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MINUTES OF THE OPEN MEETING HELD AT 7.00pm ON MONDAY 3rd SEPTEMBER 2018:

DONCASTER GOLF CLUB, 278 BAWTRY ROAD, DONCASTER DN4 7NY

Present:

Dr R Shah (Chairman) Dr D Eggitt (Medical Secretary)

Dr C Vicary Dr A Bray Dr V Kumar

Dr K Singh Dr V Rehman Dr A Khan

Dr M Sheikh Dr S McHardy Dr A Oakford

Mr E Emovon (Trust Medical Rep) Dr A Locking (GP Reg Rep) Mrs R Fells (Non-medical)

In attendance:

Dr D Crichton (Clinical Chair NHS Doncaster CCG)

Anthony Fitzgerald (CCG - Director of Strategy and Delivery)

Laura Sherburn (PCD)

Dr R Suckling (Public Health)

Jane Torn – LMC Executive Officer

**2018.39 CHAIRMAN’S ISSUES**

* The Chairman welcomed everyone to the meeting and introduced Dr A Lucking the new GP Registrar Rep.
* Apologies had been received Dr K Lee, Dr Rehman

The committee were invited to lodge any new declarations of interest with the Executive office.

**2018.40 MINUTES OF THE LAST MEETING -** The minutes of the meeting held on 30th April were approved as an accurate record**.**

**Matters Arising from the last meeting**

**2018.24.4 -** Dr Shah asked if there had been any developments regarding Dr Singh’s suggestion to form a group to concentrate on the non-elective pathways which would include general surgeons, acute physicians and representatives of primary care, CCG would play host. Anthony Fitzgerald confirmed that there is already a bi monthly clinical reference group that discusses pathway redesign. It has become clear that there is a need for clinical partners to discuss what is happening here and now. It has been suggested that during the other month they hold a “here and now” meeting with representatives of primary care, secondary care, LMC and CCG. They have a paper going back to the next CRG which is in September and this will then be taken forward.

**2018.41 DCCG UPDATE – Dr D Crichton gave updates on the following: -**

**GP Leads** – The CCG went out for expressions of interest for GP leads – 4 came forward all with different skills and they are now in discussions with them how to take this forward. The process should be completed by the end of the month.

**NHS England IAF Framework** – Doncaster CCG has received an overarching rating of outstanding for the second year.

**Constitutional changes went through NHS England**. A further two practices have now merged leaving 40 practices and 4 neighborhoods.

**Doncaster Care record went live in June –** feedback showsstaff are positive and patient live data seems to be benefiting patient care.

**DCC are continuing to work with the local authority** and there have been several joint committee board meetings. It is hoped this will help to break down barriers between health and social care.

**Hospital Services Review** has now been reported, the next stage is for an NHS response which is called the Strategic Outline Case. This is currently going through various boards and bodies.

**STPs have had a change of name** and are now known as Integrated Care Systems. South Yorkshire and Bassetlaw are a level 2 and will be given a degree of autonomy going forward. There is a new memorandum of understanding between NHS and the ICS which will come into effect on 1st October. They have refreshed their executive so that there is more representation from chief executives from across the patch. Richard Parker (Chief executive of DRI) Jackie Pederson and David Crichton are all representatives there. Along side this there is a governance review being undertaken by an independent organisation. One of the main points of moving to an ICS is that each organization had to share their financial position which have been collated across the patch with the exclusion of Rotherham Hospital because their financial position is not feasible. For the ICS to get further money is needs to ensure it can balance the books over the wider footprint. Realistically this means that new money that comes down the system will not go to individual organisations. This has recently happened with IT as the money has gone to the ICS to share out instead of directly to the CCG. It also received a large amount of money for estates which Doncaster benefited from.

Other updates included:

The House of Commons published a joint commissioning document**.** National consultation is ongoing.

National consultations are ongoing regarding the integrated care provider contract.

Discussions are taking place between the BMA and the Department of Health regarding the GP contract.

A new model has been proposed for the CCG constitution which will support a new way of working.

Questions were asked regarding the new money that went into estates. Dr Crichton confirmed that Sheffield had received money and DRI had received money. Doncaster has been looking at re-designing A&E to enable it to link up with the surgical specialties. A new scanner is also being looked at. Maternity services are also being looked at as there is very limited capacity at present. Discussions took place on smarter working, the use of existing space and moving service out into the community.

