

Monmouthshire Select Committee Minutes

Meeting of Public Services Scrutiny Committee held at Council Chamber, County Hall, The Rhadyr USK on Monday, 20th April, 2026 at 10.00 am

Councillors Present

County Councillor Armand Watts (Chair)
County Councillors: Jill Bond, Steven Garratt, Meirion Howells, Penny Jones, Malcolm Lane, Emma Bryn, Tudor Thomas, Jan Butler, Ian Chandler and Alistair Neill

Officers in Attendance

Hazel Ilett, Scrutiny Manager
Robert McGowan, Policy and Scrutiny Officer
Sharran Lloyd, Community and Partner Development Manager

APOLOGIES: Councillors Tony Kear and Dale Rooke

1. Apologies for Absence

Councillors Dale Rooke, and Tony Kear, with Councillor Alistair Neill as a substitute for Councillor Kear.

2. Declarations of Interest

Councillor Penny Jones declared a personal but non-prejudicial independent member of ABUHB and Chair of Mental Health and Learning Disabilities Committee.

Councillor Bond declared a personal but non-prejudicial interest as a psychotherapist and a volunteer for Base Camp in Chepstow.

Alistair Neill a personal but non-prejudicial interest as an independent board member of Digital and Healthcare Wales.

3. Public Open Forum

None.

4. Adult Suicide:

PART 1: To hear from MIND on how Mental Health Services in Monmouthshire are impacting both positively negatively on the individuals they support

Megan Escott introduced the report and answered the members' questions:

Megan explained that Mind Monmouthshire had submitted a letter and report to the Putting Things Right department after Christmas, highlighting serious concerns arising from their work with clients, supported by case studies. She described a follow-up meeting on 27th January with the local Community Mental Health Team (CMHT), where

the team acknowledged the issues raised and were apologetic. A key problem identified was persistent difficulty contacting CMHT, including unanswered calls, voicemails, and emails, which she stressed was due to lack of resources rather than the commitment of staff. She noted high sickness levels within CMHT, leading to missed opportunities to intervene when clients were reporting suicidal thoughts. Megan highlighted recent improvements following the meeting, including direct escalation contacts, the recruitment of two new Community Psychiatric Nurses, better communication, and CMHT inviting Mind to attend ward rounds to strengthen joint working.

- *Are Mind Monmouthshire's services free to clients, how are they funded, and is there a waiting list? I am also interested in whether earlier or broader provision could help prevent people reaching crisis point.*

The service is free to clients and is funded through the Welsh Government's Housing Support Grant, specifically to support people experiencing both mental health challenges and housing difficulties. There is a waiting list, but it is actively managed so that individuals waiting for full support receive weekly phone calls to monitor risk and ensure any emerging crisis is identified quickly. A strong emphasis is placed on early intervention, with clients being signposted to counselling or therapy wherever possible, as this can often prevent escalation to more serious crisis situations.

- *Do you signpost people to alternative or additional community-based providers, such as Base Camp, to reduce pressure on statutory services and support people earlier?*

Yes, signposting to other providers is a routine part of the approach. Clients are regularly referred to community-based and lower-level support services where appropriate, including Base Camp, and the Pathways scheme is also used extensively. This wider, preventative approach helps meet people's needs earlier and can reduce the likelihood of individuals reaching a crisis point that requires intensive statutory mental health intervention.

- *What impact are staff shortages and high sickness levels within the Community Mental Health Team having on service users and on the wellbeing of the staff themselves?*

Informal discussions with Community Mental Health Team staff indicate that the pressures they are working under are having a significant impact on their wellbeing. There have been situations where staff acknowledge that an individual urgently needs assessment but there is nowhere suitable to refer them. Spending prolonged periods responding to people in acute crisis, while knowing there are insufficient services available, is extremely distressing and helps explain the high levels of sickness within the team.

- *Given that funding and capacity pressures across public services are unlikely to improve significantly in the near future, what more can be done within communities themselves to help support people with mental health needs and intervene earlier, particularly through town and community councils?*

Communities have an important role to play in supporting mental health and that there is considerable goodwill and informal capacity within them. Strengthening awareness, training, and community-based support could help people identify symptoms earlier and provide help before individuals reach crisis point. While Mind does not currently run a specific community-training programme of this kind, the importance of community-level involvement and preventative approaches was acknowledged.

