Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: MONDAY, 6 FEBRUARY 2017 at 3:00 pm

P R E S E N T :

Present:

Councillor Rory Palmer (Chair)	–	Deputy City Mayor, Leicester City Council.
John Adler	–	Chief Executive, University Hospitals of Leicester NHS Trust.
Lord Willy Bach	–	Leicestershire and Rutland Police and Crime Commissioner
Andrew Brodie	–	Assistant Chief Fie Officer, Leicestershire Fire and Rescue Service
Councillor Piara Singh Clair	–	Assistant City Mayor, Culture, Leisure and Sport, Leicester City Council.
Councillor Adam Clarke	–	Assistant City Mayor, Energy and Sustainability, Leicester City Council.
Frances Craven	–	Strategic Director, Children's Services, Leicester City Council.
Steven Forbes	–	Strategic Director of Adult Social Care, Leicester City Council.
David Henson	–	Executive Officer, Healthwatch, Leicester
Wendy Holt	–	Better Care Fund Implementation Manger, Central NHS England, Midlands and East (Central England)
Andy Keeling	–	Chief Operating Officer, Leicester City Council.
Chief Superintendent	–	Head of Local Policing Directorate, Leicestershire

Andy Lee		Police.
Sue Lock	–	Managing Director, Leicester Clinical Commissioning Group
Dr Peter Miller	–	Chief Executive, Leicestershire Partnership NHS Trust.
Councillor Abdul Osman	–	Assistant City Mayor, Public Health, Leicester City Council.
Councillor Sarah Russell	–	Assistant City Mayor, Children's Young People and Schools, Leicester City Council.
Ruth Tennant	–	Director of Public Health, Leicester City Council.

In attendance

Graham Carey	–	Democratic Services, Leicester City Council.

48. MEMBERSHIP OF THE BOARD

The Board noted the following changes to the membership of the Board:-

Leicestershire Fire and Rescue Service have nominated Andrew Brodie, Assistant Chief Fire Officer, to be their representative on the Board.

NHS England – Midlands and East have nominated Roz Lindridge, Interim Locality Director, Central NHS England to be their representative on the Board in place of Trish Thompson.

The Chair welcomed the new members of the Board together with Lord Bach who was attending his first Board meeting.

49. APOLOGIES FOR ABSENCE

Apologies for absence were received from:-

Karen Chouhan	Healthwatch Leicester
Prof. Azhar Farooqi	Co-Chair Leicester City Clinical Commissioning Group
Roz Lindridge	Roz Lindridge, Locality Director, Central NHS England.
Dr Avi Prasad	Co-Chair Leicester City Clinical Commissioning Group

50. DECLARATIONS OF INTEREST

Members were asked to declare any interests they might have in the business to be discussed at the meeting. No such declarations were made.

51. MINUTES OF THE PREVIOUS MEETING

RESOLVED:

The Minutes of previous meeting of the Board held on 15 December 2016 be confirmed as a correct record.

52. CHILDREN'S JOINT STRATEGIC NEEDS ASSESSMENT

The Director of Public Health submitted a report providing an update on the progress Children's and Young People's Joint Strategic Needs Assessment (JSNA) for 2016.

The Director of Public Health gave an overview presentation in which the following was noted:-

a) The JSNA presented a series of challenges to services for children and young people in the city. Not only were a number of key services provided by the Council and the NHS currently undergoing substantial reconfiguration and restructuring; but the data collected in the JSNA identified the key health outcomes for children. The changing demographics of children and young people in the City also presented challenges to proving services for these emerging needs.

b) The JSNA did not make specific recommendations for service change but provided data and evidence for key health outcomes for children. The JSNA was used by public service, voluntary and community organisations and those bidding for funding to provide children's services, as it provided a digest of children's health issues in city.

c) In addition to the JSNA, a children and young people's survey was currently being undertaken in the city in both primary and secondary schools and with those children who were home schooled The survey aimed to seek young people's views on how they viewed their own health and wellbeing and the services they would like to see provided. The report of the findings of the survey should be available in the next few months and then discussions would be held with young people to see how the survey results could influence future service provision.

d) The data collected in the JSNA could change quickly and it had been decided to move away from large printed documents to a web based document. This would allow it to be updated and refreshed frequently with new information and links to nationally collected data and the data collected routinely in the council. The web page can be found at www.leicester.gov.uk/JSNA and the list of topics on the page are:-

