A lifetime of specialist care

Royal Brompton & Harefield NHS
NHS Foundation Trust

Minutes of the Board of Directors meeting held on 20 May 2015 in the Concert Hall, Harefield Hospital, commencing at 10.30am

Present:	Sir Robert Finch, Chairman	SRF
	Mr Neil Lerner, Deputy Chairman & Non-Executive Director	NL
	Mr Robert Bell, Chief Executive	BB
	Pr Timothy Evans, Medical Director & Deputy Chief Executive	TE
	Mr Richard Paterson, Associate Chief Executive - Finance	RP
	Mr Nicholas Hunt, Director of Service Development	NH
	Ms Joy Godden, Interim Director of Nursing & Clinical Governance	JG
	Dr Andrew Vallance-Owen, Non-Executive Director	AVO
	Ms Kate Owen, Non-Executive Director	KO
	Mrs Lesley-Anne Alexander, Non-Executive Director	LAA
	Mr Richard Jones, Non-Executive Director	RJ
	Mr Philip Dodd, Non-Executive Director	PD
	Pr Kim Fox, Professor of Clinical Cardiology	KF
	Mr Richard Connett, Director of Performance & Trust Secretary	RCo
By Invitation:	Ms Carol Johnson, Director of Human Resources	CJ
	Ms Jo Thomas, Director of Communications & Public Affairs	JT
	Ms Jan McGuinness, Director of Patient Experience and Transformation	JM
In Attendance:	Mr Anthony Lumley, Corporate Governance Manager (minutes)	AL
	Ms Gill Raikes, CE Royal Brompton & Harefield Hospitals Charity	GR
Apologies:	Mr Robert Craig, Chief Operating Officer	RCr

2015/40 DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING

None.

2015/41 MINUTES OF THE PREVIOUS MEETING HELD ON 29 APRIL 2015

The minutes were approved subject to the following amendment:

Page 3, item 2015/27, fifth para., delete sentence commencing 'NL said that …' and ending ' …possible worlds.'

Matters Arising

Page 2, item 2015/27, second para. (Report from the Chief Executive: Finances)

SRF asked if there was an update on Monitor's potential referral of NHS England's (NHSE) offer of a block contract to the Competition and Markets

Authority (CMA). BB said an article in *HSJ* had reported that Monitor was considering referring the 2015/16 settlement between NHSE and the Project Diamond Trusts to the CMA on the basis that no decision had as yet being made by Monitor on the 2015/16 tariff. BB said he did not know what Monitor would do though he believed it was being discussed at their Board meeting on 28 May 2015. A referral to the CMA would be unprecedented. BB added that he did not think there would be a resolution of the tariff question for many months if not for the whole year to come. This left a question mark hanging over reimbursement. The Trust had agreed a block contract with NHSE. This (i.e. a signed agreement) should be received shortly but it was unlikely it would have any status in law. The legislation laid down that there had to be a tariff. The majority of the teaching hospitals were operating on a rolled over tariff which did have legality. BB said what was occurring was a tussle between Monitor and NHSE with the latter apparently usurping Monitor's role as the tariff determinant. CMA was likely to rule that Monitor must re-issue the tariff. In short there was now an extremely uncertain environment.

RP said he agreed with this summary but added that there had been encouraging news informally from Monitor that if the Trust did sign a contract they would view it as a local variation agreement and it would be untouched even if a referral to the CMA went ahead. He added, as a further source of comfort for the Board, that the Trust had been paid - two block contract payments had been received to date. BB said the Trust had agreed local variation contracts in the past and subsequently had not been paid. NH said this was correct – the Trust had not been reimbursed for a contract variation in relation to additional 18 week target activity.

SRF said the legislation appeared to have created a conflict of interest for Monitor. He hoped that the CMA's lawyers might look at this to come to a resolution. BB said that at the time the Health and Social Care Bill (2012) was passing through Parliament there had been a major debate about whether Monitor would have a conflict of interest if its role was both to determine tariff and act as the regulator. At the time, legislators had concluded that there was no conflict. However, this debate was not the Trust's immediate issue, the Trust's overriding concern is 'are we being paid?'.

2015/42 REPORT FROM THE CHIEF EXECUTIVE

BB gave an oral report.

