SHROPSHIRE AND TELFORD & WREKIN JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Minutes of the meeting of the Shropshire and Telford & Wrekin Joint Health Overview and Scrutiny Committee held on 5th July 11.00am in Quaker Meeting Room, Meeting Point House, Town Centre, Telford, TF3 4HS

Present: Councillors: A. Burford (Chair), G. Dakin, V. Fletcher, H. Kidd, R. Sloan and

Co-optees: D. Beechey, I. Hulme, R. Mehta.

Also Present: A. Begley, Director of Adult Services, Shropshire Council (J HOSC 5); D. Evans, Chief Officer Telford and Wrekin Clinical Commissioning Group and Accountable Officer, Shropshire Clinical Commissioning Group (J HOSC 5); J. France, Head of Nursing for Children & Families, Shropshire Community Health Trust (J HOSC 5); Steve Gregory, Executive Director of Nursing & Operations, Shropshire Community Health Trust (J HOSC 5); A. Hammond, Deputy Executive for Commissioning and Planning (Integrated Care) Telford and Wrekin CCG (J HOSC 6); D. Vogler, Future Fit Programme Manager (J HOSC 5); S. Wright, Chief Executive Shrewsbury and Telford Hospitals NHS Trust (J HOSC 5)

In Attendance: F. Bottrill, Scrutiny Specialist, Telford & Wrekin Council (minutes); A. Holyoak, Democratic Service Officer, Shropshire Council; D. Moseley, Democratic Services & Scrutiny Team Leader.

J HOSC-1 Apologies for Absence

Apologies were received from Cllr. J. Cadwallader and Co-optees: B. Parnaby, D. Saunders and M. Thorn.

J HOSC- 2 Declarations of Interest

B. Parnaby declared an interest in Item 5 as a director of HealthwatchTelford and Wrekin.

J HOSC- 3 Minutes

A member asked for clarification about the National Symposium on rural issues. It was confirmed that this would be held in February 2017.

RESOLVED that the minutes of the meeting of the Shropshire and Telford & Wrekin Joint Health Overview and Scrutiny Committee held on the 2nd March be confirmed and signed by the Chairman.

J HOSC - 4 Review of the Terms of Reference for the Shropshire and Telford & Wrekin Joint Health Overview and Scrutiny Committee

The Scrutiny Group Specialist informed the Committee that it was good practice that the terms of reference was reviewed annually, and confirmed that there were no proposed amendments so the terms of reference considered by the Committee were the same as last year.

RESOLVED that draft terms of reference be endorsed.

J HOSC – 5 Progress of the Future Fit Programme and Submission of the NHS Sustainability and Transformation Plan.

Before taking the report on the Future Fit Programme and Sustainability and Transformation Plan the Chair informed the Committee he was aware that the issue regarding stroke services was of concern to members and that this was not included on the agenda as a specific item. He informed the Committee that this would be covered under the Chair's update and he would ask the Chief Executive of SaTH to provide some assurance to the Committee.

The Chair welcomed the officers to the meeting and provided some background to this item. The Chair recognised that there is continued public interest in the Future Fit Programme and he confirmed that the role of the Joint Health Overview and Scrutiny Committee was to be an independent body, which does not represent the views of either local authority or a particular political party. The role of the Committee was to hold NHS Commissioners and providers to account and ensure that sufficient information is provided to enable the Committee to carry out this role. The Chair clarified that at previous meetings the Committee had supported the direction of travel

for the Future Fit Programme, but there had been a number of caveats where members had said that additional work was needed. The Chair recognised that some of this work was still in progress and the Committee would continue to scrutinise these issues which included ensuring that hospital services are sustainable and that demand for community and primary care services in the clinical model could be managed. The Committee would not come to a formal view on the proposals until after the formal consultation period.

The Chair informed the Committee that after the last Committee meeting the Chairs had met with the Chief Executives at the Shrewsbury and Telford Hospitals NHS Trust (SaTH) and the Chief Officer / Accountable Officer for the CCGs. Following these meetings the Committee had agreed some questions which had been sent to the NHS on the 26th May. The response to these questions was received on the 8th June. The Committee met informally to consider the response and had requested clarification on a number of issues. The initial response and clarification had been circulated with the agenda for this meeting.