- Demographic profile of Children and Young People in Leicester
- Pre-birth to early life
- Early years (0-4 years)
- School years (5-19 years)
- Young Adulthood (20-24 years)
- Mental Health of Children and Young People
- Looked After Children
- Youth Offenders
- Other Vulnerable groups (including Female Genital Mutilation, Child Sexual Exploitation and Gypsy & Traveller Children)

For each topic there will be

- A summary on a web-page
- A link to a fuller briefing (printable PDF)

Both the summary and the briefing would contain links to further information

e) The Health and Wellbeing Strategy – Closing the Gap would be updated from the JSNA and Board members were encouraged to share the JSNA within their own organisations and with partners. There was useful data on youth offenders and on some of the big issues facing children and young people; such as female genital mutilation, child sexual exploitation and gypsy and travellers children. Although these were small groups they had complicated health needs.

f) The JSNA Programme Board had been working closely with the Children's Trust Board and the Leicester City Children's Safeguarding Board

g) One item of note emerging from the JSNA was the huge change in the demographics within the city; with a big expansion of children and young people within the population. From 2005 to 2015 there had been a 25% increase in number of children aged 0-5 years old, which was double the rate of increase in the rest of country. There had also been a 12.5% increase in the 0 -25 years old age range which was above the national average. This had put huge pressures on services and would continue to do so in future years. There was now some stabilisation of the number of women of child bearing age. Services would need to plan for the future demands for services for older children as they progressed through the system.

h) There was still a large gap in life expectancy from birth for the city compared with the national average and there were variations of life expectancy across different parts of city. Given future pressures on resources, it would be necessary to target those areas with the highest need. Diabetes continued to rise in the city so it would be important to ensure children and young people enjoyed good health for the future.

i) The recommendations of the JSNA had recently been discussed at the Children's Board and they were currently out for consultation. These

recommendations would be circulated to Board members for comment. These included:-

- 0 to 19 Year Olds
- 20 to 24 Year Olds
- Mental Health
- Looked After Children
- Youth Offending
- Female Genital Mutilation
- Child Sexual Exploitation
- Gypsies and Travellers

j) Other emerging issues were:-

- That the city was still below the national average for expectant mothers being seen within the first 12 weeks of pregnancy; so there were some challenges for ante-natal services to improve the situation.

- It was also important to keep a focus on those initiatives which were currently performing well such as immunisation and vaccinations and breastfeeding initiatives to maintain good performance.

- Childhood obesity was still an issue and so was the issue of underweight children. Some elements of these involved ethnicity and work was continuing with schools to try and understand the wider determinants of health which may be involved.

- Good early years and nursery provision so that children were well equipped with social and communication skills before starting school.

- Addressing mental health issues for young children as many experienced anxiety and social behaviour issues. This involved not only having improved access to services such as CAMHS, but also providing initiatives to making young people more resilient to mental health issues.

- Providing services for the health needs for looked after children and young offenders.

Members of Board, in discussing the report and the presentation, made the following comments and observations:-

a) The Council had adopted Sport England's initiatives in early years to work with schools so that children had physical activity as early as 5 years of age. 1 in 7 children had some form of special needs in education and these issues could be addressed through work with early mums and premature births groups providing advice on smoking and

drinking. The Active Leicester scheme had been launched last year and would strengthen the work with schools to increase health and wellbeing and work with community groups to encourage physical and sporting activity.

b) The Assistant City Mayor Children, Young People and Schools stated that the report had been well received at the Children's Trust Board in the previous week; especially by the voluntary and community organisations.

c) The increase in the young population should not be under estimated. Leicester would need a minimum of 5 new secondary schools in the next 3 years which was a significant impact upon providing day to day services in future years.

d) The Chief Executive, Leicester City CCG felt that the regular updates of data and the maps that showed the different needs in different parts of city were extremely useful in identifying needs for future health planning.

e) Healthwatch, Leicester reported that they were embarking on engaging with the Gypsy and Travellers community in relation to their health needs and would be contacting the Director of Public Health so this work was not carried out in isolation to other initiatives in the future.

f) The Chief Executive of LPT stated that he had been involved recently in meetings to engage with the asylum seekers in the city, currently estimated to be in the region of 130 -150. They had multiple health needs as a group and should not be overlooked in the work involving vulnerable groups.

g) The effects of the environment and air quality on health and wellbeing could have a higher profile in the JSNA.

h) The Police and Fire Rescue Services participation in the Braunstone Blues initiative in working with a community need programme had produced a number of beneficial outcomes and there was now an opportunity to use the programme to spread the initiative across city using existing resources in the police and fire services.

