APPENDIX 1

Commissioning of Dental Services across West Yorkshire

At its meeting in July 2018, the West Yorkshire Joint Health Overview and Scrutiny Committee considered an update from NHS England regarding access to dentistry across West Yorkshire.

Following the meeting, a series of supplementary questions that warranted further discussion and consideration were raised with NHS England regarding the commissioning and provision of non-specialist dentistry. The additional questions related to services provided on a West Yorkshire and Harrogate basis, but also the placed based developments specific to Leeds.

The additional questions are detailed below, along with NHS England's initial response (provided in September 2018), which will be considered by the JHOSC at its meeting in April 2019, alongside any further details provided by NHS England. Any matters specifically relating to individual local authority areas will be brought to the attention of the relevant local health overview and scrutiny committee.

	Question	**Initial Response (September 2018)**
1	The report refers to a review of the availability of access to dental services and development of a strategy to improve dental access across Yorkshire and the Humber. Please provide the following: (a) A copy of the review report, the associated strategy and implementation plan. (b) Details of any financial/budgetary implications and how any additional spending will be financed. (c) Details of any public/stakeholder engagement undertake as part of the review and development of the strategy.	Please see Annex 1.

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Commissioning of Dental Services across West Yorkshire

	Question	**Initial Response (September 2018)**
2	Please also confirm where (and when) the review and strategy were reported and agreed.	The discussion regarding the dental strategy was held at the Direct Commissioning Management Team on 14 August 2017 and 11 September 2017 when the following was agreed: • The criteria for selection with include the Y&tH commissioned UDA average will be combined with their deprivation scores to prioritise areas for investment. • Assuming they have delivered their core contract, primary care providers in the identified constituencies will be offered a 3 year contract variation. • The average UDA value of £28.30 was agreed as a unit of value – set as at 14/08/17 • The ambition is to bring all commissioning areas up to the Y&tH average 1.72. The value of 1.72 will be set for future investment decisions as the ambition for Y&tH. On the basis of these principles, it was agreed to undertake some modelling to support the utilisation of available recurrent funding.
3	As a profession body, dentists are largely behind a more responsive approach to practice. The NHS Dental contract has been in reform for some considerable time and the current dental contract is seen (by many) as unhelpful and a barrier to a responsive approach. Some dentists in Leeds have expressed a great deal of enthusiasm for reform but felt 'the brakes are still on'. Are there any plans to progress this area? If so, what are they? If not, why not?	NHS England's national dental team is leading on a programme of work looking at reforming the current contract used for primary care dental provision. As the local direct commissioning office, NHS England – North (Yorkshire and the Humber) is also keen to see these reforms - and the proposed revised contract - but there are no defined timescales identified by the national team.

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Commissioning of Dental Services across West Yorkshire

	Question	Initial Response (September 2018)
4	NHS dental contract reform work includes the piloting of different arrangements, such as the Dental Prototype Agreement Scheme. There appears to be no mention of this scheme with the report for JHOSC – including the overall aims and objectives of the scheme; levels of take-up within WY&H; how long the scheme has and will continue to run; how the scheme is being evaluated; how successful (or otherwise) the scheme has been in achieving its original objectives. Please provide some specific details.	The prototype programme is run by the Department of Health in conjunction with the NHS England central dental commissioning team. There are currently two practices in West Yorkshire taking part in the programme and these will be joined by a further three during this financial year. The length of the prototype work, monitoring and measurement of the outcomes is being managed centrally.
5	Previously, the JHOSC has been advised that the three tests to consider whether or not issues should be considered on a WY&H basis are: • Scale • Good practice to share • Issues cannot be resolved individually/locally. As such, given the issues patients face regarding access to dental services, why is access to dental services not a specific aspect of work within the WY&H&CP. What freedoms might be available to help better support and drive this area of work forward?	This refers to national policy so not something we are able to comment on locally. If this is not the case then, we would be happy to review if a further explanation could be given.

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Commissioning of Dental Services across West Yorkshire

<table>
<tr><th></th><th>Question</th><th>Initial Response (September 2018)</th></tr>
<tr><td>6</td><td>During the discussion at the JHOSC meeting, the annual ‘underspend’ or ‘clawback’ was referenced (i.e. money clawed back from dentist because they do not deliver the amount of dental care for which they were originally commissioned). However, no specific details were provided or presented in the report. Whilst it may be difficult to predict likely levels on underspending in the current year, please provide details on the level of underspending/ clawback across Yorkshire and the Humber (and specifically WY&H) in each of the last three full financial years. Please also detail levels of any variation against the financial trajectory in the current financial year.</td><td>Dental practices are paid an annual contract value that is spread equally across 12 months – within this, the practice has the ability to flex their activity between months so it is not a straight line projection of activity for us to detail any variances within this financial year.

The table below details the clawback for the last 3 financial years for Yorkshire and the Humber, and then specifically for West Yorkshire. Please note the following:
2017/18 reconciliation has not been completed.
For the purposes of this exercise, West Yorkshire does not include Harrogate.

<table>
<tr><th>Year</th><th>Total clawback Y&H</th><th>West Yorkshire clawback</th></tr>
<tr><td>2015/16</td><td>£8,669,260</td><td>£1,917,132</td></tr>
<tr><td>2016/17</td><td>£13,336,042</td><td>£2,973,367</td></tr>
<tr><td>2017/18</td><td>£19,450,202</td><td>£5,724,024</td></tr>
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Commissioning of Dental Services across West Yorkshire

	Question	**Initial Response (September 2018)**
7	Early dental disease is unevenly distributed across WY&H. Where are those areas and how is better access being targeted through regular access to a dentist?	Following investment in the identified areas to improve access to a dentist from 1 July 2018, work will now focus on how the access can deliver better outcomes in oral health. The Dental Clinical Commissioning Executive is currently working with Public Health England to develop appropriate initiatives, using the learning from other projects such as Starting Well (currently implemented in Wakefield) which focuses on dental service for young children. The first data is due in October 2018.
8	The Leeds DPH report indicates significant preventable disease on average but hides very high rates in poorer areas of the city. Therefore, in terms of dental care, how do we identify, target and improve the health of the poorest fastest?	Please see the answer to point 7. There are also arrangements in place to link in with Leeds Plan
9	How and where will the 'Starting Well' scheme be rolled out, monitored and reported across the WY&H footprint?	The Starting Well programme has been developed nationally by the NHS England and Public Health England central teams. There are 13 areas that have been identified to take part in this programme. As stated above, this will be considered in terms of the future access work.

