ROYAL BROMPTON & HAREFIELD NHS TRUST

Minutes of a Meeting of the Trust Board held on 23 November 2005 in the Boardroom, Royal Brompton Hospital

Present:	Lord Newton of Braintree: Chairman Mr C Perrin: Deputy Chairman Mr R Bell: Chief Executive Mrs S Bhatt: Non-Executive Director Mrs I Boyer: Non-Executive Director Professor T Evans: Medical Director Professor M Green: Non-Executive Director Mrs M Leadbeater: Director of Finance Mrs S McCarthy: Non-Executive Director Mr P Mitchell: Director of Operations Mrs S McCarthy: Non-Executive Director Professor A Newman Taylor: Deputy Chief Executive Dr. C Shuldham: Director of Nursing and Quality
By invitation:	Mrs M Cabrelli: Director of Estates Mr R Craig: Director of Governance and Quality Mr N Hunt: Director of Commissioning and Business Development Ms J Thomas: Director of Communications Mr T Vickers: Director of Human Resources Ms J Walton: Director of Fundraising
Observer:	Ms J Ocloo: Chair RBH&H Patient & Public Involvement Forum
In Attendance:	Mrs E Schutte: Executive Assistant

The Chairman welcomed Professor Yi Mien Koh, members of the SHA Review Panel, staff and members of the public to the meeting. He announced the appointment of Mrs Jennifer Hill as a Non-Executive Director when Mrs Isabel Boyer's term of office ceased at the end of November. A press release would be issued. The Chairman also informed the Board that Mrs Suzanne McCarthy's appointment as a Non-Executive Director had been extended for one year to 30 November 2006.

REF

2005/119 MINUTES OF TRUST BOARD MEETING ON 26 OCTOBER 2005

The minutes of the previous meeting of the Trust Board which was held on 26 October 2005 were confirmed.

2005/120 SHA CLINICAL GOVERNANCE REVIEW OF SURGERY AT HAREFIELD HOSPITAL

The Board received the final report from the SHA Review on clinical governance at Harefield Hospital and the Chairman invited Professor Yi Mien Koh, Chair of the Review Panel, to present the findings. Professor Yi Mien Koh indicated that she was also the Executive Director of Public Health and Medical Director of North West London Strategic Health Authority (NWL SHA).

Professor Koh explained that in the Autumn of 2004 the Trust had made the SHA aware of concerns about sufficient back up from other specialties and whether its post operative wound infection rates could be improved. The SHA decided to review clinical governance at Harefield including whether its survival rates for coronary artery bypass grafts (CABG) and aortic valve replacements (AVR) and post operative wound infections were within national averages.

The review began in July 2005 and found that there were no statically different outcomes for CABG and AVR. They were satisfactory compared to other cardiothoracic centres nationally. Neither were there significant statistical differences between post operative wound infection rates for Harefield and the Royal Brompton. Patients were also seen within Department of Health recommended waiting times, the staff were dedicated and robust systems were in place to manage clinical governance. However the leadership of the clinical team at Harefield needed to be strengthened. The Hospital was also operating in relative clinical isolation without medical or surgical sub-speciality support and although the Trust had made several attempts to address matters, it had not been successful to date in securing long-term arrangements.

A SHA estates survey had further identified failings in parts of the buildings which could impact on patient safety. These related to fire evacuation procedures, poorly-removed asbestos, sub-standard thoracic operating theatres and patient areas which were not up to current standards.

The key recommendations were that the problems identified had to be addressed or the services reprovided elsewhere so that patient care met current safety, privacy and dignity standards. Effective clinical leadership in the Surgical Directorate should be established and the recommendations of the NSCAG report on transplantation services should also be implemented.

The Chairman thanked Professor Yi Mien Koh for her presentation and her recent involvement in securing sub-speciality support services from Hillingdon Hospital for Harefield Hospital.

