GOVERNORS’ CONSULTATIVE COUNCIL
ANNUAL GENERAL MEETING

Minutes of the Governors’ Consultative Council
Annual General Meeting
held on Monday 20th September 2010 , Heartlands Education Centre
Birmingham Heartlands Hospital

Present:

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<tr>
<th>Name</th>
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<td>Governors:</td>
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<td>Ms Arshad Begum</td>
<td>Mr Mike Kelly</td>
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<td>Ms Famida Begum</td>
<td>Dr Sunil Kotecha</td>
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<td>Ms Kath Bell</td>
<td>Ms Gwynneth Lamb</td>
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<td>Prof Ian Blair</td>
<td>Ms Frances Linn</td>
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<td>Ms Sheila Blomer</td>
<td>Ms Veronica Morgan</td>
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<td>Mr Aftab Chughtai</td>
<td>Mr David O’Leary</td>
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<td>Mr Stuart Clarkson</td>
<td>Mr Barry Orriss</td>
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<td>Dr Olivia Craig</td>
<td>Mr John Roberts</td>
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<td>Ms Valerie Egan</td>
<td>Mr Paul Sabapathy</td>
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<td>Mr Albert Fletcher</td>
<td>Ms Yvonne Sawbridge</td>
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<td>Mr Tim Freeman</td>
<td>Mr Roy Shields</td>
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<td>Ms Frances Hamer</td>
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<td>Ms Patricia Hathway</td>
<td>Ms Liz Steventon</td>
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<td>Mr Richard Hughes</td>
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<td>Mr John Jebbett</td>
<td>Ms Margaret Veitch</td>
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<td>Mr Clive Wilkinson</td>
<td>Chairman</td>
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<td>Ms Mandy Coalter</td>
<td>Director of H.R. and O.D.</td>
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<td>Mr Ian Cunliffe</td>
<td>Medical Director</td>
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<td>Ms Lisa Dunn</td>
<td>Director of Corporate Affairs</td>
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<td>Mr Simon Hackwell</td>
<td>Commercial Director</td>
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<td>Mr Andrew Laverick</td>
<td>Chief Information Officer</td>
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<td>Dr Mark Newbold</td>
<td>Chief Executive</td>
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<td>Mrs Ellen Ryabov</td>
<td>Chief Operating Officer</td>
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<td>Mr Adrian Stokes</td>
<td>Finance Director</td>
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<td>Ms Mandie Sunderland</td>
<td>Chief Nurse</td>
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<td>Mrs Sandra White</td>
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<td>Mr David Bucknall</td>
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<td>Mr Paul Hensel</td>
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<td>Mr Richard Samuda</td>
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<td>In attendance:</td>
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<td>Ms Lisa Jennings</td>
<td>Executive Assistant</td>
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<td>Ms Cat Little</td>
<td>PricewaterhouseCoopers (PwC)</td>
<td>KL</td>
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<td>Ms Amanda Marnock</td>
<td>Group 3 Operations Director</td>
<td>AM</td>
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<td>Miss Chantelle Osborne</td>
<td>Governor Support Officer</td>
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<td>Dr Roger Stedman</td>
<td>Group 3 Medical Director</td>
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Introduction and Welcome to AGM

The Chairman opened the meeting and welcomed everyone to the Annual General Meeting of the Governors' Consultative Council.

A special welcome was given to the following newly elected and appointed Governors:

- Mr Albert Fletcher and Dr Olivia Craig, Birmingham North
- Ms Gwyneth Lamb and Mr John Roberts, Sutton Coldfield
- Mr Barry Orriss, South Staffs
- Mr Paul Sabapathy, Stakeholder, North and East Birmingham PCT
- Mr Max Stirk and Mr Michael Strange, 6th Formers from King Edward V Grammar School, Five Ways, who would be representing the interests of children and young people as formal Governors as well as attending as members of the public.

The Chairman wanted to put on record, on behalf of himself, the Board and the Executive Team, a real big thank you to every one of the Governor's for their hard work and time freely given over the past year in generating and improving the quality of services for patients across the Trust and for ensuring the Board had delivered on all its plans and programmes.

