DERBY & DERBYSHIRE LMC LTD

Derby & Derbyshire Local Medical Committee Ltd Meeting
Higham Farm Hotel, Main Road, Higham, Alfreton, Derbyshire, DE55 6EH
Thursday 2 April 2014 – 13:30 to 16:30

PRESENT:	Dr Peter Williams (Chair)	
	Dr Peter Holden	Dr Peter Enoch
	Dr John Ashcroft	Dr Ruth Dils
	Dr Andrew Jordan	Dr Jane Perry (Registrar)
	Dr Vineeta Rajeev	Dr James Betteridge
	Dr Paddy Kinsella	Dr Sean King
	Dr Brian Hands	Dr Greg Crowley
	Dr Jenny North	Dr Kath Markus
	Dr John Grenville	Dr Pauline Love
	Dr Peter Short	Dr Murali Gembali
	Dr Jane Perry	Dr Denise Glover
APOLOGIES:	Graham Archer (Chief Officer - LPC)	Dr Doug Black (Medical Director – Area Team)
	Dr Mark Wood	Hannah Belcher (Contracts Manager – Area Team
	Dr Gail Walton	
IN ATTENDANCE:	Hazel Potter (Minutes)	Dr Janet Williamson – Deputy Chief Inspector - CQC
	Lisa Soultana	Jackie Pendleton (Chief Officer - ND CCG)
	Nwando Umeh	

15/52 WELCOME & APOLOGIES

Hazel Potter asked attendees to ensure that the Fire Register for the Hotel and that the LMC attendance register are both signed. Also that all meetings attended on behalf of the LMC are recorded in the attendance register as this is used for remuneration.

Apologies were received from Dr Doug Black, Hannah Belcher, Dr Mark Wood and Dr Gail Walton.

Guest speaker today is Dr Janet Williamson, the Deputy Chief Inspector – General Practice and Dentistry for CQC.

- **Meetings attended on behalf of John**

Dr King reported on two meetings he had attended on behalf of Dr Grenville, the 111 Call Review meeting and also the 111 Clinical Governance meeting, both on 25 March 2015. DHU had asked him to remind people to get repeat prescription done before the bank holidays. DHU are having problems in recruiting GPs and nurses. Dr Holden reminded us that the biggest problem with working out of

hours is indemnity insurance cover. DHU have agreed to reimburse for additional cover until the end of April 2015. Dr Sasha Wheatcroft has resigned as Clinical Lead for Derbyshire 111.

15/53 CLOSED SESSION (MEMBERS ONLY)

- **Payment by BACS – personal / practice split? - Form to be completed**

15/54 GUEST SPEAKER – Dr Janet Williamson, the Deputy Chief Inspector – General Practice and Dentistry for CQC.

- **New Inspection Regime**

Dr Williamson presented the new inspection regime on the link below.

I will email the link separately as it is too large.

Dr Williamson said it is CQC's intention to inspect all practices by 2016. Practices need to prepare for the inspection by drawing up a presentation for the inspectors describing what they are proud of and also areas where they recognise improvement is required. The CQC has a website with a GP web page which gives good tips on what is expected at an inspection. Dr Williamson is keen to work with anyone to see where there is good practice that can be publicised. Linda Hirst(CQC Regional Inspection Manager) is happy to speak to anyone at any stage of the process.

Questions and Answers, and Discussion

- How does Primary Care rate compared to other sectors such as education? Dr Williamson said that such comparisons were not possible.
- A practice had been asked for cleaning schedule for a blood pressure cuff on the grounds that it should be cleaned after every use. This is not practical in general practice although it might be essential in a high risk environment such as intensive care. The committee emphasised that inspections within a sector should be proportionate and consistent. It was commented that practices are required to deliver what is in their contracts and that it is unreasonable for CQC to require practices to perform to higher standards than are resourced by that contract.
- Dr Williamson was asked how CQC deals with the situation where key people, such as the responsible person or the registered manager, are out of the practice for holidays or sick leave on the day of inspection. Dr Williamson said they do not want be unreasonable so take that into account but a practice should be able to run effectively in all situations. However, issues like this can be discussed with the inspector prior to the inspection.
- If a Practice manger or a key member of staff were off on the day of the inspection is there an opportunity to give the information to CQC after the inspection? Dr Williams said "Yes".
- Dr Williamson suggested learning from any neighbouring practices that have achieved good or outstanding to help with your inspection.
- If a practice does not do extended hours would you still be able to achieve outstanding? Dr Williamson said they could if they meet all of the criteria regarding access for all the defined patient groups. Dr Grenville commented there will be increasing problems with patient access over the next few years. VTS recruitment for next year stands at only 30% and we will not have new GPs in 3 years' time. GPs are retiring early. There are fewer GPs and far fewer very experienced GPs.
- Dr Williams said there would also be an issue if a practice closed down and the patients were transferred to another neighbouring practice. How can you be expected to deal with all of the additional patients without extra resource? Dr Williamson said

