ROYAL BROMPTON & HAREFIELD NHS TRUST

Minutes of a Meeting of the Trust Board held on 26 January 2005 in the Concert Hall, Harefield Hospital

Present: Lord Newton of Braintree: Chairman
Mr C Perrin: Deputy Chairman
Mrs I Boyer: Non-Executive Director
Mrs M Leadbeater: Director of Finance
Mrs S McCarthy: Non-Executive Director
Mr P Mitchell: Director of Operations
Professor A Newman Taylor: Acting 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 Hodson: PHCD Project Director
Mr N Hunt: Director of Commissioning and Business Development
Ms J Ocloo: Co-Chairman Royal Brompton & Harefield Patient & Public Involvement Forum
Dr. R Radley-Smith: Associate Medical Director HH
Ms J Thomas: Director of Communications
Mr T Vickers: Director of Human Resources
Mrs J Walton: Director of Fundraising

In Attendance: Mr J Chapman: Head of Administration
Mrs W Riddle: Project Manager Agenda for Change

Apologies for absence were received from Professor Tim Evans and Professor Malcolm Green.

The Chairman welcomed members of the public and members of the Trust staff to the meeting which, for the first time, was taking place in the morning. The Chairman reported that he had received a letter from Mr David Potter, Vice-Chairman Heart of Harefield and Chairman of Rebeat, which had asked him to review the starting time of morning meetings at Royal Brompton Hospital. The Chairman explained that he had asked Mr John Chapman to enquire whether some meetings at Royal Brompton Hospital could instead commence at 2.00pm. The Chairman said any meetings at Royal Brompton Hospital which still take place in the morning would commence at 10.30am. He would write to Mr Potter as soon as possible.

REF

2005/01 APPOINTMENT OF CHIEF EXECUTIVE

The Chairman reported that the Board had appointed Mr Robert (Bob) Bell as Chief Executive of Royal Brompton & Harefield NHS Trust. Mr Bell was currently Chief Executive of a group of four substantial hospitals in Toronto Canada and intended to take up the post with

Royal Brompton & Harefield NHS Trust on 28 March 2005. In due course the Board would express its gratitude to Professor Anthony Newman Taylor who had been Acting Chief Executive since the departure of Dr. Gareth Goodier.

2005/02 MINUTES OF TRUST BOARD MEETING ON 15 DECEMBER 2004

The Board received the minutes of the previous meeting on 15 December 2004 and the following amendments were noted;

(i) Mrs Pauline Crawley informed the Chairman she is Chairman of Harefield Tenants and Residents Association.

(ii) Dr. Caroline Shuldham said she referred to efficiency savings in catering and estate services as well as nursing in Minute 2004/147, Page 10.

Mrs Suzanne McCarthy said she and others had not received the minutes but was content for the Board to approve them subject to any comments she may have, which she would report to the Board at the next meeting. This was agreed.

2005/03 AMENDED MINUTES OF TRUST BOARD MEETING ON 23 NOVEMBER 2004

The Board received the previously approved minutes of the meeting on 23 November 2004 with corrections Ms Josephine Ocloo had requested. These were accepted and the revised minutes were approved.

2005/04 REPORT FROM THE CHIEF EXECUTIVE

Professor Anthony Newman Taylor presented a report and referred to five matters.

(i) Paddington Health Campus Development

At its previous meeting the Board had supported the submission of the Outline Business Case to the SHA with comments about the financial risks of the acquisition of land. The SHA approved the OBC with similar comments and had sent it to the Department of Health which was currently considering it. A formal response from the Department of Health or the SHA was awaited.

(ii) Financial position

The Trust's financial position remained very difficult and at the end of Month 9 (December 2004) a deficit of £1.7mn was projected. The Executive Directors were making every effort possible with the Clinical Directors and Directorate Managers to achieve break-even at the end of the year.

(iii) Research and Development

The Department of Health had given comments to the Trust on its research and development report for 2003/4. Ten of eleven submitted research programmes were assessed as strong with sufficient critical mass, a good number of publications, attracting considerable external funding. One programme was not rated because it did not use NHS R&D funding and thus

did not fulfil the criteria. The Department of Health was also complimentary about research in the Trust and expressed its intention to continue the current level of funding from the R&D subvention.

(iv) Major review of healthcare programmes: Thames Valley University

In partnership with the Nursing and Midwifery Council, the Health Professions Council and the Workforce Development Confederation the Department of Health had contracted with the Quality Assurance Group to review all NHS funded healthcare education programmes in 2003/4. The QAA reviewers may visit Royal Brompton Hospital on 3 February and 23 February to assess the quality and consistency of practice-based learning. They would focus on pre and post registration nursing courses.

(v) Counter fraud arrangements

Mrs Suzanne McCarthy, nominated Non-Executive Director for promoting issues of countering fraud within the Trust, had met with the Counter Fraud Service Management Team and had indicated she was satisfied that appropriate arrangements are in place. Mrs McCarthy would attend a seminar to be run by the NHS Counter Fraud and Security Management Service to build on the information provided by the Trust Counter Fraud Team.

The Board thanked Professor Newman Taylor for his report.

2005/05 PADDINGTON HEALTH CAMPUS DEVELOPMENT: RESOLUTION OF SUPPORT FOR THE OBC

The Board confirmed a resolution of support for the Outline Business Case for the Paddington Health Campus Development.

2005/06 AGENDA FOR CHANGE

Dr. Caroline Shuldham, Director of Nursing and Quality, gave a report on the implementation within the Trust of Agenda for Change (AfC), a new system of pay that will apply to all staff except medical staff and the most senior managers at or just below Board level. The Trust had begun the process of transferring staff to the new pay system from 1 December 2004 with the expectation that it would completed by September 2005. New pay rates would be effective from 1 October 2004. All staff who would be subject to AfC would have new job descriptions agreed with their Manager. One set of terms and conditions would apply to all staff groups except those working unsocial hours. From 1 December 2004 a phased move to a standard working week of 37 ½ hours for all full-time staff was taking place. Staff would receive new entitlement to annual leave varying between 27 and 33 days. Staff who will have to be available to provide on-call cover may remain on any current agreements for up to four years or agree to a fixed pay supplement. Existing schemes that provide additional pay for working in high cost areas

would be replaced by harmonised supplements for London and fringe areas or by recruitment and retention premiums outside London. Phased arrangements known as assimilation would be applied to transfer staff to the new pay system. When staff are already paid above the maximum of the new pay band their pay would be protected including one year's protection with a pay uplift followed by five years pay on a mark-time basis.

