CITY OF WOLVERHAMPTON COUNCIL

# Health Scrutiny Panel

Minutes - 24 March 2021

## Attendance

**Members of the Health Scrutiny Panel**

Cllr Obaida Ahmed
Tracy Cresswell
Cllr Bhupinder Gakhal
Cllr Lynne Moran
Cllr Phil Page (Chair)
Cllr Susan Roberts MBE
Cllr Paul Singh (Vice-Chair)
Cllr Wendy Thompson
Rose Urkovskis

**Witnesses**
Professor David Loughton CBE (Chief Executive of the Royal Wolverhampton NHS Trust)
Paul Tulley (Managing Director of Wolverhampton CCG)
Mark Docherty (Director of Nursing and Clinical Commissioning – West Midlands Ambulance Service University NHS Foundation Trust)
Pippa Wall (Head of Strategic Planning – West Midlands Ambulance Service University NHS Foundation Trust)
Karen Davies (Interim Head of Public Health Commissioning – NHS England and Improvement)
Dr Rajeev Raghavan (Consultant and Clinical Director – Diabetes & Endocrinology – The Royal Wolverhampton NHS Trust)

**Employees**
Martin Stevens (Scrutiny Officer) (Minutes)
John Denley (Director of Public Health)
Becky Wilkinson (Deputy Director of Adult Services)
Ainee Khan (Consultant in Public Health)
Julia Cleary (Scrutiny and Systems Manager)
Earl Piggott-Smith (Scrutiny Officer)

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# Part 1 – items open to the press and public

*Item No.* *Title*

1 **Apologies**
An apology for absence was received from Panel Member, Cllr Milkinderpal Jaspal.

Cllr Jasbir Jaspal sent her apologies as the Cabinet Member for Public Health and Wellbeing.

Vanessa Whatley, Deputy Chief Nurse – The Royal Wolverhampton NHS Trust sent her apologies to the Panel.

Marsha Foster, Director of Partnerships, Black Country Healthcare NHS Foundation Trust sent her apologies to the Panel.

2 **Declarations of Interest**

There were no declarations of interest.

3 **Minutes of previous meeting**

The minutes of the meeting held on 14 January 2021 were approved as a correct record.

4 **Matters Arising**

The Vice-Chair asked the Managing Director of the CCG if he could give an update on the work ongoing on structures for the CCGs merger. The Managing Director of the CCG responded that the merger had been approved. The appointments had been made to the new Governing Body and also to the Wolverhampton Commissioning Board. The Governing Body would be meeting for the first time formally after the 1 April 2021. In addition, during April there would be the first meeting of the Wolverhampton Commissioning Board. There was an ongoing management change process in relation to the management structure to support the single CCG. They were partly through the process; the first phase had been completed earlier in the year. They were currently out to consultation with effected staff on the second phase of the management of change process.

5 **Diabetic Eye Screening Procurement Programme in Birmingham, Solihull and the Black Country**

The Interim Head of Public Health Commissioning NHS England and NHS Improvement presented a report on the Diabetic Eye Screening Programme in Birmingham, Solihull and the Black Country. The current programme contract expired on the 30 June 2021. They therefore needed to undertake a procurement exercise for the programme. It was possible that the way the services were currently provided could change. This was because the new provider could provide services in a different way or because the existing provider had a reduced amount of venues to use because of the Covid-19 restrictions. There were two types of venues where diabetic eye screening could be provided. One was GP practices or Health Centres and the other one was High Street opticians. Mobile vehicles were an alternative option for diabetic eye screening providers to use as long as they delivered the services in line with the national specification.

The Interim Head of Public Health Commissioning NHS England and NHS Improvement stated that as part of the patient engagement exercise they would use existing users' feedback as part of the annual contract review from the existing provider. There had been other procurements locally within the Midlands and so they could use this feedback as well but recognising that the population would not be reflective of the Birmingham and Black Country area. They would be conducting some work with Diabetes UK, who had completed similar exercises to support patient engagement. In addition, following discussions with the Chair and Vice-Chair of the Panel earlier in the day, she had agreed to form a set of questions which they would like responses to from users of the service. They were particularly keen to receive responses from hard to reach groups.