they would consider this but it is still expected that a patient would be able to get an appointment in a timely manner.

- Is there any gradation within the "good" category? Dr Williamson said there is not.
- A practice had been criticised as they did not have a cleaning schedule for their doctors' bags. Practices need to know what they are being inspected on and, again, this needs to be proportionate. Dr Williamson said that CQC are not here to trip people up and the guidance explains what criteria practices will be judged on.
- Jackie Pendleton said that the CCG meets with CQC ahead of the inspection schedule.
- Where there are issues with a practice which could drag a practice down to being graded inadequate if there is a lack of resource, how does CQC deal with it? Dr Williamson said that CQC reports on what it finds and if patients, for instance, complain about lack of access, that is what the report will say .Practices may use their reports in discussions with their commissioners
- Some practices are still waiting 3 months after the inspection to get their reports. Dr Williamson said they have had timeliness issues and they are working to improve this but there has been a lot of sick leave. Dr Grenville asked if inspectors are stressed by their workload? Dr Williamson said they have a lot of new starters and they are still recruiting. Like any large organisation they have issues. They had underestimated the amount of time it takes to get the reports right and check they are accurate.
- Dr Short commented that everyone would like to be rated above average but that is not how average works. He noted that he would prefer to work in a clean practice that doesn't have a cleaning policy, rather than a practice that has a cleaning policy but is not clean. As an expert, he commented that the management of IT and IG needs a common sense approach.
- For access in deprived areas where there is often higher demand, do CQC look at the metrics that may show that a practice is underfunded? Dr Williamson said they look at the context of where a practice is sited.
- Dr Grenville said if a practice is rated "inadequate" due to a premises problem that cannot be resolved within 6 months and it can provide all relevant documents to show that it is trying to resolve the problem, is that sufficient? Dr Williamson said in theory any practice that is in special measures should get support.

ACTION: All practices - Please view slides and feel free to contact:
Dr Janet Williamson (email: janet.williamson@improvement.nhs.uk) and / or
Linda Hirst (email: Linda.Hirst@cqc.org.uk) if you have any further questions.

15/55 MINUTES OF PREVIOUS MEETING

The Minutes of the meeting on the 5 March 2015 were approved and signed by the Chairman as an accurate and true record except for:-

15/26 Creswell and Langwith Practice

The first paragragh should be subtitled Co-Commissioning. The second paragraph is about Creswell and Langwith Practice.

15/40 PAG / PLDP

Dr Crowley attended a "*PLDP / PAG training*" panel…

15/46 GP Leadership Program Selection Panel

Dr King *"submitted a report"* on a meeting…

ACTION: Hazel Potter to invite Dr Ken Deacon instead of Dr Doug Black, who has retired as Medical Director.

ACTION: Hazel Potter to remind Stephen Bateman of DHU of his promise to send the figures for the breakdown / benchmarking for each individual surgery. The committee had agreed that anonymisation was not required.

15/56 MATTERS ARISING

15/32 Maternity IT Letter

Hazel Potter had spoken to Pauline Twigg who explained the new maternity IT is not ready to go live yet. She had said that GPs will have access to patient hand held records as seen by the GP at the hospital so it will be better information than they currently have.

ACTION: Hazel Potter and Dr Williams to send another letter to Pauline Twigg at Chesterfield Royal Infirmary as she has not understood there is a massive risk once the amount of data that is available to a clinician as s/he sees a patient is reduced.

15/26 Email response from Robert Morley re Creswell and Langwith

Dr Williams read out an email response from Robert Morley stating that NHS England policy and procurement guidance is for an APMS contract.