NHS England – Congenital Heart Disease Review

BB said that RCr was absent from this Board meeting as he was attending a meeting about the Congenital Heart Disease (CHD) Review. Board members would recall that after the Safe and Sustainable Review the CHD review had been established to develop national service standards for both children and adults. Since the general election (7 May 2015), there had been an acceleration by NHSE to get the standards finalised with a series of regional meetings convened. Headed up by Chris Hopson, former Chief Executive of the FTN and now leader of the its successor body NHS

Providers, NHSE's position and approach to the review was that it was not imposing services changes but rather encouraging providers to meet and find ways to deliver the standards through networks or other structures.. To date there had been two quick meetings in London, including today's. BB said he regretted to report that the some of the same 'forces' that had been against the Trust during Safe and Sustainable had arisen again. This was highlighted in the participation of two clinicians one from Great Ormond Street Hospital for Children (GOSH) and Guys' and St Thomas's Hospital (GST). The GOSH representative had said that based on the standards set by the CHD Review RB&HFT should close. The GST representative appeared to agree. In short the Trust was now back in a fight which was why he felt RCr should be directed to attend today's meeting to forcefully put the Trust's views across (and to support the clinicians Lorna Swan and Jan Till from the Trust). BB added that on 19 May 2015 he had met with GOSH's Chief Executive, Dr Peter Steer, and had left him in no doubt about his strong feelings. Dr Steer was coming to the Trust to meet BB next week. The principles adhered to in 2008, when the Trust had explored a joined up service with GOSH, still held today. Furthermore, in 2012 there had been a review chaired by Sir Liam Donaldson that had concluded that the three distinct centres in London should would be preserved. NHSE was attempting to distance itself from the manoeuvres made by other Trusts by saying that the process was now clinically driven and providers had autonomy.

KF asked who were the clinicians from GOSH and GST. BB said the GOSH representative was Professor Andrew Taylor but he did not know who had come from GST; although neither of the clinicians had been prominent during the earlier Safe and Sustainable review. He added that he had assured the Trust's representatives that they have the support of our Board. SRF endorsed this comment and said the Board also fully supported BB in his actions.

2015/43 <u>CLINICAL QUALITY REPORT FOR MONTH 01: APRIL 2015</u>

Introducing the report RCo said the highlights were.

Monitor Risk Assessment Framework

- *Clostridium difficile*: 2 cases in M01 had been reported to Public Health England.
- 18 Weeks Referral to Treatment (RTT) Admitted: following an update received from the Head of Information that morning, RCo said he could report that as of 20 May 2015 performance was 90.09% which meant the target was met. This was very important because under Monitor's Risk Assessment |Framework failure of any one month would mean a failure for the quarter.
- Cancer 62-day wait for cancer first treatment: performance for Q1 was 50%. There were four cases where reallocation of breaches was being sought and letters had gone out to the Chief Executives of the referring Trusts. These included West Hertfordshire Hospitals NHS Trust (Watford General Hospital) who were the main source of late referrals. RB&HFT's Cancer Manager and Niall McGonigle

(Consultant Thoracic Surgeon at Harefield) had met with them. West Herts had appointed a new cancer manager and a service improvement manager and the diagnostic pathway was being expedited with an agreement that patients would have CT scans in time for their first outpatient appointment i.e. within two weeks of referral. It was hoped this would shorten the waits.

Standard Contract:

- The 18 Weeks Referral to Treatment (RTT): RCO confirmed that for Incomplete Pathways, Admitted and Non Admitted all three targets had not been met at specialty level for National Speciality Cardiothoracic Surgery.
- Serious Incidents(SIs): there had been four SIs in April 2015. The report included a summary of the incidents.

LAA asked what was the outcome for the patient who had a haemothorax. TE said the patient was still in ICU. LAA said the report did not provide her with an understanding of the impact of the SI. TE said that by definition SI meant life threatening.

NL said he had noted that cancelled admissions / operations as a percentage of completed spells was much more stable in March at around 5%. He asked if the Trust had a target of where it would like this figure to be (LAA added to this that it was about having a sense of what was a 'good' figure). RCo said reducing the number of operations cancelled for non-clinical reasons was part of the Quality Priorities for 2015/16. The metric would compare 31 March 2015 with 31 March 2016 so it was a year on year comparison. BB said that statistically if a given figure was 30 and the target was 29 you were therefore targeting a reduction. NL said he was content to leave his question 'on the table' and accepted that 5% may (or may not) be a reasonable minimum. RJ said that he recalled that RCr had previously answered this question and it was agreed that this would be followed up.

