Minutes of the Board of Directors meeting held on 25th January 2012 in the Boardroom, Royal Brompton Hospital, commencing at 2 pm

Present:	Sir Robert Finch, Chairman	SRF
	Mr Robert Bell, Chief Executive	BB
	Mr Richard Connett, Director of Performance & Trust Secretary	RCo
	Mr Richard Paterson, Associate Chief Executive – Finance	RP
	Mr Robert Craig, Chief Operating Officer	RCr
	Pr Timothy Evans, Medical Director	TE
	Mrs Jenny Hill, Senior Independent Director	JH
	Pr Sir Anthony Newman Taylor, Non-Executive Director	ANT
	Ms Kate Owen, Non-Executive Director	KO
	Mr Neil Lerner, Non-Executive Director	ML
	Dr Caroline Shuldham, Director of Nursing & Clinical Governance	CS
By Invitation:	Mr Nick Hunt, Director of Service Development	NH
	Ms Jo Thomas, Director of Communications and Public Affairs	JT
	Ms Joanna Axon, Director of Capital Projects & Development	JA
	Ms Carol Johnson, Director of Human Resources	CJ
	Mr Piers McCleery, Director of Planning & Strategy	PM
	Dr Anne Hall, Director of Infection Prevention & Control	AH
	Mr Richard Goodman, Director of Pharmacy & Medicines Management	RG
	Dr Angela Cooper, Associate Director of Research	AC
	Pr Margaret Hodson, Pr of Respiratory Medicine/Hon Consultant Physician	MH
In Attendance:	Mr Anthony Lumley, Corporate Governance Manager (minutes)	
	Ms Christine Denmark, Marketing & Communications Manager	
	Mr Gerrie Coertzen, Marketing & Communications Officer	
	Ms Jessie Mangold, Head of Media Relations	
Apologies:	Mr Richard Hunting, Non-Executive Director	
	Mr Nicholas Coleman, Non-Executive Director	

2012/01 MINUTES OF THE PREVIOUS MEETING HELD ON 30 NOVEMBER 2011

The minutes of the meeting were approved.

2012/02 REPORT FROM THE CHIEF EXECUTIVE

BB gave verbal updates on the following items:

Judicial Review

BB gave an update on the events, in sequence, since the last Board meeting. The JCPCT had filed for an appeal and the High Court had decided that the hearing will be on 19 and 20 March 2012. Just before Christmas, BB said he had been surprised to learn that the JCPCT had applied for an accelerated hearing on a single date on either 16 or 17 January 2012. They had not informed the Trust's legal team that they had asked for this. The JCPCT had argued that an accelerated hearing was required because of immediate risks to patient safety and lives and had

issued witness statements on these grounds. The Trust's legal team worked over Christmas and the New Year and managed to get the matter reviewed by a judge. The judge ruled that the JCPCT acted with undue haste and that to enable due consideration, the hearing should therefore take place over two days. This led to rescheduling the hearing in March. The Trust can only expect to be given papers outlining the JCPCT's case, 14 days before the appeal is heard. In the meantime the Trust has filed notice of a series of counter appeals.

BB said it was regrettable that the JCPCT's legal team (Capsticks) had acted in this way.

BB continued his description of the events in sequence. He referred the Board to the Chairman's report at the last Board meeting and his comment that 4 charities (Cystic Fibrosis Trust, Muscular Dystrophy Campaign, Asthma UK, and the Primary Ciliary Dyskinesia Family Support Group) had written to the JCPCT. On 17 January 2012 Sir Neil McKay had written back to the charities. His comments should be considered in the context that the JCPCT had planned for their legal arguments to have been submitted at the appeal hearing on 16 January. Sir Neil McKay had stated that the JCPCT was 'sympathetic' but its mandate was paediatric cardiovascular surgery. The charities could consider referring the process to the Overview and Scrutiny Committees of Kensington & Chelsea Council and Hillingdon Council, and they in turn could raise any concerns with the Secretary of State. Subsequently, the JCPCT had informed the Trust that it was not their duty to be concerned by the knock on impact and this was the prerogative of London wide commissioners. Sir Neil McKay said he had been assured by London Specialised Commissioning Group (LSCG) that they had acted in accordance with the duty to consult as prescribed in the NHS Act 2006.

