BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4.00pm 19 NOVEMBER 2025

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Wilkinson (Chair)

Also in attendance: Councillor Evans (Deputy Chair), Hill, Hogan, Lademacher, Mackey, O'Quinn and Parrott

Other Members present: Nora Mzaoui (CVS), Geoffrey Bowden (Healthwatch), Bernadette Kent (Older People's Council)

PART ONE

15 PROCEDURAL BUSINESS

15(a) Substitutes

15.1 There were none.

15.2 Cllrs De Oliveira and Simon sent apologies for the meeting. Mary Davies (Older People's Council) sent apologies. Bernadette Kent attended the meeting as a guest to represent the Older People's Council.

15(b) Declarations of Interest

15.3 There were none.

15(c) Exclusion of press & public

15.4 RESOLVED – that the press and public be not excluded from the meeting.

16 MINUTES

16.1 The minutes of the 09 July 2025 and 26 September 2025 meetings were agreed as an accurate record.

17 CHAIR'S COMMUNICATIONS

17.1 The Chair gave the following communications:

Firstly, we have a new member on HOSC. I'd like to welcome Cllr Marina Ladermacher, who will be replacing Cllr Julie Cattell on the committee. I hope that Marina enjoys her time on the committee. I'd also like to thank Cllr Cattell for all her work with HOSC.

We're looking at a wide range of issues today. First up is our annual paper on plans to deal with additional pressures this winter. There will be a presentation from partners across the health and care system reflecting the fact that this is a partnership endeavour. There will be a follow-up paper next summer evaluating how the system performed across winter.

We also have a paper on cancer diagnosis and treatment. Improving cancer outcomes is both a local and a national NHS priority. Brighton & Hove performance has not always been as good as it might be, and I'm sure members will be keen to hear where we are currently and what improvement plans are in place.

Members may also be aware that there's currently lots of activity in terms of NHS commissioning arrangements. These are important issues, and I've asked NHS Sussex to provide a quick verbal update at this meeting on where we are locally.

The Government has recently announced that it intends to do more to share information on NHS performance with people who use NHS services. As part of this, we had the first NHS Oversight Framework dashboard released this summer, followed by the publication of league tables for both acute and non-acute trusts in September. Where this data shows that local NHS trusts need to make substantial improvements, I feel it's important that the HOSC talks to the trusts concerned about their improvement plans. We've got Sussex Partnership here today, and I'll invite other local providers to future meetings.

The last item on today's agenda is for Sussex Partnership Trust to explain why they need to temporarily close Chalkhill, their young person inpatient unit at Hayward's Heath.

Finally, I'd like to update members on the correspondence sent on behalf of the to the Secretary of State for Health regarding the future of local Healthwatch organisations.

The Committee's letter emphasised the importance of the local Healthwatch role in representing residents' experiences and ensuring strong public involvement in health and care services. A reply has now been received from the Department, acknowledging our concerns and outlining the Government's current position. I will share these with members for information.
No action is required at this stage, but the correspondence will be kept on file should the matter come before us again.

18 PUBLIC INVOLVEMENT

18.1 There was a public question from Mr Adrian Hart. Mr Hart asked:

In January, HOSC heard a presentation from the Sussex Gender Service (SGS) but many questions on prescribing practice, age of access, and pathway safeguards were not answered and remain outstanding. The Cass Review nationally, the ongoing NHS Sussex review locally alongside the jaw-dropping New Statesman expose of the scandal here in Brighton & Hove, emphasise the need for clear safeguarding protocols and transparent communication with families. The Council's Trans Inclusion Schools Toolkit and the role of activist organisations in schools have correlated directly with NHS pathways for gender care such as SGS (yet this committee applies zero scrutiny). In light of these links, what steps will HOSC take to assure residents that appropriate safeguarding oversight exists between education, primary care and specialist services (and data on referrals and prescribing are available for scrutiny), and that the affected families whose invitations to meet councillors are typically ignored, will henceforth be consulted?

18.2 The Chair responded:

Thank you, Mr Hart, for your question and for raising these concerns with the Committee. I want to begin by saying that safeguarding is taken extremely seriously by this Council, and we work closely with our local children's and adults' safeguarding partnerships.

