NHS
Stockport
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE
Public Meeting
Agenda

Date of Meeting:	16 February 2022	Time	From	To
			15:00	17.00
Venue:	Virtual Meeting via Microsoft Teams			

Item No	Agenda Item	Papers	Action required	Lead	Time
1.	Welcome and apologies		To note	Chair	15:00
2.	Notification of Items of Any Other Business		To note	Chair	15:00
3.	Declarations of Interest: (any interest on any issue arising at the meeting that may conflict with agenda items)		To note	Chair	15:00
4.	Minutes from previous meeting (8 December 2021) and Extraordinary meeting (12 January 2022)	Pages 3 - 18	To approve	Chair	15:00
5.	Matter arising and actions:				15:00
	(i) Actions from the previous meeting	Page 19	To approve	Chair	
	(ii) Contract Variation from PMS to GMS – South Reddish Medical Centre	Pages 20 - 26	To approve	GE	
	(iii) Update on Practice Mergers – Next Steps	Verbal	To note	GE	
Standing Items					
6.	Primary Care Updates	Verbal	To note	SWo	15:15

Quoracy requirements – three members of the Committee which must include: The chair or vice-chair of the Primary Committee; The Chief Nursing Officer or Chief Finance Officer; and another Lay Member

Membership – 3 x lay members; Executive Nurse; Chief Finance Officer; Stockport Healthwatch; LMC representative; and NHSE representative.

7.	Chairs' Update: ICS (Integrated Care Systems)	Verbal	To note	Chair	15:20
8.	Notification of any GM updates	Verbal	To note	GM representative	15:25
Primary Care Development					
9.1	Vaccine Programme Update	Verbal	For Assurance	SWo	15:30
9.2	(i) Update on Winter Access Fund (ii) Update from Workshop with Elected Members – Stockport MBC: Primary Care Access	Verbal Verbal	To note To note	GE GE	15:35
9.3	Primary Care Provision for Asylum Seekers and Afghan Evacuees in Stockport	Pages 27 - 31	To note	GMi	15:55
9.4	GP Retainer Scheme Application – Chadsfield Medical Practice	Pages 32 – 35	To Approve	GE	16:05
Performance					
10.1	(i) Stockport Quality Update Report (ii) Primary Care Quality Report	Pages 36-38 Pages 39 - 44	For assurance	AR	16:15
10.2	PCCC Finance Report	Pages 45 - 49	For assurance	DD	16:35
Any Other Business:					
11.		Verbal	To note	Chair	16:50
Date and time of next meeting:					
	Wednesday 13 April 15:00 – 17:00, Microsoft Teams Meeting				

Quoracy requirements – three members of the Committee which must include: The chair or vice-chair of the Primary Committee; The Chief Nursing Officer or Chief Finance Officer; and another Lay Member

Membership – 3 x lay members; Executive Nurse; Chief Finance Officer; Stockport Healthwatch; LMC representative; and NHSE representative.

NHS
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Primary Care Commissioning Committee (Public)
DRAFT MINUTES of the Virtual meeting held on Wednesday 8 December 2021
15:00 – 16:55 pm, Microsoft Teams

Present:

Peter Riley	Lay Member for Primary Care Commissioning, (**Chair)**
Michael Cullen	Chief Finance Officer (CCG)
Gail Henshaw	Senior Primary Care Manager, NHS England/Improvement
Don Phillips	Lay Member for Patient and Public Involvement (CCG)
Anita Rolfe	Executive Nurse (CCG)
Paul Stevens	Local Medical Council (LMC)
Phillip Winrow	Lay Member for Audit and Governance (CCG)

In attendance:

Dr Javaid Ali	Primary Care Clinical Lead, Workforce and Women & Children's Clinical Lead (CCG)
David Dolman	Deputy Chief Finance Officer (CCG)
Gale Edwards	Commissioning Lead, Primary Care (CCG)
Paul Lewis-Grundy	Deputy Director of Corporate Affairs (CCG)
Gillian Miller	Associate Director of Commissioning (CCG)
Melissa Maguinness	Director of Integrated Commissioning (CCG)
Alison Newton	Corporate Support Administrator (Minutes) (CCG)
Kimberly Roberts	Primary Care Lead (CCG)
Dr Simon Woodworth	Medical Director (CCG)

Apologies:

David Kirk	Stockport Healthwatch
Dianne Oldfield	Senior Management Accountant, (CCG)

Minute	Action
1. Welcome & Apologies	
The Chair welcomed everyone to the meeting. Apologies were received as listed above and for late arrival from D Dolman. The meeting was quorate.	
2. Notification of Any Other Business	
There were no items of other business declared.	
3. Declarations of Interest	

Members were reminded of the need to declare any interest they may have on issues arising during the meeting that may conflict with the business of the Committee. Dr S Woodworth, Medical Director declared an interest as GP Partner at Beech House Medical Practice and Non-Executive Member of Stockport Local Medical Committee (LMC) in all items on the Agenda that related generally to all GP Practices and GP's respectively. In accordance with the CCG's Conflicts of Interest Policy S Woodworth could participate in the discussions. Dr J Ali declared an interest as a Locum GP working in Stockport practice. P Stephens joined the meeting. P Stephens declared that he worked for the LMC (Local Medical Committee) but he did not work directly with any specific practice in Stockport. G Henshaw referred to item 9.4 on the agenda and declared an interest as a patient at one of the practices involved. The Chair accepted the declarations; as there were no direct interests in any of the decisions to be taken, these members could participate in discussions. The Chair reminded members to declare an interest during the meeting if any of the discussions had a direct impact on their work in general practice.	
4. Minutes from previous meeting (13 October 2021)	
The minutes of the previous meeting held on 13 October 2021 were received. **RESOLVED:** **That the minutes of the previous meeting held on 13 October 2021 be approved as a correct record.**	
5. Action Log from Previous Meeting	
The Chair presented the action log and the following updates were given at the meeting. MA29: The CCG Policy on Practice closures, in line with national and local specifications had been reviewed and discussed with the LMC. A copy of the Policy was circulated with the papers. G Edwards briefed on the process for reviewing this Policy and an agreement that practices would inform the CCG when they planned to close for half a day but there remained the requirement to obtain approval from the CCG for regular half day closures in accordance with the national DES (Direct Enhanced Services) for primary care. This item had been discussed several times. **RESOLVED:** **That Primary Care Commissioning Committee Approve the CCG Policy on Practice closures.**	

Action completed. **Remove from the log.** MA200: G Miller advised that the CCG Policy on Practice closures would be circulated at the next PIN (Partnership Involvement Network) for information with a view to closing this action at the next meeting. **Remove on the log.** **RESOLVED:** **That the actions arising from previous meetings and the assurance given, including the updates provided at the meeting and outlined above, be noted.**	
Standing Items	**Action**
6. Primary Care Updates	
S Woodford highlighted the challenges faced by primary care. There had been an indicative ballot issued by the BMA (British Medical Association) regarding the requirement for GPs to see all patients face to face. It had been acknowledged that it was not safe for all patients to travel whilst ill to a practice when a telephone or video appointment could take place. Discussions continued regarding supporting asylum seekers on a longer-term basis. Members were assured that medical cover was being provided to support this vulnerable cohort of patients. A letter had been published to primary care regarding reducing activity to focus on the vaccination programme to reduce the impact of Omicron. D Phillips questioned whether patient involvement would be at a PCN (primary care network) level or via Viaduct Care going forward. S Woodford explained that engagement with patients was now via network groups as practices worked more collaboratively in each area. P Stephens assured the meeting that practices continued to liaise with patients, including the use of surveys or network champions for example.	
7. Chairs' Update: ICS (Integrated Care Systems)	
The Chair reported that the Chairs of Primary Care Commissioning Committees across GM (Greater Manchester) continued to meet with the Strategic Lead for ICS in GM. A lot of work was taking place to transition to an ICS, and this would continue after 1 April 2022. It was noted that a lot of work was taking place at CCG level, including regular briefings, to support staff during the transition. In response to a question regarding the governance of the transition, G Henshaw advised that there was a task and finish group (contract and commissioning) that was overseeing this work including the safe transition of contracts and services. This work would also include considering the population needs for each area and how this would be managed. A Rolfe suggested setting up a meeting within the CCG to provide assurance to this Committee and Governing Body on due diligence. P Lewis-Grundy	

confirmed that all the CCG functions would be transferred from 1 April 2022 into the ICB (Integrated Care Board) and this would include Primary Care Commissioning and the delegation agreement between NHS England and the CCG. P Winrow assured members that the CCG Audit Committee were also reviewing due diligence for the safe handover of items and issues to the new ICS. P Lewis-Grundy provided further assurance on the process for close down of CCG functions and transition to an ICS.	
8. Notification of any GM (Greater Manchester) updates	
G Henshaw outlined the details of the letter circulated to primary care on 7 December 2021 regarding temporary GP changes to support the Covid-19 vaccination programme to include: • Suspension of specific QOF (Quality and Outcomes Framework) indicators. • Investment and Impact Fund (IIF) indicators – suspended apart from Flu. • Enhanced PCN support. • Routine CQC tests suspended. Members were briefed on the Winter Access Fund (Winter Access Fund) and the allocation for GM (Greater Manchester), to increase and optimise capacity. G Miller advised that local plans were being developed, working with PCN Clinical Directors, to invest this funding locally to support general practice. An update on this work had been discussed at the CCG Finance, Performance and Delivery Committee. The Chair thanked members for their updates.	
Primary Care Development	**Action**
9.1 Vaccine Programme Update	
A Rolfe briefed the meeting Covid vaccination data and drew attention to several key points: • There continued to be an `Evergreen Offer' (Pharmacy) to support cohorts 1 – 12. • The Health and Care Support Worker vaccination programme at SFT (Stockport Foundation Trust) had ended. • There were a range of places offering vaccinations including walk-ins, such as the One Stockport Hub and Trinity Methodist Church to facilitate access for as many as people as possible, whilst reducing inequality. • Over 500 thousand vaccinations had been issued to Stockport residents. • 48.6% of those aged 12-15 years had received a first dose. • Trinity Methodist Church were vaccinating seven days a week with an average of 1000 vaccines a day. • The PCNs who were delivering services to the Refugees and Asylum	