Noting that NHSE's response to the Trust's Lung Cancer 62 day trajectory for achieving compliance had been to request full compliance is achieved by 30 September 2015, NL asked if that was realistic. PD pointed out that in the Corporate Governance Statement it was recorded that the Trust was working with NHSE to enable the target to be met by 'the end of 2015/16'. RCo clarified the discrepancy saying that the 2015/16 date was the Trust's submission and was contingent upon referrals being made by referring trusts at an earlier stage in the pathway.

The Board noted the report.

Action: clarify what is a reasonable percentage of cancelled operations (RCr)

2015/44 FINANCIAL PERFORMANCE REPORT FOR MONTH 01

RP said this was a streamlined summary firstly because the finance team were quite stretched at this time of year and secondly the report was being revamped for future Board meetings so that the format responded better to the block contract. It was intended that the Financial Performance Report presented to the Board meeting in July 2015 would be in this new format.

He reported the following performance for M01. I&E account: a deficit for the month of £2m which was on plan in the context of budgeting for a deficit of £10m over the year. This was front end loaded with £5m of the deficit in the first quarter because there were relatively few working days (phased budgets were driven by working days) and because substantial cost saving initiatives would not gain traction until later in year. On the prior year basis of 'cost and volume' NHS England income for M01 was £17.4m which was shown for transparency: this was £0.9m behind the phased plan for the month of £18.3m. An adjustment had been made to recognise a further £0.9m to bring income into line with the phased plan. This approach would be consistently applied to the cumulative position in line with the arrangements of the block contract throughout 2015/16. Private patient income was behind plan. This was disappointing but RP cautioned that not too much should be read into performance in a single month. Pay was marginally overspent; non-pay was below Plan owing to underspends on drugs and clinical supplies, particularly high cost devices.

AVO said at the last Board meeting BB and SRF had agreed that the aim was to get back to financial balance and moreover that there was a fiduciary duty to achieve this. He was now disappointed to read that this appeared already to have been disregarded. RP said how the Trust performed was always clinically led and the aim was always to try to get the best possible result. Based on projections the Trust was not going to achieve break even during 2015/16. NL agreed and said this had always, on the record, been stated as the Trust's position. AVO said he understood that a balanced budget strategy was agreed at the last Board meeting. KF asked what level of confidence there was that the Trust would at least achieve the projected budget of a £10m loss as it was dependent on savings later. RP said he had a reasonable degree of confidence that the target was achievable. Contingencies and the ability to manage demand on the basis of a block contract would be critical. What was different now was that the Trust could no longer carry out as much activity as possible to maximise revenue and margin. However, if the Trust did underperform for a month it would in effect receive a top up from NHSE. NL said that when the budget was debated by the Board in April of this year it was described as 'challenging'. Not much time had passed since then and the position had not improved. £10m was not a given. RP said that the earliest a balanced budget could be contemplated was 2016/17 but this was largely dependent on factors outside the Trust's control such as tariffs including the resolution of HRG4+. He said he understood AVO's sentiment but he was not able to state that the Trust was likely to record a surplus in any of the next three financial years. TE said seven of the Trust's clinical services were currently over-

performing. It would be a challenge to direct staff, who did not understand how a block contract worked, to rein in services.

BB reminded Board members that the minutes of the Board meeting held on 29 April 2015 stated that his view was that correcting a deficit position could 'take years'. The Trust would be making a mistake to rely wholly on tariff adjustments - the only way to get back to balance was to diversify income sources and move into new ventures to offset the chronic shortfall from NHSE. The Board should track against objectives. BB said he could not give an assurance that even after the next three years the Trust finances would return to surplus as there would be not be a resolution of the tariff issue within a reasonable timeframe.

RP returned briefly to summarise his report: cash was the other key performance indicator for finance. So long as the Trust had sufficient cash it could run deficits. The real risk was running out of cash. The cash position was better than a month earlier. NHSE were paying £19m a month instead of £17m as in the previous year. Cash 'on the nail' meant the cash position was reasonably healthy. The Trust had collected some Project Diamond money and some (though not all) over-performance money.