The Chair asked if he could have some more information on the patient engagement exercise. The Interim Head of Public Health Commissioning NHS England and Improvement responded that they had some existing information from users of the service from the current provider. They had previously completed a procurement in the area of South Staffordshire and so they had all of this information on file. They were meeting Diabetes UK on the forthcoming Friday to discuss how they could help access the views of patients and users. They recognised that people from hard to reach and deprived communities did not traditionally come forward to give their views. They were happy to develop a set of questions which could illicit responses from patients in terms of priorities and issues they may have when accessing the service. Members of the Panel could then distribute these questions to their contacts. They were also open to suggestions on how they could obtain the views of patients in deprived Inner-City settings.

The Chair asked if there were any plans to introduce new digital solutions to improve the eye screening programme. The Interim Head of Public Health Commissioning NHS England and NHS Improvement responded that there were no plans currently that would impact on the current procurement. The Diabetic Eye Screening Programme was a nationally specified service in terms of how it was carried out and conducted. She was aware that there were some experimental assessments on the use of artificial intelligence (AI) to read some of the screens. When the results of these studies came to fruition, if it was decided to go ahead nationally, then it would be added into future service provision. She did however think this initiative was some years off being rolled out on a national scale.

The Chair asked the Consultant and Clinical Director for Diabetes at the Royal Wolverhampton NHS Trust what improvements he would like to see to the Diabetes Eye Screening Programme in an ideal world. He responded that clearly diabetes was the main problem and ultimately why a person attended eye screening appointments. The general health of a person would have an impact on eye health and it was important that this was recognised from the beginning of the process. Diabetes should be the central tenet of the process. An integrated approach would also ensure that patients also received all the information in relation to their health, which allowed them to make informed decisions regarding matters such as eye screening attendance. If they knew their eye health was connected to the rest of their health, it would hopefully engage the patient to make the right decisions and engage with the eye screening programme.

The Consultant and Clinical Director for Diabetes at the Royal Wolverhampton NHS Trust stated that collecting feedback continuously from patient groups, particularly patients that found it difficult to access services or had other challenges, he believed to be a good approach. He spoke in favour of NHS England and NHS Improvement and the current screening programme working with Diabetes UK. He thought if this could be done on a more regular basis there would be benefits, particularly in allowing the screening programme to be more flexible and meet service users' needs.

The Vice-Chair asked the Consultant and Clinical Director for Diabetes at the Royal Wolverhampton NHS Trust, if he could explain how enhanced information sharing would help the eye screening programme. He responded that the Eye Screening Programme had started to share information with Primary Care. Having information

fed back both ways, from Primary Care into the eye screening programme and from the eye screening programme into Primary Care was very valuable. This was because it meant the right patients were being called up for screening and the Primary Care Providers were receiving important information about their patients. He believed eye screening should be promoted by GPs and care providers amongst their patients across the Midlands. Enhanced data would allow for risk-based screening allowing resources to be better allocated with a targeted approach.

The Vice Chair asked the Consultant and Clinical Director for Diabetes at the Royal Wolverhampton NHS Trust how Covid-19 had impacted on the Eye Screening Programme to date. He responded that Covid-19 had been a huge challenge to all of healthcare. Eye screening had been significantly impacted particularly in the first wave of the Covid-19 pandemic. Once the first lockdown restrictions had been eased, the eye screening programme restarted and had been catching up with appointments since that time. Some patients had been reluctant to attend eye screening appointments due to the fear of becoming infected with Covid-19. They had tried to reassure patients about the infection prevention measures which had been put in place. The effects of people not attending appointments would become known in the next year to two years. Covid-19 had led to some positive steps, there had been more innovation, particularly in the areas of targeting people in different ways and making the service more impactful.

A Panel Member commented that she was pleased to be involved in the consultation for the Eye Screening Programme and that it was being discussed by the Health Scrutiny Panel. She highlighted the importance of being in contact with specific ethnic groups who may be more predisposed to diabetes.

A Panel Member remarked that he had a diabetes eye screening test in October of last year. He had been told that his next test would be in two years because his results did not cause concern rather than the usual year. He asked if this was a dangerous new course. The Consultant and Clinical Director for Diabetes at the Royal Wolverhampton NHS Trust responded that it was a good question to ask. Extensive research had shown that people's eyes did not change every year and it may take several years for changes to occur. When changes did occur the rate of progression would vary depending on the person and the risk factors that the person carried, such as blood pressure, cholesterol levels and the control of their diabetes. Consequently, based on research it had been found that people who had been stable for a few years, the risk of progression in a year was very low and therefore interval screening was the best approach. If, however the person felt their eyes worsening they could have their eyes assessed earlier.

