Healthier Greenwich Partnership (in public via MS Teams)

Date: Wednesday 24 July 2024
Time: 12.30 – 14.00
Venue: MS Teams Click here to join the meeting
Chair: Iain Dimond

AGENDA

	Item	Page no.	Presented by	Time
Opening Business				
1.	Welcome, introductions and apologies.	Oral	Chair	12.30
2.	Questions from the public related to today's agenda – to be submitted in advance	Oral	Chair	12:35
3.	Declarations of interest	Oral	Chair	12:45
4.	Minutes of the meeting held 24 April 2024.	1	Chair	
5.	Action Log and Matters Arising	16	Chair	
6.	Positive Partnership Story – Greenwich and Bexley Community Hospice	Oral	Kate Heaps	12.55
Public Engagement				
7.	Healthwatch Thematic Reviews	18	Joy Beishon	13:10
Items for Noting				
8.	Operose ownership update	48	Maria Howdon	13:25
9.	Healthier Greenwich Partnership – Quarterly Partner Update	100	Jessica Arnold	13:30
10.	Risk update	109	Chair	13:40
11.	Healthier Greenwich Partnership – update to Terms of Reference	114	Chair	13:45
Closing Administration				
12.	HGP Forward Planner	122	Chair	13:50
13.	Any Other Business		Chair	13:55
14.	Next Meeting in public: 23 October 2024		Chair	
Meeting closes at 14:00				

Healthier Greenwich Partnership
Meeting In Public
Minutes of the meeting held on Wednesday 24 April 2024
MS Teams

Members	
Iain Dimond	Chief Operations Officer, Oxleas NHS Foundation Trust (ID) (Chair)
Nayan Patel	PCN Clinical Director (NaP)
Neil Kennett-Brown	Borough Chief Operating Officer Greenwich (NKB)
Tuan Tran	Greenwich LMC (Local Medical Committees) Chair (TT)
Chris Dance	Associate Director of Finance, Greenwich, SEL ICB (CD)
Kate Heaps	Chief Executive, Greenwich, and Bexley Community Hospice (KH)
Kate Anderson	Director of Corporate Affairs, LGT (KA)
Lisa Thompson	Director of Children & Young People's Services, Oxleas (LT)
David Borland	Integrated Commissioning Director for Children and Young People – RBG/ICB (DB)
David James	Chief Executive, Greenwich Health (DJ)
Steve Whiteman	Director of Public Health, RBG (SW)

In Attendance	
Ike Philip	Corporate Governance Lead, Greenwich (Minutes) (IP)
Daniella Finch	Groundwork London
Members of the Public	Five

Apologies

None received	

1.	**Introduction**
1.1	**Introductions and Apologies for Absence**
1.1	The Chair welcomed everyone to the meeting. The Chair noted this was a meeting in public and explained the ground rules for effective conduct of the meeting. This was followed by introductions.
2.	**Declarations of Interest**
2.1	The Chair asked if anyone had any interest to declare on any of the agenda items. None was declared, although NaP noted that PCNs are employers of physiotherapists and have circle physiotherapists in GP practises. This would be relevant for agenda item 11 MSK update.
3.	**Minutes of the Previous Meeting Held on 27 March 2024**
3.1	The minutes of the meeting held on 27 March 2024 were reviewed and approved as accurate.
4.	**Action Log & Matters Arising**

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4.1	The action log was reviewed, and updates noted. It was noted the action for AN to have offline discussion with Kate Heaps relating to capturing the end-of-life investment and work in the local plan update for 2024-25, will be followed up by Lisa Wilson and should be closed. NKB committed to follow up the other open action with Victoria Stanway.
5.	**Positive Partnership Story**
5.1	This item was skipped as Deborah Browne was not available due to emergency leave.
6.	**Public Forum Feedback**
6.1	Russell Cartwright introduced the item, noting the HGP Public Forum was held on 25/03/24 and the theme was 'Tackling Cancer Together'. It was the seventh public engagement forums. The turnout was low compared to previous ones, although it was heavily promoted throughout the Greenwich West area and digitally. It was a hybrid format; four people attended in person at West Greenwich Community Centre and 7 joined online. RC commented that previous forums that were disease specific recorded lower turnouts than the ones with more general topics like physical activity.
6.2	RC noted the participants had some valuable discussions. There were lots of questions around screening regarding availability of information for screening and screening uptake in ethnic minorities. There were lots of interest around inequalities and its effect on preventing, finding, and treating cancer. There is also an appetite to be part of the solution and to help work together to improve prevention.
6.3	RC explained some of the key issues participants raised at the forum. • Data - reports on screening which in terms of ethnic minorities does not break down far as it is broad. RC noted there is hope of getting access to better data soon. • Health inequalities and access to AGP, including being able to get GP appointments, were seen as barriers. • People not always feeling welcome, and that was not just in GP services, but it was in services, across the board. • There was discussion about providing more opportunities for people to stay healthy in their communities. • Personal experience - quite a few people shared how cancer has touched them and affected their lives. Some were keen to talk about encouraging screening. • Information - more awareness, culturally appropriate information around what getting screened involves into in terms of the process. There were some questions around accessibility of screening venues and perception of accessibility. • Work with local community champions and groups - have a local cancer community champions programme and work with existing community groups and the wider community. • Promotional campaign came up as a suggestion, which is good because Greenwich is running a breast screening campaign now.

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6.4	Participants talked about what might help people attend screening, and they were things like being able to bring a friend or family member with them. There was also suggestion of a kind of friend scheme which could fit in with the Community champions. You know, if somebody has not got somebody, they can bring with them, there could be a scheme to match people up.
6.5	RC disclosed that eight of the participants completed the feedback forms about the forum and the information demonstrates increase in knowledge of cancer in Greenwich, which was highlighted through the session. Caroline Hollington delivered an update on cancer and cancer prevention. So, that led to a good increase in knowledge, which is good and a good increase in knowledge scores about Healthier Greenwich Partnership and what we do so. So, there were some positives there.
6.6	RC noted the participants suggested some topics to be considered for future forums - GP services and appointments, autism, ADHD, and diagnosis of these kind of conditions. The next public forum would be held in July.
6.7	The Chair thanks RC for the feedback and asked for comments or questions from members. NKB acknowledged that RC gave a good summary of the event, noting it is always good to get out and go to different venues in various locations and meet with people. Obviously, it is always interesting to see how many people physically come versus how many people come online.
6.8	JB commented that Healthwatch and a couple of other organisations have done some public engagement work recently about raising awareness of women's cancer screening – (https://healthwatchgreenwich.co.uk/news/2024-04-08/raising-awareness-womens-cancer-screening) JB asked if anyone is actually collating and pulling all this together because some of the things that that Healthwatch found, some of the themes are very similar to some of the themes that that RC found from the public forum? JB asked how the challenges identified would be taken forward and what action is going to be taken as a result?
6.9	KH noted Greenwich and Bexley Community Hospice have been doing some work with an organisation called D Changer who are local organisation who focus on counts of people who have cancer and who are from the Black African community. KH suggested in terms of action planning, it might be good to involve them in. KH confirmed they meet at the Hospice once a month, so happy to provide introduction if that is helpful. (Contact email: dchangercharity@gmail.com).
6.10	The Chair invited RC to respond to the comments and questions. RC noted in terms of putting together all the different feedback and insight, it will be helpful to have a conversation with that at the Cancer Group, which is cross organisational and which Sheila Taylor leads and coordinates. RC has been involved in a huge amount of insight for the breast screening campaign that he has been developing and has a huge amount of stuff which could be supplemented with. One of the insights into the breast screening

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	campaign was about capacity and this would be taken on board with other insights from the public forum.
6.11	In terms of learning from the event, RC suggested it would help to avoid disease specific themes in future forums as they tend to have lower turnouts. There was some discussion about whether the HGP would like future forums to prioritise rotation around the borough or being held in areas most likely to yield higher turnouts. RC asked the HGP to clarify which one to prioritise?
6.12	The Chair noted it is a crucial point and asked members for comment. NKB made a separate comment based on his experience from going to these events, noting that people's personal experience and their personal championing of issues feels like it has the biggest impact in terms of deep reach into local communities. NKB gave example from someone from the Plumstead area who came and shared some of the approach at this event where she talked about how she was going to be championing this issue. NKB suggested there is something about building on that kind of community champion. There is more work to do to address hesitancy about getting involved in screening. The biggest message with cancer is early identification and prevention in the first place. There is need to continue the promotion work around that.
6.12	NaP expressed the view that although the turn out might not be great at every event, however, this is a new way of doing things. There is work to be done with building neighbourhoods and primary care networks, et cetera. It would not be right to switch the focus and just focus on areas where there is greater turn out. NaP thought it is imperative to continue holding the public forums around the various areas of Greenwich, noting in time that will build awareness as people get the idea of how neighbourhoods work.
6.13	The Chair noted there is strong steer to carry on rotating the public forums and to get good coverage across the borough and then grow the momentum.
7	**Questions and comments from members of the public**
7.1	The Chair explained this is an opportunity for members of the public to ask questions or make comments on any of the items on the agenda.
7.2	John Kenny (JK), a member of the public, commented based on his previous existence in housing, both in Greenwich and London wide, there existing historic structures around tenants and residents' associations, some of which are successful, they meet in existing buildings premises. These could become useful partners in reaching neighbourhoods and RC could liaise with them for future public forum engagements. They could provide a doorway into health issues around not just housing, but also community issues.
7.3	JK spoke about the Thamesmead APMS procurement process and asked how much weight is attached to the involvement of patients in that? He noted this is a contractual obligation in changes of service, in decision making and patient participation groups (PPGs). JK expressed concern that little attention is paid to supporting that process and

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	supporting practises in that process. For example, in choosing a new provider at Thamesmead, what weight, if any, has been attached to their performance regarding patient involvement? What involvement should there be of patients in any future procurement process?
7.4	The Chair acknowledged the first point is helpful, noting that certainly the forum that he attended in Plumstead back in the winter there was a strong kind of presence, from the local resident groups and there was a particular conversation around housing and the kind of changes to housing in the area and particularly around tenancy. The Chair stated the HGP is feeling our way through these kinds of forums so any steer JK or other members of the public want to give the HGP around groups that the HGP should be in touch with, would be helpful. Such suggestions should be made to RC and other colleagues. The Chair asked NKB to respond to the question about the involvement of residents and PPGs in procurement process.
7.5	NKB noted he and some primary care team members met with the Thamesmead Health Centre's PPG and talked about the procurement and the need to involve them. Some members of the PPG would be involved in evaluating bids during the procurement process. The wider practice population have also been engaged about the procurement.
7.6	Denise Beckles (DB), a member of the public, was delighted to hear about the meeting held with Thamesmead Health Centre's PPG, noting it is important to involve all stakeholders. DB observed that most things are integrated now, and everything tends to relate to another - the neighbourhood, the housing, everything are related to the healthcare system. DB expressed concern that the turnout at the public forum is not representative of the population of that area of Greenwich, noting it is important to get inclusion of more people to attend future forums to make them more diverse and representative of the local population. DB asked RC what could be done to get more people to participate in future public forums?
7.7	RC responded and clarified the biggest issue with the last forum was small numbers of attendance rather than diversity. RC noted that in previous forums there were quite good representation amongst people from all aspects of community. RC noted he and his team would welcome any helpful suggestions about how to increase participation in future public forums.
7.8	DB made a point there is a real concern about hesitancy and the numbers have gone down of those coming to get screening for breast cancer and a lot of it has to do with the trust issues. There is need to get past that historical trust issues. DB suggested that more and wider engagement would help increase screening numbers among the sufferers of breast cancer in Black and ethnic minorities, and prostate cancer in men. DB mentioned the use of community champions and linking up with existing patient groups.
	The Chair thanked DB and JK for their comments and questions noting RC would

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7.9	welcome any further helpful suggestions.
8	**Greenwich Assistive Technology Enabled Care (ATEC programme)**
8.1	Lisa Wilson introduced the item and presented it jointly with Kit Collingwood. Both are the joint Senior Responsible Owners (SROs) for the programme. LW noted a lot of work was done over the last two years to design and prepare to deliver a joint model of assistive enabled technology care for Greenwich. It is a partnership between the NHS and the Royal Borough of Greenwich as a local authority, with an important aim to improve outcomes.
8.2	LW explained there was engagement with residents and staffs to design the programme, including having a residents' design group for the programme. There has been public consultation, engagement with staff leaders and service providers. LW spoke about the drivers for change, including the policy landscape, the role of the Care Quality Commission (CQC). There is expectation that strong ATEC offers by Councils is a good thing and would benefit residents and partners.
8.3	LW noted RBG is the main commissioner and SEL ICB is an associate Commissioner. Other partners include Oxleas NHS FT, voluntary sector and care providers. The proposed model would go to cabinet for a formal political decision around the commissioning and then the operationalising of the model. The programme would offer a range of technologies to residents. There is a whole training and learning and developmental culture change programme being delivered over the coming months in readiness for delivery from the autumn this year.
8.4	KC spoke about some of the operational aspects of the programme, the model and resident outcomes. KC explained the ATEC customer journey. The programme would be training a range of people to help identify opportunities for where assistive technology can be of assistance. There will be a personalised assessment, that a range of practitioners will be able to assess somebody for these kinds of technologies and make sure that whatever technology they receive is right for their circumstance. Following installation, there would be training for the person or friends or family or loved ones to help them use the technology as well as well as they can.
8.5	KC explained there would be telecare service which would link up with emergency service when needed and there would be routine ambient monitoring of people, noting the team is designing the detail of that now. A data team would boost the programme team to support monitoring and gain insights. There would be a culture change team and monitoring of the service would be inclusive, both from practitioner and user points of view.
8.6	The technology offer contains the list of various devices. ATEC service providers would source the right technologies from different hardware manufactures. The scope and phasing show the phases of the programme, with go live planned over 12 months.

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8.7	LW spoke about the modelling and explained how the costings and benefits were modelled for a range of areas. It was noted there is a 10-year plan for both the gross and net benefits.
8.8	The contract period will be 5+2+2+1 years. The contract period is balanced between how adaptive this market is and how much it is expected to mature in coming years and making sure there would be continuity of service.
8.9	It was noted that Oxleas is one of the key partners for the Community and mental health services in the borough and is involved in the programme governance and design. In terms of clinical governance, the programme team would look at the relationship between the response service and the joint emergency team and Greenwich one-on-one services and the borough-based interaction there.
8.10	The Chair thanked LW and KC for the presentation. The Chair noted that the ATEC programme is also making its way through Oxleas governance structure. The Chair expressed the view that ATEC is something that seems absolutely the right thing to do for residents. The Chair commented briefly about the inbuilt costings and benefits realisation plan and asked do we track the benefits realisation, particularly from well from a financial point of view, but also from a kind of resident point of view?
8.11	LW responded that the team are designing and building a local benefits model with those partners from finance and performance. As this is an integrated health and care model, performance tracking is being developed with a range of partners. The expectation is that it would be tracking in real time with data. Some of benefits tracking is about skills, and we are being very. The programme team is specific about making sure that there are right skills in in the programme to do proper impact modelling and that includes that culture change and working with practitioners and clinicians to make sure they can forecast and then can track against a forecast. Some of that is good science making sure you have a control group, or you know as good as control group and applying those proper techniques.
8.12	The Chair asked if members have any comments or questions? KC observed that benefits of the programme is not just benefits to the NHS and local authority. It is about we are part of the system, and it would be nice if we stopped talking about individual parts of the system, instead of the system. KC referred to the phasing and suggested whether end of life care specifically needs to be a category on its own. The phasing has things like COPD, long term conditions, all the rest of it, and therefore whether we do need to think about the phasing around training of Hospice staff. This is because it is likely that several people being seen in hospice rehab type services will be using this technology, but hospice staff will have no idea about any of that.
8.13	NaP commented that this his is a good presentation and he shared the team's enthusiasm around the potential for this, especially the possible benefit of keeping people out of hospital. NaP would like to see if there is a potential for this to be linked up with some of the proactive care work that primary care is doing, because when you

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	do the case finding, et cetera, there is mileage in getting this to link up at a much earlier phase than the phase journey indicated.
8.14	NaP presumes the 10% reduction in hospital admission was just a very conservative estimate, noting that when we start talking about savings, we need to recognise that the population will continue to age, new people will come into it. When we are talking about savings, it is not this cohort we would have prevented 10% of admissions in. It is in the future cohort we would have done it. It would be valuable to see if that modelling exists. NaP also suggested it really would be valuable if the programme can get people who receive devises linked onto the NHS app because that will help them access general practise services and then we can start looking at other potential avenues that NHS app will start offering and delivering in the future.
8.15	TT remarked that this was a great presentation and explained he had a bit of firsthand experience with some of this technology with monitoring patients at home who had SAT monitors during Covid-19. TT saw how effective and convenient it was and it is completely right that we use any such available technology to help enhance the care. TT suggested, firstly, there is need for confidence building - you need to build confidence and trust at the very start of the process. Ensure there is a safety system in place that the patient and relatives can trust their contingency planning, noting that is key. TT also added whilst recognising we need to be creative and innovative in the state of the health and social care, he is mindful as a clinician that there is a lot of things that are noticed home visits, that kind of soft signs and things that would not necessarily be picked up by assistive technology. While recognising we need to modernise, we do recognise there might be something we are missing by reducing that patient contact whereby you pick up signs and information that you would not otherwise pick.
8.16	NKB expressed full support of the ATEC programme, noting as an active member on the ATEC boards he is delighted that it looks like Greenwich is going to be leading the way nationally in having an integrated model from the start. NKB thinks the potential is massive but thinks the point on that culture change piece is a fundamentally unique way of is seeing technology as part of the wider support that is there and about promoting independence for people. Some of that is about their own kind of confidence in using that technology and for the staff as well. NKB noted there are real potentials and opportunities for the programme, such as proactive care, response models, falls and frailty. There is opportunity to bring those aspects together.
8.17	NKB noted there is also question about how the system would manage risk? This would require conversations. There is also need to understand how to manage people differently. Part of that is about equipping them and enabling them to respond differently and work in more integrated way. NKB thinks there is a massive opportunity both with the neighbourhood working but also with our federation, running the urgent treatment centre, the 111 side of things, all those kind of response aspects and the jet team. We need to make sure that when things happen, we respond in the right way.

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	NKB noted this is an important work and thanked LW and KC for their leadership on this.
8.18	JB would like a bit more of an understanding about how we are going to build the confidence and trust of residents. JB also raised an issue about cost-of-living crisis and would like assurance there won't be cost implications for residents for using these technologies or if there are, how that will be managed?
8.19	The Chair thanked everyone for the questions and comments. LW said she made note of the questions and KC and her would draft responses for IP to include in the minutes.
8.20	The Chair asked if members would like to approve the assistive technology enabled care service (ATEC) model and integrated commissioning approach? This was unanimously approved. **RESOLVED**
8.21	The Board approved the assistive technology enabled care service (ATEC) model and integrated commissioning approach
	POST MEETING NOTE
8.22	The following was provided by LW and KC in response to the questions and comments.
8.23	**The potential of ATEC in prevention work**: the skills we are building into the team, and the platform, will give us a capability that goes beyond the current scope of the programme. This includes generating large data sets which can allow us to improve our decision-making about an individual, and potentially build predictive models at a cohort level which may allow us to prevent, reduce or delay health or care services being needed.
8.24	We are starting this work in May via funding from the Accelerating Reform Fund https://www.gov.uk/government/publications/accelerating-reform-fund-for-adult-social-care/accelerating-reform-fund-for-adult-social-care-guidance-for-local-authorities , where we will undertake a discovery piece of work to understand how effective predictive modelling might be for reducing hospital admissions in the borough. This work will align with and use data from the ATEC devices we provision. We are also aware of the Healthy Intent work and making relevant links to colleagues for these pieces of work.
8.25	The comments on the role of primary care are welcomed and we are keen to work together – we have had some engagement with primary care, but we are keen to do more. Let us know the forums to come to with you, or we would be happy to or arrange

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	a time to meet. This could include how we might find ways to help residents to better access the NHS app. **Phasing**
8.26	We are already planning to talk more about the phasing for people with long term conditions such as COPD, and where those who are end of life access the service. We are happy to listen to the board's views on this. Action to include Greenwich and Bexley Community Hospice colleagues in discussions planned. **Cost benefit and tracking**
8.27	We are continuing to mature the model we will use to track the benefits to ASC and the NHS; we also want to capture wider system benefits as was noted in the discussion. The impact model was built on some assumptions - we are confident these are cautious, and we will be tracking actual benefits once we go live. We have learned from other authorities who have designed and implemented benefits tracking for ATEC, altering these models to suit the Greenwich system. We will share the model as part of our evaluation of how the service is delivering against planned benefits and outcomes. Partners in the wider delivery work will be able to inform the design of the model for tracking. **On inclusive service design**:
8.28	We are already working with a resident design group, as we mentioned in the pack, and every part of the programme has been informed by them. However, in our determination to make sure these technologies are usable and useful to everyone, we are also including many other ways to bridge the digital exclusion gap. These include: • all ATEC devices coming with guidance and a support from a combination of the technology provider and the ATEC team, both at the point of installation and afterwards. These will be offered in other languages as needed. • some devices being provisioned with SIM cards to make sure that those without reliable Wi-Fi are not disadvantaged • discussions with a local fibre broadband/council joint venture to explore social tariffs for those lacking Wi-Fi • nobody will be charged for ATEC devices. We have an ongoing discussion about whether and how to charge for response services (which some devices may require), but under current telecare arrangements this is means-tested in any case so those who cannot afford any charging regime will not be excluded. **On clinical monitoring**:
8.29	The use (and monitoring) of health tech devices for clinical purposes is not in scope of the first phase of the programme. This is partly because there is an existing virtual ward pilot happening across Greenwich and Bexley (using Doccla https://www.doccla.com/)

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	which we intend to learn from. Our intent is that the Doccla work will be absorbed into the ATEC programme during year 1 of rollout. We would appreciate a conversation with primary care practices to talk about the potential to use ATEC. It was also noted the importance of looking across the workforce going into people's homes when considering who will come in to contact with or play a role in ATEC **On making ATEC part of our system DNA:**
8.30	**W**e are very firm on the principle that we are building 'the new normal'. This means making sure that ATEC in Greenwich is sustainable in the financial sense, but also in terms of health and care practice. This means a lot of learning and training, and being patient in terms of the years it will take to make technology a core part of how we do things. There is a huge opportunity for practitioners who want to pioneer this, and a great chance to upskill for those who want to develop. **On ATEC being a good thing, not a threat to human connection or practice:**
8.31	This programme is designed as a win-win: better for residents, better for our system. We believe - and have learned from other authorities - that assistive technologies can genuinely help people improve their independence, better connect to loved ones, and manage their health conditions with lower intervention from public services. We know that some people will feel threatened or unconvinced of this - and we are open to working across the system to finding opportunities to test our hypotheses. Where technology replaces direct human contact, some people in particular fear alienation, loneliness, or a sense that care will be diminished; we are determined that not only will this not happen, but that these technologies will afford people more opportunity to connect and thrive.
9	**Reprocuring APMS Thamesmead Medical Practice**
9.1	The Chair noted this item was discussed in March HGP and is on the agenda to consider the recommendation from the Primary Care Working Group (PCWG).
9.2	Ginny Morley introduced the item and gave a brief background about the need to reprocure the APMS contract, noting the PCWG discussed the options appraisal at their meeting on 28 March 2024. PCWG agreed with the recommendation of Option 3 for a full procurement. The HGP is being asked to approve the decision to undertake a full contract Procurement for the Thamesmead Health Centre contract which expires in March 2025.
9.3	The Chair asked if members would like to approve the PCWG recommendation for a full procurement. This was unanimously endorsed. **RESOLVED**
9.4	The Board endorsed the PCWG recommendation to undertake a full contract procurement for the Thamesmead Health Centre contract which expires in March 2025.

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10	**HGP Partner's Report and Sub-committee assurance report**
10.1	NKB introduced the item and noted the paper is taken as read. He indicated that Daniella Finch from London Groundwork would like to give an update about the work for the Greenwich Healthier Communities Fund.
10.2	DF stated that the first round of funding is now live, and applications are open for this, which is exciting. DF explained that this is the enabling strand and gave a little bit of context. So, with this fund, this is a new grant programme that has been established to support organisations and communities in Greenwich to tackle healthcare inequalities. The aim of this strand is to increase the ability and the resilience of groups and individuals to deliver and improve their services to address healthcare inequalities. The grant would support providing training or equipment or venue space that would help the sustainability of the work that they are doing.
10.3	DF explained there would be a second strand of funding which will launch on the 1st of May, if everything goes to plan. This is the delivery strand, and this round of funding will be more focused on project work. So, funding actual projects that tackle inequalities in Greenwich. DF would like HGP members to share the news with their networks and any groups that would be interested in applying. DF noted Groundwork London are hosting application workshops across this week and offering one to one support for groups that want to talk about their applications or project work. More information is available on the website via the link which is on the partners report.
10.4	The Chair remarked it is positive and it feels like a good inclusive and very thoughtful process. The Chair asked if other members had any questions or comment?
10.5	JB commented it is great to hear the fund is live and taking applications. JB gave a little bit of feedback received from a couple of smaller community groups, noting that the enabling fund, which is the one which is open now, which is capacity building. You cannot build an awful lot of capacity or sustainability with £10,000. JB suggested increasing the amount if we really want to try and build capacity and sustainability of smaller organisations.
10.5	NaP asked if practises could apply for funding to start up groups in the neighbourhood on their behalf that are not there now? The reason this arises is because of a piece of work that the practice would like to do with the community around diabetes, prediabetes and culinary medicine, food, and nutrition. Now it fits in with all the HGP alignments etcetera. But as a pump primer, practices have not got anyone to sort of bid for this money. Would practises be able to bid the for the money and hold it in trust as such for the group?
10.6	NKB noted he is manager for the charity fund, and he is delighted about the launching of the funding. This fund has been in Greenwich for about 10 years but getting it to a point where we can properly give away funding is remarkable. NKB noted the aim is to disperse all its resources of £6 million over a 5-year period and the main objective is to make a

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	difference to our really grassroots organisations to make impact.
10.7	NKB responded to JB's comment about the £10,000 maximum grant. The idea is there are some organisations or groups who are not constituted at all, who are just people who work in a very local area but do not have anything around them, as they work voluntarily. So, part of it is very much about giving that very grassroots level of funding support for very simple enabling things like booking venues and things like that.
10.8	In response to NaP's question, NKB explained the fund made an active decision not to fund any NHS organisation directly. It would be possible if GP practise would partner with another organisation. NKB clarified the model very much allows another organisation to host on behalf of others. There are multiple charities in in the borough or community organisations, so it might be possible to facilitate those conversations. In that instance, the GP practice would not be the host of where the money goes to but the partner organisation.
10.9	NKB asked KH if she had any further update about the hospice staffing? KH noted they have a long journey to travel in terms of building relationships, particularly with primary care in Greenwich. KH is glad that the hospice now has a medical director who is a GP because it will hopefully help some of those conversations.
10.10	The Chair thanked NKB, DF and KH for the updates.
10.11	The Board noted the partnership report update.
11	**MSK update**
11.1	Lisa Wilson introduced the item and gave a brief update about two MSK engagement events held recently. These were the following: • a service design event on the 22nd of February 2024 to review the current MSK model and pathways including feedback already received over the last few months; • an MSK community event held on the 20th of March at Sutcliffe Park in Greenwich.
11.2	LW gave the highlights from both events, noting there would be continuing engagement with partners on the MSK work. LW explained in terms of next steps, all the feedback received would be used to develop a service specification.
11.3	The Chair thanked LW for the update and asked if members have any comment or questions? NaP disclosed that the current MSK provider threw in a free good for practises which was a physiotherapy service (ARS), with physiotherapist inside each practise. Practices do not want a reduction in MSK capacity that has been provided in primary care. Practices got used to that service and built on it with practice staff paid for practices. So, any future provider should need to match that. NaP would want a future tender to capture that somehow.