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Commissioning of Dental Services across West Yorkshire

	Question	Initial Response (September 2018)
10	What other schemes of prevention or better early intervention are being deployed across WY&H? In which areas? How have these been decided? How are such schemes funded, and is the funding recurrent? How do any such schemes connect to the wider prevention approach that is fundamental to the WY&H HCP?	The Office of the Chief Dental Officer has proposed a number of initiatives, within a 'SMILE4LIFE' programme. The programme is intended to increase access for children to dental services particularly supporting preventative interventions. 'Starting Well Core' is one of these initiatives and NHS England North - Yorkshire and the Humber's dental commissioning team is working with Public Health England and local dental clinicians to identify areas of the highest deprivation and where access to dental services for children under 4 years of age is particularly low. The purpose of this scheme is to encourage practices to accept more children in to their service and to spend more time with them encouraging tooth brushing, improving diets and reducing sugar intake. This work has just started and implementation of the scheme will be put in place once areas have been identified.
11	If through local care partnerships, one of the overall aims is to make community services more joined up through primary care networks across WY&H how are we enabling dentistry to join up better with other parts of primary care in local areas – such as GPs?	Links are being made with the networks through the STP/ICS function. This is in early stages but there is a commitment to explore how these services can be more effectively aligned.

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	Question	Initial Response (September 2018)
12	How are new roles and culture for dental health professionals and sufficiency of supply being explored? In Leeds, we are working on different roles for the rest of primary care and we are developing a Health and Care Academy to support this – how can this local approach with NHSE role as commission of dental services?	NHS England – Yorkshire and the Humber has strong links with Health Education England (HEE). They have a seat on the local Dental Clinical Commissioning Executive and play a key role in developing a workforce to support the services we commission.

Access to General Dental Services – Yorkshire and Humber

Introduction

This paper should be seen in the context of the wider dental commissioning plan which considers the approach to 111 signposting, urgent dental services and primary care access to dentistry.

In order to prepare for this, it will be beneficial to understand the specific issues affecting dental access across the geography so options can be discussed, and the preferred recommendation developed, ahead of consideration of the wider plan.

Background

Yorkshire and Humber commissions 9.5 million UDAs across 651 General Dental Services contracts - this excludes specialist contracts like Orthodontics and Urgent Care. These contracts were agreed prior to the inception of NHS England in 2013 and have resulted in inherited legacy arrangements which, in the main, cannot be changed.

UDA values vary from around £19 to over £40, with an average of £28.30. This figure has been reconciled for the year 17/18. A precedent for using the average price per UDA has already been set within two recent procurements, Great Horton in West Yorkshire and Scunthorpe in North Yorkshire and Humber where £27.12 was the value used. This has changed due to the DDRB uplift and renegotiations of contracts since that time.

The rate of 'UDAs Commissioned per Capita' is 1.72, compared to 1.62 across England. Across each parliamentary constituency, these rates vary from 0.8 in Scunthorpe to 3.5 in Hull West and Hessle.

The lack of routine dental care impacts on the demand and availability of urgent care. GP Patient Survey results for January to March 2017 show that 63% of patients in West Yorkshire were successful in getting an appointment when new to a practice, 66% in North Yorkshire and 80.4% in South Yorkshire, compared with 74% across England. The use of 111 and dental urgent care services has increased which also highlights that patients are unable to gain access to regular dental care. The providers of this care have reported that the weekend slots are being filled during the week as patients are unable to gain care during weekdays.

In financial year 15/16 a significant amount of clawback from contracts was identified due to underperformance. This occurred for a variety of reasons and has affected the ability for patients to gain access to dental services. This funding is contractually allocated, so opportunities to release funds need to be explored, and priorities set on how that funding will be re-commissioned. It is noted that there is still a significant number of areas that have a high level of underperformance. This is due to a number of factors but the main one is the difficulty in recruitment of dentists to practices on the East Coast. The explanation of this from practices is the areas are remote from main travel systems and dentists do not want to move to an area that is difficult to travel to and is away from families, friends and peer groups made during training.

Another contributing factor is that some practices have a very low UDA rate this prevents the practice from offering a premium to attract dentists and still maintain a viable practice.

<u>Oral health Health Needs:</u>

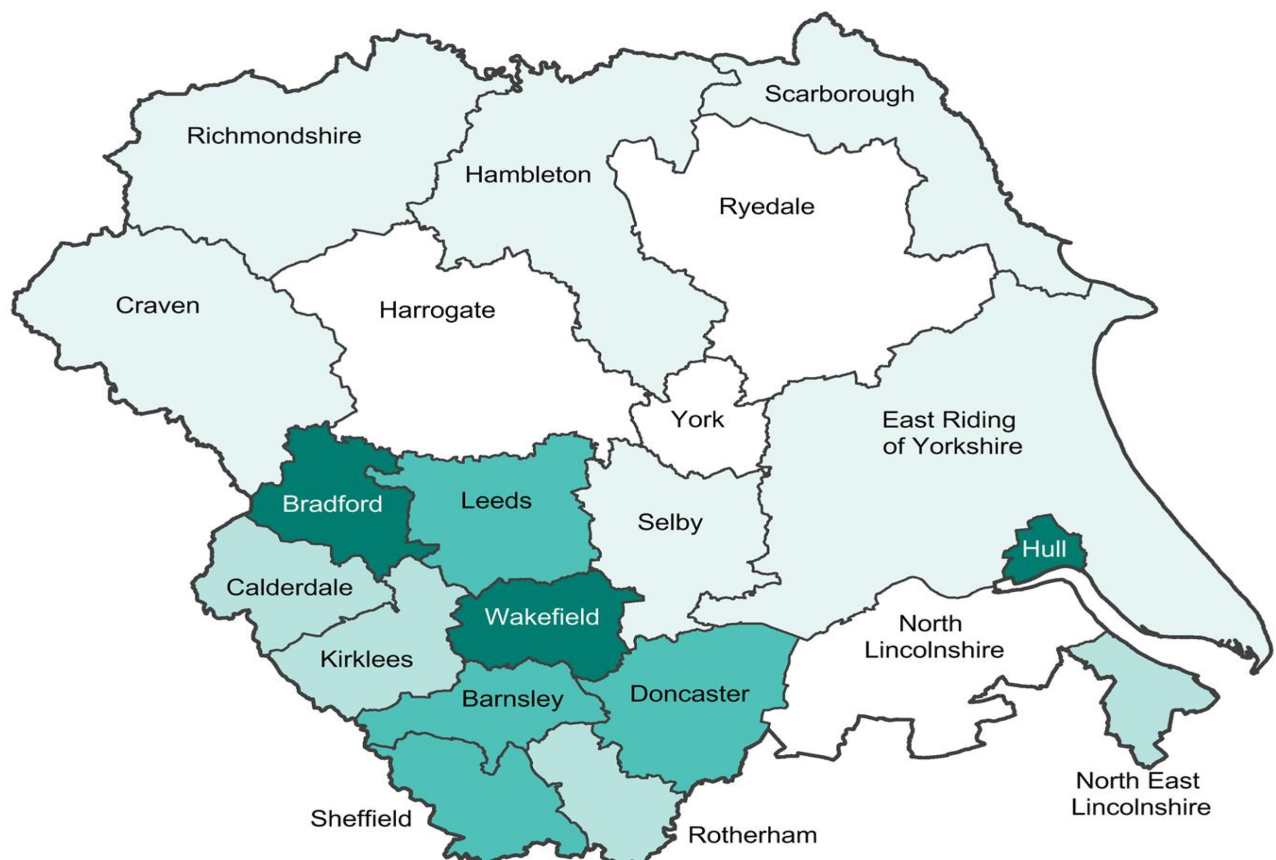
Despite improvements in oral health over the last forty years, many people continue to suffer the pain and discomfort associated with oral diseases, which are largely preventable. The distribution and severity of oral diseases varies between and within areas with the more disadvantaged and socially excluded groups experiencing higher levels of disease.