Anthony Fitzgerald confirmed that the CCG had commissioned a review of all the estate from health and social care across Doncaster. This will help facilitate conversations regarding where people can be used more effectively.

Questions were asked regarding Rotherham’s financial deficit. Dr Crichton confirmed that their deficit was too large to allow them to sign up and that other organisations will not be expected to contribute to the balancing of its books.

**Anthony Fitzgerald gave updates on the following: -**

Primary Careis to remain in Anthony’s portfolio. He is in the process of visiting all practices in Doncaster to meet the GPs and Practice Managers. Themes coming out of the meetings include: -

* Rentals and reimbursements.
* Practices wanting to understand more clearly where money has been spent by the CCG ie Five Year forward View money. The CCG is aiming to put on some forums to cover this topic.
* The role of the CCG/LMC/PCD. A meeting has been arranged with representatives of these organisation which aims to give clarity to this.
* Wound care. The CCG has recently attempted to procure a wound care service which was unsuccessful. The executive committee have sent a letter to practices proposing to continue the current service model for 6 months for practices that are able to do so. The funding arrangement is based on £1 per weighted practice list and would run from 1st October to 31st March 2019. For practices not able to provide the service the CCG will confirm alternative pathways for this period. The CCG need to get an idea of volume in practices so during the 6 months practices will be asked to document this.

Dr Eggitt informed the committee that historically wound care had been provided throughout Doncaster in an ad hoc way via the Treatment Room LES. The Treatment Room LES contains a phrase about providing wound care based on experience and knowledge. Over the years it has come down to the application of a Mepore dressing, anything beyond that requires understanding of the wound and knowledge therefore requiring further funding provided by a Wound Care LES, which is what the LMC has been trying to achieve. During meetings Dr Eggitt on behalf of the LMC has expressed frustration that this is the third audit. He has pointed out that there needs to be ongoing investment to train staff and to provide a sustainable service, they would need to be able to access CPD which would enable them to continue to provide a service of high quality. The payment would also need to reflect the contact with the patient as this would vary.

The problem with tier 3 patients was discussed, Dr Crichton confirmed that tier 3 is tissue viability in the community and the hospital and that both RDaSH and the hospital provide this. Rose Fells pointed out that RDaSH believe their contract is to assess the patient and give advice to practices on how to manage the wound and not to care for the wound until it is no longer a tier 3. Laura Sherburn confirmed that this was expressed by RDaSH during PCDs discussions around procurement. At that point the commissioners confirmed that separate contract negotiations would be made with RDaSH regarding tier 3. It was agreed that clarification was needed regarding tiers and contract specification. It was also pointed out that there are increasing patients that need wound care on Saturdays and Sundays.

Dr Eggitt acknowledged that the CCG were trying to create a solution but pointed out that until that time there would be unsafe practice as untrained staff in practices would be left trying to manage wounds. Dr Crichton stated that PCD had fed back to the CCG that ¾ of practices do have trained staff who can provide the service. The ¼ that was left can refer tier 2 to the hospital and RDaSH are contracted to see housebound patients.

Anthony Fitzgerald confirmed that the audit would need to be completed before things could be moved forward.

**2018.42 PRIMARY CARE DONCASTER UPDATE – Laura Sherburn gave an update.**

**Extended hours contract** was awarded to PCD and they have been in the process of mobilising that. There will be four elements that will be implemented form 1st October. The first being Saturday morning clinics which will be run from 9 -12 in hubs in the south, north and east.

First to physio service which will be based in a central hub which is Devonshire House and will be a mixture of in hours, evenings and weekend provision (36 hours total). An element of same day provision has been sub contracted to FCMS which will total 60 hours of provision that practices will be able to book into. The remaining 18 hours of the 160 hours that have been commissioned will be devoted to inclusion health. There will be 3 drop in clinics run by a GP and a nurse. The ethos of those clinics will be to route clients back to mainstream services.

Some of the clinics have been piloted and have been running since around June. Feedback form the pilots was that every practice will need hands on help as there has been confusion with what’s on offer, how to book in and access the services. Appointment books should be available for all practices to see and be shared.

