# The Royal Wolverhampton NHS Trust

**Minutes of the meeting of the Board of Directors held on Monday 29 February 2016 at 10.00am in the Boardroom, Clinical Skills and Corporate Services Centre, New Cross Hospital, Wednesfield, Wolverhampton**

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| **PRESENT:** | Mr J Vanes | Chairman (part) |
| | Dr J Anderson | Non-Executive Director |
| | Mr R Dunshea | Non-Executive Director |
| | Ms R Edwards | Non-Executive Director |
| | Ms C Etches OBE | Chief Nursing Officer |
| | Mr D Loughton CBE | Chief Executive |
| | Mrs M Martin | Non-Executive Director |
| | Ms G Nuttall | Chief Operating Officer |
| | Mrs S Rawlings | Non-Executive Director |
| | Mr K Stringer | Chief Financial Officer |
| | Mr S Mahmud | Programme Director |
| | Ms L Holland | Interim Director of HR and OD |
| | Dr J Parkes | Associate Non-Executive Director |
| | Mr M Sharon | Director of Strategic Planning and Performance |
| **IN ATTENDANCE:** | Mr A Sargent | Trust Board Secretary |
| **OBSERVERS:** | Dr Tinsa | Member of public |
| **APOLOGIES:** | | |
| | Councillor P Bateman | Wolverhampton City Council |
| | Mr J Hemans | Non-Executive Director |
| | Dr J Odum | Medical Director |
| | Mr S Marshall | Wolverhampton CCG |
| | Dr A Sen | Wolverhampton HealthWatch |

## Part 1 – Open to the public

In the absence of the Chairman at the beginning of the meeting, the Vice-Chair, Mrs M Martin, took the chair.

**TB.5819: Declarations of Interest from Directors and Officers**

**RESOLVED: That the declarations of interests by Directors and officers be noted.**

**TB.5820: Minutes of the meeting of the Board of Directors on Monday 25 January 2016**

**RESOLVED: That the minutes of the public session of the Trust Board held on Monday 25 January 2016 be approved as a correct record.**

**TB.5821: Matters arising from the minutes of the meeting of the Board of Directors held on 25 January 2016**

TB.5732/5766: *Patient Identification by NHS Number* – Mr Stringer said that the IG team were working up an action plan for the conversion from hospital numbers to NHS numbers. A progress report would be brought to Board in due course (KS).

TB.5770: *Rate of mandatory training by ED staff* – Ms Etches confirmed that the information requested had been circulated.

TB.5775: *Business case for the use of charitable funds for the supportive discharge service provided by Age UK* - Mrs Martin queried the absence of this item from today's agenda. Ms Nuttall indicated that this report would be brought to the March meeting (GN).

TB.5785: *Clinical audit issues* - it was noted that Dr Odum had requested responses on the matters raised at the January meeting and would circulate these as soon as they were available (JO).

TB.5786: *Professor Sque* - it was noted that Professor Sque was due to give a presentation at the March meeting.

TB.5783: *Revalidation* – Dr Anderson indicated that this related to a matter on the Trust Risk Register, namely job plans. She pointed out that job plans needed to be signed off so that appraisals could be completed. Mr Dunshea told the Board that last week's meeting of the Audit Committee had referred the outstanding management actions in respect of the Internal Audit report on consultant job planning to a future Board meeting (GN/JO).

**TB.5822: Board Action Points**

**RESOLVED:** That the Board Action Points list be noted.

**TB.5823: Chief Executive's Report**

Mr Loughton guided the Board through his report, highlighting progress with consultant appointments and the City of Wolverhampton Charter on Procurement and Commissioning.

Commenting on the NHS employers' reference group, of which he was a member, he explained that the letter to the Secretary of State, of which he had been a signatory, had been misconstrued as support for the forced implementation of the new contract for junior doctors. It was no such thing, he said, and along with a number of other NHS chief executives he had issued a statement confirming that whilst members of the reference group believed that the final agreement was fair and reasonable (including a further offer to be made in regard to Saturdays), the imposition of the contract was not what they had intended. Subsequently, the BMA had announced dates for three more strike days. He added that proceeding with the contract as imposed by the Secretary of State would require considerable goodwill in terms of its implementation.