BB said Sue McClellan and Teresa Moss, Chief Operating Officer and Director respectively of the LSCG had met with Great Ormond Street Hospital (GOSH) on 10 January 2012 to see if GOSH was prepared to take over all services. GOSH's formal response was awaited.

The Board then discussed the issues raised by BB. The NEDs present agreed this had been a clear briefing. Various points raised by them were:

- ANT asked why was it that London was not being isolated if it is a London issue?
- ANT also asked if the judgement is upheld, what BB and SRF thought could happen?
- NL asked what might happen if the Trust's counter appeals are upheld?

BB replied in turn to each point:

- This was not solely a London issue. The Trust's case was that the process was flawed and this affects everyone. The Trust had challenged the JCPCT's authority. There had been other instances of opposition around the country. The Northern Overview and Scrutiny Panel had

challenged the North East Specialised Commissioning Group, and in the Midlands and Leeds there had been opposition.

- As of today, the consultation remains quashed. The JCPCT were preparing a new consultation questionnaire. They had re-scored the Trust's research performance from 2 out of 5 (poor) to 3 out of 5 (adequate). This should still enable the JCPCT to meet its target to make a decision in late Spring 2012.
- The other points the Trust had raised (i.e. the 5 counter appeals) depend on the final judgement, but the Trust would have to respond to the ruling on all 5. SRF added two points: firstly the best outcome for RBHFT would be that the committee that originally set the Terms of Reference for Safe and Sustainable is judged to have acted unlawfully so that the JCPCT is forced to go back to the start. Secondly, if the Trust wins its appeal, then 3 centres should be a viable option for the provision of services, the JCPCT would have to ask the public if they would prefer 2 or 3 centres.

BB sought to assure the Board that the Trust could face the year forward with a large degree of confidence. Effectively the Trust had actually had 5 consecutive 'wins': firstly, the initial decision to accept that there was a case to be heard; secondly, in July 2011 Mr Justice Bennett had ruled that there was a case to be answered; thirdly, Mr Justice Owen had ruled on the 7 November 2011 that the consultation was unfair; fourthly, Mr Justice Owen had further ruled that a written request for appeal would not be acceptable because the prospects were poor; and fifthly, a Judge had ruled against holding an accelerated hearing. BB concluded that this does not alter the fact that the JCPCT have not changed their stance and it serves to illustrate that what remains is a contest of wills.

Relocation

BB tabled an email he had received from Mark Davies (MD), Chief Executive of Imperial College Healthcare NHS Trust (ICHT) on 30 December 2011 and his response (also by email) on 4 January 2012. MD had copied his email to Sir Keith O'Nions (KN), Rector of Imperial College London (IC) and Sir Richard Sykes (RS), Chairman of ICHT. In this he had commented that the ICHT could only support the move of the Royal Brompton Hospital (RBH) on to its Hammersmith Hospital Campus site and was against what they described as RBHFT's proposal to move to new green/brown field sites which they believed were all over a mile away from their campus. BB said he had replied to MD pointing out that all the sites under consideration were under a mile away from the front door of Hammersmith Hospital. MD's letter was disappointing in the light of the open collaboration between ICHT's and the Trust's clinical teams lead by their respective medical directors, and the meetings he had held with ICHT's former Chief Executive, Steve Smith and subsequently with MD. As far back as October 2011 the Trust had concluded that the Hammersmith campus was unsuitable for a variety of reasons.

SRF said that with he had taken this up with KN. KN had said that MD's email had come as a surprise to him and he felt it reflected the views of the previous Chairman. SRF said he had then met with RS. RS had agreed there was no sustainable reason to crowd the Trust on to the Hammersmith campus. SRF said this meeting had been extremely helpful and he had put across his view that RBH relocating to a new stand alone site near ICHT answered a number of issues: services ICHT provide at St Mary's, the services jointly shared for Cardio Vascular and Respiratory, and it was essential in the context of the Academic Health Sciences Partnership. A meeting had now been arranged with their director of strategy on Friday 27 January. SRF said the Trust should produce a paper to indicate the way to proceed together with ICHT and seek the endorsement of Ruth Carnall, Chief Executive of NHS London.

TE said that what was disappointing was that MD had already signed up to co-location of services. He noted that a new document, as proposed by the Chairman, would help the Trust understand the issue in relation to the AHSP.