There have been some IT difficulties but once these are sorted Primary Care Doncaster plan to attend the practice managers meetings and to visit practice teams during September to inform them about the extended access service and discuss how it will work.

Rotas have been put up on the Lantum e rostering tool and these are 60% populated at present.

Dr Oakford asked how much resilience had been built into the rotas in the eventuality of a GP not turning up for shifts. Laura confirmed that the agreements in place with the hubs would mean that the hubs would do their best to find a replacement. It was pointed out that there would need to be a plan B to fall back on at the responsibility lies with the provider.

Discussion followed on booking appointments and Laura went on to say that appointments will be pro rata between SystmOne and Emis. Questions were asked regarding management of appointments as some practices could effectively book the extended access appointment before using their own practice appointments. It was suggested that if certain practices were over using the service they could be asked for the reasons.

Questions arose as to when the service should be used. Dr Vicary said that there should be clear guidance for practices stating when and how the slots can be used. It was acknowledged that some practices would inevitably over utilise the service. Dr Eggitt suggested that patterns of use should be audited to try and understand who is booking and why. Debate took place with varying views on how practices should fulfil their contracts and if action should be taken and by whom if it was found that they were not fulfilling them.

**2018.43 PUBLIC HEALTH UPDATE – Dr R Suckling gave an update.**

**Seasonal flu –** to be covered in AOB

**Weight Management tier 2 –** the joint commissioning board have agreed to extend the funding for the next 2 years for adults on the proviso that Public Health continue with ongoing weight management services.

**Increased work going on around integrated neighborhood working.** RS will access information from the PCD audit regarding the workforce when it has been produced.

**Town Centre weekly meetings–** following increased reports of drug taking and homelessness there will be more police and neighborhood response team patrols of the town centre. There are ongoing discussions regarding how to respond to these issues and they are currently tackling this via the specialist commissioned services such as the drug service. RDaSH and further conversations will take place with PCD. There has been some dispersal following the Public Place Protection Order in the town centre but this may impact on practices on the edge of Doncaster. Dr Suckling asked anyone affected to get in touch with him.

**2018.44 CORRESPONDENCE FOR INFORMATION ONLY**

**LMC minutes: Sheffield, Rotherham, Barnsley**

**APC Minutes**

**2018.45 REPRESENTATIVE REPORTS OF MEETINGS – (For information only)**

03.07.18 – Laura Sherburn/Nabeel Alsindi

01.07.18 – Lisa Swainston (Stronger Communities, DMBC) Nabeel Alsindi - Accreditation

12.07.18 – Primary Care Committee

16.07.18 – Evening Safeguarding Education Event

17.07.18 – Anthony Fitzgerald

19.07.18 – GPC

26.07.18 – APC

31.07.18 – Nabeel Alsindi

02.08.18 – Jackie Harper (LMC PM rep)

07.08.18 – Cheng Looi – Intermediate Care

09.08.18 – Health Watch DNA CPR

09.08.18 – PAG – Oak House

16.08.18 – Richard Wells – Flu Vaccs

16.08.18 – Nabeel Alsindi

16.08.18 – Cheng Looi, Clinical Governance

21.08.18 – Dianne Goddard/Jackie Harper, (LMC PM reps)

23.08.18 – Andy Dunhill, Diabetic foot health

28.08.18 – Nabeel Alsindi, Nick Hunter, Sally Eapon Simon – Flu vaccines

28.08.18 – CHP payment issues

28.08.18 – Safeguarding feedback

30.08.18 – PCD and care of the homeless

Dr Sheikh asked for further information on the meetings with Cheng Looi (Intermediate Care) the meeting with Dr Alsindi, Nick Hunter and Sally Eapon Simon, the Health Watch/DNACPR meeting, the PAG meeting and CHP payment issues.

07.08.18 – Cheng Looi – Intermediate Care

16.08.18 – Cheng Looi, Clinical Governance

Dr Eggitt informed the committee that Dr Looi is a Community Geriatrician and that she has is very keen on the governance and in particular the governance when moving a patient from one organisation to another. At present there is no joint learning so she is trying to reestablish the governance links.

