the one thing that really caused me significant concern as I went round meetings such as this was that in general the public who, you know, hadn't worked in the medical profession or, you know, worked in the health service didn't know a great deal about it other than what they

thought happened, they really felt that if you had an Accident & Emergency sign above the door that the services behind that door in Bishop Auckland were the same as they were in Durham, the same as they were in the RVI in Newcastle or St. James's University Hospital in Leeds, and that really did vex me because in my time as Medical Director I have to say that rather than there being issues that worried me about patients having to travel a bit further for treatment when they've had to go and bypass Bishop because they were trauma cases is that we've had a number of close calls, there hasn't been anybody died because of it, but there've been bits of delay where people have self-presented perhaps with a very sick child in the back of the car in mum's arms and we don't have, you know, the paediatricians have closed down for the night as it were, now fortunately they've been available to cover the unit at pretty short notice, but despite the fact that we did a lot of what we thought publicising what was there, there was a lot of people that just didn't seem to have gotten the message. We've had people who've self-presented with other problems that have deteriorated rapidly and we've had to very quickly, and we must thank the ambulance service for that, is that they have managed to get them to Darlington or to Durham very very quickly for, you know, as it were life-saving treatment, so there is ... we've got to be honest with people, we've got to say, what is there, what is available and what is not available.

DG: OK. Thank you. I think that was a useful discussion. I think that certainly once we get to the point where whatever comes of the consultation, you know, if the proposals are taken forward, there's a role for us to play as well within the PCT to actually just help people understand exactly what you go to which facility for because there is a lot of confusion and I think we need to clarify that.

RB: *But where does that come into the consultation process? Is it after the consultation process or before?*

SE: Well OK.

NM: We can do it in the next few days.

DG: We can do it in the next few days. I think Steven's offered to do that. Can I ask the gentleman there, given he's got the microphone or he can pass it over?

?: *If the public of County Durham and Darlington are going to be consulted on this document, it really ought to know what's ...fairly clear as to what's happening over the details of the proposal that are being changed, so are you closing a considerable number of beds and a considerable number of amounts of activity are being shifted from one place to another ... why do we not have that in the consultation document because this consultation document is not a strategy, it's one for closure and change of use of facilities and it should be made fairly explicit what those changes of use are and what the cost implications of the changes are and what the cost implications are of all the options. And you've not done anything.*

DG: Well I think what we've tried to do ...

?: *And you're not doing anything.*

DG: I think what we've tried to do in the document is to actually outline exactly what the changes are. I don't know if Bob wants to ...

SE: (inaudible) I think there is a significant amount of detail, I know there's a bit of a glossary, but I wanted just to pick up on one thing that you've said and it seems to have been an issue and I know it was an issue in one of the District Council meetings, about closures of beds and reductions of beds. Quite honestly I don't think people should get too hung up on beds. If ...

?: (inaudible)

SE: No, but can I explain ... sorry, can I explain what I mean. If you take my own specialty ... when I joined Darlington Memorial hospital very early in 1993, in south Durham there were 34 inpatient Gynae beds in Bishop Auckland, there were 32 inpatient Gynae beds in Darlington, right? We were very busy Gynae units, we did loads and loads of hysterectomies, we did this, we did that, if I tell you that, you know, in 2002 we merged the two units into one unit that actually had about 30 beds, not 66, about 30, and then the Gynae unit for the whole of south Durham is now operating off somewhere between 12 and 14 inpatient beds and I would commend to you that the Gynaecology service being provided in south Durham now is as good as it has ever been, probably better than it's ever been and the inpatient bed base is much less, so you can actually deliver modern care ...

?: (inaudible)

SE: You can ...

?: *But 32 beds at Bishop was totally unrealistic wasn't it, I don't think ... they didn't have that many beds anyway.*

SE: Yes, well they're a Gynae ward. Right.

?: (inaudible)

SE: Right. What I'm saying is, and the point I'm trying to make is that with 21st century care the need for the same inpatient bed base as we did 25, 15, 10 years ago, is significantly reducing. It's the quality of the care we provide.

