COUNTY DURHAM & DARLINGTON NHS FOUNDATION TRUST
ANNUAL GENERAL MEETING

Minutes of the fifth Annual General Meeting of County Durham and Darlington NHS Foundation Trust (CDDFT) held on Wednesday 12 September 2012 at 5.30 pm in the Central Hall, Dolphin Centre, Darlington.

BOARD MEMBERS PRESENT
Mr Tony Waites  Chairman
Rt Hon Baroness Hilary Armstrong  Non-Executive Director
Ms Kathryn Larkin-Bramley  Non-Executive Director
Dr Ian Robson  Non-Executive Director
Mrs Lynne Snowball  Non-Executive Director Designate
Mr Andrew Young  Non-Executive Director
Mrs Sue Jacques  Chief Executive
Mr Tom Hunt  Executive Commercial Director and Acting Executive Director of Finance
Dr Robin Mitchell  Executive Medical Director
Mrs Diane Murphy  Acting Executive Director of Nursing

GOVERNING COUNCIL MEMBERS PRESENT
Mrs Adele Bone  Public Governor (Chester le Street)
Mr Stephen Coad  Staff Governor (Community)
Clr Veronica Copeland  Appointed Governor (Darlington Borough Council)
Dr Ken Davison  Public Governor (Wear Valley & Teesdale)
Mrs Marjorie Dunn  Public Governor (Darlington)
Mrs Barbara Dyer  Public Governor (City of Durham)
Mr Bob Erskine  Public Governor (City of Durham)
Ms Janice Fenny  Staff Governor (Nursing & Midwifery)
Mr James Heap  Public Governor (Tees Valley, Hambleton, Richmondshire)
Clr Lucy Hovvels  Appointed Governor (Durham County Council)
Mrs Betty Hoy  Public Governor (Darlington)
Mr Kevin Hull  Staff Governor (Ancillary)
Prof Paul Keane OBE  Appointed Governor (Local Universities)
Ms Amanda McEwan  Staff Governor (Community)
Ms Linda Moore  Public Governor (Sedgefield)
Mr Alex Murray  Public Governor (Easington)
Mr John Short MBE  Public Governor (Teesdale)
Dr Oliver Schulte  Public Governor (Gateshead, S Tyneside, Sunderland)
Mr Ray Taylor  Public Governor (Wear Valley & Teesdale)
Mr Laurence Welsh  Public Governor (Derwentside)

IN ATTENDANCE FOR THE TRUST
Mr Bill Headley  Executive Director of Estates & Facilities
Ms Chris Lisle  Executive Director of HR and Organisational Development
Mr Edmund Lovell  Associate Director of Marketing & Communications
Miss Donna Swan  Trust Secretary
Ms Gaye Ferguson-Boyes  Trust Secretariat Coordinator
Miss Gillian Parsons  Communications Manager
Mr Stephen Curry  Marketing Manager
Ms Joanna Tyrrell  Freedom of Information Officer
Mrs Diane Mann  FTO Support Officer
Miss Vicki Rose  Administration Assistant/Membership Secretary
Miss Rachel Cassidy  Administration Assistant
Miss Carol Wellings  Corporate Records Officer
Ms Lynne Henry  Communications Coordinator
Ms Suzanne Jarvis  Minute Taker
There were also in attendance 74 Trust staff and public members and 17 members of the public whose names were recorded separately.

Trust Board Members introduced themselves to members of the public.

1 WELCOME & APOLOGIES FOR ABSENCE

Apologies for absence had been received from:
- Dr Mike Waterston Non-Executive Director
- Mr Derek Atkinson Public Governor (Sedgefield)
- Ms Carole Bailey Staff Governor (Nursing & Midwifery)
- Mr Roy Beckwith Public Governor (Derwentside)
- Mrs Janet Brown Public Governor (City of Durham)
- Mr Colin Burnett Stakeholder Governor (NE Chamber of Commerce)
- Mr Keith Gunning Staff Governor (Medical)
- Mrs Patricia Mason Public Governor (Derwentside)
- Dr Mohammed A Quader Public Governor (Darlington)
- Mrs Dorothy Teasdale Appointed Governor (North East Ambulance Service)

2 DECLARATIONS OF INTEREST

 Anyone who was aware of a conflict of interest relating to any item on the agenda was required to disclose it at this stage or when the conflict arose during consideration of a particular item.

Ms Larkin-Bramley declared an interest in respect of her membership of the Durham Police Authority.

No other declarations of interest were made.

