NHS
Liverpool
Clinical Commissioning Group

Status of these minutes *(check one box)*:	
Draft for Approval:	☐
Formally Approved:	☒

Report to:	**Governing Body**
Meeting Date:	**14 September 2021**

MINUTES OF THE MEETING OF

Primary Care Commissioning Committee

Date:	15 June 2021	Time:	10.00am
Venue:	MS Teams Conference call		

Name	Job Title (Division/ Organisation*) *if not Liverpool CCG
Present:	
Gerry Gray (GGR)	Lay Member for Finance - Chair
Mark Bakewell (MBA)	Chief Finance & Contracting Officer
Helen Dearden (HDE)	Lay Member for Governance
Jane Lunt (JLU)	Director of Quality, Outcomes & Improvement (Chief Nurse)
Cathy Maddaford (CMA)	Non-Executive Nurse
In Attendance:	
Scott Aldridge (SAL)	Senior Performance Manager
Val Attwood (VAT)	Deputy Chief Contracting Officer
Rob Barnett (RBA)	LMC Secretary
Paul Brennan (PBR)	Primary Care Accountant, Liverpool and Knowsley CCGs
Kellie Connor (KCO)	Senior Contracts Manager
Paula Finnerty (PFI)	GP Director
Paula Guest (PGU)	Head of Planning and Delivery – Out of Hospital
Dave Horsfield (DHO)	Director of Transformation Planning & Performance
Richard Houghton (RHO)	Corporate Services and Governance Manager
Peter Johnstone (PJO)	Head of Medicines Optimisation
Fiona Lemmens (FLE)	Chair LCCG
David O'Hagan (DOH)	GP Director
Jacqui Waterhouse (JWA)	Senior Programme Delivery Manager, Provider Alliance
Debbie Richardson	Committee Secretary, Liverpool CCG
Apologies Received:	
Stephen Hendry (SHE)	Head of Governance and Corporate Services
Victoria Horton (VHO)	Primary Care Accountant
Jan Ledward (JLE)	Chief Officer
Cheryl Mould (CMO)	Director Provider Alliance
Carol Rogers (CRO)	Lay Member for Patient & Public Involvement
Maurice Smith (MSM)	GP Director

ISSUES CONSIDERED
2021

A1 WELCOME

1. GGR welcomed all those present to the meeting noting that business would be conducted on the assumption that members had read all papers ahead of the meeting.
2. Introductions were made and all members welcomed. Both Paul Brennan and David O'Hagan were attending as observers to the meeting.
3. GGR formally noted thanks to MSM for his contributions to the committee.

A2 APOLOGIES FOR ABSENCE

4. The apologies for absence received for this meeting were as detailed above.

A3 DECLARATIONS OF INTEREST

5. In addition to the declarations already listed on the LCCG register FLE commented that as a GP it was possible that items may be discussed which she may declare an interest in as they arose. Members agreed that a clinical perspective would be valued, and items would be discussed on an individual basis with any conflicts dealt with as they arose. RBA reported an interest in Greenbank Road Surgery and the Liverpool and Wavertree PCN.

A4 MINUTES OF THE MEETING HELD ON 20 APRIL 2021.

6. The minutes of the previous meeting held on 20 April 2021 were accepted as an accurate record.

A5 ACTION LOG

7. The action log was discussed with the following points made:
    a. Item 1 – Review of Primary Care Networks (PCNs) with maturity matrix in year-end review. DHO reported that work continued around this item however it was not the responsibility of the CCG alone. Members agreed that the item could be closed and brought back to the committee in the future once it was appropriate to do so. Item closed.
    b. Item 2 – searches for assurance regarding extraction data. The information had been circulated to practices. 8 practices indicated problems and work had been undertaken to identify patients. Item closed.
    c. Item 3 – Update committee work plan in line with discussions. On the meeting agenda. Item closed.
    d. Item 4 - complete, item closed.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the progress with previous action points.			
Further actions required: • Update the action log in line with discussions.	D Richardson	ASAP	Completed

A6 COMMITTEE WORK PLAN

8. DHO presented the committee work plan which had been reviewed noting that there were no major changes, the reporting descriptions had improved and it included a review of the committee Terms of Reference (TOR). Any other suggestions made previously had also been incorporated.
9. RBA asked how many PMS practices were left and KCO responded that there was just one.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the committee work plan			
Further actions required: • None identified.			