BB said he had recently attended a seminar hosted by McKinsey's. Their assessment had been that less than 20% of the so called 'funding gap' for the NHS (£30bn or £22bn if the £8bn pledged by the Conservative Party prior to the General Election was forthcoming) could be achieved through reconfiguration and the remaining 80% through service improvements and productivity gains. BB observed that he spent over 50% of his time fighting reconfiguration disruptions which McKinsey stated would yield less than a 20% gain. There was an imbalance in society with a disproportionate concentration of effort on issues. RCr had been called away from the Trust Board to deal with a matter related to reconfiguration. BB reiterated his view that the Trust must grow and diversify income sources. If this did not happen then it might be in trouble.

The Board noted the report.

2015/45 <u>RESEARCH UPDATE</u>

TE introduced the report and said there were three issues he wished to add.
i) In March/April 2016 the Trust would have to rebid for whatever replaced BRUs (Biomedical Research Units) – either upgrade to BRC (Biomedical Research Centre) or two BRUs. This would be an important strategic decision.
ii) The two Annual BRU reports were due which would illustrate the strength in depth of medical research. The external panel (Translational Research Advisory Group) of experts from Canada, United States and Scotland was reviewing the science.
iii) Annual Away Day for the research unit in June 2015. This would look at themes for inclusion in the October update.

TE said the next year would be particularly demanding.

KF asked if the respiratory BRU was stronger than the cardiac BRU. TE said in breadth it was. KF said the cardiac BRU required more work to come closer to the respiratory BRU. TE said direct discussions with Imperial College Healthcare NHS Trust (ICHT) and Jonathan Weber, Director of Imperial BRC, about a joint Trust/ICHT BRC were being made. The opinion of the National Institute for Health Research of how this might be formulated would be very important. KF said a BRC could include cardio vascular as a theme.

AVO congratulated TE again on the continued rise year-on-year in the numbers of patients recruited into NIHR studies. TE said the Trust was ably supported in this by the work of Angela Cooper, Associate Director of Research.

The report was noted.

2015/46 AUDIT COMMITTEE (AC)

(i) REPORT FROM MEETING HELD ON 19 MAY 2015

NL said he would account for the activities of this meeting in discussion of the Going Concern Consideration (see minute 2015/47) and Approval of Annual Report and Accounts including Quality Report (see minute 2015/48).

(ii) MINUTES FROM THE MEETING HELD ON 28 APRIL 2015

The minutes were noted.

2015/47 GOING CONCERN CONSIDERATION

RP said the Finance Committee (FC) had reviewed the cash forecasts for this year (2015/16) and next year (2016/17) as summarised in the report. On the 'sensitised' basis the Trust was not projected to achieve the planned CIPs (Cost Improvement Programmes) target by £5m in each year. The outcome of both cases was as follows: on the base case the Cash Flow forecast disclosed a figure of £13m on 31 March 2017; in the Sensitised Plan the cash balance at that date would be nil although the Trust would not have utilised its anticipated £10m revolving credit facility. These figures assumed another £17.5m of ITFF funding. The Trust had received an email from ITFF which stated, in principle, that an additional £20m loan facility had been approved. RP said that in the event this facility did not come through, two things could be done: firstly, linked charity funds might be accessed; and secondly capital expenditure could be reduced by £17.5m The conclusion of the Finance Committee was that the proposed going concern statement by the Board was appropriate. The definition of 'foreseeable future' was twelve months from the approval of the accounts so this would be to the end of May 2016. RP said he was comfortable with the statement on Going Concern and content that it was one that the Board could make.

NL said the Audit Committee had spent a considerable amount of time on this and concluded that the statement had been compiled appropriately and was in itself appropriate. He added that compared with where the Trust thought it might have been (i.e. financially) three months ago, it had actually been an easier process.

The Board approved the Going Concern statement in the 2014/15 Annual Report.

2015/48 APPROVAL OF ANNUAL REPORT & ACCOUNTS INCLUDING QUALITY REPORT 2014/15

Introducing the report RCo said it had been reviewed thoroughly, page by page by the Audit Committee (AC) on 19 May 2015. Areas outstanding were off-payroll arrangements in the remuneration report, to include the policy on off-payroll arrangements. Deloitte had asked that information regarding Never Events be included and following discussion it was agreed that this would be included in an expanded Risk and Safety Committee report which would be finalised by RCo and AVO.