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11.4	TT took a quick opportunity to declare conflict interest, being a GP in a practise but also a stand-alone PCN. His practice has Physio and ARS staff as well, but from the NMC point of view, TT supports NaP's comments regarding parity of MSK service currently delivered in GP practices.
11.5	LW responded that, depending on feedback from providers or partnerships that come forward, the team would think about social value and those added advantages when developing the specification. Based on the feedback received so far, primary care really came out strongly as a key connection to the MSK service. LW explained the specification would specify that the links to primary care are critical.
11.6	JB commented that the model of World Cafe style event used for bringing together potential MSK suppliers and service users was a great idea. JB asked about how many service users came along to that and if there are any other opportunities now and going forward for patients and the public to feed into this process? LW affirmed they would be widening out those opportunities to involve residents and patients, linking with other services in the borough.
11.7	NKB responded to NaP's point about the current MSK service in practices being a free good. NKB clarified that it was not free as such. It was more the way the model was procured in the first place because it was looking at the total cost of all MSK services, both everything that went in the hospital and in the community. It is now separated, so it just covers the community. So, the previous model was just looking at the total cost. The new model would clearly specify what the various parts of the service would cost.
11.8	The Chair thanked NKB for the point of clarification.
11.9	The Board noted the MSK update.
12	**Risk update**
12.1	Ike Philip introduced the item, noting the changes to the risk register since the last update in January. Within the period 2 new risks we are added to the register and three were closed. The summaries were in the report and full details in the risk register.
12.2	The Chair enquired about the individual CHC one being added to the register? IP explained it was because it had wider financial and legal implications.
12.3	JB asked about closed risk on primary care access - was the risk purely about whether practises have digital telephony systems or was the risk about access more broadly? That is, do we have enough GPS you know, are we enabling people to use other appropriate healthcare professionals? IP explained that risk was narrowly defined with respect to digital telephony or remote access as it were.
12.4	NKB revealed there is quite a live conversation in NHS SEL ICB about looking at system wide risks, in terms of next steps in risk management. Actually, HGP as an LCP, is seen as one of the best and most advanced in this aspect because we have actually described

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	most of our risks around the delivery of the health well-being plan because it is about our strategic direction rather than just on specific kind of what were ICB risks relating to, say, finance or a specific quality matter. It is a live conversation across southeast London and there is a working group working on it, which NKB is a member. There could be some recommendations about it from that group later.
12.5	In terms of moving forward, NKB noted the ICB function at Place level can only report its risks through this forum, but many other partners can all express their risks elsewhere. The important thing is we should be trying to sort of work as a system so that the aim is we highlight our key risks here as the system in Greenwich. Obviously, there's interrelations for other aspects. That is the direction of travel.
12.6	The Chair thanked NKB for the clarification.
12.7	The Board noted the risk register update.
13	**HGP Forward Planner**
13.1	This item is for information. NKB noted the next HGP would be used for HGP Development session but there could a change of date.
14	**Any Other Business**
14.1	• Farewell to Ginny Morley – It was noted that this is GM's last meeting. Members bade her farewell. • NKB also noted that IP has secured a new role at SLAM. Members congratulated him.

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Action Log for the Healthier Greenwich Partnership – March 2024

Updated 30.04.24.

OPEN ITEMS						
Meeting date	**Minute Ref**	**Action no**	**Action**	**Action Owner**	**To be Completed**	**Comments**
27.03.24	8.17	003	Victoria Stanway to compare the outcomes from the 100-day challenge and the Know Your Numbers road show held a few years ago, to see if there are some lessons that could be learnt by comparing both models.	Victoria Stanway	23.04.24	Completed
23.04.24	6.11	001	HGP members to feedback to Russell Cartwright on future public forums	All	19.06.24	Next public forum booked for 17th July, Progress Community Hall, SE9 1SL- Note: public forum has been cancelled
23.04.24	6.11	001	ATEC follow up with more details to respond to questions	Lisa Wilson	01.05.24	Completed and incorporated into minutes

AGENDA ITEM: 6

Healthier Greenwich Partnership

Date: 24/7/24

Title	Positive Partnership Story	
This paper is for **noting**		
Executive Summary	A presentation of a hospice patient case study which focuses on our system role and on rehabilitation and wellbeing.	
Recommended action for the Committee	To note the presentation	
Potential Conflicts of Interest	None	
Impacts of this proposal	Key risks & mitigations	None
	Equality impact	Not required for the purposes of the report
	Financial impact	None
Wider support for this proposal	Public Engagement	Not required for the purposes of the report
	Other Committee Discussion/ Internal Engagement	Not required
Author:	Kate Heaps	
Clinical lead:	n/a	
Executive sponsor:	n/a	

AGENDA ITEM: 7

Healthier Greenwich Partnership

Date: 24 July 2024

Title	The Power of Listening: Healthwatch Greenwich 2023-24 Annual Report
This paper is for **noting**	
Executive Summary	Purpose of presenting to the HGP: As directed by the Health and Social Care Act 2012, and the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013, Healthwatch Greenwich are required to present their annual report to key bodies to ensure transparency and accountability, including: • Healthwatch England: To ensure national oversight and integration of local insights. • Royal Borough of Greenwich: To ensure Healthwatch Greenwich is accountable for how public funds are spent, and to demonstrate transparency in our activities and findings. • NHS England: To share feedback on services directly commissioned by NHS England. • SEL ICS: For insights relevant to local health and care planning and commissioning. • Care Quality Commission: To support the CQC's regulatory functions with local feedback. • RBG Health and Wellbeing Board: To influence local health and social care strategies and policies. • The Public: By making the report accessible online and through our public communication channels. Summary of HWG's annual report: In the past year, Healthwatch Greenwich has actively engaged with the community to understand their health and social care needs, with 3,450 people sharing their experiences and 24,208 seeking advice. We published 101 updates, briefings, advice and guidance pieces, and reports and conducted visits to 11 care homes, supported by 67 volunteers. Notable achievements include collaborating on maternity care for asylum-seeking women, supporting Home First with a deep dive on reablement, facilitating GP practice changes for over 200 patients, working with Black and ethnic minority carers to identify their needs, and hosting mental wellbeing workshops with community leaders.

	Our work has led to commitments from local services to improve communication, cultural competence, and accessibility, demonstrating a significant impact on local health, care, and wellbeing initiatives.	
Recommended action for the Committee	• HGP to review Healthwatch Greenwich annual report, integrating insight into HGP's planning and decision-making processes to ensure services are aligned with community and residents' needs. • HGP to engage with Healthwatch Greenwich and other stakeholders to discuss the annual report's findings and collaborate on action plans. • HGP to provide feedback to HWG on how the annual report's findings will be addressed.	
Potential Conflicts of Interest	There are no conflicts of interest	
Impacts of this proposal	Key risks & mitigations	None
	Equality impact	HWG's annual report highlights a number of health inequality implications for health and care services.
	Financial impact	Not applicable
Wider support for this proposal	Public Engagement	Healthwatch Greenwich has actively engaged with the community to understand their health and social care needs, with 3,450 people sharing their experiences and 24,208 seeking advice.
	Other Committee Discussion/ Internal Engagement	Presented to the Health and Wellbeing Board. Annual report has been published on our website and circulated amongst key stakeholders.
Author:	Joy Beishon	
Clinical lead:	Not applicable	
Executive sponsor:	Not applicable	

Presentation to RBG Health and Wellbeing Board

healthwatch Greenwich

What do we do?

- 3,450 people shared their experiences of health and social care services with us, helping to raise awareness of issues and improve care.
- 24,208 people came to us for clear health and wellbeing advice and information on how to access services and get the support they need.
- We published 101 updates, briefings, and reports about residents' experiences and the improvements people would like to see to health and social care services.
- We've conducted Enter and View visits in 11 learning disability care homes in Greenwich.
- We've been supported by 67 volunteers and been awarded the **Investing in Volunteering** quality mark.
- We've also won the '**Employability Award**' from Greenwich University, beating finalists GSK and AstraZeneca.

We teamed up with the South East London maternity system to learn more about the experiences of pregnant women who have recently arrived in the UK, either seeking asylum or having just migrated. We worked alongside a group of these women as co-researchers, meaning they helped us design, run, and develop the whole project.

As a result of our work, South East London Local Maternity and Neonatal System (SEL-LMNS) have committed to:

- Deliver cultural competence training for staff
- Make sure migrant and asylum-seeking women know their rights with information available in multiple languages.

We supported people to switch to a new GP practice when Clover Health Centre closed offering a face-to-face, telephone, and on-line service.

As part of this process, we gathered feedback from patients' and made recommendations on how to make changing GP practices easier - such as differentiating between child and adult registration forms to avoid age-inappropriate questions and simplifying the registration process. We also flagged the lack of consistency in communication styles from GP reception staff, and inaccurate GP registration documentation requests.

Working with RBG Public Health, Healthwatch Greenwich facilitated interactive workshops that brought together community leaders to discuss mental well-being support. These workshops provided a platform for leaders to voice their concerns and share their insights on the barriers their communities face in accessing mental health resources.

Access to mental wellbeing support varies within and between communities.

Leaders spoke about younger people as both being more open to discussing their mental wellbeing/health but more disadvantaged when needing help because they don't know how the 'system' works.

"Speaking from a Black African (Nigerian) context, and intergenerational differences reflects how younger people are starting to speak about mental health, but that doesn't mean they know where/how to engage with services."

Stigma is a key driver within many communities.

"There are also cultural barriers, communities differ, such as in certain Asian communities, mental health/ illness can be a taboo subject. Mental illness is still stigmatised."

Awareness of mental wellbeing information and resources is low.

Leaders highlighted a range of barriers and challenges leading to low awareness, including:

How resources are described or labelled can be confusing, often with a lack of clarity making it hard to know what each resource/service provides. '***Social prescribing'*** was given as an example of this.

- Information is distributed as a 'one size fits all'. Information is not tailored to different communities and therefore does not meet their needs.
- Resources and services are not culturally relevant, or trusted, so communities are reluctant to use them. The ***'Live Well'*** service was given as an example of this.
- Over-reliance on traditional communication channels like leaflets only in English (which excludes some) or putting everything online (which excludes others).
- Signposting to information and resources from statutory services like GPs is poor.

Communities choose and prefer to seek support/information/resources from trusted community/project leaders/advocates over statutory or RBG funded central services.

There is a high level of trust between community members and community leaders.

There is a low level of trust between community members and statutory or RBG services. ***Live Well*** was given as an example of a service that is not widely used or trusted. Many choose and prefer to seek resources, information, and support from community or project leaders.

"... people might go onto the Internet, but they would just prefer going to community leaders. We still signpost. But they feel [the borough services] just aren't going to solve their problems, they trust leaders in the faith, culture, to solve their problems for them. But it becomes very challenging to help everyone."

More community engagement and outreach are needed to increase awareness of mental wellbeing information and resources.

Ways to increase awareness include greater use of public spaces, existing events, and community communication channels to make information more accessible.

"Something similar to a careers fair, where organisations and services get together every month, invite commutes". If you advertise, people would come. at the moment, these things are only once a year. It's not enough."

Another suggestion was the development of ***'ambassadors',*** members of communities/groups, trained, supported, and empowered to serve as advocates, signposting and sharing information about mental wellbeing resources.

"Create a layer of community advocates, who contact LiveWell for them, get the information back to the people who need it without fear of repercussion."

Consistent and ongoing dialogue with RBG PH is needed to increase awareness of mental wellbeing information and resources.

Current community champions approach was described a ***'one way'*** information distribution channel, with little or no dialogue. Moreover, leaders suggested coverage is '***patchy***' with some groups and communities taking part as community champions, while others do not.

"A lot of community work is already going on. But we should bring community work to the people. Different cultural perception of public health services need to be communicated [to service providers]."

"Forums need to be available to everyone and must be very much focused on dialogue. We need discussions, not seminars."

Better signposting using trusted advocates is needed to facilitate easy access to mental wellbeing resources and services.

"Sometimes it's not what you know, it's who you know"

Ambassador roles (trusted community members) can actively engage and raise awareness of mental wellbeing information and resources. Ambassadors can advocate to destigmatising mental health, work to create greater openness and acceptance and reduce barriers to accessing mental wellbeing information and support.

"…There has to be ambassadors who people trust in their different communities. …then services can be used to its fullest. It is important to destigmatise, but there is also a need to keep the community in mind… Each community has their own peculiarity."

While mini grants kickstart initiatives, they are not necessarily effective or sustainable.

Mini grants do not promote sustainability.

"I would use the money to start a project, but we need continuity after the grant. We need to think realistically."

"Grant is an extremely one-off solution."

"The grant is not helpful…. It is just not sustainable."

Not all communities are on an equitable footing to access funding. Greater and more tailored support is needed.

"The <name> applied for the innovation grant but wasn't able to complete the form on time. We didn't have the access to resources on time. Many of us don't speak English, especially women."

How we've made a difference

- The workshops were instrumental in identifying that the existing Be Well Hubs approach could be tailored to address the challenges identified by community leaders, in particular - trust, cultural relevance, and sustainability.

- Be Well hubs are based within community organisations where members have received training to become Be Well Champions. Be Well Champions will be equipped to listen to people in the community, provide information, resources and signpost to mental health support.

- The hubs' main purposes are to de-stigmatise mental health, to use community organising principles to build strong relationships with local health services, and to organise leaders to listen and take action on the barriers and systemic problems impacting mental health. They will report back on key themes and trends from their communities.

- Be Well Hubs, supported by Be Well Champions, are positioned to make a positive impact by improving access to mental health services, and fostering a supportive community environment.

Reablement: In collaboration with Oxleas, we prioritised understanding the views and experiences of carers who support family members receiving reablement services. By focusing on carers, we aimed to gain insights into their challenges and needs.

Black and Ethnic Minority Carers: Using the principles of co-production, we recruited, trained, supported, and paid a group of Black and ethnic minority carers. Our peer researchers helped to shape the project design, tools used, and conducted interviews with other Black and ethnic minority carers. This inclusive approach not only enriched our research but also empowered carers by involving them directly in the research process.

REABLEMENT FINDINGS

“I was very stressed, but she didn't give me any information. It was just about how many hours I wanted, what time, male or female. She didn't tell me that the OT or physio would be involved.” -Participant 2

“You can see the confusion in people's faces. We do have to explain our service quite a bit, not just our role, but the service in general, because they do think that we are a care package, you know, and we are there to do domestic work and hoover.” -Staff member 4

“I felt assured because I knew that the care she would get from the reablement team would be suitable for her.” - Participant 6

FINDINGS (contd.)

"They went far beyond what they should have when they were trying to help me settle him, even when he was going ballistic and walking and slinging stuff around the bedroom. They would sit there and try to talk to him so calmly, peacefully, even when they were worried for their own safety, they managed it. I can't fault them in any way."
-Participant 3

"That gives me a break knowing that there is health care professionals there to take care of my wife, knowing that there is somebody that is looking after my wife's means that I'm not tethered to her all the time. It also gives her a chance to talk to somebody else rather than me, so it helped her."
- Participant 9

FINDINGS (contd.)

CHALLENGES

Before the reablement service:
-gaps between what was expected and what was delivered.

During the reablement service:
-cultural considerations
-lack of clarity on the role of reablement support workers
- timing of the service

End of the reablement service:
- carers felt unprepared and uninformed about further support and what the financial implications might be.

"I would have to be there and say [explain] to my dad because they said to me "we're not here to wash him. We're not carers, we're reablement". But this where I didn't know what reablement was. I just thought it was about his mobility helping his mobility."
-Participant 2

"I think the biggest problem, I think was the timing. If they'd been here at certain times before I'd actually done it. It may have been better"
-Participant 1

"A bit stressful for me because I've got male carers now all the time and because I'm a Muslim and I have to wear a scarf and cover myself because sometimes they're here four times [a day] and there's no specific time that they'll come. it's difficult...."
- Participant 2

How we've made a difference

- More information on reablement will be given to patients and carers at discharge.
- Regular check-ins will be made to review goals and expectations and address queries or concerns.
- When reablement ends, carers will be given advice/signposting to other support services.
- EDI training for all reablement staff and an appointed EDI champion to support wider understanding and meeting of cultural needs and preferences.

Black and Ethnic Minority Carers

“I don't see myself as a carer per se, in the fact that because it's my mum.” –Participant 17

“It's a shift from passive caregiving to active advocacy, proactive engagement with healthcare professionals….it's something that sort of shifted from me feeling like I don't think I always realised I was one” –Participant 8

“Because I care for her [mom] full time and I also have family, I'm also a mother. Yes. So it's a whole lot of things required of me. Sometimes I have to be honest. It's overwhelming. “ –Participant 21

Access to Information and Support

"I have not, and I will repeat, categorically not found out anything from Greenwich Council themselves. You ring them, nobody answers, nobody follows up anything."
–Participant 6

"In terms of support, it was primarily myself, my mum and my brother." -Participant 12

"the social support, the support at home has been lacking. I suppose there's a lack of information about resources .....we've been given quite limited information about what's available through the community service." -Participant 9

- Lack of awareness of support services.
- Delay in receiving services puts additional pressure on carers.

"I have been waiting nearly three years in for adaptation for walking shower and it's very, very slow, nobody takes responsibility and how many times I called. Still, I'm waiting." -Participant 7

Cultural Sensitivity & Intersectionality

- Carers' experiences varied due to cultural sensitivity factors:
  - cultural background (inc stigma)
  - gender–related preferences
  - cultural expectations of being a carer
  - ethnicity, gender, and judgement/bias
  - language and ethnic identity
  - immigration status

What is cultural sensitivity?

Cultural sensitivity refers to the ability to recognise, understand, and respect the diverse cultural backgrounds, beliefs, practices, and preferences of both the caregivers and the individuals receiving care.

Intersectionality is a broader concept that considers how different social identities intersect and shape individuals' experiences.

In the context of carers role, it means recognising that people who take on caregiving roles may face challenges and opportunities shaped by multiple aspects of their identity and social position.

"Maybe when I will speak to someone for an information, the person will feel like this girl is not understanding me or something like that. So, language barrier has been a challenge and also sometimes people feel that I'm lazy, that I don't want to talk. I feel that because I'm black and because of my language accent you are not giving me the attention. I have to strive to get attention. Yeah, sometimes I have to even make a scene to get to get the attention that I require, that I'm not being respected enough because of my colour." - Participant 20

Carers Health and Well-being

“It's been a very lonely, isolating, quite demoralising…avoid everything and everybody. I'm always tired…lonely, isolating, quite demoralising, and very draining, physically, mentally, emotionally."

- Participant 6

Professional Stakeholders Insights

"I would say that our biggest client group is still white."
-Stakeholder 1

"Outreach work is still relatively new to us. We are seeking to do is to go to places where we know those communities are so, for example, trying to get into mosques and temples and those places so that we can actually be talking to people in a setting where they will be comfortable. But wait, I mean, wait, wait, wait, … a long list of being achieving all that yet. Our plan is to start pushing those forward."
-Stakeholder 1

"I know Greenwich has their new care strategy, so that sort of helps, but they still need a lot, a lot of work, a lot of work on that."
- Stakeholder 2

Professional Stakeholders Insights (contd.)

- services/projects not meeting the cultural needs/requirements .
- inability to self-identify as carers, leading to a lack of awareness about available support services.
- broader systemic issues.

"It is a challenge for us to make sure that we get our information out to them in a way that they can access it. There is obviously cultural issues for some communities."
-Stakeholder 1

"A lot of ethnic groups don't see themselves as carers, they just do things out of the family. And you'll find a majority of ethnic mental health carers are not aware of support that's out there."
-Stakeholder 2

"I think stigma is the number one issue. They don't want too many people to know." –Stakeholder 2

"you look at a form that's 60 pages long and think, oh, do you know what? I'm not going to bother. It needs to be much more community focused at the moment. There still needs to be much more where the information is taken to the community and not the other way around.... and they need to make the system work better"
-Stakeholder 1

"Having everything digital is a problem. There is still a significant number of people that don't understand the Internet and have access to that. "
-Stakeholder 1

Recommendations

Review:	Conduct a comprehensive review of existing carer support services to evaluate the adequacy of existing services for Black and ethnic minority carers and ensure that services are equitable and accessible for all carers.
Community Engagement:	Actively engage with Black and ethnic minority carers to understand their challenges and preferences.
Culturally relevant support:	Develop culturally relevant support and resources tailored to the needs and preferences of Black and ethnic minority carers.
Collaboration with community organisations:	Forge partnerships with Black and ethnic minority-led community organisations to co-create and deliver support services.
Representation:	Establish community-led advisory groups to provide ongoing feedback and input into carer service design and delivery.
Information accessibility:	Increase accessibility to information about carer support services, benefits, rights, and entitlements, and provide greater access to interpretation services.
Addressing stigma:	Address cultural taboos and stigma. Develop awareness campaigns to challenge stereotypes and promote positive attitudes towards seeking support.
Research & Evaluation:	Conduct research and evaluation to assess the impact of support services on Black and ethnic minority carers and ensure accountability in service delivery.

- Every month, we compile the feedback received through our channels into a summary report. We gather this feedback through our regular outreach and engagement events, calls and emails to our signposting team, and meetings with community groups and organisers.

- Our feedback report is one of the important ways we share timely and regular feedback directly from Greenwich service users.

The **concerns** we hear most often are often related to:

GP surgeries:

- difficultly getting through on the phone
- Difficulty getting a timely appointment
- Communication style of front desk staff

Queen Elizabeth Hospital

- Long waits at Emergency/Urgent care
- Lack of communication on the complains process
- Poor communication/information sharing between primary and secondary care

Our feedback report often contains case studies providing rich information about resident's experiences.

Vanessa is a carer for her mother Penny. Earlier in the year, Penny, aged 91, fell and broke her hip. Although Penny received good care, her home rehabilitation became difficult because of delays and miscommunication.

After her injury, Penny was in hospital until she was able to return home and begin rehabilitation. Vanessa, who lives in Spain, had to return to England to look after her mum: *"Mum was always out, she had local church group meetings, a social club lunch and other clubs that she regularly went to. She hasn't been able to do any of that since the fall, she's desperate to get back to it all".*

As part of Penny's rehabilitation, the physiotherapist placed an order with **NRS Healthcare**, for a shower stall and grab bars for the shower and toilet. These aids would help Penny to have a shower and use the toilet without assistance. When NRS Healthcare delivered the equipment, **the order was incomplete and there was no plan to install it**. The equipment was too big to store in the bathroom, so Vanessa had to put it in the lounge: *"Mum already had to move her bed down to the lounge, I had to move furniture around to find a place for the wet room chair, it's awkward".*

The following week, NRS staff arrived to install grab bars in the shower and toilet but claimed not to have enough information to complete the work. Vanessa tried to negotiate: *"I told him that the Physio and Occupational Therapy had already sent the details to NRS. I emphasised that it wasn't difficult to see where they needed to be placed."* **NRS staff left without installing the grab bars.**

Vanessa contacted the Physio team, who ordered a smaller shower stall. **NRS, however, delivered the wrong product**. Vanessa contacted NRS again: *"When I asked when the smaller shower stall was coming, she said there's nothing on order! They made me feel guilty like I was asking them to do me a favour, imposing myself on them. She said I should try Amazon or Argos or a mobility shop instead of NRS... **Mum went six weeks without a shower**."*

Eventually, NRS delivered a small shower stall. *"No one from NRS showed up to install the toilet and shower grab bars, and Greenwich Council had to step in and do it. It should have been done weeks ago. My mother could not have a shower the whole time and she had to have strip washes ... If Greenwich Council hadn't come to do the bars, I'd still be waiting."* [27]

AGENDA ITEM: 8

Healthier Greenwich Partnership

Date: 24 July 2024

Title	**Due diligence process related to APMS contracts held by AT Medics**
This paper is for **noting**	
Executive Summary	AT Medics Ltd holds Alternative Provider Medical Services (APMS) contracts with the NHS to provide general practice services. AT Medics Ltd is owned by Operose Health Ltd. On 30 November 2023, South East London ICB (alongside other relevant ICBs in the country) was asked by AT Medics Ltd to authorise a change of control under relevant general practice contracts held by AT Medics. The change of control was expected to arise due to the potential transfer of the ownership of Operose Health Ltd from MH Services International (UK) Ltd, a subsidiary of Centene Corporation, to T20 Osprey Midco Ltd. South East London ICB initiated a due diligence process in relation to the change of control request received. The process was undertaken in partnership with other London ICBs with support from Hill Dickinson. SEL ICB was informed in writing on the 15th March that a 'change of control' took place on 28 December 2023. The NHS was not informed of the change of control at the time it occurred. Our due diligence process had also not been completed at that stage - but has now been finalised. A short briefing note is attached at Appendix A, the due diligence report is attached at Appendix B and a statement from Operose following further enquiries into debt charges is attached at Appendix C.
Recommended action for the Committee	The Committee is not being asked to decide on whether the change of control should be authorised, given that the change of control has taken place. However, it is important that the Committee have reviewed the outputs of the due diligence process and any findings of note and have put in place any actions deemed appropriate to maintain assurance as to the quality and safety of general practice services. We would recommend that the Committee: • seeks further information from AT Medics, Operose and the Buyer as to the debt charges and the scale of any potential liabilities.

