NHS
North Central London
Integrated Care Board

NCL ICB PRIMARY CARE COMMITTEE (PCC)

Minutes of Meeting held on Tuesday 16 April 2024 between 9:30am and 11:00am

NCL ICB, Clerkenwell Room, 2nd Floor, Laycock Centre, Laycock St, London N1 1TH.

Voting Members	
Mr Usman Khan	Non - Executive Member & **Committee Chair**
Ms Liz Sayce	Non - Executive Member & Co - Chair
Ms Sarah McDonnell-Davies	Executive Director of Place & **Executive lead for the Committee**
Dr Josephine Sauvage	Chief Medical Officer
Ms Chris Caldwell	Chief Nursing Officer
Ms Sarah Louise Morgan	Chief People Officer
Ms Sarah Rothenberg	Director of Finance
Non – Voting Participants & Observers	
Ms Sarah Mcilwaine	Director of Primary Care
Mr Phill Wells	Chief Executive Officer
Dr Katie Coleman	Clinical Director for Primary Care
Ms Vanessa Piper	Assistant Director for Primary Care Contracting
Mr Anthony Marks	Primary Care Contracting Senior Manager
Ms Su Nayee	Primary Care Contracting Senior Manager
Ms Deidre Malone	Deputy Director of Quality & Clinical Standards (deputised for Jenny Goodridge)
Ms Carol Kumar	Assistant Director for Primary Care Planning, Operations and Improvement.
Ms Clare Henderson	Director of Place (East)
Ms Rebecca Kingsnorth	Assistant Director for Primary Care Strategy & Change
Mr Adam Backhouse	Head of Primary Care Strategy & Change
Ms Lorna Reith	Community Participant
Mr Ken Kanu	VCSE Alliance Representative
Ms Michelle Malwah	Healthwatch Representative (deputised for Albie Stadmiller)
Mr Andrew Spicer	Assistant Director of Governance, Risk and Legal Services
Mr Chris Hanson	Deputy Head of Governance, Risk and Legal Services
Ms Usha Bhanga	Senior Commissioning Manager
Ms Saro D'Souza	Primary Care Contracting Manager
Mr John Pritchard	Senior Communications Lead
Ms Isha Richards	Communications and Engagement Manager (Place and Primary Care)
Mr Andrew Tillbrook	MS Teams Live Producer
Ms Vivienne Ahmad	Board Secretary **(Minutes)**
Mr P Richards	Member of the Public
Apologies:	
Mr Mark Agathangelou	Community Participant

Ms Donna Turnbull	VCSE Alliance Representative
Mr Albie Stadmiller	Healthwatch Representative
Ms Jenny Goodridge	Director of Quality
Ms Nicola Theron	Director of Estates
Ms Diane Macdonald	Interim NCL Estates Finance Lead
Mr Will Maimaris	Public Health Representative
Mr Jamie Wright	LMC Representative

	INTRODUCTION
1.1	**Welcome & Apologies**
1.1.1	The Chair welcomed everyone to the PCC meeting. Apologies were recorded as above. The Committee was quorate. Will Maimaris and Jamie Wright were unable to attend online due to technical issues in the Clerkenwell Room. The Chair informed the Committee that minor amendments were being proposed to the PCC Terms of Reference to reflect the outcome of the Change Programme. As a result, the standing participants and job titles were being updated as follows: • Sarah Mcilwaine – Director of Primary Care • Vanessa Piper – Assistant Director of Primary Care Contracting • Carole Kumar – Assistant Director of Primary Care Planning, Operations and Improvement. • Becky Kingsnorth – Assistant Director of Primary Care Strategy and Change. And a formal welcome to Dr Katie Coleman – Clinical Director of Primary Care The Terms of Reference will be going back to the ICB Board in May to approve these minor amendments. The Chair reminded everyone that members of the public can attend committee meetings. It is important to note that this is a meeting held in public, it is not a 'public meeting'. This means that members of the public can: ➢ Attend meetings, in person or virtually. ➢ Listen to the proceedings and observe our decision-making process. ➢ Ask questions relating to items listed on the agenda in advance by email. Where appropriate, questions will be addressed in the introduction to relevant agenda item. Formal responses will be published on the ICB website after each meeting. No questions had been received for today's meeting.
1.1.1	**Action:** • **To circulate the PCC Terms of Reference after the May ICB Board**. ***(Andrew Spicer)***
1.2	**Declarations of Interests (not otherwise stated)**
1.2.1	• Committee Members were invited to note their entries on the Register of Declarations of Interest. No additions were made. • The Chair also invited members of the Committee to declare any interests in respect to the items on the agenda. No interests were declared. • The Chair invited members of the Committee to declare any gifts and hospitality received. No gifts and hospitality items were declared.
	The Committee NOTED the Declarations of Interest.