Members of the Committee had also received a submission from Shropshire, Telford and Wrekin Defend Our NHS. The Chair has spoken to the representative who had sent the letter and explained that questions from the public would not be taken at the meeting. However, some of the points raised may inform the future work of the Committee.

Prior to the meeting the Committee had agreed 4 main lines of inquiry which broadly cover the response from the NHS. The Chair confirmed that the Committee would consider these 4 issues rather than go through the response point by point.

First line of inquiry: Safety
The Chair said that there had been articles in the press which questioned the safety of the current A&E service at SaTH. The Committee asked for assurance that the A&E services provided are safe.

The Chief Executive of SaTH explained that the Trust is assured about the safety of services through a number of mechanisms and this is not carried out in isolation. Assurance is provided through the commissioning and contracting process which involves detailed discussions with clinicians, and with other external organisations including the Care Quality Commission and Healthwatch in Shropshire and Telford and Wrekin and the Community Health Council in Wales. The Committee was informed that all these organisations are aware of the frailty of the A&E service and that last week there had been external validation of the service when the West Midlands Ambulance Service validation process did not raise any concerns about either hospital site. However, the Chief Executive said that the Committee was right to ask questions about the frailty of the service as the staffing levels were only just

adequate and that the reduction in the number of junior grade doctors who will join in the August rotation was an additional risk. There were a significant number of gaps in the rotation for the Deanery which needed to be filled. Maintaining the safety of the service required constant vigilance.

A member asked how the Trust can maintain the service with low staff levels when other areas had closed the A&E department with higher staffing levels.

The Chief Executive from SaTH responded that the safety of the A&E department was also dependent on other services e.g. respiratory, gastroenterology and stroke. The role of the extended nurse practitioners also had to be taken into account. It was explained that it is important not just to look at the speciality but to take a team focus and this allowed the A&E to remain open. The decision has been made that the change to A&E services must be made in a planned way and it was important to find ways of keeping both A&Es open until then. The Chief Executive said he could not speak for other areas but in some cases the decision to close an A&E may have been taken without due diligence.

A member asked about the consequences of delaying the Future Fit Programme particularly on the Trust's ability to retain A&E staff. The Chief Executive of SaTH said that staff were aware of the implementation timetable and that once a decision is made it will take several years to implement. Staff had confidence that a decision would be taken and once the decision has been made other staff will join the Trust. If there were a delay the level of frustration for A&E staff would increase and the Trust could not afford to lose consultant staff without consequences.

Second Line of Inquiry: Activity and Capacity
A member asked how confident the Chief Executive was that 69% of current A&E attendances would be seen at an Urgent Care Centre and how the figures in the locality table which showed an average of 47% compared with the 69% previously quoted.

The CCG Chief Officer / Accountable Officer responded that the table related to walk-in activity.

The Chief Executive of SaTH said that the figures for the proportion of people who could be seen at a UCC were robust and based on modelling over a number of years. He explained that this would require the correct staffing and required commitment from the whole system. Another important aspect is the confidence of the public in the service. Where the system has not worked in other areas they have not got near 69% e.g. where the UCC is not on a hospital site and the risk appetite is lower. The Chief Executive of SaTH was confident that 69% of front door urgent care activity could be managed at Urgent Care Centres if there is work with Primary Care and the public

have confidence in the service. He also confirmed that in the Future Fit Model patients would not have 'walk in' access to the Emergency Department.

The CCG Chief Officer / Accountable Officer added that currently 20% of people who attend A&E can self-manage and the GP at PRH has shown that 27-26% of patients can be treated in primary care. When these figures are added together it makes the total of 69% more realistic.

A member also questioned the figure that 109,000 patients attend A&E per year which would mean that on average there were 298 per day. It was confirmed that the figures were correct.

A member highlighted that the figure of 69% urgent care patients being treated at a UCC seemed high considering the continued high number of patients attending A&E at RSH after the Walk In Centre/Urgent Care Centre had moved there from its previous location in Monkmoor.

The Chief Executive of SaTH said that this is based on a different model. When asked how long it would take to implement the new model for Urgent Care he responded that, based on the experience of the UCCs at Runcorn and Widnes, it could be done within 1 year and would need to be planned and implemented with the West Midlands Ambulance Service (WMAS) and other partners.