B UPDATES

B1 NHS ENGLAND UPDATES

10. DHO reported that he had received no response from contacting Tom Knight directly. He had tried to contact Tom's team for a response, seeking clarity that Tom was the right person or if NHSE attendance was necessary and had received no response to date and would continue to follow this up.
11. RBA suggested emailing Tony Leo who may be in a more appropriate role. DHO thanked RBA for the suggestion agreeing to contact Tony.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the update.			
Further actions required: • Seek clarification from Tony Leo who may be the NHSE contact for the committee.	D Horsfield	Aug 21	On PCCC Aug 21 agenda.

C GOVERNANCE

C1 PRIMARY CARE COMMISSIONING COMMITTEE RISK REGISTER

12. DHO presented the Primary Care Commissioning Committee (PCCC) Risk Register (RR) reporting that it had been fully reviewed with updates annotated in blue ink.
13. All risks had been reviewed and two risks with no blue ink were reviewed but required no updating.
14. Two risks were retired from the register as recommended at the last committee meeting, these were PCCC0.8 regarding medicine shortages which no longer exist and PCCC0.9 which was related to COVID-19 and had been superseded by the refocussing of the standard operating procedure document for COVID-19 which looked at primary care recovery.
15. Risk PCCC0.10 had also been retired. It referred to the flu vaccination programme for 2020-21. Although there would be a risk in 2021-22 it was not clear yet how this risk would evolve and how it would be managed and so it was not appropriate to be included in the risk register yet.
16. RBA noted that regarding PCCC0.10 risks were already becoming apparent not least of all supplies of the flu vaccine itself stating that if the original supplier could not deliver the orders originally envisaged as it had indicated the cost of another vaccine was doubled. This had been accepted by NHSE as suitable but this was a risk for practices in purchasing it. Also there was real anxiety within the system regarding how the flu campaign would be run and by whom which was another potential risk. The risk was also in the knock-on effect to other services. DHO thanked RBA for the comments suggesting that an action on the risk register to cover those items be included at the next meeting. FLE agreed.
17. HDE pointed out that it was a broad risk commenting that there was a need to look more widely at the impact it would have on patient care asking would it cause avoidable pressures elsewhere. HDE asked if patient engagement was included within the mitigating actions listed on the risk register and could this be considered.
18. DHO responded that there was a meeting on 22nd June (Primary Care Recovery) which would help to further develop the risk register and he would mention patient engagement there.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Committee is asked to:			

• Note the contents and updates of risks for the commissioning of General Practice. • Considers current control measures and whether action plans provide sufficient assurance on mitigating actions. • Review the mitigations and progress; approve the recommendation to step down risk. • Agree that the risk scores accurately reflect the level of risk that the CCG is exposed to given current controls and assurances.			
Further actions required: • Include flu vaccine risks within committee risk register as discussed. • Consider patient engagement within risk register actions at Primary Care Recovery meeting.	D Horsfield D Horsfield	Aug 21 Aug 21	On PCCC Aug 21 agenda. On PCCC Aug 21 agenda.