1.3	**Draft Minutes of the PCCC meeting of 20 February 2024**
1.3.1	The minutes of the NCL Primary Care Contracting Committee Meeting on 20 February 2024 were agreed as a true record of the meeting subject to two amendments: • In the finance report, section 3.2.1, bottom of page 7, the third paragraph says '*year to date position is £12.6m overspent for 2023-24, but that should be mitigated by £12.3m expected income relating to the Additional Roles Reimbursement Scheme (ARRS). NHS England has informed the ICB the funding will come in month 11. Once funding is in there is expected to be as £329k underspend overall'*. Is this an underspend or overspend? It was noted the last sentence will be corrected to state – Once funding is in, there is expected to be £329k full year overspend. • '*£251k of overspend is due to cost pressures in Minor Surgery, Quality & Outcomes Framework, Clinical Waste and the cost of the PCSE patient letters service'*. It was noted this sentence will be corrected to say the £251k year to date overspend is due to cost pressures in Minor Surgery, Quality & Outcomes Framework, Clinical Waste and the cost of the PCSE patient letters service.
	Subject to the two amendments, the Committee APPROVED the minutes of the meeting dated 20 February 2024.
1.4	**Action Log**
1.4.1	The Committee reviewed the action log as follows: Four actions are in amber which are due to come back in June and December. One of the amber actions states a paper on St Ann's Road Surgery will come back to the part 1 of the meeting in April 2024. Due to purdah, this decision will be referred to an extraordinary meeting being considered for May 2024. Please note we are in the process of organising a date and time for this which will be published in due course. There are two actions in green which have been completed and therefore recommended for closure.
	The Committee APPROVED the action log.
1.5	**Matters Arising**
1.5.1	The Chair read a statement on the change of control at AT Medics: • As many of you will know, AT Medics Ltd provides general practice services to patients from a number of sites in North Central London. They currently hold 8 contracts with us and nationally operate approximately 60 GP practices. • On 30th November 2023, Integrated Care Boards (ICBs) received a request seeking prior authorisation for a change of control of AT Medics Ltd. • Following this request, ICBs began a due diligence process to determine whether the proposed owner was qualified to hold an Alternative Provider Medical Services contract. • On 15th March 2024, the NHS was notified that ownership of Operose Health Ltd transferred from MH Services International (UK) Ltd (a subsidiary of Centene Corporation) to T20 Osprey Midco Ltd on 28th December 2023. • This resulted in a 'change of control' for AT Medics Ltd. • In light of this new information, we are looking at our options and reconsidering the process and timeline.