As you'll be aware, the issues you refer to are currently the subject of a live and independent investigation being led by NHS England and NHS Sussex. That investigation focuses on prescribing for under-18s and is being carried out by independent clinicians. The Terms of Reference set out the safeguarding duties involved, and the process is already underway.

Because that work is ongoing, and because it relates directly to clinical practice and individual patient care, HOSC, like the Health & Wellbeing Board, must respect the boundaries of that process. We cannot comment on individual cases or make assumptions about clinical decision-making while the investigation is under way.

What we can do, within our scrutiny role, is ask NHS Sussex and NHS England to provide HOSC with the system-level information that can lawfully be shared during the investigation. That includes updates on safeguarding arrangements between schools, primary care and specialist services, and any aggregated activity data that NHS Sussex is able to publish at the appropriate time.

I am aware that some stakeholders have suggested a range of actions for HOSC to take at this stage. It would not be appropriate for the Committee to commit to any such actions while the NHS Sussex investigation is still in progress. However, once the investigation concludes and the final report is available, HOSC will consider its findings openly and transparently, and will then determine whether any further scrutiny activity is necessary. That ensures we remain within our statutory responsibilities, avoid prejudging independent clinical processes, and uphold appropriate safeguarding and governance standards.

On the point about families, I want to be clear and consistent with the position already set out by the Chair of the Health and Wellbeing Board. Councillors cannot engage with individual clinical cases. However, once NHS Sussex is able to report on broader system issues, those will be considered openly by HOSC in the usual way.

Also, just to be clear: schools are not involved in the prescribing of medication, that is a clinical decision between the patient and their doctor. The schools Toolkit was revised earlier this year taking into account the Cass Review, and emphasised the need for a case by case approach seeking legal advice where necessary. There has been no legal challenge to the Toolkit. If there are safeguarding concerns about an individual child, there are mechanisms to report them to Childrens Services.

Finally, NHS Sussex has committed to publishing as much information about the investigation as it can on its website, and will continue to update the public as more can be shared

HOSC will continue to scrutinise this matter carefully, within the limits of our statutory role, and we will ensure residents are kept informed at the appropriate and lawful points in the process.

18.3 Mr Hart asked a supplementary question:

Given the weight of parental evidence already known to the council, and given that NHS Sussex is effectively investigating its own actions, how does HOSC justify taking no direct scrutiny action to ensure children in this city are safe — including considering whether the threshold has been met to request a Child Safeguarding Practice Review? Thank you.

18.4 The Chair responded:

Mr Hart, HOSC must follow a due process. We cannot intervene in or run parallel to an active clinical and safeguard investigation. Our role is to receive the completed findings and then consider what if any scrutiny action is necessary. Acting prematurely would risk undermining both the investigation and our statutory responsibilities.

If the final investigation report identifies systemic issues, HOSC *will* scrutinise the response and may make formal recommendations, but we will not pre-empt the findings of an active independent process. Thank you for your supplementary question.

19 MEMBER INVOLVEMENT

19.1 There were no member questions.

20 SUSSEX WINTER PLANNING 2025-26

20.1 The item was presented by Nicki Smith, NHS Sussex Director of Emergency Preparedness, Resilience and Response. Joining her were Steve Hook, BHCC Director of Adult Social Services; Nigel Kee, University Hospitals Sussex NHS Foundation Trust Chief Operating Officer; Michelle Arrowsmith, University Hospitals Sussex; Tanya Brown-Griffith, NHS Sussex Director for Joint Commissioning and Integrated Care Teams (Brighton & Hove); John Child, Chief Operating Officer, Sussex Partnership NHS Foundation Trust; and Dr James Simpkin (primary care).

20.2 Ms Smith outlined planning for winter 2025-26. This year's planning builds on learning from previous winters with particular priority given to starting the planning cycle early; developing clear escalation plans; focusing on discharge, staff vaccination and communications; and holding 2 discharge events relatively early in the winter.

20.3 Ms Brown-Griffith added that Brighton & Hove specific work includes: focus on the unscheduled care hub which helps deliver effective use of ambulances; the development of a neighbourhood health alliance which offers proactive care planning to people most at risk of un-planned admission; a particular focus on supporting people with COPD; and an integrated approach to admission avoidance via Better Care Fund supported collaborative work.

