Appendix 1

Kirklees Shielded Patients Support Offer

Evaluation Report

V2.1

1. Introduction

1.1. As part of its response to COVID-19 the Government introduced a Shielded Patient Programme. It produced a Shielded Patient List (SPL) of all patients required to shield. Those on the SPL were asked not to leave their home and the Government put in place systems to support them with essential daily living tasks: essential supplies of food, delivery of medicines, and social support. The patient's clinician was asked to ensure that ongoing medical care needs of the patients continued to be met.

1.2. The support offers are a combination of national and local ones. These have evolved quickly in response to the ongoing pandemic. The government announced that the shielding programme will be paused from 1 August 2020, and that national support offers will largely end at this point. Shielding may be re-introduced if required – either on a local of national basis.

1.3. This means that some of our local arrangements can now be stood down whilst the shielding programme is paused. However, there may be some ongoing support needs that we need to continue to address these. In addition, we need to be in a position to rapidly step back up to the full range of arrangements should this be required if the shielding programme is re-instated.

1.4. This paper summarises the work that we have done to support the Shielded Patient Programme. It is intended to act as a reference document to help us remember what we have done in the event that shielding is reintroduced. It should be read in conjunction with our 'Shielding Patients Taking Stock Action Plan' which contains more detailed actions relating to the pausing of shielding.

1.5. The key learning points from the work are highlighted in the document and a summary of the **Key Learning Points arising from this work is included in Appendix A**.

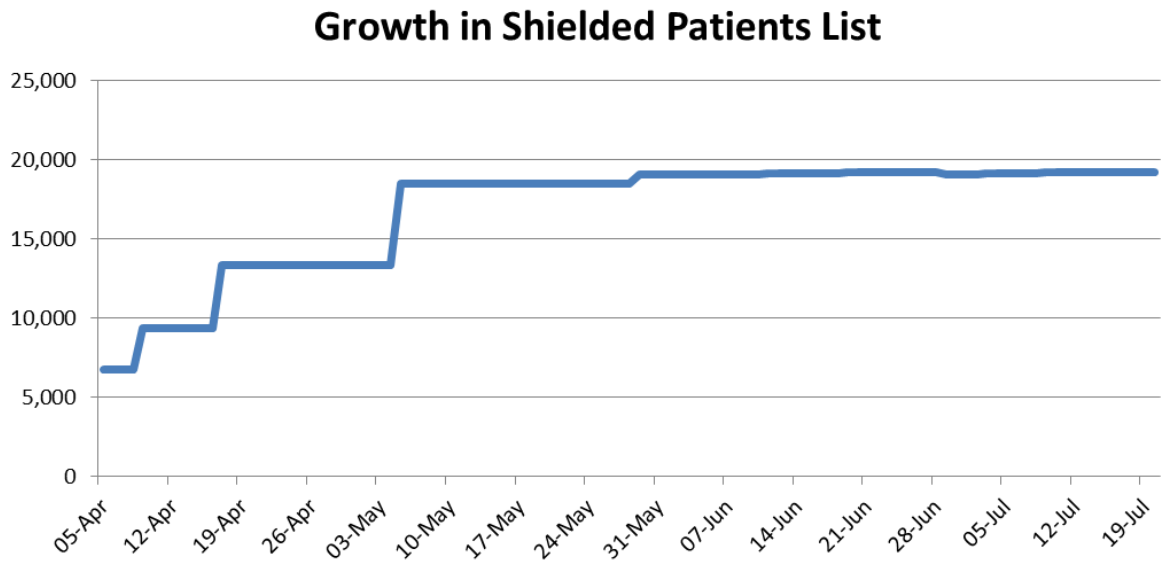
2. Overall Number of Patients on Shielded Patient List

2.1. This section provides background information on the number of patients on the shielded patient list (SPL) and how these have changed over time.

2.2. Number of Shielded Patients

2.2.1. Since the introduction of the SPL there has been an increase in the number of patients on the list from around 6,700 to just over 19,000 at anyone point in time. Overall the total number of patients who have been on the shielding list is just over 20,200. These increases have happened in a number of stepped changes as national guidance on who should shield was implemented in stages. More recently, the numbers on the SPL have been steady with some minor movements as individual patients are added and removed. Figure 1 shows the growth in the SPL.

Figure 1 Growth in Shielded Patient List



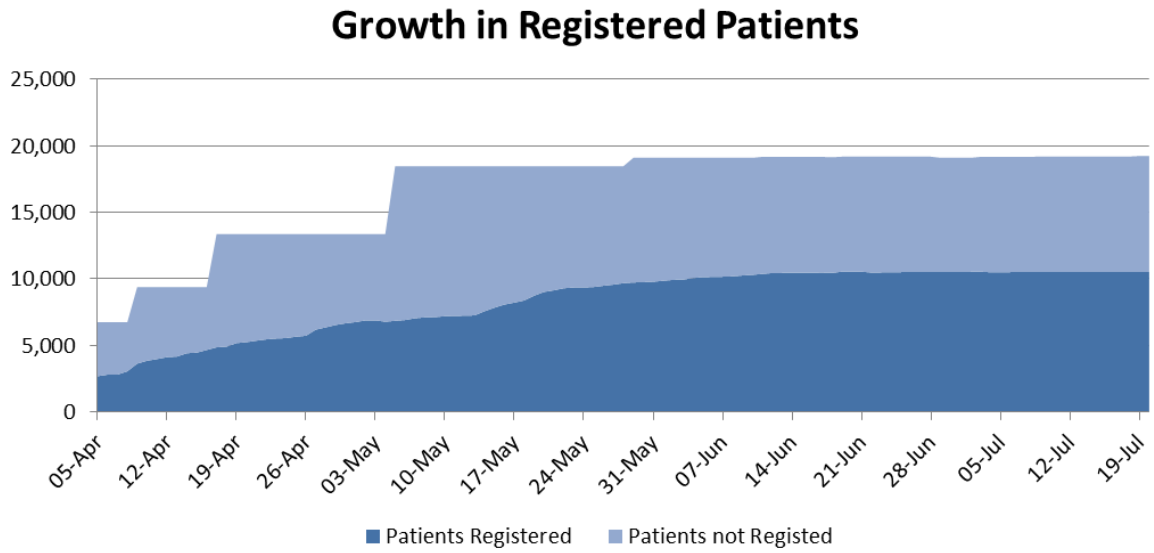
Source: Daily Shielded Patient List download