Dr. Shuldham said the Trust had recruited 50 staff internally to undertake the process of matching job descriptions agreed between members of staff and their managers with the national Agenda for Change profiles. Job matching had commenced and was expected to be completed by June 2005. Where matching against profiles was not conclusive or possible evaluation would be undertaken by using questionnaires. Skills reviews would follow job matching which would lead to allocation of the job to a pay band and the creation of a new contract of employment.

North West Thames Strategic Health Authority had developed a system to measure the performance of Trusts against milestones for implementation. Mrs Wendy Riddle, Project Manager, reported that the Trust had achieved the first milestone with 10% of posts matched by the end of January 2005.

Mrs Mary Leadbeater advised the Board that the financial implications of Agenda for Change would be very significant for year-end accounting and budget costs. Dr. Shuldham said it was not possible yet to quantify the costs. On the other hand there were also benefits which would materialise through a benefits-realisation scheme.

Ms Josephine Ocloo asked, given the emphasis on equal pay for work of equal value, whether the process was being monitored in terms of adverse impact under the Race Relations Amendment Act on particular groups of staff. The Trust was required to examine adverse impact on any policy and given the process and the massive impact on staff Ms Ocloo said this was a prime time to begin thinking about adverse impact, which she would be following closely. Mr Tony Vickers confirmed that the process was not being assessed for adverse impact. He said the Trust was aware minority ethnic people were underrepresented at managerial level and this was under review by the Diversity Steering Group. Appropriate representation of minority ethnic people was recognised as an important organisational quality indicator.

Mrs Suzanne McCarthy asked how the Board would be updated on progress. It was agreed that reports would be given bi-monthly from March 2005.

2005/07 GOVERNANCE AND QUALITY REPORT

Mr Robert Craig, Director of Governance and Quality, presented a report with four items;

(i) Clinical Governance Quarterly Report for July-September 2004
The report gave details of adverse clinical events, clinical audit of wound infection rates, the Trust's input to national audit data sets, the results of the ongoing audit, specific audits in Critical Care and Anaesthesia and Thoracic Surgery and patient feedback.

Ms Josephine Ocloo asked why wound infection rates differed between Royal Brompton and Harefield Hospitals. Mr Craig said the reason why higher rates persisted despite action taken at Harefield in 2002 and 2003 remained unclear. Wound infection rates at Harefield had however fallen in 2003/4 but were nevertheless still above the Trust 2% target rate. Wound surveillance at Harefield continued in order to establish the reasons. The Trust was also taking vigorous action through initiatives such as the Clean Hands Campaign, over practices that can cause wound infection. The NHS Surgical Surveillance Scheme came into operation in 2003 and would provide benchmarks for good performance. The Trust would take any action necessary to help reduce wound infection rates.

Ms Ocloo asked what action had been taken following her question at a previous Board meeting on lay involvement in Clinical Governance. Professor Newman Taylor said the Trust had sought advice from the Strategic Health Authority and the Clinical Governance Committee was now considering the matter. Proposals would be made to the Patient & Public Involvement Forum in the near future.

Ms Ocloo also asked whether any comparable data was available about adverse clinical events in other Trusts. Mr Craig said there was no current national NHS database of adverse event reporting. However from January 2005 the National Patient Safety Agency had established a national reporting and learning system under which every Trust would submit reports. It would however be some years before reliable data sets became available and comparisons could be made.

(ii) Standards for Better Health
The report drew attention to a consultation paper from the Healthcare Commission on the new core standards and development standards that NHS organisations are expected to meet from 2005/6. Mr Craig explained that the standards would be consistent with the principle of "light touch" with an emphasis on self-assessment. Healthcare Commission visits to

NHS organisations would be the exception rather than the rule. Consultation on the standards would conclude on 28 February and decisions would be announced in April. The Board would be expected to agree a public declaration of compliance with the care standards in September 2005 to include the views of patients and partners. The declaration would be expected to incorporate opinions from the Trust Auditors, a commentary from the SHA, the Patient & Public Involvement Forum and the Overview Scrutiny Committee of the Royal Borough of Kensington and Chelsea.

Mr Craig said the Trust had appointed a group chaired by Helen Sumner, Acting Head of Performance, to oversee and manage implementation of the standards. Leaders were being appointed to the seven domains on which compliance would be assessed. The Board would be informed of progress through the Risk Strategy Committee.

(iii) Development of Integrated Care Pathways

Work continued to develop integrated care pathways as the basis for delivering services. The report explained progress to date. Ms Josephine Ocloo asked for a clearer explanation of integrated care pathways and how they related to healthcare and use of resources in the Trust which Professor Newman Taylor gave.

Mrs McCarthy commented that the report contained no reference to financial implications. Mrs Leadbeater indicated that it was planned to pilot one of the initiatives and the financial impact would be studied closely. Mr Craig agreed to give the Board a fuller report on the development of integrated care pathways at the meeting on 23 March.

(iv) Meeting of the Risk Strategy Committee

The Risk Strategy Committee met on 11 January 2005 and considered the development of the Trust's risk register and the Trust Auditors would review progress. It also received the quarterly Risk Management and Clinical Governance reports, considered information currently available about standards for better health and reviewed the Trust's key performance indicators. The internal auditors had raised concerns about the Trust's assurance framework which will be pursued through the Audit Committee.

The Board thanked Mr Craig for a very comprehensive report.

2005/08 REPORT FROM THE FINANCE COMMITTEE

Mrs Mary Leadbeater gave an oral report from the meeting of the Finance Committee earlier in the morning. The Committee had

reviewed the Month 9 financial position, the recovery plan, the budget setting approach for 2005/6, a draft private patient strategy, a business case to replace two gamma cameras, an update on Payments-by-Results and the initial approach towards a medium term financial strategy.

The financial position at the end of December 2004 with a forecast year-end deficit of £1.7mn was cause for great concern and the Committee gave full support to all action that was being taken to achieve break-even by 31 March 2005. If the Trust Board failed to achieve break-even the deficit would be rolled forward to 2005/6. The Committee received the first early indication of savings in the order of £10mn that could be required in 2005/6 should the recovery plan have to continue beyond March. In view of that the Committee expected to consider the first cut budget and business plan at its meeting in March with the aim of a seamless transfer into the next financial year.

The Trust had expected to benefit financially from April 2005 through the operation of Payments-by-Results but the NHS Executive Director of Finance had since December 2004 indicated that less activity would be regulated by it and thus there would be less gain to the Trust.

The Committee endorsed the approach that was being taken over the medium term financial strategy and the impact it would have on the business plan and budget capital programme and planning for Payments-by-Results in 2005/6.

The Chairman said the Board could not be comfortable with the current financial position and its concerns should be shared throughout the Trust. The Board would give its full support to all the action that had been taken and all that directors, managers and staff could do to break-even at the end of the financial year.