20.4 Cllr O'Quinn asked about staff vaccination. She was informed that current rates are around the national average. This year's focus includes having roving teams rather than expecting all staff to book slots at a clinic. Some partners are also offering vouchers.

20.5 Cllr O'Quinn asked about use of AI. Mr Child responded that there is work in its early stages looking at supporting clinical triage. This has very careful governance in place. Mr Kee added that the hospital trust is similarly in the early stages of developing AI programmes, also with robust governance.

20.6 Cllr Parrott asked about consideration of people with protected characteristics. Ms Brown-Griffith assured members that there is a robust equalities impact assessment of winter plans. Specific work includes information on falls prevention being translated into 30 languages.

20.7 Cllr Parrott asked about planning for people in a mental health crisis. Mr Child responded that there have been improvements made to the urgent mental health pathway in recent months, for example the establishment of crisis cafes with extended opening hours. SPFT mental health liaison teams work in A&E and ensure timely assessment of mental health needs. However, there remain significant challenges in terms of waits for mental health beds and in terms of mental health phoneline capacity. There has been no specific additional national resourcing made available for the coming winter.

20.8 Geoffrey Bowden asked about provision for the homeless and for asylum seekers. Md Brown-Griffith responded that Arch provides a range of services for these vulnerable communities, including pop-up on-street vaccination offers. Steve Hook explained the important role that SWEP (severe weather emergency protocol) arrangements play in supporting homeless people. In past years there has been additional national funding for SWEP, but none has been offered this year.

20.9 Bernadette Kemp (Old People's Council) voiced concerns about the impacts of midday discharge on older patients. Mr Kee responded that there is a big push for earlier discharge but there is recognition that there are specific issues relating to some patients, particularly for people who live alone. Mr Hook added that homecare commissioning has been revised to provide additional discharge support. There are particular issues for people with dementia and additional step-down beds are being provided at Ireland Lodge. There is a multi-disciplinary admission prevention team operating from the Royal Sussex and this has diverted around 2000 people from hospital admission since 2023.

20.10 Cllr Mackey asked what had been learnt from the previous winter. Ms Smith replied that the main learning points were to begin planning earlier in the year, to have clear escalation routes, to schedule testing events at an earlier point, to be really focused on vaccination and communications, and to ensure that clinicians are fully engaged with every initiative. Mr Kee added that learning also included the importance of good quality staff engagement and using discharge lounges in more intelligent and holistic ways. Dr Simpkin noted that from a primary care perspective learning included the need to focus on the patients at highest risk of admission and on making early referrals into multidisciplinary teams.

20.11 Cllr Parrott asked whether staff vaccination schemes extended to community & voluntary sector workers playing a key role in winter planning and delivery. Ms Smith responded that she was unsure but would be happy to provide a written response.

20.12 Mr Bowden asked about the negative impacts of beginning planning later last year. Steve Hook replied that one negative example concerned the multi-agency discharge events. Last year the first of these events took place in the week before Christmas which presented a number of logistical problems which could have been avoided had the event been held a week or so earlier.

20.13 Nora Mzaoui noted that Community Works will meet imminently to discuss winter plans. She asked whether it will be possible to adjust plans if community sector colleagues identify gaps. Ms Brown-Griffith replied that local plans can be flexed in this way.

20.14 Cllr O'Quinn asked a question about access to GPs over the Christmas period. Dr Simpkin responded that GP surgeries are in fact open as usual on every day other than bank holidays. While January is a busy time, the period before Christmas is not always particularly busy.

20.15 Cllr Hill asked about ambulance handover performance and how the ideas of non-managerial staff on improving performance are captured. Mr Keen responded that there have been dramatic recent improvements in ambulance wait times, particularly with regard to the 60 minute target. UHSx works very closely with South East Coast Ambulance NHS Foundation Trust on this and key roles are played by non-clinical staff across the emergency department.

20.16 Cllr Hill asked about the potential impact of strikes across winter. Mr Kee responded that services have become increasingly adept at managing industrial action and maintaining good standards of both emergency and elective performance.

20.17 Cllr Hill asked about waiting times for acute mental health beds. Mr Child responded that the waits are longer than anyone would want. However, there has been some recent improvement in terms of patients waiting at the Royal Sussex (RSCH) A&E for a mental health admission.