seekers in Stockport had received support with the vaccination of this patient cohort. • All GPs continued to administer vaccines to the housebound. • The National Booking site continued to offer appointments. • The CCG PMO continued to support all primary care providers with staffing resource. A Rolfe advised that discussions were taking place regarding opening a second delivery site for pharmacy (Medichem) and accessing use of the military to provide additional resource. It was anticipated that the military would assist the PCNs who need support with vaccinating their housebound patients. A request had been submitted to NHS England to clarify the requirement for people to wait 15 minutes after the vaccination if they had received a first and second dose of Pfizer to support the flow in the clinics. All PCNs had been approached with regard to the provision of the Stockport Hub pop up, with the opportunity for all PCNs to provide a clinical lead for each session. Six of the PCNs had declined this offer, with one GP practice confirming they would support. A community pharmacy was also supporting the Hub. However, all PCNs had confirmed their 'opt in' to support the next phase of the vaccination programme. A further discussion took place on the progress of the vaccination programme. A Rolfe highlighted the tremendous support provided by volunteers within the community – this had a significant impact in supporting the delivery of the vaccination programme. D Phillips sought clarification on Trinity Churches' capacity to deliver vaccines; A Rolfe clarified that it had the capacity to delivery 1k vaccines a day but had surpassed 8k in a week recently. G Henshaw added that the smaller sites had capacity to issue 100 vaccines a day and medium sites 350 vaccines a day. It was noted that across all the sites, 11-112k vaccines a week were being issued across Stockport. **RESOLVED:** **That Primary Care Commissioning Committee note the update on the Covid vaccination programme.**	
9.2 GP Masterclass update	
S Woodworth reported on the recent GP Masterclass that had taken place two weeks ago. The virtual event, including interactive workshops had been well attended. The Chair thanked S Woodworth for the update.	
9.3 Update on PCN (Primary Care Network) DES (Direct Enhanced Service)	
G Edwards provided an update on the PCN DES and the focus for the next 12 months. It was noted that the report had been written prior to the issue of the letter circulated to primary care on 7 December 2021.	

Due to the current pressures in general practice, NHS E had delayed introducing new service specifications until 2022/23.

The focus for primary care would include prevention and tackling health inequalities, improved patient access, proactive primary care, improved outcomes for patients on medication and helping create a more sustainable NHS.

An update on the changes to the PCN DES would be provided at the next meeting.

G Miller advised on the allocation of funding to support practice services and workforce.

P Stephens sought clarification on those practices that did not sign up to phase 3 of the vaccination programme – would they continue with QOF and IIF. It was noted that QOF changes would apply to all practices regardless of whether they were participating in phase 3 of the vaccination programme; an explanation was provided on how this would be implemented.

The Chair highlighted the importance of ensuring that primary care could continue to deliver services to support the population. G Edwards reiterated that practices were still required to provide services and these included health checks for Learning Disability (LD) patients.

Members were assured that the CCG would continue to work with Viaduct Care and PCNs to ensure a smooth transition as determined locally and would support PCNs with available data on health inequalities.

RESOLVED:

(i) That Primary Care Commissioning Committee note the update on PCN (Primary Care Network) DES (Direct Enhanced Service).

(ii) That Primary Care Commissioning Committee note the funding and additional requirements for PCNs as set out in the Investment and Impact Fund (IIF).

9.4 Practice Merger of Marple Cottage Surgery and The Guywood Practice

G Edwards advised on the proposal to formally merge Marple Cottage Surgery (a PMS – Primary Medical Service contract) with The Guywood Practice (a GMS – General Medical Service contract) into a partnership operating under one GMS contract.

The merger would require PCN (primary care network) membership changes with The Guywood Practice moving away from the Werneth PCN. This would result in the PCN list size being slightly below the recommended 30k. The CCG had met with the Clinical Directors for the PCNs and was assured that Werneth PCN would be sustainable to continue to deliver against the DES.

It was pointed out that this would also impact on care homes as GPs were aligned to a home. The CCG was assured that there would a positive impact

for patients as it provided the practices with a longer-term sustainable future. Patients would be able to access services at both sites.

There had been extensive engagement with registered patients at both sites on the proposed merger.

The CCG sought further assurance that agreements were in place for the use of the branch premises with the landlord and the merged practice in order that there was no impact on the provision of primary medical services for the patients currently registered with The Guywood Practice. A discussion took place on this issue – further discussions would need to take place as to the format of the assurance to be received and whether it would be a lease agreement. Members were advised on the difference between a PMS and a GMS practice. P Lewis-Grundy advised that the proposal could be approved subject to lease arrangement being in place. It was pointed out that due to the complexities involved, a lease arrangement would not be possible for the next meeting and this issue required action now as it impacted on patients and to safeguard the future viability of a practice.

The Chair highlighted the importance of making it clear to patients that they would have dual access to both sites and requested an update on this issue at the next meeting.

P Winrow questioned whether engagement had taken place using different formats as not all patients would be able to use a mobile or a computer. Notices had been put up in the practices, there was a link to a survey on the website, a zoom meeting had taken place involving 25 people and the issue had been included in a newsletter. It was pointed out that patients should not notice anything different as the same clinicians would be in place and there would also be increased access to ANPs (Advanced Nurse Practitioners) across two sites.

D Dolman joined the meeting.

In response to a question about travelling between the sites, there was two miles between the sites and patients would only be expected to travel to access a service that was not previously available at their site.

In response to a further question on the timeline for the merger, if the proposal was approved it was likely to take place towards the end of April 2022.

Dr Ali highlighted the challenges practices faced in recruiting GPs or Locum GPs and for a single-handed practice, this placed them under increasing pressure. A brief discussion took place regarding the rights of the GP on another site. This issue would be discussed outside of this meeting as it related to individual GPs.

RESOLVED:

(i) That Primary Care Commissioning Committee note and approve the contractual merger of the two practices onto one contract with a single registered patient list, subject to:

a. Marple Cottage Surgery agreeing to a contract variation

to move onto a GMS contract in preparation for the merge. **b. A lease arrangement being in place with NHS Property Services or assurance on the rights for the new merged practice to use The Guywood premises post-merger.**	
9.5 Update on Asylum seekers: GP Registration	
G Miller updated the meeting on the ongoing discussions that were taking place to secure full GP registration for Asylum seekers. An update would be provided at the next meeting.	
Performance	**Action**
10.1 Quality Report	
A Rolfe present a report on screen; K Roberts drew members' attention to several key highlights: • There was continued focus on SMI (Severe Mental Illness) and LD (Learning Disability) patients – the target figure for health checks had increased from 60 to 75%. • The data for these health checks had been analysed and the target had been achieved for LD health checks but there remained further work to take place. • The target for SMIs had not been achieved due to ongoing pressures - this was a similar position across GM and nationally. It was difficult to benchmark as not all practices had achieved all six components so there was a focus on three indicators (blood glucose, blood lipids and alcohol). Good practice was shared across PCNs. • There was a LD Nurse available to support practices with these checks. • The CCG BI (Business Intelligence) team were collating data monthly for SMI and LD health checks. • Targeted discussions would take place with practices where appropriate. • Mental Health practitioners were being recruited via ARRS (Additional Roles Reimbursement Scheme) to support practices. D Phillips questioned how the outcomes for these patients were measured. K Roberts explained that PCNs had care coordinators in post that work with these patients to support them in accessing services and signposting them to several public health interventions. S Woodworth highlighted the importance of these care coordinators being aware of the impact of SMI on a patients' physical health. A discussion took place on the work taking place involving partners across the system to reduce health inequalities and support those patients that were reluctant in accessing health services.	

RESOLVED: **That Primary Care Commissioning Committee note the Quality Report update.**	
10.2 Quality Report – Learning Disability (LD) health checks	
As covered under item 10.1.	
10.3 PCCC Finance Report – H2 Plan 2021/22	
D Dolman presented the H2 (second part of the year) plan for 2021/22 and highlighted the key points: • In the absence of a finalised plan and ability to upload H2 budgets there had been no Month 7 reporting. • The indicative plan presented at the October meeting had since been revised to include a £22.556m allocation, a decrease due to an efficiency target of £0.604m included in the revised figure. • The LCS (local commissioned services) would be delivered via remaining non-recurrent flexibilities and improvements against planning assumptions. • Premises cost reimbursement – costs would be £0.127m less than originally planned but there was an increase in Locum costs. P Stephens highlighted that NHS Property Services circulated a schedule of charges each year including changes for each practice and there were ongoing discussions regarding some of the charges. • The CCG would implement the national guidance for the second half of the financial year and would work with primary care colleagues to implement the recommendations of the LCS review. **RESOLVED:** **(i) That Primary Care Commissioning Committee approve the Primary Care Delegated Commissioning expenditure plan for H2 2021/22.** **(ii) That Primary Care Commissioning Committee note that in the absence of a finalised plan and ability to upload H2 budgets there no M7 reporting. Budgets were uploaded by the deadline of 26 November 2021.**	
ANY OTHER BUSINESS	
11. There were no other items of business to discuss.	
Meeting Governance	
Date and time of next meeting:	

The next meeting of the Primary Care Commissioning Committee would take place on Wednesday 16 February 2022 15:00 – 17:00 pm, Virtual Meeting. The meeting closed at 16:55 pm	

NHS
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Primary Care Commissioning Committee (Public)
DRAFT MINUTES of the Extraordinary meeting held on
Wednesday 12 January 2022
16:00 – 17:00 pm, via Microsoft Teams

Present:

Peter Riley	Lay Member for Primary Care Commissioning (**Chair)**
Michael Cullen	Chief Finance Officer (CCG)
Gail Henshaw	Senior Primary Care Manager, GMHSCP
Maria Kildunne	Chief Executive, Healthwatch Stockport
Don Phillips	Lay Member for Patient and Public Involvement (CCG)
Anita Rolfe	Executive Nurse (CCG)
Paul Stevens	Executive Officer, Local Medical Council (LMC)
Phillip Winrow	Lay Member for Audit and Governance (CCG)

In attendance:

Gale Edwards	Senior Commissioner, Primary Care (CCG)
Dr James Higgins	Clinical Director, Tame Valley PCN
Paul Lewis-Grundy	Deputy Director of Corporate Affairs (CCG)
Nora Hussein	Corporate Affairs Manager (CCG)
Gillian Miller	Associate Director of Commissioning (CCG)
Melissa Maguinness	Director of Integrated Commissioning (CCG)
Alison Newton	Corporate Support Administrator (Minutes) (CCG)
Dianne Oldfield	Senior Management Accountant, (CCG)
Kimberly Roberts	Primary Care Commissioning Lead (CCG)
Dr Simon Woodworth	Medical Director (CCG)

Apologies:

Andrea Green	Chief Accountable Officer (CCG)
David Dolman	Deputy Chief Finance Officer (CCG)
David Kirk	Stockport Healthwatch

Minute	Action
1. Welcome & Apologies	
The Chair welcomed everyone to the meeting.	
2. Declarations of Interest	
Members were reminded of the need to declare any interest they may have on issues arising during the meeting that may conflict with the business of the Committee.	