A discussion followed where Jackie Pendleton said that APMS contract can be offered for longer terms of up to 10 years. However, the LMC members agreed unanimously that Creswell and Langwith need continuity and stability and therefore a GMS contract is the preferred contract.

ACTION: Dr Williams to ask Hardwick CCG if they feel all options have been explored with the patients at the practice and ask them if they would prefer an APMS, PMS or GMS contract.

15/57 GPC Regional Representative – Dr Holden

Dr Holden was congratulated on being re-elected the GPC Regional Representative.

15/58 New Care Model - Vanguard Sites

Dr Grenville reported that a Vanguard site led by DCHS FT has been announced. The LMC was not consulted or involved in the application. Lisa Soultana confirmed that nothing came into the office about this. The Vanguard Site is a collective site with Erewash CCG, Out of Hours and 111 and serves 97,000 patients and 12 Practices. There has been £4.5m funding. Dr Hands is delighted that it is happening in Erewash. Jackie Pendleton said that Hardwick has submitted a bid but nothing has been decided yet. There was very little time to submit an expression of interest to obtain the challenge funding. The new scheme in Erewash is trying to create two new hubs, one at Ilkeston and one at Long Eaton. The money is non-recurrent. Lisa Soultana said its vision is to work across disciplines including mental health, urgent care practitioners, nurses etc. Dr Ashcroft said it is about using specialists to work in the community. Dr Kinsella said she has been talking to Dr Avi Bhatia at Erewash about an application. Dr Betteridge suggested we have something planned and ready for when the next tranche of funding is announced. Dr Holden agreed this as there is a need to plan for the future. Dr Ashcroft said it is good that people are recognising the importance of general practice again.

ACTION: Lisa Soultana to take this back to Erewash CCG for Vanguard application.

ACTION: Hazel Potter to invite Avi Bhatia or Rakesh Marwaha to attend the LMC as a guest speaker.

15/59 Focus on GP Contract Payments

Dr Williams said there have been questions raised about the change of contract. Dr Betteridge thinks it's ironic that the changes arrive on Aprils Fools day. Dr Grenville said that a practice in another part of the country had commented that they are losing money when they apply the pence per patient figures that have been announced to their own population. He emphasised that the figures represent the national amounts of money moving from one pot to another divided by the number of patients affected nationally. Because practice populations vary there will be winners and losers.

Dr Holden noted that gender and age are far and away the principle determinants of practice workload overall. This does however disadvantage small practices as they have disproportionate overheads. In Derbyshire we are known to be innovative. He suggested that smaller practices should consider merging now in order to survive. Small practices are at serious risk. Dr Hands said that it will take a generation for single handed practices to disappear. Lisa Soultana commented that some relatively large practices are now single handed due to the 'last man standing' effect.

Funding for Sexual Health

This was discussed and applies to Derbyshire County only. Dr Grenville said that DCHS have won the contract for an integrated sexual health service across the County. Derbyshire County Council had previously served notice on county practices regarding the provision of Long Acting Reversible Contraceptive Services (LARCs). DCHS sent an email at 5pm on 30 March asking Practices whether they wished to be sub-contractors for LARCs from 1/4/15. The pricing had been reduced by 5% and the fee for insertion of IUCDs and IUSs appeared to include the insertion, removal and replacement of the device. Dr Grenville had contacted DCHS as a matter of urgency and was able to read an email that states that the individual fees will remain unchanged from last year and that the insertion fee is payable again when a device is replaced.

Dr Holden explained that DCHS had put in a bid that recognised the County Council's need to make savings because of the savage cuts to their budgets. That did not mean that practices had to accept proportionate cuts if they did not think that they were being offered an economic fee. It was now for DCHS to arrange an effective and accessible service within the cost envelope they had agreed. Dr Love asked if this is the same price for IUDs and IUSs and Dr Grenville said that it is.
Lisa Soultana mentioned an email that she had received from North Derbyshire Provider Group and needs to speak to Dr Grenville about it after the meeting. *(Post meeting note – there has been considerable confusion in the North, where the Provider Group has bid for the sub contract on behalf of its members, but it is hoped that this is being resolved and the services and fees will be uniform across the County).*

15/60 New GMC Consultation – changes to improve our fitness to practice investigations and hearings

Dr Williams reported that the GMC has begun an 8 week consultation regarding their Fitness to Practice investigations and hearings. Hopefully, a potential outcome will be to reduce time and stress for the doctors involved. Dr Williams encouraged everyone to respond to the consultation.