Since the last AGM there have been some significant changes within the Trust:

- Dr Mark Goldman had resigned as the Chief Executive and thanks were recorded for his outstanding contribution to the organisation over the past number of years in his role as Chief Executive, former Medical Director and Consultant Surgeon.

- Dr Mark Newbold had been appointed as Chief Executive and was welcomed to the meeting.

- Professor Christopher Ham had resigned from his position as Non-Executive Director to take up the role of Chief Executive Officer at the Kings Fund in London. Thanks were recorded for his invaluable contribution during his time at the Trust.

- Mr Ian Cunliffe would be stepping down as Medical Director at the end of September 2010, and thanks were noted for his hard work and dedication over the past few years. Ian would now be returning to his clinical practice as a fulltime Consultant Surgeon in Ophthalmology.

The Chairman reported that it had been a tough year for the organisation and that the Trust was disappointed when the Monitor had given it a red rating around the 4-hour access target. Things had now improved, following the hard work of all the Executive Director's and staff across the Trust, resulting in this rating now been down graded to amber green. The year end had ended better than anticipated and noted that the organisation remained focussed on improving quality and safety.

It was noted that the Trust had been advised at registration that the Care Quality Commission (CQC) had identified three areas where the Trust was not compliant, two of these had now been removed and the Trust was confident that the
organisation would be compliant with the third area of concern, undertaking staff appraisals, by the end of September 2010.

To improve patient safety and quality across the organisation, nursing metrics have been introduced by the Chief Nurse, Mandie Sunderland, and the Trust, as a whole, is now scoring green for nursing care with no red wards reported for the month of August. This information would now be triangulated with Patient Satisfaction Surveys; PALS; complaints and governance issues. Anna East and Sarah Woolley had also developed a system to measure quality and safety performance and were regularly updating the Board. Implementing these measures will provide reassurance on safety.

10.49
1. **Apologies**

Apologies were received from Ms Anna East; Ms Beccy Fenton; Ms Najma Hafeez; Richard Harris; John Sellars; Councillor Ian Lewin; Ann Brierley; Mr Shahid Mir; Ms Bridget Sproston.

10.50
2. **To approve the minutes of the Public and Private Governors’ Consultative Council meetings held on 26th May 2010**

The minutes of the private meeting held on the 26th May were agreed as a correct record subject to the following amendments being made:

Page 4, Paragraph 5: The comment made by Dr Mark Goldman needed to be amended to read “Dr Goldman added that there had been a lot of work done due to the need to abolish mixed sex accommodation”.

Richard Hughes had been present at the meeting and asked that his name be added to the attendance list.

The minutes of the public meeting held on the 26th May 2010, were agreed as accurate record.

10.51
3. **To approve the reappointment of Richard Samuda as Non-Executive Director**

The Governors’ Consultative Council unanimously voted and endorsed the reappointment of Richard Samuda as a Non-Executive Director from the 14th June 2010 to the 13th June 2014.

Richard has undergone a rigorous interview process, as outlined in the constitution, and his re-appointed was strongly recommended by the Governors’ Consultative Appointments Committee and the Board.

10.52
4. **To approve the appointment of the Rt.Hon.Lord Phillip Hunt PC OBE as Non-Executive Director**

The Governors’ Consultative Council unanimously voted and endorsed the appointment of the Rt.Hon. Lord Phillip Hunt from the 1st October 2010 to the 30th September 2014, following the resignation of Professor Christopher Ham.

Q. Is Lord Hunt at the meeting this evening?
A. No, the Rt. Hon.Lord Hunt was asked not to attend this evening’s meeting until his appointment had been formally endorsed. It is his intention to attend future meetings and to meet with sub-Groups.
Q. Can I ask where this post was advertised? Could I suggest in future that the Trust advertise in the Staffordshire papers i.e. Tamworth Herald, Sutton Observer and Lichfield Mercury.

A. The Chairman stated that as far as the Trust were aware the advertisement for this post had been put in all the local papers serving the Birmingham, Solihull, Sutton Coldfield and Tamworth area's, Including being put on the NHS Jobs and Trust websites; albeit there was uncertainty about whether this position had been advertised in the Lichfield Mercury?