?: *But the number of beds now and the number of beds in the future is going to change. Was it not reasonable to expect to see that in the consultation document?*

SE: Yes, I mean I did answer that question. Your question was can we see the detail that's not in the document? The answer is yes, so ...

?: (inaudible)

SE: Of course, we've done a huge amount of work over the last few months, looked at the analysis, very happy to provide a summary of the analysis and the detail that's not in the document and it's on the website too, but I think if this gentleman feels he wants to see that then I think we can allow him to see that and point him towards it, but the detail is there. Can I just ...

?: *Is it just me then? Nobody else?*

SE: No, we can provide it to everyone, but if you ...

?: *Is it on the website. I was looking at the website, I couldn't find anything.*

SE: It's on the website.

?: *Which website?*

SE: Well we'll explain to that later on, but can I just make another point, just building on Bob's point about beds. If you look at the question nationally, the Health Service is delivering something like 40% more activity in something like 35% less beds over the last five years, and that's the trend. You know, 80% of surgery these days is provided on a day to day basis and the other thing that really to get across about our proposals which I ... I understand why people understand about beds, and beds are important, but it's what are the beds actually being used for.

?: *(inaudible)*

SE: Let me finish. You've had your say. Let me finish. A very important point I think to get across here is that what we're saying is we want to minimise the length of time that people stay in an acute hospital bed. Any research you care to look at, patient research, nationally, internationally, will tell you people do not want to be in a hospital bed, they want to be back in their local community and back at home, so the currency of beds as far as acute hospital stay is about reducing length of stay, reducing the number of beds and using the resources that we can generate as a result to provide the models of care that we are talking about and that also are being delivered in the plans of the Primary Care Trust.

DG: Thank you Steven. I'll come to the gentleman in the brown, but I think the lady at the back in yellow has got a point to link to that last point.

?: *No, I want to speak to that gentleman, yes, you with the glasses on please. You were talking about Gynaecology.*

?: *Well I've had some Gynaecology problems, I waited two years for a Gynaecology appointment. When it came to it I needed a bed and you did an operation. Darlington couldn't provide me with that, I was then sent to the Woodlands which the NHS paid for me to go into a private bed and have my operation. Now I think you standing there saying that you've closed beds isn't good enough. I needed a bed and it wasn't there for me, and you paid for me to go private, now that in my mind is disgraceful. I pay into the NHS, I work fulltime and I pay into that and as far as I'm concerned my money has been wasted.*

SE: Can I just say ... I'm appalled, if you say you waited ... if you waited two years for an appointment I find that staggering.

?: *Yes.*

SE: Could you contact my office with the details ...

?: *Oh I'll contact your office, yes.*

SE: ... and I will look into it. Yes?

?: *Yes. I will do.*

SE: And, you know, give you some personal attention on that to find out why it happened.

?: *Yes, I will do.*

SE: Yes?

DG: OK. Yes, and actually wherever people's care is provided, if it's provided by or for the NHS, that's funded from the PCT, so you know ... and we do send patients to some private hospitals to get the quickest care ...

?: *But you should not have to. You should not have to.*

DG: And that's what the proposal is about, but I think if you have word with Diane at the back there she'll actually pick up your details and try and find out what's gone wrong in your instance because I think people are appalled by what's happened there. The gentleman here has been very patient... sorry the gentleman to the front.