Dr S Woodworth, Medical Director declared an interest as a GP Partner at Beech House Medical Practice and as a Non-Executive Member of Stockport Local Medical Committee (LMC). It was noted that the practices included on the agenda were not part of the same PCN (Primary Care Network) as his practice.

Dr J Higgins declared an interest as a GP and Clinical Director of Tame Valley PCN. Dr J Higgins noted that while he had an existing relationship with the area, his focus as a GP was to ensure patients were able to access health care.

P Lewis-Grundy advised that the remit of this Committee was in relation to the GP contract and whilst there was no financial interest in item 3 on the agenda, there was an in-direct interest being a GP in Stockport.

P Stevens declared that he worked for the LMC (Local Medical Committee) that represented practices and noted his involvement with Tame Valley PCN.

In accordance with the CCG's Conflicts of Interest Policy J Higgins, P Stevens, and S Woodworth, could participate in the discussions.

3. Proposed Merger of Heaton Norris Health Centre and South Reddish Medical Centre

G Miller outlined the background to the proposed merger of Heaton Norris Health Centre and South Reddish Medical Centre.

The CCG had received a merger application from the above-named practices, to form one partnership operating under one GMS (General Medical Services) contract.

The CCG had ensured that the regulations for a merger had been adhered to and options for future arrangements had been considered. The options available included:

Option A: To undertake a procurement exercise.
Option B: A dispersal of the registered patient list.
Option C: To consider the proposed merger application.

An Equality Impact Assessment (EIA) had been carried out (Appendix 1). Consideration had been given to the resilience and sustainability within Tame Valley PCN, particularly on the retention of clinical staff due to current pressures within primary care. There had been an increasing number of closures of single-handed practices.

Several patient engagement sessions had taken place. It had been acknowledged that there would an impact for those patients reliant on public transport.

G Edwards advised on the requirements within the delegated agreement with regard to primary medical services and assured the Committee that patients would have continued access to a range wide of services for patients.
The Committee were informed that patients and stakeholders were engaged in accordance with national and local primary care directions, taking into account the resilience and capacity of other local practices within the network

and the current challenges of recruitment. Practice staff and patients had shown support for continuity of care and access to a wide range of high quality care.

In order to continue providing primary health care to patients registered with South Reddish Medical Centre the preferred option to the CCG was option C.

M Kildunne sought assurance that the digitally excluded patients had been given the opportunity to provide feedback either by letter or telephone. K Roberts explained that the initial engagement had relied on notices in the practice, promotion through the prescriptions and comments box and an email to all registered patients who provided an e-mail address. There had also been social media updates.

Members were reminded that this was the start of the process and further engagement would take place with patients via targeted work.

M Kildunne highlighted that during Covid-19, many patients had been unable to visit the practice, particularly vulnerable patients. K Roberts commented that individual letters had not been sent out at this stage, however the South Reddish Medical Centre had been one of the first sites to offer vaccinations in Stockport therefore there had been an increased footfall at the practice. M Kildunne stated that she would not be assured until vulnerable patients had received a letter or been directly contacted about the proposed changes.

D Phillips questioned the impact on staff at both practices. G Edwards responded that the practices had engaged with their staff, acknowledging that extra travel could be required. The Committee were informed that it would affect one employee and that all other staff were supportive of the changes. The two practices had already started to consider how to bring the two teams together. A merger would provide opportunities for a wider staff base.

P Stephens reiterated that there had been increased footfall at practices during the Covid vaccination programme, including the flu programme. The GPs from both practices had been supportive of the proposal as well as staffing within the practices.

P Winrow questioned whether the resignation from the GP would be withdrawn if the merger was approved. G Edwards confirmed that the resignation of the GP would be withdrawn if the merger was to proceed and progress within the necessary six-month period. P Winrow advised that this be considered as a possibility for any future mergers and that the retention of a GP should also be considered, as well as the practice's long-term viability.

P Winrow asked whether the six-month timescale was achievable. It was explained that if the merger was approved, a schedule would be put in place for IT to make the necessary adjustments, commencing late April 2022.

Dr J Higgins highlighted that the reason for the resignation was that a single-handed GP had become unsustainable. The Committee were informed that GP had agreed to stay on if they were part of a larger partnership that would provide cover for her patients.

In response to a question regarding the ownership of the current site in Reddish, G Edwards responded that this was owned by NHS Property Services and the Trust (SFT – Stockport NHS Foundation Trust) were the current leaseholders of the additional rooms. Any future discussions regarding use of the site would need to involve the current leaseholders.

Dr J Higgins pointed out that PCNs had taken on additional staff via the ARRS (Additional Roles Reimbursement Scheme) including pharmacists, care coordinators, and physiotherapists for example and it was a benefit to patients to have the provision and space for these additional roles within their local community.

D Phillips asked if there had been any problems progressing with this proposal. The Committee were informed that regardless of the timescales, the CCG would follow the required regulations including engagement with wider stakeholders.

M Kildunne reiterated that further assurance would be required to ensure the digitally vulnerable were given the opportunity to participate in the engagement process. P Stevens reported that he had received no concerns from other practices with regards to the proposals and that virtual meetings had taken place that had included a patient and their carer. Word of mouth was also used through those patients that did visit the practice, or could access information online.

K Roberts reiterated that the engagement process would continue, and this could include face to face meetings once restrictions had lifted. A Rolfe assured M Kildunne that there would be further engagement.

It was questioned whether patients could travel to another practice in the locality if they could not travel to a new practice. Members were referred to the map included within the paper, outlining the practice boundary. Family Surgery (next door to South Reddish Medical Practice) had the capacity to take on additional patients and Park View in Reddish. It was added that the GP's practice had originally been on the site and had moved next door and so there would not be a significant change for patients. Additional services could be accessed at the Heaton Norris site and this is where the travel element would be impacted.

A discussion took place on the issues raised. It was commented that it could change the performance indicators whilst the transition took place if the proposal was approved but this would be aggregated over time.

The Chair thanked Dr J Higgins for his attendance; Dr J Higgins left the meeting.

The Chair requested that non-members step out of the meeting, switching their cameras and microphones off, whilst members voted on the proposal.

G Edwards, P Lewis-Grundy, N Hussein, G Miller, M Maguinness, D Oldfield, K Roberts and Dr S Woodworth left the meeting.

P Riley, M Cullen, G Henshaw, M Kildunne, D Phillips, A Rolfe, P Stevens, and P Winrow remained on the call.

A vote was taken on the proposal to merge South Reddish Medical Centre and Heaton Norris Health Centre. M Kildunne abstained from the vote.

RESOLVED:

(i) That Primary Care Commissioning Committee NOTED and APPROVED the contractual merger of the two practices onto one contract with a single registered patient list, subject to:

South Reddish Medical Centre AGREEING to a contract variation to move onto a GMS contract in preparation of the merger.

G Edwards, P Lewis-Grundy, N Hussein, G Miller, M Maguinness, D Oldfield, K Roberts and Dr S Woodworth were invited to re-join the meeting.

Members were referred to the next steps to be taken following the decision.

4. Vaccination Programme Update

A Rolfe highlighted the success of the Vaccine programme in Stockport. It was brought to the Committee's attention that there would be a handover of Senior Responsible Officer (SRO) duties from herself as Executive Nurse and Deputy Accountable Officer for Stockport CCG, to Ben Fryer, Consultant in Public Health, Stockport MBC.

The focus of the handover would be the CCG's quality functions. It was pointed out that the CCG Executive Nurse and the CCG Quality team would continue to support the delivery of the vaccine programme across Stockport.

A Rolfe assured the Committee that there would be no risks involved within the handover as it involved the same team that had been part of the programme throughout the whole pandemic. The Committee were informed that it had been a system response on delivery of the programme involving multiple partners.

The handover should have taken place during December 2021 however, due to the Omicron variant and changes in guidance to encourage as many people to be vaccinated as possible by the end of the year, it was agreed to defer the handover until January 2022.

Dr Woodworth congratulated the team, including primary care on the delivery of a successful vaccination programme.

In response to another question, it was noted that over 640 thousand vaccines had been delivered in Stockport over the last 12 months. A Rolfe, as current SRO, thanked all members of the Stockport population that attended their vaccine appointments and to staff in GP practices, community pharmacies, the Trust, CCG, Stockport MBC team and volunteers, Viaduct Care, St John Ambulance, the military and all other volunteer organisations that had played a crucial role in sustaining delivery of the vaccine programme.