	• continues to maintain scrutiny (via its Primary Care Group) on the quality and delivery of services delivered by the practices impacted by the change of control, in particular monitoring the stability of the practice workforce using data available through the National Workforce Reporting Service.	
Potential Conflicts of Interest	• Any member of the Healthy Greenwich Partnership that has an interest in or relationship with AT Medics / Operose Health Limited and the Thamesmead Health Centre that could affect decision making	
Impacts of this proposal	Key risks & mitigations	The due diligence process has not identified any concerns that the change of control will impact the care that residents currently receive. We have recommended that the Committee retain scrutiny over key aspects of service delivery via their Primary Care Working Group
	Equality impact	This is a contractual change that is not expected to impact on service delivery or patient care.
	Financial impact	There is no direct financial impact on the ICB arising from this contractual change. Paragraph 2.6.5 of the due diligence report notes that "the Companies House documents for AT Medics Limited and AT Medics Holdings LLP, show that a charge was registered against both on 13 March 2024 for the benefit of HSBC bank" which arose through a refinancing of existing group debt with HSBC UK Bank in March 2024. The ICB have made enquiries about these charges and further information from Operose Health has been attached as Appendix C to this paper. The refinancing of group debt is not an unusual activity and does not impact on the overall assurances the due diligence report provides. However, we are recommending that the Committee continues to seek further information from AT Medics, Operose and the Buyer as to the change in potential liabilities on AT Medics.
Wider support for this proposal	Public Engagement	The following engagement activities have been undertaken to keep our residents informed of the change of control process, to seek feedback and to

		ensure a route for members of the public to seek answers to their questions regarding the process: • On 6th December 2023, we wrote to stakeholders and published communications on our website regarding the request from AT Medics for authorisation of a change of control • On 28th December 2023, we published updated communications on our website, set up a feedback form for patients and publicised an upcoming webinar that patients could attend. • During late December 2023 and early January 2024, AT Medics text patients from practices affected setting out the proposed change of control and put up posters within waiting rooms. These materials referred patients to the SEL feedback form and webinar invitation. • On 23rd January 2024, we hosted a webinar setting out the change of control process answering questions submitted from the public. • On 15th April 2024, we wrote to stakeholders and published communications setting out our understanding that the change of control had taken place.
	Other Committee Discussion/ Internal Engagement	The matter has been discussed by the Greenwich Primary Care Working Group
Author:	Holly Eden, Director of Community Based Care (South East London) Maria Howdon, Assistant Director of Primary Care (Greenwich)	
Clinical lead:	Dr Jose Garcia, CCPL Lead for Greenwich	
Executive sponsor:	Jessica Arnold, Director of Primary Care and Neighbourhoods	

APPENDIX A

Summary Briefing Note on the due diligence process related to AT Medics general practice contracts

Purpose

This paper outlines the due diligence process undertaken by South East London Integrated Care Board, in partnership with other London Integrated Care Boards, in relation to the change of control of 7 Alternative Provider of Medical Services (APMS) contracts that AT Medics Ltd holds across South East London.

Background

AT Medics Ltd holds Alternative Provider Medical Services (APMS) contracts with the NHS to provide general practice services. AT Medics Ltd is owned by Operose Health Ltd.

On 30 November 2023, South East London ICB (alongside other relevant ICBs in the country) was asked by AT Medics Ltd to authorise a change of control under relevant general practice contracts held by AT Medics. The change of control was expected to arise due to the potential transfer of the ownership of Operose Health Ltd from MH Services International (UK) Ltd, a subsidiary of Centene Corporation, to T20 Osprey Midco Ltd.

South East London ICB initiated a due diligence process in relation to the change of control request received. This was done in partnership with other London ICBs who had also been asked to authorise change of control under relevant general practice contracts. North Central London ICB commissioned Hill Dickinson to undertake a due diligence exercise on behalf of the five London ICBs, including South East London ICB.

SEL ICB was informed in writing on the 15th March that a 'change of control' took place on 28 December 2023. The NHS was not informed of the change of control at the time it occurred, and our due diligence process had not been completed at that stage.

It would not be appropriate to ask the Committee to retrospectively decide on whether the change of control should be authorised, given that the change of control has taken place. However, it is important that the Committee has reviewed the outputs of the due diligence process and any findings of note and have put in place any actions deemed appropriate to maintain assurance as to the quality and safety of general practice services.

The findings of the due diligence exercise

A due diligence exercise was completed for the change of control arising from the sale of Operose Health Limited (Operose) by Centene Corporation (the Seller) to T20 Osprey Midco Ltd (the Buyer).

Following the change of control, Operose sits within a large group structure, with two corporate entities as the ultimate beneficial owners of the whole Group (IJMH Limited, Twenty 20 Capital Limited). IJMH Limited is controlled by Ian James Munro, an individual who is a British national and resident of England. Twenty 20 Capital Limited is controlled by Tristan Nicholas Ramus, an individual who is a British national and resident of England.

In the new structure, 100% of the shares in Operose, and a 1% minority interest in AT Medics, are owned by the Buyer. In the new structure, Operose sits underneath the Buyer (a special purpose vehicle used only as a holding company for Operose) and shares a holding company

with HCRG Care Group Holdings Ltd but is not directly linked. Operose confirmed that the Buyer is registered, managed, and is paying tax in the United Kingdom

A full report of the due diligence exercise undertaken by Hills Dickinson on behalf of London ICBs is attached as ***Appendix B***. This sets out:

- Key findings of the due diligence exercise (pages 3 – 5)
- Hill Dickinson's approach to the due diligence exercise (page 6)
- Structure charts for:
    - The Buyer - T20 Osprey Midco (page 9)
    - The Buyer's Group - T20 Pioneer Midco Ltd and its subsidiaries (page 7)
    - The Buyer's two main businesses – HCRG Care Group (page 8) and HCRG Workforce and Sugarman Holdings Limited (Page 10)
- All of the questions posed to the Operose Health and the responses received (pages 11 – 39)

The due diligence process provides evidence that the proposed new owner and associated group structures are of good standing.

The process has not identified any concerns that the change of control will impact the care that residents currently receive. Paragraph 2.2.2 of the due diligence report sets out that "it is intended that Operose and AT Medics will continue to operate as a financially sustainable standalone business focused on delivery of primary care services following the Change of Control, and that the arrangements relating to staffing and data protection in particular will remain the same".

The Committee are asked to consider paragraph 2.6.5 of the due diligence report. This paragraph notes that "the Companies House documents for AT Medics Limited and AT Medics Holdings LLP, show that a charge was registered against both on 13 March 2024 for the benefit of HSBC bank. We have asked Operose for details of this, and they noted that T20 Osprey Midco Ltd, the parent company of Operose Health Limited, and its sister company HCRG Care Group Holdings Ltd, refinanced existing group debt with HSBC UK Bank in March 2024. Therefore, AT Medics are now subject to additional potential liabilities following the Change of Control, relating to pre-existing debt of the Buyer's group. However, we have been unable to ascertain the extent or significance of these liabilities."

Further enquiries on the debt charges have been made to Operose Health. Operose Health have provided the further statement at Appendix C.

Whilst the refinancing of group debt is not an unusual activity and does not impact on the overall assurances the due diligence report provides, the scale of any potential liabilities has not been confirmed. We would recommend that the Committee continues to seek further information from AT Medics, Operose and the Buyer as to the change in potential liabilities on AT Medics.

Impact on service delivery

This change of control is not expected to result in any change to:

- The legal entity holding the APMS contracts (AT Medics Ltd)
- The APMS contracts themselves; and
- The services AT Medics Ltd are required to provide, including locations, opening hours and service standards (including in respect of access and staffing).

AT Medics Ltd has previously informed the NHS that there are no intentions to change service delivery, or the personnel involved in providing care. This remains the case and has been re-asserted at meetings between AT Medics and the NHS since 15 March 2024. There is nothing within the due diligence findings that would suggest otherwise.

We would recommend that the Committee, via its relevant primary care group, continues to maintain scrutiny on the quality and delivery of services delivered by the practices impacted by the change of control, in particular monitoring the stability of the practice workforce using data available through the National Workforce Reporting Service.

Other actions for the committee to note.

Under the terms of the standard APMS contract, providers may not undergo a change of control without the NHS's prior authorisation. SEL ICB (alongside other London ICBs) has determined that the action taken by AT Medics to undergo a change of control without the NHS's prior authorisation constitutes a breach of the terms of the APMS contracts held by AT Medics within South East London.

As a result, SEL ICB has issued a formal breach notice to AT Medics for each of these contracts following approval by the relevant Place Executive Leads. In Greenwich, this breach notice relates to the Thamesmead Health Centre practice. We retain our right to take any further contractual action that is required should there be evidence of a need to do so, as would be the case with all of our contracts.

Engagement

The following engagement activities have been undertaken to keep our residents informed of the change of control process, to seek feedback and to ensure a route for members of the public to seek answers to their questions regarding the process:

- On 6th December 2023, we wrote to stakeholders and published communications on our website regarding the request from AT Medics for authorisation of a change of control
- On 28th December 2023, we published updated communications on our website, set up a feedback form for patients and publicised an upcoming webinar that patients could attend.
- During late December 2023 and early January 2024, AT Medics practices sent texts to their patients setting out the proposed change of control and put up posters within waiting rooms. These materials referred patients to the SEL feedback form and webinar invitation.
- On 23rd January 2024, we hosted a webinar setting out the change of control process and answering questions submitted from the public.
- On 15th April 2024, we wrote to stakeholders and published communications setting out our understanding that the change of control had taken place.

Recommendations

The Healthy Greenwich Partner Board is asked to;

1. Review this summary paper, the full due diligence report and the follow-up statement from Operose Health on the debt charges
2. Request further information from AT Medics, Operose and the Buyer as to the debt charges, in particular the change in any potential liabilities impacting on AT Medics

3. Continue to maintain scrutiny (via its Primary Care Working Group) on the quality and delivery of services delivered by the practices impacted by the change of control, in particular monitoring the stability of the practice workforce using data available through the National Workforce Reporting Service.

Date: 14 May 2024
Ref: 12019917.95

HILL DICKINSON

Dated 14 MAY 2024

NORTH CENTRAL LONDON ICB

DUE DILIGENCE SUMMARY REPORT

CONFIDENTIAL AND SUBJECT TO LEGAL PROFESSIONAL PRIVILEGE

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Hill Dickinson LLP
The Broadgate Tower
20 Primrose Street
London
EC2A 2EW

North Central London ICB
Due Diligence Summary Report

1 INTRODUCTION

1.1 North Central London ICB (the **ICB**) asked Hill Dickinson (**HD**) to undertake a due diligence exercise in relation to the change in control request received by the ICB from Operose Health Limited[1] (**Operose**), which described a sale of Operose by Centene Corporation[2] (the **Seller**) to T20 Osprey Midco Ltd[3] (the **Buyer**) (the **Change of Control**).

1.2 The Buyer is part of the same group of companies as HCRG Care Ltd[4], an existing provider of APMS contracts to the NHS. HCRG Care Ltd (through its holding company[5]) and the Buyer are both owned by T20 Pioneer Midco Limited[6].

1.3 Operose requested the consent for the Change of Control on behalf of its subsidiary company, AT Medics Limited[7] (**AT Medics**), which holds the APMS contracts commissioned by the ICB (and other ICBs).

1.4 This due diligence (**DD**) exercise was undertaken in connection with the requirement under the APMS contracts for AT Medics to obtain the ICB's prior authorisation before undergoing a change of control.

1.5 We set out as appendices to this report the timeline of events to date, the questions asked of Operose (the **DDQs**), and information provided by Operose in response to such questions (the **DD Responses**).

1.6 This report contains the following sections:

[1] Company no. 10014577

[2] A publicly traded company incorporated in the United States with an address 7700 Forsyth Blvd., St Louis, MO 63105, USA.

[3] Company no. 15294854

[4] Company no. 05466033

[5] HCRG Care Group Holdings Ltd - company no. 03201165

[6] Company no. 14266834

[7] Company no. 05057581

2 OUR FINDINGS

We set out below our findings based on the responses and information provided by Operose and also based on our searches (see Appendix 1 for the approach to this). Please note that HD has not independently verified the information provided by Operose, though we have not seen any indication that the factual information provided is incorrect.

2.1 Corporate Structure

2.1.1 Please see **Appendix 2.** The DD responses received, including the structure chart at Appendix 2, show the corporate structure that Operose sits within.

2.1.2 This is a large group structure, with two corporate entities as the ultimate beneficial owners of the whole Group (IJMH Limited[8], Twenty 20 Capital Limited [9]). IJMH Limited is controlled by Ian James Munro, an individual who is a British national and resident of England. Twenty 20 Capital Limited is controlled by Tristan Nicholas Ramus, an individual who is a British national and resident of England.

2.1.3 In the new structure, 100% of the shares in Operose, and a 1% minority interest in AT Medics, are owned by the Buyer. In the new structure, Operose sits underneath the Buyer (a special purpose vehicle used only as a holding company for Operose), and shares a holding company with HCRG Care Group Holdings Ltd[10], but is not directly linked. Operose confirmed that the Buyer is registered, managed, and is paying tax in the United Kingdom.

2.1.4 The Buyer refers to HCRG Care Group in some of its responses. HCRG Care Group is a description of the various entities in the company group, including HCRG Care Group Holdings Ltd and its subsidiaries (including Peninsula Health LLP – see Structure Chart). We understand that HCRG Care Group was "leading the process" with Operose. We also understand that it is intended that the Operose group, in the ownership of the Buyer, will operate as a separate business division to the HCRG Care Group (see next).

2.2 Operational running of the Business

2.2.1 The Buyer's group (T20 Pioneer Midco Ltd and its subsidiaries) operates two main businesses, being HCRG Care Group which provides health and care services to NHS and local authorities, and HCRG Workforce and Sugarman Holdings Limited [11], which provides staffing services and workforce solutions to NHS Trusts and Local Authorities.

2.2.2 It is intended that Operose and AT Medics will continue to operate as a financially sustainable standalone business focused on delivery of primary care services following the Change of Control, and that the arrangements relating to staffing and data protection in particular will remain the same.

2.2.3 HCRG Care Group Holdings Ltd has been one of the largest independent providers of primary and community services to the NHS and Local Authorities since 2006. Operose referenced experience in the healthcare sector in its responses, and in particular noted that HCRG Care Services Ltd holds APMS contracts currently. Many of the DD Responses are provided on the basis that the ICB should seek

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[8] Company no. 11409826

[9] Company no. 11455082

[10] Company no. 03201165

[11] Company no.13184278 (note: the name of this company changed in April 2024, and so the Structure Chart shows the previous name).

assurance from the business and performance of the HCRG Group, since Operose sits within the same overall corporate group which houses HCRG Group.

2.2.4 Please see **the responses in Appendix 3** - Operose notes that following the Change of Control, there will be an aim for closer working within the Group, including that HCRG Workforce Solutions (a subsidiary of HCRG Care Ltd) may provide staffing services, and Sugarman Occupational Health (a subsidiary of HCRG Care Ltd) may provide such services to staff.

2.2.5 It is intended, subject to confirmation by the management team at Operose of sufficient capacity, that within 12 months of the Change of Control, all of the APMS services provided by the companies within the HCRG Care Group will transfer to management by Operose.

2.2.6 Operose confirmed that, though there are no planned governance changes (except for necessary removal of directors from Operose), it is possible that opportunities to combine the governance functions of the organisations may be identified in the future.

2.3 **Compliance**

2.3.1 As a recently established special purpose vehicle, and a holding company, the Buyer itself does not hold licences or consents or provide regulated healthcare services itself.

2.3.2 Operose confirmed no changes will be needed to licences and consents required to carry on the business. Operose did not provide currently held licences/ consents.

2.3.3 Operose provided copies of the Buyer's Anti-bribery and Fraud policies and also set out the procedures in place for compliance with data protection laws, but those are for companies within the HCRG Care Group and so were provided for context/ information as we understand it. The Operose policies will remain in place for Operose and its subsidiaries (and so there is no anticipated changes in the way that Operose will approach these issues).

2.3.4 Operose confirmed that there is no intention to transfer data outside of the UK, and there is no planned transfer of assets or data generally.

2.3.5 HCRG Care Services Ltd is regulated by the CQC and currently rated "Good" overall, "Good" in the domains of "Safe", "Effective", "Caring", "Responsive" and "Outstanding" in the domain of "Well-led".

2.3.6 HCRG Care Group is subject to oversight by NHS England within its Hard to Replace oversight framework, though we have not seen evidence of this. NHS England have confirmed that Operose Health Ltd and its subsidiaries including AT Medics Limited and AT Medics Holdings LLP will form part of the NHS England monitoring process going forward. The companies will report on a quarterly basis with the HCRG Care Group from 1 April 2024.

2.4 **Liabilities**

2.4.1 Operose confirmed that, other than ongoing medical claims which are part of the usual running of a health and care service provider (in respect of HCRG Care Group), there is no ongoing or threatened litigation, arbitration, mediation or similar disputes, proceedings, judgments, orders, findings or decisions of a regulatory body which could affect the Buyer or its business.

2.5 **Staffing**

2.5.1 As of 30 September 2024 there were 1,219.9 FTE employees of Operose, and the headcount for Operose was 1,574. Operose confirmed that it will continue to operate

as before, and that there is no change of employer and so TUPE is not engaged. Operose also provided information relating to the stability of the workforce, and in particular, the Buyer cites awards won or shortlisted for in the last 10 months.

2.5.2 Operose confirmed that there is no intention to change or merge the operating models of HCRG Care Group and Operose Health, including with regards to the use of Physician Associate roles. Operose described the services provided within HCRG Care Group, and by Operose, as well reviewed by regulators and confirmed that the intention is not to merge the operating models of HCRG Care Group and Operose, but instead to continue to provide high quality care within both organisations.

2.6 **Financial**

2.6.1 HD has not reviewed the financial documents provided as part of the DD Responses from an accounting perspective, but has reviewed them with a view to flagging high level legal risks.

2.6.2 Operose provided the financial details of the Buyer for the financial year ending April 2023, but at the time of the response the Buyer had not yet published audited accounts as it is a special purpose vehicle which was established within the previous year to hold the shares in health and care services businesses. Operose provided unaudited accounts for the period ending 31 March 2023. Operose also provided an overview of the financial position for HCRG Care Group which is relevant to the Change of Control as the Buyer has linked the different group companies throughout the process.

2.6.3 All companies above Operose in the new structure, as well as HCRG Care Group Holdings Ltd and HCRG Care Ltd (see the full companies list in paragraph 1.4 of Appendix 1), have a complete Statement of Good Standing (which shows that, at the date of the statement, there are no relevant liquidation or other arrangements pending, and that the companies are in existence). The World Check searches came back for all of the companies listed below as clear, which means that the searches did not expose any potential criminality, Politically Exposed Persons (**PEPs**) or heightened risk individuals and organisations being involved in any of the companies.

2.6.4 All companies above Operose in the new structure, as well as HCRG Care Group Holdings Ltd and HCRG Care Ltd, also have clear insolvency checks, which shows that there are no winding up actions (current or past, being within the last 36 months, including notice of intention to appoint an administrator), published insolvency notices, relevant entries in the filing history, and charges, though there are charges listed on each which the ICB may find relevant or want to be aware of.

2.6.5 We noted to Operose that the Companies House documents for AT Medics Limited and AT Medics Holdings LLP, showed that a charge was registered against both on 13 March 2024 for the benefit of HSBC bank. We asked Operose for details of this, and they noted that T20 Osprey Midco Ltd, the parent company of Operose Health Limited, and its sister company HCRG Care Group Holdings Ltd, refinanced existing group debt with HSBC UK Bank in March 2024. Therefore, AT Medics are now subject to additional potential liabilities following the Change of Control, relating to pre-existing debt of the Buyer's group. However, we have been unable to ascertain the extent or significance of these liabilities.

3 ADDITIONAL INFORMATION

3.1 For your information/ further reading if required, a PDF of all information provided by Operose in this DD exercise, as well as the Companies House searches referenced in Appendix 1 accompanies this report.

APPENDIX 1: HD INPUT

APPROACH TO DDQS AND RESPONSES

1.1 HD and the ICB formed a view on what would be an appropriate level of due diligence for the Change of Control. This decision was made by reference to previous examples of similar changes in control/ decisions made.

1.2 Please see the timeline below.

30/11/2023	Change of Control letters issued to commissioners.
12/09/2023	Due diligence questionnaire sent out to Operose (“**DDQ 1”)**
06/12/2023	Response received from Operose.
28/12/2023	Change in control takes place.
19/02/2024	Supplementary due diligence response sent out to Operose.
06/03/2024	Supplementary due diligence response received from Operose.
15/03/2024	Change in control notified to ICB by email.
19/04/2024	Further due diligence questions sent out to Operose.
25/04/2024	Response received from Operose.

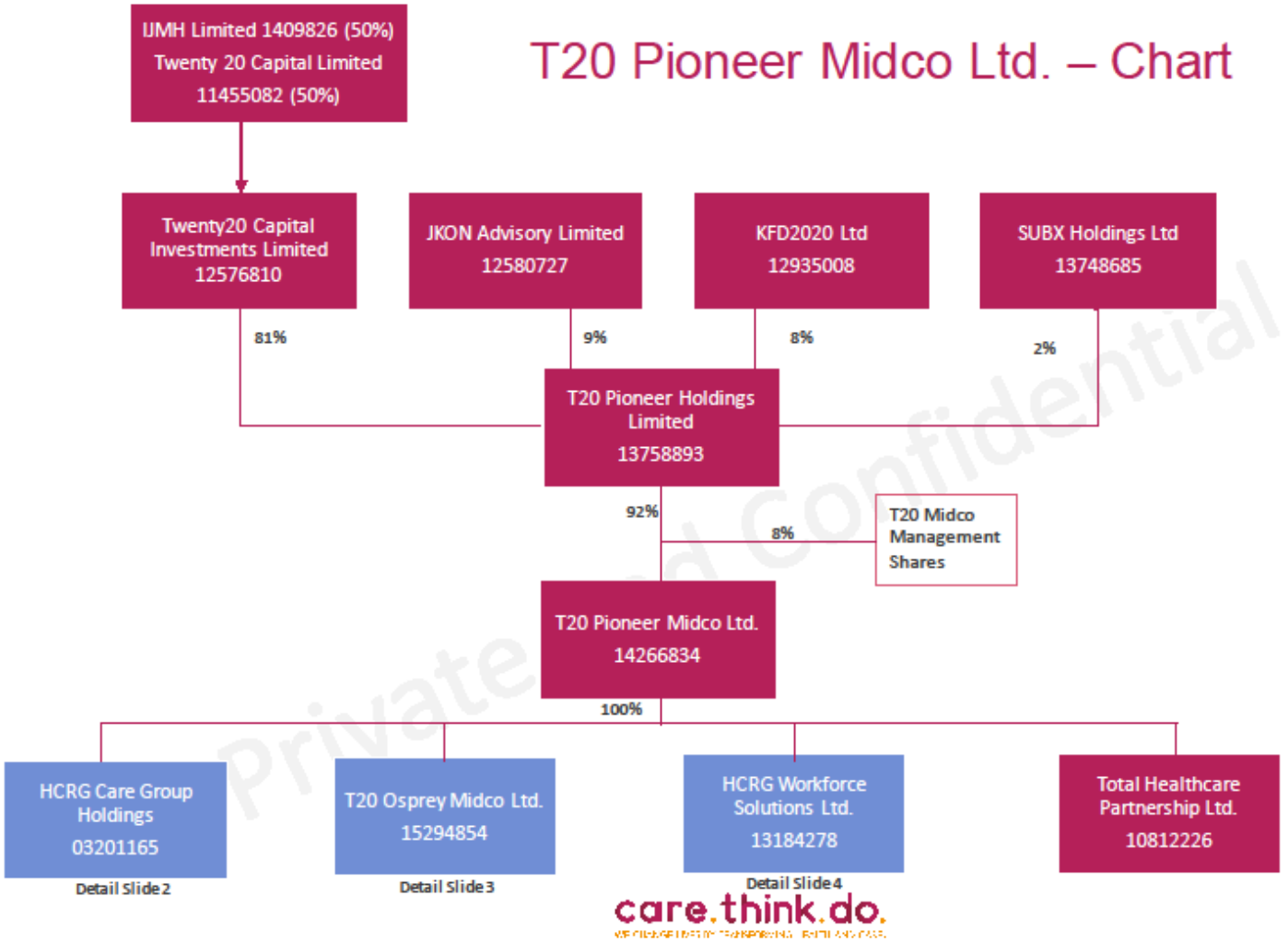
1.3 HD was asked to undertake searches/ requests as follows:

- Companies House Certificates of Good Standing,
- Bankruptcy Searches, and
- World Check Reports.