PR: *Paul Ryman, District Councillor. You alluded to the fact that you're going to put greater expenditure into ambulance and paramedics. I think that's a great idea but doesn't it fly in the face of the fact that in recent months you've gone through this process of rationalising the ambulance service and closed several ambulance stations. Can you really make it clear to us here tonight exactly how you're going to put this money into a greater and better ambulance service and paramedics and where are they going to be located because you've just closed St. John's Chapel in Weardale which is reduced the facility for paramedics and ambulances to the remote areas which is where, the way you're talking, you were going to get people to the centre of excellence better and quicker but if the ambulances and the paramedics aren't located in the remote areas then it seems to be to me a contradiction in terms.*

DG: OK. I know there have been some issues that we've been trying to deal with over a number of months now, if not years, about ambulances in the Dales and actually we're putting £625,000 into extra ambulance provision. That's not about ambulance stations, it's about having the ambulance crews available, the paramedics available and there's a lot of evidence to suggest that actually the key thing is you get a paramedic to you wherever you're having the accident or whatever it is and they treat you on the scene and then get you to the right hospital so we are actually putting more investment into that and as part of this work we'll be looking to see if we need to put more money into it. We need to actually see what comes back from the consultation though, so ... you know, we haven't forgotten about it, we'll be doing more about that probably in the future.

PR: *Does it not seem strange that you've just gone through this process of closing down the ambulance station and you're going to put more money into it?*

DG: No, sorry Sir, you might have misunderstood what I said. We're not closing down the ambulance, we're actually putting in extra now ... an extra £625,000 into it.

PR: *(inaudible) now, but in recent months you've closed St. John's Chapel.*

DG: Yes, but we're actually putting the ambulance service out there, and a bit like the comment about 'it's not about the beds, it's how they're used', it's about how the ambulances and the ambulance crews are used and, you know, we think we've addressed that.

SE: If I can just offer a comment on ... I can understand the point you're making, but if I can just offer a comment. I'm not ... none of us are from the ambulance service but I think the key point is what matters, as David says, is ambulances and people on them. Now the stations, and I think this is going on all over the country, the fact is that we've got a lot of capital stopped there, it's very under-utilised, not just in the Dales, I mean all over the place, and I think the whole point is concentrating those resources so that you're reducing your capital spend on facilities that are under-utilised so that we can invest more money in the ambulances and the paramedics on them. That's what that's about. Now I think where your point is really really important and I'm sure that we're picking it up on the record, is the access issue for people who may have to go that extra mile so to speak to get specialist treatment and that's where I think your point is important, it's absolutely essential that we're able to support by means of the investment in ambulance those communities where that distance is reasonably significant. So hopefully that helped to clarify what might appear to be confusing there. OK.

DG: Thank you Steven. I think we've got a gentleman at the back, then we've got a lady here and a gentleman there.

JW: *Councillor John Watson, Teesdale District Council. Some while ago, not long perhaps after I became established on the District Council, we were issued with a report emanating from Professor Lord Darzi, and in that report he specified that he would be taking action which has been beefed up since he became a Minister in the Blair/Brown administrations, the process of eliminating the local general hospitals in favour of a smaller number of establishments which would encompass a full range of treatments from trauma to elective, and we're seeing a similar situation occurring with our neighbours in east Durham aren't we, with the elimination of North Tees and the elimination of the Hartlepool hospitals, merging into a brand new establishment in the Wynyard area.*

There's a curiosity with this arrangement in that the triangle on which this report is based, and I think most of us can understand the reasoning behind the specialisms developing within the triangle as opposed to the duplications and triplications, is odd because two members of the triangle are brand new PFI financed hospitals. Darlington is the rogue, it's actually younger than North Tees which is about to be eliminated in its general hospital routine. Frankly my constituents here, most of whom are channelled to Darlington and have been for years, have very mixed feelings about Darlington because it's not rated a star performer and they have evidence in unhappy circumstances such that there is a tendency where possible to utilise patient choice. I have experience of that in my family very recently when we elected to go out of the area and received, within the NHS, received excellent treatment on the elective ... under elective arrangement. Couldn't have been better. The treatment and a system that was just not available within the triangle for south west Durham so one would hope that there are going to be efforts to dramatically improve the situation in Darlington, but because Darlington is the odd boy out, it's part of the 1960s package, build fast, build cheap, don't bother about architectural standards and patient comfort and friendliness, it clearly is a hospital where it's days are numbered and one would worry that we're artificially burying into Darlington.