	• GP practice services should continue uninterrupted. This does not mean that these GP practices will close or that registered patients need to find a new doctor. • As a commissioner of NHS services our main priority is to ensure the provision of high quality, safe and accessible services for local people. • We monitor the quality and performance of services ongoing to ensure residents receive care that meets the strict standards and regulations that apply to all providers of NHS services. • The due diligence process and our patient, public and stakeholder engagement will continue, to ensure when it considers its options, the Primary Care Committee understand people's views. • Our public information and communication and engagement materials will be revised to reflect this change. You can share your views and feedback and ask questions by completing a short survey available on our website. • This committee will consider all relevant information and make the necessary decisions in due course at a meeting held in public. • Further information is available on our website.
1.5.2	In considering the points made, the Committee noted the following: • AT Medics hold the contracts and are accountable for the contracts and the provision of services. • Regardless of the Change of Control, the ICB needs to understand the organisations that have control of its APMS contracts. Therefore, the due diligence process shall continue. • The ICB will consider its options regarding the breach of contract by AT Medics at a future Primary Care Committee meeting.
	The Committee NOTED the statement on the change of control.
2.0 BUSINESS	
2.1	**Special Allocation Scheme – APMS Contract Expiry**
2.1.1	The Committee was asked to approve the recommendation to extend the APMS contract for the remainder of its term to 3 November 2029. The following was highlighted: • The Special Allocation Scheme (SAS) is a specialised primary care service in place to manage patients that have been de-registered from a practice list for displaying threatening or violent behaviour where a police reference number has been obtained. • In 2019, following a procurement process, NCL ICB commissioned one provider, Medicus Health Select to deliver the service for the five Boroughs (Camden, Islington, Haringey, Enfield and Barnet). The practice has 274 registered patients as of 1 January 2024. • The services are provided under an Alternative Provider Medical Services (APMS) contract. • The current contract commenced on 4 November 2019 with an initial 5-year term and provision to extend for a further 5 years. The contract is approaching its first review point as it expires on 3 November 2024. • The contract has a block value of over £220,000 and has not seen an uplift since the contract started in 2019. • To date the practice has achieved 'Band A' achievement for all KPIs. • The practice has been inspected by the Care Quality Commission (CQC) twice (2021 and 2023) and rated *Outstanding* in the Well-Led domain and *Good* in all other domains (Safe, Effective, Caring and Responsive) and overall.

	• The practice does have some work to do in terms of improving screening, immunisation uptake and patient satisfaction, although it is important to note that no patient that's with this scheme is there by choice. • The recommendation is to extend the contract for a further five years until November 2029, and an uplift to the contract to a little over £264,000 being a £43,000 uplift, for 2024-25 and then to have further uplifts in line with the global sum to reflect the increased practice costs over this time and the growth in the list size.
2.1.2	In considering the paper, the Committee made comments and asked the following questions: • The amount per patient seemed excessive at £900 per patient per year. In comparison to other primary care contracts, it is nine times more expensive. It is understandable this a complex group of patients so require more additional support, but it is not translating into quality e.g. achieving the screening targets. • What are the characteristics of the patients being served? Ethnicity, learning disabilities, mental health etc. Are they getting the adjustments and support they need and being reached. • Has a quality and equality impact assessment been completed. • Nursing ratios showed that instead of having up to 9 appointments per week, there are only 2. • It did not feel right that a patient would check in every two weeks for the purpose of getting a repeat prescription. If they do, is this not an opportunity for health checks, blood pressure checks, screening, immunisations etc. • Has been an increase in referral to this service? • There have been several appeals that have been upheld and would be useful to know the patient's point of view. • To provide appropriate support to people with complex needs, does primary care have all the guidance to ensure a proper, fair process of learning is working. • It is worth understanding what has been achieved against the contract terms in the first five years. However, if offering the Special Allocation Scheme service, need to understand what is required from the contract with the funding that has been offered. Also, the second term of extension should take account of that. • There is a need to understand the importance of the balance between the abuse that practices report as being on the rise, and the reasons for referral to the Special Allocation Scheme (SAS). So, with physical violence, verbal abuse, racism and many other things happening, the criteria will need to be examined again. • With access, it is the service provider's duty to find premises from which to deliver the services. Therefore, need to get the provider's perspective before approving any renewal on how they are going to close that gap between what should be a five-day access to services and also looking to Saturdays. • This is an opportunity to review how the service compares to other services before any approval is given to a five-year continuation as well as put in place more robust actions and requirement for progress against quality indicators and access. • Is an expectation to provide enhanced services. For example, the Long-Term Conditions locally commissioned service is now available across all the practices in NCL. • Do all the individuals, who are part of the service, have access to the wider multidisciplinary team that is now available within the primary care team.
2.1.3	In responding it was noted: • The service can participate in every initiative and scheme and is for adults. • Premises have been looked at since starting the contract, but many have not been available for long or are practical enough. All these sites are further north and hopefully deliver services a bit closer to patients' homes.