This is to be investigated.

Q. Do we advise Governor’s when posts go out to advert to enable them to check what papers they are in?

A. We don’t, but this is and excellent suggestion and something worth considering in the future.

10.53

5. Board Appraisal Update

The Chairman reported that both he and Professor Ian Blair had carried out all the Non-Executive Director appraisals for 2009/10, with the exception of Richard Samuda and Najma Hafeez. The Non-Executive Directors were doing an excellent job, above and beyond their contracted hours, and were delivering a very good service on behalf of patients and Governors. They were all members of the Audit Committee and each individual brought their own specialism(s) to the Trust.

Richard Samuda had not been appraised due to being on annual leave, but had undergone a rigorous interview process.

Najma Hafeez had been unable to attend an appraisal due to ill health. Najma’s current term of office ends on the 31st March 2011, and the Governors’ Appointments Committee will then apply the re-appointment procedure to determine whether to re-appoint or go out to public advertisement.

The meeting formally received and approved this report.

10.54

6. Lead Governor Appointment

Lisa Dunn confirmed that the appointment of the Lead Governor would be undertaken by a postal vote and that freepost envelopes and papers were available in the foyer before and after the meeting. This information would be sent out to those who had not been in attendance at this evening’s meeting.

All votes needed to be returned by the 6th October 2010. All Governors’ would be notified of who has been successfully appointed on or before the 15th October 2010.

10.55

7. Finance Position and Update on Month 4 Position 2010/11

Adrian Stokes gave an overview presentation of the Trust Month 4 (July 2010) position which was taken as read. Highlights included:

- £3.3m operational surplus reported, £1.3m better than Monitor plan
- Financial Risk rating 4 achieved
• Good cost control measures being implemented resulting in a healthy balance sheet
• Clinical income over performance £9.4m, 4.1% YTD, across most patient classes
• Discussions with Primary Care Trust’s (PCTs) over demand management initiatives being developed
• Most areas now in line with budget with the exception of medical staffing, mainly due to shortfall against Cost Improvement Plan (CIP) and private sector work
• Significant progress made on CIP delivery
• The Trust had now become the preferred provider to Solihull Care Trust
• Revised forecast £11m

In summary, the level of cost control has improved since last year and the Trust now has a healthy balance sheet.

Over performance / demand management against the Local Delivery Plan (LDP) is causing difficulties for the PCT’s and the Trust is working with them to try and make the level of growth affordable. Compared to previous years the level of demand management had not materialised but there has been growth in some areas, most particularly Outpatients. The new Government NHS White Paper suggests that some services could be provided in the community and this is something that will be explored across the health economy.

It was also noted that the Trust will need to be compliant with ‘Access to Healthcare for People with Learning Difficulties’ by the end of 2011.

Questions were invited from the Governors:

Q. What does over performance mean and what effect does it have on the PCT’s?
A. At the start of the financial year the Trust agrees levels of activity with the PCT’s for which it gets paid a tariff/price. Over performance is anything above the agreed levels of activity for which additional payment is required. At the start of the year the PCT’s believed the level of activity would fall but this has not materialised and activity has increased by approx. £9m, mainly due to an increase in G.P. referrals for outpatient appointments.

Q. What led to the assumption that activity was going to fall?
A. Estimating demand management is difficult and the PCT’s were not expecting the level of growth from G.P. referrals and new follow-up appointments.

Q. Has there been any previous history when the numbers have reduced and is there a reason why there has been an increase in over performance this time?
A. The Chairman stated that if you look at the trend there has been a reduction.

Dr Mark Newbold commented that there has been a view in the health service, which many of us have shared for 5-years now, that much more care could be provided within the community to avoid unnecessary admittances, especially now that many treatments were shorter today with the provision of walk in centres. In principle, care is changing but change needs to happen sooner. People are recognising that being
treated in the community would provide better care and the Trust needs to work on implementing this across the whole health economy.