The problem is ... colleagues have said about car parking, but a problem about the whole organisation of the place. It just isn't up to current standards and we should be doing something about that, not building a strategy that's based on Darlington being projected ... secondly, even with this triangle, the actual treatments are relying on contracts with private providers, of which the new Darlington private hospital is one such, and patients are being

fed in there, so it's what that's saying is that the triangle alone isn't capable of delivering the treatments and I'm very disturbed that the whole network isn't spelled out here in this report, i.e. the elective impact where people choose to find centres of excellence elsewhere, the impact of secondly the use of private providers to deal with the NHS backlog, and thirdly something that's missing totally in the NHS at the moment, and to be fair, not specifically the fault of the Primary Care Trusts involved here, it goes right up to Westminster, and that's an utter failure in this document, in Ministers' thinking, to take any account of the demographic change and I very much doubt with the reshuffles that you actually get away with centring single facilities in the likes of Darlington with the growing elderly population and their needs and finally on that score patient transport is a problem. I have constituents with severe orthopaedic problems, they're not being handled by the ambulance service in the conventional way, they're presented with a single driver in a private car and if you've ever seen a poor soul trying to wriggle into a private care with an acute arthritic hip and the pain that they go through, it's appalling. So we really need to re-jig the ambulance service before it becomes Blue Light and stretcher only and everybody else is fighting on either with a one driver car or their own transport ...

DG: OK.

JW: ...to cover the centre and the multiple treatments, that's the other worry that people have.

DG: Yes.

JW: *Patients have, because they will be like freight in some instances having to pass around the Dryburn, Bishop Auckland and Darlington circuit for treatment for different complaints under this arrangement and that is a real problem for the elderly and vulnerable, never mind the younger people.*

DG: OK. Thank you sir. There are some issues there about Darlington, how that fits in, which I'll ask Steven to respond to. There are issues about elderly and access and others which we'll see if we can try and respond to.

SE: Yes, thank you, I can see you're extremely passionate about those points and I understand that. I'm going to ask Bob to make a comment about Darlington in a moment but if I could just make one or two points about what you said. There is actually quite a lot of movement around that triangle already and I would accept actually in some cases that that movement perhaps, you know, is sometimes inefficient for people, especially older people. We see massive improvement in that in the way that we're planning to organise here because with trying to streamline, as I hope Bob and Neil have explained, care and where care can be provided locally, this isn't just about the hospital it's also about the community service as well, we expect more of that to be done locally. You know, you've got to remember that if you just take Bishop Auckland as an example, that we're going to have a whole range of diagnostic facilities, MRI scanner, state of the art stuff, there, so that isn't about ... you know, our whole focus is about trying to get the treatment up from where we can. If I can comment on what you said about the private sector and it came up I think in an earlier point as well, it is Government policy and has been for the last five years, to augment the public service by using private capacity to deliver public care and that's given rise to massive improvements in waiting times. That's Government policy. You have to say an awful lot of tax payers' money's been spent on that, there are very clear results. So I don't want to comment on whether that's right or wrong but there's definitely been a significant improvement, and the other comment I would make, and my colleagues may know more about this than I do, you

did mention the Woodlands, I mean there is a degree of private sector activity there but we're very clear that it's reducing, the demand is going down quite significantly, it has little impact on what we do in our hospitals, so if I could just hand over to Bob who's going to say something about your other good point I think about the Darlington site and some of the issues there.

JW: Was it the issue of demographic change. (inaudible)

BA: The elderly population generally, I mean we've taken that into our analysis when we've looked at choosing which site should be the third site and, you know, patients who have to travel etc. etc. etc. I think I alluded to it earlier on but I didn't give the detail. If I can just provide you with some of that detail and the background, we actually did a lot of the travel analysis looking at if we move people around, and there wasn't really a significant increase in the proportion of patients who are having to travel and if we concentrate on getting the PTS and the Blue Light ambulances right then people shouldn't be disadvantaged by it and we even actually looked at, particularly under ... what is it, traditionally under-represented groups, so the elderly, the deprived populations etc. etc. etc. but I think ... you mentioned Darlington being old plant and you're absolutely right, and it is in need of some tarring up to quote an old Scottish phrase as I say, but when we did, you know, the timescale and the financial analysis about if Bishop was the third site or Darlington or whatnot, then just the high level capital costings, if Darlington became the third site to provide the capacity at the two PFI hospitals to allow us to deliver our activity going forward, would cost about £120m.