Deprivation in Yorkshire and the Humber is higher than the England average with 47.4 % of the population of Y&H in the lower two national quintiles of deprivation.

Oral health of children in Yorkshire and the Humber 2015

Findings from the most recent survey of five-year-old-children indicate that Yorkshire and the Humber remains the second worst region in England with 28.5% of children experiencing tooth decay compared with 24.7% nationally. Within Y&H the proportion of children with dental disease varied from 16.5% in York to 37.8% in Hull (Figure1).

Figure 1. Map of percentage of five-year-old children with tooth decay experience in Y&tH by local authority, 2015



Published data shows that 220 children aged 0 -19 years had extraction of one or more teeth under general anaesthesia in 2012/13. However, it is likely that this figure underestimates the true figure due to inconsistencies in hospital coding and may not include all activity carried out by a primary dental care provider at Hull Royal Infirmary. Dental treatment under general anaesthesia is expensive for the NHS, disruptive for families and presents a small but real risk of life threatening complications for children.

Adults

Across the UK the oral health of adults has improved significantly over the last 40 years. More people are retaining more of their natural teeth into older age. Trends from national and local surveys show that edentulousness (having lost all teeth) is now uncommon amongst people over the age of 65 years of age. Even the very old (85 years plus) have in many cases retained some natural teeth. This has important implications for the future in terms of good oral function but carries service, including oral health improvement programme, implications related to the continued maintenance and advanced restorative and preventative care of older adults who are likely to be increasingly frail with complex medical histories and difficulties accessing dental services.

Between 1998 and 2009 the prevalence of active tooth decay in England fell from 46% to
30%. There were reductions across all age groups but the largest reduction was in those aged 25 -34 years. As adults age the accumulated effects of gum disease may cause exposure of root surfaces, therefore with age the prevalence of decay on the root surface is likely to increase. Seven per cent of adults in England had active decay

Further analysis of the data shows that those children living in the most deprived quintiles experience significantly higher levels of dental disease.

Oral health of adults

A self -reported adult postal survey was carried out across Y&H in 2008, the key findings were:

- Adults living in the most deprived areas reported poorer oral health and more difficulties accessing dental services.
- Almost a third of respondents reported that that they had a painful ache in their mouth, occasionally or more often, this varied from 23% in East Riding to 35% in Bradford and Airedale.
- A quarter of adults rated their oral health as fair, poor or very poor
- A quarter of respondents felt that they required treatment
- 23% reported that they had difficulties gaining access to routine dental care and 18% to urgent dental care. Difficulties varied across Y&H and by deprivation quintile.

- Respondents living in North and North East Lincolnshire experienced difficulties due to the lack of dentists taking on patients.

In conclusion the report highlighted variations in reported oral health status, experience of using dental services and demand for dental care by former PCT area.

The 2009 Adult Dental Health Survey reported that the average number of decayed teeth was higher in Yorkshire and the Humber than the England average. Mouth cancers account for 1-2% of all new cancers in the UK. The risk of developing mouth cancer is greater in people living in areas of deprivation.

Dental Services

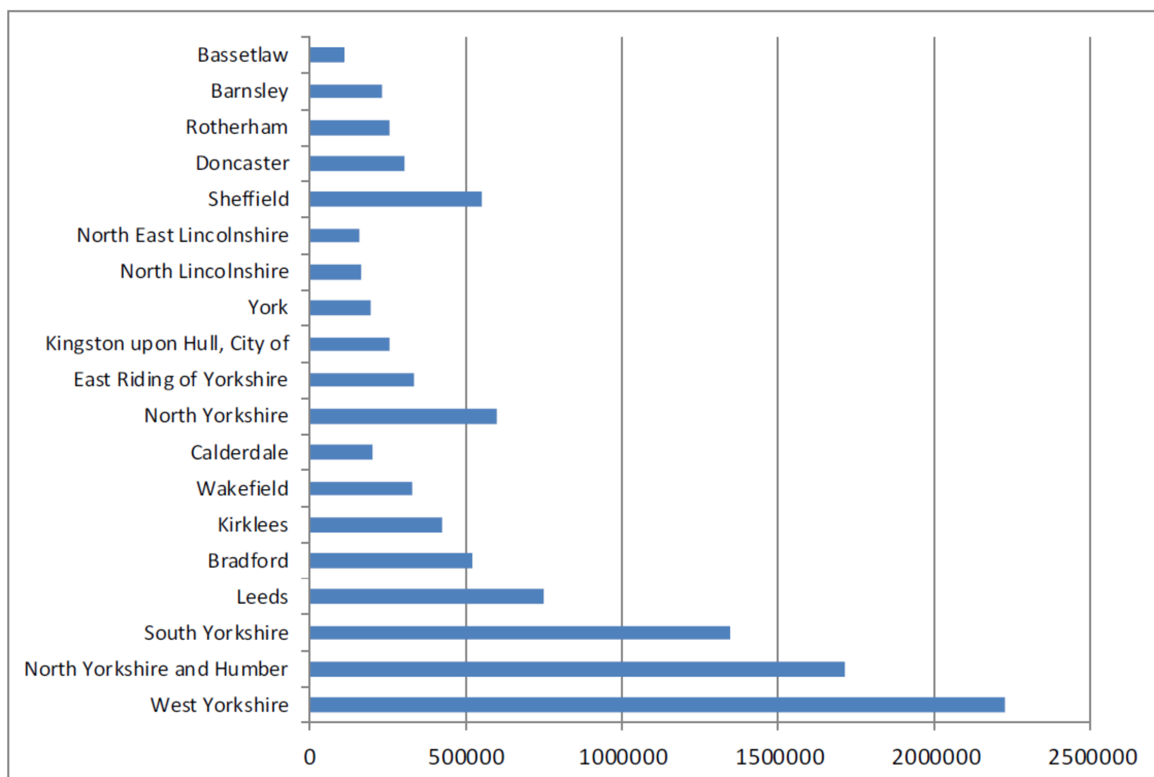
The access rate, which is number of patients seen as a proportion of the resident population is a measure of the effectiveness of dental commissioning. Access rates can be influenced by a number of factors such as the number of dentists in an area, the oral health needs of the population, levels of deprivation and patient choice.