Mr Loughton indicated that there should be a report to the next Board meeting on progress with the Carter Programme insofar as it related to the use of Safe Hands technology in the hospital, highlighting benefits to be gained such as early identification of patients likely to be readmitted to hospital within 48 hours.

Referring to the work by PWC on delayed transfers of care, Mr Loughton reported that the City Council had returned to a good level of performance around patient discharges, after a

period of difficulty. The Board noted that in January emergency activity had risen by 10% over the same period the previous year and yet there had been only two days when through-flow problems had been attributable to a lack of beds. The advances in technology now assured a very high turnaround of beds when patients vacated them. However, the time until first assessment in A and E remained a challenge.

**RESOLVED: That the Chief Executive's monthly report be noted.**

**TB.5824: Patient's Story**

The Board viewed a DVD recording, highlighting the positive experience of a patient who had taken part in research at the Trust. He spoke highly of staff attitudes, helpfulness and communication.

Mr Dunshea picked up the patient's favourable comment about staff explaining the purpose of drugs administered to him.

**RESOLVED: That the Patient Story be noted.**

**TB.5825: Patient Experience – Q3 2015/16**

Ms Etches guided the Board through this quarterly report which provided an update on patient experience and complaints during Q3 2015/16. Some of the highlights included:

- Reduction in the number of complaints regarding clinical treatment and diagnosis, and patient discharge
- Increased number of complaints regarding the general care of the patient
- Work underway to identify the outcome of complaints and carry out trend analysis
- A 27% reduction in PALS activity, the reason for which was unclear
- FFT showing variations in response levels recorded. The TDA had offered to share their learning around complaints with a view to improving response rates across the trust
- Particular interest in the reasons for the low response rates for FFT in Maternity Services given the high footfall there – this was given fresh relevance following the findings of the National Maternity Review by Baroness Cumberlege published in the week prior to the Board meeting.

In response to a question by Dr Parkes, Ms Etches said that there were between 450 and 500 volunteers, compared to less than 100 about 11 years ago. The Trust's volunteer arrangements had been updated in recent years and the role of volunteers had been clarified. She added that about 30 volunteers left every quarter, mainly due to students going away to university.

Mr Dunshea noted that the Trust website had recently been upgraded, and asked whether that played any role in the quality of patient care, and whether it should be developed further to address issues raised in this report. Ms Etches confirmed that there was further work to be done on the website, both in terms of making it more interactive and also to put more information on it. Ms Holland indicated that phase 1 of the upgrade was the migration of

information from the old to the new website, and that phase 2 would begin in June and would focus more on the contents and its interactivity. Ms Etches also made the point that the Trust intranet contained a large volume of data which was not available to the public, and that further thought would be given to whether some of this should also be made available on the website to provide greater transparency.

Dr Anderson noted that the FTT was relatively low at the Durnall Suite, and asked why this should be. Ms Etches suggested that it could be due to changes in pathways for Durnall patients, some of whom may still be dissatisfied. However, there will be further investigation to identify the reasons.

**RESOLVED: that the report on patient experience in Q3 2015/16 be noted.**

**(At this juncture the Chairman joined the meeting and took the chair)**

**TB.5826: New Horizons – Our Vision for the City of Wolverhampton in 2030**

The Board received the recently published strategic document "New Horizons" which the City Board had launched in January 2016. The Chairman explained that the recent peer review had been critical of a lack of overall vision for the city, in response to which the City Board had drawn together documents from key organisations to produce "New Horizons". Ms Edwards thought the Trust as a large employer had a vital part to play in the strategy. Mr Sharon asked whether it was intended to develop a brand for the city as a whole, in view of certain negative attitudes which were evident in some quarters. Mr Vanes replied that it was expected that a combined West Midland-wide authority would be formed, including Wolverhampton. It was likely that after that had happened Wolverhampton would review how it could retain and develop something of its own identity.

**RESOLVED: That the strategic document "New Horizons – Our vision for the city of Wolverhampton in 2030" be noted and welcomed.**

**(Note: Dr Parkes declared a pecuniary interest in the following item, withdrew from the meeting while it was under discussion, and only returned to the room when the next item of business started)**

**TB.5827: Vertical Integration**

Mr Mahmud guided the Board through a report on progress with Vertical Integration. He explained that following the acquisition of Cannock Chase Hospital in November 2014 the Trust began talking to local GPs about closer working together, which culminated in three practices approaching the Trust with a request to undertake a pilot vertical integration arrangement with the Trust. These practices represented just under 10% of Wolverhampton's health population. He reminded the Board of the wider context, namely that while primary care had 90% of NHS contacts with patients, its funding had been effectively frozen since 2006, and the number of consultations had risen by over 66%. Given the Trust's history of successful change management, vertical integration seemed to be an approach which could be attempted with confidence and which would be groundbreaking nationally.