??: Well it's not a realistic options is it?

BA: Well sorry, can I ... excuse me, can I finish ... I'm trying to answer this gentleman's question.

??: (inaudible) at Darlington ...

BA: Well if you let me finish what I'm going to say, hopefully you might better understand why, yes?

??: (inaudible)

BA: No, well you don't want to understand, sorry, that's what it's coming across to me. You've come with your opinions really fixed, give us a chance to answer people's questions please. So if it was Darlington that was the third site, it would ... to provide the capacity £120m. If Durham was the third site about £80m to provide the capacity, if Bishop was the third site it was going to cost, you know, £7m, maybe approaching £10m, so from a financial point of view it was a pretty clear cut decision. But let's try and address ...

??: (inaudible) make some sense of it.

BA: No, can I try and ... well you know ...

??: (inaudible) in the consultation document (inaudible)

BA: Can I just deal with the activity thing and ... you know, a spell of activities, a patient presenting and we treat them. Yes? And when we looked at the analysis I alluded to earlier on about if we move, if we make that third site blah blah blah, and then looked at the

potential for travelling to local Trusts, right? If Darlington was the elective site, with the potential to lose about 9,000 spells of activity, which is a significant chunk of income if you consider that we would pay under PVR now. If Durham was the third site that went up to about 22,000 spells of activity which would be liable to basically destabilise us as an organisation, yes? If Bishop was the third site we lose in the small hundreds of spells of activity outside the organisation, that is if people travel to their nearest available service, so on all fronts it looked really like Darlington needed to be one of our acute sites to protect our business and to allow us to maintain a clinical service of high quality that we could provide to the people of County Durham, yes? I thought, like lots of other people, if I had a blank piece of paper, 12 years ago, I would probably have said the answer to this is to build a great big hospital sitting in the middle of the County and that would be the answer. Having been very closely involved with the analysis that we've done during that, we would leak so much activity over the borders into Gateshead and Sunderland and North Tees and Middlesbrough that it would probably destabilise County Durham and not allow it to be able to provide a District General hospital at all. So I'm convinced this is the way forward.

DG: Thank you. We want to move on to have some discussion round the tables. I'm conscious there's a lady here who's got a question. Is it a very quick question?

?: *Yes, very quick.*

DG: If you could. And we'll get a very quick answer to it.

?: *It's just about the link between A&E and the out of hours service. People from this area would use the out of hours service that's in Bishop Auckland. I just wonder if the impact of the out of hours service being in Bishop Auckland and Bishop Auckland no longer being a level 3 A&E unit has been considered.*

DG: Can I ask Neil just to comment quickly on that please?

NM: I think it's very important. We would ... we applaud side by side the co-location of having the out of hours service physically adjacent to the current emergency department and in fact that's something we would like to see on the other sites as well. We're moving slightly closer within Durham, we've actually got it in the same building, although not through the same door. We'd like to enter discussions with the PCT about out of hours services in Darlington and try and get those as close as possible. We really think there's real advantages in having general practitioners and their staff close to the emergency departments. Now there will still be patients who come to the out of hours service who need to be admitted to hospital and if that happens under these proposals they may have to be admitted to Durham or Darlington. Equally there may be some patients who come to the out of hours service into the early evening when we still plan to have the rapid access medical assessment who can be seen in that assessment service and perhaps avoid coming into hospital in the early evening. So we see the current co-location continuing and working ever closer with the Primary Care Trust and out of hours services. I think that is actually vitally important for the whole out of hours provision of care within the County.