NL asked what MD's purpose was? BB reminded the Board that MD had been brought in by NHS London as a contractor on a 2-year assignment. ANT added that the substantive post of CEO of ICHT had now gone out to advert. BB said that MD's stance appeared to reflect a view that RBH is digestible within ICHT, a view which also appears to be held by others.

Board members felt that the Trust should not be discouraged. JH said that the paper as suggested by the Chairman was essential and should set out a backstop position not to be slipped back from, while ANT said the email did not reflect the views he had heard in his conversations with RS.

BB said the Trust was set on a journey to a new site and it should not waver from its course. It was not just about IC or ICHT: RBHFT should welcome any relevant player to join it at a new location. The key driver for the Trust is transforming the landscape of how biomedical services will be delivered in the future.

The Board acknowledged TE's request for its support in his continuing partnership work on a clinical level, but agreed that a finalised position paper would help him move forward. It was agreed that PM would work with TE to produce a position paper. In the meantime BB said he would meet with MD.

Academic Health Science Partnership (AHSP)

BB reported that at the AHSP Board meeting on Wednesday 7 March 2012 the job specification and recruitment of a Managing Director would be discussed. Various working parties would be operating in the background. A unitary Board of equal members with one vote each had been set up. There would be a common charge to everyone for membership, rather than graduated charge based on turnover etc.

2012/03 PROPOSAL FOR IMPERIAL COLLEGE LONDON (BARONESS MANNINGHAM-BUTLER) FOR RBHFT TO JOIN NEW COURT OF IMPERIAL COLLEGE

BB presented a letter from Baroness Manningham-Buller, Chairman of Council of Imperial College London which invited the Trust to put forward a nominee to sit on IC's Court. BB said he endorsed the proposal and recommended that the Board support it and agree that SRF be named as RBHFT's nominee. Board members welcomed the invitation and supported BB's proposal. ANT said there was a real feeling on the part of IC's Council to have a much greater engagement with the Court, and they therefore saw it as important to have the right people sitting on it. JH also noted that IC was clearly trying to improve the Court and KO said it would open the Trust up to the wider activities of the university.

SRF indicated that he was willing to be proposed to be the Trust's representative.

The Board agreed that the Trust should accept the offer of a place on the New Court and agreed that SRF should be the Trust's nominated representative.

2012/04 NHS NORTH WEST LONDON RECONFIGURATION PROGRAMME PROPOSAL TO PARTICIPATE

BB presented a paper and said he advised that the Board endorse RBHFT's involvement in the programme by agreeing to the attached form being signed off by himself. The Board were asked to take into account the views of TE and NH before taking a decision.

TE said he had attended meetings, chaired by a general practitioner; about a quarter of the members were general practitioners, another quarter medical directors, and another quarter from McKinsey & Co (who were coordinating the work). RBHFT has been graded along with the other Trusts and as a highly specialist trust had been given a grade 5, which was the same given to the Royal Marsden who to date had been present at all meetings and were fully engaged. Papers were produced within 7 to 10 days of meetings and signed off. In his view, the meetings to date had been of little relevance to RBHFT. PM and NH have met with Dr Penny Dash, lead Partner from McKinsey & Co. The agenda appeared to be merging smaller District General Hospitals and the closer integration of services. There were concerns such as West Middlesex University Hospital NHS Trust's position and the finances of ICHT. TE concluded that the process would lead to the issue of a strategy that all the Trusts would be expected to sign up to. In response to a question from SRF on whether Harefield Hospital (HH) was part of the discussion TE assured him that it was. Overall, it was considered better to attend and contribute and he felt that those Trusts who are members but don't attend (e.g. The Royal National Orthopaedic Hospital) would be disadvantaged.

NH said he had attended monthly meetings. Sue Callaghan, Senior Nurse/Modern Matron had also been in attendance and referred any issues which needed the Trust's approval to NH. The meeting held with McKinsey & Co had confirmed 2 things: firstly that the process would not lead to tangible outcomes without big capital expenditure; and secondly, RBHFT's relocation plans made it the only Trust in a position to provide capital. NH added that he had also made clear that HH was not 'on the table'. McKinsey had described the Trust as 'independent' and it could be assumed this reflected NHS London's view. TE agreed and said it underlined the Trust's relatively strong position compared to other organisations currently lacking the will and resources, financial or strategic, to develop in the way RBHFT envisages.