ACTION: All to respond to the GMC Consultation.

15/61 PREMISES UPDATE

- **Update on letter from CHP to practices regarding outstanding invoices**

Nwando Umeh spoke about the letter that she has received from CHP has been sent to eight practices in LIFT buildings. We have 5 in NHSPS/Health Centres. This letter is in regards to the transition of finances from NHSPS to CHP for billing arrangements. Where practices have already received funding from NHS England for reimbursable elements of charges this should be remitted to CHP immediately or else interest will be added and formal proceedings initiated. Ongoing issues still persists with non-reimbursable elements and at the last meeting we had, CHP indicated they were willing to come out to practices and help sort this out.

- **GP Premises Funding Announcement and other Premises Issues**

Dr Williams said that Swadlincote and Darley Dale practices had been successful in bids for the first tranche of money under the new premises development fund. Dr Holden said there will be a further announcement in June after the election.

Dr Grenville reported on a High Court decision regarding the rateable value of general practice premises. The effect is that the business rates for many practices may be reduced but practices would need to appeal to secure these reductions. Business rates for GP practices are reimbursable for all premises, or parts of premises, on which rent reimbursement is paid. This means that for practices in premises that are fully rent reimbursed (cost rent, notional rent or direct rent reimbursement) there is no financial advantage to securing this reduction – the advantage would accrue to NHS England. Jonathan Rycroft has sent an email to practices offering the help of NHS Property Services to apply for a business rate rebate. Practices should consider carefully the time that could be consumed by the appeal process if they decide to assist NHS England in this way. Practices are strongly advised not to incur costs with third party external legal or property experts touting for business in this matter as they are likely to gain nothing, even if a rebate is obtained.

GPC have foreseen a potential problem, in that if business rates are reduced NHS England might seek to secure reductions in rent reimbursement values. This is, however, thought to be a small risk. Dr Holden commented that there may be significant advantages in securing these business rate reductions, provided that the savings made are ring-fenced for future investment in premises; it will be recurrent money.

ACTION: Dr Grenville to write an email advising practices not to take part in the rate reduction until GPC has concluded negotiations to ring-fence money for general practice premises for the future.

15/62 INFORMATION MANAGEMENT TECHNOLOGY (IMT)

- **Focus on the new IT requirements of the GP Contract in England.**

Dr Short spoke about the summary care record and said that practices need an internal process to ensure regular SCR upload where smart cards are not universally used.

The GP2GP record transfers still have issues with large messages and these are being addressed through the new spine contract. If there is an inbound GP2GP record and it is rejected, the rejection is permanent and cannot be requested again. Once the practice has decided to reject the record it can currently not be re-constituted. Recommendation is to accept incoming GP2GP transfers to ensure continuity of the record.

Dr Markus said that her practice had had a lot of problems with patients registering and asked whether, if the transfer fails at the receiving practice end, is it (the SCR) deleted? Dr Short said that each summary care record over-writes the previous one. Upon moving practices, each new practice has to determine when to overwrite a previous (potentially richer) SCR. Dr Markus said they never get that far with it. Dr Short noted that the most difficult are the patients with a complex medical history. HSCIC are working with the software suppliers on the size or 'attachment number' limitation to GP2GP as a high priority. This is backed by NHS England and GPC. When this is fully functional there is likely to be the opportunity to abandon transfer of paper records. Dr Markus said there is a clinical risk with large paper records. Dr Williams said that you need to make sure you store the record electronically in a user friendly way. Dr Short said that attention to the ongoing data quality of the record is increasingly important to support good patient care.

In response to the contractual Record Access targets for 2015-15, there is also the option for patients to be able to view elements of their own record online. The HSCIC has carried out a risk assessment of the current software that is in place and determined it is safe to use to fulfil the 2014-15 contract

minimum requirements. If patients request access to their records and they have a verified identity, they can access their records to the level of the core SCR as a minimum. For more detailed medical record information access, they will generally have to wait until new approved software is deployed later on this year, unless a practice feels that such access using existing software is in the best interest of the patient. Current Patient Access software is not assured as safe and appropriate for under 16 year olds or for use by proxies. There will be choice of which software to use in the future for patients and attention is being paid to transitioning to the new software offerings. It is up to the practice to decide when they are confident to verify the patient identity and allow them access to their records. The practice also has the right to decline access.