Ms Edwards asked about the impact of this development upon estates held by both the Trust and by GPs, and in particular whether patients would in future receive care in places which served them better. Mr Loughton answered that he had held discussions with the City Council about developing two or three primary care hubs, incorporating social care services, in areas in need of regeneration. It was hoped that this development would ensure good

access to primary care, as well as ease pressure on the Emergency Department. Dr Anderson noted that the presence of mental health advisers in the Emergency Department 24/7 would be a great step forward, and added that if it was rolled out to GP practices it would be even better. Mr Loughton commented that it was suspected that a high percentage of primary care patients suffered from undiagnosed mental health issues. He thought the ideal would be for a CNS to be located in each of the three practices to help patients and try to resolve these underlying issues, potentially releasing 30-50% of GP clinic times and reducing the length of waits for GP appointments.

Mr Sharon said that this was one of the most significant changes currently being attempted anywhere in the NHS in the UK. GP workloads had doubled during the last 15 years but their share of resources was static, or even falling, and if RWT could play a part in tackling the crisis in primary care it would be of great interest to external stakeholders.

In response to a question by Mr Vanes, Mr Mahmud said that the CCG was supportive of the proposals and that both organisations were developing a shared communications plan.

Mr Mahmud said that the business case for the Vertical Integration project would be brought to the Board for approval in March.

Mr Dunshea welcomed the proposals, and said he thought that to be a success it would be necessary to focus equally upon dealing with practical matters (such as pensions) in the contractual arrangements, agreeing care pathways with GPs, and overcoming any mindsets about a service distinction between “hospital” and “GP”. He asked how the success of the project would be evaluated. Mr Loughton said patient groups in all three practices had been consulted, and the views expressed by them would help the Trust measure standards of care and treatment post 1 April. He added that the Trust was working with three GP practices which were particularly keen to participate in the initiative. Mr Mahmud assured the Board that the Nuffield Trust had been engaged to provide independent evaluation of the progress of vertical integration and in particular to assess the feasibility of the benefits realisation plan. Dr Odum was leading the work stream on “clinical pathways” and had received positive feedback from hospital consultants.

Dr Anderson asked whether the practices involved in this project would have limits placed on their list sizes. Mr Loughton said that this would have to be reviewed after three months. He thought that the project might be extended to include more practices in October and again in April 2017. He thought that a list size of around 20,000 patients was about right for this trial.

Mr Vanes noted that this model was embedded in several other countries and had made a successful impact on the life expectancy of patients covered by it.

**RESOLVED: That the report on Vertical Integration be noted.**

**(Note: Dr Parkes re-joined the meeting)**

**TB.5828: Integrated Quality and Performance Report**

The Board received the monthly Integrated Quality and Performance report.

In respect of operational issues, Ms Nuttall highlighted the continuing pressures on performance in the Emergency Department. The target for the first assessment remained a challenge, but there had been improvements with delayed discharges and transfers of care, and the clinical model was proving to be the correct one. She mentioned the increased number of ambulance conveyances since October 2015, but pointed out that admission

rates had not increased pro-rata. There were some recruitment challenges in the Department and although nurses were being recruited turnover remained high, and the shortage of middle grade doctors and consultants would be resolved only in the longer term. The Board heard that from 1 March there would be 24/7 mental health support in the Department, based in the Lavender Suite. The Human Factors team was continuing to attempt to engage with staff. From 1 April the Urgent Care Service would be working on the first floor, provided by Vocare (formerly known as Northern Docs), which it was hoped would relieve pressure on the first assessment. Ms Nuttall then drew attention to cancer targets (page 27), which were affected by capacity issues, especially in Urology. The Intensive Support Team had been invited to work with the Trust on three pathways and would meet the clinical teams in the next week with a view to making recommendations on which pathways were the most effective.