2005/09 PERFORMANCE REPORT

The Board received the performance report for the year up to 31 December 2004. NHS activity was 4% below target and private patient activity 13.7% below. The financial position was the result of un-met savings targets, under performance against private patient income targets, shortfalls against SLA income and overspends against non-pay expenditure. The overspends were partially offset by other income gains and savings in pay expenditure. No patients breached the maximum nine month waiting time target or the six month revascularisation target. There was no breach of the maximum seventeen week wait for an outpatient appointment. Staff turnover and vacancy rates were stable.

The impact of underperformance in activity was currently leading to a year-end forecast that would result in the loss of the Trust's current three star rating.

Mrs Isabel Boyer observed that the Trust's 2.41% death rate thirty days after CABG surgery was above the star rating threshold of 2.1%. Mr Craig explained that the star rating was based on a three-year position and that over the three years on which the 2004/5 star rating would be based the Trust would be within the threshold.

The Board noted the report.

2005/10 COMMENTS FROM MEMBERS OF THE PUBLIC

Mrs Hill referred to wound infection rates at Harefield Hospital and asked how many Consultant Microbiologists were employed there. Mr Craig said there was a full-time Consultant Microbiologist at Harefield Hospital.

Mrs Hill also asked why the new Pathology Department at Harefield had not been given CPA accreditation. Mr Craig explained that the Trust had registered the new department with the CPA and assessment had been booked for Summer 2005. Mrs Hill said assessment should have been undertaken by the end of 2004. Mr Craig replied that CPA accreditation was a national system and the CPA had a timetable for assessment and accreditation, over which the Trust had no influence.

Mr Kenneth Appel asked what type of bacteria were the main causes of wound infection at Harefield Hospital. Professor Newman Taylor said the reviews in 2002 and 2003 identified no single organism as the cause of wound infection at Harefield. Mr Craig indicated that wound infection was monitored by the Hospital Infection Control Team and details were available from the Infection Control Department. Dr. Rosemary Radley-Smith informed the Board that members of the public would be concerned over whether MRSA was the main cause. It was not the main cause at Harefield Hospital and Royal Brompton and Harefield Hospitals had the second lowest incidence of MRSA infection rates in London.

Mrs Pauline Crawley, Chairman of Harefield Tenants and Residents Association, asked if any Trust Non-Executive Director participated in scrutiny of complaints. Dr. Caroline Shuldham said there was no Non-Executive Director scrutiny. A complaints working group which she chaired reviewed all complaints. Dr. Shuldham monitored complaints and reported to the Board.

2005/11 CAR PARKING CHARGES AT HAREFIELD HOSPITAL

Mrs Maria Cabrelli, Director of Estates, presented a report which explained the background to the decision to implement charges for car parking at Harefield Hospital, the process Trust Management had followed to determine the charges and, following receipt of the petition signed by 534 members of staff that was presented to the

Board on 23 November, how Trust Management had reviewed staff concerns.

As a consequence proposals to implement charges had been modified. In particular, charges for parking permits would be fixed for three years; 50 additional marked spaces had been provided; the scale of charges had been adjusted to ensure that lower paid staff are not disadvantaged; a fourth pay band had been created for the lowest paid staff. The Trust had also allocated £85,000 available through slippage in the capital programme which would reduce the amount of income to be recovered from charges paid by members of staff. This reduced the total income recovered from staff through permit charges from £42,826 to £38,506 annually. Charges to visitors would commence on 1 February and staff charges from 1 April 2005.

Professor Newman Taylor said the Board should appreciate the introduction of car parking charges at Harefield would always be contentious. Trust Management had tried to ensure that it complied with the Board's requirement that a break-even position was achieved in the car parking programme at the Hospital and that staff concerns were addressed. While charges for visitors remained unchanged a means would be found to ameliorate charges for frequent visitors to the Hospital.

Comments from members of the public

Mr Kenneth Appel, a member of the Patient and Public Involvement Forum, said that he was concerned not only about the charges but the effect of those charges on staff morale, which could have an impact on the patients. Mr Appel had looked at the figures carefully and had also noted that the Trust had taken legal advice on imposing care parking charges on its staff. While aware that the Trust under Employment Act could vary the terms of its staff employment, Mr Appel commented that the staff could also turn to legal remedies if they so wished. Having researched the parking policy of other local hospitals, Mr Appel reported that neither Mount Vernon nor Hillingdon Hospital charge their staff for parking. Some other local hospitals made a charge of 0.03% of salary, whereas the Trust's proposed charges were 2.5, 6, 9 and 13 times greater. There were several other hospitals where parking policy was similarly advantageous to their staff. Mr Appel reiterated that the main consideration should be the effect on staff morale.

The Chairman said any change would have an impact of some kind but he hoped that against the background of a very substantial response to what was said at earlier stages there would at least be a recognition that a genuine attempt had been made to respond to the concerns that were expressed.

Mrs Jean Brett, Chair Heart of Harefield, said that she was very sorry that the problem had arisen. With no disrespect to anyone, part of

the problem was a lack of joined up writing. Nor had the issues been looked into enough. Those with knowledge of possible problems did not appear to have given that knowledge quickly enough to those organising car parking charges. For example a staff survey in 2003 had shown that a very much higher percentage of Harefield's staff drove to work. Therefore anyone attempting to implement car parking charges, without fully consulting staff, was in for a very sticky run indeed. Mrs Brett said she was not favouring those responsible for organising the car parking policy, but was pointing out possible communication problems within the Trust. Neither did Heart of Harefield think that the commitment within the staff employment induction literature, that parking would be free, had been fed through.

However Mrs Brett said that the Trust having consulted solicitors on this matter was unwise. It could lead to a dangerous game, with staff through their Unions, also consulting solicitors. Stressing that she was speaking on behalf of Heart of Harefield, two patient groups, visitors to the hospital and echoing opinion in the village, Mrs Brett said that conduct of the staff was admired. They had courteously presented their petition and were fighting for the principle that no charges should be made for car parking at Harefield. Mrs Crawley, Chair of the Harefield Tenants and Residents Association, had also asked what progress had been made on this at the last Board meeting. There was no shortage of space on the 44 acre site and any improvements to its infrastructure were the financial responsibility of the Trust, not of those there for health reasons or the public good. Recently there had been more approaches to her on this issue than on any other. It was also unacceptable that the Board paper on parking charges had not been consulted upon with staff or sent to the staff before the Board meeting. The timing of the Board meeting had also made it near impossible for the staff to be present. Heart of Harefield's Chair said that this was not the way to treat staff, there should be consultation not confrontation.

Mrs Brett ended by explaining that so many members of the public were present, despite the extremely inconvenient time, because they felt strongly on this matter. There was admiration for the staff. It was realised that it must be very difficult for them, to have a meeting called when it was known they could not be present.