C2 PROCESS FOR ASSIGNMENT OF AN 'ORPHAN' PRACTICE TO A PRIMARY CARE NETWORK

19. VAT presented the process for assignment of an 'orphan' practice to a primary care network explaining that in 2020-21 one practice opted not to sign up to the Primary Care Network (PCN) Directed Enhanced Services (DES) contract. At that point, a local incentive scheme was arranged to provide services to their patients.
20. The practice would now like to sign up to the second year of the DES but was unable to secure membership of a PCN. In these circumstances the CCG had an obligation to identify a PCN that the practice could join. LCCG had not had to do this before and so did not have a process document in place.
21. NHS England were consulted and a local process document was drafted which detailed the process for the assignment of an orphan practice to a PCN with a step by step process of what the CCG needed to follow, what the practice needed to do, what the PCNs needed to be aware of, the involvement of LMC in negotiating or mediating the assignment of a practice to a PCN (this was not something that would normally happen but needed to be included should the need arise). The document described the criteria considered when aligning a practice to a PCN along with the details of how to appeal should an appeal be necessary and the steps involved in this. The PCN DES was a GP level contract agreement and any disputes would have to be raised as a contractual dispute.
22. The document was not easy to draft, it was written in conjunction with NHS England and being mindful of the guidance. The proposal was for Liverpool and the CCG was not aware that it had been done in any other areas previously.
23. There was no financial risk involved, however there was a risk that if no protocol was in place there was potential to create inequality for patients.
24. The committee was asked to note the process and approve the implementation of the process. Colleagues had to then proceed to allocate a practice to a PCN.
25. PFI asked what was happening with the patients in the practice at that time and was informed that the CCG had negotiated with other practices and service providers to provide additional input so that there was still a route for patients to access services in the interim and so that patients were not disadvantaged. PFI went on to ask about the dispute process asking if each practice was able to raise a formal dispute with NHS England would they do this concurrently or consecutively. VAT responded that the understanding was that they would need to be submitted concurrently and she would explore this further, noting that the process had not operated previously either locally or further afield. PFI commented that the CCG had tried to mitigate the situation with the most suitable PCNs asking would the CCG reset and approach the same PCNs again to which VAT responded that all networks would be considered and the likelihood was that the LMC would be introduced as mediator

working with the two networks previously spoken to. The expectation was that the networks would appeal however this introduced an objective process. PFI pointed out that NHS England insisted networks accepted more practices into the networks when they initially formed.

26. RBA clarified that no one was imposed upon anyone when the DES came out, people voluntarily agreed to things possibly under pressure but no one was imposed on anyone. RBA went on to point out that section 7.3 referred to section 4.2.4.b which was actually in the PCN DES specification not the process document being considered and needed clarifying within the document. While acknowledging the section on criteria, RBA argued that the criteria listed under 2: geographic area of a PCN in relation to patient population was misleading. The geographical areas of PCN patient populations in Liverpool could not be drawn around. It was important to have a process there however RBA felt there was something missing relating to why a PCN may not wish to have something imposed upon them. It was regarding finances; ideally PCNs were made up of practices that chose to work together for a common aim, if another practice were imposed on the PCN with a different objective this would not be ideal and could lead to financial risk and appeal after appeal.
27. RBA had discussed the process with a neighbouring LMC for fairness and to resolve the matter efficiently.
28. VAT responded that those were important points and pertinent to the finance impact commenting that without being explicit the financial impact and how it could be managed had been discussed internally. PCN boundaries were included within the document at the request of NHS England; the policy needed to be tested and was a base position at this point if it became problematic then areas would be tweaked.
29. HDE welcomed the process stating that it was a sensible approach and that it was important to have a clear independent way to assess while being sensitive to all concerned, however she wondered how the criteria was determined. VAT responded that NHS England supplied the list of criteria which the CCG had looked at in detail and worked through an example following which it became clear weightings were needed for a ranked order. Criteria from within the DES was also included and if the position was reached where there were two PCNs in a similar position then the CCG would look at the longer list. HDE suggested a flow chart of the process would be helpful and VAT agreed to work on that.
30. DOH commented that a lot of work had gone into the process and it was important to have an objective clear process which was difficult when the policy was controversial. He had concerns that practices may not accept the process pointing out that patients remained the responsibility of the CCG. Any practices patients not included within the DES needed to be considered and it was important to put a process in to ensure that patients were being looked after. There was a possibility that practices and PCNs could get stuck within the process and consideration should be given to how to prevent this. In response VAT reported that the process was yet to be tested to see how it operated. NHS England litigation authority would test it, there was a need to be pragmatic and to have a starting point and bring it back to the committee if there were further issues to address. It was not clear if NHS England national team would step in to make the decision which was not the preferred option but the patients were the priority and needed to be managed.
31. CMA stated that it was good that the CCG was ahead of the game noting that the process may take some time before a resolution was found asking if the assurances given for how patients would be managed in the interim were sustainable for the longer term. VAT responded that they were sustainable however it was preferable to have one provider for the longer term commenting that some PCNs had been reluctant to provide services across areas and the current arrangements would continue for the time being.
32. RBA stated that members had been advised that ultimately the decision would be made by people who did not know Liverpool; one from general practice and one from the NHS and there was a preference to avoid that scenario and try to find a resolution locally that was acceptable to all. Looking at the financial consequences would sway peoples decisions, if income was at risk PCNs would refuse and the CCG needed to take this into account.
33. DOH remarked that the PCN policy was deliberately disruptive to shake up primary care