A discussion took place around the current rates of infection and impact on hospital beds at Stockport NHS FT. It was highlighted that whilst the number of people requiring intensive care due to Covid had significantly reduced, there remained a high number of patients on Covid wards. **RESOLVED:** **That Primary Care Commissioning Committee NOTED the update on the change of Senior Responsible Officer for the Vaccination Programme to Ben Fryer (Stockport MBC) and on the Covid vaccination programme.**	
ANY OTHER BUSINESS	
5. There were no other items of business to discuss.	
Meeting Governance	
Date and time of next meeting:	
The next meeting of the Primary Care Commissioning Committee would take place on Wednesday 16 February 2022 15:00 – 17:00 pm, Virtual Meeting. The meeting closed at 17:00 pm.	

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PRIMARY CARE COMMISSIONING - ACTION LOG - 8 December 2021

Action Number	Meeting Date	Agenda Item	Current Status	Action Description	Action Lead	Target Date	Comments
MA200	16.06.21	5	In progress	To engage on Practice Policy re: Practice Closures - liaise with Communications team	GMI	Mar-22	Approved Policy on Practice Closures to be circulated at the next PIN meeting for information

Contract Variation from PMS to GMS - South Reddish Medical Centre

Report To (Meeting):	Primary Care Commissioning Committee		
Report From (Executive Lead)	Anita Rolfe		
Report From (Authors):	Gale Edwards		
Date:	16th February 2022	**Agenda Item No:**	5
Previously Considered by:	Not previously considered		

Decision	**x**	**Assurance**		**Information**	**x**

Conflicts of Interests	
Potential Conflicts of Interest:	Any attendees of the meeting that are associated with general practice or a member practice within the CCG

Purpose of the report:

The purpose of the report is to request the Primary Care Commissioning Committee (PCCC) approval for a contract variation for South Reddish Medical Service from a Personal Medical Services (PMS) to General Medical Services (GMS) in accordance with the NHS General Medical Services (GMS) regulations and NHSE Primary Medical Services (PMS) policy and guidance.

Key points (Executive Summary):

- In January 2022 the PCCC approved the merger of two practices South Reddish Medical Centre (PMS) with Heaton Norris Health Centre (GMS) to create one partnership operating under one GMS contract, with a single registered list of patients. Subject to: South Reddish Medical Centre agreeing to a contract variation to move onto a GMS contract in preparation for the merger.

- On the 26th January 2022 the contract holder of South Reddish Medical Centre requested a variation in her Personal Medical Services (PMS) contract to be changed to a General medical service (GMS) contract as from the 1st March 2022 in order for the two practices contracts planned merger to proceed

- The report considers the differences and similarities of the two contract types and conclude that there is no significant impact to both the provider and commissioner in varying this contract. Patient service provision will not be impacted.

- Once the contract variation has been approved and enacted the approved merger of the two practices will be able to proceed within the required regulations and planned timescales.

- There is no financial impact to the Commissioner as a result of this contract variation as funding arrangements for PMS and GMS contracts have been aligned following the PMS premium review process undertaken in 2015/16.

Recommendation:

It is recommended that the Primary Care Commissioning Committee:

- **R**eview the content of this report considering the points raised in relation to the contract variation

- **A**pproved the contract variation effective from the 1st March 2022 for South Reddish Medical Centre to move onto a GMS contract from an existing PMS contract. Noting that this is required as part of the further preparation for the merger of South Reddish Medical Centre and Heaton Norris Health Centre

- **N**ote and Approve the next steps

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Aims and Objectives:

Which Corporate aim(s) is / are supported by this report:	• Start well • Live well • Age well • Die well • Lead well
Which corporate objective(s) is / are supported by this report:	The following objectives are: - • Continuously improve the quality and safety of care • Support people to remain healthy and independent as long as possible • Improve early identification of health conditions • Reduce health inequalities faster • Empower people to live well & proactively manage long-term conditions • Support people to remain healthy and independent as long as possible • Financial balance across the system • Patients and their families will receive high quality support at the end of life • Implement new and sustainable model of care • Ensure people can access safe, high quality care when necessary

Risk and Assurance:							
List all strategic and high-level risks relevant to this paper	None identified						
Consultation and Engagement:							
Patient and Public Involvement:	Contractual changes with no impact to service provision and no patient and public involvement required.						
Clinical Engagement:	Engagement with PCN Clinical Director and CCG Clinical Lead – required as part of merger progressing and PCN in support of merger						
Potential Implications:							
Financial Impact:	Non-Recurrent Expenditure	None					
	Each cost pressure has been identified in the options considered						
	Expenditure included within CCG Financial Plan	N/A as no financial difference in contract type					
Performance Impact:	Performance impact is considered low as patients will continue to have access to services irrespective of contractual type						
Quality and Safety Impact:	No impact as service provision the same for both GMS and PMS contracts						
Compliance and/or Legal Impact:	Stockport CCG needs to act within the terms of the Delegation Agreement with NHS England undertaking the functions relating to Primary Care Medical Services. The CCG have followed the processes as set out in NHS England Primary Medical Care Policy and Guidance Manual (PGM)						
Equality and Diversity:							
	Has an equality impact assessment been completed?	Yes		No		N/A	X
	If N/A please explain why	Covered in the options appraisal paper presented to PCCC in January 2022					

1. INTRODUCTION

1.1. Every individual or partnership of GPs must hold an NHS GP contract to run an NHS-commissioned general practice. These set out mandatory requirements and services for all general practices, as well making provisions for several types of other services that practices may also provide.

1.2. There are three different types of GP contract arrangements used by NHS commissioners in England

1.2.1. General Medical Services (GMS),
1.2.2. Personal Medical Services (PMS)
1.2.3. Alternative Provider Medical Services (APMS).

1.3. The GMS contract is the national standard GP contract. This contract is negotiated nationally every year between NHS England and the General Practice Committee of the BMA. It is then used by either NHS England and/or CCGs (depending on delegated powers) to contract local general practices in the locality.

1.4. The PMS contract is another form of core contract but unlike the GMS contract, is negotiated and agreed locally by CCGs or NHS England with a general practice or practices. This contract offers commissioners an alternative route with more flexibility to tailor requirements to local need while also keeping within national guidelines and legislation. The PMS contract is being phased out over time.

1.5. Changes to GP contracts must be approved by the CCG as a fully delegated co-commissioner of primary care. All GP contracts – General Medical Services (GMS), Personal Medical Services (PMS) or Alternative Medical Services (APMS) – are underpinned by the Primary Medical Care Policy and Guidance manual, and the contract which the commissioner has with each individual practice. The content of the PGM is based on the relevant regulations CCG's are required to work in line with the PGM when undertaking delegated commissioning decisions.

1.2. In January 2022 the PCCC approved the merger of two practices South Reddish Medical Centre (PMS) with Heaton Norris Health Centre (GMS) to create one partnership operating under one GMS contract, with a single registered list of patients. Subject to: South Reddish Medical Centre agreeing to a contract variation to move onto a GMS contract in preparation for the merger.

1.3. In order for the merger to happen both practices need to be on the same type of contract so that they are contractually compatible with the same contractual requirements.

1.3. The CCG received a letter from South Reddish Medical Practice on the 26th January 2022 requesting a contract variation from a PMS contract to a GMS contract to be effective from the 1st March 20022.

2. GENERAL PRACTICE CONTRACTS

2.1. The core parts of a general practice contract include:

- agree the geographical or population area the practice will cover
- require the practice to maintain a list of patients for the area and sets out who this list covers and under what circumstances a patient might be removed from it
- establish the essential medical services a general practice must provide to its patients
- set standards for premises and workforce and requirements for inspection and oversight
- set out expectations for public and patient involvement
- outline of key policies including indemnity, complaints, liability, insurance, clinical governance and termination of the contract.

2.2. In addition to these core arrangements, a general practice contract also contains a number of optional agreements for services that a practice might enter into, usually in return for additional payment. These include the nationally negotiated **Directed Enhanced Services (DES)** that all commissioners of general practice offer to their

practices in their contract and the locally negotiated and set **Local Enhanced Services (LES)** that vary by area.

2.3. General practices are generally contracted to provide the following types of service for the NHS, although some of these services are optional.

- Essential Services
- Out of hours services
- Additional Services
- Enhanced services
- Locally commissioned services

2.4. Essential services are mandatory for a practice to deliver to registered patients and temporary residents in its practice area. They include the identification and management of illnesses, providing health advice and referral to other services. GPs are required to provide their essential services during core hours, which are 8.00am–6.30pm Monday to Friday, excluding bank holidays.

2.5. Out-of-hours services are those provided outside core working hours. A practice is assumed to provide these by default but can opt out. Where a practice opts out, as most practices do, commissioners have the responsibility for contracting a replacement service to cover the general practice area population.

2.6. Additional services include specific other clinical services that a practice is assumed to provide but can opt out of, for example, minor surgery.

2.7. Enhanced services are nationally agreed services that holders of almost all GP contracts (GMS/PMS/APMS) can also provide if they choose to opt in. Services specified for 2020/21 include some vaccination programmes and a health check scheme for people with learning disabilities. Primary care networks (PCNs) have also been established via an enhanced service agreement.

2.8. Locally commissioned services are locally set services that practices can also opt in to. Unlike other GP services, these might also be commissioned by non-NHS organisations such as local authority public health departments.

3. PMS V GMS CONTRACT REQUIREMENTS

A general overview of the similarities and differences that exist between a contractors' obligations and requirements depending on whether they hold a GMS Contract or PMS Contract are set out below:

3.1. Core services

3.1.1. Core Hours covers the period beginning at 8:00 am and ending at 6:30pm on any day from Monday to Friday except Good Friday, Christmas Day or bank holidays

3.1.2. The contractor must: provide those essential services (and such other services as the contractor is required to provide to its patients)

3.1.2.1. At such times, within core hours

3.1.2.2. As are appropriate to meet the reasonable needs of its patients.

3.1.2.3. To have in place arrangements for the contractor's patients to access such services throughout the core hours in case if emergency

3.1.2.4. There is no difference for provision for core services between the two contract types

3.2. **Out of hours services**

3.2.1. A GMS contract automatically includes the need to provide OOH services. A PMS Agreement can provide OOH, but with the agreement of the commissioner, be varied to exclude the requirement to provide the OOH services.