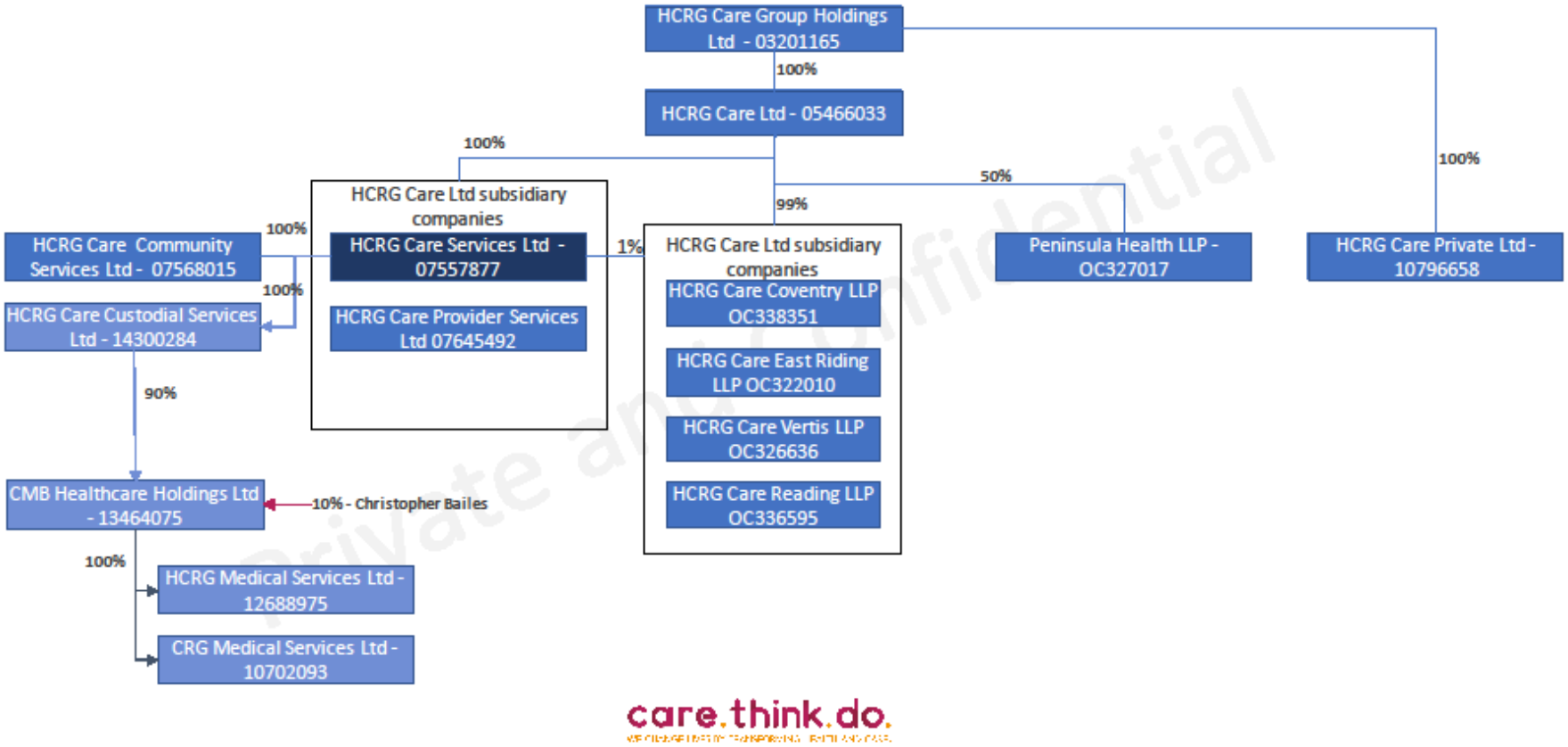
1.4 We determined that the most relevant companies for these searches would be all companies up the chain on the company structure chart provided, up to the ultimate owners of Operose Health Ltd should be reviewed. We also considered that it would be helpful to review HCRG Care Ltd and HCRG Care Group Holdings Ltd as much of the due diligence response received had referred to the success/ standing of those companies. We have listed these companies in full below for reference:

- IJMH Limited (11409826)
- Twenty 20 Capital Limited (11455082)
- Twenty20 Capital Investments Limited (12576810)
- JKON Advisory Limited (12580727)
- KFD2020 Ltd (12935008)
- SUBX Holdings Ltd (13748685)
- T20 Pioneer Holdings Limited (13758893)
- T20 Pioneer Midco Limited. (14266834)
- T20 Osprey Midco Ltd. (15294854)
- HCRG Care Ltd (05466033)
- HCRG Care Group Holdings Ltd (03201165)

APPENDIX 2: STRUCTURE CHART



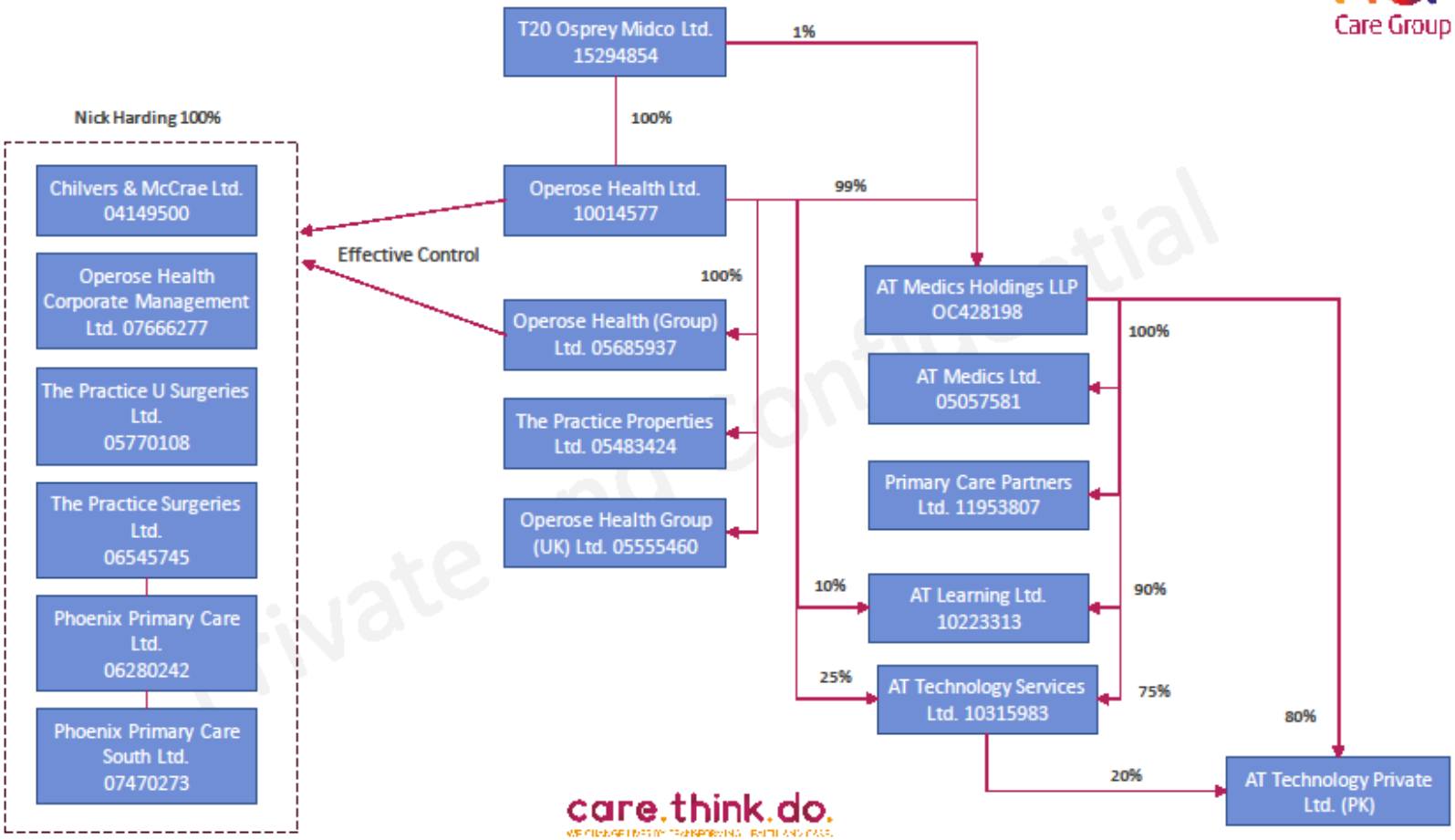
HCRG Care Group - Detail



Private and Confidential

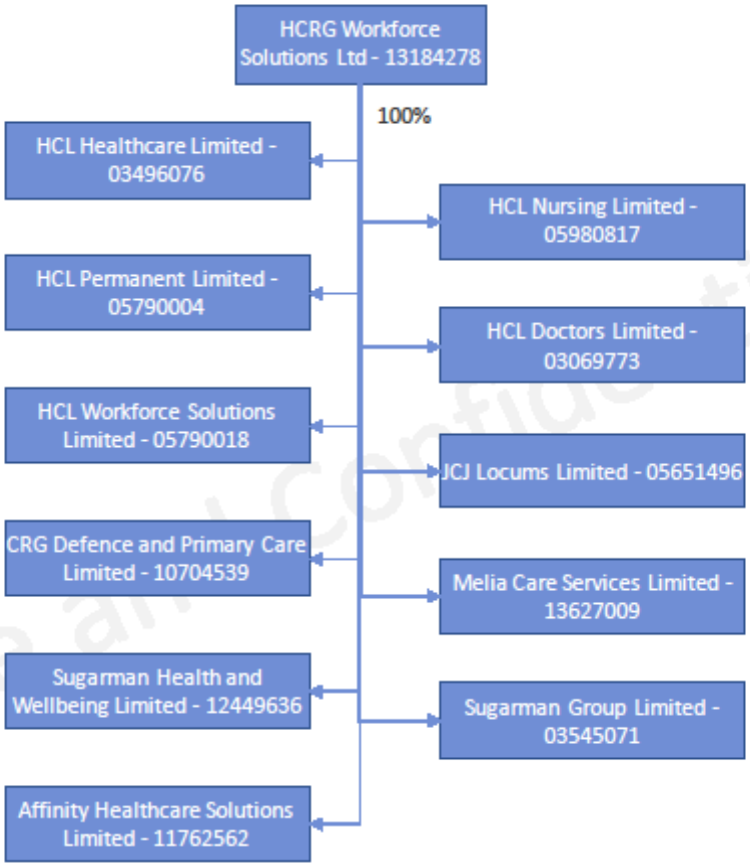
care.think.do.

T20 Osprey Midco – Detail (Operose)



Private and Confidential

HCRG Workforce Solutions - Detail



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APPENDIX 3: RESPONSES

1 **RESPONSE RECEIVED 6.12.2023**

Note: Included with the response at 5.4 was a comment from the Buyer as follows: "The only entity licensed w/ NHSE is HCRG Care Services Limited."

#	Question	Buyer Response
1		
1.1	Confirmation of the company(s) to whom Centene proposes to transfer its Operose Health shares (**the Buyer**), including the Company House details for a UK-based entity, or equivalent if the company is based elsewhere.	**The Buyer** will be a special purpose vehicle holding company as part of our health and care group, through the entity T20 Osprey Midco Limited (registered with Companies House in England and Wales number 15294854 at 33 Soho Square, London, W1D 3QU). The largest company within the Buyer's Group and that leading the process with Operose Health Limited ('*Operose Health*') is HCRG Care Group, an NHS England accredited and licenced "Hard to Replace" provider of community services which has been supplying clinical services to the NHS and Local Authorities since 2006. Other group companies also contract extensively with the NHS to deliver on-framework staffing and care services.
1.2	Brief details of the Buyer's branches, agencies and places of business in the UK and elsewhere, and the nature of its businesses.	The Buyer is registered, managed, operating and paying tax in the UK. The Buyer primarily contracts with the NHS, Local Authorities and others for the provision of health and care services. **The Buyer** currently operates two main business lines: **HCRG Care Group** – The provision of health and care services to the NHS and Local Authorities. This business line is the largest, and is the entity leading the transaction with Operose Health. **HCRG Workforce Solutions** – The provision of staffing services and workforce solutions (including the provision of complex care support in patients' homes) to NHS Trusts and Local Authorities. We enclose a map (1-2 Service Location

#	Question	Buyer Response
		Map.pdf) detailing the locations of services operated by the Group.
1.3	A full structure chart showing the Buyer and all of its holding companies and its subsidiaries (each a "Group Company").	A structure chart is enclosed (1-3 Group Structure Chart.pdf). The Buyer and its holding companies are registered, managed and pays tax in the UK.
1.4	Copies of the Buyer's register of members, register of directors and register of persons with significant control.	A copy of the register of members, register of directors and register of persons with significant control is enclosed (1-4 PSC Register.pdf, 1-4 Register of Directors.pdf, 1-4 Register of members.pdf).
1.5	Confirmation of which Group Companies will have membership interests in Operose Health, and the proposed percentage of shares being transferred.	T20 Osprey Midco Limited will acquire 100% of the shares of Operose Health Limited and a 1% minority interest in AT Medics Holdings LLP, the holding company of AT Medics Limited.
1.6	Confirmation of the ultimate beneficial owners of the Buyer (i.e., the ultimate owners of any of the Buyer's holding companies).	Structure chart provided at 1.3 provides this detail (1-3 Group Structure Chart.pdf).
2		
2.1 187804214.1	A brief description of the business of each Group Company in the UK including a summary of contracts for NHS services held by each such Group Company. In particular, detail any existing or prior experience of any Group Company in running GP practices, including: a. Number of contracts held, b. Length of the contracts, and c. Commissioning organisations.	HCRG Care Group is one of the largest independent providers of primary and community services to the NHS and Local Authorities and has been part of the health and care system in England since 2006. The company holds more than 50 contracts with the NHS and local authorities to deliver community health and care services and employs more than 5,000 people delivering services ranging from District Nursing to Community Hospital Wards to Sexual Health and Health Visiting and School Nursing services. The company has operated primary care services for more than a decade, predominantly holding APMS contracts and successfully working closely with commissioners to transform or improve challenged services. All primary care services operated by the organisation are rated "Good" or "Outstanding" by the CQC. a. Entities within the HCRG Care Group currently hold contracts to operate 13 primary and urgent care

#	Question	Buyer Response
		services. b. Contract lengths vary from between 2 years and 13 years in total with an earliest start date of 1 May 2011. Of 10 contracts held, 6 have expired already or are due to expire on 31 March 2023 but have verbal or written intent to extend, with paperwork awaited. The remaining 4 are due to end on 31 March 2026. c. The services are commissioned by Birmingham and Solihull ICB, Buckinghamshire Oxfordshire and Berkshire West ICB, Coventry and Warwickshire ICB, and Mid and South Essex ICB. It is intended, subject to confirmation by Operose Health Management of sufficient capacity, that within 12 months of the transaction completing HCRG Care Group's current primary care services will transfer to Operose Health Management. The attached document (2-1 Primary Care Induction.pdf) is taken from HCRG Care Group's new Colleague Induction and provides details of the culture, values, successes and structure of HCRG Care Group's primary care operation.
2.2 187804214.1	Names of any UK company or businesses which were formerly a Group Company but have been wound up or sold within the last three years.	During 2020, HCRG Care Group (then known as Virgin Care) undertook a project to simplify its corporate structure. As part of this, legal entities which no longer held contracts (where these had been transferred to another Group legal entity, ended or transferred to another provider) were wound down. There have been no winding up proceedings initiated by third parties. The entities which were wound down as part of this exercise were: ▪ Virgin Care Corporate Services Limited ▪ VH Doctors Ltd ▪ Virgin Care Hampshire Health LLP ▪ Virgin Care Leeds LLP ▪ Virgin Care Chelmsford LLP
2.3	A brief description of any services provided by any Group Company to Operose Health or AT Medics Ltd and whether any such services will be	The **Buyer** and HCRG Care Group does not provide any services to Operose Health or AT Medics Ltd.

#	Question	Buyer Response
	affected by the change in control.	
2.4	Confirmation of whether any data or other assets currently held by Operose Health or AT Medics Ltd will be transferred to any Group Company and in particular any Group Company outside the UK.	There is no transfer of data outside the UK. Operose Health and AT Medics will operate in line with current status quo and, therefore, there is no transfer of assets, within or outside of the UK.
2.5	Confirmation that no changes in the governance structure or management of Operose Health, or AT Medics Ltd, including of its directors, are proposed.	There are no proposed changes to the governance structure or management of Operose Health or AT Medics Ltd as part of the transaction. There will be necessary changes to directors appointed by the current ultimate controlling party Centene Corporation. These individuals will resign as directors when the transaction completes, and the **Buyer** will appoint replacements. As Operose Health joins an established and experienced group of health and care organisations with governance arrangements praised by the CQC, it is possible that opportunities to combine the governance functions of the organisations may be identified in the future. Any changes would, of course, be carefully managed to maintain safety and Operose Health Management Team would continue to engage with commissioners regarding any changes as they would today.
3		
3.1	Details of, and copies of all documents relating to, any licences, consents, registrations, approvals, permits and exemptions (whether public or private) required or obtained by the Buyer in connection with the operation of its business, insofar as it is relevant to the AT Medics Ltd contract ("Consents").	Copies of various licences, consents, registrations, approvals, permits and exemptions are attached. While Operose Health and AT Medics will continue to operate, HCRG Care Group presently operates 7 APMS primary and urgent care services for the NHS and has significant experience of governing and delivering these types of services.
3.2	Will any of the Consents be affected by the proposed change of control? If yes, please provide details.	No.
3.3	Details of, and copies of all documents relating to, any investigation, enquiry, prosecution or other enforcement proceedings or process by any governmental, administrative, regulatory	There have been none.

#	Question	Buyer Response
	or other body or organisation in relation to or affecting the Buyer or its business and details of any facts or circumstances that may give rise to any such matters.	
3.4	Details of any matter or circumstance that constitutes, or may constitute, a contravention or breach by the Buyer (or any of its officers, agents or employees) of the provisions of any Consent, statute, order or regulation made in the UK, and copies of all related documents.	There have been none.
3.5	Details of, and copies of all documents relating to, any anti- corruption policies and procedures that have been implemented by the Buyer to ensure compliance with the Bribery Act 2010.	We enclose a copy of the relevant policy (3-5 Anti Bribery and Anti Fraud Policy.pdf). The Buyer regularly demonstrates its governance and compliance with these regulations as part of tenders operated by the NHS and local authorities.
3.6	Details of the Buyer's procedures for ensuring and monitoring compliance with applicable data protection legislation.	HCRG Care Group is an experienced provider of health and care services and has a comprehensive set of procedures and policies to ensure its compliance with data protection legislation. The organisation has been awarded "Substantial Assurance" – the highest possible accreditation level – for handling information and data security against the NHS Data Protection and Security Toolkit. The organisation employs a dedicated Information Security team within its IT function as well as contracting with external experts to meet, and exceed, the relevant standards.
4		
4.1	Details of any ongoing or threatened litigation, arbitration, mediation or similar proceedings or disputes involving or otherwise affecting the Buyer or its business which may be reasonably considered to be material in relation to us.	The Buyer has no ongoing or threatened litigation, arbitration, medication or similar proceedings or disputes. HCRG Care Group, as a provider of health and care services, has from time to time ongoing or threatened medical claims. All claims are subject to rigorous internal investigation by our clinical quality, legal, governance and Customer Experience teams to establish the circumstances of each claim and lessons learned are escalated and disseminated within the organisation to avoid recurrence.

#	Question	Buyer Response
		Each claim is covered by insurance policies and none of these cases would be considered material in relation to this transaction.
4.2	Details of, and copies of all documents relating to, any outstanding or pending judgment, order, finding or decision of any court or regulatory body affecting the Buyer or its business.	There are no outstanding or pending judgements, orders, findings or decisions of any court or regulatory body which could affect the Buyer or its business.
5		
5.1	How many employees are employed by Operose Health? How many of those employees are involved in the provision of services by Operose Health (and AT Medics)?	As at 30-Sep-23: ▪ FTE = 1,219.9 ▪ Headcount = 1,574 All employees are involved in the provision of services by Operose Health (and AT Medics).
5.2	Is Operose Health contracting with any other entities which supply staff needed to deliver the APMS contract, and if so, please confirm details of any such contracting arrangements.	No sub-contracting arrangements are in place for core APMS contracts.
5.3 187804214.1	Will there be any change to the staff working with Operose Health , or AT Medics? Confirm if TUPE will apply to the transfer.	As the Buyer will acquire 100% of the shares in Operose Health and a 1% minority interest in AT Medics Holdings LLP, and Operose Health and AT Medics Limited will continue to operate as previously, there is no change of employer and TUPE is not, therefore, engaged. At the point of the transaction, there are no changes proposed to the staff working within Operose Health or AT Medics.
5.4	Does the Buyer run any equivalent healthcare businesses, and if so, please provide any information which could be relevant to understanding their workforce model, including: a. Stability of the workforce, b. Number of employed to temporary staff, c. Temporary staff and how the Buyer anticipates they will be affected.	Yes. HCRG Care Group operates 21 primary care and urgent care services alongside a wide range of community services for adults and children for the NHS and Local Authorities. As a result, HCRG Care Services Limited is licenced and monitored by NHS England under the 'Hard to Replace' provider regime. HCRG Care Group employs more than 5,000 people in the delivery of these services with the majority of staff employed on a substantive basis. Colleagues are employed on market-competitive terms, and receive a full range of benefits. The organisation has been shortlisted or won several awards during the last 10

#	Question	Buyer Response
187804214.1		months for its employee support and benefit programmes, including winning “Best Cost of Living Response” at the CIPP Annual Excellence Awards and has been shortlisted for Best Employer for Diversity and Inclusion at the Nursing Times Awards for its comprehensive menopause support programme and policies. The organisation is also able to definitively demonstrate that it is an attractive employer within the sector, despite sector-wide shortages of professionals and has welcomed an additional 50WTE colleagues to its team since 1 April 2023. HCRG Care Group closely monitors key workforce metrics ensuring visibility at every level of the business from floor to board. Turnover, sickness and other key metrics are comparable with the broader health and care sector. In addition to a stable workforce model, the organisation has been commended for its ability to deliver improved health outcomes and high quality services in partnership with commissioners over many years. For example: • Following being awarded a contract to create and run Wiltshire-focused children’s services in 2017, Wiltshire Council have renewed for another five years until 2029 • Essex County Council have extended their contract to deliver improved outcomes for families for a further 3 years • Coventry City Council and Warwickshire County Council have appointed us to deliver the largest sexual health contract across their areas, following the successful transformation and delivery over several years in Teesside, Greater Manchester and Lincolnshire. 97% of the organisation’s services rated by CQC hold “good” or “outstanding”

#	Question	Buyer Response
		ratings, higher than the industry average, and reflecting the organisation's track record of transforming and improving the services it takes on.
6		
6.1	Details on the financial position for the past three years of the Buyer and the Group Companies, including in particular: - Income and Expenditure, - Profit and Loss; - Debts; - Information held pertaining to bankruptcy and/or liquidation which could be deemed relevant.	Please see the attached information relating to HCRG Care Group's financial performance over the last three years demonstrating a robust and sustainable financial approach to the delivery of primary and community services (*6-1 Financial Position.pdf).* As a non-trading holding company established within the last year to hold the shares in health and care services businesses, T20 Osprey Midco Limited has not yet published audited accounts. The use of the holding company increases resilience and reduces risks and has been and continues to be subject to oversight by NHS England within its Hard to Replace oversight framework. There are no concerns raised via the Hard to Replace oversight framework.
6.2 187804214.1	Details of the impact any failure of the Buyer or any would have on the ability of AT Medics Ltd to continue to deliver the APMS contract.	It is intended that Operose Health and AT Medics will continue to operate as a financially sustainable standalone services focused on delivery of primary care services, and therefore there would be no impact of the failure of the Buyer (or any other Group company) on the continuing ability of Operose Health to continue delivery of the APMS contracts. In addition, HCRG Care Group is scrutinised closely and regularly by NHS England as a result of its designation as a Hard to Replace Provider and commissioners can therefore be assured by the significant oversight of the Group's affairs and its strong financial performance, given the lack of concerns raised through this process to date.

2 RESPONSE RECEIVED 06.03.2024

#	Question	Further Question/ clarification required – January 2024	Clarified answer – February 2024
1			
1.1	Confirmation of the company(s) to whom Centene proposes to transfer its Operose Health shares (**the Buyer**), including the Company House details for a UK-based entity, or equivalent if the company is based elsewhere.	n/a	**The Buyer** is a special purpose vehicle holding company as part of our health and care group, through the entity T20 Osprey Midco Limited (registered with Companies House in England and Wales number 15294854 at 33 Soho Square, London, W1D 3QU). The largest company within the **Buyer's Group** (T20 Pioneer Midco Limited and its subsidiary companies) and that leading the process with Operose Health Limited ('*Operose Health*') is HCRG Care Group, an NHS England accredited and licenced "Hard to Replace" provider of community services which has been supplying clinical services to the NHS and Local Authorities since 2006. Other group companies also contract extensively with the NHS to deliver on-framework staffing and care services.
1.2	Brief details of the Buyer's branches, agencies and places of business in the UK and elsewhere, and the nature of its businesses.	Please confirm if this is correct – does T20 Osprey Midco Limited contract with the NHS, Local Authorities and others for the provision of health and care services? We understand that this is a special purpose vehicle and so are not aware of any contracts currently held by T20 Osprey Midco (the Buyer).	The Buyer's Group (as defined above) is registered, managed, operating and paying tax in the UK. The Buyer's Group primarily contracts with the NHS, Local Authorities and others through its subsidiary companies for the provision of health and care services.

#	Question	Further Question/ clarification required – January 2024	Clarified answer – February 2024
		Please confirm if this is correct – T20 Osprey Midco is the Buyer. This response appears to refer to T20 Pioneer Midco Limited as the Buyer. Please confirm who "the Group" is in the context of this response.	**The Buyer's Group** (as defined above) currently operates two main business lines: **HCRG Care Group** – The provision of health and care services to the NHS and Local Authorities. This business line is the largest, and is the entity leading the transaction with Operose Health. **HCRG Workforce Solutions** – The provision of staffing services and workforce solutions (including the provision of complex care support in patients' homes) to NHS Trusts and Local Authorities. We enclose a map (1-2 Service Location Map.pdf) detailing the locations of services operated by HCRG Care Group.
1.3	A full structure chart showing the Buyer and all of its holding companies and its subsidiaries (each a "Group Company").	We note that the Buyer (as defined above - T20 Osprey Midco Limited) is not included in this structure chart. Please provide an updated structure chart including the Buyer.	A structure chart is enclosed (1-3 Group Structure Chart.pdf), updated to reflect the creation of the T20 Osprey Midco Limited SPV. **The Buyer's Group** (as defined above) and its holding companies are registered, managed and pays tax in the UK.
1.4	Copies of the Buyer's register of members, register of directors and register of persons with significant control.	We note that documents labelled "1-4" relate to T20 Pioneer Holdings Limited, rather than the Buyer. Please provide this information for the Buyer, i.e. T20 Osprey Midco Limited. Please confirm what the difference between T20 Osprey Midco Limited B1 and B2 class ordinary shares is. If there are differences in share	An updated copy of the register of members, register of directors and register of persons with significant control is enclosed (1-4 PSC Register.pdf, 1-4 Register of Directors.pdf, 1-4 Register of members.pdf). The differing classes of shares attract the same rights.