delivery and there was a need not to make it easy for the wrong approach to be taken, commenting that disruption was not a pleasant process for anyone involved and should be avoided if possible.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Committee is asked to: • Note the contents of the assignment process. • Approve the process for assignment of an 'orphan' practice to a Primary Care Network.			
Further actions required: • Explore dispute process with attention to concurrent or subsequent appeal submission. • Clarify reference to PCN DES specification within document as discussed. • Consider flow chart of process to accompany document.	V Attwood V Attwood V Attwood	Aug 21 Aug 21 Aug 21	On Aug 21 PCCC agenda. On Aug 21 PCCC agenda. On Aug 21 PCCC agenda.

D PERFORMANCE

D1 PRIMARY CARE COMMISSIONING COMMITTEE PERFORMANCE QUALITY AND CONTRACTS REPORT

34. DHO delivered the performance report highlighting the following:
    a. Temporary changes to the GP contract in England would continue under the pandemic regulations until 30 June 2021.
    b. Practices were struggling to meet health check targets for patients with learning disabilities and COVID-19 took some of the blame for this although there was a variation in that some practices had completed 100% returns, and some had completed 0%. Work was underway focusing on addressing the practices which were struggling. This would have to be investigated further as more details became available regarding recovery and which tests could be managed face to face. It was on the agenda for the primary care recovery meetings.
    c. The CCG had been communicating regularly with practices regarding mapping of appointments in an attempt to encourage appointments throughout the year to support this.
    d. NHS England had written to the CCG and practices to say that regarding the PCN DES practices would be performance managed this year. The CCG was aware that there was a lot of variation and would be communicating with practices over the coming weeks regarding completion of tasks.
    e. Around 37% of the ARRS budget was claimed in April and 15% in May and this created an underspend which needed to be managed, the trajectory went in the wrong direction.
    f. Long term conditions trajectories could now be monitored monthly which should help practices meet their quality outcomes framework targets. The CRT team were looking at ways to support this.
    g. The Enhanced Access Service had reached 87% of utilization which was good however there was still capacity and practices could utilize this.
35. VAT proceeded to highlight partnership changes noting that one of the partnership changes within the report had not been processed yet due to an issue with the PCSE online system.

When a partner leaves a practice they are required to agree and acknowledge this on the PCSE system, however when the partner has not agreed to leave this causes a problem. Legal advice was being sought and it was a peculiarity of this scenario.

36. JLU drew members attention to the quality team review of two SEAs and the STEIS reporting of a COVID-19 vaccination incident which would follow due process noting that considering the volume of immunizations nationally, one incident was testament to the safe delivery of the campaign overall.
37. MBA suggested introducing a RAG rating system on Appendix 2 of the report in particular for the PCN DES section for clarity.
38. RBA reported that the ARRS scheme caused issues due to the strict criteria set around the roles the scheme allowed practices to employ, it had introduced an expansion of the ability to employ people without having people to employ. Furthermore, people had concerns around the method people were employed on and where the risks of the scheme rested. The report referred to the DES continuing only until March 2024 which led to risks for those who employed people. There appeared to be an expectation that a PCN would manage it however the PCNs were originally funded differently and given management costs to enable the ability to hit the road running while some were still floundering and RBA was not surprised by the mess the system finds itself in. Regarding enhanced access delivered by PC24, RBA stated that the understanding was that PC24 in its core role was so brilliant that patients were not being seen. In relation to what was currently happening in enhanced services the suspicion was that if you looked across the patch there would be great variation amongst those who used it and those who didn't with enhanced access services being used as an absolute last resort with practices working all hours rather than refer to enhanced access services as it didn't answer the problems but was more of a tick box and there was a need to be careful in what was being measured to be seen as good.
39. DOH expressed an opinion that the ARRS scheme was there to ensure PCNs fit the new model of working which had not yet been clearly communicated and which made it difficult to plan. There was a need to be careful about whether the roles were suitable for the PCNs as having the wrong roles in the wrong place was not a good plan. It was important to the PCN scheme that there was work in progress and it was not yet demonstrated that it was there to help primary care to do primary care work and to have an underspend reflects the ability of the PCN to answer the needs in the system.
40. MBA responded that he recognised the points made while stressing that the ARRS was a reimbursement scheme noting that staff were not available to be recruited quoting mental health as an example. The issue was one of clarification from NHS England whereby the CCG was told funding not utilised would be clawed back when at the end of the year it was not called back which gave more problems. It was important to get a realistic robust model and clarity was being sought from NHS England for planning to maximise the opportunities.
41. RBA stated that he would like money to be spent appropriately on staff doing worthwhile patient care and throwing more money on top was not always the answer, the right people were needed to enable practices to achieve something useful.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Committee is asked to: • Note the performance of the practices in delivery of the Primary Care KPI performance. • Note the performance of the CCG in delivery of Primary Care Medical commissioned services.			
Further actions required: • Reflect on introducing a RAG rating system on appendix 2 of the report.	D Horsfield	Aug 21	On Aug 21 PCCC agenda.