DG: OK. Thank you. I'm really sorry, I want to move on to another piece now which is still an opportunity for people to have their say. What we want to do is ... and probably organised around the four tables that we've got here, sorry, I'm being told five tables. Diane's telling me from the back. We'll organise it so that we have a facilitator for each table and we want to actually go through some of the issues and actually get your responses to some of the

questions as part of the consultation, and then we'll have a chance to feed that back in about 20 minutes, about twenty to or quarter to, so people have a flavour for the discussions going on, so if I can ask the facilitators to arrange people around the tables please and ...

DG: People who are sitting on the outside of the room, sorry, if the people who are sitting on the outside of the room could actually move to the table that's free at the top and we'll kind of make that a fifth table and then we'll kind of distribute ourselves around to look ...

MEETING MOVES INTO ROUND TABLE DISCUSSION GROUPS

(General talking as people move around the room)

FEEDBACK FROM ROUND TABLE GROUPS

DG: But, just so we don't go through death by feedback, we'll ask ... people are laughing, they know what we mean, what we're going to do is we'll just ask the facilitators on the table to feedback one key point which Vaughan will capture on the flipchart but we have got the rest of it, rest assured, and then I'll explain a little bit about where we go from here, so Vaughan I'll let you ...

VL: OK. Just ... we also captured what I think, or summarised the question and answer session, you're more than welcome to come and have a look at this at the end of the meeting. If you feel that the questions haven't been summarised we're more than happy to amend that for you and this evening has been recorded, it will be transcribed and the Word document will be available on the website to download within a week's time, so there's going to be ample information out there for you to have a look at what's happened in tonight's meeting, so I'm going to come round the tables, I'll hand out the mic and if we can have a summary. I'll pass over to you (inaudible name).

??: *One key point, I think what came out of all of the questions that we discussed here was that actually people didn't feel they had sufficient information or data to really make an informed choice. OK?*

DG: OK thank you (inaudible name). I'll explain how people can get hold of more information when we close, so that's helpful, thank you.

??: *Ours is mainly based around transport I think, probably the main point is do we actually know what is the maximum travel time we have where it will start affecting you clinically, so is it 20 minutes, is it 30 minutes, is it 40 minutes?*

DG: OK. Does somebody want to respond to that now or ... ?

SE: We should take the questions, then the response.

DG: Yes. OK. Thank you. Jill?

J?: *I think we had a number of good points raised. The one that stands out which we didn't really have a chance to elaborate on was a query about Option B, when we came on to discussing whether Option B or Option A are the preferred options of the group. And the issue raised was if we were to choose Option B would the quality of the services listed under Option A be*

diluted in any way and I think certainly a request from the group to have further information as to the thinking behind those two options?

DG: Ok. Thank you. And last, but by no means least ...

?: *Again, I think, you know, a lot of the points that have been raised on the other tables were also picked up here, but one specific question that was asked here was ... we're obviously being told that a lot of the changes we're proposing are to do with getting patients to travel to specialist centres and whilst people accept that there's a lot ... you know, a lot of sense, a lot of sensible reasons for that, why aren't we competing for some of those specialised services actually within County Durham?*

DG: OK. So rather than actually centralising ... move people to the centralisation, actually get some of those services in more locally. OK. We've got probably five minutes. I don't know if members of the panel just want to respond to any of those points?

?: I think Neil's going to say something about the time issue.

DG: OK.

NM: Thanks very much.

?: (inaudible)

NM: Do you want me to do that as well?

?: If you like, yes.