3 MINUTES & MATTERS ARISING FROM THE ANNUAL GENERAL MEETING HELD ON 20 JULY 2011

(a) Accuracy
The Minutes of the previous meeting were signed as a true and fair record.

(b) Matters Arising from the Minutes of the Previous Meeting
There were no matters arising from the Minutes of the previous Annual General Meeting.

4 CHAIRMAN’S OPENING REMARKS

The Trust Chair was delighted to welcome so many Trust Governors and members of the public to the Annual General Meeting of County Durham & Darlington NHS Foundation Trust (CDDFT). He went on to announce that the purpose of the meeting was for the CDDFT Trust Board to formally submit the Trust’s Annual Report for 2011-12 to CDDFT’s Governing Council. This followed the Annual Report having been laid before Parliament on 2 July 2012. It was noted that, in the past, CDDFT’s AGM had taken place in July or August but it had been hoped to gain a larger audience by delaying the presentation of the Annual Report until September.

The Chairman also advised that, as a result of comments received from the public in the past, it had been decided on this occasion to change the venue of the AGM from Durham to Darlington.

It was officially put on record that the AGM was open to the public, as indeed were all of the meetings of the Governing Council and joint meetings of the Trust Board and Governing Council. The Trust Chair advised, however, that from April 2013 all Trust
Board meetings were also to be open to attendance by members of the public. Attendance by the public at this particular meeting was then put into context. Essentially, whilst the public were invited to attend the AGM to listen to discussions, they were not entitled to actually participate in the debate. However, there would be an opportunity for members of the public to raise questions and to make comments once the deliberations of CDDFT’s Trust Board and Governing Council had been concluded.

It was noted that, in terms of the various presentations to be made, CDDFT’s Executive Directors were to be asked to comment on key issues in the Annual Report for 2011-12 and also upon the outlook for 2013.

The Trust Chairman wished to draw the attention of those present to certain issues within the organisation. Specifically, there had been a number of changes to the composition of the Trust Board during the year. At the end of March 2012, Mr Stephen Eames, CDDFT’s Chief Executive for some four years, had left the organisation in order to take up a very difficult job on the part of the Department of Health to address problems in an NHS organisation in Yorkshire. The Trust Chair commented that Mr Eames had been well chosen for that particular task. The departure of Mr Eames had, however, provided an opportunity for CDDFT’s Trust Board to appoint Mrs Sue Jacques as Chief Executive. It was formally noted that Mrs Jacques had long been identified as the very obvious successor to Mr Eames and that the organisation had been delighted to make that appointment. Mrs Jacques was to make a report later in the meeting in respect of CDDFT’s performance throughout 2011-12 and upon her role as Chief Executive from March 2012. Other changes within the year had been the appointment of Ms Chris Lisle as Executive Director of Human Resources & Organisational Development. Around Christmas 2011 and somewhat to the surprise of the Trust Board had been the decision by Ms Laura Robson, CDDFT’s Executive Director of Nursing for some years, to retire. The organisation had, however, been very fortunate in that another of CDDFT’s serving nurses, Mrs Diane Murphy, had acted as Executive Director of Nursing since that time. The Chairman put on record his thanks to Mrs Murphy for all of her hard work. A substantive appointment had now been made to that post from 5 November 2012.

The sterling efforts of all of the staff of CDDFT were recognised. Essentially, those staff on the ground made the organisation work and it was extremely important that tribute was paid to those members of staff.

There were, however, two very specific instances to which the Trust Chairman wanted to draw the attention of Members of the Governing Council.

- The Chairman's first tribute was for the work of Ms Katherine Larkin-Bramley who had served as a Non-Executive Director of the County Durham & Darlington Foundation Trust, and its predecessor NHS Trust, for a period of nine years. All NHS good governance guidance was, however, that any Non-Executive Director should serve for a maximum of nine years. It was put on record that Ms Larkin-Bramley had chaired the Trust Board's Audit Committee for a number of years and, for the last year, had been CDDFT's Deputy Chair. On behalf of the organisation, and on a very personal level, the Trust Chair thanked Ms Larkin-Bramley for her valuable contribution to the organisation. He wished her well for the future in her other appointments in the North East of England.

  There was then a round of applause.

- It was noted that, from 17 September 2012, Ms Larkin-Bramley was to be succeeded by Mrs Lynne Snowball who had recently been appointed by CDDFT's Governing Council as a new Non-Executive Director. Mrs Snowball, like Ms
Larkin-Bramley, was an accountant and, having been a very senior official in the Audit Commission, would bring a very considerable level of skill to the organisation.