D2 PRIMARY CARE COMMISSIONING COMMITTEE FINANCE UPDATE

42. MBA reported that generally at this time of year there was not a Finance Report due to delays in data. This year was probably more difficult than previous years with the new framework to model and understand as a system.
43. At this point the CCG was not aware of any exceptional issues against the delegated budget, overall assumptions gave a deficit against the H1 period and it was expected that there would be a need for efficiency savings in general terms and work was underway around this.
44. The team was currently working through assumptions, looking at how to bring back on line cash releasing efficiency savings, aware that this would not be an easy task, however the ask appeared to be for a 2% saving for the H1 period. The expectation was that this would be managed through some slippage and system level resources reporting that there would be data to report on at the next meeting.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Committee is recommended to: • Note the update.			
Further actions required: • None identified.			

E STRATEGY AND COMMISSIONING

E1 GP LES AND GP SPEC INCOME

45. DHO delivered the report mentioning the new position from NHS England regarding the new quality outcomes framework (QOF) and directed enhanced services (DES) which was going to be performance monitored with financial implications looking to pay by results back to pre-COVID-19 approaches.
46. The CCG had reviewed its position regarding the local enhanced services (LES) and the GP specification. Guidance had been received from NHS England to say the LES and DES would be operated on financial performance however there was no national guidance or requirement regarding the GP specification and matrix that the CCG had to follow. The CCG wished to maintain its position not to performance manage and to give practices an element of protected income.
47. RBA commented that there needed to be a degree of common sense and a degree of pragmatism, it was impossible to devote time and effort to the vaccination campaign while recovering all services and the CCG approach was sensible. It was difficult to know what was happening nationally as no discussions were taking place; there appeared to be a breakdown of relationships and difficulties arose when NHS England and Improvement (NHSEI) asked practices to forget everything and concentrate on the vaccination programme and then told them to complete everything else too.
48. DHO reported that the new LQIS scheme had not been implemented and this would come to a future committee.
49. HDE concurred that this was a sensible approach given the pressures practices were under and a review later was the way forward.
50. PFI commented that it was a sensible pragmatic decision that she supported.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Committee is recommended to: • Approve the proposal to return LES schemes to payment by results for 2021-22, in line with NHS England practice for DES			

schemes. • Approve the proposal to retain the current matrix of indicators associated with the CCG's GP specification, to support practices in recovery of service and protect this element of their income.			
Further actions required: • None identified.			