KO said she believed the Trust's contribution was being well managed. JH agreed with the proposal but said the Board should seek frequent assurance that its independence was recognised and this should be recorded. NL also welcomed McKinsey & Co's involvement but noted they were stronger on presentation than implementation.

In conclusion, the Board approved the Trust's participation in the North West London Reconfiguration Programme and mandated the Chief Executive to sign and return the Participation Form.

2012/05 <u>RESEARCH STRATEGY</u>

Dr Angela Cooper, Associate Director of Research was invited by the Chairman to present the report. She highlighted that this was a new strategy for 2012-15 with some measurable targets, including those put forward by the Governors' Research & Development Working Group.

SRF asked if the report could have shown some reflection on the debate about paediatrics? AC said that the research was about disease/disease based groups. The disease-based groups within respiratory and cardiovascular covered all ages, i.e. both paediatrics and adults, and this matched the Trust's model of care.

TE said the metrics of success had been debated at length. The Research Management Committee was focused on providing a timeline for delivery.

NL commented that the metrics were largely input-based. These were easier to design than outputs. Noting that there was only one metric on quality, he asked if there was anything that could be done to get more focus on quality? TE did not agree that the metrics were simply inputs, and that quality had been addressed, in part via proxies. Some of the targets, such as increasing the number of promotions (e.g. from Lecturer to Reader or Chair), were far from easy and were good markers for the quality of academic output. TE did, however, completely agree that some science outcomes could be added (for example stem cell research). ANT commented that the true outcomes of research were often not known until 5 to 10 years down track. In the meantime the main output had been

publications which were widely cited by the National Institute of Health Research (NIHR). TE said there were 4/5 areas in which they would be applied.

Other NEDs voiced their approval for the strategy. Both JH and KO thought the strategy was excellent. JH asked if more could be made of nurses' research and engagement with nurses at the highest level. KO praised the quality and comprehensiveness of the document and had noted how the projects were raising the profile of research activities.

In response AC agreed that engaging with nurses was important and said a reference in the strategy had been made to non medical-led capacity (8.6) but she acknowledged that this needed a higher profile.

ANT highlighted the appended letter signalling collaboration signed by the respective Directors of the Trust's Cardiovascular and Respiratory BRUs and the Director of ICHT's BRC. The strategy demonstrated that there was a great opportunity for people in the College to work cross faculty, for example natural sciences with medicines, and this could open up further grant opportunities.

BB said that it was necessary to counteract the perception that the Trust had slipped in its research standing. He suggested that a 'knock-out' story was needed to put RBHFT back on the map, for example, something which crossed a new horizon or some new discovery. The NIHR had different metrics to the Trust, such as enrolled patients.

ANT said there had been a change in the pattern of research. Thirty years ago staff had a lot more time than they had now. In particular, Respiratory medicine was the jewel in the Trust's crown, unrivalled in the UK and unequalled in Europe.

2012/06 <u>SELF CERTIFICATION REVIEW – REPORT FROM KPMG</u>

RCo introduced the report and said KPMG had concluded that there had been no evidence to indicate significant governance failings. He drew members' attention to the management responses to the recommendations by KPMG which the Board were being asked to approve. In summary these were:

- Put in place a reporting structure to replace the board assurance framework, linking the top risks from the risk register to the Monitor quality governance framework.
- Review of the Terms of Reference of the Audit Committee and Risk and Safety Committee
- Maintaining the Information Assurance Framework
- Prioritising Clinical Audit
- Early Liaison with Monitor. To this end he would be meeting with the new Monitor Portfolio Director, Frances Shattock, on 8 February 2012.

RCo said the proposal was that this report was sent to Monitor today with the accompanying transmittal letter. This was agreed.

RP said in his view it was a good, fair report. In reply to a question from SRF on whether the Trust could be satisfied this was being escalated within Monitor to the appropriate level, RP said from the meetings he has attended, he understood it was taken on board at the right level.

2012/07 CLINICAL QUALITY REPORT FOR MONTH 9: DECEMBER 2011

RCo reported that there had been 10 cases of *Clostridium difficile* at Month 9 so the recommendation is that the Trust declare to Monitor that the *Clostridium difficile* objective is not met at Q3 2011/12. He also recommended that the Exception Report was sent to Monitor.