Members recognised that it would take time to train and recruit staff with the correct skill set. The Chief Executive of SaTH explained that some A&E staff would transfer and that having links between points of access would make it easier to attract staff. Staff working at the UCCs would have exposure to lower risk work and also have the opportunity to rotate through other services which will help to develop their career and retain staff. It was explained that for this to work the Emergency Department must not be isolated from the UCCs, and the UCCs must not be isolated from other settings.

A member asked about the additional work load that the Future Fit Model will place on GPs in primary care based on the figure that 40% of current attendances at A&E could be treated in Primary Care. What plans are in place to ensure that GPs will be able to cope as they are already under pressure, what funding will be available for additional staff and services in primary care and what outcomes will be expected?

The CCG Chief Officer / Accountable Officer responded that 35-40% of A&E patients could be seen and treated in primary care and this would be a challenge. It was clarified that that primary care included other professionals e.g. Advance Nurse Practitioners. The Neighbourhood work identified in the Sustainability and Transformation Plan (STP) included building resilient teams and improving access. It was confirmed that funding for the additional work in primary care has been built into

the plans.
A member asked how it was ensured that all the parts of the health and social care system would work together so that they plans did not fall down if one link was missing? It was recognised that it was particularly important to engage GPs in this work.

The CCG Chief Officer / Accountable Officer replied that the STP which was submitted the previous week would bring the different parts of the system together. The STP will enable the NHS to access funding and allow some double running of services. The CCGs were working with the GPs in the Shropshire localities and the Telford GP forum. Discussions were taking place about a different model for primary care and an expanded care offer.

A member expressed reservations that the GPs and primary care would be able to cope.

The CCG Chief Officer / Accountable Officer said that there are some reservations, but that if changes are not made the system will collapse. The concern for GPs is the additional work and how this is paid for. He explained that the additional resource in primary care could be staff or funding e.g. the staff and equipment to manage outpatient appointments in primary care.

A member asked about the figure of £6million in the plan to be invested in new primary community care and social care capacity and asked for confirmation if this was dependent on savings made in the system.

The CCG Chief Officer / Accountable Officer responded that the £6 million was built into the STP which includes the transformation money.

In response to a comment that the STP money needed to be used in many ways the CCG Chief Officer / Accountable Officer said that there are some nationally mandated areas of work e.g. 7 day working in primary care.

The Chief Executive of SaTH said that there was a joint narrative that was owned by all the boards in the county. He explained that it is not a simple process but that there are pockets of excellence. It was recognised that GPs are under pressure and to attract GPs to the area will require a different model. GPs will have to engage but they still question if it will work. As the prototypes develop they can then see how it will work and this will help to arrest their anxiety.

A member confirmed that the Committee understood that it is a complex process and asked for clarification on the number of staff that would be required in the acute hospital, in the UCCs and in primary care.

The CCG Chief Officer / Accountable Officer replied that staff employed by the hospital trust could work in or support colleagues in primary care. The example was given of respiratory patients. Follow up appointments could be held at a local level where either staff from secondary care would come out to provide this service or provide support using video conferencing. Each speciality will look at how it can work.

The Chief Executive of SaTH gave the example of stroke service. The early support discharge team supports patients at home rather than prolonging their stay in hospital. The Trust has a large work force and the staff do not have to work in fixed buildings. He explained that some models of care are unaffordable and that the funding for some services does not relate to the cost to provide it. There is a lot of duplication e.g. families receive visits from health visitors and other health professionals. It would be more efficient to have fewer visits which provide a wider range of services. The hospital must focus on improving wellbeing and the moment the services focus on diagnosis and treatment.

A member asked when the details of the new pathways will be available.

The CCG Chief Officer / Accountable Officer responded that within the next year there will be prototypes.

The Chief Executive of SaTH said that the work force plans need to be different from the current model. Some workers will still be needed in the long term but there are opportunities for local people to do things differently e.g. Assistant Practitioner roles.

Members questioned the predicted reduction in A&E attendances of 24% based on the preventative work on high risk factors e.g. smoking, high cholesterol and high blood pressure. Members were concerned that this was very optimistic.

The CCG Chief Officer / Accountable Officer responded that some preventative work will produce a change in the long term e.g. smoking. However, addressing other health issues such as blood pressure and diabetes has a much shorter lead in time and can have immediate results. He explained that the preventative work was broader than the usual public health messages and included issues such as reducing falls for older people.