NM: Just ... the amount of time it takes, you know, the difference in time before you change your clinical state as it were, clearly that's going to depend on a lot of things, it's going to depend on what condition you're talking about, what treatment you received before the ambulance crew have got there, what treatment the ambulance crew can give you when you're there and then, of course, the actual travel time to the appropriate centre. There's a sort of golden hour in most conditions that you have to make a difference and with the best will in the world we can all raise an example of a dark, stormy winter's night, but I think we have travel time information that says that an hour is well within the radius for our major centres. Paramedics, as we've said on many occasions, can intervene if you've got asthma or bronchitis they can start nebulisers, if you're losing blood they can start fluids, if you need painkillers they can start those sort of things, and they can do resuscitation for heart problems etc. so all ... and your general practitioner may have seen you beforehand and already started some of those things even before the ambulance crew have got there, so it's difficult to give an actual time and I don't think you could give an actual time for most conditions, but I think the key thing is what treatments are out there in the community and what sort of things that you can offer on the way to the hospital, and the information that modern technology allows us to pass ahead to the hospital so that they are ready for you when they arrive. You can transmit ECGs, heart tracings, to the A&E department so that they know what to expect when you get there. You can transfer information and vital signs so they can be set up ready to go, you're not just arriving, knocking .. oh hello, you're there, you know, there's more than that to it.

Specialist services somebody mentioned as well. I mean, yes, we said about people going to James Cook and the Freeman hospital for heart attack services, is that the sort of thing you

were referring to? Part of this is your regional health policy, indeed national health policy, to have certain centres, a small number of centres through the country doing very specialised things and one of those things, as I mentioned already, was opening up heart arteries. To a certain extent you need even more backup than you can provide in the average District General hospital. If you are trying to open up somebody's heart artery and in doing so you rupture that vessel, you need to have a heart surgeon available to do an emergency operation there and then. Now, with the best will in the world we cannot produce a heart surgery service in County Durham in the same way that they can produce a heart surgery service in York or Sunderland or a variety of other places. People will go to, for example, Leeds, for that sort of service from North Yorkshire. They won't go to a hospital in Bradford, they'll go to Leeds for those sort of services, so you need to be able to provide the whole range of backup. The same applies to neurosurgery. It is not feasible for us to set up a neurosurgical centre in County Durham in the same way that you wouldn't try and do it in Sunderland, you wouldn't try and do it in North Tyneside, you wouldn't try and do it in Scarborough or York or somewhere like that. These are very specialist centres that require concentration of effort, not just doctors, specialist nurses, intensive care units, X-ray departments etc. so yes, it would be great to say that we could provide everything on all sites, but the reality is that it's just not feasible, there are not the staff out there to do it, there are not enough neurosurgeons in the country to have neurosurgery on more sites than we have at the present time.

SE: Thanks Neil, but I think it's important to say that ... because I think it's a very important point, the thrust of what you were saying was why couldn't we do more things in County Durham and Darlington? Well I think Neil's very clearly outlined why we can't do those sorts of things but our proposals are about doing some things in County Durham and Darlington that are actually for the wider community and what we're describing as centres of excellence. I'd remind you about what we were saying around the rehabilitation service that we're looking to provide, you know, we're looking to centre that at Bishop Auckland hospital, we're looking for that to become a sub-regional centre. The day surgery facilities we're going to provide, we want those to be leading edge, we want them to be the best in the country. We're looking to centre those at Bishop Auckland hospital, so as Neil said much earlier, we want to be the best at what we can do and, you know, and we're really committed to that, so we ... and that ought to enable us, if we are the best to bring care back into the local setting because it's an interesting fact that, and this is ... it varies from specialty to specialty, but about nearly 50% of our elective, our routine activities, are offered by other organisations, not the local hospitals, so you know we're very keen to bring that work back if we can ... provided the PCT will buy it of course!

DG: One very quick point now then we need to wrap up.

BA: It's a very quick point but it's not so much specialist emergency services but specialist elective services, I mean one of the things that we're having to tackle at the minute as well, there's almost a national unwritten recommendation that the catchment population for the District General hospital going forward will be about half a million people, which happens to be, you know, the population roughly of County Durham and we've ... we've got some challenges where we try and maintain for example we feel very strongly we should have a stroke unit within County Durham, the population for that is about 500,000 people, so we've got to find innovative ways of working together to be able to deliver that service and compete against other local services. Things that have been developed recently, we've got a specialist upper limb service that we've developed. Five years ago the people used to travel elsewhere to have, you know, shoulder replacement surgery, we're now providing that within the County, you know, very very highly specialised colorectal service, colorectal surgery

services, vascular surgery services, based in Durham, so we are fighting very hard to maintain and to develop, further specialise on the elective front as well.