Although dental services are demand led, they should be targeted to those population groups and areas where oral health is poor.

Population estimates

80% of the Y&tH population live in urban areas with WY being the most densely populated (42.1%).

Population of Yorkshire and the Humber (year/ reference)



Source: Office for National Statistics, Census Sex, 2011 (QS104EW) 2011

Population projections suggest a 4.6% increase in population across Y&H in all areas with the exception of Richmondshire. (ONS ref)

Findings

From the information provided it is difficult to identify one particular measure to prioritise areas for investment eg Scunthorpe constituency UDAs per head is 0.8 but the deprivation ranking is 162 (the range is between 11 and 530) and the average percentage of patients seen in the previous 24 months is 34%.

What do we know from patients/MPs/public

The West Yorkshire MPs for Dewsbury, Bradford and the North Yorkshire MP for Ryedale are raising concerns about access to dental services regularly with NHS England both locally and centrally also via Parliamentary questions.

Complaints – the Dental team has received 23 complaints around access to dental services since the start of June 2018.

Healthwatch – are receiving complaints from patients about the lack of access to regular dental services and undertake regular surveys. Feedback from these surveys is shared with NHS England.

What have we done so far?

The Oral Health Needs Assessments completed in each of the localities, and published in September 2015, highlighted areas where additional services are required, but do not allow for comparison of these areas to assist in prioritisation for commissioning. To this end, a new database of commissioning and access information has been developed to enable us to drill down to Council Ward and Constituency level. This data is being triangulated with deprivation and health needs data to support prioritisation areas for commissioning.

Access Pilot Schemes

North Lincolnshire

The North Yorkshire LDN developed a scheme whereby 8 practices in North Lincolnshire were commissioned to deliver an access/unscheduled care service, signposted through the existing urgent care provider and 111, on the following principles:

- The ran over January to March 2017
- Practices were to provide dental care for new patients only
- The activity target for each practice was 333 UDAs
- The activity will be mainly for urgent, band 1 and band 2 courses of treatment
- Practices submitted a simple audit, the verified results of which are below:

Provider	Patients Treated	General Child No of Pts	Band 1 Treatments	Band 2 Treatments	Band 3 Treatments	Urgent Treatments
Barton Dental Care Limited	119	20	51	51	10	7
OASIS DENTAL CARE LTD	209	22	155	39	3	10
MR AN GATECLIFF	117	23	55	48	6	8
MR A BAGGA	128	24	73	43	11	2
Winterton Dental Practice	85	27	50	22	2	20
The Dental Design Studio	119	63	79	26	1	14
The Dental Design Studio	70	15	25	14	2	28
K L DOBBS	136	26	33	45	9	49

Bradford and North Kirklees

Practices participating in this scheme were required to keep free an agreed number of one-hour slots in which to see four new patients. They agreed to provide full courses of treatment, offering further appointments where appropriate. Patients were initially all booked in to these slots directly by Local Care Direct (LCD), via 111. £100 per slot was paid to practices to keep the surgery time free, and 12.8 UDAs per slot (or 3.2 UDAs per patient) are also awarded. Participating practices are required to deliver the additional UDAs awarded as part of this scheme, in addition to their contracted UDAs, in the 2016-17 financial year.

Jan–Mar 2017

Over the period of 9 January to 31 March 2017, 25 practices participated in total (9 in Bradford City, 8 in Bradford District and 8 in North Kirklees). 4,260 appointments were made available for new patients (1,764 in Bradford City, 1,292 in Bradford District and 1,204 in North Kirklees). 13,582 additional, non-recurrent UDAs were commissioned in these areas (5,644 in Bradford City, 4,135 in Bradford District and 3,803 in North Kirklees.

Challenges:

- The activity at LCD was lower than expected throughout January to March, resulting in some unfilled appointments. We are still working through the data, and the activity picked up through February and March, but we know that in January 92.5% of Access Scheme appointments were filled in Bradford, and 66.95% in North Kirklees (84.29% in total).
- Because of the lower than expected overall activity at LCD, activity at the Bradford urgent care service at BRI was at times been significantly affected by the diversion of patients into regular practice appointments.
- There has also been a relatively high rate of patients failing to attend appointments: 18% in January (the LCD UDC rate is usually around 10%).
- None of the practices in Dewsbury expressed interest initially. After conversations with these practices, however, one practice joined the scheme to deliver 40 access slots in March 2017.

The challenges of low activity at LCD, and patients failing to attend, were somewhat mitigated, as the additional UDAs awarded under the scheme still being delivered. Unfilled appointments are, however, very frustrating for all involved.

Revision

From April 2017, participating practices filled two appointments per slot themselves with new patients, and have two patients booked in directly by LCD. LCD were then able to fill the slots easily, with most appointments being booked days in advance, including the urgent care service at BRI. This change also addressed the disparity between patients who may have been on a waiting list for some time, and patients who are contacting 111 to find a dental appointment, being able to access the appointments available as part of the scheme.

April – June 2017:

In March, practices already participating in the scheme were asked if they would be willing to continue in the scheme over April - June. One Dewsbury practice participated. Over the period of April -June 2017, 20 practices participated in total (9 in Bradford City, 6 in Bradford District and 5 in North Kirklees). A maximum of 3,508 appointments have been made available for new patients (1,840 in Bradford City, 1,112 in Bradford District and 556 in North Kirklees). 11,225 additional, non-recurrent UDAs have been commissioned in these areas (5,889 in Bradford City, 3,557 in Bradford District and 1,779 in North Kirklees.

Appointments made available under the scheme:

Area	Appts available - Jan to March	Appts available - April to May
Bradford City	1,764	1,840
Bradford District	1,292	1,112
North Kirklees	1,204	556

We know that patients failing to attend for appointments will mean that the actual numbers of patients seen are less than the numbers of appointments available. Work continues to reconcile the data from LCD and logs of patients seen from the participating practices.