A member asked about the 4072 patients that would be seen and treated through the rural urgent care service. It was highlighted that across the 5 areas this did not seem a high number. The Member asked if the money for this service would be better spent on prevention?

The Chief Executive at SaTH responded that the effect of preventative work will be cumulative and that there is good evidence from other areas that where there is a focus on the wellbeing agenda this had a direct impact on health and money can be invested in other preventative areas.

The Executive Director of Nursing & Operations from Shropshire Community Health Trust added that the basis of the STP is to join up health and social care. He said that Shropshire and Telford and Wrekin was starting from a relatively low base on wellbeing and so the plans were prudent. Where people are treated as individuals this saves money.

The Chair said that the Committee has not questioned the principles of improved prevention or the principles of the STP. The Committee was trying to make sense of a difficult and complex programme, and wanted to know if this would work given the resources available and the speed that was necessary to meet the timescales. He recognised that some of the processes are enormously difficult to achieve in a short space of time. The concerns expressed by the Committee do not dispute the objectives but question can it be achieved?

The CCG Chief Officer / Accountable Officer responded that the local health economy was currently spending money it did not have. He added that it could be argued that the current funding is not enough but that the local organisations believe that the change set out in the Future Fit Programme is the right change and that this must be financially and clinically sustainable.

The Chief Executive of SaTH said that the programme is achievable and that organisations must stop doing things that do not contribute to this agenda. Part of this must be to reduce the number of meetings and bring in experts to provide support if needed. He explained that it is incumbent on a chief officer to take the difficult problems and work with the community to provide solutions. He gave the example of recruitment of medical staff where a married couple are both qualified medics and how both clinicians in primary care and the acute hospital could be employed to work in the area. He added that there is the determination to make this work and that it was the first time that all the Chief Executives had accepted that this is the one agenda.

A member asked about rural areas as the discussion focussed on urban areas. The information on the travel times was not accurate and concerns were also raised about treatment by a paramedic as the ambulance response times were so poor. The point was made that health services need to improve for everyone. Further information on the work in other rural areas was requested and also reassurance that the role of the West Midlands Ambulance Service (WMAS) is included in the planning for future services.

The Chief Executive of SaTH said that it was a fair point that the roles of the WMAS and mental health services were not recognised in the STP submission and that this would be amended. He added that the Board will want to see a level of evidence, but that it is important not to spend too much time analysing data and work should start where there is evidence that things work

A member commented that the issues faced by rural communities were much broader, for example, housing and infrastructure cost much more in rural areas.

The Chief Executive of SaTH said that he recognised the higher cost of delivering services in rural areas and that changing services does not always mean that it will be cheaper, but the decision should be made because it is the right thing to do.

Third line of inquiry: Interdependencies with other programmes
The Chair said he wanted to move the discussion on to the issue of the interdependencies between the Future Fit Programme, Community Fit and Rural Urgent Care Centres. He explained that the Committee's concern for some time has been that other areas of work had not been as advanced as members would have liked and that this had been recognised by the local NHS organisations. The written response to the Committee's questions had been that a prototype was being developed but the question remained that if this shift in activity does not happen what are the implications for the acute sector? The Committee was being asked to hope that the Community Fit Programme and Rural Urgent Care services will take the pressure off. The worry for the Committee was that if this does not happen that the UCCs and Emergency Department would become overwhelmed.

The Chief Executive of SaTH said that focus of work had been on Future Fit, but that 75% of the STP focussed on resourcing and architecture for neighbourhoods. He explained that it is not difficult to design hospital services but the support and infrastructure for community services more challenging. What he heard the community saying is that there is a lot of good work and this must be brought together in a single narrative and should not be separate projects.

The Chair said he understood that Telford and Wrekin Council had made progress with the neighbourhood work, however his concern remained the timeframes and the amount of work that needed to be achieved in a relatively short space of time.

The Executive Director of Nursing & Operations said that clinical design meetings had taken place which included the WMAS and Shrop Doc. He agreed that it was important to get Community Fit right and then the hospital services must follow. He explained that one size does not fit all and that it is important to map out the services that are currently available.

The CCG Chief Officer / Accountable Officer said that 6 different pathways were being developed with GPs and public health. This work was being done at pace and should be available in the next 3 months.