#	Question	Further Question/ clarification required – January 2024	Clarified answer – February 2024
		classes for any other company that may have a director or indirect ownership of Operose (should the Change of Control Request be granted) we also need to know what they are so we can understand control of T20 Osprey Midco Limited.	
1.5	Confirmation of which Group Companies will have membership interests in Operose Health, and the proposed percentage of shares being transferred.	As above please provide information to determine ultimate ownership of the Buyer.	100% of the shares of Operose Health Limited are to be held by T20 Osprey Midco alongside a 1% minority interest in AT Medics Holdings LLP, the holding company of AT Medics Limited.
1.6	Confirmation of the ultimate beneficial owners of the Buyer (i.e., the ultimate owners of any of the Buyer's holding companies).	As above, we note that the structure chart does not show the Buyer, and so we cannot infer the ultimate beneficial owner from this. Please provide confirmation of the ultimate beneficial owner.	Amended structure chart provided at 1.3 provides this detail (1-3 Group Structure Chart.pdf).
2			
2.1	A brief description of the business of each Group Company in the UK including a summary of contracts for NHS services held by each such Group Company. In particular, detail any existing or prior experience of any Group Company in running GP practices, including: a. Number of contracts held, b. Length of the contracts, and c. Commissioning organisations.	We note that: 1. "HCRG Care Group" is referenced in this response – which company or companies within the group structure is being referenced? 2. Only one of the Group Companies is dealt with in this response. Please provide information as requested in relation to all of the Group Companies. Please provide evidence of the CQC ratings of all of the regulated healthcare services provided	HCRG Care Group (HCRG Care Group Holdings Limited and its subsidiaries) is one of the largest independent providers of primary and community services to the NHS and Local Authorities and has been part of the health and care system in England since 2006. The company holds more than 50 contracts with the NHS and local authorities to deliver community health and care services and employs more than 5,000 people delivering services ranging from District Nursing to Community Hospital Wards to Sexual Health and Health Visiting and School Nursing

#	Question	Further Question/ clarification required – January 2024	Clarified answer – February 2024
		by each Group Company. Please confirm why there are 13 primary and urgent care services listed in this response, but the Primary Care Induction document also contained in 2.1 shows on slide 15 that ~~they~~ HCRG operate 6 GP practices and 4 urgent care services. We also note that slide 4 of the same presentation notes that HCRG runs 21 primary care services across the country. And the response to question 3.1 states that "HCRG Care Group presently operates 7 APMS primary and urgent care services for the NHS". Please confirm exactly how many primary care contracts and urgent care contracts companies in the HRCG group hold. Where any contracts are due to expire shortly, please confirm the reason why these are not being renewed or extended. *Buyer: Where differences in numbers appear within different documents, this relates to the difference between locations / services and contracts; we apologise that this is unclear. The business operates 7 stand-alone APMS contracts but also delivers other primary care services (urgent care services, prisons primary care services) via other contracts, leading to a total 21 'primary care' locations from where primary care is delivered.* *We are not aware of any primary care contracts*	services. The company has operated primary care services for more than a decade, predominantly holding APMS contracts within this business area and successfully working closely with commissioners to transform or improve challenged services. All primary care services operated by the organisation are rated "Good" or "Outstanding" by the CQC. a. Entities within the HCRG Care Group currently hold contracts to operate 13 primary and urgent care services. b. Contract lengths vary from between 2 years and 13 years in total with an earliest start date of 1 May 2011. Of 10 contracts held, 6 have expired already or are due to expire on 31 March 2023 but have verbal or written intent to extend, with paperwork awaited. The remaining 4 are due to end on 31 March 2026. c. The services are commissioned by Birmingham and Solihull ICB, Buckinghamshire Oxfordshire and Berkshire West ICB, Coventry and Warwickshire ICB, and Mid and South Essex ICB. HCRG Workforce Solutions (HCRG Workforce Solutions Limited) provides staffing and

#	Question	Further Question/ clarification required – January 2024	Clarified answer – February 2024
		which are due to expire shortly. Where contracts are due to expire for other types of services, these are the natural end of contracts which were re-procured through competitive tender processes.	workforce solutions through frameworks and master vend contracts to the NHS and Local Authorities. The company does not hold any contracts for the provision of GP practice services but does have extensive experience in the provision of locum staffing both in GP practices and the wider health and care service.
		Please confirm: - Which company is referenced when "Operose Health Management" is described? - Which companies make up "HCRG Care Group" for this purpose, and which primary care services will transfer (all HCRG primary care services or only some)? What will be the impact on AT Medics of this change, and where will the HCRG primary care services sit in the new T20 Osprey MidCo structure?	It is intended, subject to confirmation by the management team at Operose Health Limited of sufficient capacity, that within 12 months of the transaction completing all of HCRG Care Group's current APMS primary care services will transfer to management by Operose Health. The APMS contracts are currently held by HCRG Care Services Limited. The impact of the transfer would be less than but similar too the acquisition of a new contract by Operose Health / AT Medics. This is a process both HCRG Care Group and Operose Health are familiar and experienced with and – therefore – ultimately, expect there to be no negative impact on either companies' services to patients. The transfer would be subject, of course, to negotiation with current commissioners of these services and a detailed planning process which would determine where the primary care

#	Question	Further Question/ clarification required – January 2024	Clarified answer – February 2024
			services would sit within the legal structure of Operose Health Limited.
		Please confirm the relevance of this to the Buyer (T20 Osprey Midco Limited) and the Buyer's governance and values – is the same induction pack to be used for new starters at the Buyer?	The attached document (2-1 Primary Care Induction.pdf) is taken from HCRG Care Group's new Colleague Induction and provides details of the culture, values, successes and structure of HCRG Care Group's primary care operation. This pack has been provided for commissioners' information only, to provide assurance of HCRG Care Group's approach, attitude and experience and we apologise for any confusion its inclusion may have caused.
2.2	Names of any UK company or businesses which were formerly a Group Company but have been wound up or sold within the last three years.	Please confirm that this is an exhaustive list and no further wind down or sale proceedings are planned.	During 2020, HCRG Care Group (then known as Virgin Care) undertook a project to simplify its corporate structure. As part of this, legal entities which no longer held contracts (where these had been transferred to another Group legal entity, ended or transferred to another provider) were wound down. There have been no winding up proceedings initiated by third parties. The entities which were wound down as part of this exercise were: ▪ Virgin Care Corporate Services Limited ▪ VH Doctors Ltd ▪ Virgin Care Hampshire Health LLP ▪ Virgin Care Leeds LLP

#	Question	Further Question/ clarification required – January 2024	Clarified answer – February 2024
			▪ Virgin Care Chelmsford LLP We can confirm that this list is exhaustive.
2.3	A brief description of any services provided by any Group Company to Operose Health or AT Medics Ltd and whether any such services will be affected by the change in control.	Please confirm any services planned to be provided by HRCG companies to Operose companies post-completion.	The **Buyer** and HCRG Care Group does not provide any services to Operose Health or AT Medics Ltd. Following the completion of the transaction, we will look for areas where companies in the **Buyer's Group** may be able to work together more closely. For example, HCRG Workforce Solutions is ideally placed to provide staffing services as it does for other providers of similar services and Sugarman Occupational Health, as one of the UK's leading providers of Occupational Health services, is ideally placed to provide this service to Operose Health staff.
2.4	Confirmation of whether any data or other assets currently held by Operose Health or AT Medics Ltd will be transferred to any Group Company and in particular any Group Company outside the UK.	Please confirm any assets or data planned to be transferred between HRCG and Operose companies post-completion.	There is no transfer of data outside the UK. We re-assert that Operose Health and AT Medics will operate in line with current status quo following completion and, therefore, there is no planned transfer of assets or data, within or outside of the UK. With regard to data, the identification of areas where the companies work more closely together may in the future require the transfer of data. In these circumstances, the Buyer's Group is well aware of its responsibilities for maintaining the safety and security of data and

#	Question	Further Question/ clarification required – January 2024	Clarified answer – February 2024
			for complying with data protection legislation and all companies within the Buyer's Group have a strong track record of compliance with these rules.
2.5	Confirmation that no changes in the governance structure or management of Operose Health, or AT Medics Ltd, including of its directors, are proposed.	Please confirm which directors will change, and if any other governance changes or combining of HCRG/Operose governance/ services are anticipated and what their effect will be on AT Medics. Please provide details of such proposals. Please also confirm what entity is being referenced as "Operose Health Management Team".	There are no proposed changes to the governance structure or management of Operose Health or AT Medics Ltd as part of the transaction. There will be necessary changes to directors appointed by the current ultimate controlling party Centene Corporation. This will result in the removal of those directors appointed by Centene Corporation: Tricia Dinkelman Beau Scott Gaverick Following the completion of Change of Control, the **Buyer's Group** will appoint replacement directors. As Operose Health joins an established and experienced group of health and care organisations with governance arrangements praised by the CQC, it is possible that opportunities to combine the governance functions of the organisations may be identified in the future. Any changes would, of course, be carefully managed to maintain safety and the management team of Operose Health Limited would continue to engage with commissioners regarding any changes as they would today.

#	Question	Further Question/ clarification required – January 2024	Clarified answer – February 2024
			(Added in March 2024) In addition to the information originally provided (now clarified), the Chief Executive Liz Perry has announced her intention to resign following the completion of the Change of Control process. The "GP Directors" who previously led the AT Medics business prior to its acquisition by Operose Health have also chosen to leave the business, and are currently working their notice period. Samantha Kane, formerly Chief People Officer at HCRG Care Group, will take up the role of Interim Chief Executive Officer on 1 March and will work closely with Liz until she leaves the organisation. Professor Nick Harding will continue in his role as Chief Medical Officer, providing excellent and consistent clinical leadership, and there will be no negative impact on the provision of services, nor Governance structures.
3			
3.1	Details of, and copies of all documents relating to, any licences, consents, registrations, approvals, permits and exemptions (whether public or private) required or obtained by the Buyer in connection with the operation of its business, insofar as it is relevant to the AT Medics Ltd contract ("Consents").	Please provide these documents which have not been made available. In particular, we assume that existing Operose registrations will continue, and Buyer will not need any additional registrations, but this should be confirmed. Any registrations to be acquired by Buyer (T20 Osprey Midco) should be confirmed.	Copies of various licences, consents, registrations, approvals, permits and exemptions are attached.

#	Question	Further Question/ clarification required – January 2024	Clarified answer – February 2024
		Please explain this response in more detail, as per our additional question in 2.1 above.	While Operose Health and AT Medics will continue to operate, HCRG Care Group presently operates 7 APMS primary and urgent care services for the NHS and has significant experience of governing and delivering these types of services.
3.2	Will any of the Consents be affected by the proposed change of control? If yes, please provide details.	Please confirm if your answer is changed in view of the additional information requested.	We have reviewed, and our answer remains: No.
3.3	Details of, and copies of all documents relating to, any investigation, enquiry, prosecution or other enforcement proceedings or process by any governmental, administrative, regulatory or other body or organisation in relation to or affecting the Buyer or its business and details of any facts or circumstances that may give rise to any such matters.	Please confirm if your answer is changed in view of the additional information requested.	We have reviewed and our answer remains: None.
3.4	Details of any matter or circumstance that constitutes, or may constitute, a contravention or breach by the Buyer (or any of its officers, agents or employees) of the provisions of any Consent, statute, order or regulation made in the UK, and copies of all related documents.	Please confirm if your answer is changed in view of the additional information requested.	We have reviewed and our answer remains: None
3.5	Details of, and copies of all documents relating to, any anti- corruption policies and procedures that have been implemented by the Buyer to ensure compliance with the Bribery Act 2010.	Please confirm if this will apply to the Buyer, as currently this is unclear.	We enclose a copy of the relevant policy (3-5 Anti Bribery and Anti Fraud Policy.pdf), which we can confirm applies to the directors of T20 Osprey Midco Limited.

#	Question	Further Question/ clarification required – January 2024	Clarified answer – February 2024
			As an SPV, this company does not have any other employees. The OHL policy remains in place for this company and its subsidiaries.
		Please confirm if this answer is in relation to the Buyer as defined (T20 Osprey Midco Limited) or another entity.	The companies within the **Buyer's Group** regularly demonstrate their governance and compliance with these regulations as part of tenders operated by the NHS and local authorities.
3.6	Details of the Buyer's procedures for ensuring and monitoring compliance with applicable data protection legislation.	Please respond to this question by reference to the Buyer. The response as currently drafted is in relation to HCRG Care Group (note that it is unclear which legal entity this refers to).	T20 Osprey Midco Limited is a non-trading holding entity created as a special purpose vehicle for the acquisition of Operose Health Limited. As such, the company does not hold or process any information. The Buyer's Group, however, has substantial experience: HCRG Care Group (HCRG Care Group Holdings Ltd and its subsiduaries) is an experienced provider of health and care services and has a comprehensive set of procedures and policies to ensure its compliance with data protection legislation. The organisation has been awarded "Substantial Assurance" – the highest possible accreditation level – for handling information and data security against the NHS Data Protection and Security Toolkit.

#	Question	Further Question/ clarification required – January 2024	Clarified answer – February 2024
			The organisation employs a dedicated Information Security team within its IT function as well as contracting with external experts to meet, and exceed, the relevant standards. HCRG Workforce Solutions (HCRG Workforce Solutions Limited) is an experienced provider of staffing and workforce solutions and has a comprehensive set of procedures and policies to ensure its compliance with data protection legislation. The organisation has completed Cyber Essentials Plus accreditation, and additionally holds ISO27001 accreditation. The organisation employs appropriate expertise within its IT function, as well as contracting with external experts, to meet and exceed the relevant standards.
4			
4.1	Details of any ongoing or threatened litigation, arbitration, mediation or similar proceedings or disputes involving or otherwise affecting the Buyer or its business which may be reasonably considered to be material in relation to us.	Please confirm if this answer is provided in relation to the Buyer, or another entity? Please also answer this question in relation to all other entities in the group structure chart provided, in order to provide the ICB with the required information given that the Buyer is a new company.	The **Buyer's Group** has no ongoing or threatened litigation, arbitration, medication or similar proceedings or disputes. We have clarified that this answer applies to the Group as a whole.

#	Question	Further Question/ clarification required – January 2024	Clarified answer – February 2024
		n/a	HCRG Care Group, as a provider of health and care services, has from time to time ongoing or threatened medical claims. All claims are subject to rigorous internal investigation by our clinical quality, legal, governance and Customer Experience teams to establish the circumstances of each claim and lessons learned are escalated and disseminated within the organisation to avoid recurrence.
		Is this the case in relation to the Buyer also? Does the Buyer hold relevant insurance policies?	Each claim is covered by insurance policies held by the various entities within the **Buyer's Group** and none of these cases would be considered material in relation to this transaction. The Buyer is covered by appropriate insurance with regards to its activities.
4.2	Details of, and copies of all documents relating to, any outstanding or pending judgment, order, finding or decision of any court or regulatory body affecting the Buyer or its business.	Please confirm that this answer is in relation to the Buyer (T20 Osprey Midco Limited).	There are no outstanding or pending judgements, orders, findings or decisions of any court or regulatory body which could affect the Buyer or its business. This answer applies to all companies within the Buyer's Group.
5			
5.1	How many employees are employed by Operose Health? How many of those employees are involved in the provision of services by Operose Health (and AT Medics)?	n/a	As at 30-Sep-23: ▪ FTE = 1,219.9 ▪ Headcount = 1,574 All employees are involved in the provision of

#	Question	Further Question/ clarification required – January 2024	Clarified answer – February 2024
			services by Operose Health (and AT Medics).
5.2	Is Operose Health contracting with any other entities which supply staff needed to deliver the APMS contract, and if so, please confirm details of any such contracting arrangements.	Please confirm what is meant by "core APMS contracts". Do any other organisations supply staff and will they continue to?	No sub-contracting arrangements are in place for APMS contracts. Like all providers, Operose Health Limited works with a range of agencies and independent contractors for the supply of staffing and it will continue to do so.
5.3	Will there be any change to the staff working with Operose Health , or AT Medics? Confirm if TUPE will apply to the transfer.	n/a	As the Buyer will acquire 100% of the shares in Operose Health and a 1% minority interest in AT Medics Holdings LLP, and Operose Health and AT Medics Limited will continue to operate as previously, there is no change of employer and TUPE is not, therefore, engaged. (March 2024) Given the extended length of the due diligence process, proposed to last until at least August 2024 before a decision can be made, it is prudent to note that any business will, over the course of almost a year, experience changes to staffing both as a result of natural attrition and as part of normal business reviews to ensure optimal performance.
		Does the Buyer currently anticipate making any changes to the staff working within Operose Health or AT Medics (either at the time of transaction or afterwards)?	As part of the transaction, there are no changes proposed to the staff working within Operose Health or AT Medics and there is no plans to make changes to the staffing of services.

#	Question	Further Question/ clarification required – January 2024	Clarified answer – February 2024
5.4	Does the Buyer run any equivalent healthcare businesses, and it so, please provide any information which could be relevant to understanding their workforce model, including: a. Stability of the workforce, b. Number of employed to temporary staff, c. Temporary staff and how the Buyer anticipates they will be affected.	We note that this response does not refer to any equivalent healthcare businesses run by the **Buyer** (T20 Osprey Midco Limited) and so understand that the answer in relation to the Buyer would be no, they do not run any equivalent healthcare businesses. Please confirm. The information in relation to HCRG Care Group is useful, please specify the legal entity/ "organisaton" being described in this response. Please also provide information about whether the HCRG Care Group's use of physician associates and whether it is intended to replicate HCRG Care Group staffing models involving physician associates in the Operose Health business.	The Buyer is a special purpose vehicle set up for the acquisition of Operose Health Limited. The **Buyer's Group**, however, does run equivalent healthcare businesses. HCRG Care Group (HCRG Care Holdings Limited and its subsidiaries) operates 7 APMS contracts and other primary care services alongside a wide range of community services for adults and children for the NHS and Local Authorities. As a result, HCRG Care Services Limited is licensed and monitored by England under the 'Hard to Replace' provider regime. HCRG Care Group employs more than 5,000 people in the delivery of these services with the majority of staff employed on a substantive basis. Colleagues are employed on market-competitive terms, and receive a full range of benefits. The organisation has been shortlisted or won several awards during the last 10 months for its employee support and benefit programmes, including winning "Best Cost of Living Response" at the CIPP Annual Excellence Awards and has been shortlisted for Best Employer for Diversity and Inclusion at the Nursing Times Awards for its comprehensive menopause support programme and policies. The organisation is also able to definitively demonstrate that it is an attractive employer

			within the sector, despite sector-wide shortages of professionals and has welcomed an additional 50WTE colleagues to its team since 1 April 2023. HCRG Care Group closely monitors key workforce metrics ensuring visibility at every level of the business from floor to board. Turnover, sickness and other key metrics are comparable with the broader health and care sector. In addition to a stable workforce model, the organisation has been commended for its ability to deliver improved health outcomes and high quality services in partnership with commissioners over many years. For example: • Following being awarded a contract to create and run Wiltshire-focused children's services in 2017, Wiltshire Council have renewed for another five years until 2029 • Essex County Council have extended their contract to deliver improved outcomes for families for a further 3 years • Coventry City Council and Warwickshire County Council have appointed us to deliver the largest sexual health contract across their areas, following the successful transformation and delivery over several years in Teesside, Greater Manchester and Lincolnshire.

#	Question	Further Question/ clarification required – January 2024	Clarified answer – February 2024
			97% of the organisation's services rated by CQC hold "good" or "outstanding" ratings, higher than the industry average, and reflecting the organisation's track record of transforming and improving the services it takes on. There is no intention to change or merge the operating models of HCRG Care Group and Operose Health, including the use of PA roles. As above, both organisations' services are well reviewed by regulators and we intend to continue to provide high quality care within both organisations.
6			
6.1	Details on the financial position for the past three years of the Buyer and the Group Companies, including in particular: - Income and Expenditure, - Profit and Loss; - Debts; - Information held pertaining to bankruptcy and/or liquidation which could be deemed relevant.	As above, the information provided does not relate to the Buyer – please provide as much financial information as possible as requested in relation to the Buyer, or note the reason this cannot be provided (we note that you have stated that there are no audited accounts). Please, if this is not information which is available for T20 Osprey Midco Limited, provide the requested information in relation to the companies further up the structure (T20 Pioneer Midco Limited, T20 Pioneer Holdings Limited, Twenty20 Capital Investments Limited, IJMH Limited and Twenty 20 Capital Limited).	We have provided accounts for the companies: Twenty20 Capital Investments Limited, T20 Pioneer Holdings Limited and T20 Pioneer Midco Limited. As a non-trading holding company established to acquire the Operose Health business, T20 Osprey Midco Limited has not yet published audited accounts.
6.2	Details of the impact any failure of the Buyer or any would have on the ability of AT Medics Ltd to continue to deliver the APMS contract.	Please provide more detail about the financial separation between the Buyer and Operose Health and AT Medics.	It is intended that Operose Health and AT Medics will continue to operate as a financially sustainable standalone services focused on

#	Question	Further Question/ clarification required – January 2024	Clarified answer – February 2024
		Buyer: We are unclear on how to best respond to this request. Operose Health and AT Medics are financially sustainable businesses, and we intend for this to continue. While we have provided various assurances regarding other Group companies, the failure of any Group company would not impact on the ability to deliver the APMS contracts as the business will not be dependent on financial support from the Group.	delivery of primary care services, and therefore there would be no impact of the failure of the Buyer (or any other Group company) on the continuing ability of Operose Health to continue delivery of the APMS contracts. In addition, HCRG Care Group is scrutinised closely and regularly by NHS England as a result of its designation as a Hard to Replace Provider and commissioners can therefore be assured by the significant oversight of the Group's affairs and its strong financial performance, given the lack of concerns raised through this process to date.

3 **RESPONSE RECEIVED 25.04.2024**

1	Question
1	We understand from Stephen Collier's email dated 15 March 2024 that a purchase agreement was entered into by MH Services International (UK) Limited and T20 Osprey Midco Limited. As a result, from 28 December 2023 T20 Osprey Midco Limited became the legal owner of Operose Health Limited. As a result, a change of control of AT Medics Limited occurred on that date. That change of control was the subject of AT Medics Limited's request for prior authorisation to undergo the change of control dated 30 November 2023 and of the ongoing due diligence exercise. Please confirm on what basis did AT Medics Limited determine not to inform us or the ICBs of this at the time of the change of control or at any time until 15 March 2024, despite the ongoing due diligence process (including further queries raised by us on 19 February 2024 and responses provided to us on 6 March 2024)? Please also confirm on what basis did no other company with ownership/control of AT Medics Limited (including but not limited to Operose Health Limited and T20 Osprey Midco Limited) or part of the same overall group (including but limited to the HCRG Group) determine not to inform us or the ICBs of this at the time of the change of control or at any time until 15 March 2024, despite [regular] meetings/communications between representatives of such companies and representatives of NHS England and the ICBs occurring between 28 December 2023 and 15 March 2024?
1	The background is that as negotiations with the seller, Centene, progressed it became apparent that the seller was not prepared to enter into a contract that was conditional on change of control approval. Rather Centene required a rapid and full completion, by the end of December 2023. When this occurred, we viewed it as a change of ultimate ownership rather than operational control. For that reason, and to preserve the status quo, we did not action any associated tasks or business activity connected with a change of control, such as for example making director appointments etc.. We left operational control with the Operose management team, under the leadership of Liz Perry. However, when Liz indicated that she intended to leave the company we recognised that it was no longer appropriate to continue on this basis. We therefore made the notification of 15 March 2024. We now accept that earlier disclosure would have been appropriate and apologise for the frustration and disappointment our actions may have caused. As a proven and experienced provider of health and care services, including APMS delivery, we hoped that due diligence would conclude at pace and we could move forward, working together to improve outcomes, experience and access for patients, as our track record can evidence us doing so historically. We fundamentally believe in UK ownership for UK NHS services and have already started to lead improvements including increasing the number of employed GPs in our practices. In services nothing has changed, the practices are still led by the same leaders and patients are cared for by the same clinicians and medical staff. Our intention has always been to respect the change of control process and our commitment to this has been demonstrated through our active co-operation and engagement.
2	**Question**
2	Is there any change to the due diligence answers provided to date required now that the change has taken effect? For example, you note in the responses provided in March that certain actions would be undertaken *"following the completion of the change in control".* Please confirm if you are aware of any updates to the position set out in your previous responses (excluding the fact that the change in control has happened).
2	We can confirm that there has been no change to the due diligence answers provided to date. There are no updates to the position set out in our previous responses.
3	**Question**

3	Has Operose Health Limited, AT Medics Limited or AT Medics Holdings LLP directly or indirectly borrowed or provided collateral for any of the wider company group's borrowings? If so, please confirm the level of such debt held by any of these companies. We ask this question as we note that the Companies House documents for AT Medics Limited and AT Medics Holdings LLP, show that a charge was registered against both on 13 March 2024 for the benefit of HSBC bank. We note from a search at Companies House that AT Medics Limited and AT Medics Holdings LLP, each have charges registered against them on 13 March 2024 for the benefit of HSBC bank. d. Please provide details of any of the following given by or to Operose Health Limited: • debentures, mortgages, charges, or other security together with details of the secured obligations to which these and any other security relate; and • guarantees, indemnities, bonds, comfort letters or other sureties or assurances together with details of the secured obligations (including value or potential value) to which these and any other sureties or assurances relate. e. Please provide details of any of the following given by a third party (including AT Medics Limited and AT Medics Holdings LLP) in respect of any of Operose Health Limited's obligations: • debentures, mortgages, charges, or other security together with details of the secured obligations to which these and any other security relate; and • guarantees, indemnities, bonds, comfort letters or other sureties or assurances together with details of the secured obligations (including value or potential value) to which these and any other sureties or assurances relate.
3	T20 Osprey Midco Ltd, the parent company of Operose Health Ltd, and its sister company HCRG Care Group Holdings Ltd, refinanced existing group debt with HSBC UK Bank in March 2024. All material subsidiaries of T20 Osprey Midco Ltd. and HCRG Care Group Holdings Ltd. are Obligors under the borrowing arrangement, and therefore have debentures in relation to HSBC UK Bank. This includes Operose Health Limited, AT Medics Limited and AT Medics Holdings LLP. All debentures are available on Companies House. HCRG Care Services Ltd, the main trading subsidiary of HCRG Care Group Holdings Ltd, was designated as a 'Hard to Replace Provider' by NHS England in 2023. As a result of this, HCRG Care Group holds quarterly meetings with the NHS England Independent Sector Provider Monitoring team and provides a quarterly financial template that includes financial performance of the group, debts of the group and financial covenants. NHS England have confirmed that Operose Health Ltd and its subsidiaries including AT Medics Limited and AT Medics Holdings LLP will form part of the NHS England monitoring process going forward. The companies will report on a quarterly basis with the HCRG Care Group from 1 April 2024.
4	**Question**
4	We note that the licences requested have still not been provided. Please could these be provided? Operose, at 3.1 of the supplementary response, notes that *"copies of various licences, consents, registrations, approvals, permits and exemptions are attached"*, however we cannot see that such are attached to the email which was sent.
4	There are no additional licences required as a result of the transaction, the reference to appendices was an oversight on the previous response.

5	Question
5	We note that the confirmation statement for Operose Health Limited was due to be filed at Companies House by 4 March 2024 and remains overdue. Please confirm the reasons for this, when it will be filed, and any details to be included within the statement that are in addition or contrary to information currently available on Companies House and/or that you have provided to us previously?
5	Operose Health Limited's confirmation statement was filed on 19th April 2024. All details can be seen on Companies House.
6	**Question**
6	In an email of 15 March 2024, Stephen Collier stated, relation to the sale agreement between MH Services International (UK) Limited and T20 Osprey Midco Limited, *"The sale is partly conditional upon the ICBs' consent to the change, in that the ultimate purchase price is determined by whether approval is granted."* Please provide full details about how the commissioners' decisions to approve or refuse authorisation to the change of control affect the purchase price to be paid under the sale agreement?
6	As you will appreciate, there are comprehensive confidentiality restrictions in place within the sale and purchase agreement which prohibit us from being able to provide any more detail in respect of the consideration mechanics and values, other than allowing us to confirm that there was an element of conditionality in respect of the purchase price related to the change of control process.
7	**Question**
7	Please confirm whether the properties from which Operose operates its services are freehold or leasehold. If leasehold, please confirm details of: 3. the landlord and whether they are a party directly or indirectly connected to Operose 4. the term of the lease 5. the rent payable under the lease 6. the rent reviews applicable under the lease
7	See attached 'Operational Estates' excel which addresses the full question.
8	**Question**
8	Please provide details of what (if any) applications or notifications have been made pursuant to the National Security and Investment Act 2021 or Competition Act 1998/Enterprise Act 2002 in respect of the acquisition of Operose.
8	No applications or notifications have been made pursuant to the National Security and Investment Act 2021 or Competition Act 1998/Enterprise Act 2002 in respect of the acquisition of Operose.

APPENDIX 4 LETTER NOTIFICATION

Frances O'Callaghan
NHS North Central London ICB
Laycock PDC
Laycock Street
London
N1 1TH

30th November 2023

Dear Frances

CONSENT FOR CHANGE OF CONTROL

Further to our recent correspondence, we are now writing to you to formally to seek your consent to a change of control in accordance with clause 54.3 of the APMS contracts listed in **Annex 1** to this letter ("**APMS Contracts**").

The change of control arises as a result of a change in ownership of Operose Health Limited ("**OHL**"). OHL is currently wholly owned by MH Services International (UK) Limited, however it is intended that the ownership of OHL will transfer to T20 Osprey Midco Limited ("HCRG Care Group"). The HCRG Care Group is a UK based company, and one of the largest independent providers of NHS-funded primary and community services operating across England and Wales.

We have set out more details of the current and proposed ownership structure to ensure you have the complete information, in **Annex 2**.