Ms Josephine Ocloo, Chair RB&H Patient and Public Involvement Forum, quoted from the review report which stated 'the review has exposed serious concerns in relation to both the patient experience and potential threats to patient safety from poor facilities and clinical isolation'. Ms Ocloo felt that some of the findings of the Review Panel were similar to those of the Bristol Report which highlighted a number of factors impacting upon patient safety such as separate sites, the poor state of buildings, lack of effective teamwork and poor clinical leadership and management. She asked the Review Panel, why notwithstanding the issues to do with infrastructure, which were more outside the Trust's control, the issues to do with poor clinical governance had taken so long to be discovered and addressed. She was concerned that urgent action was required to achieve improvement. She also did not feel that the Panel addressed her question.

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Mr Charles Perrin, Deputy Chairman, sought clarification on what needed to be done immediately to effect improvements in line with the review recommendations, compared to the long term objectives. It was agreed that the Trust would address immediate improvements while also looking at long term objectives.

Judith Worthington, a lay member of the review panel, stressed the importance of facilities on site being up to current standards to facilitate patient recovery. It was crucial for the Trust to address infrastructure improvements in its future plans.

Mr Robert Bell, Chief Executive, thanked the Review Panel, commended the process of acting constructively and assured that he would be taking appropriate action. Mr Bell advised the Board that the Trust needed to act swiftly to implement the actions required to address the issues identified in the report. Furthermore, the Trust recognised the risks identified in the Panel's report and

acknowledged the fact that they had, in effect, been placed on notice to act on the implementation of urgent operational solutions to address the issues and outcomes outlined in the report.

Mr Bell advised the Board that the Trust senior management and senior clinical leadership had considered actions to address these issues. Mr Bell said that the Harefield Hospital serves, annually, tens and thousands of inpatients and outpatients with ever increasing demands and needs for a large volume of interventional and urgent cardiology, complex cardiac and thoracic surgery, heart and lung transplantation, cardiac rehabilitation, follow up and diagnostic services. He advised that the Trust management was of the view that it would be highly disruptive and would endanger the patient population, to consider relocating elsewhere when no such alternate facilities were available. Mr Bell explained that the Trust clinicians had emphasised to him that managing and solving the issues on the Harefield site was preferable to putting patients at higher risk by contemplating closure.

Mr Bell pointed out that, notwithstanding the facility challenges identified by the review, as well as the potential risks associated with the circumstances of clinical isolation, the review had concluded that the clinical outcomes analysed by the review were satisfactory. Although the review concluded that certain services (inpatient wards and thoracic theatres) need to be re-provided in facilities that meet current safety standards as well as dignity and privacy standards, Mr Bell said that the Harefield site had several facilities that were recently refurbished and re-built. These included surgical theatres, outpatient facilities, diagnostic facilities and clinical laboratories. Therefore, in order to address the urgent health and safety concerns identified by the review, Trust management believed that the appropriate immediate solution was to re-build the required inpatient units and the thoracic theatres on the Harefield site and that this course of action was within the purview of the Trust's responsibilities, role and mandate. This solution would be undertaken while the Hospital continued its operations and the detailed implementation of the other recommendations were pursued. He advised that suitable land was available on the site, alternative fast-track building solutions were being explored and the related capital expenditures were being identified, and project timescales were being established.

Mr Bell informed the Board that as the Trust may not have the full means to cover the expected capital expenditures for a potential re-

building solution, a business case would be submitted to the SHA Capital Investment Committee for the required funds.

In addition to the re-build proposition, Mr Bell advised that Trust management proposed to engage the local health economy served by Harefield Hospital and request their support, interest and commitment in providing assistance with the required capital expenditures. He explained that the local health economy, served by Harefield Hospital, was much wider than North West London with 54% of the Harefield activity being derived from the regions of Bedfordshire, Hertfordshire, Buckinghamshire and Thames Valley, 29% of activity from the North West London, with the balance of 17% of activity coming from other parts of Southern England. To this end Trust management proposed the appointment of a Project Review Panel led by experienced, external and independent individuals who would oversee the process and report back to the Trust within three months.

On the issue of clinical isolation, Mr Bell said the Trust was in the process of signing a contractual agreement with Hillingdon Hospitals NHS Trust to provide interim comprehensive sub-speciality support to the Harefield Hospital with immediate effect. Mr Bell then invited Professor Tim Evans, Medical Director, to inform the Board of the detailed actions already taken in response to the operational recommendations.