20.18 Mr Bowden asked about capacity issues at RSCH A&E. Ms Smith responded that a new acute medical unit will open imminently. This is a key stage in the implementation of planned emergency floor improvements and will help increase capacity.

20.19 The Chair asked whether the winter plans were adequately resourced. Mr Kee replied that close working is the key factor: if partners work well together and each organisation manages staff sickness effectively, the system should cope.

20.20 The Chair asked about contingency plans. Mr Kee responded that there are a range of Sussex-wide escalation plans. Ms Smith added that there are also close links across the south east region.

20.21 Cllr Hill proposed an amendment to the report recommendation to include an additional recommendation: "that HOSC Committee recommends that consideration be given to a planned roll-out of vaccinations for individuals working in the Voluntary, Community, and Social Enterprise sector who play a vital role in supporting the winter plan". This was seconded by Cllr Parrott and agreed by the committee.

20.22 RESOLVED – that the report be noted; and that HOSC Committee recommends that consideration be given to a planned roll-out of vaccinations for individuals working in the Voluntary, Community, and Social Enterprise sector who play a vital role in supporting the winter plan.

21 CANCER DIAGNOSIS AND TREATMENT

21.1 This item was presented by Nigel Kee, University Hospitals Sussex NHS Foundation Trust Chief Operating Officer, and by Stephen Peacock, NHS Sussex Deputy Director, Acute Services Commissioning and Transformation, Cancer & Diagnostics.

21.2 Mr Peacock told the committee that the post-Covid recovery programme for cancer treatment is progressing. Services are now meeting the 28 day target. There are still issues with the 62 day target, but this is also showing consistent improvement. Efforts are focused on the areas of most concern and on the greatest impact areas. Mr Kee added that lower GI treatment has now been consolidated on the Worthing site and services are performing well. There is still room to improve co-working across the Sussex Cancer Alliance.

21.3 Cllr Evans asked why the statistics show an increase in referrals but a flat rate for cancers detected. Mr Peacock responded that this is being evaluated. It may be that this just shows enthusiastic referral patterns from primary care.

21.4 Cllr Evans suggested that this may be linked to a de-skilling of NHS services with more workers who are not doctors now involved in assessing patients. Mr Peacock replied that this is an area under investigation. However, the NHS does need a broad skills-mix across its workforce. Mr Kee added that the majority of cancer referrals are made by GPs, with some from dentists also. GPs have ample guidance on making cancer referrals, and it may be that some of the increase in referrals is due to greater awareness of cancer symptoms across the general population.

21.5 Cllr Parrott asked about staff shortages. Mr Keen responded that some cancer posts are difficult to recruit to, including oncologists and radiographers. There have been some successful recruitment rounds recently plus retention has been good. Cllr Parrott noted that the 2024 system review of staff retention had identified aggressive behaviour by colleagues as a major factor in high turn-over. Mr Kee replied that this is monitored closely; the local rates for staff to staff aggression are low.

21.6 Cllr O'Quinn asked why the 62 day performance and national survival rates are so low. Mr Peacock replied that UK survival rates have long lagged behind other European countries, and particularly behind Scandinavia. There is a long term national improvement plan. Mr Kee added that cancer care is complex and is always evolving. Improving performance against different cancers may require quite different actions. We are seeing consistent improvement across cancer types, and the development of the new Sussex Cancer Centre will help cement this.

21.7 Geoffrey Bowden noted that 62% of local patients rated their experience of cancer services as good. However, there remain serious issues with access to diagnostics, for example in terms of breast and cervical cancer screening rates for older women. Mr Kee agreed that more needs to be done to help people access diagnostic services.

21.8 Cllr Mackey asked what the benefits of the performance oversight regime were. Mr Kee replied that there were many advantages in working with the Cancer Alliance, particularly in terms of learning from national best practice. Mr Peacock added that it is useful to be able to highlight issues to NHS England in a proactive way.

21.9 Bernadette Kemp asked why there were no equalities implications in the report. The scrutiny officer explained that report implications outline the implications of the report recommendations. Where a report recommendation is 'to note' there will not usually be any implications to capture. This does not mean that equalities issues are not of importance in terms of the diagnosis and treatment of cancer.

21.10 Cllr Hill asked about developing future workforce. Mr Peacock replied that work is ongoing with the University of Chichester to develop a diagnostics faculty. Mr Kee added that it is also important to share information with schools.