NL confirmed that the Audit Committee had gone through the Annual Report line by line. Substantive improvements had been suggested as well as minor corrections and all had been incorporated. NL reported that the Head of Internal Audit opinion to the Board of Royal Brompton & Harefield NHS FT had been that of significant assurance with minor improvements required; which was satisfactory.

LAA voiced concern over the content and style of the narrative and questioned whether the Annual Report could be made more "readable". The narrative was more about processes than people. LAA asserted that the Trust had a great story to tell and worked hard to change people's lives. She suggested that the Board should focus on shifting the culture to be about people and the outcomes for patients. She recalled that she had said this last year and had been given reassurances then that it would be addressed. NL said the substantive appointment of Jan McGuiness addressed the issue of patient experience. RP said that the Trust also produces another 'Annual Report' known as the 'Annual Review' and BB added that this was the more public document which was more widely read. LAA said the default in the Annual Report appeared to be what the Trust was telling Monitor. She acknowledged BB's point that the Annual Review was outcome and patient centred but reiterated that everything the Trust did should model this tone. JG commented that incorporating some quality information into the Annual Report would give it more balance, and should be straightforward as the information is available in other formats.

PD asked why in the section on Staff Involvement and Staff Survey the numbers of staff who had received health and safety (H&S) training had gone down. CJ replied that H&S training was generally provided by the Trust every two years, while the staff survey asked about annual training. The Trust was moving to annual training so a higher percentage should be

seen in the next survey. She assured the Board that there was no issue with the provision of this training and the Trust was fully compliant with H&S directives on training for staff.

LAA said that for the second year there was an error in her name in the attendance record for NEDs at Council of Governors' meetings. [*Secretarial note: this has been amended and included in the version submitted to Monitor*]

RP introduced the Financial Statements for 2014/15 included with the Annual Report The unaudited accounts had been filed with Monitor before the last Board meeting (29 April 2015). The auditors had proposed no changes to the figures. This was the first time the auditors were reporting using a 'long form' audit report. NL said the AC had reviewed the accounts and the auditors' report was included in the papers. The risks the AC had identified had correlated with the risks identified by the auditors.

RCo gave a round-up of the quality report and referred Board members to the Quality Priorities reported on from 2014/15 , the new Quality Priorities for 2015-16, and the statements from stakeholders – both Hillingdon Council and the Royal Borough had provided commentaries.

NL said (referring to the recent Audit Committee meeting) that the auditor's report on the annual accounts had been an 'Unqualified Opinion'. However for the Quality Account they had given a 'Qualified conclusion' because of 18 Week Referral to Treatment (RTT) data issues which were similar to the difficulties other Trusts were experiencing. There had been errors in inputting some of the data. This was a difficult area for the auditors to assess where an audit trail was lacking. NL added that this was a culture failure and not a system failure: the culture of putting accurate data into the system and then retaining the documentary evidence that backed it up was not instilled in the organisation. In response to a question from SRF about how this should be addressed, NL said the AC had a target of significant improvement by July 2015. An internal audit review of actions in relation to RTT would be presented to the AC meeting in July 2015. AVO asked if this meant the six recommendations being referred to. NL said that was correct. The Trust wanted to show Monitor that there is a plan to address the issue. He added that it was firmly on the AC agenda for its July meeting. AVO added his assurance that the RSC would be looking at this too.

NL said that one further internal audit report had been received since the last Board meeting, this one on clinical audit. The assurance given was 'partial assurance with improvements required'. A lot of work is being done in the divisions but central resource is also needed to ensure it has been carried out systematically and with an audit trail. JG said this was being looked at and she was satisfied appropriate action was being taken.

NL said the AC had also received the annual review of the effectiveness of the Committee. There were some recommendation but overall it was a positive assessment.

On behalf of the Board SRF expressed his gratitude to the Finance team for their efforts in relation to the year end.

The Board approved the Annual Report and Accounts.

2015/49 CORPORATE GOVERNANCE STATEMENT

Introducing the paper RCo said under the terms of the NHS Provider Licence, Monitor required the Trust to approve two self- certificates and that these were required to be uploaded to the MARS Portal by 29th May and 30th June respectively.