	• The service needs to engage with patients early and help to rehabilitate them back to mainstream primary care. • They have not applied many personalised care adjustments (removing patients from the QoF). • There is limited data for this practice largely due to their size. So, need to work with the provider to better understand their patient cohorts and needs, and how to help them improve outcomes for these groups. • There are four KPIs in the contract now, but these can be refreshed.
2.1.4	The Chair concluded: • The Committee cannot approve the item today as it needs to be able to review the responses to the questions that have been raised and therefore an updated paper will need to come back to the next meeting. • Although the performance against the KPIs in the contract is good, work will continue with the provider in the meantime to ensure the right provision is given to a group of people who are particularly complex in multiple different ways.
2.1.5	**Action:** • **To bring back an updated SAS paper.** ***(Anthony Marks)***
	The Committee could NOT APPROVE the recommendation to extend the APMS contract for the remainder of its term.
2.2	**APMS Procurement – Contract Award**
2.2.1	The Committee was asked to approve the award of the NCL APMS contract to the following bidders: - Lot 1 - Barnsbury Medical Practice (Islington) – Bidder C - Lot 2 - Hanley Primary Care Centre (Islington) – Bidder C - Lot 3 - JS Medical Practice (Haringey) – Bidder G The Committee was asked to approve the recommendation that the following reserved bidders are advised of reserve bidder status: - Lot 1 - Barnsbury Medical Practice (Islington) – Bidder G - Lot 2 - Hanley Primary Care Centre (Islington) – Bidder G - Lot 3 - JS Medical Practice (Haringey) – Bidder A The following was highlighted: • The paper sets out the process and outcome of a procurement exercise to identify new providers to deliver services under an APMS contract for three practices: Barnsbury Medical Centre, Hanley Primary Care Centre and JS Medical Practice. • A good response from 12 bidders was received. • The names of the bidders could not be given as the Committee would take the decision today and then we enter a 10-day standstill period, which will allow any bidder to challenge the outcome of the procurement. • There has been extensive work carried out before going out to procurement in terms of the revision of procurement documentation: the questions, interview and written questions, and the memorandum of information (MOI). The updates now reflect the ICB strategy in terms of population health, social value and making sure that it provides its focus on retention and recruitment of staff, as well as retaining the standard safety aspects of the patient services in terms of clinical and operational values. • The KPIs have been updated to include indicators on social value, inequalities of health and population health as well. • Patient and stakeholder views were included within the MOI documentation to enable the bidders to respond specifically to any patient / stakeholder concerns.