- *Are there particular groups within the county that should be prioritised for early intervention because they are at higher risk, specifically farmers and rural communities, where suicide rates are known to be significantly higher?*

The farming community is a key area of concern. Mind previously ran a Rural Relief Project which involved outreach at livestock markets and built strong relationships with farmers, recognising that mental health issues in farming are often hidden and difficult to address due to the nature of rural life. That project ended due to loss of funding, but one rural relief worker still maintains a presence at livestock markets and works alongside other organisations. Mind remains keen to revive the project and regularly applies for funding to do so.

- *Is there more that can be done to support young people and intervene earlier, given increasing mental health challenges among students and young adults, and the fact that many individuals are presenting in crisis as soon as they reach adulthood?*

Mind Monmouthshire currently works only with adults aged 18 and over and is increasingly seeing people referred immediately after turning 18 who are already at crisis point. This suggests that opportunities for earlier intervention have been missed. While there is no dedicated youth project locally at present, Newport Mind, with whom Monmouthshire Mind has recently merged, operates youth wellbeing and counselling programmes within schools. There is interest in extending similar provision locally, but this would require additional funding.

- *Following a suicide, what forms of post-suicide support have the greatest impact in reducing long-term psychological harm for those affected, including families, friends, witnesses, emergency responders, and professionals such as train drivers, and where are the main gaps in current provision?*

People who are close to someone who has taken their own life are statistically at increased risk themselves, despite common assumptions to the contrary. While support services do exist for those affected by suicide, a significant challenge lies in ensuring people access that help at the right time. Specific agencies provide post-bereavement support following unexpected deaths. Recent improvements were also noted in how police notify families, with mandatory training introduced to improve sensitivity and support at the point of first contact.

- *Given limited resources and long waiting times for clinical services, how can low-cost, rapid, and coordinated forms of support – such as early contact, clear guidance on grief after suicide, and a single point of coordination – be strengthened to prevent longer-term harm?*

Timely, coordinated responses can be particularly effective, especially in the period immediately following a death. Voluntary and third-sector organisations play an important role in filling gaps where statutory services are overstretched. However, waiting times – particularly for children and young people – remain a serious concern. An example was given of a young person who discovered a parent after suicide and waited a prolonged period for counselling, highlighting both service delays and the need for alternatives such as mentoring or more informal support, which may be more appropriate and less intimidating than formal counselling.

- *Where can the greatest benefit be achieved by making better use of existing resources, including community, faith, and voluntary groups, and how can these be better coordinated with clinical services to support people after suicide?*

Community-based and pastoral support can add significant value, particularly through simply “sitting alongside” individuals and families in distress. Community and faith groups already provide informal but meaningful early support and can help reduce isolation. Better coordination between clinical services, voluntary organisations, and community support is essential, ensuring people are supported consistently rather than being passed between services during periods of acute vulnerability.

- *If Mind has specific projects that need financial support, would it be helpful to approach town and community councils with a clear funding proposal, including the possibility of bidding for earmarked reserves?*

Yes, we welcome that approach. Having clearly defined projects with identified funding needs makes it much easier to have constructive conversations with town and community councils. If proposals are specific and well-scoped, there is greater potential for councils to consider supporting them, including through earmarked reserves where those are available.

- *How are people in crisis supported if they cannot get through to statutory mental health services, and are they being clearly signposted to alternatives such as the Samaritans so they are not left feeling abandoned?*

We are seeing improvements, with more calls to the Community Mental Health Team now being answered directly rather than diverted to voicemail. We also provide clients with small safety-plan cards that list practical coping strategies alongside key crisis contact numbers, including the Samaritans and other helplines. This means people have support details readily available and do not have to search for help while they are distressed.

- *What more can be done to ensure support is available for people who struggle with telephone-based services, particularly when 111 waiting times are long and face-to-face reassurance may be needed?*

We recognise that telephone services work well for some people but not for everyone. There are situations where individuals in serious mental health crisis have waited a long time on 111 or been disconnected, which is extremely difficult for someone who is feeling suicidal. We raise these concerns with the Community Mental Health Team and

continue to look for alternative responses, particularly for those who need in-person reassurance to feel safe.