3.2.2. All practices in Stockport have opted out of providing OOH and this is commissioned from Mastercall Healthcare

3.3. **Additional Services**

3.3.1. The PMS and GMS contract provides for the possibility of additional services being supplied by the GP practice and therefore there is no difference between the two contracts

3.4. **Sub-contracting of work (other than OOH's)**

3.4.1. A PMS practice can subcontract without the approval of the commissioner

3.4.2. To subcontract work a GMS contractor must have the prior approval of the commissioner unless the subcontract is with

3.4.2.1. a healthcare professional or

3.4.2.2. in the case of OOH Services is with one of four specified people (including another GMS contractor who is contracted to provide OHH Services themselves)

3.5. **Duration and Termination of contract**

3.5.1. Under GMS the contract runs unless and until terminated in accordance with its terms. (unless a temporary contract of not more than 12 months is in place)

3.5.2. Under PMS the contract runs unless and until terminated in accordance with its terms.

3.5.3. The key difference between the two contract types is that, unlike the PMS contract**,** the GMS contract do not allow the commissioner to voluntarily serve notice to end their core contract. This right is bestowed solely on the contractor.

3.6. **Compliance and Quality Standards**

3.6.1. Although under the PMS Contract, there are far broader obligations and requirements than are contained in the GMS Contract. both GMS and PMS practices will be equally subject to the requirements of CQC**.**

3.7. **Staff & conditions for employment/ engagement**

3.7.1. Under both the GMS and PMS contracts there are various requirements concerning the staff used in providing services under the relevant contract.

3.7.2. Although there is significant cross over between the GMS and PMS the PMS contract has more prescriptive additional requirements on contractors when it comes to the management and recruitment of their staffing.

4. . RECOMMENDATIONS

It is recommended that the Primary Care Commissioning Committee:

4.1. Review the content of this report considering the points raised in relation to the contract variation

4.2. Approved the contract variation effective from the 1st March 2022 for South Reddish Medical Centre to move onto a GMS contract from an existing PMS contract. Noting that this is required as part of the further preparation for the merger of South Reddish Medical Centre and Heaton Norris Health Centre

4.3. Note and Approve the next steps

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5. NEXT STEPS

5.1. Update commissioning and contractual impacts following the committees' decisions

5.2. Inform the practices of the Committee decision and any further contractual requirements to process

5.3. Inform NHSE of committee decision

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Primary Care Provision for Asylum Seekers & Afghan Evacuees in Stockport

Report To (Meeting):	Primary Care Commissioning Committee		
Report From (Executive Lead)	Anita Rolfe		
Report From (Author):	Gillian Miller		
Date:	16 February 2022	**Agenda Item No:**	9.3
Previously Considered by:	Stockport CCG Executive		

Decision	**X**	**Assurance**		**Information**	**X**

Conflicts of Interests	
Potential Conflicts of Interest:	Attendees of the meeting that are associated with general practice or a member practice within the CCG

Purpose of the report:

The purpose of the report is to provide PCCC members with an overview of the requirement for primary care provision for two new populations of patients placed in Stockport in 2021. These are new emergency programmes during the Covid pandemic. Also, how this requirement has been met.

Key points (Executive Summary):

- CCGs are responsible for commissioning health services for new populations of asylum seekers and Afghan evacuees who have been placed in temporary accommodation in Stockport by the Home Office in 2021
- GP Registration and Enhanced Health Care has been commissioned from local GP Practices.
- Interim urgent primary care provision was provided by Mastercall Healthcare for the asylum seekers in Hotel A, between October 2021 and 17th January 2022.
- Wrap-around care is provided with system wide support. However, this rapid influx of a large, vulnerable group of people with significant health, language and social needs is putting extreme pressure on local services, already struggling to respond to the Covid pandemic. This risk has been escalated to the ISC and to the Home Office.

Recommendation:
It is recommended that PCCC: • Note the requirement for GP registration and enhanced primary care provision for both Afghan evacuees and asylum seekers placed in Stockport, in accordance with the Home Office requirements for these two programmes. • Note the provision (direct award) enhanced primary care for the Afghan Evacuees at Hotel B, from two local GP Practices. Alvanley Family Practice and The Guywood Practice, who are the registered GP Practices. • Note the provision (direct award) of enhanced primary care provision from Heaton Moor Medical Group, from 17th January 2022, who are the registered GP Practice. • Note the interim primary care service provision that has been provided by Mastercall Healthcare as an immediate and urgent response for the asylum seeker population at Hotel A (October 2021 to 17th January 2022) • Note the next steps.

Aims and Objectives:	
Which Corporate aim(s) is / are supported by this report?	Start well, Live well, Age well, die well and Lead Well
Which corporate objective(s) is / are supported by this report:	Improve quality and safety of care. Support people to remain healthy and independent as long as possible. Improve early identification of health conditions. Ensure people can access safe, high quality care when necessary. Financial balance across the system.

Risk and Assurance:	
List all strategic and high-level risks relevant to this paper	Primary care engagement

Consultation and Engagement:	
Patient and Public Involvement:	*[N/A]*

1. Introduction

Two new populations of patients were placed (without notice) in Stockport in 2021 under two different Home Office programmes. These programmes were set up in 2021 by the Home Office/NHSE as emergency responses to manage the flow of Afghan evacuees and asylum seekers into the UK during the Covid-19 pandemic.

Under both schemes, the requirement is for CCGs to commission GP Registration and an additional Enhanced Primary Care Health Check for all patients.

This has had a significant impact on local services, already under extreme pressure responding to the Covid pandemic. Commissioning arrangements have been carefully managed to secure safe primary care provision under exceptionally difficult circumstances.

2. Afghan Relocation (ARAP Scheme)

2.1 Policy

- The UK's support to the conditions in Afghanistan in Autumn 2021, was set up under an Afghan Relocations and Assistance Policy (ARAP) programme, the relocation of Afghan workers and their families. The government confirmed it would relocate vulnerable Afghan citizens

- All families and individuals relocated under ARAP are legally entitled to access all NHS healthcare services under their 5 years 'Leave to Enter the UK' immigration status

- CCGs to work with wider system partners, such as the Local Authorities (LAs) and Voluntary, Community and Social Enterprises (VCSEs), at a place based and wider ICS footprint to meet the health, wellbeing, and safeguarding needs of this vulnerable population.

2.2 Commissioning Response

- Circa 80 Afghanistan evacuees were placed in Hotel B in Stockport in August 2021 under the ARAP scheme. A further 76 residents have been placed week commencing 19th January 2022. This population has the right to reside in the UK.

- GP registration and enhanced primary care has been provided by 2 local GP Practices, Alvanley Family Practice and The Guywood Practice. The Enhanced Health Check is commissioned through a local contract with the 2 Practices. There has been a transition of provision from the hotel to residents being encouraged to make appointments directly with the GP practice and are seen at the practice locations.

- Wrap around support is provided by system partners. including, interpretation services, safeguarding, special public health support for vulnerable people, specialist midwifery and health visiting, covid testing and vaccination teams. Serco are responsible for the operational management of the residents in the hotel and work closely with health partners.

3. Asylum Seekers in initial accommodation

3.1 Policy

- CCGs are responsible for commissioning health services for asylum seekers who have been placed in 'contingency/initial' accommodation by the Home Office.

- NHSEI advised commissioners to support [full] GP registration. This provides a sustainable approach to accessing care and recognises anyone is entitled to register for GP services.

- Commissioners are responsible for deciding on the best approach to support the needs of this population, such as using a locally enhanced service and keeping it under review.

3.2 Commissioning Response

- circa 320 asylum seekers placed in Hotel A in Stockport in October 2021 on a temporary basis. There has been a significant movement of this population. Over 130 residents have been moved out of Hotel A and replaced with new residents.

- Residents are from 13 countries; main countries of origin are Iran and Iraq. Main language is Kurdish Sorani. Mix of families and single men and women. As at 18th January 2021, 96, females, 6 single and 221 males, 130 singles, of which 56 are children.

- Commissioning arrangements were made as an immediate response with Mastercall Healthcare. Mastercall stepped in to provide urgent primary care, setting up a bespoke service in the hotel. Contract terms were agreed within a financial envelope, until 17th January 2021.

- Wrap-around care has been provided by system partners including, interpretation services, safeguarding, special public health support for vulnerable people, specialist midwifery and health visiting and covid testing and vaccination teams. Serco are responsible for the hosing provision and work closely with health partners.

- This was at the height of pressures in primary care. No Stockport GP Practice was able to safely offer GP registration to this large cohort of temporary, high-need, vulnerable new residents. Approaches were made through NHSE to providers outside of Stockport to provide GP registration, but no provider was able to make such provision.

- All Stockport GP Practices were asked for expressions of interest to provide GP registration for the asylum seeker cohort (Primary Care Newsletter - November 2021 and direct approaches to PCN Clinical Directors)

- Only one GP Practice, Heaton Moor Medical Group agreed to provide GP Registration. Contractual arrangements have been agreed for the provision of the Enhanced Health Check, within the financial envelope, Service to commence from 17th January 2022. Provision of care from a local branch surgery – Little Moor Health Centre, 10 minutes' walk from Hotel A.

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4. Risks & Issues

- Commissioning arrangements reflect the immediacy of the requirement for primary care provision. Also the need to provide GP registration and enhance primary care safely and locally to the two hotels.

- Accommodation is interim and many patients have already moved out of Stockport and replaced with new residents. This limits the effective monitoring and continuity of health care. Bespoke safeguarding oversight has been put in place.

- These groups of vulnerable people have significant health needs and require high levels of support to integrate into the UK health and care system. There has been considerable good will and co-operation from a number of providers and system partners and volunteers to support this need. The need for care provision for vulnerable groups of asylum seekers and evacuees is likely to continue.