Dr Williams said their practice has declined a few as it was not appropriate. He has found that those that have access like to use when interacting with consultants. Dr Short said you can also use the software to turn off or on some of the online functionality in response to unforeseen priorities – the practices remain in control.

Dr Jordan asked about access to children's records.Dr Short said that at the moment if a practice considers it in the interest of the child to grant proxy access, this is up to individual practices. However, the current software does not identify know who the proxy is. GPSoC assured software available later this year will remedy this. In the meantime the RCGP & NHS England guidance should be followed.
http://www.england.nhs.uk/patient-online/
http://elearning.rcgp.org.uk/course/view.php?id=180&section=0

ACTION: To be put in the LMC newsletter advice about when parents can be allowed access to their children's records.
(See Proxy Access section in RCGP link above as part of the Patient Online Practice Toolkit)

- **Derbyshire Information Delivery Board (DIDB) - Draft Project Outline Summary.**

Dr Williams said we have a draft outline summary. All stakeholders want one portal for information and they are working towards it. This is the aspiration but it is unclear how long it will be until it is delivered. Dr Short commented this has been tried nationally dozens of times before.

- **Pharmacy 2 U – Email from Graham Archer**

Dr Williams read out an email from Graham Archer regarding the Daily Mail headline about patient confidentiality. To summarise it said "If the allegations were true, it would be investigated and appropriate action taken".

- **Email from the Area Team regarding paperless accreditation**

Dr Williams read an email from the Area Team regarding paperless accreditation. The Area Team wants to visit each practice. He questioned if we wanted to have a visit from them and also if there would be funding to support it.

15/63 CLINICAL COMMISSIONING GROUPS (CCGs)

Jackie Pendleton said there is still no formal tariff but most contracts had been agreed. It is a pre-election close down so it can't be taken further until after the election.

Dr Grenville said in the summer we want to discuss primary care contracts with the CCGs. We would like consistency across all four CCGs. We would like Derbyshire's' success to continue and he asked Jackie if this could be mentioned at the next 4 plus 4 meeting. Jackie Pendleton said that Jonathan Rycroft will soon issue dates for a Strategic Group which the LMC will be invited to attend.

15/64 NHS ENGLAND NORTH MIDLANDS (formerly AREA TEAM)

- **Easter Saturday Opening**

Dr Grenville spoke about a letter from Vikki Taylor dated 4 March asking practices to open on Easter Saturday morning and offering £200 for staff costs plus £300 for each 3 hour GP session. On 26 March; Dave Knight had offered only £80 for staff costs if no nurse was involved. Dr Grenville noted that most receptionists would be paid double time so two receptionists at double time would not be a viable economic option. It has been a total disaster from beginning to end. Dr Grenville did not blame the Area Team as they have been told to do it by the Centre. Dr Holden noted that, after deductions, a GP would take home £72 for working a 3 hour session during a Bank Holiday weekend. DHU had been as surprised as everybody else when this scheme was announced. Jackie Pendleton said she had spoken to Stephen Bateman at DHU and North Derbyshire and Hardwick CCGs (as co-commissioners of primary care) had decided to offer the same rates as DHU so as not to undermine them.

- **PAG / PLDP**

Dr Crowley is waiting to see what will happen regarding this.

15/65 CARE QUALITY COMMISSION (CQC)

No items were raised.

15/66 PRIMARY CARE DEVELOPMENT CENTRE (PCDC)

- **CEPNs**

Lisa Soultana spoke about the Community Education Provider Networks (CEPNs). Moss Valley is going to be the hub for Derbyshire. PCDC have been approached by HEEM to help identify support CEPNs hubs and spokes in Derbyshire and Nottinghamshire. The PCDC is keen to support this initiative to ensure its success. Dr Crowley said he does not understand what they are trying to achieve as there is not enough funding. Lisa Soultana agrees and the PCDC is keen to invest support for data and information gathering to see how it all works and also the challenges and issues. Dr North was keen to say that she felt that the CEPNs can be good news for General Practice. The PCDC will have further discussions with Jacki Hewlett- Davies and jointly agree the best possible support package. There is a lot of work to be done, this is a complex environment and needs a simple common sense approach to realise any potential successes.