- *Is there more that can be done to strengthen support for children and young people, including bereavement services such as Cruse, staff training in schools, or approaches similar to Nightline for younger age groups?*

We recognise the value of these approaches. Text-based services are widely used by younger people, who often find it easier to communicate in writing rather than speak, especially when distressed. Increasing awareness and access to these services is a practical way of improving support for young people.

- *What longer-term support is available for people affected by traumatic events such as flooding, where individuals may still be experiencing distress well after the immediate incident has passed?*

We recognise that the emotional impact of flooding can be long-lasting and that many people remain traumatised well beyond the initial response period. Continuing engagement, outreach, and access to mental health and wellbeing support are important to help people move forward from both the immediate crisis and the longer-term emotional effects.

- *When I refer to people being directed to 111 for mental health support, am I correct that this means using 111 option 2, and can I clarify how effective this service is in practice?*

Yes, I am referring to 111 option 2. For the majority of people, this is an effective and valuable service that provides advice, arranges assessments where appropriate, and offers practical suggestions that people may not have considered. However, there are occasions where the service does not work well, particularly when individuals experience long waiting times or are disconnected, which can be very difficult for someone who is already in mental health crisis.

- *What happens in situations where someone presents in acute crisis, is told not to attend A&E, and is then unable to get through to 111 'Option 2' in a timely way?*

We have encountered cases where individuals who feel unable to keep themselves safe have been advised to contact 111 Option 2 and then experienced waits of up to 40 minutes or have been cut off. In those situations, the service is not effective, particularly for people who need immediate reassurance or face-to-face contact rather than telephone support. This remains a significant concern and is something I continue to raise through ongoing discussions with the Community Mental Health Team.

- *Do the seriousness of the situations you describe, and the wider systemic pressures, have an impact on the wellbeing and sickness levels of your own staff?*

Yes, this work does take a toll on staff. Although we manage this by working closely together, debriefing regularly, and not working in isolation, some sickness has occurred because staff feel that it should not be this difficult to help people in crisis. That said,

staff retention is high, with long-serving team members, which helps maintain continuity for clients and provides a strong support network within the team.

- Has there been a positive difference since the recruitment of two additional Community Psychiatric Nurses within the Community Mental Health Team?

Yes, we are seeing a positive difference. Communication has improved, more calls are being answered, and there is greater capacity for staff to engage with clients. While the system remains under pressure, the addition of the two new CPNs has helped to ease some of the immediate difficulties and has improved responsiveness overall.

- *Councillor Bond highlighted that there is already a range of community-based mental health support available, including Andy's Man Club in Chepstow and mindfulness and wellbeing groups delivered through Together Works. She noted that schools do provide counselling and support, but that some interventions, such as ELSA, are only accessed once a problem has been identified. She expressed hope that a stronger focus on social and emotional learning for all pupils could help address issues earlier and improve outcomes in the longer term, and she closed by thanking Megan and her colleagues for their work.*
- *Councillor Thomas commented on the increasing mental health pressures faced by young people and students. Drawing on his background in teaching and education, he highlighted the combined impact of adolescence, exam pressures, social media, peer relationships, and the growing emphasis on performance and outcomes. He expressed concern that these pressures are greater than in the past and questioned whether sufficient resources are available to support young people through these challenges.*

We see these pressures increasingly in our work. Young people are dealing not only with academic expectations, exams, and peer pressure, but also with constant exposure to social media and to wider political and global issues that are difficult to escape. Alongside the internal pressure to succeed, there is a growing sense of anxiety about the state of the world, which can feel overwhelming. We believe it is important that young people have safe spaces where they can express these worries without being dismissed or told there is nothing they can do. We recognise that it is valid for them to feel anxious, and we see a real need for reassurance and appropriate emotional support to help them manage these pressures.

- *Cabinet Member Councillor Chandler explained that his comments were given from a council and partnership perspective and that detailed operational responses would be more appropriate from officers and the Health Board. He emphasised that mental health support in Monmouthshire is delivered through partnership structures, including Integrated Service Partnership Boards and Neighbourhood Care Networks, which bring together the council, health services, and third-sector organisations. These networks focus heavily on signposting, wellbeing support, and linking people to community-based provision such as Mind, Men's Sheds, and other voluntary services.*

They stated that while a wide range of activity is already taking place, it will never be sufficient on its own and that mental health support needs to be better targeted. He argued for a clearer focus on specific cohorts rather than a broad, one-size-fits-all approach, particularly by age and gender. In relation to young people, he noted that Child and Adolescent Mental Health Services tend to engage individuals only once they reach crisis point and that earlier intervention remains a major challenge, largely due to resource constraints.