The Chief Executive of SaTH said that he was not able to turn back the clock and that the hospital does not have time for another delay to the Future Fit Programme. If there is a delay the hospital would not be there. He explained that there is the determination to continue the work and the public want a decision to be made.

The Chair asked if the work on Community Fit and the other related programmes would be included in the Future Fit consultation.

The Chief Executive of SaTH confirmed this information would be included in the consultation.

The CCG Chief Officer / Accountable Officer said that Primary Care colleagues had made it clear that resources must follow the services that will be required in primary care. This message has been sent clearly to the CCGs.

A member asked how the wider message about health improvement was communicated to the public.

The Chief Executive of SaTH replied that more can be done by the NHS to influence the choices that people make that affect their health. He said that communities are resilient, some rural communities have had to be, but not all areas are at the same level. Diabetes, mental health and falls for older people are all areas where people can be helped to help themselves.

Fourth line of inquiry: Finance

The Chair said that the final area the Committee wanted to explore was finance and how the deficit was going to be addressed. He asked how robust the figures for the Future Fit Programme and the STP are and if the programme is aspirational or achievable?

The Chief Executive of SaTH responded that if you do not believe that it is achievable it will fail. He added that the honest answer was that he did not know, but that there is currently duplication and complexity which cost the Trust. The current staffing and rotas means that the Trust is not an attractive place to work. He said that there is a good evidence base that what is in the plan can be achieved and that using technology can reduce waste. The Trust can learn from primary care about how to reduce the amount of paper used. He said that if what is planned is not enough he did not know what more could be done.

A member asked about the added pressure on carers and family if patients have to go out of county to receive care.

The Chief Executive of SaTH gave the example that patients from Telford and Wrekin and Shropshire can go to Stoke to have a procedure that is carried out by a consultant from SaTH. The patient is then seen as an outpatient at SaTH. He explained that where it is sensible services should be provided in county and some service could be brought back.

A member asked about the health economy's ability to make savings. There were a lot of assumptions in the responses given to the Committee about savings but the Trust had not delivered the Quality Innovation Productivity and Prevention (QIPP) savings.

The Chief Executive of SaTH responded that the Trust had saved £50 million and that the local authority had also saved a huge amount. If an organisation is only making cuts this makes people anxious, but if the savings can be made by removing waste and variation this provides more confidence. There is a collective view on the way forward and there is good external scrutiny of the programme. He explained that it is a hard process and that in 18 months' time the Committee would be able to see if it had been successful.

A member commented that making changes to influence choices people make that affect their health requires political will and gave the example of the reduction in smoking since the smoking ban in public places.

The Chief Executive of SaTH responded that there are changes that can be made at a local level e.g. removing the sugary drinks vending machine in the paediatric department at the hospital. It has also been recognised that Council's licencing function has a role e.g. take-aways near schools. He said it is important to support families and that changing attitudes takes time but it can be done.

In response to a question about the implications of Brexit, the Chief Executive of SaTH replied that it did not help to become frightened about things that local organisations have no control over. The Future Fit Plan and the STP is the starting point and if local organisations are doing the right thing then this will determine the cost.

The Chair concluded the discussion and said that the Committee would continue to look at the issues of safety, activity and capacity, interdependencies with other programmes and funding for the Future Fit Programme. He recognised that the views of the Clinical Senate and the outcome of the non-financial option appraisal would be key stages in this work. He informed the Committee that enquiries were being made

regarding a visit to the Urgent Care Centres at Runcorn and Widnes to inform the Committees work.

RESOLVED that:

a) **the progress of the Future Fit Programme and the submission of the Sustainability Plan be noted**
b) **arrangement be made for Committee members to visit the Urgent Care Centres at Runcorn and Widnes**
c) **the Committee agree further questions to scrutinse the progress of the Future Fit Programme**

HACSC- 6 Update on the consultation and engagement if the procurement of the Child and Adolescent Mental Health Services for Telford and Wrekin and Shropshire

The Chair invited the Deputy Executive for Commissioning and Planning (Integrated Care) at Telford and Wrekin CCG to present the report on the procurement of the Child and Adolescent Mental Health Services.

The Committee was informed that the CCG had worked with Experienced Led Commissioning (ELC) to get the views of children, young people and their families and carers, professionals, community groups and organisations. This had provided valuable information which will inform the commissioning of the Emotional Health and Wellbeing Service.