The Interim Head of Public Health Commissioning NHS England and NHS Improvement commented that they did not make the decisions about how regular someone had eye screening locally. It was a nationally prescribed service and so they had to follow the parameters set nationally.

A Member of the Panel asked what date the deadline was for feedback on the patient experience of the current Eye Screening Programme. The Interim Head of Public Health Commissioning NHS England and NHS Improvement responded that the procurement process had been paused whilst they completed due diligence and so ideally, they wanted responses back over the next 10-12 weeks. A temporary extension to the existing contract would allow a meaningful consultation.

A Panel Member commented that the elderly community could be sometimes hard to reach, particularly those classified as BAME. His suggestion was producing literature in Punjabi and Urdu which could be distributed to places of worship.

The Chair, on behalf of the Panel, thanked the Interim Head of Public Health Commissioning NHS England and NHS Improvement, and the Consultant and Clinical Director for Diabetes at the Royal Wolverhampton NHS Trust for their contributions to the meeting.

**Resolved:** That NHS England and NHS Improvement write to the Scrutiny Officer with a list of questions they would like help with answering, regarding patient engagement for the Diabetes Eye Screening Programme. The Scrutiny Officer can then arrange for onward circulation to Panel Members and also consult with our own Public Health Team.

6 **West Midlands Ambulance Service University NHS Foundation Trust**

The Panel agreed to take the West Midlands Ambulance University NHS Foundation Trust item before the item on Covid-19 cases, testing and vaccinations due to the Director of Public Health experiencing IT issues.

The Director of Nursing and Clinical Commissioning, and the Head of Strategic Planning of the West Midlands Ambulance University NHS Foundation Trust gave a presentation on their Trust's response to Covid-19 and on some other matters that had been requested. Members complimented the representatives from the Ambulance Service on their thorough presentation, the slides of which were despatched with the agenda. They also thanked the Ambulance Service for their vital courageous work in the health system. They noted the outstanding rating of the service.

The Chief Executive of the Royal Wolverhampton NHS Trust remarked that the Royal Wolverhampton NHS Trust's performance of ambulance turn around times in the last few months of 2020 had been appalling. This was because normally to release ambulances they would put patients in corridors in the Accident and Emergency Department and provide nurses. Due to Covid-19 they were not able to continue with this practice. He therefore considered it remarkable the performance of the West Midlands Ambulance Service, in terms of response times, in Wolverhampton had not suffered. They had provided a brilliant service. He was pleased that the performance at New Cross Hospital had improved substantially, in terms of releasing ambulances.

The Chair asked for the results of the Covid-19 antibody testing carried out on West Midlands Ambulance Service staff. The Head of Strategic Planning responded that 22% of the staff tested for Covid-19 antibodies had them. It had been sometime though since the tests had been conducted.

The Vice-Chair stated that the NHS 111 Service was a vital service to help prevent A&E attendance and unnecessary ambulance call-outs. He asked what steps were being taken to improve the service further. The Director of Nursing and Clinical Commissioning responded that the 111 Service had been provided by West

Midlands Ambulance service for approximately the last 18 months. They had already carried out a number of improvements including ensuring that calls were answered promptly. They had ensured that the training of the call handlers was robust and that they were appropriately supervised. Every single call was recorded. There was now a much larger clinical support into the 111 Service. This included pharmacists, mental health nurses and Doctors. People working for the 111 Service would also be trained to answer 999 calls and so the service was becoming more integrated. He hoped this would encourage people to stay with the Ambulance Service. He saw no reason why a call handler or paramedic could not one day work their way up the organisation to the role of Chief Executive.