DG: OK. Thank you. Just looking at the clock, we've got about 10 minutes left. What I want to do now is just to sort of wrap this up a little bit and explain what the next steps are. The first thing to do though is to thank you all, one, for turning out on an inhospitable night really but, secondly, and more importantly actually, for the level of your contribution, it's been really useful, it's very good to hear your views, and that's the whole point of this consultation exercise. One of the things that we've tried to do as the PCT in this process is to make sure that we act almost as the honest broker and it's our job really to make sure that people have a fair and equitable say in this, that the discussion is robust and we actually capture all of the issues and hopefully we're doing that through this process. We've certainly captured all of the issues that have been raised today, either audibly with the microphone and the sound system but also either on the flipcharts or the things written down, and as Vaughan's described to you that will be available so that people can actually see what we've actually captured as part of this process.

This all feeds into this consultation process that runs up to 12th January and it's a statutory consultation process and that's one of the reasons for doing all of this recording so we make sure your views are fed into it. What will then happen is that colleagues in the Foundation Trust will actually look back and reflect on the issues that are being raised at consultation, try and address those issues and decide how they shape the proposals in the document that you've seen and all the other information which I'm going to mention in a moment to see how they actually finalise that and they'll ultimately bring that to us in NHS County Durham to .. I suppose seek permission is a bit of a hard way to describe it, but actually to get approval to proceed or not, and I must stress the only decision that's been made thus far is to actually embark on this consultation process. Our Board has had a discussion with the Foundation Trust Board, we've had a public meeting where we've listened to the case for change if you like, so some of the issues you've heard tonight, and all we've agreed to thus far is that, yes, we think there is a case for change, the issue is now listening to your views, across the County, and that's one of our jobs to make sure that everybody across the County has a fair say and that that is then fed into the ultimate solution.

Only once we've heard what the FT comes back to us, probably in February, will a final decision be made on this, so it's really important that you're having your say today, but there are a number of other opportunities that you can take. One to actually look at more of the information and there's a number of websites there, the particular one probably is the www.seizingthefuture.org.uk. All the consultation documentation's there, but there's a wealth of information behind that and all of the hard work that the Trust have put in to actually articulate those and the option appraisal that we've heard about. All of that information is there. If you want that information and either you can't access it or you think there's something missing then please get in touch via any of the routes that are here and we'll try and get you the information so you can understand, because it's really important that we have the debate and the discussion but it's crucial that it's an informed debate and discussion so that people understand exactly what is available now, and I think that's one of the discussions we've had this evening, and what is on offer through these proposals, because only then can you make a judgement on whether that's the right thing to do or not and you need to help us in actually making our final decision on that.

There are a number of ways that you can actually get involved with the consultation. Obviously being here tonight is part of it, but you can feed formally into the consultation by a

Seizing the Future Public Meeting
Teesdale District Council
Teesdale House, Barnard Castle
Tuesday 4th November

range of mediums, so you can log into our website, NHS County Durham, you can visit the Seizing the Future website, you can actually email comments to the email address there, comments@seizingthefuture.org.uk, or you can write in to the Freepost address and you can actually fill in, on the back of the tabloid sections that we had, that were coming through people's doors, and there are some available tonight, there's actually a section there to answer some of the questions that the consultation feed into it. It's really important you have your say because one of the things that we listen to when we actually make the final decision in NHS County Durham is the views of local people and as part of that consultation because our role, as I said at the start, is to make sure that the services that we buy are safe, they're sound and they're sustainable, and you know we need to do that for the whole of County Durham and Darlington.

So having said all of that, it's five to eight, I want to thank you all for your time and your patience and particularly for your input and hope you have a safe journey home. Thank you all, and thank you to the staff for all of their input into this as well.

(End of recording)