Turning to the aspects of the report dealing with quality, Ms Etches drew attention to the following:

- Nine complaints took longer than the 35 day timescale to investigate and respond to – she would meet the directorates to discuss them.

- Although the number of falls had increased during January, it remained below the Trust target

- Point prevalence data showed a reduction of pressure ulcers both old and new, but information gleaned from the safety thermometer showed an increase from 11 in December to 15 in January and all of these were subject to an RCA and scrutiny

- C section rates fell in January

- The midwife to birth ratio remains on target, reflecting on an earlier decision to "grow our own"

- The improvement against "smoking at time of delivery" may be related to a rise in vaping, the carcinogenic risk of which was yet unknown

- C.difficile infection rates had been better in January, possibly attributable to the impact of deep cleaning of wards; it is also thought that infection rates were related to the extent to which patients were moved around the hospital

Mrs Rawlings asked whether lessons could be learned from the high FFT response rate on Ward B8. Ms Etches answered that there tended to be a long established relationship with patients and carers on this ward, by comparison with wards with a higher turnover of patients.

Mrs Rawlings asked whether there was any benchmarking of medication incidents (page 16) between trusts, and whether in this regard RWT had a low number. Ms Etches replied that from time to time pharmacy were asked about this but there was no central collection of data on medication incidents, and trusts appeared to be coy in sharing their own position. She added that a new post had just been authorised in pharmacy, part of whose role would be to obtain data which until now trusts had been unwilling to share.

Mr Mahmud noted the reduced number of falls in January. Ms Etches pointed out that this was based on point prevalence data and that the full picture could be gleaned only by looking at rates over a period of time. What was clear, however, was that there had been a

significant drop in falls in the AMU over a period of time which was thought to be due to the ward's design, whereby toilets were now located in bays and nurses located on the bays continually observing patients.

Mr Dunshea asked whether the reduced number of emergency admissions would have a beneficial impact on the number of cancelled operations. Ms Nuttall acknowledged that it should have this effect over time.

**RESOLVED: that the Integrated Quality and Performance report be noted.**

**TB.5829: Chair's report of the Quality Governance Assurance Committee on 24 February 2016**

Dr Anderson presented the summary of the Committee meeting held on 24 February. She highlighted major concerns around sickness absence and staff turnover compromising the delivery of services, and in this connection raised concerns about the possible detrimental effect of 12 hour shifts on employees, linked to sickness absence and burnout (particularly in the Emergency Department). This had been picked up by the Audit Committee last week when there had been a discussion about possibly undertaking an audit. Ms Etches said that a local audit on this had not been undertaken but said that research by the RCN indicated that 12 hour shifts were linked to raised sickness rates. However, nurses appreciated 12 hour shifts not least because it gave greater flexibility, and reduced costs, for childcare and if the Trust moved more nurses onto eight-hour shifts turnover would almost certainly increase. For the time being managers were tasked with identifying sickness and stress patterns. She also said that there was great concern over the workload of staff in the ED.

Dr Anderson asked whether stress was something being raised at return to work interviews. Ms Etches indicated that HR worked with managers to identify who was taking sick leave, when it occurred, and whether there were any patterns which could be identified. Mr Loughton concurred that staff in the ED were contending with a very significant increase in workload and that the pressure, for example, when 12 ambulances arrived in a period of 20 minutes, was unimaginable.

Dr Anderson also referred to the discussion at QGAC around the BAF, and the ongoing work to present it in a more readable format. She said that the Committee had also noted the NMBRACE data for 2013 and 2014, which merely demonstrated that fluctuations should be expected year-on-year.

**RESOLVED: That the report be noted.**

**TB.5830: Safe Staffing - Planned Versus Actual Staffing by Ward – January 2016 data**

Ms Etches presented this item, which gave details of the average fill rate by registered nurse/care staff, shift and ward for January 2016. She mentioned the work of Rose Baker, formerly Head Nurse on Division 2, who had been seconded into a new corporate role to focus on a coordinated approach to recruitment, rostering, sickness absence, retention and related matters. Last week, the national lead for AHPs had visited the Trust to focus on AHP productivity.