Councillor Chandler also highlighted particular risk groups, including post-natal women and middle-aged men, and stressed the importance of community-based responses for men, such as peer support groups, sports clubs, and reducing stigma around mental health. He raised concerns about the impact of social issues, including body image, eating disorders, toxic masculinity, and misogyny, and their effects on both young people and adults. He concluded by emphasising that community involvement, partnership working, and open discussion are essential to tackling suicide and mental health challenges, while acknowledging the limitations imposed by current service capacity and resources.

- Do we have sufficient data locally to understand the causes and drivers of suicide, given that national trends suggest a significant gender imbalance and growing concern about outcomes, but local intelligence appears limited?*

Data at a local level is limited and does not always clearly show cause-and-effect. While national statistics indicate that around two-thirds of suicides are men, it is harder to draw firm conclusions locally because outcomes, pathways, and contributory factors are not consistently captured or shared. This lack of detailed local data makes it more difficult to design targeted, evidence-based responses.

- Is the higher prevalence of suicide among men reflected locally, and what are the key factors driving this, particularly in relation to family breakdown, housing insecurity, and prolonged involvement in systems such as family courts?*

Locally, many men presenting with suicidal ideation are experiencing complex and interlinked issues, including separation from family, housing problems, substance misuse, and long periods of stress linked to legal or statutory processes. It is often unclear whether mental health issues lead to family breakdown or whether separation and isolation exacerbate mental health difficulties, but these factors frequently coexist and reinforce one another.

- Are men becoming trapped between traditional expectations around providing and emotional strength and more modern expectations to be open about their mental health, and does this create an additional barrier to seeking help?*

Yes, many men are caught between competing expectations. There remains a strong sense for some men that they must be the provider, remain resilient, and not express vulnerability, while at the same time being told it is acceptable to talk about mental health. This conflict can discourage engagement with support services and delay help-seeking until individuals reach crisis point.

- *Do housing processes and the way housing associations operate risk compounding mental health problems, particularly where cases shift quickly from a human-centred approach to a rigid, process-driven response?*

Relationships with housing associations are generally positive, and there is good engagement at officer level, particularly where individuals are known to support services. However, once behaviour is categorised as antisocial, responses can become heavily process-led, with limited scope for understanding underlying mental health concerns. There is scope for more specialised mental-health-focused training within housing services to ensure responses remain proportionate and preventative.

- *Is there room to strengthen collaboration further with housing providers so that early warning signs are acted on before situations escalate to crisis or homelessness?*

Yes, closer collaboration and shared understanding can help prevent escalation. When housing officers recognise mental health concerns early and work alongside support services, outcomes are better. Strengthening training and communication can improve consistency and ensure issues are addressed before they reach a crisis point.

Chair's Summary:

The committee thanked Megan and her team for their work. The Committee agreed to explore with the Council's Communications Team whether the website could signpost people to support services (Action).

PART 2: To receive a presentation from Aneurin Bevan University Health Board (ABUHB) to provide a progress update

Dr Emily Clark delivered a presentation, delivered opening remarks with Liz Andrew and Jackie Williams, and they answered the members' questions with Megan Escott:

Questions from Members:

- *Do we have sufficient and meaningful local data to understand suicide trends in Monmouthshire, particularly causes and drivers, and how confident can we be in comparisons between areas?*

Local data is limited in its ability to show clear cause-and-effect relationships. Much of the real-time suspected suicide surveillance data is provisional and can overestimate final figures, while confirmed Office for National Statistics data arrives with significant delay. Suicide remains a relatively rare event, meaning that small changes in numbers can create apparently large differences in rates. At present, Monmouthshire's figures fall within normal statistical variation, and ongoing monitoring rather than firm conclusions is required.

- *If Monmouthshire appears relatively high in headline rates compared to places like Newport, why are pilot interventions not being targeted there first?*

The suicide prevention service being referred to has not yet launched and is being introduced on a Gwent-wide basis rather than targeted to one local authority. The pilot

is designed to operate across the whole health board area so that access is consistent and learning can be shared, rather than concentrating resources in a single locality based on early surveillance figures.