Q. With regard to the interest receivable income balance of £1m - now that interest rates are low how is this affecting the Trust?
A. Due to the current financial climate the Trust is getting less interest than previous years. The Trust also has a policy stating where it can and cannot invest based on risk. The Trust does get a low return on cash balances but it does not rely on this.

Q. What does ‘Access to Healthcare for People with Learning Difficulties’ mean?
A. Mandie Sunderland advised that this national standard is about improving the quality of access to care for patients with learning difficulties, whilst in A&E and hospital, and for ensuring patient information is written in a simple way.

The meeting formally received and approved the Finance Position and Update report.

10.56
8.

**Performance Position and Update on ½ Year Position 2010/11**

Mrs Ellen Ryabov presented the ‘Performance Position Update’ which was taken as read.

It was noted that things had changed this year in that the CQC was no longer publishing an annual health check and that there was no clear guidance on what would be replacing it, albeit the Monitor Compliance Framework was still in place. There had also been some changes to the national targets e.g. the access target (now 95%) and 18-weeks.

The Trust was slightly behind on the overall 62-day cancer target. It was also noted that if there were any 62-day treatment delays for tertiary patients these automatically become a shared breach between the Trust and the other organisation providing treatment. There were also capacity issues within Thoracic surgery with regard to the 62-day target but the Trust is working hard to resolve these issues.

The Trust is on target regarding the 28-day re-admission of patients whose operations had been cancelled.

With regard to waiting times and over performance in Trauma and Orthopaedics no agreement had been reached with the PCT’s regarding this.

In summary, the Trust is doing better and has seen significant improvements in performance between April 2009 and August 2010, but challenges remain regarding 62-day cancer waits; waiting times in certain areas i.e. Dermatology and Ophthalmology; improving the emergency pathway, reducing length of stay and ensuring patients are in the right place at the right time. Planning for winter pressures is also being undertaken and work is ongoing to reduce the number of delayed transfers of care which have increased slightly.

The Chairman clarified that delayed transfers of care related to patients who were available to leave the hospital, who no longer required treatment, but were unable to leave as they needed care and support from other agencies / local authorities. There were currently 53 people across the organisation who were awaiting transfer.
Q. The Chairman asked the Governors’ if they would like to receive a copy of the performance presentation?
A. The audience thought this was an excellent idea and the Chairman asked if Lisa Dunn would circulate the presentation via email to all the members.

Governors’ asked if the information provided could be broken down in future to show the performance of the three individual hospital sites, including comparable figures against last year’s data and waiting times shown by speciality not just averages.

Ellen Ryabov agreed to this request.

Q. What is the current A&E position compared to August 2009?
A. We are not performing as well as last year but we have seen more patients. There has also been a 17% increase in the number of elderly patients over the age of 85 with varying complexities. We are currently working on improving the emergency pathway in addition to using the ‘One Plan’ to get us to where we should be in terms of meeting the A&E target and reducing length of stay (LOS).

Governors’ highlighted that reducing waiting times to 9-weeks in certain areas meant the PCT’s having to pay more. It was very important that the Trust and PCT’s managed patients together.

With regard to clinical governance it was noted that the Trust worked well with the PCT’s across the whole health economy and that huge progress has been made in this regard.

Q. Can you confirm if the 62-day target for cancer patients starts from the time of referral or the time of treatment?
A. Yes, the whole package starts from the time of referral.

Q. On Page 112 of the Annual Reports and Accounts for 2009/10 there seems to be a significant increase in staff sickness, Can you identify a higher sickness rate at any of our three establishments or is it just across the board?
A. Mandy Coalter explained that the Trust monitor sickness levels on a monthly basis, both at Exec Director and Trust Board level, and targets are set each year to reduce. The Trust experienced a huge reduction in sickness levels about 3-years ago but this had recently levelled off and we have seen an increase in sickness levels over the past 12-months. Swine flu had a significant impact on staff sickness levels last year (late summer and early winter). We have been on target throughout the year, although the indicator has just turned red this month. Regular meetings take place with Staff Side and the Union’s to monitor and reduce staff sickness and to develop actions plans. To support Ward Managers in tackling sickness absence and other issues the Trust has organised a meeting which will be taking place shortly. Currently Good Hope has the highest sickness rate.