A Panel Member complimented the Ambulance Service on their performance during the last year. She asked how reflective the West Midlands Ambulance staff profile was of the general population in terms of equalities. She also asked about the service's Whistleblowing Policy for in the event of inappropriate behaviour. The Director of Nursing and Clinical Commissioning responded that the service's staff were their greatest asset. Staff retention was very important to them. Their staff had access to the most modern vehicles and up to date equipment. They were also looking at introducing stab vests and body cameras. The service was not fully reflective of the general population. The gender balance was almost right. Just over half of the service's paramedics were female. There was a good gender balance at Board level, as was the diversity level from a BAME perspective. The general diversity of the staff though was not at the point which they wanted. The service employed local people. Brierley Hill had been chosen as a site for a new control centre, this was a deprived area. The career opportunities offered to staff would help the local people in the neighbourhood. The paramedic programme offered people the chance to obtain a foundation degree. They were hoping to increase the diversity at student paramedic level. There was a Whistleblowing Policy for people that had concerns, there was also the Freedom to Speak up Policy and Freedom to Speak up Champions. Significant development work was taking place on equalities. The Head of Strategic Planning referred to the staff networks for staff in certain groups, which were hugely beneficial. There was also an extensive staff liaison service. Staff engagement events and surveys were conducted.

A Panel Member commented on a personal experience, where in their family a premature baby had died after an ambulance was called but was diverted to Hereford for a coronary heart case. It was 24 hours before the baby was picked up and had by that time had two cerebral haemorrhages. She asked if this was still a possibility today or whether there were now safeguards in place. The Director of Nursing and Clinical Commissioning firstly expressed how sorry he was to hear of the Councillor's experience. Babies were incredibly sensitive to temperature changes. He could guarantee that an ambulance would not be diverted in a case like this in the future, because in situations like these babies were now treated as category one patients. The West Midlands Ambulance Service were one of the few ambulance services that had put a lead mid-wife into the organisation. There were currently about three babies being born a day in the region before they were at hospital. They wanted to provide a safe service to a high standard. They were still looking to make improvements to the service.

A Panel Member asked for the statistics relating to the promotion prospects for people falling in the BAME group. The Director of Nursing and Clinical Commissioning stated that he would send him some figures about the diversity within

the organisation. He thought that he personally had never worked for an organisation in the NHS as diverse. There was a well-established LGBTQ Group in the organisation. There was not the amount of diversity he would like at senior manager and paramedic level. The Head of Strategic Planning referred to the mentoring services available to help BAME staff receive promotions. They were also doing some useful work with the University of Wolverhampton.

The Chair asked about the overall financial situation of the West Midlands Ambulance Service University NHS Foundation Trust. The Director of Nursing and Clinical Commissioning responded that for the last fifteen years as an organisation they had balanced the accounts. The accounts would also be balanced for the current financial year. The moving towards the Integrated Care System meant the financial position was uncertain for the future. For the first half of the next financial year they would be going into a blocked contract. He did have some concerns that the finances might suffer in the future if the Ambulance Service was asked to do more. He was also concerned, that as part of the Integrated Care System, they potentially might not be given the finances to continue high standards such as having the latest equipment and vehicles, if other organisations within the system were in a bad position financially.

The Vice Chair asked for more information about the lateral flow testing process at the organisation. The Director of Nursing and Clinical Commissioning demonstrated how a test was done and added that staff had been issued the test kits for them to use in the home environment. The test was not 100% accurate. Staff were asked to conduct a test twice a week which increased the accuracy level. People who tested positive from a lateral flow test were generally asked also to take a PCR test, which were more than 90% accurate. The Head of Strategic Planning added that 70,000 tests had been taken by the staff and 69,500 of them had been negative.

The Chair asked if there were any more infection prevention measures planned to help keep patients and staff safe from the more transmissible Covid-19 variants. The Director of Nursing and Clinical responded that staff were able to wear level 3 PPE in ambulances if they wished to, even though level 2 was deemed sufficient by national guidance. Air changes in ambulances was important, therefore having the doors and windows open was encouraged. For new vehicle procurement in the future they were looking at better air flow systems and supplementary heating systems, which were not dependent on the main engine running. Cleary vaccinations and social distancing were important measures. They had not run out of PPE during the pandemic. They had introduced the electrical charged peroxide cleaner which was sprayed in ambulances to disinfect them. Thankfully no member of staff had lost their lives.

The Chair thanked the representatives from the West Midlands Ambulance Service for an excellent informative presentation. He asked for the compliments of the Panel to be passed on to the staff for their excellent work.