Impact of the scheme on the Urgent Care service in Bradford

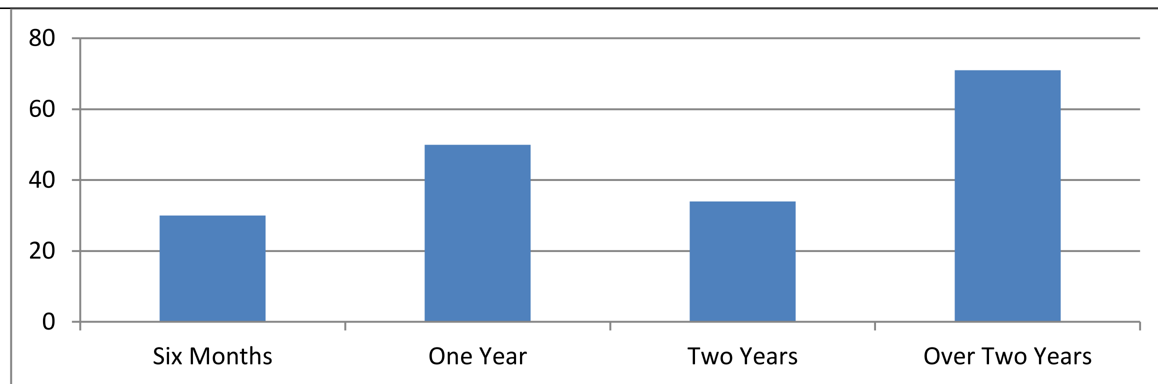
LCD have advised they are seeing increasing levels of activity and that, since the scheme stopped, patients are having to wait around 5 days for an urgent care appointment in Bradford. Evidence of this from LCD is not yet available but will be for September.

Patient Questionnaire:

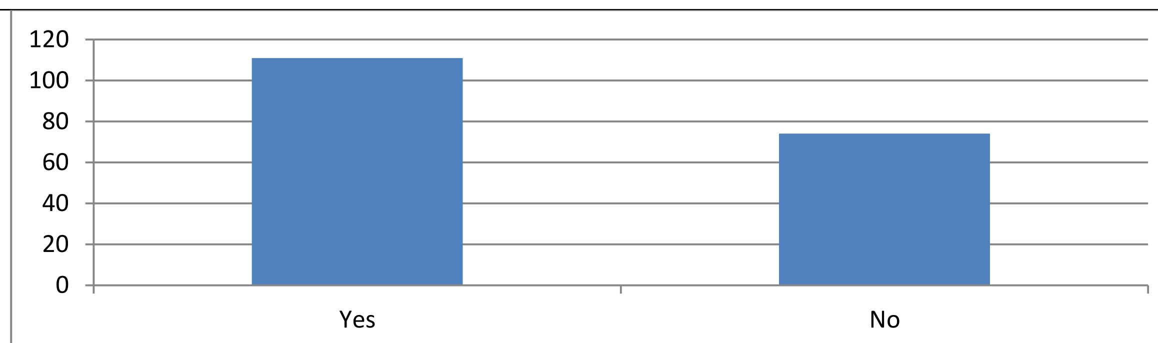
Over the final 6 weeks of the pilot scheme, participating practices were asked to request that patients seen under the scheme complete questionnaires. 185 completed questionnaires were received, the results of which are illustrated below:

Annex 1

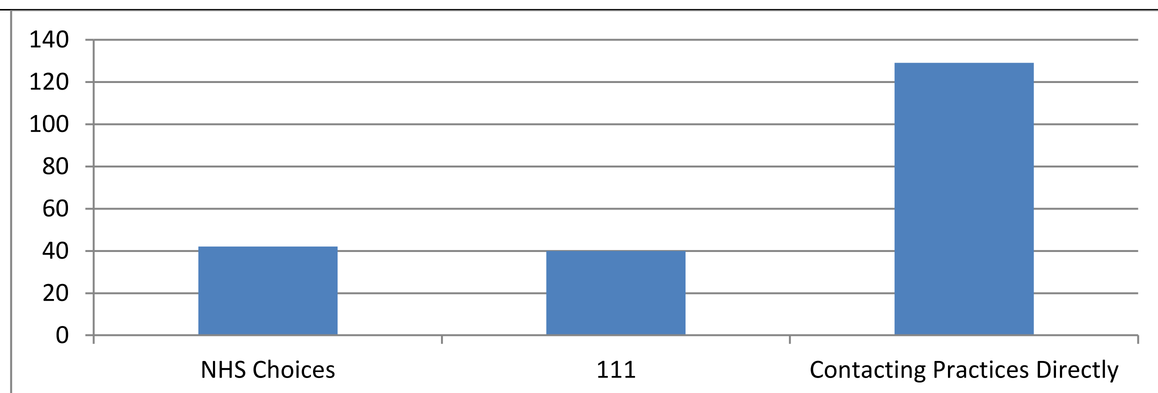
Q1. Roughly how long has it been since your last dental appointment?



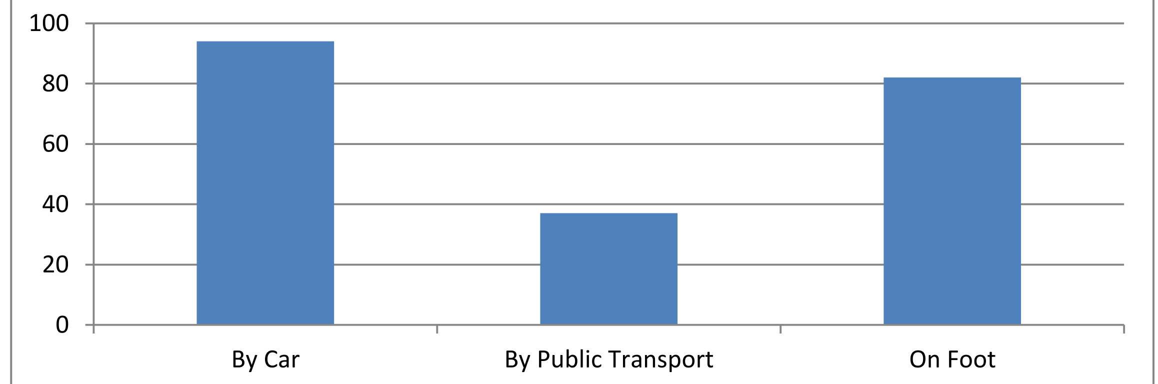
Q2. Have you been trying to register with a dentist in this time?