Q. What are the Trust doing to reduce outpatient waiting times in Dermatology and Ophthalmology?
A. Ellen Ryabov confirmed that there has been a huge increase in the number of referrals in these areas and that the organisation were putting on extra clinics to meet demand. We have also recruited an additional
consultant in Dermatology and are in negotiations with the PCT’s to try and reduce the number of referrals in these particular areas.

The Chairman reiterated the importance that we must stick to the levels agreed with the PCT’s because if we reduce waiting times and more people come in it will have an impact on their budgets. It was important to remember that the PCT’s have a cash limit and that the two things needed to be managed in a balanced way before the cash runs out.

Q. Going back to the cancer referrals from GP’s and Dentists. You agreed that it’s not good enough that people have to wait as long as they do and you said that the reason for that is because they are being outsourced elsewhere. My question is what actions are we taking to ensure the work that is outsourced is being done much better and quicker? and if we’re paying for the service, like anything else, you want the job done quickly or you go elsewhere. Also, what is a tertiary centre?

A. Ellen Ryabov, the Chairman and Dr Mark Newbold responded by saying that we do not pay extra for cancer care. The problem with other people taking on our patients (as we are not a specialist cancer centre) is that we become part of their timescale. Both hospitals share responsibility if any breaches occur. It is also important that patients are referred in a timely manner to the tertiary centre to avoid unnecessary breaches. Breaches also occur when the patient delays surgery because they aren’t ready, but we do work closely with our partners.

A tertiary centre is a hospital that provides specialist treatment across a large geographical area.

Q. Does the waiting time start again when a patient starts treatment at a tertiary centre?

A. No, we all work within the agreed timeframe from the time of referral.

Q. One of the things there is a lot in the press about is working time directives (WTD). I just wanted to hear if there were any problems?

A. All our rota’s are compliant with WTD, although there had been some challenges in A&E last year due to difficulties in recruiting middle grade doctors but these issues had now been resolved. The Trust was also making good use of the simulation centre which provides skills and training locally in a safe environment.

The meeting formally received and approved the Performance report.

UltraGenda

The Chairman introduced Ms Amanda Marnock, Group 3 Operational Director, Ambulatory Care and Dr Roger Stedman, Group 3 Medical Director, who had been invited to provide the audience with an update on the UltraGenda scheduling system and to address any concerns raised.

Q. What is UltraGenda?

A. UltraGenda is a direct booking scheduling system where patients can choose and book their own OPD appointment, (including some diagnostic services) either on-line or via telephone. A special password is given to the patient by the G.P. at the time of referral which the patient will need to use at the time of booking. Appointments can be booked before a patient leaves the G.P. surgery or later to suit themselves.
Q. What does a direct booking service mean for patients?
A. Providing a ‘Direct Booking’ service gives patients absolute choice and control in enabling them to choose the date and time of their OPD appointment. A timeframe is set for appointments which vary for each speciality and the Trust is working closely with the PCTs who agreed these timeframes.

Q. Why have people had difficulties booking appointment slots on their first attempt?
A. There were issues back in June and July, where appointment slots weren't available on the first attempt, but these problems have now been resolved, although there are still issues in some specialties, i.e. Dermatology and Ophthalmology, due to the high volume of G.P. referrals. Capacity in Dermatology has now been increased due to the appointment of a new consultant, however this has not completely solved the problem as the service is continuing to grow.

The Chairman said that one of the issues that has been raised by patients, and brought up at Finance Committee, is the issue of patients getting numerous letters all stating different things. We are then told that we can’t stop the letters going out as the system automatically generates them. This has resulted in a massive increase in our postal costs. Can we get this myth sorted out, does it send too many letters out, confusing patients, or is it because we’re not operating the system correctly?

A. The system is programmed to automatically generate letters every time an appointment is made or rescheduled and we are currently unable to override this. In the interim, we are trying to resolve this issue manually by taking on additional staff who are sending out letters to patients 4-6 weeks before their appointment until an I.T. solution is identified.