OHL is the holding company of AT Medics Holdings LLP which in turn is the holding company of AT Medics Limited, the contractor under the APMS Contracts. This makes OHL a "Holding Company" of AT Medics Limited under clause 54.3 of the APMS Contracts.

Therefore, we believe the change of ownership of OHL amounts to a Change of Control envisaged by clause 54.3.

The change in ownership reflects Operose Health Group's current owner, Centene Corporation, continued execution of its value creation efforts as the company refocuses its portfolio on core lines of business.

Benefits of new ownership for patients and the NHS

- The new ownership brings together two highly experienced care providers with a shared mission to improve patient outcomes and experience across primary and community care.
- There will be no changes to frontline services or clinical leadership in your area and with HCRG Care Group's full support and backing, our practices will continue to serve their communities with high quality NHS primary care, clinically led and powered by sector-leading technology.
- Our core commitments also remain unchanged: to see patients as quickly as possible; improve quality; recruit and retain dedicated staff and; use social value activity to have a wider positive impact on the populations we care for.
- New ownership opens up significant opportunities, creating a single UK-owned organisation with greater expertise, scale and resilience to help deliver the NHS's priorities for primary and community care, including faster access, better integration, eradicating health inequalities and the use of digital, tech and data.
- HCRG Care Group is an experienced operator and partner for OHL. It operates 21 primary care and urgent care services alongside more than 400 community services for adults and children for the NHS and Local Authorities, employing more than 5,000 staff in the delivery of services and with a strong track record of delivery on behalf of the NHS. All of HCRG Care Group's CQC ratings are "Good" or "Outstanding", aligning with OHL's own strong track record.
- HCRG Care Group brings with it access to investment and the support of one of the UK's top 10 recruitment and workforce solutions groups, as well as a track record of a 'healthcare first' approach, minimising costs and maximising efficiency of support services.

Engagement

- We have been working closely with NHS colleagues to make sure all parties have clarity on relevant change of control contractual obligations, processes and timelines, including appropriate public engagement.
- We will continue to provide reassurance to our patients, staff and stakeholders that this change of control will not impact on our continued delivery of, and commitment to, high-quality patient care in our local surgeries.

What are the implications from a procurement law perspective?

As AT Medics Ltd will continue to hold the APMS Contracts, there should be no concerns for the commissioners in relation to procurement law compliance, as the same contractor will be holding the APMS Contracts.

What are the implications in relation to service delivery?

AT Medics Ltd will continue to be responsible for providing primary care services under the APMS Contracts, and there are no intentions to change the personnel involved in providing the primary medical care services. The 6 GP founders of AT Medics Limited will also remain in their current regional roles within the company. On that basis, we do not intend to make changes in relation to service delivery. We believe our collaboration with HCRG Care Group will drive even better clinical outcomes and broaden access for patients.

Do the APMS contracts need to be novated?

No – the APMS Contracts between AT Medics Ltd and the commissioners will remain intact, and no novation is required, as AT Medics Ltd remain liable for its obligations under the APMS Contracts. The change of control does not affect the APMS Contracts, except for the fact that your consent is required prior to such change of control taking place in accordance with clause 54.3.

What do I need to do to agree to the change of control?

Please review, sign and return the enclosed form in ***Annex 3,*** *at your earliest convenience.*

What if I have any further questions or require more information?

Should you have any questions, please contact me via liz.perry@operosehealth.co.uk.

Yours sincerely

Liz Perry
CEO | Operose Health

CC Vanessa Piper - Assistant Director of Primary Care Contract and Commissioning NCL ICB

Annex 1

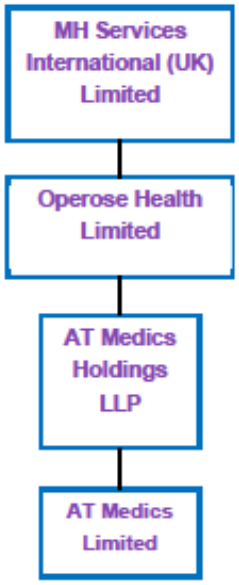
List of APMS Contracts

Mitchison Road Surgery	F83056
Hanley Primary Care Centre	Y01066
Kings Cross Surgery	F83635
Somers Town Medical Centre	F83683
Brunswick Medical Centre	F83048
Camden Health Improvement Practice	Y02674
St Ann's Road Surgery	Y02117
GP Hub Camden (Somers Town / Brondesbury)	AF006 AF009 AF008 AF007

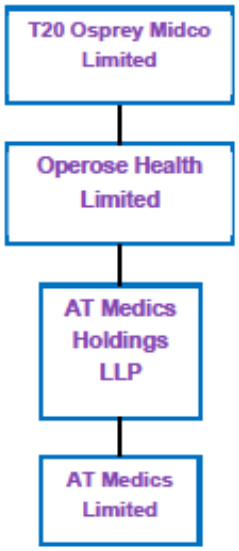
Annex 2

Group Structure Details

Before



After



Annex 3

ICB Consent Response

FROM: NHS North Central London ICB ("the Commissioners")

TO: AT Medics Limited

The Commissioners acknowledge that AT Medics Limited has requested they consent to a change of control, in respect of the following APMS Contracts ("**the Contracts**"):

Practice name	**Contract reference**
Mitchison Road Surgery	F83056
Hanley Primary Care Centre	Y01066
Kings Cross Surgery	F83635
Somers Town Medical Centre	F83683
Brunswick Medical Centre	F83048
Camden Health Improvement Practice	Y02674
St Ann's Road Surgery	Y02117
GP Hub Camden (Somers Town / Brondesbury)	AF006 AF009 AF008 AF007

Change of control

Clause 54.3 of the Contracts requires AT Medics Ltd to receive prior authorisation of the relevant Commissioner prior to any change of control, as defined in the Contracts.

The change of control that AT Medics Ltd is seeking consent to relates to a change of the proposed ownership of Operose Health Limited which amounts to a change of control in the Holding Company of AT Medics Ltd. Subject to the completion of the transaction, the intention is that the ownership of Operose Health Limited will transfer to HCRG Care Group See Annex 1.

AT Medics Limited has confirmed that it will continue to provide the services under the Contracts, and there will be no adverse changes to the services under the Contracts as a result of this change in control. No changes are proposed to the terms or operation of the Contracts.

Consent

By signing this letter, the Commissioners hereby confirm that they consent to the change of control referenced above in respect of the Contracts, such change of control to take place on completion of the transaction. Signed for and on behalf NHS North Central London ICB.

Name	
Date	
Signature	

APPENDIX C

Operose Health Limited Clarification Statement

We understand that queries have been raised by ICB colleagues regarding a debt reduction exercise that Operose Health have recently undertaken with HSCB UK Bank. We have prepared the below to provide further context and reassurance for our ICBs on this matter.

Operose Health Debt-Reduction Arrangements

Operose Health is now part of a UK-based-and-managed health and care group.

Our group is one of the largest independent health and care groups in the UK, providing millions of hours of care and support to patients and service users across the UK in primary care settings, their own homes and in the community. We hold a substantial number of positive CQC ratings demonstrating our commitment to high quality services and – through our ultimate ownership – we benefit from access to investment to enable transformation.

Debt reduction and financial standing

Earlier this year, we went through a debt reduction exercise. This exercise conducted with HSBC UK Bank, resulted in the routine registration of a bank charge at Companies House against group companies. This is a positive endorsement of the financial stability of the Group. As a result of this exercise, Operose Health is now borrowing less than one-third of the amount borrowed under its previous US-based owner.

This stability enables us to invest in our services to the benefit of our patients. For example, we have recently invested in tools and systems that have allowed us to increase clinical capacity – a key priority for us.

The documentary evidence submitted as part of the Due Diligence response, reflects a stable and financially sound organisation. Our practices are now part of a UK-based-and-managed health and care group which pays tax in the UK and has a strong track record of delivering NHS high quality services.

The Group is accredited by NHS England as a ‘Hard to Replace’ provider, and as such is subject to stringent quarterly audits of its financial position. We are pleased to report that we have always passed those important tests. We have discussed this matter with our NHS England colleagues who are able to liaise with ICB colleagues to provide further reassurance on the Group’s financial standing.

We are committed to being a long-term partner to NHS and hope this information helps to provide clarity and reassurance on this matter.

Our main priority has, and will always be, providing our patients with high quality primary care.

ENCLOSURE:
AGENDA ITEM: 9

Healthier Greenwich Partnership Board

DATE: 24 July 2024

Title	**Partnership Report**	
This paper is for **information.**		
Executive Summary	The purpose of this report is to provide the Committee with an overview of key work, improvements and developments undertaken by partners within the Healthier Greenwich collaborative.	
Recommended Action for the Committee	The Committee is asked to note the update	
Potential Conflicts of Interest	None.	
Impacts of this proposal	Key risks & mitigations	Not Applicable
	Equality impact	Not Applicable
	Financial impact	Not Applicable
Wider support for this proposal	Public Engagement	Not Applicable
	Other Committee Discussion/ Internal Engagement	Not Applicable
Author	Joint Reports from Partners	
Clinical lead:	Not Applicable	
Executive Sponsor:	Sarah McClinton, Place Executive Lead	

Partnership Report – July 2024

Table of Contents

1. Healthier Greenwich Partnership (HGP)

The HGP held a development workshop for partners on 29th May to consider how to take forward neighborhood work in Greenwich in response to the Fuller stock take. On 26th June there was a further seminar to agree how to take forward the outputs from the development workshop and to consider changes to ToR.

2. Connecting Greenwich; General Practice Development Support

Current health challenges and system pressures highlight the need to extend and support Neighbourhood development and collaborative working.
Neighbourhood development in Greenwich takes a human-centred approach to addressing health inequalities by mobilising and connecting people, local assets and resources, ensuring local health and care systems work together with communities on an equal basis.
This has the potential to create a responsive, effective, and collaborative health and care service delivery model that is better equipped to meet the evolving needs of the population. Using this approach, and in addition to the aforementioned, Greenwich is expected to continue to deliver against national imperatives, including recovery plans for primary, urgent and emergency care, the Fuller Stocktake as well as other locally agreed priorities.

General Practice is a critical partner in delivering system integration across Greenwich, but feels under-supported, under-resourced and not properly connected with their wider

system partners or the local communities they serve.

Taking on board this feedback, the co-designed Practice Development Programme provides opportunities for practices to work on projects they have identified with bespoke packages of support aligned to ensure the best chances of success.

There are several routes that practices can use to join the programme with 7 currently working on projects, a further 4 in the pipeline plus a specific cohort for Practice Nurses. The attached slide deck at **Appendix One** provides further details on project themes as well as information on the evaluation aspects of the program.

For further information, please contact Maria Howdon, Assistant Director of Primary Care.

3. Royal Borough of Greenwich, Public Health Update

In Public Health, we will be re-commissioning a number of major service areas to commence mid-way through 2025-26. We have already undertaken a year of market engagement activity and will be continuing to develop the model prior to the formal procurement phase.

Our services will be commissioned in a more joined-up way, with a requirement for providers to work in partnership arrangements to ensure services are well connected and centred around the needs of residents.

There will be three lots:

1. Sexual and reproductive health
2. Drugs and alcohol treatment
3. Live Well Prevention:
   Tobacco treatment
   Diet and nutrition
   Physical activity
   Health and wellbeing
   NHS Healthchecks

We have also started work on a new Addictions Strategy for the borough, working with a range of partners to develop a joint approach to tackling the health harms caused by tobacco, drugs, alcohol and gambling.

We will soon be welcoming two new Assistant Directors / Consultant in Public Health.

- In August, Helen Buttivant will be joining the team following a number of years in the Lewisham Public Health team. She will be overseeing a wide portfolio of

public health work, including health intelligence, public mental health and children and young people.

- In September, Samantha Bennett will be joining us. Most recently, Sam has been working for a large NHS Trust in Kent. She will be leading on healthcare public health, working closely with ICB and NHS Trust partners, public health commissioning, health protection and the neighbourhoods agenda.

4. Update from Oxleas NHS Foundation Trust

1. Community physical health services

Urgent Community Response London Ambulance Service Car Pilot
In June, our urgent community response services joined forces with London Ambulance Service (LAS) paramedics to launch a new response paramedic car service.

The new Urgent Community Response (UCR) car is now in operation across the boroughs of Bexley, Greenwich and Lewisham, treating patients at home and reducing the need for a hospital visit by ambulance. Staffed four days a week, our Greenwich Joint Emergency (JET) and Bexley Rapid Response teams work alongside an LAS paramedic, responding to category 3 and 4 calls, freeing up ambulance capacity and reducing the numbers being transported to Queen Elizabeth Hospital.

The new service is already having an impact and, in the first four days of operating, 31 patients were attended to, 21 of which were assessed, treated and referred on to community services. We have been able to respond to a higher number of people who have fallen at home. Previously we would have required a referral from 111 or LAS and then staff would attend from the JET team. Now we can respond directly, more rapidly and to more referrals.

The Source Phase 2
The Source is a drop-in service, open for the past 18 months, located in the Horn Park area of the borough. Development of the clinical services at The Source continues with the Nurse Specialist Advanced Clinical Practitioner extending the drop-in service to work with under 18s from 1 August 2024.

Working closely with colleagues from the Royal Borough of Greenwich and commissioners, we are supporting the renovation of this community asset so that we can proactively see more patients living within the Horn Park area. This neighbourhood has high levels of health inequality, and our caseload data shows that people living here use a range of Oxleas services. The phase 2 development will create additional clinical space so that we will be able to deliver interventions

closer to their homes.

2. Specialist Children's Services

We recognise that waiting times continue to grow due to significant increases in demand, particularly with regards to Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) assessments.

We continue to provide additional capacity for these via our online assessment pathway. In addition, the new diagnostic pathway is anticipated to be mobilised shortly with the following key benefits:

- Elimination of waits for triage
- Enable inter-pathway assessment e.g. if a child is referred for an ASD assessment and shows signs of ADHD, we would not need to refer them to the beginning of the ADHD waitlist
- Enable referrals from Special Education Needs Coordinators (SENCo)

We are also reviewing and redesigning our communication around waiting times and referrals, so families get specific information regarding their child's pathway.

We are developing a waiting well offer for some of our services and have a graduate role commencing in August to support this. This role will work closely with community partners, voluntary services and Place to identify and co-ordinate support for our children, young people and their families while they are waiting for services.

The supply chain for ADHD medication continues to impact and affects various ADHD medication at different times. Initiation of medication was paused due to national shortages and has been increasing steadily as supplies replenish. We are currently at 75% of medication initiation activity and will review in August to establish if normal service can resume.

3. Child and Adolescent Mental Health Services

Greenwich CAMHS are undertaking an improvement plan, focused on transforming services to improve access. The service continues to make positive progress in reducing waiting times in line with the South East London ambition to eliminate all 36+ week waits for initial assessment by October 2024. The average wait across the service is currently at 17 weeks although this will vary across the pathway based on individual needs of children and young people.

More broadly, Greenwich CAMHS is also undertaking work to review treatment pathways utilising the principles of the nationally recognised i-THRIVE framework. The service is currently undertaking a series of focus groups with staff, young people and their families to shape further plans.

In addition to the participation work happening as part of the redesign work, Greenwich

CAMHS have also been offering additional participation groups for both young people and parents/carers. These have focused on the experience of receiving care and treatment from CAMHS, both in terms of the interventions offered but also the physical environment of the clinic. The service has been able to make some positive changes to Highpoint House based on the feedback of young people.

Greenwich CAMHS continues to have a positive working relationship with social care colleagues at the Royal Borough of Greenwich (RBG). After much development work, the newly formed Integrated Clinical Team (a dedicated Oxleas team working within the local authority) launched in June and is now taking referrals. This service can offer both timely consultation but also deliver some 1:1 intervention to children and young people who do not require CAMHS but would benefit from some therapeutic support with their emotional health and wellbeing. The clinical offer by Oxleas into the RBG Adolescent Assessment Residential and Resource Centre (ARRCC) is also due to commence in August with staff coming into newly created clinical posts.

Finally, Greenwich CAMHS Mental Health in Schools Team (MHST) will benefit from an additional wave of funding and planning is underway to extend this service, including through the training of additional Educational Mental Health Practitioners (EMHPs). This will increase the number of schools in the borough able to benefit from this service.

4. Adult Mental Health Services/Adult Learning Disability Services

Oxleas has implemented a new learning disability mental health liaison function from April to support local inpatient mental health wards to:

- Identify inpatients with learning disabilities.
- Assess the needs of identified patients with a learning disability (cognitive ability, sensory needs and mental capacity etc.).
- Make individual recommendations for the support of identified inpatients with a learning disability, to help tailor treatment options, assess risk and expedite discharge.
- Assess the support needs of local inpatient services and the workforce regarding effective provision/outcomes for people with a learning disability.
- Make wider recommendations for service and practice improvements relating to more general reasonable adjustments.
- Support practice development to improve the confidence, knowledge and skills of the inpatient workforce.
- Create/provide information and resources for patients and families.
- Engage with the wider system to effectively communicate how risks have been assessed and how they can be mitigated in appropriate community services.

Within the last three months of operation, the learning disability mental health liaison team (which is a team of two comprising a Nurse and Support worker) has focused on three strands of activity:

1. **Promotion** – raising awareness of their availability to inpatient services and the level of support on offer.

2. **Teaching** – developing staff confidence, knowledge and skills relating to meeting the needs of people with a learning disability.
3. **Patient Contact** – responding to the presenting needs of patients currently admitted to wards.

This has enabled ongoing support to be put in place for six patients in relation to diagnosis, treatment options, discharge planning and practice development.

The work of the learning disability mental health liaison team recognises ward pressures and the impact this can have on the capacity to carry out the level of assessment needed to effectively identify and respond to the nuanced risks associated with cognitive impairment, sensory needs and mental capacity. Discharge is expedited when the system effectively understands the diagnosis and risk that informs the mitigations possible in the community. The learning disability mental health liaison team is already proving to be key in supporting this process.

Environmental sustainability projects at Memorial Hospital
Oxleas Charity Fund has been awarded a grant of £143,000 by the Greener Communities Fund to create and improve green spaces for the benefit of patients, staff and local communities at Memorial Hospital in Greenwich.

Oxleas is one of eight NHS charities across the UK to receive a share of over £1 million. The Greener Communities Fund is a partnership between environmental charity Hubbub and NHS Charities Together, funded by the Starbucks 5p cup charge.

Oxleas in Bloom will develop a mosaic of wildlife habitats across the 7.5-hectare. Aiming for completion by February 2026, the project is designed to significantly increase overall biodiversity, and provide an engaging and safe space for therapy and wellbeing activities.

This will complement the e-bikes that have already been introduced at the site. Oxleas is piloting pool e-bikes as an alternative to using cars for home visits in Greenwich.

5. Greenwich Healthier Communities Fund

The Greenwich Healthier Communities Fund is awarding its first round of funding for the Enabling Strand.

The Enabling Strand was designed to increase the capacity and resilience of groups and individuals to deliver and improve services that address health inequalities.

In the first round of funding, eight organisations have been awarded and are in the process of formally accepting their offers. Information on these groups and their work will be promoted via our website this month. The type of work supported has been training

costs for staff, for the set-up, purchasing of equipment and venue space for pilot projects and to help new organisations become formally constituted

All unsuccessful applicants were given personalised feedback from the panel and offered a 1-2-1 meeting to go through their feedback. We have also requested feedback from all applicants on the application process, so we can implement any improvements in order to make this funding accessible to the community.

The Delivery Strand has received 66 applications, which are in the process of being assessed. This strand will provide funding to constituted community and voluntary sector organisations, for projects that tackle health issues across the borough. We anticipate awards to be made for this strand mid-August 2024.

We are also in the process of designing a further strand of funding which we aim to launch later this year. Our ongoing community consultation will feed into this new strand, which will likely offer longer-term funding to help organisations build their sustainability.

6. Primary Care Network Update

Heritage PCN:

- Have developed a Pan PCN PPG. We have few members but are building upon it.
- CKD Pilot project- it is going very well, with fantastic partnership with Secondary care and neighbourhood teams but is paused now due to Cyber-attack.
- The PCN are doing Health check clinics at a local temple and plan do some more outreach clinics where unregistered immigrants will be signposted for registration at local GP practices and health education, role and functionality of NHS will be discussed.

Ferryview PCN

- PCN status from 1st Jan 2024
- ARRS funding being deployed with strategy to deploy full allocation to support practice (Valentine Health PMS)
- EA DES delivery compliant
- Full participation in requirements of PCN DES
- Innovation by participating in pilots of various initiatives with partners across health economy

Blackheath & Charlton PCN

- Currently working on developing a nutrition and healthy eating project. Working with an external company and RBG.LVS. Early stages. A more disease focused approach in bringing the community together.

- Wanting to revive the Community Café and Community Corners. Work on this slowed but needs to be revived once we find out why? Lots of potential to deliver proactive care.
- Exploring ways of how to better engage with patients using the registered lists. Looking at working with All Together Better, a national NHS organisation that has experience of delivering on this.
- Developing an urgent on the day and proactive model of care (Foundry). Total triage for urgent on the day has been rolled out and are collecting data re impact. Positive results so far.
- Working with practices in the PCN as well as in neighbouring PCN (Eltham Medical) so we can roll out wider.
- Looking at developing a new interface with Oxleas Frailty to help deliver the Proactive model.

7. Greenwich and Bexley Community Hospice

In our 30th anniversary year, the hospice will be launching a new brand and website on 1st August. Further information will follow and partners will be invited to hear more soon.

We hope through this important piece of work we will reduce fear of hospice in the whole community and increase our reach and impact, especially to ethnically marginalised groups. The work is also vital to help drive additional charitable income, which will in turn help support the sustainability of our hospice for the next 30 years.

AGENDA ITEM: 10

Healthier Greenwich Partnership

Date: 24 July 2024

Title	HGP Risks update	
This paper is for **noting**		
Executive Summary	The paper provides update about the latest review of some of the risks on Greenwich risk register. A range of actions are being undertaken to manage and mitigate the various risks.	
Recommended action for the Committee	HGP to note the update.	
Potential Conflicts of Interest	None	
Impacts of this proposal	Key risks & mitigations	None arise directly from the report
	Equality impact	Not required for the direct purposes of the report
	Financial impact	Not Applicable
Wider support for this proposal	Public Engagement	Not required for the direct purposes of the report
	Other Committee Discussion/ Internal Engagement	Not Applicable
Author:	Business Support Lead Greenwich	
Clinical lead:		
Executive sponsor:	Sarah McClinton	

HGP Risk register update July 2024

Since the last update to HGP in April, one new risk was added to the register. There are currently 12 open risks on HGP Risk register, with seven of them relating to the delivery of the HGP 2024/25 plan.

The updates are noted below. Full details about each risk is available on the risk register.

1. **Risks recently added to the Risk register.**

Risk No.	Risk Title
538	Risk of an overspend of the Greenwich Prescribing Budget for 2024/25

2. **Risks reviewed during the period.**

Risk No.	Risk Title	Latest update
465	Risk to development of an iThrive and preventative system approach to children's mental health and wellbeing including a new Single Point of Access and Schools offer	07/05/2024 - In relation to delivering Thrive, we have undertaken workshops and identified the key priorities with our newly established CYP Mental Health and Emotional Wellbeing Partnership. I am also engaging with Transformation Partners who will establish the delivery / implementation plan, which we will again take back to partners for their agreement. Another element to the Thrive model is the development of a Signs and symptoms guide which explains all our MH provision to professionals, YP, parents and carers. We do have a deficit in our team, whereby we have roles that have not been recruited to yet; of whom would be responsible for operationalising what I have just discussed above.

470	Risk to fully implementing new funding for drug and alcohol treatment through our local partnership arrangement, ensuring increased access to high quality treatment	14/05/2024 - Regarding workforce, the two remaining posts are now at interview stage. All the posts recruited into the programme are fixed term due the nature of the funding. Where possible, looking at establishing some of the posts as part of core delivery through restructuring. The trauma informed training has been rolled on to March 2025 and additional harm reduction training (Noloxone) is being offered. To date 80 practitioners in the local partnership have been trained. The current grant funding period would end in March 2025 and there are no indications yet from the government as to whether this would be renewed. The risk score should be reduced to 6 as objective of enhancing treatment services and employing specialist support in the local partnership has been met.
469	Risk to ensuring that food and nutrition is included as part of all diet-related disease care pathways such as hypertension, CVD, diabetes, and excess weight.	17/05/2024 - There is a work plan still in place relating to food and health. There is training taking place across primary care on food and nutrition and weights stigma. The continued risk to this work relates to how it is embedded within primary and secondary care work programmes. Monthly meetings between Public Health and the ICB Long Term Conditions team are in place. Reduce the risk score from 12 to 9.
538	Risk of an overspend of the Greenwich Prescribing Budget for 2024/25	03/07/2024 - Review of risk has taken place. No changes to score.
466	Risk relating to Rollout of the Family Hubs programme including the Start for Life Offer on parenting, parent-infant relationships and perinatal mental health support, home learning environment and infant feeding support.	11/07/2024 - Risk score has lowered to 4. Service is now up and running, mitigations in place where staffing issues. The community grants programmes to support perinatal mental health are all being delivered.

494	Risk to delivery of Greenwich delegated performance targets Updated into 24/25 financial year	11/07/2024 - Risk level remains the same. Work continues to improve areas of underperformance. Review risk again in 3 months.
495	Risk relating to co-ordination of timely discharge support for residents.	11/07/2024 - Risk scoring remains the same. Timely discharge remains a key focus, the TOCC work to ensure scrutiny of any delays and mitigations ongoing. We have the oversight of the FLOW coordinator in place. Work ongoing at Home First Board to make sure we have the appropriate capacity in services to manage timely discharge. In addition, the 7 day social care working model in JET has funding confirmed until March 25.
521	There is a clinical risk to a CHC funded individual in Greenwich and financial/legal/reputational risk to ICB	11/07/2024 - Cynthia noted the meeting to be cancelled and rescheduled. "The meeting scheduled for tomorrow has been cancelled. Because they have to make arrangements for their benefits, the customer will be relocating on June 24th 2024." 16/05/2024 - A home has been identified in Surrey to move the individual, noting a Best Interest Decision is being made as the client lacks the requisite capacity. This decision will be made subject to a court application. The plan is to do a phased placement or transfer. The transition plan will involve getting her to move voluntarily initially but if it does not work an alternative option would be used. When she moves, Surrey would take over the costs from then. The cost spent so far since 5th March is about £13k per week, noting the cost to the point of transfer would be negotiated with Surrey. She is definitely moving. Both the new Surrey home and the current home are working together to facilitate the move. There is no likelihood of legal interventions between the 2 ICBs. Reduce the risk score to 4 with expectation to close it at next review.