28.08.18 – Nabeel Alsindi, Nick Hunter, Sally Eapon Simon – Flu vaccines

Dr Eggitt gave some background on the flu vaccines that have been recommended for this year. The Trivalent vaccine is recommended for the over 65 age group and the Quadrivalent vaccine for the under 65 year age group and both are more efficacious for respective age groups. Problems have occurred as there is only one provider of the Trivalent vaccine worldwide and when vaccines were allocated to the UK they ensured there were enough vaccines for the UK population but it was decided to be given out on a first come first served basis meaning it has not been spread equitably throughout the UK. It has been found that some practices have been left without any vaccines and others have no where near enough. Dr Vicary pointed out that some practices had ordered vaccines for the upcoming year and when guidance changed they went back to the supplier to amend the order but were unable to.

The LMC gave guidance to practices in February this year and some practices have had confirmed orders and others have now found that they are without any. There is a big discrepancy between patient lists and the number of vaccines practices will receive.

Practice are now left with the problem of how to vaccinate the most vulnerable patients who are 65 and older, often in care home or house bound. Dr Eggitt advised practices that if they didn’t have Trivalent they could still vaccinate them with Quadrivalent as this was better than nothing. Checks were made to ensure practices would still get paid for giving these vaccines and this was confirmed. Following this distribution Dr David Geddes Director of Primary Care Commissioning, NHS England contacted the LMC office and whilst agreeing that the information was correct he stated that it wasn’t what they wanted practices to do. They wanted GPs to signpost patients to pharmacy if they hadn’t got Trivalent. Unfortunately, no one knows locally who has got stocks of Trivalent meaning that the options would be practices would have to find out which pharmacy has the stock before signpost patients to them, signpost them to pharmacy without knowing if they have the vaccine or to vaccinate the patient with Quadrivalent because of the concern that they wouldn’t get any vaccine. Dr Eggitt pointed out that David Geddes was not keen on the idea of vaccinating patient with Quadrivalent. When national guidance does come out it will not be to give the Quadrivalent vaccine but to signpost patients to someone who does have Trivalent. Another suggestion made by Dr Geddes was the possibility of sharing vaccines but under current legislation you cannot share vaccines unless you have a wholesale license.

Dr Vicary said that her practice was doing a flu clinic the following weekend and they had prepared a brief statement informing patients of the recommendations, telling them what the practice had available at present and stating that the recommended vaccine may be available in November. The patient would have the option to either source the recommended vaccine themselves or take up the offer of the alternative vaccine on the basis that something is better than nothing.

Dr Eggitt said that the executive committee had discussed the issue in detail and were not keen on giving any guidance telling people what to do because it has to be decided on an individual patient basis. The most important thing to recognize is that if you are going to vaccinate with Quadrivalent based upon the likelihood of risk and benefit to the patient informed consent must be taken and documented.

Questions were asked regarding the fact that some practices had been informed that vaccines would not be delivered until November so what advice should they give patients seeking the vaccine earlier. Dr Eggitt confirmed that there was no one answer for this and the committee could not give advice as it should be treated on and individual patient to patient basis with advised consent. Further difficulty would arise as a nurse can take consent, but a healthcare assistant can’t (nurses give vaccinations under a patient group directive and the healthcare assistant under a named directive) Every individual named patient on the list would have to be seen and consented by a senior clinician.

Following the conversation when Dr David Geddes suggested stock sharing (which is not allowed) Dr Eggitt met with Dr Alsindi from the CCG, Richard Wells from the Local Pharmaceutical Committee and Sally Eapon Simon the Y&H Screening and Immunisation Lead so that each of the organisations could get a better understanding of the others difficulties and to help each other. The pharmacy regulations are much more specific and they are not able to deviate meaning that they have to give the correct vaccine to the specific group. During the meeting it was agreed that pharmacy would proactively offer help to practices to deliver the vaccines and although there would be financial benefit to the pharmacy it would mean that the patient is receiving the recommended vaccine.

Financial loss to practices was discussed and Dr Eggitt confirmed this would be fed back.

A guidance document was drafted to represent the opinions of Doncaster LMC/NHS England / LPC and CCG which has yet to be signed and this has been populated nationally.

09.08.18 – Health Watch DNA CPR

Dr Eggitt referred to previous discussions at the LMC meeting regarding End of Life Care. He has now produced an End of Life Protocol which is a template that any practice can put their name on and use as their own. It is a step by step guide on how to deliver primary care end of life. As part of that DNA CPR was discussed in conjunction with Health Watch and other partner organisations partly because DNA CPR forms are changing again. This is partly to educate the public so that they can go to a GP already informed.