- The Trust Chair then extended thanks to Members of the Governing Council for their hard work throughout the year. He shared his very genuine belief that the Trust itself and the community as a whole would be very much poorer without the work of the governing body and the frequently wise counsel that the Governors brought to the organisation.

5 CHIEF EXECUTIVE’S REVIEW 2011-12

The Trust Chief Executive drew the attention of those present to the various stalls around the room and recommended that participants take this opportunity to visit them.

Mrs Jacques then gave an overview of highlights during 2011-12 with specific reference to the fact that CDDFT was now an integrated organisation, having reorganised its structure by welcoming 3,000 new members of staff from the community. Of the eight acute foundation trusts in the North East, CDDFT has the largest population.

6 GOVERNING COUNCIL AND MEMBERSHIP

Miss Donna Swan, Trust Secretary, delivered a presentation on the Governing Council and membership. She highlighted her appreciation of the work of the Governing Council’s Membership & Engagement Committee as well as the efforts of the wider Governing Council and Trust Members who had acted as recruiting partners in disseminating information about the meaning of Trust membership. Membership application forms were available for collection.

7 PRESENTATION OF THE ANNUAL REPORT AND ACCOUNTS 2011-12

(a) Quality Accounts
Mrs Diane Murphy, Acting Executive Director of Nursing, spoke to her presentation on CDDFT’s Quality Accounts.

(b) Financial Accounts
Mr Tom Hunt, Acting Executive Director of Finance, then gave a presentation on the Trust’s financial performance for the year 2011-12. Full sets of Financial Accounts were available upon request.

8 OPEN QUESTION AND ANSWER SESSION

The Trust Chairman then announced the conclusion of formal presentations and opened up the floor for questions from the public.

- Mr Brian Ashton raised concerns around the difficulties experienced by patients with muscular and joint related problems accessing MRI scans and X-rays. It appeared to him that the first port of call was always physiotherapy at DMH and then it took some 12 weeks before any further action was taken. He, himself, had experienced a very painful back problem and had resorted to private treatment whilst his sister had spent three months in physiotherapy before finally getting an X-ray. She now faced a two month wait for a hip replacement. In his view money was being wasted on physiotherapy treatment – with long waits for scans.

Dr Mitchell was extremely sorry to hear of the difficulties experienced by Mr
Ashton and his family. However, the problem faced by CDDFT as a provider of health care services was that this organisation could only provide those services which were commissioned. Essentially, commissioning pathways were not within the remit of the Trust. CDDFT operated in a world where health care provision and commissioning were separate and there had been a clear decision on the part of those who commissioned health care, currently between the former PCTs and the emerging GP Clinical Commissioning Groups (GP CCGs), on those care pathways which were to be commissioned. In terms of capacity, once a patient was involved in CDDFT’s own clinical pathway, the clock would start ticking as soon as a patient came to the attention of the Trust. Imaging and MRI provision was very complex in Darlington - with a private sector provider working to contract. There should, however, not be a capacity issue as CDDFT had a high level of provision, having invested heavily in imaging and MRI over the past two years. It was difficult for Dr Mitchell to comment on the incident in respect of the need for a hip replacement as had been described by Mr Ashton because that led to Tier 2 services which was an agreed pathway for patients presenting to primary care with musculo-skeletal conditions.

Mrs Murphy added that there was quite a body of evidence that referral to physiotherapy services and physiotherapist intervention could quite often resolve problems and avoid the need for surgery. There were, however, a proportion of people who would require surgery and that was, perhaps, the reason for the establishment of the pathway. She undertook to speak to Mr Ashton at the end of the meeting, to obtain all of the details for further investigation and to highlight this matter with commissioners.

- Mr Karl Banzymi raised the issue that, in his experience, A&E staff did not always wear identity badges. He suggested, however, that hospital staff might spread infection via identity badges worn around the neck or clipped to their uniforms and he suggested that IDs worn around the arm might reduce contamination in clinical areas.

Dr Mitchell thanked Mr Banzymi for this question. He expressed concern that staff might treat patients without identification. He expected that all CDDFT staff would identify themselves to patients both verbally and with clearly displayed name badges. He offered to obtain further details of when and where Mr Banzymi had encountered these problems and to issue a reminder to those staff involved. He confirmed that name badges were available either in a clip-on form or on a lanyard - which was very popular amongst those staff who were required to be bare below the elbows. Whilst it would be difficult to decontaminate badges in microbiological terms, all badges were expected to be clean. He was, however, able to assure Mr Banzymi that ID badges never came into contact with patients or any clinical equipment.