The accompanying paper set out the matters which required a declaration by the Trust Board as to whether they were 'confirmed' or 'not confirmed'. Each matter included sources of assurance and, where required, risks and mitigating actions and drafts of narrative responses for submission to Monitor. The statement on the Training of Governors could be approved by the Board today but, as a necessity would be presented to the Council of Governors meeting on 1st June 2015 when Governors would be asked to confirm the veracity of the declaration.

NL asked if it was a reasonable statement for the Trust to make that it expected to achieve the target for 62 cancer 'by the end of 2015/16' given that it was reported in the Clinical Quality Report that NHSE had requested that the Trust achieved full compliance by the end of September 2015. RCo said the trajectory made it clear that achievement was contingent upon earlier referrals from referring hospitals. NL said that point was not made in the statement. It was agreed to qualify the statement as described.

NL asked, in relation the declaration on Certification on AHSCs (Academic Health Science Centres) and Governance, which were the relevant AHSC ventures. BB said the Trust was not currently part of any major joint venture or AHSC. A Memorandum of Understanding was in place in relation to Chelsea and Westminster Hospital. He assured Board members that this declaration was a general statement and the Trust was able to respond positively respond to each of these bullet points in the statement.

Subject to inclusion of the qualification suggested by NL the Board approved each recommendation.

Action: RCo to upload self-certification returns to Monitor's Monitoring and Regulatory System (MARS) portal

2015/50 RECOMMENDATIONS OF ADVISORY APPOINTMENTS COMMITTEE

The Board was presented with one ratification form for the appointment of a Consultant in Respiratory Medicine with Expertise in Cancer and

Interventional Bronchoscopy. AVO said there had been four candidates, two of which had been strong contenders but there had been a clear leader. (However, the unsuccessful candidate was being encouraged to consider a future appointment at the Trust). TE said this was a new appointment made in part to address the Trust's cancer service concerns. At the RBH site the bronchoscopy service was the leading one of its kind in Europe and arguably worldwide. The new appointment was complimentary to the HH appointment.

The Trust Board ratified the appointment of Dr Samuel Kemp as a Consultant in Respiratory Medicine with Expertise in Cancer and Interventional Bronchoscopy.

2015/51 AOB

SRF reported that the Nominations and Remuneration Committee of the Council of Governors, Chaired by Ray Puddifoot, had recently met to consider the appointment of a new NED. They would be recommending to the Governors that they confirm the appointment of Luc Bardin, a former executive in Castrol and BP, at their meeting to be held on 1 June 2015. Two candidates had been identified from the four interviewed as having the experience and skills to be appointed. SRF added that the unsuccessful candidate was being encouraged to retain an interest in working for the Trust and was coming to meet him shortly. It was likely Mr Bardin would be offered membership of the Finance Committee and Audit Committee in place of Richard Hunting (RH). KO was taking over from RH as Chair of the Nominations and Remuneration Committee of the Board.

2015/52 QUESTIONS FROM MEMBERS OF THE PUBLIC

Mr Ken Appel (KA) said he had come to the end of his six year period as a Governor. Before that he had worked as a Laboratory Assistant (penicillin). He thanked all of the Trust for the courtesy and respect paid to him. He recounted that he had first attended a Board meeting in 2000 when there was the great threat of closure. In recent years SRF had been a great champion of RB&HFT.

SRF said it gave him real pleasure to respond to KA and on behalf of the Board and the Trust's staff he thanked him for his marvellous service and said he hoped his interests in the Trust would continue. It would be timely still to have his input as HH's operation was expanded over the next year.

Mike Gordon (MG) asked, as a representative of Community Voice (Harefield Residents), two questions: firstly, how did the Trust handle and mitigate no-shows (Did Not Attends – DNAs) and what was the cost of non-attendance at HH; and secondly, did the Trust have any plans to expand Cherry Ward.

NH replied in turn to each question:
- the DNA rates ran at about 5-6% across the Trust. There was very little difference between the two sites with the exception of paediatric heart

patients at HH which was known to be running at about 9%. The total potential income loss across the Trust is c £1.3m. He added that MG had given the Trust good feedback on the appointment letters which had led to changes in the text (for example more specific detail on the day of the week, am/pm, location, and follow up appointment).
- the Trust did have plans to expand Cherry ward but did not as yet have the capital.

MG thanked NH for his response.

NEXT MEETING Wednesday 29 July 2015 at 2pm in the Board Room, Royal Brompton Hospital