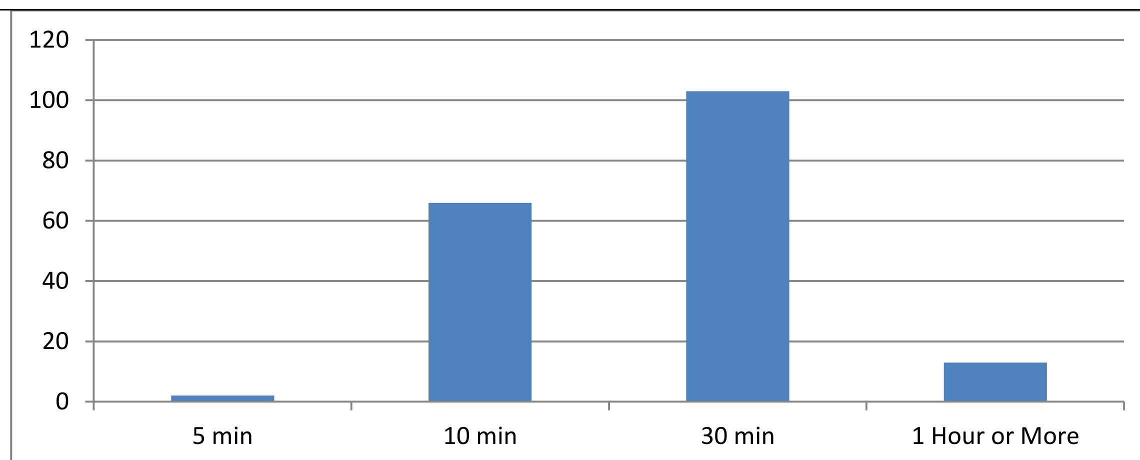
Q3. If yes, how have you been trying to register?



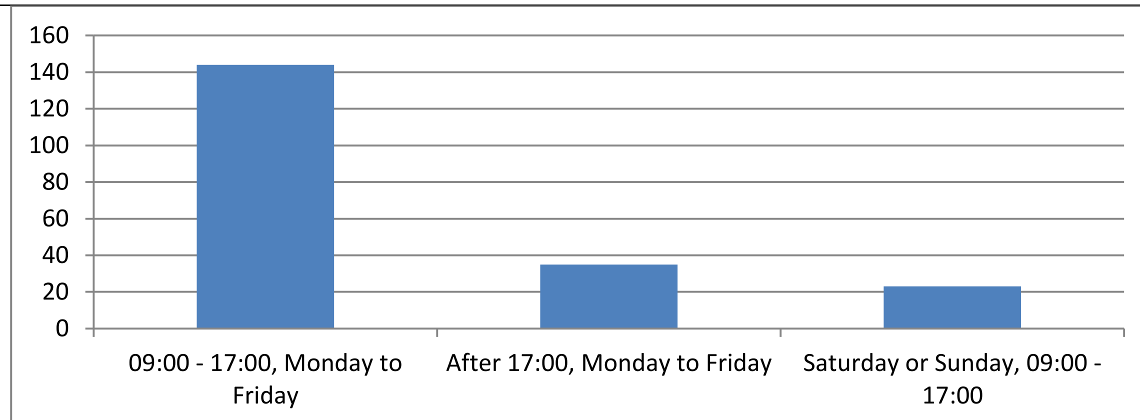
Q4. How do you travel to dental appts?



Q5. Roughly how much time would you be willing to spend travelling to a dental apt?



Q6. When would be most convenient to you attend a dental appointment?



What does good look like and what service do we wish to commission for the patients of Y&H

The ideal situation is that all practices are equal in the access they are offering and they are able to meet clinical need rather than patient demand. A measure to use to achieve this is UDAs per head of population.

Challenges:
Once prioritisation of areas for additional investment has been identified the challenge is how do we address the shortfall?

Recommendation 1: That the main level for the data available to be considered should be subdivided by constituency.

This will gives enough sensitivity in the data to identify local issues without being too small to have any meaning. Local Authority level is too big and lacks that sensitivity as some areas where the access is good masks the areas where access is poor – ie

Kirklees and Dewsbury Ward level is too small as there are many wards that do not have a dental practice within them. However, the agreed list by constituency can be broken down further by Ward so the resources can be directed to the correct areas.

Within these areas the criteria for prioritisation was agreed as:
Primary criteria: The number of UDAs commissioned
Secondary criteria: the number of patients seen (this will be the number of patients from within the constituency seeing a dentist anywhere)
Tertiary criteria: Deprivation by constituency appendix 3

Recommendation 2: Price per UDA £28.30 which is the Yorkshire and Humber average

UDA's commissioned to increase activity – 3 per additional patient. The following figures are based on the 10 constituencies with the lowest UDA per head followed by the lowest percentage of patients seen and finally by the deprivation ranking for the constituency.

UDAs per head of population

This indicator is based on the UDAs commissioned shown against the total population within the area being reviewed. This relates to an amount being commissioned and not to the need of the patients within the area.
Based on UDAs per head of population

- National average 1.65 UDA per head
- Yorkshire and Humber average 1.72 per head
- The 10 areas of lowest commissioning range from 0.8 to 1.17 per head
- Should the aim be to build this figure to the national average of 1.63 at a total cost of £12.4 million

The number of patients seen in the last 24 months

This indicator is based on the number of patients seen in a practice within the area being reviewed – this is regardless of where the patient lives – so they could live in the area in which the practice is based or be travelling in to that area. Based on % of patients seen in the last 24 months

- National average of 55.4%
- Yorkshire and Humber average 57.4%
- To build this to the National average % and using 3 UDAs per head of population the cost will be £11.8m
- Yorkshire and Humber average the cost will be £15.5m

The funding for the increased commissioning will need to come from within the existing dental budget. This funding is tied up in contracts so cannot be easily moved to support this initiative. Underperforming contracts can be renegotiated but this does need to be with the agreement of the provider. If there has been underperformance for 2 years or more gives greater leverage for re-negotiation.

Patient engagement

The patients who will be accessing this service are those who are currently without a dentist so are hard to reach to obtain their views on the service they require. Dental practices will be contacted to get an understanding of the numbers of patients that they have waiting to get access to their services.
Learning from the pilots that were undertaken in both West Yorkshire and North Lincolnshire will also be fed in to the model to assist in developing the service that patients are seeking.

Commissioning Model

The above figures are made on assumptions that will bring services up to either the national or Yorkshire and Humber averages. This may not be appropriate so need to be tested around the number of UDAs required and the percentage of the population that wishes to see a dentist on a regular basis. The amount on investment in an area will determine if another practice should be commissioned or if the additional activity is offered to current providers. This can bring additional challenges.