The Chair commented that it was important to address intergenerational issues such as lifestyle and mental health etc, as the behaviour of adults in being role models to children had an enormous effect. He welcomed the survey in obtaining the views of young people about health and how they managed their own health needs. He felt the result of the survey should be seen as being of equal importance as that of empirical data.

He also felt that, whilst the change in demographics of the city posed a number of challenges, it also provided a massive opportunity to make changes in the future. If the work with schools and young people could create a community and a generation of healthy conscious youngsters from a public health view, it

could be instrumental in breaking the current generational cycles of poor health. Other initiatives, such as smoking cessation, had shown the impact that children and young people can have in changing the lifestyle habits of their parents and adults around them.

In response to the comments from Board members the Director of Public Health stated that:-

a) She recognised the importance of the opportunities to work with schools. The 'sugar tax' would be a big opportunity as the levy from the tax was being given to schools for physical activity. Part of the challenge would be to get all schools participating up to the current levels of the best schools.

b) Midwifery services were important in working to address issues such as domestic violence, smoking and especially maternal obesity. There were intergenerational issues and the importance of parental support in early years and parenting programmes and the support from health visitors would play a vital role in getting the right messages across changing these issues for future generations.

c) The JSNA contained a lot of data about asthma and the link between air quality and asthma was well known. The work on air quality would be taken on board and incorporated in the JSNA.

d) There was currently no data collected for asylum seekers and this could be looked at in more detail particularly if this group had multiple health issues.

RESOLVED:

That the report be received and that further consideration be given to the recommendations of the JSNA when they are circulated to Board Members.

53. TRANSFORMATION PLAN FOR MENTAL HEALTH AND WELLBEING FOR CHILDREN AND YOUNG PEOPLE - REFRESH 2016/17

The Board received a report on the review and a refresh of the Transformational Plan developed in 2015 as part of the LLR Better Care Together Programme. There was a national requirement to refresh the plan to reflect the progress that had been made in 2015.

Chris West, Director of Nursing and Quality West Leicestershire and East Leicestershire and Rutland CCGs and Tim O'Neill, Director of People, Rutland County Council presented the report and answered Members questions.

The 6 core work schemes in the Plan were:-

- Improve Resilience.

- Enhance Early Help.
- Improve access to specialist Children and Adolescent Mental Health Services (CAMHS).
- Enhance the Community Eating Disorder Service.
- Develop a Children's Crisis and Home Treatment Service.
- Workforce development.

In presenting the report it was noted that:-

a) Phase 1 of improving resilience was underway and 11 out of 24 schools in city were currently involved in the work stream. The procurement process was underway and it was envisaged that the 3 year contract would be up and running in July 2017.

b) CAMHS access had improved and the service was now meeting the 13 weeks' target for assessments to be carried out.

c) The service for eating disorders was now available 24 hours and 7 days a week and was running fully.

d) The crisis and home treatment service had started but was as yet not fully operational. Staff had been recruited and the service was moving into new premises with an on line direct phone line service at the end of February 2017.

e) The workforce development work-stream had concentrated on identifying the training needs of the staff that were already in place and the development of staff moving forward. This was currently at the assessment stage and some non-recurrent funds were being used to fund training resources packages for staff.

f) The steering group overseeing the process had encouraged members to see that the 6 work-streams were connected to each other and good progress had been made. Parts of the procurement process had been both complex and challenging but there had been good engagement and support across the partnership in the city. The challenge moving into next financial year would be to gather the data to assess the impact of the work that had been put in place.

g) The procurement for early health had gone ahead as planned but it had not been possible to secure a provider that met the required needs across the LLR. It was accepted that the plan did not fully reflect the work that had already been done in the city around early health.

h) The next refresh to the Plan would be a more comprehensive explanation of all of the work under each of the work-streams and an assessment of how it was making a difference for children.