	• There were 21 evaluators and moderators in total with expertise across the ICB. Each independently evaluated bidder responses to the questions. There were two people evaluating per question with moderation undertaken only with those evaluating that question. • The oversight and collation of the notes and scoring was managed by the NEL Procurement team, and scores were not held by the ICB during the procurement stages. • To safeguard against potential conflicts of interest all panel members signed conflict of interest declarations and non-disclosure agreements. Project members and Evaluators were carefully selected, informed of their role and the importance of the confidential nature of this procurement. The Committee agreed the paper was extremely comprehensive with the attention to detail and processes. It was satisfied with the assurance that due process had taken place on the proposed awarding of the contracts.
	The Committee APPROVED the award of the NCL APMS contract to the following bidders: - **Lot 1 - Barnsbury Medical Practice (Islington) – Bidder C** - **Lot 2 - Hanley Primary Care Centre (Islington) – Bidder C** - **Lot 3 - JS Medical Practice (Haringey) – Bidder G** **The Committee APPROVED the recommendation that the following reserved bidders are advised of reserve bidder status:** - **Lot 1 - Barnsbury Medical Practice (Islington) – Bidder G** - **Lot 2 - Hanley Primary Care Centre (Islington) – Bidder G** - **Lot 3 - JS Medical Practice (Haringey) – Bidder A**
3.0	**OVERVIEW REPORTS**
3.1	**Quality & Performance Report (Q&P)**
3.1.1	The Committee was asked to review both the executive summary and dashboard itself and note any questions, issues or themes that would benefit from further discussion or investigation. The following was highlighted: • The report is for general practice services rather than the primary care in the round. • In terms of the activity and workforce information on the dashboard, existing trends continue as expected. • As part of planning for the forthcoming financial year, the ICB has proposed activity levels are maintained rather than increased. • Practices are providing 92% of appointments within two weeks (above national target of 90%) and clinical workforce continues to increase. • The focus for this year will be on maximising use of the additional roles reimbursement scheme (ARRS) allocations in primary care networks, noting it is the last year of the current GP contract and is expected to change for next year. • The focus on learning disability health checks (LD Health Checks) was an action from a previous meeting that had been picked up in more detail but important to note there was a data lag here. Provisional data indicated that NCL had met the national long-term plan and target of achieving 75% health checks completed. However, practices approach LD Health Checks in different ways, which is why a cumulative trend is seen coming through the year. This will be revisited with the final end of year position and there may be learning to understand different practice approaches. This will include learning from practices that do this very well and exploring who the ICB supports practices who might benefit from additional

	support. This will require thinking about how to triangulate the LD Health Check with data from other teams and other areas of the ICB to make sure there is good understanding. • The report notes the changes to the remit of this Committee and also the changes to the primary care structures in the ICB in order to think of how to evolve the Q&P report further. Simon Wheatley did a lot of work on this previously, so need to continue iterating it and being articulate about how the data and Committee discussion links clearly to the work of the new primary care team in terms of how action then happens.
3.1.2	In considering the report, the Committee made the following comments: LD health checks • It would be good to understand the impact on outcomes from the LD health checks and whether it makes any difference to help reduce inequalities in poverty, mortality and unnecessary morbidity. • It would be useful to have the ICB borough teams work with the quality team and others to look at the quality of LD health checks in more detail and provide more insight into the other issues and challenges. It might be good to spend some time at a future meeting to look at the patterns in this data and generate ideas. • Why do practices focus on LD health checks before the end of the year? It may be possibly because they struggle with the huge demand they have to pick up and deliver against on a month-by-month basis. Also, due to the constrained capacity in general practice and the infrastructure needed to do this work well, many practices find it easier to have a sustained focus at one point in the year. • There is good learning from LD health checks. Although there may be focus on the negatives and gaps in the quality of life, there is also a need to capture the positive and good work that is being done. • It would be useful to do a deep dive on LD health checks to see what is going on and why there is a difference between practices. Workforce • Need to spend more time in future meetings on the workforce data, linked to content that was discussed in the workforce paper in February. • The clinical workforce has been growing for the last five years under the additional role reimbursement scheme. • The budget for these roles will not increase again and there is currently no major funding stream for primary care to continue to grow its workforce. Therefore, we need to look carefully at what the ratios of patients to different roles are and what plan is there for continued development of the general practice workforce in NCL. Interface between general practice and secondary care • Need to discuss the interface between general practice activity and secondary care activity in terms of advice and guidance, consultant connect, referral, ED attendances etc. • This also includes patient experience which seems to fall short especially when trying to get the GP to help you get into the service you are waiting to access or the availability to start the services. Interface between Quality and Safety Committee and the Primary Care Committee • The Committee has already had a seminar with the Quality & Safety Committee which looked at quality of people's experience between primary care, secondary care, social care, mental health care etc. • The ICB has a quality vision which sees quality in terms of patient access, patient experience, and outcomes and service delivery, staff experience and then financial value of the services in terms of their impact. That would be showing whether the ICB is delivering the population health improvement and integration