Professor Tim Evans, Medical Director presented specific actions that had already been taken in respect of the urgent operational recommendations and Ms Maria Cabrelli updated the Board of the state of the hospital fabric and plant.

(i) State of the fabric and plant

Ms Maria Cabrelli, Director of Estates and Facilities, advised the Board that an urgent review of fire safety had been commissioned from Lawrence Webster Forrest with the understanding that, whilst the review was underway, the Trust would be informed of any immediate safety threats and recommendations for immediate solution. In addition, prior to the receipt of the clinical governance review of surgical services at Harefield Hospital report, a review of electrical safety had been commissioned the report which was due in approximately four weeks. The findings would be presented to the Board at the earliest opportunity.

Ms Cabrelli explained that a full risk assessment of management of potential legionella infection was already underway, with the results due in early 2006. Trust management agreed the reprovision of thoracic theatres was necessary. With regard to the patient experience, the Board was informed that best attempts to maintain the current build had been made, and although the Trust had received excellent PEAT assessments, the current design did not allow for further improvements.

(ii) Non cardiorespiratory services; Retirements and other vacancies

Professor Evans explained that a system of clinical cover was already partly in place to address the lack of non cardiorespiratory services at Harefield Hospital. Other services were currently being established where such cover was lacking. Gastroenterological cover had been agreed with Hillingdon Hospitals NHS Trust. Renal cover was already in place from Hammersmith Hospital and neurological services from Charing Cross Hospital. Psychiatric cover was already provided by West London Mental Health Trust.

In respect of Trust consultant appointments, Professor Evans advised that a medical workforce strategy was being developed with involvement from the Clinical Directorates as well as Human Resources. New appointments had been made in microbiology, cardiology and transplantation and were imminent in haematology. A strategy for Thoracic Surgery had been developed.

(iii) Patient pathways and Clinical conduct

Professor Evans informed the Board that surgeons now attended daily MDT (Multi-Disciplinary Team) meetings and ICU rounds. He also advised that the surgeons' job plans had been modified to take their new commitments into account.

Following the recent Senior Advisory Committee (SAC) visit and their recommendations, Professor Evans informed the Board of the action plan in place to address their recommendations. Furthermore, a review of surgical codes of practice was completed in mid-November.

(iv) Governance, clinical outcomes and infection rates

As acknowledged by the Clinical governance review, the Trust has robust clinical governance system and outcomes which are discussed regularly at Board proceedings. Professor Evans informed the Board of the monthly meeting between cardiology, surgery, anaesthesia

and critical care would be attended by all medical, nursing and pharmaceutical staff with the intention to grade death reports. Records of deaths would be tabulated with the issues arising from each case and the actions that were taken distributed to all those involved in delivering care. Furthermore, directorate feedback of (graded) adverse incidents and quarterly Surgical Site Surveillance Scheme (SSISS) data would be supplied to surgeons.

(v) Clinical leadership

The Board was informed of the interim appointment of Mr William Fountain as the new head of cardiothoracic surgery. In addition, the Trust was actively attempting to recruit and appoint a new head of transplantation and surgery. A clinical leadership strategy and programme of training had been completed to be implemented in 2006.

In summary, Professor Evans stressed that patients undergoing first time CABG surgery at Harefield Hospital in its present state had acceptable survival rates. Moreover, the Health Protection Agency identified no statistically significant differences between Harefield Hospital and the Royal Brompton Hospital or other Trusts in terms of wound infection rates. Further Harefield had recently become a major centre for percutaneous acute coronary revascularisation with excellent results. Professor Evans stated that surgical services were required at Harefield Hospital in order to support this service.

The Chairman thanked Mr Bell and Professor Evans for their presentations.

Mr Perrin asked the Review Panel whether in their view the clinical support arrangements with the various surrounding Hospitals were considered sufficient in addressing the issue of relative clinical isolation at Harefield Hospital.

Professor Peter Hutton and Professor John Dark, Members of the SHA Review Panel, commended the Trust on the steps already taken to move forward. Professor Dark urged that solutions should be sought which were long term as well as immediate.

Mr Perrin asked whether the Trust had costed and included in its financial projections recent, and planned, staff appointments and a sum for work recommended by the reviews commissioned in respect of fire and electric safety. The Board was reassured by the Medical Director and Director of Operations that the required funding had

been identified in line with the current financial constraints. The Chairman requested an assessment of the financial implications to the Board at its December meeting to understand fully the implications of the staff appointments and commissioned reviews.