CV asked if patient already a DNA CPR had would they need a new form completing. Dr Eggitt confirmed that is should still stand and not need upgrading.

09.08.18 – PAG – Oak House

Professional Advisory Group is the group that discusses GPs who have had complaints made against them and reported to NHS England. GPs may not be aware that they are being discussed at PAG. LMCs are invited to attend the meetings to ensure that fair process takes place. Sheffield LMC send a representative to the meetings to cover the area but as they were unable to attend this meeting Dr Eggitt went on behalf of SYLMC. The meetings look at the quality of the GP and whether they should be looked at in more detail.

28.08.18 – CHP payment issues

The CCG had agreed to pay practice reimbursables directly to CHP to avoid the money having to pass through practices, however NHS England have now said that although it is a feature in the Premises directions it is only there to be used in difficult circumstances. The CCG are now seeking legal advice regarding this and until this is received the CCG are not drawing down the money from NHS England.

**2018.46 OFFICERS’ ACTIONS**

Press article produced by Dr Eggitt in response to articles in national publications about GPs working part time.

**2018.47 FORTHCOMING MEETINGS:**

To supply information to the Executive Officer on any forthcoming meetings**.**

**2018.48 Sodium Valproate – Rose Fells**

Guidance has been issued stating that women of child bearing age need to be reviewed by a specialist who needs to complete a risk acknowledgement form on an annual basis. Sodium Valproate cannot be prescribed if this hasn’t been completed or if the form is older than 12 months. This means patients who have been managed in primary care will have to be referred back to secondary care. Rose Fells asked if there was a Doncaster wide solution. Dr Crichton confirmed that this had been discussed at APC and neurology and RDaSH have been asked to report back on the need to review. The overview is South Yorkshire is not consistent with Sheffield referring all patients back into the service. There are some patients who on an annual review could have the form signed by a GP and this will need decided with a patient by patient review. The point was raised that the form does state that it has to be signed by a specialist. DC confirmed that on some occasions it would be ok for the GP to sign the form if the GP has gone through a review and documented the discussions that have been had with the patient. However, if there are any concerns the patient should be referred back to the specialist. The need for local guidance was reiterated if there is this amount of scope. This will be discussed again at APC.

**2018.49 School letters - Dr McHardy**

Dr McHardy contacted the LMC office as there had been an increase in requests for appointments following a local academy asking for details of child absences to be documented in a letter from a GP. Although there had been an agreement in place with schools run by DMBC this did not cover privately run schools. Dr Eggitt has since written a further letter which has been circulated to all local privately run schools informing them that it is not appropriate to send patients to GPs with conditions that can be safely managed at home. Dr Eggitt confirmed that there is ongoing work with schools regarding absences and over the counter drugs. He has already created guidance and is in the process of arranging meetings with Teachers Unions to ratify this. Dr Rupert Suckling offered to provide help if required.

**2018.50 A&E - The wait prior to reaching the FDASS desk – Dr Oakford**

Patients had been attending the GP practice stating that they had waited for 45 minutes at A&E before being able to speak to anyone. Dr Oakford has verified this and confirmed that patients are waiting in the ques for upwards of 35-40 minutes before an initial assessment. He asked if the clock should start ticking when the patient walks through the door to encourage a more efficient service. Anthony Fitzgerald confirmed that CQC had also picked up on this issue during an inspection and the department was starting to count the time from entry. He stated that he had contacted the department that day and been told that there wasn’t a problem. He agreed to take the information back and look into it further.

**2018.51 The use of pathways at OOH. – Dr Oakford declared an interest as he, Dr Shah and Dr Singh all work in OOH**

Whilst accepting that NHS pathways is mandated for front end OOH there appears to be a problem locally in the lack of differentiation between urgent need and urgent demand as a lot of patient with chronic illness or minor illness that are being sent to urgent care which is causing delays in the system for patients with genuine need. Dr Oakwood asked if the dispositions could be looked at. Dr Eggitt stated that this role now lies with the ICS’s. He has already broached this at the last ICS management meeting and requested ownership of the dispositions as the people currently editing them are not clinicians. He is now awaiting interaction.