21.11 Cllr Hill asked about self-referral. Mr Peacock replied, noting that there had been a self-referral pilot in East Kent. Mr Kee added that being able to share information from this type of initiative was one of the benefits of working with the Cancer Alliance.

21.12 Cllr Hill asked for clarification on plans to phase-out endoscopy in 'low-yield cases. Mr Peacock explained that this is about using less invasive alternatives to endoscopy for low risk bowel cancer patients. This works well, and includes the ability to refer those who test positive for further investigation via endoscopy.

21.13 The Chair asked about 62 day breaches. Mr Kee responded that when delays do occur, services examine what caused the delay and also conduct harm reviews.

21.14 Nora Mzoui (CVS representative) asked about delays in getting appointments for breast cancer screening due to capacity issues at the Park Centre. Mr Peacock agreed to provide a written response.

21.15 Members discussed whether to request a further update on cancer performance and agreed that one was required within the next 6 months. Members also agreed to hold a work-planning session.

21.6 RESOLVED – that the report be noted and an update on cancer performance be brought to a future committee meeting.

22 NHS CHANGE

22.1 This item was presented by Tanya Brown-Griffith, NHS Sussex Director for Joint Commissioning and Integrated Community Teams, Brighton & Hove.

22.2 Ms Brown-Griffith outlined recent and planned changes to NHS commissioning including

- The planned abolition of NHS England (NHSE) and the absorption of NHSE functions by the Department of Health & Social Care (DHSC)
- The 50% reduction in Integrated Care Board (ICB) operating costs
- The merger of Sussex and Surrey Heartlands ICBs
- A shift in focus of ICB commissioning, away from year on year commissioning to a more strategic focus with a 3-5 year commissioning cycle
- The implementation of the NHS Long Term Plan
- The agreement of an ICB redundancy plan
- The continuing development of primary and acute provider collaboratives
- The development of a local Neighbourhood Health Alliance
- The appointment of a new ICB Chair and CEO
- The development of the Sussex Major Service Review
- The progress of the ICB's commissioning intentions.

22.3 Geoffrey Bowden asked about the future of patient voice and uncertainties about Healthwatch contracts. Ms Brown-Griffith confirmed that Healthwatch funding will continue for 2026-27. The ICB recognises the importance of patient voice and will continue to commission services.

22.4 Cllr Parrott asked about the impact of redundancies on ICB staff. Ms Brown-Griffith acknowledged that this is a very difficult time for staff. There is health and wellbeing support in place, but sickness rates have increased.

22.5 Cllr Hill asked about how NHSE's oversight role would be continued. Ms Brown-Griffith replied that these duties would be taken up by DHSC.

22.6 Cllr Hill asked whether ICBs have worked well compared to the Clinical Commissioning Groups (CCGs) they replaced. Ms Brown-Griffith responded that ICBs are more focused and streamlined than CCGs, although some functions have been lost.

22.7 Cllr Hill asked why Sussex ICB was merging with Surrey Heartlands rather than another ICB. Ms Brown-Griffith replied that a merger was essential to manage the reduction in ICB operating costs. For many reasons, Surrey was the obvious areas for Sussex to merge with.

23 NHS OVERSIGHT FRAMEWORK 2025-26: UPDATE FROM SUSSEX PARTNERSHIP NHS FOUNDATION TRUST

23.1 This item was presented by John Child, Sussex Partnership NHS Trust (SPFT) Chief Operating Officer.

23.2 Mr Child explained that SPFT has been placed in segment 4 of the NHS Oversight Framework (NOF). There are 5 segments, with the best performing trusts in segment 1.

23.3 The NOF assesses NHS mental health trusts against a series of metrics. (Different metrics apply to acute, community and ambulance trusts.)

Child & Adolescent Mental Health Services (CAMHS) access. SPFT was not scored against this metric as the trust has recently ceased providing CAMHS in Hampshire, but it was not possible to disaggregate this performance from Sussex performance.

Effectiveness and Experience. This metric assesses CQC community survey results and acute bed length of stay in excess of 60 days. The NOF does not take into account the numbers of patients who are clinically ready for discharge but who remain in acute beds, for example because suitable supported housing packages have not been identified. However, this is important context when assessing length of stay performance.