Mrs Suzanne McCarthy, Non-Executive Director, asked for clarification on the status of the Chief Executive's summary. The Chairman said Mr Bell has been speaking on behalf of Trust management rather than the Board. As he indicated, it would be necessary at a later stage for the Board to consider a business case if that appeared appropriate following the work of the Project Review Panel.

Ms Ocloo said that it was evident from the report that the cardiac surgical surgeons needed to improve working relations and wanted to know what would be done to address this. Professor Evans explained the various clinical leadership programmes that would be in support of improving these relationships. He also explained that the surgeons job plans were being reviewed to ensure they had sufficient time to participate in these programmes.

Mrs Isabel Boyer, Non-Executive Director, expressed concern that patients would be discouraged from attending surgery at Harefield Hospital after the publication of the Review Report. She was mindful how the findings about buildings and facilities may affect patient choice and that it was imperative the Trust reassures patients that they could have confidence in the clinical services provided.

Professor Malcolm Green, Non-Executive Director, enquired of the SHA Review Panel whether they would be in the position to comment on whether the action taken by the Trust to address the shorter-term urgent operational recommendations were sufficient and whether the proposed action to address the longer-term strategic recommendations was acceptable. The Review Panel advised that as this was not part of their brief they could not address it. However it was essential that the immediate and longer term concerns were both addressed.

Mrs Jean Brett, Chair of the Heart of Harefield, reminded that her organisation had already proved its acumen by its long term advice to the Board that the Paddington Health Campus was not viable. The recent independent "Lessons Learned" report to the Strategic Health Authority on the collapsed Paddington Project underlined that Heart of Harefield was correct and, had some of the money wasted

on Paddington instead been spent on Harefield Hospital, deterioration could have been prevented.

On the supposed isolation of Harefield Hospital Mrs Brett pointed out its easy accessibility by several modes of transport and ease of access to neighbouring hospitals. There was no reason for closure.

Furthermore the patient experience at Harefield Hospital was excellent so that there would be public and patient outrage at any suggestion of closure. On the same site was the renowned Sir Magdi Yacoub Heart Science Research Centre. This provision of "bed and bench" together was for the benefit of all patients. The Trust was also to be congratulated for moving so swiftly to ensure patient safety after the review.

Mrs Brett stressed there were concerns about the SHA's failure to include adequate patient and public representation on the review panel. Mr David Potter, as Chair of Re-Beat, had to decline to participate due to his questions to the SHA on the review receiving evasive answers. It was also noticeable that the SHA had not invited her to be on the review panel despite her position as Chair of the main patient and public organisation. This was despite the coordinator of the Patient Public Involvement Forum having suggested her name to the NHS manager concerned.

Mrs Brett asked Professor Yi Mien Koh for an explanation and also queried how many other 3 star Trusts the NW London SHA had reviewed.

The Chairman invited Professor Yi Mien Koh to respond to the questions. The invitation was declined.

Mr David Potter, Vice-Chair of Heart of Harefield and Chair of Re-Beat, a Patient's Charity, explained that Re-Beat had 300 members who preferred going to Harefield Hospital for treatment rather than anywhere else. Harefield was a wonderful environment for patient recovery. Mr Potter echoed Mrs Brett's concerns about the conduct of the SHA and wished it recorded that neither he nor Mr Syer (page 10 of the report) had agreed to participate in the review and then later withdrawn. They had been unable to agree to take part due to Professor Yi Mien Koh failing to answer reasonable questions. He also wished it to be placed on record that he had suggested to Professor Yi Mien Koh that Mrs Brett, due to her position and wide local knowledge, be approached to be on the review panel. He had

been assured this would be taken up and the public would be involved. This was not carried through. There was sufficient concern to consider a judicial review of the process. Requests for answers in the last SHA Board meeting had been ignored.

Mr Potter referred to the waste of public money on the aborted Paddington Health Campus warning that this went beyond the £14million expended due to lost opportunity costs estimated at £100million. He believed that money would have been better spent on the upkeep of hospitals such as Harefield.