The Chairman gave the Governors and members of the audience a chance to cite their concerns and share their experiences about UltraGenda. The main issues raised were in relation to:

- The system being unable to flag follow-up appointments despite cancer patients being told they needed to be followed-up at certain times
- GP’s wasting time trying to follow-up appointment letters on behalf of patients only to be told to make a new referral
- Patient’s who urgently needed to see a consultant being told no follow-up appointment slots were available for 3-months
- Patient’s receiving excessive amounts of letters which contained conflicting information
- Patients receiving appointment letters on dates when they’d advised the operator they’d be on holiday only to be told the penalty for cancelling appointments meant they would be put at the bottom of the queue again
- Issues with staff giving out wrong information

Dr Roger Stedman and Amanda Marnock reassured the audience that they were aware of these problems and now had a team in place, working with I.T, to resolve these issues. A new system called PMS (Pathway Management System) was currently being implemented which will tie together the whole patient pathway. Amanda stated that she hoped that from next week letters for appointments made in 6-months time wouldn’t be sent out until 4-weeks beforehand. To enable this further, staff would be put in post and training would be given, but should people experience difficulties they were advised to escalate problems to the OPD matron or manager.
Q. Where are we on UltraGenda in getting a patch to fix the system and resolve the multiple letter issue?
A. Andy Laverick clarified that this will be achieved in the next 4-weeks. We will also need to assess the consequences of people receiving letters 4-weeks before an appointment, for example, if you have an appointment in December you wouldn’t get your letter until 4-weeks before. So we need to get all these exceptions sorted.

Q. When you are given a follow-up appointment in 6-months time are you given a card and is this followed by a letter?
A. Yes, a card is given and a letter should follow.

Q. What happens if a letter is not received?
A. You would need to contact the Trust to find out why.

Q. What about child protection? What happens if the system doesn’t flag appointments that are cancelled by the family? Who would follow this up?
A. This would be a safeguarding issue and absolute assurance can be given that a process has been developed and put in place to protect vulnerable children in this situation.

One Governor stated that they had used the ‘Choose & Book’ system for one of their neighbour’s and they hadn’t experienced any difficulties.

In summary, the Chairman concluded that patients wanted a system that worked and ended the session by asking Amanda and Roger for reassurance that improvements to the UltraGenda system would be implemented before the end of April 2011, with the development of action plans to address issues, and that regular progress reports be brought to the Governor’s bi-monthly meetings. Amanda and Roger agreed to this request.

Additional information on Ultragenda has been attached (as per Attachment 1 with these notes) for Governors’ reference.

10.57
9. To receive and consider Auditor’s Report 2009/10

Kat Little, on behalf of PriceWaterhouseCoopers (PwC), gave an overview presentation of the work they had undertaken on behalf of the Trust which was taken as read.

Highlights included:

- Trust Financial and Quality Report
  - Financial Standing: Increased clinical negligence insurance contribution, bad debt provision and depreciation including reduced interest receivable had had an impact on the Trust
  - Internal Financial Control: Improvements noted in capital funding
  - Quality Report: Systems that are manually based have been identified and will be replaced by new automated systems and processes, the implementation of which will improve 18-weeks and 62-day waits

- Looking ahead 2010/11
  - Human Resources: The Trust is undergoing a big period of cultural change and PwC will be looking at how this impacts on people
The Chairman thanked Ms Little for her presentation and questions were invited from the audience.

Q. As part of your work did you review internal audits and are you able to place reliance upon the work they do?
A. Yes, absolutely, we rely very heavily on your internal audits and they have been correct.

Q. The hip data on page 18 of the Annual Report and Accounts did not make good reading, is this being reviewed?
A. Dr Sarah Woolley reported that clinical audits fell under the remit of herself and Ian Cunliffe, Medical Director. The Trust was aware of the fractured neck of femur / hip data mentioned and a paper had been documented for discussion at the Executive Director Committee being held the following day.