The report set out the 10 high impact actions that had been developed through the commissioner challenge process with ELC.

A member said that she remained concerned that the service was not cohesive and that there were long delays. As a school governor she was concerned that if children were not self-harming they were not seen as a priority.

The Executive Director of Nursing & Operations, Shropshire Community Health Trust, said that children and young people were waiting an unacceptable length of time and he recognised that the uncertainty during this period affects the child or young person and their family.

There was a discussion about the referral process and it was confirmed that in Shropshire referrals should be made through Compass. An example was given by a

member where the referral process had not worked. The Executive Director of Nursing & Operations from Shropshire Community Health Trust said he would look at the details of this case outside of the meeting.

A member asked about referrals to the service made by schools, particularly smaller schools that do not have specialist staff.

The Deputy Executive for Commissioning and Planning informed the Committee that schools have a responsibility for pupils with mental health issues. The question for the NHS is how the new service will work with schools so they can deliver what they should and how the school interfaces with NHS services. She clarified that the new service will not take on the responsibility for services that are the responsibility of schools. Smaller schools that do not have specialist staff can buy in support as a traded service.

The Head of Nursing for Children & Families from Shropshire Community Health Trust said that there is an example of a school buying in the services of a school nurse which helps to support the emotional health and wellbeing of pupils.

A member commented that a larger primary school may have the budget to do this but smaller schools would not have the resources. The Head of Nursing for Children & Families responded that smaller schools could work together to buy in this service.

The Chair said that the Committee had been very impressed with the level of engagement in the development of this service. He asked how the people who had given their views would be informed about the service as the procurement process continued.

The Deputy Executive for Commissioning and Planning replied that letters had been sent to people who had attended the engagement sessions and that a group of young people had been asked to design the questions for the Invitation to Tender process for providers.

The Chair said that young people need to see a change in the service. He was concerned that the resources may not be sufficient to meet the level of demand. He added that the process outlined showed that the CCG was doing all it could to get the views of young people. He asked when the service specification would be available for the Committee.

The Deputy Executive for Commissioning and Planning said that the final edit on the service specification would be made the following week, the 4 organisations involved would sign off the service specification on the 18th July and the invitation to tender would be issued on the 8th August.

The Chair said that due to the tight timescales it would not be possible for the Committee to meet to consider the draft service specification. He requested that the Chairs of the committee receive a copy to make any comments before the 18th July.

The Deputy Executive for Commissioning and Planning confirmed that the draft service specification would be sent to the Chairs for comment.

RESOLVED that:

a) **the Committee note the progress on the procurement of the Emotional Health and Wellbeing Service for Telford and Wrekin and Shropshire**
b) **the Committee chairs consider the draft service specification**

HACSC- 7 Chair's Update

The Chair informed the Committee that there had been media reports of the relocation of stroke services from the Royal Shrewsbury Hospital. He informed the Committee that he had received a letter from the Chief Executive of SaTH explaining that the change had been made quickly due to two consultants leaving unexpectedly and that this was the reason the Committee has not been informed. He invited the Committee's co-chair to comment.

The co-Chair said that he had also received the letter and he had accepted that the Trust was a difficult situation and that replacement staff were being sought. He recognised that this was more of an issue for patients in Shropshire and the Chief Executive of SaTH had been asked to keep Shropshire's Health and Adult Care Scrutiny Committee informed of progress.

The Chief Executive of SaTH said that he was meeting a candidate the following week and if appointed the consultant role would be filled in 3 months. He confirmed that the relocation of the stroke rehabilitation services was temporary and that the service would move back to Shrewsbury. He recognised the effect of the move for patients' families who have to travel the extra distance to the Princess Royal Hospital. The Chief Executive of SaTH had been asked at a meeting of the Trust Board about the process through which he and the Board had been informed about the decision to relocate the service. He informed the Committee that this was being investigated. He apologised that the Committee chairs' had been informed of the relocation of the service on the Thursday before the move had taken place.

The Scrutiny Specialist said that a copy of the letter to the Joint HOSC chairs had been sent to members of the Committee and paper copies were circulated at the meeting.

RESOLVED that the Chair's update be noted.

The Meeting ended at 12.57am

Chairman: .....

Date: .....