Greenwich Risk Report with Review Comments
Enterprise Risk Manager View (with Risk Owner), 15/6/2023 10:27 am

Risk ID	Opened Date	Risk Owner	Risk Sponsor	Risk Title	Risk Description	Initial Likelihood	Initial Consequence	Initial Rating	Controls	Gaps in Control	Current Likelihood	Current Consequence	Current Rating	Assurances	Gaps in Assurance	Target Likelihood	Target Consequence	Target Rating	Review Date and Comment	Next Review Due
464	13/7/23	Aideen Silke	Jessica Arnold	Risk to engagement with Greenwich communities.	There is a risk that residents will not engage with the programme and that communities will not see that they have a valuable role in this. There is a risk that there is insufficient capacity in the system to allow effective integrated teams to be developed at individual neighbourhood level. There is a risk of disconnect between patient report outcomes and community based outcomes. The impact on the HGP is potentially significant if it is not possible to achieve this priority which is also part of the Our Greenwich focus.	3	3	9	Developing appropriate communication plan that would address need of residents, ensure they feel listened to, and target the different parts of the community. This is partly included in the 100-day challenge, but would need a refined approach as part of our Neighbourhood engagement., Ensure there will be appropriate oversight for this work to ensure involvement of residents voice. This work needs to be appropriately resourced. The oversight would be provided through the Health Inclusion Steering Group and Integrated Neighbourhood Working Group., Understand and define patient outcomes that would be focused on, and making sure they are appropriately captured and reviewed. Develop a way of capturing and using appropriate data., Work to be undertaken to understand what services are operating within neighbourhoods and how they are currently working together; determine what needs to change, and what resources are required to enable an integrated neighbourhood based approach.	There are no gaps in controls	3	3	9	HGP Board has oversight of the delivery plan.	No gaps in assurance have been identified at this time.	2	2	4	17/01/2024 - The Social researcher has provided an interim report which would form the basis for next stages of the programme. The Healthier Greenwich Partnership (HGP) public forum was held on 15 January 2024 with focus on neighbourhood engagement. Community corners in GP Practices in Blackheath and Charlton PCNs being launched early 2024. Recruitment of Community Connectors planned for early 2024.\nLeave the risk score as 9. 19/09/2023 - 1. A Social researcher has been nominated for 6 months to work with three neighbourhood areas and to develop a a community engagement approach for Greenwich, including working with community researchers. There will be evaluation of the impact of this approach of community engagement on reducing winter pressures. Some winter funding has been set aside to facilitate this.\nNo change made to current risk rating.	29/3/24
465	13/7/23	Roneeta Campbell-Butler	Dave Borland	Risk to development of an iThrive and preventative system approach to children's mental health and wellbeing including a new Single Point of Access and Schools offer	There is a risk that we don't deliver on all areas of the high impact activity covered within this strand. This is as a result of current commissioning capacity including recruitment freezes. This has presented significant challenges to drive forward more complex large scale pieces of work. To mitigate against this risk re-prioritisation of other work is being undertaken to support delivery. The impact on HGP would be a higher risk that we don't deliver on all areas within this high impact activity. PLEASE NOTE: This is related to very major strategic projects and risk reviews should happen on six monthly basis.	4	3	12	Temporary utilisation of RBG funded commissioning capacity; alongside use of external capacity to support delivery of Single Point of Access., The establishment of multi-agency task and finish group to take forward the mental health in schools work.	There are no gaps in controls	4	3	12	HGP Board has oversight of the delivery plan.	No gaps in assurance have been identified at this time.	3	2	6	07/05/2024 - In relation to delivering Thrive, we have undertaken workshops and identified the key priorities with our newly established CYP Mental Health and Emotional Wellbeing Partnership.I am also engaging with Transformation Partners; who will establish the delivery / implementation plan, which we will again take back to partners for their agreement. Another element to the Thrive model is the development of a Signs and Symptoms guide which explains all of our MH provision to professionals, YP, parents and carers. We do have a deficit in our team, where by we have roles that have not been recruited to yet; of whom would be responsible for operationalising what I have just discussed above.	12/7/24
466	13/7/23	Sharne McLean (RBG staff)	Dave Borland	Risk relating to Rollout of the Family Hubs programme including the Start for Life Offer on parenting, parent-infant relationships and perinatal mental health support, home learning environment and infant feeding support.	This work is on track but due to the scale and complexity is categorised as at risk. There is a risk due to the scale that elements of the programme may be delayed. The impact to the HGP would be not achieving the most from the DfE/DHSC funded programme in strengthening our universal and prevention offer. NOTE: This risk relates major projects and review on six monthly basis is preferred.	3	3	9	Establishment of Family Hubs Programme governance, including specific work strand plans and partnership oversight group., There is regular programme reporting to the Department for Education (DfE)/ Department for Health and Social Care (DHSC) .	There are no gaps in controls	2	2	4	The Healthier Greenwich Partnership Board has oversight of the delivery plan.	No gaps in assurance have been identified at this time.	2	2	4	11/07/2024 - Risk score has lowered to 4. Service is now up and running, mitigations in place where staffing issues. The community grants programmes to support perinatal mental health are all being delivered.	23/1/25
469	26/7/23	Claire Bennett (RBG email - Claire.Bennett@royalgreenwich.gov.uk)	Steve Whiteman	Risk to ensuring that food and nutrition is included as part of all diet-related disease care pathways such as hypertension, CVD, diabetes, and excess weight.	There is a risk that there is inadequate advice and support, and insufficient action on the food environment, to enable people to eat a healthy diet, avoid diet related poor health and recover from or better manage conditions where diet is an important factor. Diet and healthy weight are complex whole system issues requiring multiple partners to take action across a wide range of factors. The ability to command and control is therefore difficult; collective commitment and leadership is needed. There is a need to review the current action plans and the co-ordination mechanisms in the borough to strengthen our local response in relation to clinical and wider food environmental factors.	4	3	12	Changes are being to the RBG Public Health department with a view to increasing capacity., Ensure the contribution of all HGP Partners to addressing this priority. Strengthen coordination mechanism for delivery of the health and well being strategy.	No gaps in controls currently identified.	3	3	9	Good Food in Greenwich Partnership will be involved in this work., Healthy Weight Task force will be involved.	No gaps in assurance at the moment.	3	2	6	04/10/2023 - 04/10/23 - As a borough with sustainable food places accreditation at silver level we have a work plan relating to the food environment including the following; A good food retail plan where partners are committed to improving the retail offer across the borough. Investment in the Healthier Catering Commitment programme with Environmental Health food environments contract with GCDA, coordinating the Good Food in Greenwich Partnership. A specific workstream relating to food insecurity, with a focus on Healthy Start, Holiday Meals and the HAF programme, food clubs, food banks and support with food access through the Live Well system commitment to develop a new food strategy with local stakeholders over the next year.\n\nLeave the risk rating unchanged and schedule next review in early March. 07/03/2024 - No new update yet 17/05/2024 - There is a work plan still in place relating to food and health. There is training taking place across primary care on food and nutrition and weights stigma. The continued risk to this work relates to how it is embedded within primary and secondary care work programmes. Monthly meetings between Public Health and the ICB Long Term Conditions team are in place. Reduce the risk score from 12 to 9.	15/7/24
470	26/7/23	John McGirr - John.McGirr@royalgreenwich.gov.uk	Steve Whiteman	Risk to fully implementing new funding for drug and alcohol treatment through our local partnership arrangement, ensuring increased access to high quality treatment	There is a risk that we will not be able to expand the treatment offer to meet the high level of needs in our population. This is due to a workforce shortage in specialist Drug &Alcohol staff at a time when all areas across the country are being given additional funding from government and asked to expand their treatment services. We will need to work closely with other boroughs and regional and national bodies to seek to grow and develop the workforce at pace.	4	3	12	Supporting the provider of drug and alcohol treatment services to expand their capacity through provision of additional funding.	No gaps in controls currently identified.	3	2	6	There is a high level community drugs partnership that will have oversight of the work.	No gaps in assurance.	3	2	6	06/10/2023 - 1. Public Health is currently working with the provider to deliver training (Trauma Informed) to existing workforce across the local partnership. Office for Health, Inequalities and Disparities (OHID, PHE) is working with providers and commissioners to develop a pan London workforce improvement programme. Nationally, OHID and Dept. of Levelling Up is developing workforce programmes to enable recruitment and retention of workforce. Of the16 posts attached to the grant funding, 14 have now been recruited to. The remaining 2 posts are in the process of being put out for recruitment. Just to note the funding is fixed for 3 years to March 2025, as yet no assurance of funding beyond that period. Risk rating should be reduced down from 12 to 9 as most of the recruitment has been done. 06/12/2023 - 1. Trauma informed training has been well received and is ongoing, with 65 staff staff trained to date and more sessions to hold next year. Looking to develop a training manual that would have the core elements of training for staff and some specialists elements. Process to recruit the 2 remaining staff is in hand, although is progressing slower than anticipated. Hopefully the posts would be recruited in January 2024. Leave the risk rating as 9 until next review in February 2024. 14/05/2024 - Regarding workforce, the two remaining posts are now at interview stage. All the posts recruited into the programme are fixed term due the nature of the funding. Where possible, looking at establishing some of the posts as part of core delivery through restructuring. The trauma informed training has been rolled on to March 2025 and additional harm reduction training (Noloxone) is being offered. To date 80 practitioners in the local partnership have been trained. The current grant funding period would end in March 2025 and there are no indications yet from the government as to whether this would be renewed.\n\nThe risk score should be reduced to 6 as objective of enhancing treatment services and employing specialist support in the local partnership has been met.	16/7/24
471	26/7/23	Michele Holmes - Michele.Holmes@royalgreenwich.gov.uk	Steve Whiteman	Risk to review, update and implement Royal Greenwich Get Active Physical Activity and Sports Strategy	There is a risk that the review of the strategy will not enable the scale of change in activity levels in our population required for improved health outcomes. The factors that determine physical activity levels are complex and wide ranging, and require a whole systems approach. We will need to review our actions and delivery mechanisms to ensure that they have the scale, reach and commitment across agencies to be effective.	4	3	12	Through the process of updating the strategy, ensure the full engagement of all HGP partners., The report is presented in variety of forums to raise awareness of the importance of physical activity to health outcomes and the need for partners to engage with the update of the strategy.	No gaps in control identified.	4	3	12	The Physical Activity and Sports Strategy Group has oversight of the work.	No gaps in assurance	3	2	6	06/10/2023 - 1. There is regular strategy group that reviews the strategy on ongoing basis and agrees actions. We need to re-establish a wider partnership group, as there are different organisations that should be involved in delivering the strategy. This action is part of the refresh, which just started now, with a plan to have this partnership group in place by December 2023. As part of the refresh, the governance around the strategy would be renewed. This would entail identifying the right partners. The aim is to have the new governance of partners in place by Spring 2024. 06/12/2023 - 06/12/23 The Risk Owner (MH) advised there is no new update yet since the last review.	21/2/24
474	16/8/23	Rachel Matheson	Lisa Wilson	Risk to optimising and developing our Home First approaches by expanding virtual wards (including a virtual ward hub) to provide assessment, treatment and care to all patients in the place that they call home.	There is a risk that the Home First (HF), and associated social care allocations, will be insufficient to meet the needs of the programme moving forward. There is also a risk to the awareness of partners and colleagues across the system of the virtual ward provision. These risks are caused by; * The anticipated financial allocations being lower than anticipated for Virtual Wards (VW). * The shift of acute care into the community increasing costs in social care and other areas of primary and community care that do not have additional funding * The lack of a fully established dashboard tracking delivery of HF and VW and understanding impacts, the cause relates to a lack of join up and capacity related to data and performance. * The availability of skilled workforce to deliver the specialist and generalist roles needed in the community. * The lack of a communications strategy to widen awareness of the VW programme across partners and the wider workforce. The impact on the Healthier Greenwich Partnership would be challenges in understanding and demonstrating the impact and benefits of the Home First approach. This could lead to a loss of confidence amongst partners and a negative financial impact in other areas of the system.	3	3	9	Operational board overseeing delivery and meets regularly., The Strategic Board receives escalations from the Operations Board and have decision making functions about workforce and financial resources. Oversee the Home first dashboard.	There are no gaps in controls	3	3	9	The Operations Board oversees delivery of Home First, receives progress reports and escalates any concerns to the Strategic Board.	No gaps in assurance identified.	2	3	6	02/05/2024 - The Home First communications strategy is in development. The risk remains the same and all the risk issues are still relevant. The risk rating remains the same too. 16/01/2024 - The Home first operational and strategic Boards are embedded. There is a Home First dashboard developed and circulated over the last 8 months for sharing data at both boards. There is also a Greenwich and Bexley (QEH System) Urgent and Emergency Care Board dashboard. This includes data relating Virtual Wards and the Urgent Community Response (UCR).\n\nFor 2023-24 there was a reduction in Virtual Wards funding against the plan from the original bid. The recurrent funding for 24/25 remains at reduced level, requiring review of virtual wards pathways against funding allocation. The risk of this is that the full number of beds that were originally planned would not be available. There has been challenges for the workforce, especially in recruiting specialist roles. For example, recruiting advanced clinical practitioners to deliver the virtual wards within JET and recruitment of a palliative care consultant within the hospice. The Communications Lead does attend the Home First Strategic Group and a number of resources are in development. The Risk score should remain at 9 due to ongoing challenges regarding funding level below original modelling for virtual wards.	19/7/24
494	29/12/23	Deane Kennett	Sarah McClinton	Risk to delivery of Greenwich delegated performance targets	There is a risk that Greenwich would not be able to deliver all the performance targets delegated to place during 2024/25. This is caused by a number of the targets not being met, those relating to IAPT access, SMI health checks, children immunisation and cancer screening. The impact on the Healthier Greenwich Partnership (HGP) would be inability to deliver all performance targets in 2024/25.	4	3	12	Oversight is maintained by Joint Commissioning Board (JCB), with monthly reviews of the performance report during JCB monthly meetings.		4	3	12	Oversight is maintained by Joint Commissioning Board (JCB), with monthly reviews of the performance report during JCB monthly meetings.		3	3	9	23/02/2024 - There is ongoing review of key performance indicators related to place delegated areas, working in partnership with SEL colleagues on provider wide metrics, such as SMI Health checks, ADHD and ASD waits. This risk would need to be reviewed in light of 24/25 plans and trajectories. 11/07/2024 - Risk level remains the same. Work continues to improve areas of under performance. \n\nReview risk again in 3 months.	15/10/24
495	29/12/23	Nick Davies	Lisa Wilson	Risk relating to co-ordination of timely discharge support for residents.	There is a risk that patients who are medically fit for discharge are unable to leave hospital. This can be caused by a combination of: internal hospital processes holding discharge up as well as pressure on community and social care services and a changing demographics of the borough. This could impact negatively on Trust A&E and elective performance as well as the best outcomes for residents.	4	4	16	UEC Board has oversight of winter planning, BCF Planning Group has oversight of BCF which has main targets for discharge and admissions avoidance, including 22/23 Discharge Fund and 23/24 planning. Home First Board has oversight of TOCC review and initiatives that support discharge processes and outcomes., SEL Discharge Solutions and Improvement Group looking for sub regional solutions to common challenges such as data analysis and insight.	Impact of Discharge Activity on social care staffing and budget resources being financially unsustainable and needing a system solution. Short term and short notice nature of winter and discharge funding flows. Specific pressures on system such as industrial action, Covid-19 outbreaks, staff shortages etc.	4	3	12	Joint commissioning Board, UEC Board, SEL Discharge Solutions and Improvement Group rolling out improvement plans for acute and mental health settings. Discharge framework issued across SEL for implementation in borough	Lack of accurate and reliable data insight on delayed transfers of care and demand and capacity planning - this is however under development	3	3	9	23/02/2024 - Reviewed the risk with Chief Operating Officer, noting the risk score should be reduced to 12 as winter is nearly over. 01/03/2024 - There is continued pressure in hospital discharge pathways. There are programmes like QE Cares, the Home First operational group and the TOCC that have focus on ensuring flow. There is a focused set of actions to ensure discharge is optimised called Super March running through March 2024 with all partners contributing. 11/07/2024 - Risk scoring remains the same. Timely discharge remains a key focus, the TOCC work to ensure scrutiny of any delays and mitigations ongoing. We have the oversight of the FLOW coordinator in place. Work ongoing at Home First Board to make sure we have the appropriate capacity in services to manage timely discharge. In addition the 7 day social care working model in JET has funding confirmed until March 25.	15/10/24
508	23/2/24	Kirsty Price	Lisa Wilson	Risk to mobilising the new Integrated Community Equipment Services (ICES) contract	There is a financial risk associated with the legal challenge related to the integrated community equipment service (ICES)	3	2	6	London consortium seeking ongoing legal advice, Participating in the London Equipment Consortium forums to keep informed on progress of the legal challenge	Limitations to decisions as part of a consortium	3	2	6	London Equipment Consortium	Assessment of legal damages to be updated based on any further information from London Consortium					26/4/24
521	15/4/24	Kimberly Blackwood	Lisa Wilson	There is a clinical risk to a CHC funded individual in Greenwich and financial/legal/reputational risk to ICB	This is caused by •Surrey CC (children's team) placed a looked after child (no local ICB (Surrey Heartlands) involvement) in unregulated accommodation in Greenwich (date unknown). •Surrey Heartlands ICB undertook a CHC assessment and deemed the individual to be CHC eligible in July 2023. •Surrey CC (children's team) failed to alert SEL ICB until 11/01/2024. •Surrey CC did not respond to SEL ICB's concerns, raised on 15/01/2024, until 28/02/2024. •The individual turned 18 years of age on 05/03/2024. •Surrey CC continue to fund the placement on a without prejudice basis (12k per week care cost/rental unknown). •Mental capacity/Best interests of KW unknown and case handover issues remain outstanding due to Greenwich not being informed in a timely manner and Greenwich concerns and queries not being answered adequately to enable safe handover of care •Concerns from CQC regarding unregulated provider (attached) •NHSE has determined that Greenwich is the responsible commissioner in line with national guidance from 05/03/2024 - notwithstanding that KW is in a placement that is not CQC/Ofsted registered •On 27th March 2024, Surrey Council wrote to Greenwich CHC Team requesting that confirmation that Greenwich take immediate responsibility and all appropriate actions regarding KW's care. Surrey CC expressed concerns that there was no clinical oversight of KW's current placement highlighting safeguarding risks. •E mail to the Greenwich CHC Team was received stating that lawyers would be instructed by 2nd April due to the failure of SEL ICB to follow Who Pay's National Guidance and the advice of NHSE. Team's advice. The e mail stated Surrey Council's intention to issue a pre-action protocol letter for a Judicial Review of SEL ICB's decision not to follow Who Pay's National Team's advice. The impact on the ICB would be •Potential legal action from Surrey Couty Council(as above) •Reputational risk – Greenwich not following national guidance on picking case up from 05/03/2024 •Risk to patient safety given concerns on unregulated provider (attached)	4	3	12	A case manager has been assigned to the case., Greenwich CHC Team are attending Round Table meetings with other organisations involved in this case - Surrey ICB and County Council., The Business Manager (KB) sent a holding email to Surrey County Council regarding the case.	No gaps in Control	2	2	4	The Nursing and Quality Directorate are briefed on the case and receiving regular updates., The Greenwich Chief Operating Officer (NKB) and Director overseeing CHC (LW) are also aware of the case.	None	2	3	6	11/07/2024 - Cynthia noted the meeting to be cancelled and rescheduled. "The meeting scheduled for tomorrow has been cancelled. Because they have to make arrangements for thierbenefits, the customer will be relocating on June 24th 2024." 16/05/2024 - A home has been identified in Surrey to move the individual, noting a Best Interest Decision is being made as the client lacks the requisite capacity. This decision will be made subject to a court application. The plan is to do a phased placement or transfer. The transition plan will involve getting her to move voluntarily initially but if it does not work an alternative option would be used. When she moves, Surrey would take over the costs from then. The cost spent so far since 5th March is about £13k per week, noting the cost to the point of transfer would be negotiated with Surrey. She is definitely moving. Both the new Surrey home and the current home are working together to facilitate the move.There is no likelihood of legal interventions between the 2 ICBs. Reduce the risk score to 4 with expectation to close it at next review.	30/7/24
538	5/6/24	Alex Pini - (email - Alexander.Pini@selondonics.nhs.uk)	Jin On	Risk of an overspend of the Greenwich Prescribing Budget for 2024/25	There is a risk that there may be an overspend of the Greenwich Prescribing Budget for 2024/25, this is caused by a number of contributing factors: •MCR process has resulted in a smaller team in Greenwich and new way of working for both MOT and primary care. Uncertainty of how implementation and delivery will pan out especially during transition period. •Drug shortages – hard to mitigate against these, becoming more frequent and widespread, impacting many clinical areas. •Drug price rises: NCSO/price concessions and Category M •Increased patient demand for self care items to be prescribed rather than purchased as cost of living increases •New SEL bariatric surgery guidelines -> primary care prescribing of vitamins for patients who have had bariatric surgery and are now deficient/will become deficient as a result of their surgery. We used to encourage self funding of this in GW but as result of SEL guidelines these will now be on FP10. •Hayfever -> Promethazine cost pressure ongoing. Difficulty in reviewing patients and deprescribing once initiated (more for mental health indications but also licensed for hayfever). •OptimiseRx: Depends on practice engagement and individual clinician action at point of prescribing. The impact on the ICB would be that Greenwich practices are overspent compared to prescribing budget.	4	3	12	Engagement with prescribers to ensure only the quantities needed are prescribed, Bromley Education and Training for Health (BETH) is now embedded as the training and development hub., Monthly monitoring of spend and also Cat M and NCSO spend. This includes monitoring of price concessions spend jointly with Meds Op and finance colleagues. Rebate scheme income maximised by MM team. Additionally, identified efficiency schemes are being monitored to mitigate the current cost pressure. This will not remove overspend entirely.	No gaps in control for now	4	3	12	The Medicines Pathway Implementation Group (MPIG) meets monthly.	No gaps in assurance for now.	2	3	6	03/07/2024 - Review of risk has taken place. No changes to score.	31/7/24

Conditional Format List

Cell	Initial Rating Between 1 And 3
Cell	Initial Rating Between 4 And 6
Cell	Initial Rating Between 8 And 12
Cell	Initial Rating Between 15 And 25
Cell	Current Rating Between 1 And 3
Cell	Current Rating Between 4 And 6
Cell	Current Rating Between 8 And 12
Cell	Current Rating Between 15 And 25
Cell	Target Rating Between 1 And 3
Cell	Target Rating Between 4 And 6
Cell	Target Rating Between 8 And 12

AGENDA ITEM: 11

Healthier Greenwich Partnership

Date: 24 July 2024

Title	Healthier Greenwich Partnership (HGP) Governance Update
This paper is for **approval**	
Executive Summary	The HGP Executive Delivery Group was agreed to be established in June 2023 and has been meeting every 2 weeks. We have reviewed its effectiveness and have proposed a few changes to its purpose and membership. The key clarification is for setting the forward plan of the HGP and driving delivery of agreed HGP priorities. The SEL ICB Constitution sets out the governance arrangements for the Integrated Care Board and its committees, which is approved by NHS England. The details are in a published governance handbook, which includes the terms of reference are included for each of the committees, including the Healthier Greenwich Partnership. A formal Memorandum of Understanding is in place (signed Sept 22) and sets out the governance and scope of the agreed delegations to the Local Care Partnerships. Within this, the delegation is made through the Place Executive Leads. This stipulates that they will be expected to discharge their delegated responsibilities, through the Local Care Partnership Committee, which will operate as a formal committee of the Integrated Care Board. It highlights that decisions related to delegated responsibilities should be made by the wider partnership, inclusively and collectively. The HGP's Terms of Reference should be reviewed on a regular basis, and they have been updated to reflect: - Rotating Chair arrangements agreed in autumn 2023 - VSCE membership proposed to be increased with a large commissioned VSCE provider representative - Membership – reflect updated role titles
Recommended action for the Committee	1. To approve the updated purpose and membership of the HGP Exec 2. To approve the changes in the TOR for the HGP, which will need to be ratified by the next Integrated Care Board meeting, through its committee report.

Potential Conflicts of Interest	There are no specific conflicts of interest identified.	
Impacts of this proposal	Key risks & mitigations	It is important that clear governance arrangements are agreed and followed for the HGP to carry out its delegated functions. A regular refresh is good practice.
	Equality impact	Delegated functions of the ICB through the HGP should be made by the wider partnership, inclusively and collectively.
	Financial impact	None
Wider support for this proposal	Public Engagement	It is important that the HGP undertakes key decision making openly and transparently and has a number of delegated responsibilities from the SEL ICB. The forward planner is used to determine which items should be approved through a public meeting.
	Other Committee Discussion/ Internal Engagement	HGP Exec
Author:	Neil Kennett-Brown, Chief Operating Officer	
Clinical lead:	n/a	
Executive sponsor:	Sarah McClinton, Place Executive Lead	

Integrated Care Board

Greenwich Local Care Partnership Committee (Healthier Greenwich Partnership)

Terms of Reference

Reviewed 26 June 2024

1. Introduction

1.1. The NHS South East London Integrated Care Board (ICB) Greenwich Local Care Partnership committee [the "committee"] is established as a committee of the ICB and its executive powers are those specifically delegated in these terms of reference. These terms of reference can only be amended by the ICB Board.

1.2. These terms of reference set out the role, responsibilities, membership, and reporting arrangements of the committee under its terms of delegation from the ICB Board.

1.3. All members of staff and members of the ICB are directed to co-operate with any requests made by the Local Care Partnership committee.

2. Purpose

2.1. The committee is responsible for the effective discharge and delivery of the place-based functions[1]. The committee is responsible for ensuring:

a. The place contribution to the ICB's agreed overall planning processes including the effective planning and delivery of place based services to meet the needs of the local population, with a specific focus on community based care and integration across primary care, community services and social care, managing the place delegated budget, taking action to meet agreed performance, quality and health outcomes, ensuring proactive and effective communication and engagement with local communities and developing the Local Care Partnership to ensure it is able to collaborate and deliver effectively, within the partnership and in its interactions with the wider ICS.

b. The Local Care Partnership can secure the delivery of the ICS's strategic and operational plan as it pertains to place, and the core objectives established by the LCP for their population and delegated responsibilities.

c. The Local Care Partnership plays a full role in securing at place the four key national objectives of ICSs, aligned to ICB wide objectives and commitments as appropriate.

[1] As defined by the South East London Integrated Care Board in the relevant delegation agreement

d. The representation and participation of the Local Care Partnership in the wider work of the ICS and Integrated Care Board, contributing to the wider objectives and work of the ICS as part of the overall ICS leadership community.

3. Duties

3.1. **Place-based leadership and development:** Responsibility for the overall leadership and development of the Local Care Partnership to ensure it can operate effectively and with maturity, work as a collective and collaborative partnership and secure its delegated responsibilities with appropriate governance and processes, development and relationship building activities and meaningful local community and resident engagement. This will include developing relationship with other parts of the system that may operate at place including the acute provider collaborative, the mental health collaborative and community networks to ensure the join up of services at place. The LCP also needs to support the Place Executive lead to ensure they can represent LCP views effectively whilst also considering the needs of the wider ICS.