In answer to a query from SRF on whether the Trust could review the test definition, AH said that by April 2012 all Trusts should have a recommendation from the Department of Health (DH) about which test to use for detection of possible cases of C. difficile. This may have a small financial implication, but it means the Trust will have fallen into line with the DH recommendations. SRF asked if it would possible to reassess failures reported as breaches. AH said this was not possible as all breaches are locked down once reported.

RCo said that the report set out a position the Trust should take in relation to the Compliance Framework 2012-13. This was to request the introduction of a de minimis for *Clostridium difficile* in the same way that a de minimis operates for MRSA and cancer targets. The Trust proposal is that a de minimis of 5 is set for each quarter. Trusts with 5 cases of *Clostridium difficile* or less in any quarter would not be scored as failing the *Clostridium difficile* objective. This would identify any major outbreaks of *Clostridium difficile*, while preventing specialist trusts from being penalised for previous periods of high performance which have led to the setting of a very small *Clostridium difficile* objective target figure.

NL questioned whether sending the exception report as currently worded could be counter productive. It was agreed that RCo should relook at the language employed and clear a new draft with CS and BB.

RCo assured the Board that his conversation with Paul Streat (Senior Compliance Manager – Monitor) indicated that declaring the *Clostridium difficile* objective not met and signing Declaration 2, meant the governance rating would not trigger an automatic amber-red rating, and in fact an amber-green rating would be maintained. The recommendation is that the Board should declare that all of the targets in the Compliance Framework have been met, apart from the *Clostridium difficile* objective, which has not been met. This meant that the Trust could not sign Declaration 1, and should instead sign Declaration 2:

'For one or more targets the Board cannot make Declaration 1 and has provided relevant details on worksheet "Targets and Indicators" in this return. The Board confirms that all other targets and indicators have been met over the period (after application of thresholds) and that sufficient plans are in place to ensure that all known targets and indicator which that will come into force during 2011-12 will also be met'.

The 'Targets and Indicators' cell on the Q3 worksheet would then be completed and this, together with the exception report of this report, will be sent to Monitor via the Monitoring and Regulatory System (MARS) portal.

Quality Governance Framework

RCo said the recommendation was that the Board should make Declaration 1 for the Q3 Quality Declaration required by Monitor. The Board agreed that it had sufficient assurance that Declaration 1 should be submitted.

Richard Goodman presented Section 4 (Controlled Drugs Governance and Activity). NL said that the report did not include comparative data with previous quarters. It was agreed that for the next report, graphs comparing quarters would be produced.

The Board noted Sections 4 (Controlled Drugs Governance and Activity).

2012/08 <u>FINANCIAL PERFORMANCE REPORT FOR MONTH 9 (M9): DECEMBER 2011</u>

Presenting the report, RP highlighted that in M9 the Trust:

- had achieved plan although, because it included the Christmas/ New Year period, this was actually a deficit of £800k. In fact the underlying performance was slightly better than plan as £200k of debtor reserves had been released.
- YTD, had a cumulative surplus of a modest £900k compared to plan of just over £2m. The result for this financial year had been reforecast and the Trust should now achieve, as a base case, a surplus (before items such as property revaluations and possible Project Diamond monies) of approximately £1m;
- on cash was slightly ahead of plan and liquidity remains satisfactory.
- Monitor Q3 reporting: M9 coincided with the Q3 quarterly return to Monitor. This would be uploaded on 31 January 2012.
- the Monitor return had been prepared under the new accounting policy for capital donations received which now went directly to the I&E account instead of being released progressively to I&E over the life of the related fixed assets. This meant potentially a lumpy result both in monthly and yearly accounts, dependent on the timing of donations. In the current year so far the I&E account had benefited by £375k from this new accounting treatment. For internal purposes the Trust continued to report financial results on the former basis. This would change from 1 April 2012;
- notwithstanding the change in accounting treatment, the method of calculating of the Trust's Financial Risk Rating (FRR) remained as

before – in other words the distorting effect of the new treatment was set aside. RBHFT's results for Q3 and YTD maintained an FRR at 3.

- each quarter the Trust is required to report to Monitor that it anticipates maintaining the FRR3 financial rating over the next 12 months. Based on the reforecast for the current financial year, RP said he was confident that would hold true for the next 3 months and for 2011/12 overall. From 1 April 2012 it would be harder to provide this assurance but for the 9 months from 1 April the Board could take 'negative comfort' as he was not aware of any reason why such a statement should not be made by the Board.