Members of the Board commented that:-

a) Prior to the publication of the refresh, it should reflect the terminology used in the city so that all agencies understood that there was a local response as well as an overall response in the county.

b) The efforts being made to strengthen early resilience were particularly welcome. The Children's Trust in the city had undertaken a great deal of work in looking at improving the earliest possible stages to engage with young people to help them develop ways of improving their own mental health and support each other. It had also looked at additional support staff may need in supporting children to ensure that the right services were in place; so that young people and their families had access at the earliest possible point. This was in response to previous evidence that had shown that some young people in the city had previously not been supported until they were in crisis. The impact of this upon the person and their family, in terms of recovery, had been significant. The measures being put in place could have huge benefits in making a difference to young people.

c) Improvement in early health in the city had been fast moving as part of the improvement journey and this could be easily be aligned to the work on early health in the Transformation Plan. The three directors of children's services in the LLR had been working closely to align processes so that it made sense to the whole partnership and not just an individual organisation within the LLR.

The Chair referred to the 11 indicators on the dashboard and stated that 10 of these were precise measures. He felt the 11th indicator for service user feedback and patient satisfaction surveys should be seen as being of equal importance in relation to the other 10 indicators. He felt that what young people said about their experiences of being able to access, or not access, services and their perception of their own health and wellbeing was fundamental to understanding how young people perceived their own health and their ability to seek support at the right point. Although it was laudable to reduce A&E and high level referrals; it was equally important to address other issues which were of concern to young people, such as cyber bullying and on-line harassment.

In response, the Director of People, Rutland County Council stated that a pilot initiative in Rutland supported this view and agreed that feedback and patient experience should be central to the plan.

The Chief Executive of LPT welcomed the investment that had been made to get the crisis team up and running and the investment of resources to improve access. A year ago, 250 children had been waiting more than 13 weeks for an initial assessment but now no one was waiting more than the 13 week target period. However, there was still an unsustainable rise in referrals; averaging a 9% year on year increase and there were still significant numbers of cases waiting between the assessment stage and the subsequent treatment programmes and this needed to be addressed.

The Director of People, Rutland County Council stated that there was a desire to get treatment services in operation as soon as possible and it was not envisaged that the procurement process would be lengthy.

The Chair commented that the Plan only referred to funding for 2015/16 but not for current or future years. As it would take 4-5 years to get resilience within the Plan, it was difficult to plan with any certainty when future funding was unknown. In response the Director of People, Rutland County Council echoed these views and shared concerns that the Department of Health's policy of providing yearly funding was not ideal.

In response to a comment by the Police and Crime Commissioner, the Director of People, Rutland County Council stated that whilst the police service had been engaged during the wider planning aspects of the Plan, there would be more specific involvement by Police Officers in the initiatives that were now in place.

AGREED:

1) That the Board support the publication of the refreshed Plan for 2016/17, subject to the extra information in relation to the early health initiatives and terminology used in the City and the financial information for 2017/18, being included.

2) The Board expressed concerns at the annual funding arrangements by the Department of Health which made long term planning uncertain.

54. STP PRIMARY CARE UPDATE

The Chief Executive Leicester City CCG reported that:-

a) The primary care developments within the STP were guided primarily from NHS England's GP Forward View. More details on the GP Forward View had recently been issued and CCGs were required to submit an improvement plan in response to them by 24 February 2017. The improvement plan was at an STP level of plan but with CCG specific sections added to it.

b) The first STP engagement event in the City was being held at the Peepul Centre, Orchardson Avenue, Leicester on 23rd February 2017 and the primary care work within the STP will be important part of that.

c) The Primary Care Commissioning draft strategy was to be considered at the CCG Board the following day and would be submitted to the Health and Wellbeing Board as part of the engagement process for the strategy.

AGREED:

That the update be noted and that the Primary Care Commissioning

draft strategy be submitted to a future Board meeting.

55. THE PERSONAL HEALTH BUDGETS LOCAL OFFER

The Board received a report from Maria Smith, Strategic Lead for Personal Health Budgets for Leicester City, West Leicestershire and East Leicestershire and Rutland Clinical Commissioning Groups. The report set out the CCG's Local Offer and the plans currently in development to expand the offer in line with national guidance.