The contract should be for 3 years to allow time for patients to have the treatment required to ensure they are dentally fit and to give the commissioners the flexibility to change the model if required at a later date.

The majority of dental practices are on GDS contracts – this does not allow the flexibility to time limit the contract (other than where NHSE has terminated the contract) so a contract variation for a GDS contract to be time limited needs to be explored or could an additional PDS agreement be used.

The current average is £28.30 so there are practices with an average both above and below this. As the additional activity is time limited this should be kept separate and offered at the average regardless of the current rate within a practice.
Staging of the contract should be considered where there are high areas of need as the initial treatment needs may be higher than in other areas. This will be limited by the amount of finance that is released either through the renegotiation of contracts after the year end or from contracts that the provider has given notice on

Finance

There have been contracts in previous years that have been renegotiated and two contracts that the provider has recently terminated that has given some finance to start this additional access work.

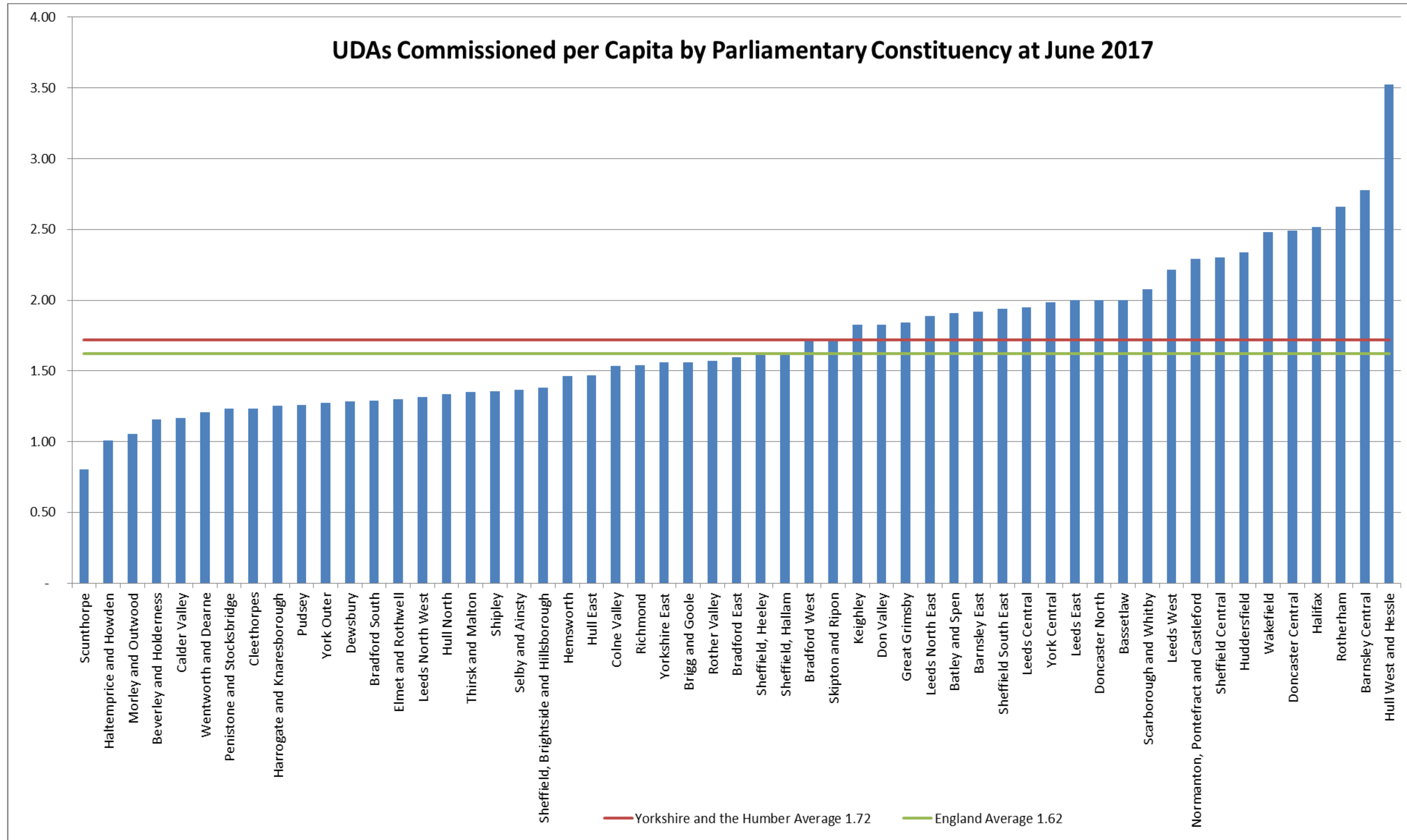
Work is ongoing to review the Urgent Care services and as there are many patients currently accessing out of hours services that should be seen in the General Dental Services any saving released will be available to invest in the General Dental services in the future.

1. The data is prioritised using Constituency as the primary level then subdivided using UDAs per head, number of patients seen in the last 24 months and then deprivation.