RP concluded his report by outlining plans for the Budget for 2012/13. He had received the so called 'road test' tariffs from DH and had therefore estimated the impact this would have on the Trust's NHS revenues, i.e. a shortfall of around £10m which had to be addressed by a combination of cost savings and contribution from incremental revenues. The Board should not underestimate this challenge as it came on the top of similar challenges in each of the past several years. That said, the challenge appeared a little easier in comparison with the equivalent figure of between £25m and £30m that the Trust faced one year ago.

The Board discussed the report. BB agreed with RP that a predicted impact of £10m did give some comfort. In answer to a question from the Chair, JA assured SRF that movements in property values were likely to produce a revaluation surplus at 31 March 2012.

NL suggested that a verbal update from the Finance Committee would be helpful and the Chairman acceded to his request. NL said it was hoped that the January (M10) report will be in a new format. Each month there is provision made in relation to income for cystic fibrosis: he asked if there would be a positive swing from releasing all or part of this provision at the end of the year. RP said Project Diamond, if received, would be positive but he was unsure whether this could be said of cystic fibrosis.

JH asked about the under performance in cardiac surgery. RCr replied that for both cardiac surgery and cardiology activity fluctuated and it was difficult to isolate specific trends. There had been no change in the pattern of activity over the previous quarter.

The Board agreed to make a declaration of FRR3 as at 31 December 2011.

The Board NOTED the report.

2012/09 <u>INFECTION CONTROL – ANNUAL REPORT 2010/11</u>

AH presented the report and asked for the Board's support for measures the Infection Control team had put forward. The last year had been a successful one with all targets met and with very active involvement at all levels in the organisation. In her view, Infection Control should be at the

heart of planning for the relocation of RBH. An inspection by CQC of HH was awaited. Board member walkrounds had been organised.

SRF thanked her for a helpful and clear report and noted her comments in relation to Infection Control being involved at the beginning of relocation to the White City corridor.

NL queried the timing of the report and asked why it had been delayed? AH acknowledged the oversight. The 2011/2 report will come to the Board in July 2012, i.e in line with the normal pattern.

2012/10 EQUALITY ACT 2010 – PUBLICATION OF INFORMATION

RCo presented Paper H. The public sector Equality Duty had been in effect since 5 April 2011. The Trust was required to comply with publication requirements contained in the specific duties in the regulation by 31 January 2012 and then annually. The report contained detailed employment information and information on Healthcare Services.

NL asked what were the data quality assurances that had gone into this report? RCo said the NHS Electronic Staff Record (where simple data on employees is held) and the Patient Administration System (the Trust's central database for holding data relating to all patients) have validation and assurance programmes associated with them.

The Board approved the information as presented in the report.

2012/11 BOARD EVALUATION

JH reported that a preferred supplier had been selected by the Working Group (comprising herself, KO, RCr and CS supported by RCo) and the appointment had been approved by SRF. SRF confirmed that he had met with them and was more than content that they had been chosen. JH outlined the process which was a delegated process, the Working Group acting on behalf of the Chairman to select a supplier and be the interface with the supplier during the period they will carry out their work. The supplier will then produce a report for the Working Group to consider in May 2012.

2012/12 QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions from the members of the public.

2012/13 ANY OTHER BUSINESS: RECOMMENDATIONS OF ADVISORY APPOINTMENT COMMITTEE

a) Educational Provider Bid.

MH gave a verbal update on the Trust's bid to provide a Post Graduate Medical Training Programme. The outcome of the application will be known on 30th January 2012. MH added that she was optimistic that it would be approved and said she had been invited to a meeting in the first week of February.

b) Recommendations of Advisory Appointment Committee.

The Chairman had agreed to take this additional item of business as a matter of urgency. The Board were presented with four ratification forms for appointments, the first three by KO, the last by JH.

The Board ratified the appointment of the following consultants at Harefield:

a) Dr Simon Mattison as a Consultant Anaesthetist
b) Dr Nicholas Lees as a Consultant Anaesthetist
c) Dr Lakshmi Kuppurao as a Consultant Anaesthetist
d) Dr Robert Smith as a Consultant Interventional Cardiologist, jointly with The Hillingdon Hospital

DATE OF NEXT MEETING

Wednesday 28 March 2012 at 10.30am in the Concert Hall, Harefield Hospital.