- There is no clear indication of when these programmes will end, or if new cohorts of asylum seekers will be placed in Stockport. The risks of pressures on local services and the need for an ISC approach to the provision of specialist care has been escalated to GM.

- The funding envelope has not been sufficient to secure provision and this may result in a financial pressure for the CCG. Additional costs will be submitted to the Home Office.

5. NEXT STEPS

- Formalise and monitor contracts with Providers.
- Continue to monitor and support provision (weekly meetings with system partners)
- Continue discussions within the ISC framework to develop an ICB approach to provision of specialist care.

6. POTENTIAL IMPLICATIONS

Potential Implications:								
Financial Impact:	Non-Recurrent Expenditure	In report						
	Recurrent Expenditure	Detailed in the paper						
	Expenditure included within CCG Financial Plan	Yes	X	No		N/A		
Performance Impact:	*[N/A]*							
Quality and Safety Impact:	*[N/A]*							
Compliance and/or Legal Impact:								
Equality and Diversity:	General Statement:							
	Has an equality impact assessment been completed?	Yes		No		N/A	X	
	If Not Applicable please explain why	Not required at this stage						

NHS
Stockport
Clinical Commissioning Group

GP Retention Scheme Application - Chadsfield Medical Practice

Report To (Meeting):	Primary Care Commissioning Committee		
Report From (Executive Lead)	Anita Rolfe		
Report From (Author):	Kimberly Roberts		
Date:	16th February 2022	**Agenda Item No:**	9.4
Previously Considered by:	Not previously considered		

Decision	**X**	**Assurance**		**Information**	**X**

Conflicts of Interests	
Potential Conflicts of Interest:	Any attendees of the meeting that are associated with Chadsfield Medical Practice

Purpose of the report:

The purpose of this paper is to provide the Primary Care Commissioning Committee with

- An outline of the national guidance to consider the GP Retention Scheme application
- Assurance that the application has already been approved by Health Education England (HEE) and is in line with the criteria and eligibility requirements

Key points (Executive Summary):

- The National GP Retention Scheme is a package of financial and educational support to help eligible doctors, who might otherwise leave the profession, remain in clinical general practice

- The application received from a GP at Chadsfield Medical Practice has been approved by HEE on the 29th December 2021 and is awaiting commissioner approval

- The application is for four qualifying sessions a week at a cost to the CCG of £15,999 per annum up to a maximum of 5 years

- The GP retention scheme is part of the national recruitment and retention programme for primary care

Recommendation:

It is recommended that the Primary Care Commissioning Committee:

1) Note the content of this report outlining the national guidance of the GP retention scheme, and that this scheme supports the national and local workforce strategy

2) Note the application from a GP at Chadsfield Medical Practice, for the GP retention scheme which meets the criteria set out in the GP retention scheme guidance and has been approved by Health Education England (HEE) on the 29th December 2021

3) Note that Chadsfield Medical Practice meets the eligibility criteria as set out in the GP retention scheme guidance and approved by HEE on the 29th December 2021

4) Note and approve the next steps

5) Approve the application

Aims and Objectives:	
Which Corporate aim(s) is / are supported by this report:	Start well, Live well, Age well, Die well and lead Well
Which corporate objective(s) is / are supported by this report:	Improve quality & safety of care Improve early identification of health conditions Ensure people can access safe, high quality care when necessary Implement new & sustainable model of care Highly skilled workforce
Risk and Assurance:	
List all strategic and high level risks relevant to this paper	*[N/A]*
Consultation and Engagement:	
Patient and Public Involvement:	*[N/A]*
Clinical Engagement:	*[N/A]*

1. INTRODUCTION

1.1. The National GP Retention Scheme is a package of financial and educational support to help eligible doctors, who might otherwise leave the profession, remain in clinical general practice

1.2. This scheme supports both the retained GP (RGP) and the practice employing them by offering financial support in recognition of the fact that this role is different to a 'regular' part time, salaried GP post, offering greater flexibility and educational support

1.3. RGPs may be on the scheme for a maximum of five years with an annual review each year to ensure that the RGP remains in need of the scheme and that the practice is meeting its obligations

1.4. This scheme was previously funded regionally, but since 2017 CCGs are responsible for reimbursing the GP Retainer and the employing practice, funded from the delegated commissioning budget

1.5. Application to the Scheme is open all year and managed through Health Education England (HEE). HEE approval process includes ensuring any doctors joining the scheme and host practices meet the necessary criteria and eligibility

1.6. This scheme enables a doctor to remain in clinical practice for a maximum of four clinical sessions per week – 208 sessions per year, which includes protected time for continuing professional development and with educational support

2. DETAIL

2.1. The application for the GP retention scheme has been received from a GP who wishes to join Chadsfield Medical Practice

2.2. The application has been approved by HEE on the 29th December 2021 and is awaiting CCG approval

2.3. The application is for four qualifying sessions a week at a cost to the CCG of £15,999 per annum up to a maximum of 5 years. This support is to be used by the practice as an incentive to provide flexibility for the GP and should be used towards their salary, to cover HR admin costs and to provide funding to cover any educational support required from the practice, including course fees where relevant

3. CONCLUSION

It is recommended that the Primary Care Commissioning Committee:

1) Note the content of this report outlining the national guidance of the GP retention scheme and that this scheme supports the national and local workforce strategy.

2) Note the application from a GP at Chadsfield Medical Practice, for the GP retention scheme which meets the criteria set out in the GP retention scheme guidance and has been approved by Health Education England (HEE) on the 29th December 2021

3) Note that Chadsfield Medical Practice meets the eligibility criteria as set out in the GP retention scheme guidance and approved by HEE on the 29th December 2021

4) Note and approve the next steps

5) Approve the application

4. NEXT STEPS

4.1. Inform NHSE regional teams of the outcome of the primary commissioning committee decision

4.2. Inform the practice of the outcome of PCCC decision

4.3. Subject to approval Stockport CCG to arrange qualifying payments to Chadsfield Medical Practice under the GP retention scheme

5. POTENTIAL IMPLICATIONS

<table>
<tr><td colspan="8">Potential Implications:</td></tr>
<tr><td rowspan="3">Financial Impact:</td><td colspan="2">Non-Recurrent Expenditure</td><td colspan="5">Nil</td></tr>
<tr><td colspan="2">Recurrent Expenditure</td><td colspan="5">Detailed in the paper</td></tr>
<tr><td colspan="2">Expenditure included within CCG Financial Plan</td><td>Yes</td><td>X</td><td>No</td><td></td><td>N/A</td><td></td></tr>
<tr><td>Performance Impact:</td><td colspan="7">[N/A]</td></tr>
<tr><td>Quality and Safety Impact:</td><td colspan="7">[N/A]</td></tr>
<tr><td>Compliance and/or Legal Impact:</td><td colspan="7">Managed by Health Education England regional teams</td></tr>
<tr><td rowspan="3">Equality and Diversity:</td><td colspan="7">General Statement:</td></tr>
<tr><td>Has an equality impact assessment been completed?</td><td>Yes</td><td></td><td>No</td><td></td><td>N/A</td><td>X</td></tr>
<tr><td>If Not Applicable please explain why</td><td colspan="5">Not required</td></tr>
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Stockport Quality Update Report

Anita Rolfe
Executive Nurse/Deputy AO
Stockport CCG
January 2022

Quality Oversight

Winter and Pandemic Pressures

During December and January the Patient Safety Group hasn't met in order to enable clinical staff to focus on the response to the pandemic and winter pressures.

There has been the common issue of workforce availability identified by all providers across Stockport due to COVID infections and isolations. This issue has been monitored closely by all partners together to reduce the risks to patient care.

There has been a system wide response through the establishment of a system Tactical Control Group where pressures have been identified and support has been shared, and staff redeployed in order to reduce the risks that the increasing infections and increasing staff sickness. The CHC team were temporarily redeployed to support the discharge team and Local authority admin personnel supported with non personal care on wards such as handing out drinks and meals to make up staff numbers. This support was useful and well received.

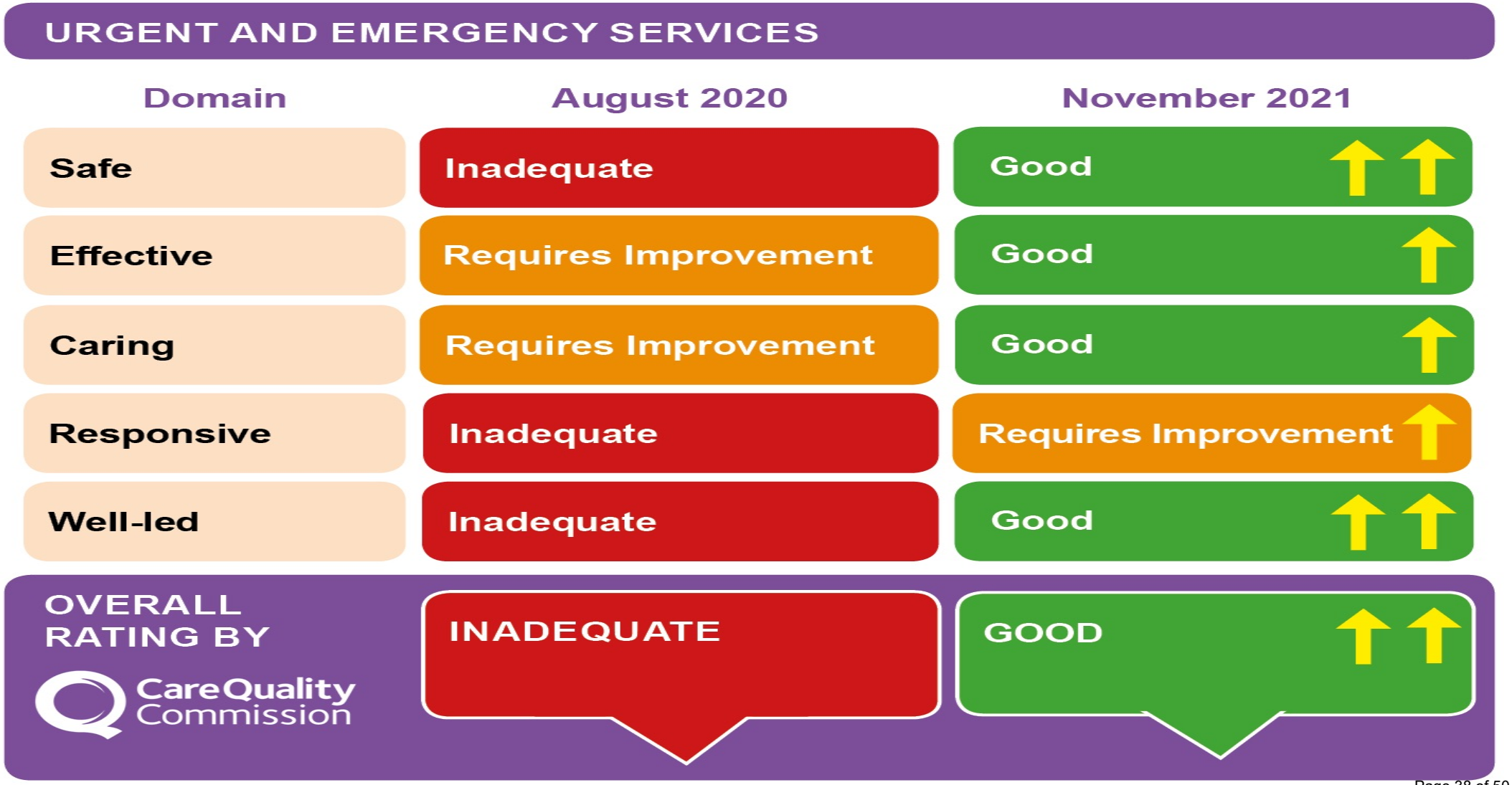
It is fair to say that Stockport has responded well to the further pressures over the last 4-6 weeks by focusing on urgent priorities together.