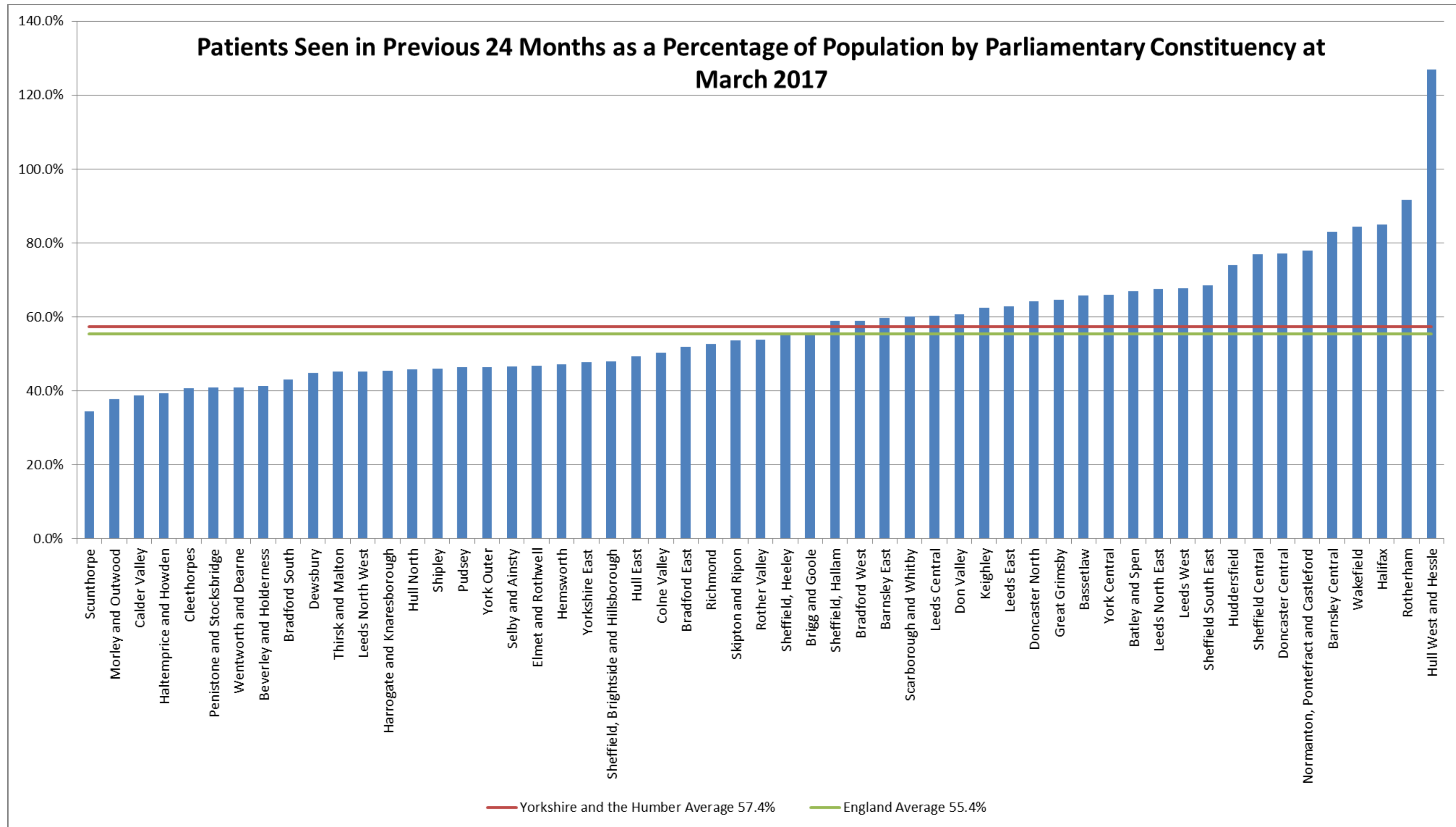
2. The average £ per UDA is used for pricing the service and a staged approach using UDAs per head of population as the measure is used to inform commissioning decisions
3. The commissioning model is to contract on a time limited basis to ensure that the amount of activity commissioned is effective and allow the flexibility to include additional services in future.

Dental Commissioning Team
Summer 2017

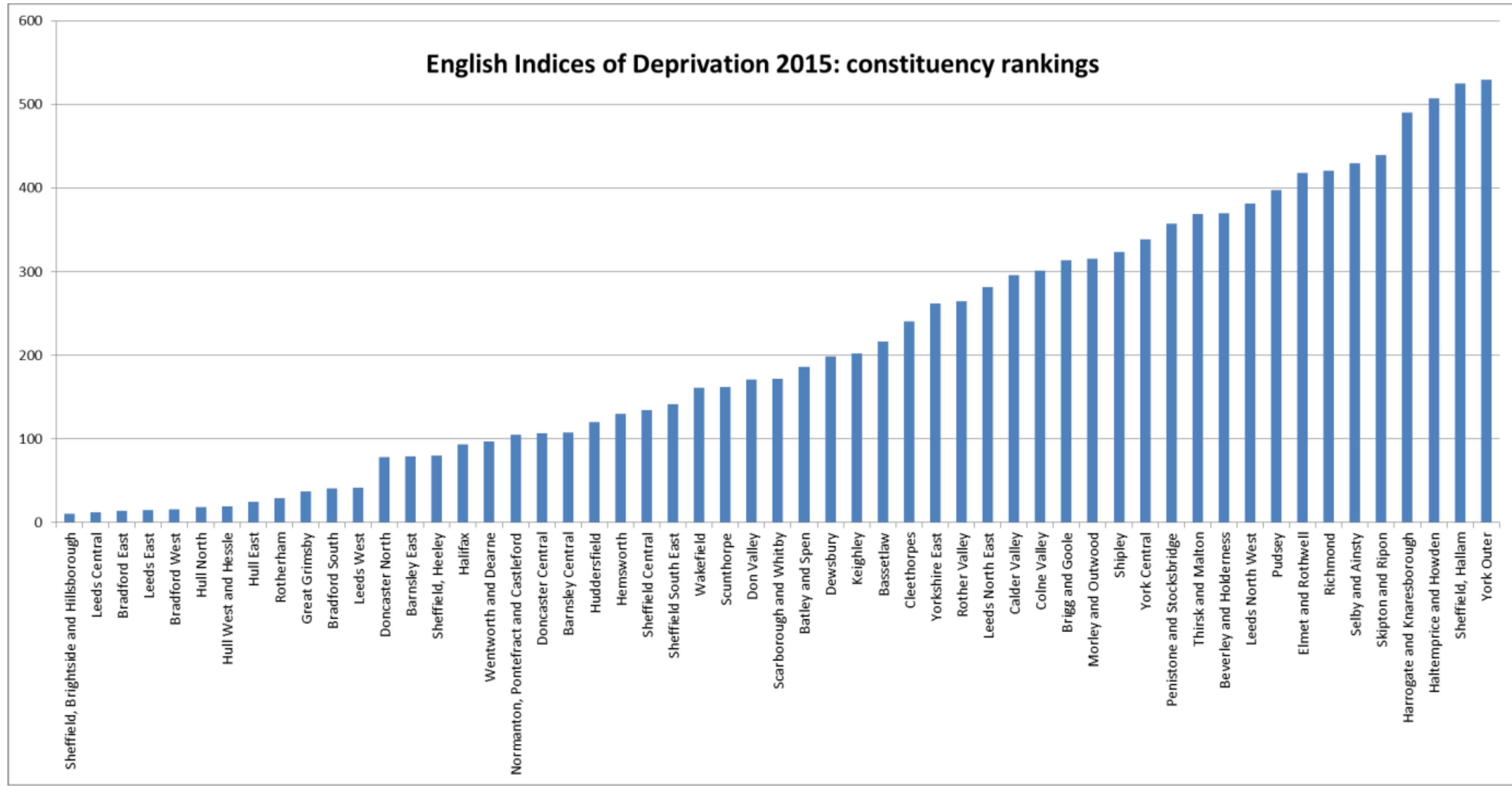
Appendix 1



Appendix 2



Appendix 3



Appendix 4