- Mr Banzymi then went on to ask Mrs Jacques if more inpatient beds could be made available for dermatology inpatients at UHND and, perhaps, that a dedicated ward might be commissioned for dermatological conditions. In particular, he was concerned to avoid cross infection in respect of those patients who required treatment for other clinical conditions. Mr Banzymi was, however, aware of the financial implications behind such a proposition.

Mrs Jacques responded by stating that CDDFT clinicians had determined that the current configuration of beds at UHND was appropriate. Clinicians were, however, aware of the potential for cross infection and there had been a recent initiative to remove all carpets from ward areas as well as from those rooms adjacent to wards. In addition, the cleaning regime on wards had been
increased.

Mrs Murphy endorsed those points made by Ms Jacques. The current configuration of UHND beds had been determined by clinicians and had taken account of CDDFT’s infection control practices. Attention to detail was also required in terms of staff and their hand hygiene and use of equipment. The organisation was confident that good infection control protocols were in place.

Mrs Jacques then responded to a question from the floor around the changes in commissioning arrangements across the entire NHS and how well CDDFT was prepared for those changes. She advised that, currently, the organisation received most of its income from Co Durham and Darlington PCTs. From April 2013 services were to be commissioned by the three local GP CCGs which were currently being established in shadow form, the National Commissioning Board and 2 local Health and Well Being Boards. To date, not all appointments had been made to the emerging bodies with the consequence that all NHS organisations were in transition. CDDFT was, however, working very closely with the existing commissioners as well as those appointed to the emerging organisation in an effort to ensure a seamless transition from one commissioner to another. On the second point raised around the use made of the facilities at Bishop Auckland Hospital (BAH), Mrs Jacques observed that on the last occasion when she had visited BAH that site had been extremely busy. The Trust continued to investigate how to use that estate to the best effect but it had not been possible to make that explicit in the Annual Report. Specifically, in the last year CDDFT vascular surgeons had commenced carrying out simple vein operations under local anaesthetic. Another piece of work was in relation to the various cancer campaigns in the media and which had resulted in extra referrals into screening services and, specifically, an increase in the number of patients needing endoscopies. As a consequence, there was an increase in the activity through the endoscopy suite at BAH.

Mr Matt Pallister highlighted that, for reasons of data protection, the Trust no longer provided the chaplaincy office with a list of elderly patients and their religious denomination.

Mrs Jacques had not been made aware of any changes. She undertook to discuss this matter at the end of the meeting.

The next question from the floor was whether there was any GMC representative present. It was established that there was no representation from the GMC. The questioner then went on to ask if all doctors were accountable to the GMC. Dr Mitchell confirmed that, if an individual was not registered with the GMC, it was not possible to practice as a doctor in Britain. It was now the case that the GMC required each foundation trust to appoint a responsible officer. Dr Mitchell confirmed that he was the responsible officer for CDDFT and that he was obliged to make recommendations regarding all of the doctors employed by the Trust and, in particular, whether they should be re-licensed under a 5-year programme. The questioner went on to express concerns about the morality of those doctors who worked for ATOS, the organisation which supervised assessments for disability living allowances, and which was receiving much attention in the media with regard to professional standards.

Whilst, the Trust Chairman understood those concerns expressed, he declared that there was no-one present who had any responsibility in that particular area. It was not possible for any CDDFT representative to speak on behalf of any other organisation. Essentially, this was not a matter for this organisation. He suggested that the individual write to the GMC to express his concerns.
Penny Caster raised the issue of the Friarage Hospital at Northallerton and, specifically, if there was the capacity for more children’s or women’s services to be delivered at DMH.

Mrs Jacques advised that CDDFT had been contacted by those commissioners who were considering changes in the Friarage Hospital. Commissioners had been assured that DMH did have the capacity to support those changes and increase paediatric and obstetric activity at DMH. Dr Cronin confirmed that CDDFT representatives had contributed to the debate.

Mr Alan Marshall referred to the number of complaints about the attitude of Trust staff and asked if disciplinary measures were in place.

Mrs Murphy responded by stating that all staff were aware of expectations around staff attitudes. However, patients sometimes had a different perspective in terms of how the organisation assessed the severity of a complaint and, essentially, there was a degree of subjectivity about this. However, if a patient was unhappy, that situation must be addressed. The first action was to share these outputs with the team and, should a complaint be upheld, then work was carried out with that member of staff. There was always a process of investigation even if this resulted in only a record on file. Further, there was an issue around recruiting staff and every effort was made to select the right people to work in the organisation. This year, the Trust had already seen a significant reduction in complaints about staff attitudes as well as in the overall number of complaints received.