	strategy. So, the Quality and Safety Committee and the Primary Care Committee will need look together and see how that can be done at place and in the system. It practically means the Quality Team who attend this committee along with the Primary Care Team (with colleagues in Primary Care Strategy and Change) as well as the new Place directors will need to work through that. • It was noted Deidre Malone and Adam Backhouse will meet this week to go through the content of the dashboard but also the narrative around quality and link into the Quality and Safety Committee which needs discussing primary care in more detail. Priorities as a System • There is a need to be mindful of what is going on at the frontline when reviewing this data. • There has been a recent national consultation around incentives and outcomes in General Practice which the ICB has responded to. As an ICB we need to ensure all are clear about the priorities and that colleagues in primary care also know and understand that everyone is working together to achieve the shared outcomes. • Will need to come back to the population health aspect of this report to ensure a comparison is being done on the operational health achievements and how general practice enables these achievements. • Further we need to consider how this is tracked and to ensure general practice has the infrastructure to enable them to achieve what is important to the ICB as well. Complaints • It was asked what themes were there for complaints and how do they contribute to the learning and improving the culture. Next Iteration of the Q&P Report • The Committee needs to see triangulated data points for example to see how the access and workforce look together. • Aim to incorporate the DES performance by the end of the current financial year into this report. • It would be useful to see how the enhanced service activity leads back to some of the outcomes particularly for key inclusion groups. The Committee agreed it was interesting to review the points raised today, and to start thinking about the immediate actions and to continue evolving the process of iterating the Q&P report considering the transition and change programme.
3.1.3	**Actions:** • **To meet and discuss links between reporting to the PCC and the Q&S Committee.** ***(Adam Backhouse and Deidre Malone)*** • **To undertake a deep dive into LD health checks to understand how we support achievement and best practice.** ***(Adam Backhouse)*** • **To develop the Q&P report further.** ***(Adam Backhouse)***
	The Committee NOTED the report.
3.2	**Primary Care Finance Update**
3.2.1	The Committee was requested to note the Primary Care budget and financial position as at Month 11 (February 2024) and additional information both on where the position landed for the year and the current draft budget for the coming year 2024/25. The following was highlighted:

	• A further £12.3m of additional roles reimbursement scheme (ARRS) funding was received as expected in month 11 and, at that point, an underspend of £44,000 was being forecast for the fourth year. <u>2023/24 Full Year Position</u> • 2023-24's full year's financial expenditure for delegated primary care was £308.3m spent against a budget of £307.8m. • At the last meeting it was highlighted that cost pressures would be reported in order to be able to better plan going forward. • As a result, a £464,000 or a 0.15% adverse variance or overspend against plan has been reported. The overspend was not anticipated for month 11 and was due to last minute submission of invoices from GP providers across several service areas as well as previously reported overspend in learning disability health checks. This deficit is being offset with underspends in other areas of the ICB. It should be noted the overspend, at 0.15%, is a very small percentage of the overall budget. <u>2024/25 Draft budget</u> • The 2024/25 budget has not been finalised but the allocation of £306.7m compared to recurrent funding of £295.1m in 2023-24. This is an increase of £11.6m or 3.9%. The ICB is still finalising its delegated primary care budget for 2024/25 and will deliver a balanced budget as required. However, this is a challenge with cost pressures spread across several areas in 2024-25. • £25m ARRS funding has been included in the baseline. Once this is utilised, as in the current year, NHS England will undertake an exercise asking the ICBs for the projected full year expenditure. They will only release any additional amounts required (up to the expected value) once they have validated the request and again what they can see on the ARRS portal. • Returning to primary care cost pressures, the draft budget currently includes cost pressures in caretaking premiums, enhanced services and premises. Caretaking contracts are generally APMS contracts, which are more expensive than GMS or PMS contracts. There are then additional caretaking costs on top of the standard APMS contract prices and so caretaking costs are considerably more expensive than standard contracts. • Premises cost pressure generally fall into two categories. The first is where the Committee approves new or improved premises, and these inevitably involve increases in rent reimbursement. There is no longer budget for these improvements. Second, there is a backlog of District Valuer rent revenues. When a rent review has concluded, there is a revised rent reimbursement payable by the ICB which is normally at a higher value. This year the ICB started with 146 overdue rent reviews and that number has reduced over the year. • In general, primary care does live within its means and does not operate at a deficit thereby supporting the ICS as a system. For example, the long terms conditions locally commissioned service has self-financed at £16m. The estates team managed to secure 5% of system capital for primary care estates. This is helpful as it enables the practices to rent premises as a shell. The capital money is then used to fund fit-out which means paying lower rents. • The 2024-25 budget will be brought back to the next meeting once it has been finalised.
3.2.2	In considering the report, the Committee made the following comments: • The revenue budget will be restrictive as it has always been. • It will be a difficult year again to balance the finances. • With the end of the financial year and the start of the next, need to consider the overall financial strategy for primary care. • Primary care does not bring any deficit to an ICS system. It is accepted that primary care works with enormous financial challenges, but the primary care

	budget is relatively small and brings with it no deficit which shows the extraordinary value for money that is generated from general practice services.
	The Committee NOTED the report.
4.0	**GOVERNANCE**
4.1	**PCC Risk Register**
4.1.1	The Committee was asked to note the report, provide feedback on the risks, and identify any areas where further work may be needed. The following was highlighted: • The risk scores do not change very often given these are significant strategic risks subject to external forces. • Discussions have been taking place with the Assistant Director of Governance, Risk and Legal Services in addressing how to handle the impact of risks at an NCL level. The Committee was reminded that deep dives on workforce and estates had been looked at in previous meetings. • With the risk around failure to effectively develop the primary care workforce**,** there has been ongoing work across NCL for years not just in GP roles but in other roles with support from the training hub. Latest data suggests that NCL is recruiting but also retaining GPs relatively well compared to other areas. Also to point out that the Additional Roles Reimbursement Scheme (ARRS) has now officially finished. This means the recruitment has happened and those roles remain in place with the investment remaining in the ICB baseline, but it is not growing. It is estimated about £30m is spent on additional roles in NCL and so will be hard for any individual ICB to meet whilst continuing to enhance the workforce locally. PCC and the People Board will need address that on an ongoing basis. Therefore, will ask the Chief People Officer and the Primary Care Team to refresh the mitigations so that the risk can be scrutinised effectively at this Committee.
4.1.2	In considering the report, the Committee made the following comments: • In regard to funding schemes, it was noted the Practitioner Health scheme which supports clinicians with health and mental health problems was due to end for secondary care colleagues this year and the contract would have ended for primary care the following year. There was outcry which has resulted in a U-turn on the decision to end the service for now. • It was noted the PCC risk register is of a high level. There are many things that sit underneath in terms of both the risks and mitigations.
	The Committee NOTED the risk register.
5.0	**ITEMS FOR INFORMATION**
5.1	**Minutes of Contract Decisions Meeting held on 20 February 2024**
	The Committee NOTED the paper.
6.0	**ANY OTHER BUSINESS**
6.1	No further business was discussed.
7.0	**DATE OF NEXT SCHEDULED MEETING**
7.1	18 June 2024