3.2. **Planning:** Responsibility for ensuring an effective place contribution to ICP/B wide strategic and operational planning processes. Ensuring that the Local Care Partnership develops and secures a place based strategic and operational plan to secure agreed outcomes and which is aligned with the Health and Wellbeing strategic plan and underpinned by the Joint Strategic Needs Assessment (JSNA) and a Section 75 agreement. The LCP must ensure the agreed plan is driven by the needs of the local population, uses evidence and feedback from communities and professionals, takes account of national, regional and system level planning requirements and outcomes, and is reflective of and can demonstrate the full engagement and endorsement of the full Local Care Partnership.

3.3. **Delivery:** Responsibility for ensuring the translation of agreed system and place objectives into tangible delivery and implementation plans for the Local Care Partnership. The LCP will ensure the plans are locally responsive, deliver value for money and support quality improvement. The LCP will develop a clear and agreed implementation path, with the resource (both financial and workforce) required whilst ensuring the financial consequences are within the budget of the LCP and made available to enable delivery.

3.4. **Monitoring and management of delivery:** Responsible for ensuring robust but proportionate mechanisms are in place to support the effective monitoring of delivery, performance and outcomes against plans, evaluation and learning and the identification and implementation of remedial action and risk management where this is required. This should include robust expenditure and action tracking, ensure reporting into the ICS or ICB as required, and ensure local or system discussions are held proactively and transparently to agree actions and secure improvement where necessary.

3.5. **Governance:** Responsible for ensuring good governance is demonstrably secured within and across the local Care Partnership's functions and activities as part of a systematic accountable organisation that adheres to the ICB's statutory responsibilities and adheres to high standards of public service, accountability and probity (aligned to ICB governance and other requirements). Responsibility for ensuring the LCP complies with all legal requirements, that risks are proactively identified, escalated and managed.

4. Accountabilities, authority and delegation

4.1. The LCP Committee is accountable to the Integrated Care Board of the SEL Integrated Care System.

4.2. The LCP Committee will provide regular updates to the Health and Wellbeing Board ensuring the alignment of work.

5. Membership and attendance

5.1. Core members of the committee will include representatives of the following:

a. LCP Clinical & Care Professional Lead

b. 1 x Local Care Partnership Place executive lead Deputy CEO and Director of health and Social Care, RBG

c. 1 x Local authority adult social care - Director of Adult Social are, RBG

d. 1 x Local authority children's services - Director of Children's Services, RBG

e. 1 x Local authority public health - Director of Public Health, RBG

f. 2 x Primary care (Nominated PCN Directors)

g. 1 x Community services provider –Director of Children & Young People's Services, Oxleas

h. 1 x Mental health services provider, Chief Operating Officer- Oxleas

i. 1 x Hospice provider – Chief Executive, Greenwich & Bexley Hospice

j. 1 x Acute services provider – Board Director, LGT

k. 1 x VCSE sector –METROGAVS

l. 1 x VCSE sector – VSCE provider representative (rotational nomination from sector)

5.2. In addition to the core membership, the following will be in attendance at the Healthier Greenwich Partnership

a. 1x ICB - Chief Operating Officer, Greenwich (SEL ICB)

b. 1 x Healthwatch - Chief Executive

c. 1 x LMC Representation (Greenwich) - Chair LMC

d. 1 x GP Federation Representative - Director, Greenwich Health

e. 1 x Adult Social Care Provider - TBC

f. 2 x Integrated Commissioning Directors - joint postholders RBG/SEL ICB

g. Director of Primary Care & Neighbourhoods

h. Clinical and Care Professional Leads (as appropriate for agenda)

i. 1 x ICB nominated - Non-Executive Director

5.3 Expectation that all members will feedback to their respective organisations, which will act as a two-way process to gain views/share decisions, noting that some members are representative of a range of organisations e.g. VSCE representatives or Primary Care

6. Chair of meeting

6.1. The committee would have a rotational chairing arrangement. The chair would be appointed by the committee on a rotational basis from the membership. The committee would also appoint a deputy chair who would be from a different organisation.

6.2. At any meeting of the committee the chair or deputy chair if present shall preside.

6.3. If the presiding chair is temporarily absent on the grounds of conflict of interest, the deputy chair shall preside, or, in the case that they also may not, then a person chosen by the committee members shall preside.

7. Quorum and conflict of interest

7.1. The quorum of the committee is at least 50% of members of which the following must be present (or their nominated deputies):

- Chair
- Two of the following:
  - Place Executive Lead,
  - Director of Adult Social care, RBG
  - Director of Children's Services, RBG
  - Director of Public Health, RBG
- 1 x Primary care
- Senior leadership representative - Oxleas
- Senior leadership representative LGT
- VSCE representative

7.2. In the event of quorum not being achieved, matters deemed by the chair to be 'urgent' can be considered outside of the meeting via email communication.

7.3. The committee will operate with reference to NHS England guidance and national policy requirements and will abide by the ICB's standards of business conduct. Compliance will be overseen by the chair.

7.4. The committee agrees to enact its responsibilities as set out in these terms of reference in accordance with the Seven Principles of Public Life set out by the Committee on Standards in Public Life (the Nolan Principles).

7.5. Members will be required to declare any interests they may have in accordance with the ICB Conflict of Interest Policy. Members will follow the process and procedures outlined in the policy in instances where conflicts or perceived conflicts arise.

8. Decision-making

8.1. The aim of the committee will be to achieve consensus decision-making wherever possible. If a vote is required, the core members and the Chair are the voting members of the Local Care Partnership. Core members are expected to have a designated deputy who will attend the formal Local Care Partnership with delegated authority as and when necessary.

9. Frequency

9.1. The committee will meet once every two months (in public) with ability to have closed session as Part B in addition to this.

9.2. All members will be expected to attend all meetings or to provide their apologies in advance should they be unable to attend.

9.3. Members are responsible for identifying a suitable deputy should they be unable to attend a meeting. Arrangements for deputies' attendance should be notified in advance to the committee Chair and meeting secretariat.

9.4. Nominated deputies will count towards the meeting quorum as per the protocol specified in the ICS constitution, which means individuals formally acting-up into the post listed in the membership shall count towards quoracy and deputies not formally acting-up shall not.

10. Reporting

10.1. Papers will be made available five working days in advance to allow members to discuss issues with colleagues ahead of the meeting. Members are responsible for seeking appropriate feedback.

10.2. The committee will report on its activities to ICB Board. In addition, an accompanying report will summarise key points of discussion; items recommended for decisions; the key assurance and improvement activities undertaken or coordinated by the committee; and any actions agreed to be implemented.

10.3. The minutes of meetings shall be formally recorded and reported to the NHS ICB Board and made publicly available.

11. Committee support

11.1. The LCP will provide business support to the committee. The meeting secretariat will ensure that draft minutes are shared with the Chair for approval within three working days of the meeting. Draft minutes with the Chair's approval will be circulated to members together with a summary of activities and actions within five working days of the meeting.

12. Review of Arrangements

12.1. The committee shall undertake a self-assessment of its effectiveness on at least an annual basis. This may be facilitated by independent advisors if the committee considers this appropriate or necessary.

Forward Planner Greenwich Meeti	Aug-24		Sep-24		Oct-24		Nov-24		Dec-24	
HGP - Healther Greenwich Partnership	in Private	28 August 2024	Seminar	25 September 2024	in Public	23 October 2024	in Private	27 November 2024	Seminar	18 December 2024
		Papers due 16/08 COP		Papers due 16/09 COP		Papers due 14/10 COP		Papers due 18/11 COP		Papers due 09/12 COP
Chair - Iain Dimond **Business Support -** Julie Mann **Standard Agenda Items** -Welcome -Introductions and apologies -Declarations of interest -Minutes of previous meetings -Action Log -HGP Partner's Report. -HGP sub-committee report - **Public Meeting** - HGP Development - **Private Meeting**		HGP Private seminar Board meeting in private (on MS Teams) **Main Business/Themed Item** SEND Strategy - Dave Borland - for noting		Quarterly HGP Development Seminar - face to face room 4 & 5 **Main Business /Themed Item** -		Board Meeting in public Face to Face Room 4&5 Booked. **Main Business /Themed Item** - Public Engagement Forum feedback – Russell Cartwright - MSK Procurement update -LW - ATEC mobilisation update - LW - Addiction Strategy - PH - Review of Health & Care Plan progress - Charity update in COO report - Sub committee assurance report - risk register for noting		Private Seminar (via Ms Teams) **Main Business /Themed Item** - Carers update		Quarterly HGP Development Seminar room 4 & 5 **Main Business /Themed Item** -
Future Agenda items - not linked to specific meeting - Public Health Commissioning - Steve Whiteman - Primary and Secondary Interface - Jessica Arnold - Clinical summit		Acute Provider Collaborative - update for HGP – Kate Anderson (LGT) MSK Procurement Update – Lisa W				Young Greenwich model - DB Update from Groundwork London on Charitable funds				

APPENDIX ONE

Greenwich General Practice Development Programme

Connecting Greenwich

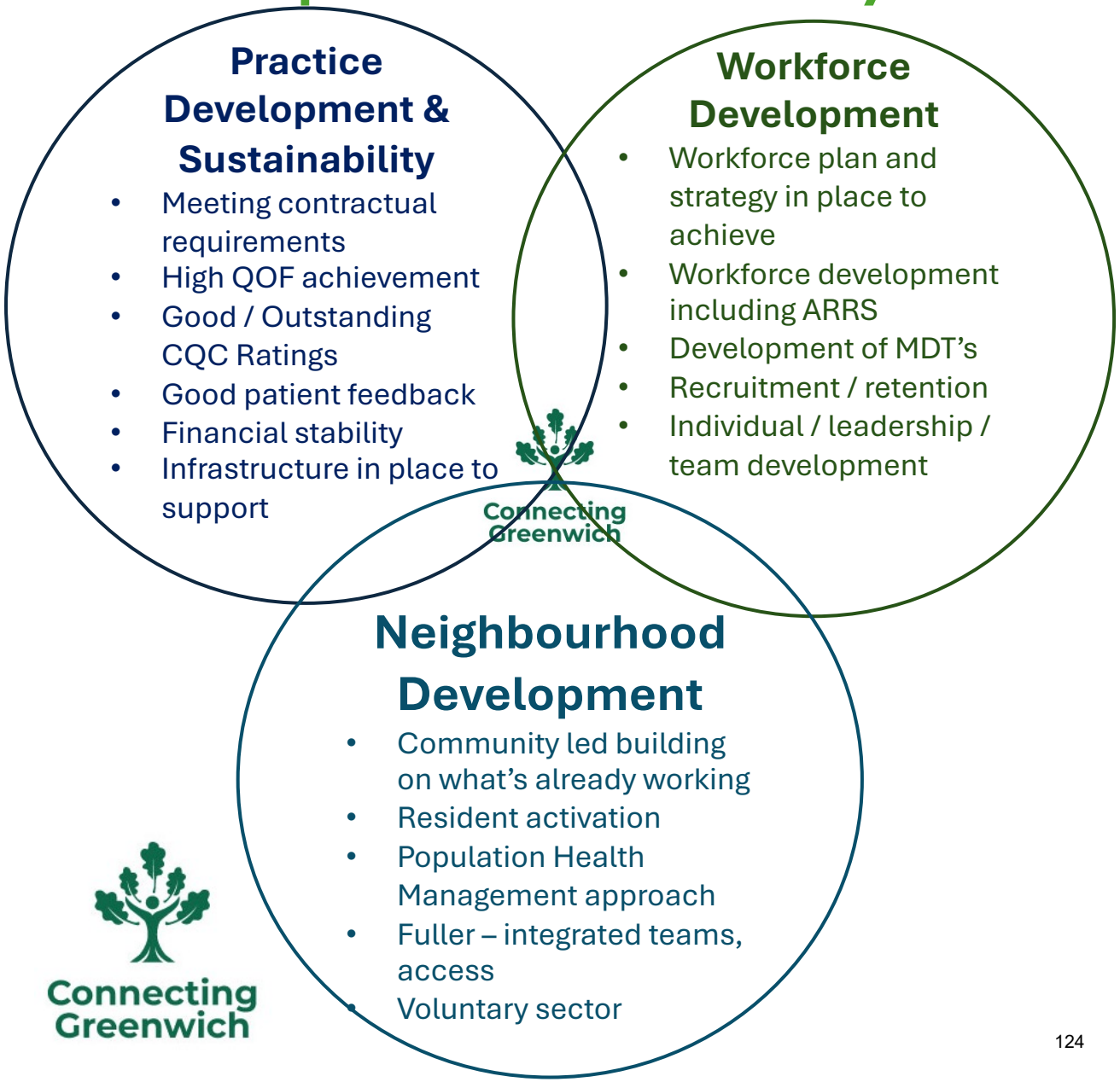
Progress Update

July 2024

Reducing inequalities in health for people in Royal Greenwich

HEALTHIER GREENWICH PARTNERSHIP

Development Summary



Connecting Greenwich

Context

In January 2023, 24/30 practices and 5/6 PCNs completed the "Strengthening our Primary Care Teams" Survey developed by SEL Primary Care Leadership Group

Apart from one PCN, there was no real understanding of why PCNs were being established, although generally people can see the potential benefits of sharing resources better

→ A belief that the lack of infrastructure – e.g. finances, estate, employment processes – is holding back development

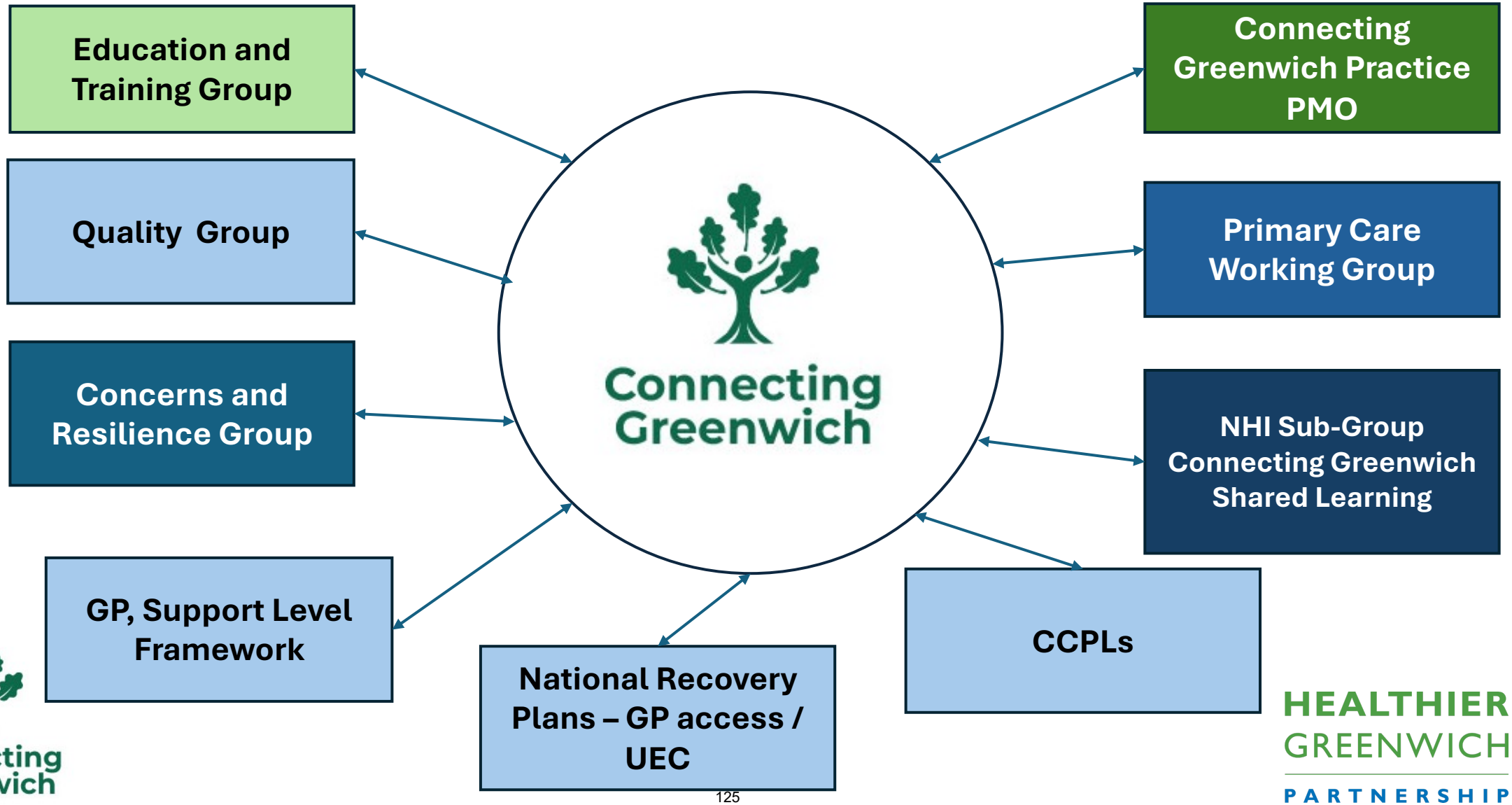
A focus on General Practice, rather than local populations / communities

→ Lack of 'team' working across PCNs, with practices maintaining their autonomy / ways of working

A minority of PCNs exploring options for using ARRS roles to change service provision and share responsibilities more widely across the different professions to address demand

HEALTHIER GREENWICH PARTNERSHIP

Development Summary – Connecting and Supporting



Connecting Greenwich

HEALTHIER GREENWICH PARTNERSHIP

A reminder - neighbourhood development in Greenwich ...is a way of 'connecting' people, priorities and places to better enable community ownership and joined up public services

Our ambition is that "everyone will be able to live a healthy, happy and independent life in a thriving community supported by joined up public services"

Developing communities of residents, patients, carers, providers, assets

We are supporting people (staff, patients, residents, etc) to work together to solve problems for themselves.

We are shifting our role from 'director' to 'connector' (facilitator and coach).

We are connecting and better balancing top-down (directive, what we think we ought to be doing) and bottom-up (learning by doing) prioritisation and decision-making.

Connecting Greenwich

HEALTHIER GREENWICH PARTNERSHIP

Research Findings & Recommendations

Research identifies the need for a **human-centred approach** to mobilise and connect people, local assets and resources, ensuring local health and care **systems work together with communities on an equal basis**…..

Focus on building & maintaining **trust**

Infrastructure to enable **connection**

Findings	Recommendations	Action
Collaboration is crucial for effecting meaningful change.	Clarity of purpose and expectations around neighbourhood development & projects is a significant factor in securing engagement and buy-in from stakeholders.	• Bottom up - using Connecting Greenwich as an opportunity to co-design, test & connect shared approaches, templates & relationships • Top down - establishing NHI Sub Group to share learning & use it to inform decision-making, including prioritisation, resourcing / funding
Leveraging local knowledge / expertise / assets through community-led initiatives ensures interventions are culturally sensitive, appropriately targeted, & locally owned.	Empower 'communities' by cultivating a sense of ownership and participation in health & social activities.	• ICB/RBG/VCSE acting as connectors, facilitating connections around locally identified, developed & delivered initiatives, e.g. Connecting Greenwich, focusing on bringing people & programmes of work together.
Continuous engagement and long-term commitments to initiatives are crucial for building sustainable community cohesion and trust.	Establish clear & consistent infrastructure, communication & access to resources to maintain trust/ensure community initiatives are transparent/aligned with community needs.	• Brand identity for Connecting Greenwich aligned with HGP to share regular updates, ideas, challenges • Establishing systematic learning / engagement through SR function / NHI Sub Group
Short-term projects tend to be less effective in maintaining community engagement and resilience.	Effective community engagement requires strong, genuine, enduring relationships with local populations through consistent approaches, resourcing decisions & prioritisation.	• Co-designing, testing & embedding robust, ongoing evaluation through agreed objectives, impacts, success measures & metrics, • Projects building on & connecting to existing opportunities, focused on long-term, sustainable impacts, creating and maintaining pace

Connecting Greenwich

HEALTHIER GREENWICH PARTNERSHIP

….**to create** a responsive, effective, & collaborative health & care service delivery model that is better equipped to meet the evolving needs of the population, improve health & well-being, stronger community resilience, & **a more sustainable health & care system in Greenwich**.

Connecting Greenwich
2-year development programme for General Practice

Programme principles

1. **Sustainability** - the impact of the project will be sustainable beyond the programme.
2. **Outcome focussed and evidence-led** - project scopes will be rooted in evidence and focused on future impact.
3. **Wider Connection** - Project activity will be at Practice (involving all staff) Community and System level.
4. **Coaching Approach** - A thinking environment is created throughout to enhance the quality of the thinking and learning that happens throughout and ensure that projects are led by Practices rather than the system.
5. **Transparency** - Learning is shared between Practices and across the system in a way that accepts what doesn't work and encourages reflection and momentum.
6. **Resilience** - all projects empower Practices to become stronger and more resilient.

Connecting Greenwich

HEALTHIER GREENWICH PARTNERSHIP

Context:

Current health challenges and system pressures highlight the need to extend and support Neighbourhood development and collaborative working. Neighbourhood development in Greenwich takes a human-centred approach to addressing health inequalities by mobilising and connecting people, local assets and resources, ensuring local health and care systems work together with communities on an equal basis. This has the potential to create a responsive, effective, and collaborative health and care service delivery model that is better equipped to meet the evolving needs of the population. Additionally, Greenwich is expected to continue to deliver against national imperatives, including recovery plans - UEC, GP access & elective care -and the Fuller Report as well as agreed local SEL and Greenwich priorities.

Problem statement / need:

General Practice is a critical partner in delivering system integration across Greenwich, but feels under-supported, under-resourced and not properly connected with their wider system partners or the local communities they serve.

Vision:

Greenwich Practices are trusted and resourced to lead positive change with their staff, patients, communities and the wider health system, where they connect effectively and widely.
This increases the quality and sustainability of delivery and improves patient outcomes.

Objectives:

1. Creating an environment of continuous improvement & the confidence to respond to future challenges in General Practice.
2. Supporting practices to understand the impact of health inequality on health & what that means for delivering accessible services.
3. Improving connection of staff, practices and stakeholders across the wider system to create 'communities' of residents, carers, patients, health & care providers and volunteers.
4. Motivating and upskilling practice staff to work as part of their 'community' to co-design and implement changes to benefit health and wellbeing experience and outcomes.
5. Helping General Practice in Greenwich improve its reputation as part of a system of connected health and care delivery.
6. Enabling learning to be pro-actively shared across the system by practices with each other and their stakeholders & to inform and influence system leadership decision making.
7. Raising awareness and motivating practice staff to seek support and collaboration from across the wider system.
8. Improving patient trust and satisfaction with the practices and wider system.

Inputs:

- Each practice receives development support for up to 6-months to deliver 1 or 2 projects
- Core team of 7 (SRO, GP, PC Lead, Programme Director, Programme Manager, Leadership Development expert)
- A PMO of 3 x 0.4 per week
- Development team, including external GPs, Nurse coaches, GP Fed, CCPLs, RBG Neighbourhood Development / Inclusion team, Community Champions and Connectors

Activities:

- Project Scoping Call
- PID Support
- Evaluation Scoping Call
- Monthly Group Coaching Call
- Monthly 1:1 Coaching Call
- Fortnightly Thinking Councils
- Monthly Masterclasses
- Evaluation Milestone meetings
- Evaluation Learning workshops
- Fortnightly 'Connections' Bulletin

Outputs:

- Community asset staff are skilled up and confident in co-delivering health / lifestyle checks.
- Improved patient activation.
- Increased take up of vaccinations, health and lifestyle checks
- Practical evidence of 'communities' of residents, patients, carers and health and care providers forming to co-design and deliver services.
- Code of practice and metrics established for neighbourhood development
- Governance & systematised learning established.

Priority outcomes / Impacts

- Increased trust in residents / patients to improve their own health, e.g. more services co-designed by 'communities'
- Strong sense of ownership and control over system/service changes
- Confidence to keep learning and sharing
- Increased awareness of impact of health inequality, particularly for health inclusion groups
- Increased awareness of services / access
- Increased connections locally and across the system
- Improvements in Greenwich population health

Further opportunities to impact residents / patients

- Increased patient satisfaction scores
- Increased awareness of services – general practice and beyond
- Improved personal activation and self-care / referrals
- Improved motivation to engage and seek support from a broad range of providers / volunteers
- Diverse range of patients / residents experiencing inclusive services
- Necessary access improvements are made

Further opportunities to impact practice staff

- Improved staff satisfaction
- Improved recruitment and retention
- Greater take-up of development & leadership opportunities by all general practice staff
- Increased collaboration with system partners
- Improved sense of belonging & pride locally & within the Greenwich system
- Improved practice efficiencies operationally and financially

Quick Progress Update

Engage

- 27/29 practices
- 17 attended April co-design workshops
- Cohort 1 (7 practices)
- Cohort 2 (existing Neighbourhood projects x4)
- Nurse Cohort

Imagine

- Project scoping meetings using agreed template
- Data analysis to identify needs, impacts and measures
- Connecting – identifying relevant existing services, potential partners, community engagement
- Confirming evaluation contract
- Developing SR toolkit

Plan

- Practice supported to develop project plan, including vision, goals, impacts, resources & measures
- Dedicated development plan & support, inc. evaluation & toolkits
- Fortnightly team coaching / Thinking Councils
- Master classes to address emerging themes

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HEALTHIER GREENWICH PARTNERSHIP

Emerging Themes

Overall, we are finding that practices are starting to focus more on ***holistic, people-centred*** health improvement and want to establish pace & trust by ***connecting*** with things that are already working.

Health inequalities / prevention

- Reaching minority groups who are not accessing primary care
- Increasing uptake of screening, health & life checks imms & vaccs

Access / Demand

- Digital inclusion / NHS App
- Secondary / Primary Care integration (LGT)
- Addressing cross-borough service issues for residents

Disease / Themes

- Complex, Long-term, co-morbidity
- CVD / BP
- Diabetes
- Food / Nutrition
- Mental Health
- CYP / families

Workforce

- Improved employee experience – recruitment, retention
- Development & teamworking
- Shifting to whole workforce / system thinking

Masterclasses

- Social Media
- Handling difficult conversations
- Finding my voice
- Group consultations
- Engaging communities
- PHM / Healtheintent

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Participation

Potential for 2 practices to additionally work on primary / secondary integration in collaboration with LGT

Cohort 1

- Triveni
- Everest
- St Mark's
- Basildon Road
- Gallions
- Plumstead Health Centre
- Abbey Wood

- Mostafa PMS - October

Existing PH-led Neighbourhood programmes

Cohort 2

- Horn Park – Cross-borough working / health and life checks
- Plumstead & Glyndon – digital inclusion
- Blackheath & Charlton - TBC
- Connecting Thamesmead – DG Cities to connect evaluation outcomes

Identified need to give the wider workforce a voice in Greenwich, starting with Practice Nurses

Nurse Cohort

- Up to 10 places to support leadership development for practice nurses
- F/T Imms & Vaccs Primary Care Lead

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HEALTHIER GREENWICH PARTNERSHIP

ROYAL borough of GREENWICH

NHS Lewisham and Greenwich NHS Trust

NHS Oxleas NHS Foundation Trust

NHS South East London

GH GREENWICH HEALTH

Primary Care Networks

healthwatch Greenwich

GAVS METRO GAVS

Reducing inequalities in health for people in Royal Greenwich