In terms of the wider clinical audit, the Trust has just appointed Miss Sunanda Gargeswari (Clinical Obs and Gynae Consultant), as Associate Director of Medical Safety, to review and develop audit systems and work with frontline doctors and nurses in terms of improving their audit systems. Part of that review will include:
- Effectiveness and quality of audits
- Sharing learning with clinicians and clinician training

Sunanda has recently presented to Trust Board and will be presenting a further report of her review findings and future plans.

The Chairman asked if there were any further questions regarding audit?

The Governors’ thanked Kat for her excellent presentation which had been delivered in a clear and concise way and had been easy to understand.

Q. I have a couple of questions, Page 107 of the Annual Report and Accounts shows a significant increase in the number of clinical negligence payments and bad debt provision.
A. The Chairman responded by saying Adrian Stokes would respond to any questions about the Annual Report and Accounts as this was next on the agenda.

The meeting formally received and approved the Audit report.

10.58

10. To receive and consider the Annual Report and Accounts 2009/10

Adrian Stokes started by thanking PwC for the work they had undertaken, on behalf of the Trust, after what had been a very challenging year. He then responded to specific questions raised directly in the previous presentation.

- Bad Debt Reserves
  - Birmingham City Council has fines relating to delayed discharges. Negotiations were ongoing to resolve these issues.
  - The Trust had yet to reach agreement with the PCT’s, by the year end, resulting in a high level of outstanding debt.
Clinical Negligence Scheme for Trusts (CNST) premiums
  - These had increased significantly from last year. These prices are determined nationally but do reflect the following discounts:
    - 20% discount for Acute Services (Level 2)
    - 30% discount for Maternity Services (Level 3)

Further questions were invited.

Q. Consultancy costs have gone up substantially, can you explain this?
A. In the last year the Trust acted as a host for a number of things, one of these being the National Leadership Council. The DoH gave us money to spend on their behalf, so this was not additional consultancy costs per-se.

Q. What exactly is the National Leadership Council?
A. The National Leadership Council is a national DoH drive to improve leadership across the whole NHS.

Q. What are the next steps to be taken with the amounts owed by Birmingham City Council?
A. The Trust is working closely with Birmingham City Council, as this is a very important relationship, and discussions are being held at Chairman and Financial Director level.

Q. How do you reconcile the income relating to car parking with costs given that lead us to believe it makes a loss in total but this cannot be seen in the accounts?
A. Whilst the income is separately identified in the accounts, the costs are apportioned over many categories of expenditure. For instance, the total rates costs contain an element that relates to the car parking land. Adrian offered to send round a separate trading account that pulls all these together. The Chairman confirmed that this is looked at monthly when presented to the Finance Committee by Adrian.

Q. Total income is nevertheless up by £400k on the one last year?
A. This relates to the number of visitors increasing as the prices themselves have remained low and in some instances fallen.

Q. With reference to Page 111, of the Annual Report and Accounts 2009/10, ‘Early Retirements Due to Ill Health’ a question on the operating expenses. I notice that in previous years early retirement was recorded as zero and the year just gone it was over half a million. Are these genuine early retirements or is this a way of managing people out of work as this is the easiest way to get them out and is this increase from zero to half a million something that we can expect to go on increasing in years to come?
A. The issues of early retirement costs within the accounts is a complicated one as it involves future provisioning for likely costs going forward. Adrian agreed to pull together a one page summary for Governors that explained the need for the charge in year and how it correlates with the cash paid out in year.

Kat Little, PwC, confirmed that the figures were correct and accurate.

The meeting formally received and approved the Annual Report and Accounts 2009/10.
Q. Are we on target to meet staff appraisals by the end of September?

A. Mandy Coalter: The Executive team has been monitoring and reviewing appraisals on a weekly basis. I have had a look at the figures this morning and we’ve actually got 5,500 staff who have been appraised year to date. We’ve still got a couple of weeks to go until the end of September, and we know that there are still a significant amount of staff, I’m talking well into the hundreds, who have got appraisals booked during that period, so we’ll continue to monitor over the next couple of weeks. We did originally set ourselves a pretty stretching target to do 8,000 by the end of September, but we’ve reassessed that and we’re confident that we’ll get somewhere between the 6,000 and 7,000 mark. There are some genuine operational reasons why some staff groups haven’t got them in but we are going to continue to put the pressure up during October.