E2 GP EXPANSION FUND

51. JWA on behalf of CM presented the GP expansion fund paper which had been to committee previously referring to funding released in November 2020 for practices to support the COVID-19 effort, the funding was accessible on a weighted population basis with seven priority areas for general practice to consider.
52. All practices were emailed and given an outline of their allocation and asked to complete a spreadsheet regarding how they would use the funding against the seven priority areas. All but 4 practices responded, and they would be contacted again to request information regarding updates and improvements against the 7 priority areas.
53. In March 2021, the CCG received a letter to say that a further tranche of money would be available from April to September 2021. This funding was again ring fenced for general practice and the seven priority areas however the system prioritised spending where the focus had been on the COVID-19 vaccination programme. Rather than create more inequalities the CCG was proposing to add a local 8th requirement which would be in two parts. Practices would be asked to continue to address health inequalities by inviting hard to reach groups in for vaccination, this supported the city plan.
54. A letter was received in May to say that the allocation would be made in June. Members were being asked to support the continued funding with a little additional work for the practices involved and the expectation was that a report would come back from practices.
55. RBA asked what if any effort did the CCG take to engage with the four practices that did not access the funding earlier in the year and, regarding the additional resource, when practices received the funding it would be halfway through the period it was for. The CCG needed to accept that there were issues in what NHS England and Improvement (NHSEI) said and when the money became available; when CCGs knew that money was coming it would be helpful if they just paid it out so that any funding got to where it was needed in an appropriate time frame.
56. HDE questioned what would happen if practices did not do what was asked of them to which JWA responded that she was not aware of a claw back mechanism however the feedback report would set the benchmark for the next tranche of funding. HDE commented that that was a concern from a governance perspective.
57. MBA acknowledged the frustration regarding the timing of funding availability commenting that the CCG was equally frustrated and had asked repeatedly when the money would be distributed and once it arrived it was passed on as quickly as possible to practices. Regarding the wider position, the amount of work going on in practices was recognised and not under estimated however from a CCG perspective there was concern that at a future date an inquiry would take place asking what had been achieved with the additional funding and the CCG wanted to be in the best position possible to articulate the tangible performance type metrics within the challenges that were around. There was a need to give some sense of an audit trail and purpose, and to try to strike a balance between overkill and governance. It had been very difficult to do this throughout the pandemic without a definitive steer, the messaging had been confused. Originally consideration at a national level had been around a claw back potential but this was not helpful for practices. The CCG was not able to give more reassurance as the system was not set up in terms of what the national agenda was asking for.
58. GGR commented that claw back was a draconian measure and it was very difficult in the current climate to set up a mechanism however practices needed to bear in mind progress

made with the previous funding received. MBA responded that having learned from the outcome of trench one the approach to trench two would not request the same evidence and it was noted that in the main everyone had demonstrated value from the additional funding.

59. DHO reiterated that in the approach to performance management the message from the centre was to share the funding and ask for an update later. There was a mechanism where any prerequisites that were not achieved against previously would have a plan to action this. The CCG had tried to find the balance with governance while trying to maintain a light touch approach.
60. RBA commented that the CCG had been supportive regarding this, and it had distributed funds equitably. General practice had been incredibly busy, when comparing the week following the second bank holiday in May with the equivalent week two years previously practices were 30% busier this year yet no practice had asked for no contacts or asked for support for other services; they had delivered the vaccination campaign only by people putting in time and effort to ensure services had been maintained and members must not lose sight of what had been taking place in the community.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Committee is recommended to: • Approve the proposed approach for accessing the funding and updates on achievement.			
Further actions required: • None identified.			

F FOR NOTING

F1 MEDICINES OPTIMISATION COMMITTEE GOVERNANCE PATHWAY

61. PJO presented a paper detailing the governance pathway and schedules for Medicines Optimisation Committee for noting. The paper had previously been presented at Clinical Effectiveness Committee (CEC), and Performance and Quality Committee (PQC).

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Agree the presented issues to be reported to this committee.			
Further actions required: • None identified			

G ANY OTHER BUSINESS

G1 SUMMARY OF BUSINESS / RISK REVIEW

62. GGR summarized the business of the committee.
63. DHO reported that the vaccination risks would be added to the risk register for the next meeting as discussed.
64. PFI suggested the allocation of an orphan practice could be a potential risk however HDE remarked that it had crystallised as an issue rather than a risk which members agreed with. The issue was happening and was being managed and so was not a risk.

G2 ANY OTHER BUSINESS

65. No other items of business were discussed. The meeting closed.
66. The next meeting will be held on Tuesday 17th August. Papers due by 6th August.