Patient Safety. This metric looks at performance in terms of seeing people in crisis within 24 hours and also staff survey responses.

People and Workforce. This metric measures sickness absence and engagement with trust staff surveys.

Finance. This metric assesses whether a trust forecasts a deficit at year end and also month on month variance from forecast expenditure. Trusts forecasting a deficit are limited to being placed in NOF segment 3 or below.

23.4 Cllr Parrott asked about physical health factors in treating people with mental health problems. Mr Child replied that this is an issue of growing importance, with increasing numbers of mental health patients also experiencing physical health issues such as chronic pain or obesity. The model of community care offered is critical here: we need to move to a model that has better integration between physical and mental health support.

23.5 Cllr Parrott asked about culture within SPFT. Mr Child responded that improving culture is a priority. SPFT has focused on increasing the rate of staff survey responses as this is a key way of receiving feedback on culture. There has been a lot of organisational change in recent years which inevitably has an impact on culture. The trust is also investing in a Continuous Quality Improvement Programme which entails working closely with staff about how it feels to work in SPFT.

23.6 Cllr Mackey asked about the role of co-production in CAMHS. Mr Child replied that SPFT is committed to improving services via a co-production approach with people who have lived experience.

23.7 Cllr Mackey asked about interventions to address excess length of stay in acute beds. Mr Child replied that some of the issues relate to delays in care packages or supported housing. However, SPFT internal procedures can also lead to discharge delays. Steve Hook, BHCC Director of Adult Social Services, added that the council has a close relationship with SPFT and although the council faces its own challenges, there has been significant improvement in discharge performance this calendar year.

23.8 Cllr Hill asked about the freedom to speak up function. Mr Child explained that there is a focus on raising staff awareness of this, via measures including having local champions.

23.9 Cllr Hill asked whether staff feel safe reporting issues relating to racist behaviour. Mr Child replied that there is a significant programme of work on racial inequality and offered to share more details of this in writing.

23.10 RESOLVED – that the report be noted.

24 CHALKHILL TEMPORARY CLOSURE

24.1 This item was presented by John Child, Sussex Partnership NHS Foundation Trust (SPFT) Chief Operating Officer.

24.2 Mr Child told the committee that SPFT had decided to temporarily close Chalkhill following CQC inspections which had identified the need to make significant improvements. The closure will allow SPFT to develop a new clinical model for the unit, address vacancy issues and make improvements to the fabric of the building. The closure is temporary, and the trust will use young people's acute capacity in Surrey and Kent to house patients until the work is completed.

24.3 Cllr Parrott asked about the quality of alternative Tier 4 provision. Mr Child replied that SPFT quality check all provision that they refer patients to. This is made easier by being a member of the provider collaborative.

24.4 Cllr Parrott asked about impacts on Tier 3 provision while Chalkhill was closed. Mr Child responded that the trust had made significant recent investment into Tier 3 provision to ensure that any additional demand can be met.

24.5 Cllr Parrott asked whether there are plans to expand capacity at Chalkhill. Mr Child replied that this is a question to be addressed as part of the refresh of the clinical model. The overall aim is to ensure that young people receive treatment in the best place for their needs.

24.6 Cllr Hogan noted that Chalkhill had long standing problems and asked whether these could be rectified. Mr Child replied that the problems can be rectified, although a lot of work will be required. However, the temporary closure is essential to do this; it would not be possible to make the necessary improvements were the unit to remain in operation. It is important to note that many Tier 4 units across the country face similar issues.

24.7 The Chair asked about engagement with the HOSC on the progression of the plans. Mr Child responded that the trust would be happy to provide the HOSC with progress updates. The CQC will doubtless look to inspect the new unit when it opens.

24.8 The Chair asked whether there was a date for re-opening. Mr Child replied that it was not currently possible to set a date. Ultimately this is likely to be dictated by the extent of building works required, but the scope of work will be determined by the review of the clinical model.

24.9 The Chair asked about staff redeployment. Mr Child replied that, because of the uncertainty of when Chalkhill will reopen, the trust had decided to permanently redeploy staff

rather than leave them in an uncertain position. Staff will consequently need to reapply for posts if they wish to return to the unit.

24.10 RESOLVED – that the report be noted.

The meeting concluded at 8.15pm

Signed Chair

Dated this day of