- **Resilience Service**

The resilience scheme for GPs will be provided by the PCDC commissioned by Health Education East Midlands (HEEM) will be soft launched in May 2015 for GPs. It might expand to Practice Managers and Practice Nurses in future years. Dr Betteridge asked if there will be any media coverage as this is what we need. Dr Grenville said there will be a hard launch in June 2015.

ACTION: Lisa to speak to Chris Locke.

- **East Midlands Leadership Academy (EMLA)**

Lisa Soultana reminded the LMC that there is fantastic FREE PCDC/EMLA training and personal coaching offers for all GP workforce.

To access this FREE offer contact James.cutler@pcdc.org.uk

Dr Betteridge said he went to an EMLA conference for training and social media training. He also went with Dr Kinsella on a GP leadership programme. The PCDC have been pivotal in shaping this and he is very pleased he's been able to access it.

- **Sessional GPs**

Sessional GPs have their own PCDC personal portal.

For further information contact ***James.cutler@pcdc.org.uk***

- **Care Certificate Guidance for General Practice**

With the support of Lisa Soultana, Claire Leggett, PCDC Senior Associate has written care certificate guidance for General Practice.

- **CLUBs**

Approximately 25% of Practice Managers have joined a "CLUB" ***set up and*** facilitated by Lisa Soultana, in the first instance to look at operational transformational agenda by focusing on reducing duplication of tasks, freeing up time and sharing roles, tasks and responsibilities across a group of 4 to 8 GP practices. If any further practice managers are keen to establish their own CLUB, please contact Lisa Soultana who will is keen to set up and facilitate any future CLUBs.

Lisa Soultana said further funding to needed to put on additional PCDC free training.

15/67 LOCAL EDUCATION TRAINING BOARD (LETB) / LOCAL EDUCATION TRAINING COUNCIL (LETC)

- **HEE Shape of Caring Review**

Dr North said that there was some optimism about this report on nurse training. There is a group of nurses that might be trained in Primary Care. Lisa Soultana said the expectation is that there is no funding again but it's great in principal that nurses will be used in Primary Care.

- **GP Training Numbers**

Jackie Pendleton said that GP VTS recruitment figures for next year are very low.

15/68 OFFICE REPORTS

Hazel Potter reported that we will be moving office on 23 April. Lisa Soultana commended Hazel for all of her hard work in project managing the office move which has been running very smoothly and said it has been especially difficult to fit in around the ongoing requirements of her normal daily job. The Committee echoed Lisa's congratulations to Hazel

Lisa Soultana said we have designed a new office newsletter which should be better, easier and quicker to read than the old version. Dr Betteridge said he is more than happy to help with any social media.

15/69 GPC NEWSLETTER – MARCH 2015

No items were raised.

15/70 ANY OTHER BUSINESS

- **Misunderstanding the nature of the GP contract.**

Dr Holden said that the GP contract resources practices, on average, for less than one hour of time per patient per year. We need to get people to understand that in the real world GPs cannot simply stretch that time to undertake work that has previously been resourced to take place in secondary care.

Dr Markus commented that GPs are used as administrators for hospitals. Dr Holden gave an example of a patient who had had a first fit at work and who had been taken to A and E but who could not be seen by a neurologist unless and until his GP referred him.

Dr Holden suggested a motion that this LMC now writes to Medical Directors "We are not your community houseman, you fix it!"

Jackie Pendleton said there are some restrictions in the contract for the consultant-to-consultant referrals.

ACTION: Dr Williams said he is happy to do this letter.

Dr Dils noted that consultants are not lazy and they work really hard. Dr Holden agreed but said that consultants may need to stand up to managers to ensure that patients' best interests are served. Dr Grenville said we need to look at policies on consultant-to-consultant referrals and if it is not safe for patients, we can and must do better.

ACTION: Arrange a meeting between CCGs and LMC Officers regarding the risks to patients of over-zealous banning of consultant-to-consultant referrals. The aim of the meeting would be to try to find a middle ground. Acute Trust Medical Directors should also be involved. All LMC Members were asked to send to the office two (anonymised) examples of patients who had been disadvantaged by bans on consultant-to-consultant referrals.

The meeting was closed at 17:00.

15/71 DATE OF NEXT MEETING – 07 May 2015