In reply the Chairman asked Professor Yi Mien Koh whether she wished to respond to Mr Potter's comments. Professor Yi Mien Koh said she had answered Mr Potter's questions in the last SHA Board meeting. Mr Potter said this was not so.

Professor Malcolm Green referred to Mr Potter's comment on opportunity costs and wished to make it clear that the £100m was a theoretical sum of money. It was not actual expenditure.

Mrs Pauline Crawley, Chairwoman of Harefield Tenants and Residents Association and a former Non-Executive Director of Hillingdon Health Authority, hoped the new Chief Executive would involve the residents of Harefield in discussions on the hospital as used to be the case in the past. Mrs Crawley also noted that because Professor Yi Mien Koh was a past Board member of the Kensington and Chelsea & Westminster Health Authority it raised concerns over her independence.

In response to earlier comments made by Mrs Brett about PPI involvement in the Review, Ms Ocloo commented that she thought that there were legitimate issues to be raised in relation to this. She pointed out that the Bristol Report highlighted the importance of PPI involvement in improving the quality and standards of patient care. Ms Ocloo felt that the Patients Forum had not been given appropriate time to arrange to participate in the Review and that she as the Chair of the Forum had not been formally invited to participate. The Forum had been contacted by the Trust which had stressed the importance of someone being involved who had particular knowledge of the Harefield site. In the future Ms Ocloo felt that it was important that the SHA wrote formally and directly to the Forum if they wished to invite their involvement in a review process.

In conclusion, the Chairman asked the Board to support two recommendations

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(i) The suggested immediate cessation of all services at Harefield Hospital was a much greater risk than to continue with services whilst addressing the risks identified.

This was agreed.

(ii) The proposal of the appointment of a project review panel to provide the necessary information to the Board to enable a longer-term decision about the future of Harefield Hospital.

This was agreed.

2005/121 NATIONAL SPECIALIST COMMISSIONING ADVISORY GROUP (NSCAG) REVIEW OF TRANSPLANTATION AT HAREFIELD HOSPITAL

Professor Evans explained to the Board that between January and March 2005 four out of ten lung transplantation patients had died within 30 days and that between April and June 2005 four out of six heart transplantation patients had died within 90 days. He explained that this had caused considerable concern for the Trust which had started an internal review in June and alerted NSCAG of the concerns.

Concurrently, NSCAG instituted an external review in which an independent surgeon reviewed the case records; UKCTA undertook a statistical review and made site visits made to Harefield Hospital. Professor Evans also informed the Board that the internal review report of the Trust was reviewed by NSCAG in October 2005.

Professor Evans summarised the findings of the NSCAG Review report on Transplantation at Harefield Hospital. The report indicated that the Trust was correct in instituting an internal review and raising its concern with NSCAG. NSCAG recognised that the Trust had well-organised clinical governance arrangements and that there was clear evidence that many of the issues had been raised in the Transplantation Directorate's audit meetings, and that these were being, or had been, addressed. Furthermore, the report identified that the team considered that recent outcomes were linked to system and process problems in donor assessment and organ retrieval and in intra operative care.

A summary of actions that had been taken by the Trust in response to the recommendations made in the NSCAG report was given to the Board.

(i) To build a surgical team with the full commitment of the surgeons to attend MDT meetings.

Professor Evans informed the Board of meetings that had taken place with each surgeon to ensure their commitment to the operational and strategic plans for transplantation. He said that the attendance at MDT assessments had been included in their job plans and that their theatre lists were amended to facilitate this. A record of attendance to the MDT assessment meetings was being made which showed an improvement. He also indicated that the surgeons at the Royal Brompton Hospital were committed to an on-call week at Harefield Hospital, where they would have no sessional commitments at RBH whilst on-call at HH.

(ii) Protocols must be agreed, owned and used by the whole team and used at trainee induction

The Board was informed of the transplantation protocols that were implemented and in use, those that were in final draft form and in the process of finalisation for implementation. Retrieval protocols had been revised and implemented. The Board was told that the Ventricular Assist Device (VAD) policy was in final draft. Furthermore, a summary of further protocols in use or near completion was provided clearly indicating the Trust's commitment. The Board was also reassured that the agreed protocols and policies were being included in the paperwork for the trainee induction programme.