Clinical and Care Professional Leadership (CCPL)

As part of the GM roll out of the CCPL, members of the Stockport patient safety group have contributed to the development of the proposed model with GM colleagues. The CCPL model is due to be presented at the Stockport Locality Board to collect further local opinion for submission to GM , and will be discussed at the next PSG.

Stockport NHS FT

The CQC have published their assessment of care in early January. The CQC have identified significant improvements, which has landed well with all staff to boost morale in this challenging time . The published improvements can be seen on the next slide


URGENT AND EMERGENCY SERVICES
Domain
August 2020
November 2021
Safe
Inadequate
Good
Effective
Requires Improvement
Good
Caring
Requires Improvement
Good
Responsive
Inadequate
Requires Improvement
Well-led
Inadequate
Good
OVERALL RATING BY
CareQuality Commission
INADEQUATE
GOOD

NHS
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Clinical Commissioning Group

Primary Care Quality Report

Report To (Meeting):	Primary Care Commissioning Committee		
Report From (Executive Lead)	Anita Rolfe, Executive Nurse		
Report From (Author):	Elaine Abraham-Lee		
Date:	16 February 2022	**Agenda Item No:**	10.1
Previously Considered by:	Quality and Governance Oversight Committee Quality and Governance Committee		

Decision		**Assurance**	**x**	**Information**	**x**

Conflicts of Interests	
Potential Conflicts of Interest:	None

Purpose of the report:
To present an overview of Primary Care Quality to the Primary Care Commissioning Committee.
Key points (Executive Summary):
1. Stockport CCG have updated the Primary Care Quality Assurance and Improvement framework and associated processes that supports the CCG to identify and support GP Practices to address variation and improve quality across a range of clinical and non-clinical areas. 2. A local bespoke dashboard is under development with an automatic data feed into Tableau. The automated dashboard is expected to be completed and available to use towards the end of January 2022. 3. An overview of NHSE closed formal complaints. 4. Stockport locality is a high performer for both COVID and Flu vaccinations.

5. The CCG is actively working with PCNs (Primary Care Networks) and practices to prioritise through delivery of an improvement project for LD (Learning Disability) & SMI (Serious Mental Illness) annual health checks, exploring opportunities to boost Health Check activity.

Recommendation:

1. To **N**ote the information contained within the quality report
2. To **N**ote the next steps

Aims and Objectives:	
Which Corporate aim(s) is / are supported by this report:	*Patient Safety, Good Quality Care, Patient Experience*
Which corporate objective(s) is / are supported by this report:	*Patient Safety, Good Quality Care, Patient Experience*

Risk and Assurance:	
List all strategic and high level risks relevant to this paper	*Patient Safety, Good Quality Care, Patient Experience*

Consultation and Engagement:	
Patient and Public Involvement:	*None*
Clinical Engagement:	*Shared with LMC for information*

1. Introduction

1.1. Stockport CCG has updated the Primary Care Quality Assurance and Improvement framework and associated processes that supports the CCG to identify and support GP Practices to address variation and improve quality across a range of clinical and non-clinical areas. As part of the process for implementing the Quality Assurance and Improvement Framework, Stockport CCG will be responsible for:

- Collation and analysis of relevant quality data and production of a Primary Care Quality Dashboard.
- Having a process in place that addresses and reduces unwarranted variation
- Providing an ongoing programme of developmental and support visits to practices, including provision of guidance, and sharing of best practice.
- A robust process for supporting practices in managing issues and incidents.
- Setting up primary care quality assurance meetings involving the primary care team and other CCG teams as appropriate.
- An agreed escalation system for issues and concerns
- An agreed monitoring process to identify, assess and address any risks to patients and assess any risks to the quality of services due to practice vulnerability

1.2. We recognise that the quality of Primary Care in Stockport is of a high standard however there are unwarranted variations in performance, quality, and accessibility of Primary Care across the locality. GPs are often unaware of the variations in quality that exist within their practices and those of their peers.

1.3. The updated framework will support a collaborative approach in quality and improvement performance and closer working relationships with the practices providing opportunities for the CCG to share new developments, providing support where required. Any areas of best practice can also be highlighted to ensure learning and good practice can be shared

2. Dashboard development

2.1. A local bespoke dashboard is under development with an automatic data feed into Tableau. This will ensure all available data is gathered and can be analysed to identify areas of variation that provides a wider holistic view of the GP Practice and how it is performing in relation to local and national datasets. The automated feed for data sets will ensure that all data is the most current available to us at any one time.

2.2. The automated dashboard is expected to be completed and available to use towards the end of January 2022. Until this time the previously used manual data dashboard will continue to be the key source of information to support the quality work.

3. Quality

3.1 NHSE Complaints

During September 2021 and December 2021, NHS England reported 2 complaints that were partially upheld with recommendations from the Clinical Advisor. These were both with regard to clinical care. Consent was withdrawn or the complaint was withdrawn in 7 cases. There were 2 complaints in regard to clinical care that were not upheld.

3.2 Incidents
During the period October to November 2021, 5 clinical incidents were reported. The main area continues to be cold chain 3, immunisations 1. Whilst the remaining clinical incident is cold chain related, this has been logged but not yet investigated and closed, so remains pending.

3.3 Friends and Family
Data collection for Friends and Family test remains paused and no future update has been provided. There has been no change to the FAQs
https://www.england.nhs.uk/fft/friends-and-family-test-development-project-2018-19/faqs/#when-will-fft-data-submission-resume

3.4 CQC Inspections
The CQC provided an update in early December 2021 to advise that inspections of services who were delivering or supporting the delivery of the booster programme was postponed. Except where there was evidence of risk to life, or the immediate risk of serious harm to people. This remains is still current and no change expected in early January 2022.
https://www.cqc.org.uk/news/stories/cqc-prioritises-activity-help-create-more-capacity-adult-social-care-over-winter

3.5 Cervical screening
The CCG is proud to have a very high performing practice in our Werneth PCN who have reached the number 1 position for England for the 25-49 age group and number 4 position for the over 50 age group.

4. Vaccination performance

4.1. Stockport locality is a high performer for both COVID and Flu vaccinations currently.

4.2. COVID vaccinations (data up to and including 10.01.2022)

- Stockport have the highest uptake in GM for those aged 12+ have received a 1st dose (85.3%)
- Stockport have the highest uptake in GM for those aged 16+ have received a 2nd dose (83.6%)
- Stockport have the 2nd highest uptake in GM for those aged 12-15 who have received a 1st dose (55.9%)
- Stockport have the 2nd highest uptake in GM for those aged 18+ who have received a booster (82.7%)

4.3. Flu vaccinations (data up to and including 11.01.2022)

- Stockport have the highest uptake in GM for flu vaccinations for those 65+ (80.9%)
- Stockport have the highest uptake in GM for flu vaccinations for those living in areas of high deprivation – quintile 1 (80.9%)

5. Learning Disability and SMI Health Checks improvement

5.1. The CCG is actively working with PCNs and practices to prioritise LD & SMI annual health checks and exploring opportunities to boost Health Check activity. Monthly reporting will allow identification and intervention where a Practice is struggling to achieve the target.

5.2. The CCG primary care quality team are engaging with each practice to understand:

- If there are plans in place to deliver on the LD and SMI performance targets and how these are progressing
- Any significant challenges and issues that might impact achievement
- Any additional support requirements
- How best to utilise the recently recruited additional Care-Coordinator roles to support this work

5.3. The year to date England average achievement for Learning Disability Health checks is 33%. the Stockport CCG average is 27.6%. To achieve the National target of 70% a minimum of 662 additional health checks need to be completed before 31st March 2022.

Date	Numerator	Calculated Denominator	Performance (YTD)
Apr-21	36	1,542	2.3%
May-21	40	1,542	4.9%
Jun-21	40	1,542	7.5%
Jul-21	45	1,542	10.4%
Aug-21	36	1,542	12.8%
Sep-21	58	1,542	16.5%
Oct-21	72	1553	21.1%
Nov-21	105	1563	27.6%

5.4. The GM average achievement for SMI Health checks is 33.2%, with the Stockport CCG average is 29.5%. The National target is set at 60%.