The Chairman referred to Mrs Brett's remark that it had been very unwise of the Trust to take legal advice. In the light of remarks that Mrs Brett had made on an earlier occasion suggesting that what was contained in the induction pack constituted part of the contract of employment Mrs Brett would have criticised the Trust quite strongly if it had not taken legal advice. Mrs Brett said she would disagree but saw no point in going into this when many other people were waiting to comment.

The Chairman reminded the meeting that all of this had proceeded for a long time on the basis of the requirements of the Local Authority, which admittedly were not to introduce charges at the time permission was given for the Anzac Centre, to improve the infrastructure and the view that this had to be paid for against the background of financial difficulties of the Trust. The Trust had not acted in any kind of bad faith.

Mr Patrick Mitchell said the Trust was well aware of what was in the staff survey as it purposefully asked for the questions to be included so it could have an indication of how many people came to the Hospital and by what means. Since planning permission was given for the Anzac Centre and the Heart Science Centre the Trust had been telling staff at Harefield Hospital through Team Brief that charges at some point would be introduced. The Trust also met with one of the patient groups over access to the site when it discussed what the Local Authority stipulated and the fact that charges would be introduced. Mr Mitchell said that since the new parking arrangements had been put in place he had received many favourable comments from staff over improved lighting, the standard of the car parks, the improvement in access to the site and reduced traffic congestion. Mr Mitchell said Trust Management approaches had been right. They had tried to listen to staff as much as they had been able to and had reduced charges for the lowest paid staff. Some staff had from rumour been expecting much higher charges than the Trust was proposing and most people whom he had spoken to believed what the Trust had done was reasonable.

Mr Ed Barnett, a member of staff who had presented the petition and a member of a local church, a voluntary worker at the school and a member of the public, said people appreciated the removal of the double yellow lines in the Hospital had cleared congestion but that should have been done years ago. However, he had spoken to different people to Mr Mitchell and had received totally different reactions from staff. The Trust could not say that the staff were content. Mr Barnett raised four specific issues;

(i) Speaking as a Deacon at Harefield Baptist Church, his concern was the congestion. On Point (g) in the report it said Professor Newman Taylor and Mr Mitchell had met with the Council and the meeting was constructive. Mr Barnett said he had no reaction from the Council to suggest that road congestion had been addressed in any way. Mr Barnett requested clarification of what transpired at the meeting.

Mr Mitchell said Professor Newman Taylor and he had met two Councillors two weeks ago to discuss the proposals and to try and allay their concerns. It was a positive meeting. They understood what the Trust was doing. They recognised the improvements made and recognised the Trust

needed to introduce charges to pay for the benefits of the scheme. When he showed them the charges they did not think that, from the point of view of other hospitals they went to, they were exorbitant. The Council was at present reviewing car parking restrictions in Harefield village and improvements were being made including controlled parking.

Mrs Crawley said that she had requested for months that the Harefield Tenants and Residents Association be included in any discussions on introducing car parking charges. Unfortunately they had never received an invitation and there was a belief they were being kept in the dark when she had asked the Board to be kept up-to-date. It would have been helpful for the Association to have been included in the meeting with the Councillors because unfortunately the Councillors do not seem able to let people know what is happening. There were many rumours that there will be yellow lines everywhere which would divert parking to local streets. Mrs Crawley asked for the Tenants and Residents Association to be included in the future and to know what the outcome was. Few people attending the meeting knew what the proposals are for the village.

The Chairman said the only people who could say what was proposed for Harefield village was the Borough Council and as far as he was aware the Trust was exploring its position with the Councillors to make sure they were aware of the Trust's position and to ensure they were fully briefed. The Trust was not seeking definitive decisions from them on behalf of the Council and indeed the two Councillors were not in a position to give them. Mr Mitchell said they were very sensitive and wanted to make sure Harefield was not a parking-zoned village. The Trust was not asking them to put double yellow lines on both sides of the Hospital entrance but they were looking at what restrictions they may have to apply as part of their overall plan for the village. That was separate from the Trust's plans within the Hospital. Mr Mitchell believed from the discussion with the Councillors that the level of charges that were proposed particularly to visitors would not mean they would instead park in the village.

Mr John McKenna asked if the two Councillors were representatives of the Council or representatives of Harefield because as far as the village is concerned they very rarely represented knowledge or information as to what the village is about. They rarely visited the village even to invited meetings. That was why it would have been important to have had Mrs Crawley there as it could have prevented generation of very bad feeling. Mr Mitchell said both

Councillors had detailed knowledge of the workings of the Hospital and from the conversation they had a detailed knowledge of the village as well.

Professor Newman Taylor said the Councillors came to see Mr Mitchell and him in order that the Trust could explain to them the position in relation to car parking, what the Trust was doing and what the proposed charges were so that they could understand them. They came to the meeting as two Councillors. He had not asked them if they were representatives of the Council or the village. Professor Newman Taylor said he had a conversation with Councillor Higgins and subsequently he approached the Trust to arrange a meeting to speak to him.

Mrs Brett said she would be meeting Councillor Higgins and had been asked to ask who made the initial approach. Professor Newman Taylor said the initial approach was made by the Councillors to his office. The Chairman added that as they asked for a meeting it was for them to say who they wanted to meet with. He had noted Mrs Crawley's firmly expressed view on the Trust not having contact Harefield Tenants and Residents Association often enough.

Mr Barnett noted it was said the charges were small. They were not small charges to the public, at least 80p an hour. He could not accept that was small.

(ii) Mr Barnett referred to point (b) which said there were 50 new spaces. Staff were not aware where these spaces were on the Hospital maps.

The Chairman observed that compared to car parking charges at the station 60 miles from London near where he lived what the Trust was seeking as a very modest contribution from the least well paid Harefield staff annually was less than what people paid weekly at the station and they paid monthly what the next staff pay band paid yearly.

In relation to the additional spaces the 50 spaces came from the number of spaces before any charges were implemented and the total number on site with two additional car parks.

The 80 pence referred to the visitor charge. It was on a scale of charges that took into account the length of time visitors spend at the Hospital. No changes had been made from the original visitor charges as they were considered to be reasonable. The Trust was considering concessions for those who came to the Hospital frequently. The Chairman said this would be kept under review.

(iii) Mr Barnett referred to point (a) about car parking permits. Some staff already had permits and asked what their position would be when they expire in December when others start from April.

Mrs Cabrelli said all existing permits would be valid. No existing staff would be charged until April when charges would apply to all staff. The Trust wished all staff to display permits as soon as possible so that when visitor charges come into operation in February the Trust could monitor car park usage and direct car drivers accordingly. Full enforcement would not commence until 15 February allowing staff time to apply for permits.