The Chairman referred to today's national news story about nursing shortages nationally, based on a BBC FOI exercise, and the impact of the shortages on patient care. Mr Loughton understood that the shortage of nurses and doctors was now an international problem, but here there was a keenly felt shortage of experienced Band 7 nurses. The Trust was looking critically at the roles of doctors and nurses and trying to identify ways of freeing them from

non clinical work, for example by increasing the availability of clerks to do typing work on wards, and increasing the hours that ward receptionists were on duty so as to save nurses from answering mundane telephone enquiries. Further to this, he told the Board that the present onerous central reporting requirements were very time consuming and took front line staff away from their duties, and so these too needed to be reviewed with a view to curbing the demands for information from trusts. Ms Edwards supported these measures, adding that the public needed to understand the value of back office staff in releasing front line staff to focus on their professional roles.

Mr Dunshea noted the high reliance on HCAs, especially at night, and asked whether there were safeguards in place to ensure that they did not work beyond their expertise and competence. He also asked whether the Trust had any policy for up-skilling them. Ms Etches then spoke of the new Band 4 role, and the intention to place one of these on each inpatient area. She said that all HCAs worked under the supervision of a registered nurse, and that they all understood from their training the limits of their competence and, in any case, had sufficient work suited to their role without having the time to stray into duties which should be performed by a registered nurse. She stressed that there was a minimum of two registered nurses on any inpatient area at any given time.

Dr Anderson asked whether it would be feasible to require those on medical training who left after the first year to repay something to government.

It was agreed that Rose Baker be invited to attend a future Board Development Session to talk about her work (CE/ADS).

**RESOLVED: That the report on actual vs planned staffing by ward for January 2016 be noted.**

**TB.5831: Finance Report for January 2016 (Month 10)**

Mr Stringer submitted the finance report for month 10 (January 2016), which showed that the Trust's actual surplus for the month was £2,640,000, (an adverse variance to the M10 plan by £1,634,000). The cumulative position showed a variance to the stretch target of £2.014m adverse. Total patient contract income at month 10 showed a deficit of £2,450,000. The Trust's income and expenditure position as at month 10 was an actual deficit of £4,026,000.

At month 10, £14,600,000 had been withdrawn from budgets for CIP which represented 70.9% of the total annual amount. The cash balance at M10 was £6,728,000 lower than plan, due to a large number of outstanding invoices that were unpaid.

By way of context, Mr Stringer outlined the growing national provider deficit at the end of Q3, and the aggregate forecast deficit among the Birmingham and Black Country provider trusts for the year of around £15 million. By contrast, the Black Country CCGs were on course for a surplus of around £30 million. He underlined the Trust's inability to meet the stretch target which had been set, the ongoing negotiations with the Staffordshire CCG's and the specialised services commissioners regarding the year-end position, and the risk that activity levels in months 11 and 12 would be adversely impacted by a further two days of strike action and Easter falling early (the end of March) thereby reducing the amount of elective work carried out around that time. Accordingly, he had advised the TDA that the Trust was likely to miss its stretch target.

In response to a question from Mr Dunshea, Mr Stringer confirmed that the CCG underspends were mostly planned although there were variations, from Wolverhampton doing better than its control total and the Staffordshire CCG's under constant pressure.

Responding to a further question from Mr Dunshea, Mr Stringer said that if the present rules continue to apply then the CCG's would be able to bring this year's savings into the next financial year, although of course it was possible that they would be required to share those savings with CCG's which were in deficit, or forced to hold in a reserve given the tough financial position of the NHS.

Mrs Martin drew out some of the highlights from the Finance and Performance Committee meeting last week. She referred to the work on transformation next year, with the teams now reconfigured to reflect the four Carter work streams. She also emphasised the need for the Board to approve the revised projected year-end outturn, subject to the ongoing work to verify the position. Ms Edwards said that the Trust must give an accurate picture of its finances to its stakeholders, including the public, and that the accounts must be meaningful as well as accurate.

**RESOLVED: That the report on the financial position of the Trust for January 2016 be noted, and that the revised projected year-end outturn figure of a deficit of £2,400,000 (before the capital to revenue transfer) be approved and communicated to the TDA.**

**TB.5832: Chair's report of the Finance and Performance Committee, 24 February 2016**

Mrs Martin highlighted the main issues dealt with at last week's meeting of this Committee.