**2018.52 ANY OTHER BUSINESS**

Dr Oakford informed the committee that Dr John Hall a previous partner at Field Road, Stainforth had sadly passed away the previous week.

**IFR/Threshold - Dr Shah** . Patients are attending hospital appontment and being told to return to the GP for a funding request. Anthony Fitzgerald confirmed that at the point of referral if a GP recognises that the patient doesn’t meet the criteria and warrants an IFR it is the GPs responsibility to do the request. However, if a referral has been done to secondary care and the specialist recognises that the patient doesn’t meet the criteria but they feel the patient warrants a procedure the funding request should be done by the specialist and not referred back to the GP. AF asked for an example so that he could feed it back.

**ERS – Dr Vicary** On three occasions the hospital had said that 2 week wait referrals had not been received. The practice interrogated their own system and found it had been logged as defer to provider and a UBRN had been issued. It was only because at the point of referral the patient was informed to return to the practice if they hadn’t received an appointment that the issue was discovered. It was confirmed that other practices had also had the same issues.

Dr Eggitt confirmed that this had been reported to the LMC and in turn Dr Eggitt had discussed the issue with Karen Leivers along with the issue of referrals being bounced back to practices because they were not done by ERS.

Dr Eggitt stated that the October “go live” is a soft deadline and the CCG could look at this if they didn’t feel the system was ready.

Anthony agreed to discuss the issues at a meeting with DBH the following week and feedback to Dr Eggitt.

**Aspen Health Care, Private Low Secure Mental Health Service** - Dr Kumar.   
In-patients are being taken to the practice by carers, the practice has no access to their medical history. This has raised safety issues when the GP is being asked to prescribe without knowing what other medication the patient is on. Dr Eggitt has met with managers at Aspen House previously to discuss this, however the staff change over frequently. Dr Kumar requested the CCG investigate this. Dr Eggitt explained that this is a private hospital with out of area patients who are being paid for by CCGs in other areas meaning that Doncaster CCGs remit to impose anything is limited.

Dr Crichton stated that if the patients are under the Mental Health Act they are the same as the patients at Tickhill Road ie inpatient and should therefore be provided with primary care directly by the hospital. Dr Eggitt stated that one of the private institutions sought legal advice who gave an official statement that every patient is entitled to GMS care whether they are an in or out patient. This is challengeable but as yet has not been.

Dr Oakford pointed out that anyone under a section any prescribing has to be approved by the consultant psychiatrist. Dr Eggitt confirmed that a GP can register them but can only provide minimal care. He suggested a conversation should be held with the consultant explaining this and pointing out that GPs cannot prescribe anything without the consultant co-prescribing it. He suggested designing a service that works for the patient such as co-clinics.

When Dr Eggitt last spoke to consultants at Aspen Lodge they agreed to forward a list of services that they require so that he could write a service specification for them however this was never received. He advised Dr Kumar to request this again, explain why he is unable to provide normal GMS services to these patients and to suggest they create a service specification. Until that time patients could attend consolations but not have anything prescribed.

**Fullerton School –** a school that looks after children with disabilities, special needs and violent children from various parts of the country – Dr Kumar wanted to inform the CCG that various medications are being prescribed by a private psychiatrist and they are now asking the GP to prescribe them on the NHS. Although they have said that this is via a Shared Care Agreement Dr Kumar has not been able to find any evidence of this. He ha written to the psychiatrist explaining that they are not able to continue to prescribe private medications on the NHS and that they do not wish to enter into any private Shared Care Agreement.

Dr Eggitt stated that he had already replied to Dr Kumar’s practice manager regarding this explaining that 1- if the medicine is prescribable on the NHS and the GP agrees that the patient requires it, even though they haver seen a private physician for it the GP does have to prescribe it. 2 – If the drug falls outside of the GPs expertise but is under a Shared Care Agreement they would be expected to enter into discussions regarding prescribing it but would not necessarily have to prescribe it. Guidance documents are available on the LMC website regarding this.

**Following discussion, it was agreed to change the date of the next meeting from November 5th to the following week Monday 12th November.**

**There being no further business the meeting was closed at 9.30pm**

**Signed…………………………………………**

**Date…………………………………………….**