(iv) Mr Barnett made a final point. The charges appeared to be based on annual salary and asked what consideration had been given to those who were remunerated in other ways, such as bank staff who worked irregularly.

Mr Mitchell said pro rata rates were established so that part time staff are paid according to an annualised salary and car park charges would be related to it. Separate ticket arrangements would be made for staff who worked irregularly.

Mr Dennis Gulliford, Secretary of Re-beat, a Patients' Charity, referred to the 80 pence per hour charge for the public. Ealing Hospital, his local hospital, charged the reasonable sum of £1.50 for four hours parking. He asked what the additional charge would be for parking longer than one hour against the reasonable charge made by Ealing Hospital. He also referred to regular patients not being charged.

The Chairman confirmed the Trust had already agreed to look into the position of patients who attend the Hospital regularly.

Mr Gulliford said that Re-beat club members were volunteers who raise funds for the Hospital and asked what their position was.

Mrs Cabrelli said volunteers would not pay charges. They would be issued with parking permits on approval of the proposed arrangements in the report to the Board.

Mrs Cabrelli indicated that although the hourly charge was 80 pence, a car park ticket for three hours would cost £1.50. The Chairman said the Trust acknowledged it was difficult for some people to know how long they would be at the Hospital. It would be rare to expect a patient to be at the Hospital for less than two hours and the proposed hourly charge for a stay longer than an hour was comparable to Ealing Hospital.

Mr Mitchell said NCP would not be intolerant to people who overstayed beyond the time they paid to park in the Hospital. Professor Newman Taylor said there was no financial advantage to NCP for penalising overstayers. Mr Mitchell added that NCP were not permitted to use wheel clamps without authorisation by Mrs Cabrelli or him.

Mrs Jean Lucas asked if members of the public would have to pay to park in the Hospital to attend Board meetings. Mr Mitchell confirmed this would be the case.

Mrs Jill McNally, Cardiology Secretary who presented the petition to the Board, said she was representing the staff who had signed the petition against car parking charges, as nobody else could be there due to the awkward time of the meeting. Referring to Mrs Crawley's comment on being left in the dark, Mrs McNally said that no one had been left more in the dark than the staff. They had not been told of the new proposals and Trust management had been extremely selective in responding to staff questions. It had again been presented as a fait accompli while ignoring the main point, which was that the staff were objecting to the charge itself, not levels of tariff. Mrs McNally said she could not understand Mr Mitchell's comments on staff reaction because everyone going to them was again saying they were not going to sign, and would not agree to money being taken out of their salaries. They were all of the same mind and that is what they would do. Mrs McNally asked how management intended to deal with it, would they sack them or clamp them all. Mr Mitchell declined to answer.

Mrs McNally also referred to the previous comment about the impact on staff morale. No one had taken into account the implications of Agenda for Change on the staff. The majority would be on protected pay for seven years which would mean pay would be frozen with no increase after April 2005 and the Trust was now deciding that it wanted to charge staff for coming to work.

Mrs Wendy Riddle, Agenda for Change Project Manager, interjected querying the source of this information. Mrs McNally referred to a meeting with managers of the previous day, in which she and her colleagues had been told of this likelihood. Mrs Riddle said she was suprised to hear this as no member of staff's job match had been verified by the Department of Health and no member of staff had been issued with a new contract of employment.

Dr. Caroline Shuldham confirmed the position to be as Mrs Riddle had described. The Executive Directors were aware that many staff were anxious about how Agenda for Change would affect them but no one yet knows the outcome. No job matching had been confirmed and no assimilation had so far taken place.

Professor Newman Taylor informed the Board that after receiving the petition an open meeting with staff took place, at which several important issues were raised that had to be addressed. The Executive Directors reflected on them and the proposals in the report took account of them. Charges for car parking would never be welcomed but had to be implemented to recoup the expenditure that had been incurred on car parking controls of the Hospital. Through the availability of capital funds the charges had been kept as low as possible and the Trust was giving a guarantee they would not be raised for three years. The charges were not a means of raising money from the staff but of covering costs. The Chairman said it should be borne in mind that car parking incurred running costs, essentially over having better car parking properly organised and controlled. Mr Appel commented that as Mrs McNally had confirmed the impact on staff morale which would undoubtedly have an impact on patients, he suggested the Board should reconsider the imposition of charges on existing staff; when new staff are engaged the Trust could write their contracts as they wish, but at this stage the existing staff wishes should be respected as not having been engaged with the intention of being charged until they leave and are replaced.

Mr Mitchell said Mr Appel's suggestion would be very difficult to control and did not meet the needs of the Trust in providing the revenue to pay for the car parking system.

Mrs Brett said the question over the Trust's intention if staff will not pay car parking charges remained unanswered. She asked if the Trust intended to clamp their cars or dismiss them from employment. Mrs Brett asked for an answer to the issue Mrs McNally raised on behalf of the 534 staff who signed the petition, which would have been 600 if it had not been curtailed by presentation to the Board meeting on 23 November. Mrs Brett said the Board had to face the problem and suggested the matter should be adjourned at this point to take the temperature down and find a solution through consultation with the staff.

The Chairman said the issue was intended to be decided three months ago and was deferred at a Board meeting recognising that it had financial implications. As Chairman he decided the proposal to implement car parking charges could not be implemented early in the new year because further consultation was necessary. But as with every consultation not every thing that is said can be accepted by those to whom it is directed. The Trust could not accept the notion that somehow there had not been an active effort both to listen and to address the concerns that had been expressed. It should be borne in mind that staff in the end would suffer in morale and in other ways, and no doubt patients as well, by a position in which the Trust is forced to make more and more cut backs in order to accommodate at

the current rate its rising deficit. Deferring or withdrawing the proposal to implement car parking charges would contribute to it.

Mr Mitchell said that for the lowest paid staff a payment of less than £1 per month for car parking at the Harefield site would not deter staff. A member of the public pointed out that Mr Mitchell had still not answered the staff's question. Mr Mitchell said he did not intend to do so.

Ms Ocloo said she felt very uncomfortable about the comments made by the staff representative and thought it was brave of her to come and express her views and that it was important that these issues were brought to the Board's attention. Ms Ocloo said she had not realised that the issue about car parking charges appeared to be about much wider issues to do with the Agenda for Change and its impact upon staff morale. Ms Ocloo thought it was worrying that staff felt strongly enough about the matter to feel pushed to refuse to authorise deductions and decline to pay car parking charges. Ms Ocloo felt that the issue of staff morale needed to be addressed, not least as issues were being raised by Mrs McNally that appeared to relate to certain staff members such as administrative staff. in this respect Ms Ocloo thought there might be particular issues of staff morale and the impact of the change agenda because these staff were not likely to be as well paid as others.