At this point in the proceedings the Trust Chair highlighted that, having received complaints that the AGM had been held in Durham for the past three years, it had been decided to change the venue to accommodate the residents of Darlington - which was the largest single area of population served by the organisation.

Mr Paul Briggs referred to the initial question from the floor regarding the location of treatment. He suggested that CDDFT had the opportunity to set objectives and its own targets to reduce the length of time for diagnoses. This could have a dramatic effect upon patients. Comments were sought from the Board.

Mrs Jacques agreed with Mr Briggs. She stated that the organisation did set its own local targets which were, in fact, harder to achieve than national targets. There were, however, necessary negotiations with commissioners to bring patients in for diagnostics and CDDFT had been successful in having patients directly referred to diagnostics. Under the national Choose & Book scheme patients were able to make their own appointments on-line and it was well known that CDDFT’s inpatient and outpatient waiting times were relatively short in most specialties. In an effort to reduce waiting times further, extra beds had recently been provided at UHND.

Mr Peter Garthwaite reported that because his son had missed one hospital appointment his diabetes care cancelled and he had been referred back to his GP

Mrs Jacques asserted that that patient should not have been referred back to his GP. She undertook to investigate this matter at the end of the meeting.

Mr Banzymi asked why the A&E area at UHND was so small.

Dr Mitchell agreed that that Department had been under pressure. When that A&E Department had been planned, more than 15 years ago, the extent to which acute medical conditions would continue to rise had not been
anticipated. Indeed, there had been projections that those numbers would go down as a result of plans for enhanced care in the community. However, changes in demographics as well as in the provision of primary care had resulted in the opposite being the case – leading to an inexorable rise in the number of emergency admissions. Further, although the reason for this was not known, the conditions of those people who came into UHND A&E appeared to be at a higher level of severity than in other foundation trusts. CDDFT was attempting to address this by examining the pathways around unscheduled care but this was a somewhat complex matter - with some areas outwith the control of the organisation. It was also the case that, when services were stretched in one department, this inevitably created difficulties elsewhere. Work was ongoing across the Trust and with colleagues in primary care to address those problems.

➢ Ms Hilda Armstrong asked who she should complain to about the attitude of staff.

Mrs Murphy advised that there were a number of routes but that, in the first instance, a complaint could be made to the nurse in charge of either a ward or the outpatient area. The Trust Complaints Department displayed notices in all public areas which indicated how a complaint might be made – either formally or informally with patient experience officers in place throughout the organisation. Cards were also made available in various areas for patients to make comments. Mrs Murphy stated that, at the end of the meeting, she would be happy to discuss any particular complaint that Ms Armstrong might wish to raise.

➢ Ms Margaret Morton declared that she had been very happy with the treatment that she had received but questioned why she had to wait longer to be treated under the NHS than if she was a private patient.

Mrs Jacques explained that there was a national requirement for foundation trusts to provide treatment within 18 weeks of a patient’s referral from primary care. CDDFT endeavoured to provide care as quickly as possible. However, referrals into the NHS system come in peaks and troughs and there was, on occasions, a glut of referrals into a particular specialty. Within the private sector, because demands were very different and, specifically, with no requirement to provide urgent care that comes with non-elective treatment and unscheduled care, patients could often be treated more quickly.

The Trust Chair concluded the session by thanking all who had raised questions. Colleagues would be happy to deal with any further questions or comments privately at the close of the meeting when it would be ensured that queries were fully answered or, if issues could not be dealt with at this time, at a later date.

9 ANY OTHER BUSINESS

There was no other business.

10 CHAIRMAN’S CLOSING REMARKS

The Chairman recommended that everyone visit the various stands around the room. He put on record that the organisation was very grateful to its volunteers who provided assistance across the Trust in many ways. He extended particular thanks to Mr Jack Besford who carried out a considerable amount of work for the organisation and who was here this evening with his Olympic torch.

There was then a round of applause for Mr Besford.
The Chairman thanked all those in attendance for taking such a degree of interest in County Durham & Darlington NHS Foundation Trust. It was important for people to share their views and problems in order for the organisation to get things right and every attempt would be made to resolve any outstanding issues.

The meeting closed at 7.30 pm.

11 MEETINGS HELD IN PUBLIC: ANNOUNCEMENTS

Governing Council Meeting 5.30 pm to 7.30 pm
Wednesday 25 September 2012 (venue to be confirmed)

Joint Trust Board & Governing Council Meeting
Wednesday 19 December 2012
(Time and venue to be confirmed)