It was noted that:-

a) There was requirement for Health and Wellbeing Board to be informed of the local personal health budget (PHB) offer.

b) Individuals eligible for continued health care (CHC) had been given the right to have a personal health budget since 2014.

c) The Integrated Implementation Group comprised representatives of all three local authority's children's, adult social care and education services, LPT, the 3 Healthwatch groups in the LLR and procurement, finance and communications representatives. The group were building the integrated personal budget process and the broad pathway for the future.

d) Services for individuals requiring a mental health package would be the main focus for 2017/18 and the focus in 2018/19 would be those with long term health conditions.

e) One challenge of offering personal budgets was that existing funds were predominately contained within large block contracts and disaggregating these elements to release the resources to offer services in a different way was a complex process. Work was progressing with LPT and contracting and commissioning colleagues to resolve these issues.

f) The proposals for the PHBs Local Offer linked well with the work already being undertaken on the STP. There were close links with the STP's Integrated Locality Teams Programme Board to ensure the models they were creating also had an integrated personal budget offer as part of their delivery offer.

In response to Members' questions the following responses were received:-

a) At present there were 105 PHBs in place within LLR and the early evidence suggested that individuals had yet not chosen to have radically different health care support than they had received in previous packages. Initial feedback from patients, their representative and carers on the group generally indicated that, whilst they were some frustrations with the process as it was being developed, there was, nonetheless, indications that recipients of PHBs were happier with their care

compared to their previous continued health care packages. A cultural change was needed within the NHS to move away from a service led approach, which may not always provide services to meet individual needs. Equally, a corresponding cultural change was also required from individuals who were still generally asking for a specified number of hours for their care rather than opting for other forms of care.

b) There was no evidence to suggest that PHBs for people with physical and mental health issues had been subjected to financial abuse. Those administering the PHBs also had some experience of monitoring budgets for those who couldn't look after themselves within the current CHC packages. Whilst financial abuse could never be guaranteed, there were safeguards and guidelines in place intended to prevent this. Third party organisations were also involved in helping to manage money in these circumstances, and, in some instances, court appointed representatives of the patients were involved. In addition, there was a stringent monitoring programme in place that reviewed the budgets every three months.

c) A recent review of equality and diversity responsibilities had indicated that data was not being collected to allow detailed monitoring of which parts of community had taken up PHBs; either in relation to ethnic diversity or in relation to taking up services which may be more culturally sensitive to their needs. This data would be captured in the future for both PHBs and CHCs and would be integrated into one team. This should make the process more efficient and responsive to patient's needs.

d) It was not possible to confirm the total financial envelope for the 1-2,000 PHBs envisaged in next 3-5 years as this was currently being scoped at present; and there were no details, as yet, of the financial resources that could be released from the large block contracts. This profiling could be shared with the Board members. In essence, there was no new money within the health system for funding PHBs and existing resources would need to be spent in different ways than at present. Staff were working with providers to examine ways in which the process could be taken forward and there was no intention to remove an existing service that worked well. The key to the process would be monitoring the risks and how those risks would be managed, as it would not be possible to provide existing services and provide different care services as part of PHBs at the same time. Resources would gradually need to be transferred from the big block contracts to the PHBs since the CCGs were not allowed to fund both.

f) It was estimated that the likely cost of CHC packages was approximately £3.9m per year per 1,000 people.

g) Staff were working with LPT to see what the potential consequences upon existing services could be and also what future services could look like. There was also a need to break through organisational barriers to

enable different service delivery. For example, PHBs may be able to provide care differently for patients with long term conditions that can't be cured but, nevertheless, could improve a patient's outcomes and prevent them going into crisis. This would benefit the system overall by enabling people to be cared for at home (or in residential setting) for longer instead of being cared for in the acute sector. Services would look very different in 5 and 10 years' time and this transition would need to done in a planned and phased way with all stakeholders involved.

The Chair commented that the Board required a more details of the financial implications for the future service provision of the expanded PHB offer as it needed to understand the potential risks involved and could only endorse the proposals if it had all the relevant information available on which to make an informed decision.

AGREED

1) That the Board support the principle and concept of Personal Health Budgets.

2) That the Board does not have sufficient financial information in relation to future years in order to endorse the planned further expansion of personal health budget/integrated personal budget offer into 2017 and beyond.

3) That the financial information be shared with the Chair to circulate to Board Members and subsequently a response to the planned future expansion.