7 **Covid-19 Cases, Testing and Vaccinations**

The Director of Public Health gave a presentation on Covid-19 cases, testing and vaccinations. For the seven days up to the 21 March, Wolverhampton had a Covid-19 case rate of 60 cases per 100,000 people. This was a marked difference from the earlier stages of the second wave, which had been a real challenge. Six weeks before Wolverhampton had a case rate of 1000 per 100,000. The average case rate per 100,000 for the region was 65.4, meaning Wolverhampton did not have a dissimilar rate. In some areas in the West Midlands the rates were increasing again. This emphasised that at a certain rate, probably around 100 cases per 100,000, any outbreaks would amplify the percentage increase rate at a local level. The levels of Covid-19 cases in Wolverhampton were now at a similar level to those in early September 2020. Due to an increase in lateral flow testing, they were now finding more cases which were largely asymptomatic.

The Director of Public Health presented a slide on Public Health's strategic approach which was based on three key principles. These were the vaccination roll out, compliance and testing, and contract tracing. Protecting the most vulnerable was a key aim. The most vulnerable were those most likely to be hospitalised and had a greater chance of death. The strategic approach was outlined in the Outbreak Control Plan which was currently being refreshed and was due to be published on the forthcoming Friday. He commented that he would welcome the opportunity to present the Outbreak Control Plan at the next scheduled Health Scrutiny Panel.

The Director of Public Health presented a slide on Covid-19 testing within the City. The lateral flow sites for asymptomatic testing continued along with PCR sites for people exhibiting symptoms. There was a total of 11 testing sites within the City. Schools children and staff were now conducting tests in the home environment. In Social Care, routine testing was taking place and also with NHS partners. A local offer had just been launched to compliment the national offer to businesses, whereby they were incentivising organisations to embrace Covid-19 testing. The more testing which took place, the earlier they could identify cases and prevent the virus spreading. 95% of the cases in Wolverhampton were now the UK variant, a very transmissible strain of the virus. There was also a mobile testing unit in the City which was used in areas of high prevalence and also areas with low uptake for testing. It had proven to be exceptionally useful. In the past 7 days up to the 21 March, there had been 42,363 tests conducted in Wolverhampton. He regarded this as a phenomenal effort. They were averaging 42,000 tests a week within the City and this would be built on moving forward. This was a good position to be in as the country came out of lockdown. He stated that the National Test and Trace system picked up 78% of cases within Wolverhampton. Through the local tracing function, they picked up 62% of the remaining 22%.

The Director of Public Health presented a slide on the Covid-19 vaccine roll-out. Over 108,000 Wolverhampton residents had received their first vaccine. He gave praise to all the people who had helped to roll-out the vaccine within the City. The City's model was largely GP led with help from the Royal Wolverhampton NHS Trust. The uptake of the vaccine for people over the age of 70 was currently over 90%. There had been a good initial uptake for people over the aged of 50 which he believed would increase with time as more people booked their appointments. The uptake for Carers (DWP) was over 60% and improving. The NHS and Social Care

Workforce rate was over 75%. For the clinically extremely vulnerable the rate was over 80% and continuing to improve.

The Director of Public Health presented a slide on why some people weren't coming forward for a vaccine. The key factors were not wanting to be first, distrust, safety concerns, people believing they did not need the vaccine, people believing it wouldn't work, people concerned if they were pregnant, breast feeding and concerns about fertility. Some people felt it was a challenge to get to a clinic and didn't realise the other options available. They were concerned about leaving the house after such a long time isolating. Some felt if they had not taken the vaccine when first offered, that it was a now missed opportunity and wouldn't be able to access it again. It was therefore useful to keep contacting those individuals to give them information.

The Director of Public Health remarked that there was a cross sector partnership in the City to maximise the uptake of the vaccine. Data sharing played an important part, linking data together from different organisations gave better profiling. They had established a dedicated call centre within the Council and working with the GPs they were able to contact the people who had not taken up the offer of a vaccine. He spoke about pop up clinics and community champions to help increase the uptake of the vaccine. They had even carried out some pilot door knocking in areas where the uptake of the vaccine had been low.

The Director of Public Health showed a Covid-19 case rate heatmap for Wolverhampton. The situation had improved remarkably since the start of January, this was down to the vaccine roll-out and the lockdown.