(iii) The development of a protocol for organ retrieval, including invasive monitoring and echocardiography for all prospective donors together with training for protocol implementation

Professor Evans assured the Board that all retrievals were consultant-supervised until the trainees were 'signed-off' as competent. He said that a protocol for anaesthetic trainees and formal assessments of organ suitability was agreed and that inter-disciplinary training programme for junior medical staff had commenced in September.

(iv) To consider additional ways in which the Trust can monitor transplant outcomes – including surgeon performance – as close as possible to 'real time'

Professor Evans indicated that this recommendation was much more difficult to implement as there was an element of subjectivity to patient assessment. The Trust would also be using national and local comparators where possible.

(v) The roles, responsibilities, handover and hierarchy of care postoperatively need to be clearly defined and acted upon

As a direct result of the NSCAG report, and as indicated in his response to the SHA Review report, surgeons now attended daily MDT meetings and ICU rounds. Professor Evans also advised that surgeons' job plans had been modified to take their new commitments into account. A review of surgical codes of practice had been completed in mid-November.

(v) The transplant leadership needs the full support of all colleagues and the whole organisation…support needs to be built around a clinical director…consideration to sharing roles so that responsibility does not fall on one individual

Professor Evans reiterated his response to the SHA Review Report on the programme of consultant recruitment and advised that a new cardiologist appointment had been made in November, with specific ties to transplantation. He advised that additional surgical candidates had been identified and approached, details of which would be provided when arrangements were confirmed. Professor Evans said he was grateful to the Director of Transplantation for the responsibility assumed for the service to date. However, the need to increase support in his responsibilities for key issues such as VADs, organ retrieval and lung transplantation had been identified and accepted. In line with the recent reviews, a strategic review of transplantation services had been commissioned.

In summary, Professor Evans advised the Board that regular contact with NSCAG would be maintained. A progress meeting would take place in December 2005, at which the Trust would have an opportunity to provide feedback on action taken and on further progress. NSCAG expected a formal written report in January 2006 which would be followed up by further site visits. It was expected that the strategic vision would be completed by February 2006.

Mrs Boyer commended the efforts to date and suggested that whilst the assessments of the protocols were required, a subjective assessment of surgeon provisions should also be investigated.

Professor Evans agreed and commented that the way in which patients were accepted for the programmes was equally important.

Discussion took place on whether it was possible to have a single-site transplantation service. It was indicated that relocating the service from Harefield Hospital would be detrimental to the future of the site as the surgeons performing transplants also performed cardiac surgery. It would also impact upon the transplant patient population who attend Harefield Hospital as once the operation had been performed a lifetime of care was required.

Mrs Brett commented that the NSCAG report was respected and that there was confidence in the clinical governance processes in place at Harefield.

2005/122 REPORT FROM THE CHIEF EXECUTIVE

The Chief Executive advised that the Board agenda covered all relevant items on which he wished to report.

2005/123 FOUNDATION TRUST STATUS

Professor Anthony Newman Taylor, Deputy Chief Executive and Chair of the internal Foundation Trust Status group responsible for the Trust's application process, reminded the Board of a paper that he submitted at the end of the 2004 as Acting Chief Executive regarding Foundation Trust status and the recommendation not to proceed at that time. He had now reviewed the recommendations and indicated how the position had changed.

Professor Newman Taylor said the Trust now had a Chief Executive, had achieved 3 star status again, had a better understanding of the new Payment by Results regime and its benefits to the Trust and was confident that the uncertainty of NHS and R&D Funding would be addressed favourably as a Foundation Trust. The Trust would also have access to capital more readily than it could achieve in its current status.

In respect of the changes described and supported by the paper given to the Board by Mr Robert Craig, Director of Governance and Quality, Professor Newman Taylor sought the support of the Board to proceed with the Third Wave DoH Foundation Trust Application process with the formal expression of interest to the DoH to be made on 2 December 2005.

The Board thanked Professor Newman Taylor for his address and noted the report from Mr Craig. The Board endorsed the proposal that the Trust should proceed with a Foundation Trust application as part of the third Wave process with the understanding that in June 2006 when the formal application to the DoH is required, should the Trust not be in the position to provide definitive business cases for the recommendations as a result of the Review Project of Harefield Hospital and the EPICentre, the Trust would advise the DoH that it would defer the application.