56. LEICESTER SAFEGUARDING ADULTS BOARD

The Board received the Leicester City Safeguarding Adults Board Annual Report and Executive Summary for 2016. Jane Geraghty, Chair of Leicester Safeguarding Adults Board presented the report and answered Members' questions.

In presenting the report, the following comments were noted:-

a) The was the first report since the Adult Leicester Safeguarding Board became a statutory body following the implementation of the Care Act and the Board was compliant with the statutory requirements Care Act requirements.

b) The Safeguarding Board was responsible for holding all partners to account for their responsibilities and to ensure that each worked with all partners in order that vulnerable adults were safeguarded. Over 350 cases had been considered as part of the Board's work.

c) The Safeguarding Board was working well having committed partners and clear priorities and partners were now engaging in the Board's work

and leading sub-groups. This was considered as a sign that significant progress had be made in partnership working.

d) It was of concern that cases coming into the system didn't reflect the ethnic population of the city and the Safeguarding Board had asked the Stakeholder Engagement Forum (Chaired by Healthwatch) to lead the work on this in order to understand the underlying reasons. Initial thoughts considered it might be that the people were not aware of the processes in place to protect vulnerable people or know how to access them. It could also be that people were being kept safe within their own homes.

e) 86 individuals had come back into the system on more than one occasion and there was currently an audit underway to investigate the reasons for this. It was important to know if this was the result of an inappropriate response being given the first time or whether there were other reasons.

f) The Safeguarding Board had asked to be part of a pilot for a peer review in May 2017 to assess whether the Board was providing good governance and to assess the impact of work being undertaken and whether the Board was able to demonstrate that its work was improving the safety of people within the system.

The Strategic Director of Adult Social Services commented that the service was not achieving its obligations on safeguarding as there were currently 548 people who were waiting to be screened or assessed and that this level of outstanding screening and assessments had been experienced for some time. The Cheshire West judgement had confirmed that this was not a new burden for adult social care services and that there were no extra resources to meet the increased demand. The service had changed the risk assessment process behind DoLS (Deprivation of Liberty Safeguards) and the biggest group affected by the changes were those coming forward from acute and hostels settings. Currently they were the least likely to be assessed at the present time. A government review was underway and some provisional arrangements and suggestions for a new approach to DoLS had emerged, but these would not have addressed the large increase in the 13 fold increase in number of cases that had come forward in recent times. The number of outstanding screenings and assessments were of concern, but it was a position that was not uncommon across country as a whole.

The Chair of the Safeguarding Board felt that the issue of repeat referrals was of concern and there was a national issue in determining the impact of initiatives and activity, particularly in relation to preventative measures, to help to determine where best to put limited resources.

AGREED:-

That that The Annual Report be received and that Members of the Board continue to improve the contributions to the safeguarding of adults

through their own areas of responsibility and through the joint work with the Safeguarding Board.

57. QUESTIONS FROM MEMBERS OF THE PUBLIC

In response to a question from a member of the public relating to the scrutiny function of the STP and being made aware of the outcomes so the public can be made aware of what is good or what is a concern, the Chair stated that :-

- The Health and Wellbeing Scrutiny Commission had the responsibility to scrutinise the STP. The Commission met in public and members of the public could make their views known to the Chair through statements of case, representations or questions etc.

- It had originally been intended to have a debate at Council in February, as stated in the minutes of the last meeting, but this may not now be until the March Council meeting, when the STP proposals announced in the engagement process would be debated and the Council would come to a view. This did not mean that the Council would not consider the issue again after the formal consultation process had started on the STP.

- It was not appropriate not for him to comment upon the scrutiny role, as comments and views on this should be discussed with the Chair of the Scrutiny Commission.

- He hoped that when the proposals were fully known and the public saw the future affects upon of specific services, then they would also make their views known and that members would also be engaged in that process.

58. DATES OF FUTURE MEETINGS

The Board noted that the next meeting would be held on Monday 3rd April 2017 at 2.00pm. Note: Meetings of the Board are scheduled to be held in Meeting Room G01 at City Hall unless stated otherwise on the agenda for the meeting.

59. ANY OTHER URGENT BUSINESS

There were no items of Any Other Urgent Business.

60. CLOSE OF MEETING

The Chair declared the meeting closed at 4.48 pm.