The Chairman said he shared that view. If what was said were to happen following Agenda for Change it would have a serious impact on the morale of staff but it did not correspond with any understanding Dr. Shuldham or Mrs Riddle had. Mrs Riddle said an immense effort had taken place to communicate information that was right and proper at this time. What made this difficult was people who perpetuated myths that were not true. This lowered staff morale.

Mr John McKenna drew attention to a similar situation that once arose in the teaching profession whereby the Government decided that teachers had to belong to a certain body, the costs of which would be borne by all teachers. It then added the costs to the salary of teachers before tax and was then paid, thus it was a paper exercise. It might be pertinent that if the Trust had to charge for car parking at the Hospital that it gives the costs into and out of pre-tax salaries. He said it would be more costly if the Trust had to make these adjustments and suggested that instead the Trust made car parking free.

Mr Mitchell said Agenda for Change increased London weightings paid to staff very considerably, certainly far more than the proposed car parking charges. Alterations to London weighting would be backdated to October 2004. The car parking charges were very small compared to the increases proposed.

Mr Tony Vickers, Director of Human Resources, said that if staff did not pay car parking charges the Trust would have to fund the costs through other efficiencies across the rest of the organisation which might include redundancies. Mrs Brett said that this could be taken as a threat. Mr Vickers said it was the truth. The Chairman commented that he did not think what Mr Vickers said had been intended as a threat.

A member of the public said the quickest way to antagonise anyone was to take money out of their pockets. By imposing charges for car parking to come to work the Trust was effectively imposing a pay cut. As a previous person had said, the Trust could give existing staff a pay rise. New staff would have to pay the charges.

Mr Mitchell reminded the meeting that the purpose of Agenda for Change was not only to change staff terms and conditions. On the whole most staff would gain not insignificant pay rises backdated to October 2004, far in excess of the car parking charges proposed. The only staff who were excluded were consultant medical staff who had recently received pay rises through the introduction of the new consultant contract. The contracted hours of some staff would also be less. Agenda for Change entirely concerned improving staff conditions and hours of work. There was also a myth about what administrative staff could get from Agenda for Change. Mr Mitchell understood how that could affect morale and the Trust was taking the issue seriously. The rumours which said staff would suffer massive pay cuts or pay freezes did not help. The Trust had not addressed this issue. It did not know how jobs would be matched. For medical secretaries the intention is to create generic job descriptions so that they match the grade the Trust wishes to pay them. The Trust was making this clear to medical secretaries at both Hospitals and was communicating information about Agenda for Change openly and fairly to staff throughout the organisation.

Mr Vickers added that Agenda for Change was about equality and transparency and was agreed by the National Trade Unions. It was not solely a Harefield issue; it was a national issue about modernising the NHS pay system to ensure fairness and transparency. The staff side were just as determined as the management side to implement it and had checks and balances in job matching and assimilation. The entire concept was to pay staff the right salary with the right terms and conditions through an open transparent system.

Mrs Brett asked how the Board could consider passing a resolution on car parking charges after just having been told staff would not pay them. The Chairman said the Board would take Mrs Brett's observation into account with others that had been made.

Professor Newman Taylor said the Executive Directors had tried as hard as possible to balance the need to find additional costs in

running the car parking scheme with the very real concern that staff had expressed and had brought back to the Board a revised set of charges which are not high compared to car parking charges in many other circumstances. Professor Newman Taylor took very serious note of what Ms Ocloo had said. The charge of less than £1 per month for the lowest paid staff reflected additional concerns that the Board should take careful note of. He recognised very clearly there are issues in relation to staff morale at Harefield because of uncertainties the Trust had experienced in recent years and the Executive Directors had endeavoured to show them that through capital investment on the site and the new programmes such as Dr. Ilsley's primary angioplasty service that the Trust believed in the work of the Hospital and support for the staff who undertake it. Professor Newman Taylor said the Executive Directors would think seriously about the concerns that had been expressed and how they could be taken forward. However the Board had to support the proposal in Mrs Cabrelli's report for the reasons given by Mr Mitchell and her.

Mr Charles Perrin, Deputy Chairman, supported what Professor Newman Taylor said.

The Chairman said the Board had undertaken a quite substantial re-examination of the earlier proposal and had reduced the overall funding that had to be raised and the costs to be recovered especially for the lowest paid staff. Charges would never be universally welcomed by those affected. The Chairman asked if any Board Member wished to oppose a resolution to implement the charges. There was none.

The resolution to implement car parking charges at Harefield Hospital, as proposed in the report, was therefore agreed.

In conclusion, the Chairman said he accepted the decision to implement car parking charges would not be welcomed. What he would not accept was that the Trust had not undertaken the greatest care to meet the concerns to the fullest extent it is able to against a background of the financial position and the ongoing cost to provide what some at least regard as a significant improvement in the Harefield environment and the amenities provided in the arrangements made for safe car parking. The Trust would take note of the wider points about staff morale.

The Chairman said he was grateful for the relative calm in which the discussion took place.

2005/12 PADDINGTON HEALTH CAMPUS DEVELOPMENT

The Board received a report from Mr Nigel Hodson, PHCD Project Director. The Outline Business Case (OBC) was approved by the respective Trust Boards, the SHA and Imperial College Steering Board in December 2004 and submitted to the Department of Health on 23

December. Officials of the Department of Health who are considering the OBC had raised questions about the financial model, the design model and estate matters. The two NHS Trusts and the SHA had agreed heads of terms with Paddington Development Corporation Limited to take forward proposals for the acquisition of land and negotiations were taking place towards completion of a contract.

Westminster City Council (WCC) had issued draft planning briefs for the St. Mary's Hospital and Post Office sites and the land identified for the Paddington Health Campus Development owned by PDCL and WCC. The Project Team aimed to respond to the briefs through a revised masterplan in mid February. A meeting of the WCC Planning Committee on 31 March 2005 would review all responses to the briefs. Consultation would take place on the new masterplan with the Council for Architecture of the Built Environment (CABE), the Greater London Authority, Transport for London, English Heritage and others.

The Board noted the report.

Mrs Jean Brett, Chair Heart of Harefield, said that the Outline Business Case had been pushed through in great haste during two Board Meetings in December 2004. Since then Appendix 14, which Heart of Harefield had requested in the correct manner but had been refused, had been leaked in London. What had been revealed was very interesting. Mrs Brett gave the Board a précis.

The rejection in September 2004 of the Paddington Health Campus 'Disunion Plan', with hospitals either side of the Grand Canal, meant that the PHC Management had from October to December to bodge something together quickly. A new OBC had to be in by the end of December, to comply with the National Audit Office, Treasury and Department of Health. The Paddington Development Corporation Ltd and PHC management had also entered into a collaboration agreement which ended on 22 December. Not getting the OBC through could also result in a penalty payment of £350,000 to that company. This was duress. No NHS Board should have the threat of a financial penalty hanging over its decisions.