**RESOLVED: That the report be noted.**

**TB.5833: Executive Summary HR Report**

Ms Holland presented this item. Answering Mr Dunshea's question about the reduced prices for the National Leadership Academy Core Programmes in 2016, Ms Holland said that this was done simply to attract more participants. Mr Dunshea also asked what quality assurance underpinned the Clinical Excellence Awards. Dr Anderson described how the Local Awards Committee largely comprised higher award holders who could benchmark and assess nominated consultants.

Ms Holland then reported that the results of the 2015 NHS staff survey, involving 297 NHS organisations in England, were to hand. In the survey, over 741,000 NHS staff had been invited to participate using a self completion postal questionnaire survey or online, and responses had been received from 299,000 NHS staff (a response rate of 41%). The response rate for this Trust had been 39%. She went on to inform the Board that the survey was shaped around the NHS Constitution and the four pledges which set out what staff should expect from their employers. The Board heard that the key results for the Trust were as follows:

- The Trust is average or above average nationally for 29 out of 32 key finding areas within the survey compared to all combined acute and community trusts

- The overall staff engagement score for the Trust has improved from last year (3.91) and is above the national average for combined acute and community trusts (3.82), where five equals highly engaged, and one equals poorly engaged. Organisations with top quartile engagement scores average 12% higher customer advocacy and satisfaction

- Staff motivation at work has improved from last year (4.11) and matches the best score nationally for combined acute and community trusts (4.11), where five equals enthusiastic and absorbed, and one equals not enthusiastic and absorbed

- Levels of staff suffering work-related stress has reduced in the last 12 months at the Trust, and matches the lowest level nationally for the combined acute and community sector – however, this is still at 24%

The Trust compares very well nationally and regionally against the key finding areas overall.

She went on to mention three areas which were below national average for combined acute and community trusts:

- Support from immediate managers, though improved from last year (3.68) was still marginally below the national average (3.72)

- Percentage of staff satisfied with the opportunities for flexible working patterns (46%) was below the national average (50%)

- The percentage of staff/colleagues reporting most recent experience of violence (47%) compared with 52% for the sector nationally

She confirmed that a press release would shortly be issued in relation to the survey results.

**RESOLVED: That the Executive Summary HR Report be noted.**

**TB.5834: Workplace Wellbeing Charter**

Ms Holland highlighted the progress made in regard to the development of a Workplace Wellbeing Charter, which the Board welcomed. Mr Stringer referred to the City Council's decision to take the Healthy Lifestyles Service and Team back in house, and asked whether that would have a negative impact on this Charter. Ms Holland thought that although the Team would not be located in the Trust, we would continue to work closely with them.

**RESOLVED: That the progress report on the Workplace Wellbeing Charter be noted.**

**TB.5835: Junior Doctor Contract**

The Board received a report on the new junior doctor contract. Mr Loughton voiced disappointment over the failure to reach an agreed settlement in this dispute. He assured the Board that this Trust was striving to maintain a constructive relationship with its junior doctors who were a vital component of the workforce.

**Resolved: That the report on the new junior doctor contract be noted.**

**TB.5836: Minutes of the meeting of the Trust Management Committee held on 22 January 2016**

**RESOLVED: That the Chairman's report and minutes of the meeting of the Trust Management Committee held on 22 January 2016 be noted.**

**TB.5837: Chair's report of the meeting of the Audit Committee on 25 February 2016**

Mr Dunshea drew out the highlights of the report of last week's Audit Committee meeting.

**RESOLVED: That the Chair's report of the meeting of the Audit Committee held on 25 February 2016 be noted.**

**TB.5838: Minutes from Earlier Board Committee meetings**

The following minutes were received and noted:

Quality Governance Assurance Committee, 20 January 2016
Finance and Performance Committee, 20 January 2016

**TB.5839: Matters raised by members of the general public and commissioners**

No matters were raised by the press or public present at the meeting.

**TB.5840: Any other business**

There were no other items of business to be considered.

**TB.5841: Date and time of next meeting**

It was noted that the next meeting was due to be held on Wednesday 30 March 2016 at 10.00 a.m. in the Boardroom, Clinical Skills and Corporate Services Centre, New Cross Hospital, Wednesfield.

**TB.5842: Exclusion of Press and Public**

**RESOLVED:** That, pursuant to the provisions of section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960, the press and public be excluded from the remainder of the meeting on the grounds that publicity would be prejudicial to the public interest by reason of the confidential nature of the business about to be transacted.

The meeting closed at 12.27 pm.