- *Are the national patterns showing higher suicide rates among men reflected locally, and what factors appear to be contributing to this?*

Men presenting locally with suicidal ideation often face multiple, overlapping pressures such as family breakdown, housing insecurity, substance misuse, isolation, and prolonged stress linked to legal or statutory systems. It is often difficult to separate cause from consequence, as mental health issues and social problems frequently reinforce one another. These complex patterns align with national observations, even if precise local causation is hard to quantify.

- *How are people who are digitally excluded, particularly older residents or those with limited access to technology, able to access mental health and suicide-prevention support when so much information is provided online through platforms such as the Melo website?*

Digital exclusion is recognised as a real issue. All content on the Melo website can be printed and shared in paper form, and partners are encouraged to do this through frontline services such as GP practices and community settings. Libraries are also used through national schemes such as Reading Well. Training and support are available face-to-face as well as online, and efforts are ongoing to ensure information is accessible to people who cannot use digital services.

- *Is additional practical support available to help people who are digitally excluded to engage with services, for example through devices, data provision, or technical assistance?*

Additional support is available at higher levels of need. Device-loan schemes, data provision, and technical support sessions are used to help people access online therapy or support where digital barriers would otherwise prevent engagement, particularly for those living in rural areas, experiencing poverty, or unable to attend services in person.

- *Are there specific trends or issues emerging in Monmouthshire that councillors should be aware of when engaging with residents, particularly when conducting door-to-door work?*

Suicide remains a relatively rare event and caution is required when interpreting small local data sets, as minor numerical changes can appear significant. At present, Monmouthshire's figures fall within expected statistical variation. The Health Board and Public Health teams continue to monitor data closely and review intelligence with partners, rather than drawing firm conclusions from short-term trends.

- *Do we have the right balance between online and face-to-face support services, and are we confident that increasing reliance on digital provision is appropriate given both resource pressures and the needs of people experiencing mental distress?*

Services are designed to be person-centred and are offered both online and face-to-face wherever possible. Patient choice is central, particularly within specialist mental health services, and people are able to choose how they engage. While online provision has expanded significantly and is often preferred because it is quicker and easier to access, face-to-face support remains available and is actively encouraged where it is more appropriate or beneficial.

- *Are face-to-face services at risk of being crowded out by online provision simply because online options are easier to deliver and fill more quickly?*

Online services are often more popular and fill faster, largely because they remove travel and time barriers. However, there is recognition that face-to-face provision offers additional value, particularly for deeper discussion and relationship-building. Efforts continue to ensure that in-person training and support remain available, especially for frontline staff and individuals with higher levels of need.

- *How effective is online training and support compared to in-person engagement, and are people receiving sufficient benefit from digital formats alone?*

Online training and support are widely used and effective for many people, particularly since the shift that followed Covid-19. However, in-person engagement is often more impactful for sensitive or complex issues. For that reason, training and services continue to be offered in both formats, with encouragement for face-to-face participation where appropriate, rather than relying exclusively on digital delivery.

- *Can additional clarity be provided on how resources such as the Padlet and the Melo platform are used to support professionals and communities?*

The Padlet acts as a shared information hub for professionals and includes data, training resources, service updates, and suicide-prevention information. Melo provides broad public-facing mental health and wellbeing resources and is widely used by both the public and professionals. Both tools are intended to complement, rather than replace, direct services and face-to-face support.

- *Have the recruitment of two additional Community Psychiatric Nurses helped address the previously reported problems with unanswered phone calls, unreturned emails, and lack of communication from the Community Mental Health Team duty desk?*

The recruitment of additional Community Psychiatric Nurses has helped improve capacity, but the main issue identified previously was operational rather than purely staffing-related. A problem with an incorrect or ineffective contact number has been resolved, and communication has improved as a result. In addition, greater emphasis is now placed on the 111 option 2 service, including its use by professionals, to ensure people have a reliable and immediate route to mental health support.

- *Given that Monmouthshire appears higher than some other areas in headline suicide-rate data, are there examples of different or better practice in places such as Newport that could explain this variation?*

Direct comparisons between areas should be treated with caution. Suicide remains a relatively rare event, and small numerical changes can produce large apparent differences in rates. Different areas also face different social pressures and population characteristics, which shape how services are designed and commissioned. Newport, for example, has a different demographic profile and different partnership arrangements, which influence how resources are targeted. There is no single model identified as clearly “better”, but learning is shared across the Health Board footprint.