Mrs Brett said that when Heart of Harefield had asked for Appendix 14 it had been told the information was too sensitive. It was not too sensitive, it was too embarrassing. It was an example of inefficiency and incompetence. It also lacked affordability and value for money, values which NHS Boards have a duty to ensure.

Appendix 14 centres on the land deal without which the Paddington Project could not go ahead. By then the owners of the land were aware that PHC Management was desperate for it. As would any business firm – they sought to extract the maximum advantage, one being a 58% premium plus £20 million for the devaluing of their adjacent site by proximity to a massive hospital.

The Chair of Heart of Harefield said that the international basis of market evaluation of property, was defined as the estimated amount for which a property should be exchanged, on a date of valuation between a willing buyer and a willing seller, in an arms length transaction after proper marketing wherein the parties had acted knowledgably, prudently and without compulsion. In this case there was huge compulsion. Mrs Brett said that she was not blaming the business firm, she was blaming PHC management.

However PDCL knowing that it had PHC management over a barrel, rather than the 58% premium, preferred to seek the forward selling to it of the valuable surplus sites of St Mary's Hospital and the Royal Brompton site in Chelsea. What is within the appendix withheld from Heart of Harefield, is a joint venture agreement – a partnership between NHS bodies and a private business company to capitalise on this site between 2005 and 2013. Heart of Harefield considers this disgraceful and uneconomic. It was foolish for the NHS not to retain ownership of those sites to gain the best possible value on the open market for the benefit of the public purse.

Mrs Brett said Appendix 14 was highly embarrassing in revealing a desperation deal. The Board would have had advice on this, but it was doubtful if solicitors paid in the region of £735,000 would say straight out that the Board was acting completely ultra vires. Berwin Leighton and Paisner would use careful clauses. Mrs Brett remarked that although having to be critical, she did not think the Board had sufficient time to go through the papers to uncover what Heart of Harefield had uncovered. It was also doubtful that many people would have had the necessary knowledge or ability. What had happened was however scandalous and Heart of Harefield would take advice on it from the best in London.

Mr Hodson said he took note of what Mrs Brett had said.

A member of the public referred to the BBC TV London News earlier in the week which reported the Government was thinking of scrapping the Development and asked if the Trust had also heard it. Mr Hodson said he was aware of the programme. The Project Team was in discussion with the Department of Health. The Chairman said the Prime Minister had made fairly positive remarks about the Development two days earlier in response to a question.

Ms Ocloo also referred to the television report which was stark in referring to a view that the costs were escalating to a point where the Project might not proceed. In the light of this the PPI Forum was receiving more enquiries about the matter. It understood there were risks with the Project and the Board would have made some assessment of them. Ms Ocloo said her understanding now was that

the risks had increased and asked for an indication of the percentage risk the Trust was working with for a project of this scale.

The Chairman commented that the Board resolution specifically referred to a number of risks and the Board's support was conditional on resolving them. The same was true of the St. Mary's Trust Board and the SHA Board. It was not possible to put a percentage risk on the project. There were a number of contingency allowances which amounted to 25% of the total figures. What was clear was that there were risks which had been identified and the Board had indicated to the Department of Health that it required their support to overcome them.

Professor Newman Taylor said the current situation was that the SHA had sent the OBC to the Department of Health. It had raised issues over which the Trust was in discussion with them but the Trust had received no formal response.

Mr Appel said that in the event that the plan had to be changed the death sentence the Board had imposed on the excellent Harefield Hospital caused him great concern. Mr Appell quoted Section 6.6.2 that "Royal Brompton & Harefield NHS Trust does not support the continuation of specialist services on the Harefield site under any future development plans". If these vary from what is projected the Board should reconsider the death sentence on Harefield.

The Chairman took note of the comment. He said that at no stage during any part of the project had any Board Member made any secret that at some stage the clinical isolation of Harefield would become a growing problem which it cannot ignore.

A member of the public asked if this was related to a transport problem. The Chairman said it was not. It was the range of specialisations on the Harefield site, and in the near vicinity, which was not as large as would be increasingly required because of co-morbidity as one considers the developing pattern of medicine. Professor Newman Taylor said this was an issue discussed at the Board on many previous occasions and had been made by him and senior clinicians at Harefield. There is increasing concern that in the future because of the nature of patients with increasing age, complexity and co-morbidity there will be increasing problems in ensuring the availability in a timely fashion of other specialities that are needed to treat them. This was a problem the Board had to address.

Mr Appel said that on a 44 acre site it would surely be cheaper to expand the specialities rather than transfer patients to Central London. The Chairman said this was not the issue. One of the advantages of co-location with St. Mary's Hospital is the range of specialities there that could address the clinical needs of patients in the future. The

notion that it would be possible to transfer services currently serving part of North West London would cause at least as great an outcry as current concerns. Professor Newman Taylor said it was unrealistic to think it is possible to build a district hospital on the Harefield site, given the number of hospitals in the vicinity, to recreate specialist services adjacent to the Trust's specialties.

Ms Ocloo said from reading the report she could see the vision but was anxious about whether there was a robust business case and whether it was financially viable. Ms Ocloo commented that if the PHCD fell through people would ask what the financial implications would be.

The Chairman said these were the issues the Department of Health was examining. There was however no risk free strategy in this context and none that would not have substantial costs and consequences. Rebuilding at Harefield would require a great deal of capital. At Royal Brompton Hospital most of the plant and equipment was becoming less satisfactory for treatment of people in the twenty-first century. Part of St. Mary's Hospital was operating in a nineteenth century building. Mrs Brett said the Chairman was referring to the Mint Wing which was a listed building. The Chairman said that doing nothing was not an option.

A member of the public asked if it would cost £900mn to develop at Harefield. There would be no problem with acquisition of land. The Board would be remiss in its duties if it did not put the whole development at Harefield. The Trust had difficulties with staffing at Harefield because for the past five to seven years it had dismissed statements that the Hospital could continue. At one time staff were clamouring to work at the Hospital.

The Chairman said it would probably not cost £900mn to build a development as sketched at Harefield. Leaving that aside one of the reasons for the changes the member of public referred to was change in demand for the Trust's services with some work going to other types of hospitals and various other changes occurring in the NHS. Part of the problem over the Trust's financial position was declining demand for its services. The Chairman also said the £900mn related to the rebuilding of three hospitals, all of them with substantial numbers of different buildings.