I think the crucial point is the impact on CQC compliance. They were not looking particularly at appraisal numbers but were more interested in the fact that from appraisals we can identify staff training needs and they wanted to make sure we had a robust system around identifying training needs and appraising them is a fundamental part of that. We’ve got absolute confidence that they will be happy because from the 5,500 that we have done we’ve got some really rich information on the training needs of our staff and we’re currently cross referencing that with statutory requirements and all other sorts of training information.

Q. Is anyone monitoring the quality of these appraisals?

A. Mandy Coalter advised that we do that through the staff survey. The annual staff survey is about to be launched and asks some very specific questions about the quality of the process and we rely on that information. We’ve also recently worked with the Audit Committee to start a very fundamental review of appraisals and how they operate within the Trust and one of the things that we’ve included in a review of policy so that we can get some real in-depth information out of that. We’ve also done a lot of training this year for people in terms of how to appraise. The quality outcome is probably still an area for us to review, but I’m more than happy to bring back information data about performance to future meetings.

Q. How has 360 been taken up? Do people like it / not like it? Have you had any feedback? As a member of staff I’ve found it really quite awkward and hard to do as I’ve never done one before.

A. Mandy Coalter commented that this was a really good point and we’ve debated this hard and long with the Union’s and Staff Side. It works really well in leadership and management roles. The clinicians have used 360 for approximately 3 or 4 years now and are comfortable with it and genuinely appreciate the reports they get. With other staff it’s very new and this is something we will re-assess for next year by learning lessons on how its worked and by making some minor changes. This is exactly what we did when we introduced it for senior staff 3 or 4 years ago.

Q. What is 360 feedback?

A: Basically, 360 feedback is where you try and seek feedback from a range of people, so as well as asking your boss what they think about you, you will ask people who you work alongside, you might ask people that you line manage, you may ask customers, you may ask patients or other colleagues that you’ve worked with locally, so it’s a way of getting a 360
view on an individual whereas in days gone by the only person who gave you any feedback was your boss and they might have a particular view but other people may see you differently.

The Chairman thanked the Governors' for attending and contributing at the meeting.

12. **Date & Time of next meeting**

   Monday 22\(^{nd}\) November 2010, at 16:30hrs, Heartlands Education Centre.

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Chairman
What is Ultragenda?

Q. What is UltraGenda?
A. UltraGenda is a scheduling system. Every clinician in the Trust has their own diary in UltraGenda. Each diary shows when a clinician is available to see patients. We also have diaries for rooms and medical equipment. It’s easy to book an appointment for a clinician and a room and a piece of equipment in one go. UltraGenda is very configurable.

Choose and Book is a national booking system. Every night UltraGenda tells Choose and Book about free time in our clinician’s diaries. GPs and patients use Choose and Book to book appointments. They can make appointments on-line or by telephone. If the appointment is at this Trust, it automatically updates UltraGenda.

Q. What does a direct booking service mean for patients?
A. Direct booking means patients can use Choose and Book with their GP to choose the date and time of their out-patient appointment in this Trust. Some GPs may begin the booking but leave the patient to make the final choice of appointment at home either on-line or by telephone. GPs use Choose and Book to send the supporting information electronically rather than sending a paper referral letter to the Trust.

Q. Why do patients get numerous letters all stating different things?
A. UltraGenda provides a button to print a letter each time an appointment is booked or moved. Most users print letters every time an appointment is moved. Some patients may receive more than one letter if their appointment is moved. Some appointment letters may be sent out many months in advance. ICT is developing a solution that will help users send out letters closer to the appointment date.

Q. Where are we on UltraGenda in getting a patch to fix the system and resolve the multiple letter issue?
A. There are two issues. Firstly, appointments are being moved and secondly that users are printing a letter every time an appointment is moved. Tackling the first issue will go some way to reducing the second issue. In addition, the solution being developed by ICT means that most patients should receive a single letter 3-4 weeks before their appointment date.