The Chair asked if the Director of Public Health could detail any particular age groups in Wolverhampton that had been vaccine hesitant or he expected to be. The second question he asked, was if he could inform the Panel how many Council staff had received a positive PCR test result for Covid-19. His final question was about the current policy for lateral flow tests for people within the City. The Director of Public Health responded that it was widely acknowledged that there were real differences between ethnic groups and the uptake of the vaccine. The current data for Wolverhampton did show that this was not significant for people over the age of 80 in the City, but it was below this age group. Rather than vaccine hesitancy being considered under one heading of BAME, he felt it was important to consider everybody's story as an individual to understand the hesitancy. Talking to people on an individual level he felt was more productive than general messaging. The uptake of the vaccine was improving in ethnic groups based on Public Health's interventions.

In response to the question on Council staff receiving positive PCR tests the Director of Public Health stated that the Council did not monitor staff having PCR tests. The Council did reinforce the pathways for people who had symptoms. The Council were encouraging staff to incorporate lateral flow tests into their everyday lives. The general policy for people in the City was to test regularly, preferably twice a week, with lateral flow tests if they did not have symptoms. He did accept though that context was important and for someone who was always at home shielding, it was less important for them to test themselves regularly.

The Vice-Chair asked if the Director of Public Health could detail any intentions for the further or enhanced use of digital solutions to prevent and monitor Covid-19 cases and increase the uptake of the vaccinations in Wolverhampton. His second

question related to whether the suspension / restriction of the use of the AstraZeneca Oxford vaccine in some European countries had impacted on the uptake of the vaccine in Wolverhampton. His final question was whether people that were eligible for the vaccine, who were housebound, had all received their vaccination.

The Director of Public Health spoke highly of digital solutions. Some people responded well to the use of digital, whilst others responded better to a phone call or a visit. The use of social media for key Covid-19 messaging had gone very well. The sharing of data across partners was a key element to digital solutions and had been embraced during Covid-19. This was a good learning point for the future. With regard to the AstraZeneca Oxford vaccine, on one day 6% people of people did not show for their appointment since the European issues. Thankfully working with the GPs, they had been able to fill the slots and no vaccine was wasted. The no show rate was now back to normal levels at about 1%. For people that could not get to a clinic, home visits did take place. They could also arrange transport for people to clinics, working with their NHS colleagues. The home visits had varied in terms of timeliness, but this was something they were trying to improve as they came down the age groups. This was all part of the equalities discussion.

A Panel Member thanked the Public Health Team for all their efforts with the vaccination programme. She commented that the amount of vaccine available was about to be reduced due to supply issues, she asked that when supplies returned to higher levels, whether the vaccination programme could be upscaled again. The Director for Public Health responded that the key element was planning and partnership working, which had been so successful. There was a partnership group which was co-chaired by him and the Managing Director of the Wolverhampton CCG. Wolverhampton did not have a mass vaccine centre, but it did have a colocation of GPs delivering at pace and scale in places like the Aldersley Leisure Village and Bert Williams Leisure Centre. The partnership working had meant they had been able to plan much better. They had been able to respond very quickly to supply changes. They were therefore ready to be able to scale up and scale down the vaccination programme within the City.

The Vice-Chair spoke about the Muslim Ramadan Festival and asked for this to be factored into the planning for the vaccination programme. The Director for Public Health responded that they were aware of the different religious festivals and celebrations approaching. Public Health Officers had successfully met with different faith groups and sometimes these meetings were occurring 4-5 times a week over the past year. Ensuring people celebrated safely and understanding the impact of religious events effecting people's willingness to have the vaccine were areas that were commonly discussed.

As it was the last meeting of the Municipal year, the Chair on behalf of the Health Scrutiny Panel thanked the members of the Scrutiny Officer Team, Martin Stevens, Julia Cleary and Earl Piggott-Smith for all their help organising the meetings throughout the last Municipal year. He commented that they did an excellent job and through their work, the meetings had run smoothly. He also thanked the Director of Public Health and his team for their excellent work over the last year and praised their partnership work. He thanked all the health partners, commenting that the last twelve months had probably been the most difficult period in the modern-day health system in Wolverhampton. Partnership working by health partners had excelled during the pandemic. He added that it had been a tragedy for some families in the

City, some of which were close to him personally. The position of the City in relation to the pandemic was now much improved. He thanked the West Midlands Ambulance Service for their efforts during the pandemic and the presentation given at the meeting. He thanked all the Panel Members for their support during the year and made particular mention of the Vice-Chair for his help.

The meeting closed at 3:53pm.