- *As elected members working within communities, what practical actions can councillors take to help reduce risk and support people who may be struggling with mental health or suicidal distress?*

Councillors can play an important role by helping reduce stigma, listening compassionately, and encouraging people to seek help. Being approachable, signposting residents to appropriate services, and reinforcing messages that support is available can help interrupt moments of crisis. Kind, timely intervention by trusted community figures can make a significant difference, particularly when someone feels isolated or overwhelmed.

- *Can third-sector organisations such as Mind refer directly into Community Mental Health Services, or formally contribute to referrals, given that they often hold detailed background information about individuals and have established relationships with them?*

Mental health teams are moving toward a more open and streamlined access model, including use of the single point of access through 111 option 2. In principle, referrals can be received from a wide range of sources, not solely GPs. However, how third-sector agencies contribute to referrals can vary in practice, and this is tied to how interfaces between services operate locally. It was agreed that this specific issue would be followed up by Mind and ABUHB outside the meeting to clarify referral pathways and ensure that the information held by trusted third-sector partners is used effectively.

- *Megan emphasised that third-sector workers often possess far more contextual and historical information about individuals than is captured in brief or minimal referrals, and that being able to pass this information on meaningfully could improve assessment and outcomes.*

This point was acknowledged, with recognition that good outcomes depend on effective information-sharing and clear communication between services. Improving interfaces between statutory and third-sector services, including how referrals are handled and supplemented with contextual detail, was identified as an important area for continued work.

Chair’s Summary:

The Chair thanked representatives from Aneurin Bevan University Health Board and the Public Health team for their detailed and informative presentation, acknowledging the complexity and sensitivity of the issues discussed. He noted that the session had

highlighted both the scale of mental health and suicide-prevention challenges and the significant amount of partnership work already underway across Gwent.

He emphasised the importance of improved visibility and understanding of data, particularly at a local level, while recognising the limitations inherent in suicide statistics and the need for caution when interpreting small numbers. The Chair stressed that scrutiny should continue to focus on outcomes, prevention, and effective targeting of resources rather than headline figures alone.

The Chair underlined the value of community-based and preventative approaches, including training, early intervention, and strong links between statutory services, third-sector organisations, and local authorities. He welcomed the development of new initiatives, including the suicide-prevention pilot and improved access routes such as 111 option 2, while making clear that ongoing scrutiny of service accessibility and responsiveness would remain important.

He concluded by confirming that suicide prevention and mental health would remain a priority area for the Committee during the remainder of the Council term, and that further scrutiny would involve continued engagement with both the Health Board and Mental Health and Learning Disability services. He formally closed the item by thanking all contributors for their openness, professionalism, and commitment to improving outcomes for residents. **Action:** to place leaflets in Member's mail trays.

5. To receive the following minutes:

Public Services Scrutiny Committee dated 13th October 2025

The minutes were agreed, proposed by Councillor Howells and seconded by Councillor Garratt.

Public Services Scrutiny Committee dated 15th December 2025

The minutes were agreed, proposed by Councillor Howells and seconded by Councillor Garratt.

6. Public Services Scrutiny Committee Forward Work Programme

The Scrutiny Manager informed members that the Committee meeting scheduled for 28th April had to be rearranged. This was because the item planned for that meeting, involving the Chief Constable of Gwent Police to discuss community safety, police resources, and outstanding scrutiny issues from December, could not proceed as intended. She advised that this meeting would be rescheduled for after the election, and members would be informed of a new date in due course.

She confirmed that the next diary-planned meeting would now be on 8th June, and that this meeting would focus on an update from National Highways, with Johnny Hill due to attend. She noted that the Committee typically schedules one substantive agenda item per meeting, as demonstrated by the current session, to allow sufficient time for in-depth scrutiny and detailed discussion.

7. Council and Cabinet Work Planner

There was a request to scrutinise the Public Services Ombudsman's Report (**Action:** to timetable this for members to highlight any areas for future scrutiny).

Strategic Risk Assessment – for us to look at that for the Public Services element? (**Action:** to be invited to P&O meeting on it and/or for PS to invite separately after that)

8. Next Meeting

Monday 8th June 2026 at 10.00am.

The meeting ended at **12.36 pm.**