The member of the public said there had never been a serious examination of rebuilding on the Harefield site. The Chairman said the member of public was making a comparison of what could be done on the Harefield site but that could not be compared with the £900mn PHCD unless it was being suggested that St. Mary's should be rebuilt at Harefield which, as he understood it, the member of public was not.

A member of the public said Harefield had an international reputation. There was an airport at Northolt and he suggested the Trust could encourage wealthy people over the world to come through the airport from where within 10 minutes they could be in a hospital where they could spend a lot of money saving their lives.

The Chairman said this again led back to the way in which health services, particularly specialised health services, need to be provided in the twenty-first century.

Mrs Hill said she was surprised the Board had become so deeply involved in the PHCD. At the SHA meeting Mrs Hill said she had heard what Mr Julian Nettel had said. She also heard what he said on the BBC TV programme. While it was in the papers that the Trust Board would be retained the experience of the NHS would indicate that once on the Paddington site it would be said that it would be too expensive and there would be only one Trust Board.

The Chairman noted what Mrs Hill said. The Board's position was clear.

Mrs Crawley referred to Paper D for the Board meeting and welcomed the reference to developing the clinical adjacencies that were needed for improving patient care. She asked if this could be done with other hospitals such as Mount Vernon Hospital which was literally minutes away. They had the staff who were competent in their specialties and it made sense to pursue that.

Professor Newman Taylor said the Trust was working strenuously to make arrangements for consultant staff at other hospitals to visit Harefield when necessary. This had not proved easy but progress was being made. However, it was not an adequate final solution because they had responsibilities in their hospitals which they had to deal with before they could consider those in other hospitals.

A member of the public asked the Board to confirm from the TV programme when it was said the estimated cost was now over £1bn and that the Government was losing interest. The Chairman reiterated that the OBC was with the Department of Health. A formal response was awaited. Mr Hodson said the capital costs for the construction was £789mn with inflation and VAT taking the total cost to just over £1bn.

The member of the public said that the cost was at one time £300mn and if the cost is now over £1bn it was not surprising if the Department of Health was losing interest. Professor Newman Taylor said there was nothing to add. If the Department of Health had concerns it was surprising it had not communicated them to the Trust. At present the Trust had received no formal response from the Department of Health.

Ms Dara Galic, a Heart of Harefield supporter, asked the Board to please explain why possibly paying PDCL 58% above the market value for land could represent value for money. Ms Galic asked if the Board had considered whether it was acting outside its lawful authority, which was to act effectively, efficiently and economically.

Mr Charles Perrin, Deputy Chairman, said Ms Galic had received information that was not in every respect correct and the Trust could therefore make no appropriate comment. The Chairman said Ms Galic referred to information that the Trust regarded as commercially confidential and although this had been leaked the Trust was unwilling to break commercial confidence in commenting on it.

Ms Ocloo asked what the position would be if the Department of Health did not support the PHCD. The Chairman said this was an issue all involved in the Project would have to address. There is an option B in the OBC which involved rebuilding in the vicinity of Royal Brompton Hospital in Chelsea which would include relocation of Harefield services. The option also included a rebuild of St. Mary's on its existing land. However, a great deal of thought would be necessary. There was no "off the shelf" substitute scheme available.

Professor Newman Taylor said the PHCD did not emerge as a project from the Trust but was the outcome of a review of the future provision of specialised services in West London. The PHCD was seen as the optimum solution for provision of specialist heart and lung services. If it did not proceed it was possible there could be further specialty reviews over the optimum solution. The Chairman said these reviews could look at the position very widely.

Mrs Brett, Chair of Heart of Harefield, commented on openness of information and what was in the public interest, pointed out that 'Building' magazine would have taken advice on Appendix 14, and had decided it was in the public interest to publicise it. On cost, it was no good saying what the PHC will cost now, when the out turn figure in the Business Case was £1,109,476,000. Mrs Brett had spoken to a PFI specialist the previous day who had advised that the probable end cost of Paddington could be between £1.5 and £2 billion. Therefore the Trust should examine what it was buying, which was basically hospital beds.

In answer to a November 2003 Parliamentary question from John Randall MP, on what the estimated patient capacity at Paddington and how much that had increased since 2000, the Minister of Health John Hutton had replied "the Paddington Health Campus will have provision for 1088 inpatient beds. This is an increase of 80 beds in comparison with the current total for equivalent services at St. Mary's and the Royal Brompton & Harefield NHS Trust. The original forecast projected bed numbers was approximately 1000. The Campus that is

now planned is 20% larger in size and will treat a higher number of acutely ill patients."

On Page 77 of the Paddington OBC, the projected beds for 2013 are 791 which is 289 fewer than the number given by the Minister to Parliament. This made Heart of Harefield very interested in a press comment made by Julian Nettel, that there was a well orchestrated campaign against Paddington – by ill informed people. Mrs Brett had therefore pointed out to Mr Nettel at the last Strategic Health Authority meeting, that while Heart of Harefield's powers of organisation were reasonable, not even Heart of Harefield could organise the level of incompetence and inefficiency of those managing the Paddington Health Campus Project. What had annoyed Heart of Harefield was being denied access to the Minister, despite its expertise.

Thanking Ms Galic for her support of Heart of Harefield, Mrs Brett said that the Board should be aware that Ms Galic spoke from a position of knowledge as a solicitor and property lawyer. On the point of how much had been spent by the PHC on professional advice, Mrs Brett said Heart of Harefield had a complete list. Comparing those costs with Harefield's staff being asked to pay for parking, made her feel ashamed.

Mr Don Chapman, Vice-Chairman Harefield Hospital League of Friends, said the Board would not have to be concerned about the future of the Mint Wing. It could let the building fall down like the Mansion in Harefield Hospital. Mr Chapman however said there appeared to be no overall plan for specialist hospital services across London. The Board was proposing an expensive hospital for North West London disregarding the requirements for South East London and North East London. It should think about London as a whole and the future of London, not solely Royal Brompton and Harefield Hospitals.

The Chairman said the PHCD arose from the work of the West London Partnership Forum and emerged as the agreed view on the future provision of specialist heart and lung services. The redevelopment of the St. Bartholomew's and Royal London Hospitals addressed the future provision of specialist services in North East London. The PHCD was not a unique development; it complemented developments in North East London.

Mr Hodson said that the new OBC provided 799 NHS beds relating to planned activity levels. The inclusion of private patient beds and beds for future activity needs took the number to 923. However Mrs Brett pointed out that they were dealing with NHS beds and that the number she had quoted came from page 77 of his own Outline Business Case and the Minister's answer on NHS beds in Hansard. Massaging the figures by including private beds was not acceptable.

At this stage the Chairman decided that the meeting should come to an end and the proceedings were concluded.

Lord Newton of Braintree
Chairman