NEXT STEPS

6.1. The primary care Tableau dashboard is fully operational, and access given to general practice and shared at the next meeting.

6.2 Development of a prioritisation matrix using the information within the dashboard.

6.3 Further develop the role of PCNs in quality improvement/reduction of variation of member practices.

6.4 Further develop role of quality primary care team in the monitoring of the PCN dashboard and reducing variation across Networks.

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5. POTENTIAL IMPLICATIONS

Potential Implications:							
Financial Impact:	Non-Recurrent Expenditure						
	Recurrent Expenditure						
	Expenditure included within CCG Financial Plan	Yes		No		N/A	
Performance Impact:	The dashboard will be used to inform practices and PCNs of their performance and areas of good practice and areas to focus on.						
Quality and Safety Impact:							
Compliance and/or Legal Impact:							
Equality and Diversity:	General Statement:						
	Has an equality impact assessment been completed?	Yes		No		N/A	
	If Not Applicable please explain why						

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PCCC Finance Report for the period ending 31st January 2022 - Month 10

Report To (Meeting):	Primary Care Commissioning Committee		
Report From (Executive Lead)	Michael Cullen		
Report From (Author):	Dianne Oldfield		
Date:	16 February 2022	**Agenda Item No:**	10.2
Previously Considered by:	Not applicable.		

Decision		**Assurance**	✓	**Information**	✓

Conflicts of Interests	
Potential Conflicts of Interest:	Any attendees of the meeting that are associated with general practice or a member practice within the CCG

Purpose of the report:

The purpose of the report is to provide an overview of the financial performance of the primary care delegated commissioning budget as at 31 January 2022.

Key points (Executive Summary):

- The CCG is reporting an adverse variance of £1.102m for 2021/22
- The CCG is forecasting to spend £2.993m (80%) of the maximum allocation entitlement for ARRS
- The CCG is forecasting to spend £1.269m (100%) of the maximum allocation entitlement for Winter Access Funding

Recommendation:
(i) **Note** the forecast outturn position is an adverse variance of £1.102m for the period 1 April 2021 to 31 March 2022.

Aims and Objectives:	
Which Corporate aim(s) is / are supported by this report:	Lead Well
Which corporate objective(s) is / are supported by this report:	Ensure financial balance across the system

Risk and Assurance:	
List all strategic and high level risks relevant to this paper	Failure to manage costs within the delegated allocation may result in the CCG failing to deliver financial targets and consequently impact the CCG annual assessment.

Consultation and Engagement:	
Patient and Public Involvement:	Not Applicable
Clinical Engagement:	Not Applicable

1.0 Introduction

This report provides an overview of Primary Care Delegated Commissioning:

- Forecast outturn as reported at 31 January 2022
- 2022/23 financial planning update

2.0 Forecast outturn as reported at 31 January 2022

The CCG is reporting a forecast outturn adverse variance of £1.102m as at 31 January 2022. The financial position is summarised in Appendix 1 where the following significant variances to budget are detailed:

GMS/PMS Contracts - £0.032m favourable variance due to patient list size growth being less than planned.

Additional Roles Reimbursement Scheme (ARRS) - Includes £0.906m adverse variance which has been offset by an anticipated allocation increase of £0.906m. The £0.906m allocation will be drawn down from the 44.4% ARRS funding held centrally. The CCG can only drawdown from the funding held centrally when actual ARRS expenditure incurred goes above 55.6% ARRS funding that the CCG has already received. The CCG has forecast to spend £2.993m (80%) of its £3.751m allocation entitlement.

Other GP Services - an adverse variance of £0.092m is forecast. This is mainly in relation to reimbursement payments to practices for locum cover for sickness and parental leave being higher than expected.

NHS Property Services - an adverse variance of £0.071m is forecast as costs are higher than planned.

Winter Access Funding (WAF) - Includes £1.015m adverse variance which has been offset by an anticipated allocation of £1.015m. The CCG received £0.254m (20%) of the CCG's WAF allocation of £1.269m in January 2022. The remaining £1.015m is held centrally by NHSE and will be drawn down when actual WAF expenditure incurred goes above the 20% funding that the CCG has already received. The CCG has forecast to spend 100% of the maximum allocation entitlement.

Non-Delegated PRC Schemes - a favourable variance of £0.047m relating to expenditure incurred directly in response to Covid being lower than planned.

Business Rules/General Reserves - £1.048m adverse variance reflects that total planned expenditure exceeds the allocation received for Primary Care Delegated Commissioning for 2021/22.

3.0 2022/23 Operational Planning

2022/23 planning is ongoing and draft plans are due to be submitted to NHSE by 17th March 2022 with final plans due by 28th April 2022. A detailed expenditure plan will be presented for approval at a future meeting.

4.0 Next Steps

1. Monitor actual spend against the Primary Care Delegated Commissioning plan for 2021/22.

2. Work with primary care colleagues to implement the recommendations of LCS review to bring the Primary Care Delegated Commissioning into balance.

3. Develop 2022/23 expenditure plan.

5.0 POTENTIAL IMPLICATIONS

Potential Implications:							
Financial Impact:	Non-Recurrent Expenditure						
	Recurrent Expenditure	The finance implications are identified in the paper					
	Expenditure included within CCG Financial Plan	Yes	✓	No		N/A	
Performance Impact:	Reporting an adverse variance of £1.102m for 2021/22						
Quality and Safety Impact:	N/A						
Compliance and/or Legal Impact:	Reporting in compliance with national guidance in response to Covid19 pandemic						
Equality and Diversity:	General Statement:						
	Has an equality impact assessment been completed?	Yes		No		N/A	✓
	If Not Applicable please explain why						

Appendix 1 – Forecast Outturn as at 31 January 2022

Service Line		Budget £m	Forecast £m	Variance £m
General Practice - GMS		**12.077**	**12.062**	**(0.015)**
	Global Sum	12.077	12.062	**(0.015)**
General Practice - PMS		**16.948**	**16.931**	**(0.017)**
	Contract Value	16.948	16.931	**(0.017)**
QOF		**5.114**	**5.114**	**0.000**
	QOF Aspiration	3.426	3.426	0.000
	QOF Achievement	1.688	1.688	0.000
Enhanced services		**5.071**	**5.972**	**0.901**
	DES- Individual Practice Payments			
	Learn Dsblty Hlth Chk	0.159	0.158	**(0.000)**
	Minor Surgery	0.316	0.316	**0.000**
	Violent Patients	0.073	0.062	**(0.011)**
	PCN-Participation	0.550	0.550	**0.000**
	Long Covid	0.157	0.157	**0.000**
	Weight Management	0.000	0.006	**0.006**
	PCN DES Expenditure - Payments to PCN's			
	PCN-Extended Hours Access	0.457	0.457	**0.000**
	PCN-Clinical Director	0.234	0.234	**0.000**
	PCN-Support	0.321	0.321	**0.000**
	PCN DES Care Home Premium	0.273	0.273	**0.000**
	PCN-IIF Aspiration	0.000	0.000	**0.000**
	PCN- IIF Achievement	0.445	0.445	**0.000**
	ARRS			
	PCN-Clinical Pharmacist	1.037	1.487	**0.450**
	PCN-Social Prescribing	0.000	0.000	**0.000**
	PCN DES Care Coordinator	0.270	0.387	**0.117**
	PCN DES Health and Wellbeing Coach	0.047	0.067	**0.020**
	PCN DES Pharmacy technicians	0.117	0.167	**0.051**
	PCN-Physiotherapist	0.571	0.818	**0.248**
	PCN DES Nursing Associate	0.013	0.019	**0.006**
	PCN DES Clinical Pharmacist Advanced Practitioner	0.019	0.027	**0.008**
	PCN DES Trainee Nursing Associate	0.014	0.019	**0.006**
Premises Cost Reimbursement		**3.480**	**3.466**	**(0.014)**
	Prem Clinical Waste	0.054	0.059	**0.005**
	Prem Notional Rent	1.049	1.052	**0.003**
	Prem Rates	0.411	0.389	**(0.021)**
	Prem Water Rates	0.067	0.067	**0.000**
	Prem Healthcentre Rent	1.572	1.581	**0.008**
	Prem Actual Rent	0.327	0.318	**(0.010)**
Other Premises Cost		**0.011**	**0.007**	**(0.004)**
	Prem Other	0.011	0.007	**(0.004)**
Dispensing/Prescribing Drs		**0.300**	**0.300**	**0.000**
	Prof Fees Prescribing	0.300	0.300	**0.000**
Other GP Services		**0.959**	**1.050**	**0.092**
	Legal / Prof Fees	0.018	0.018	**0.000**
	CQC	0.199	0.199	**0.000**
	PCO Locum Adop/Pat/Mat	0.603	0.691	**0.088**
	Sterile Products	0.004	0.004	**0.000**
	PCO Doctors Ret Scheme	0.059	0.059	**0.000**
	Translation Fees	0.063	0.076	**0.012**
	Healthcare Foundation Trust	0.009	0.000	**(0.009)**
	Indemnity	0.004	0.004	**0.000**
	Covid-19 Medical Exemption Assessment	0.001	0.001	**0.000**
Reserves				
Business Rules / General Reserves		**(1.048)**	**0.000**	**1.048**
Total PCR Excl Non Del PRC Scheme & Pass through costs		**42.913**	**44.903**	**1.990**
Non-Delegated PRC Schemes		**1.962**	**1.915**	**(0.047)**
Non-Delegated PRC Schemes	Winter Pressures Additional Capacity	**0.051**	**0.051**	**0.000**
Non-Delegated PRC Schemes	Winter Access Fund	**0.254**	**1.269**	**1.015**
	NHS Property Services	0.894	0.965	**0.071**
	Anticipated Allocations	0.000	(1.927)	**(1.927)**
Total PRC Cost Centre		**46.074**	**47.176**	**1.102**

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End of Documentation Pack