2005/124 PERFORMANCE REPORT FOR MONTH 7: OCTOBER 2005

The Board received a report on performance up to 31 October 2005. Mrs Mary Leadbeater, Director of Finance, said that the Trust had reported a surplus of £3.9m but that this was £1.1m less than the plan. Activity was 7% ahead of plan. The financial stability plan was not finished yet with delivery of £937,000 savings remaining to be defined. It had been agreed that the Trust would plan to achieve an additional £1m above the agreed surplus of £1.6m required by the SHA in recovering the overall NW London deficit, but that the additional £1m would not be in cash terms. The Board noted the position.

The current income position included activity valued in different ways according to the PbR rules. This shows that where PCTs have reduced their SLAs below outturn, that there is a cash flow impact and delay in payment due to the proportion of activity that is treated as over performance rather than through regular SLA payments.

2005/125 ATTENDANCE OF PUBLIC AND PATIENT INVOLVEMENT FORUM (PPIF) CHAIRMAN AT PART 2 OF TRUST BOARD MEETINGS

The Chairman advised the Board that Ms Josephine Ocloo, Chair RB&H Patient and Public Involvement Forum (PPIF) wrote to him earlier in 2005 to enquire whether attendance of the PPIF Chair at Part 2 of Trust Board meetings could be considered. He explained that little and inconclusive guidance on the matter was available at the time. The Chairman had asked Mr John Chapman, Head of Administration, to investigate practice at other NHS organisations. Mr Chapman's investigations indicated that the organisations that had been contacted, similarly did not have PPIF representation at their Part 2 of Trust Board meetings. Members of the Board had subsequently had discussed the issue informally and indicated that due to the sensitivity of the business there should be no PPIF attendance.

Ms Ocloo asked the Board to think again as it would be in the interest of the Trust to have PPIF representation at Part 2 meetings as an example of best practice in involving the patients and public with the added value of their perspective. Ms Ocloo also reported that some NHS bodies did have PPIF representation at Part 2 meetings. She suggested that the representation would not necessarily be by herself and that the representative would treat the matters discussed in the same confidential way that Board members were expected to treat them.

Board members were unanimous that, should it be considered in the future that PPIF representation at Board Part 2 meetings be agreed, it should be the same person attending Part 1 of the Board meetings. The Board considered an alternative proposal from Mr Bell to invite PPIF attendance at the Chairman's discretion, depending on the issues for consideration but, after further deliberation it was agreed to adhere to the original recommendation not to permit PPIF attendance at Part 2 meetings.

Mr David Potter commented that he regretted the Board's decision as he saw no reason why the PPI Chair should not attend the second part of the Board meetings. The Board's refusal to allow this would increase the public's perception of the Board as being hostile to patient and public involvement. Neither did he see any problem on the issue of confidentiality being adhered to.

Mrs Brett made clear that as Chair of Heart of Harefield she was very concerned indeed at the attitude shown in refusing to allow the Chair of the Patient and Public Involvement Forum into the second part of Board meetings. She urged the Chairman and Board to reconsider Mr Bell's suggestion of a compromise. Public and patient involvement was important and of benefit at all levels of the Trust and should be welcomed.

The Chairman thanked the public for their comments.

2005/126 <u>MRS ISABEL BOYER, NON-EXECUTIVE DIRECTOR</u>

The Chairman expressed appreciation to Mrs Boyer for her support and enthusiasm she has offered the Trust, in many spheres, in her two terms as a Non-Executive Director of the Trust. He wished her well for her future endeavours. Mrs Boyer thanked the Chairman for his comments and said it had been a privilege and pleasure to work with the Board and the truly outstanding staff of the Trust.

2005/127 ITEMS FOR INFORMATION

The Board received and noted papers on the following items which were presented to the meeting for information;

- A report from the Director of Governance and Quality which included the Freedom of Information, The Trust's experience from January to September 2005
- The Draft declaration of compliance against core standards as part of the Annual Health Check process.

Lord Newton of Braintree
Chairman