2.3. Number of Patients Registering on the National System

2.3.1. When shielded patients are advised that they should shield, the letter they receive asks them to register via a national system. This can be done via an internet portal, national telephone number, or by being proactively contacted by the national team.

2.3.2. As the number of people on the SPL has increased, so have the number registering on the national system. Figure 2 shows this trend.

Figure 2 Growth in Registered Patients



Source: Daily Shielded Patient List downloads

2.3.3. The growth in the number of registered patients has broadly followed the same pattern in the overall growth in the numbers on the SPL. The percentage of patients registered reached about 50% on the 20th May and since then has stabilised at around 55% since 16th June.

2.3.4. Councils have been asked to encourage shielded patients to register on the national system. When we have contacted patients locally we have helped just over 2,000 patients to do this, around 19% of the overall numbers registering.

2.4. Nationally Registered Patients Requesting Assistance

2.4.1. When patients register with the national system they answer a series of questions which give them the opportunity to request help with:

- Essential supplies
- Basic care needs

2.4.2. The question on essential supplies is phrased so that it is clear this includes supplies of food. Answering 'yes' to this question allows an individual to access the national food box delivery and also a priority supermarket delivery slot.

2.4.3. There is no specific question relating to supply of medicines, even though the letters received by patients and the national guidance talks about support being available for this. **[Key Learning Point 1]**

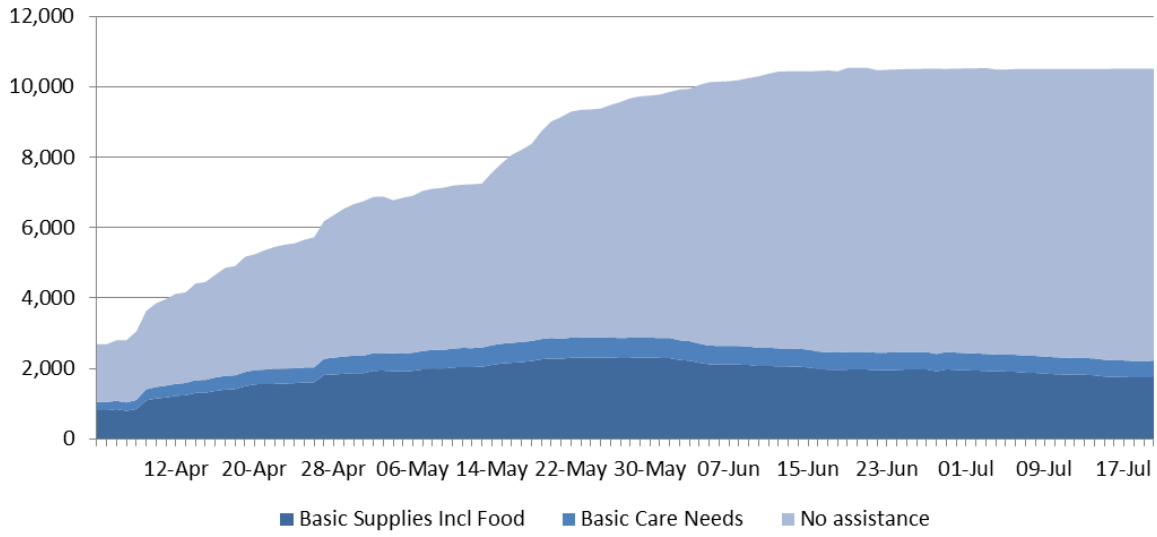
2.4.4. Additionally, patients are also able to flag if they[1]:

- Have special dietary requirements (but not able to flag any specific details of these) **[Key Learning Point 2]**
- Have no one to carry a delivery of supplies into their house.

2.4.5. The daily data downloads extracted by the Council show the number of patients who have registered on the website and their answers to these questions. Our outward bound call centre then calls those patients who have indicated that they require help with basic supplies and basic care needs.

2.4.6. Figure 3 shows how the numbers of patients registering for help has changed over the shielding period.

Figure 3 Patients Registering for Help



Source: Daily Shielded Patient List downloads

2.4.7. Patients are able to go onto the national portal and change their answers to the questions as their needs change. The number of patients requesting help on a given day peaked towards the end of May and has steadily fallen since then. This suggests as patients' needs are met of change, at least some patients

[1] A patient is able to answer 'yes' to both of these questions, even if they have not requested assistance with basic supplies including food.

go back onto the national portal and re-answer the questions to reflect these changes.

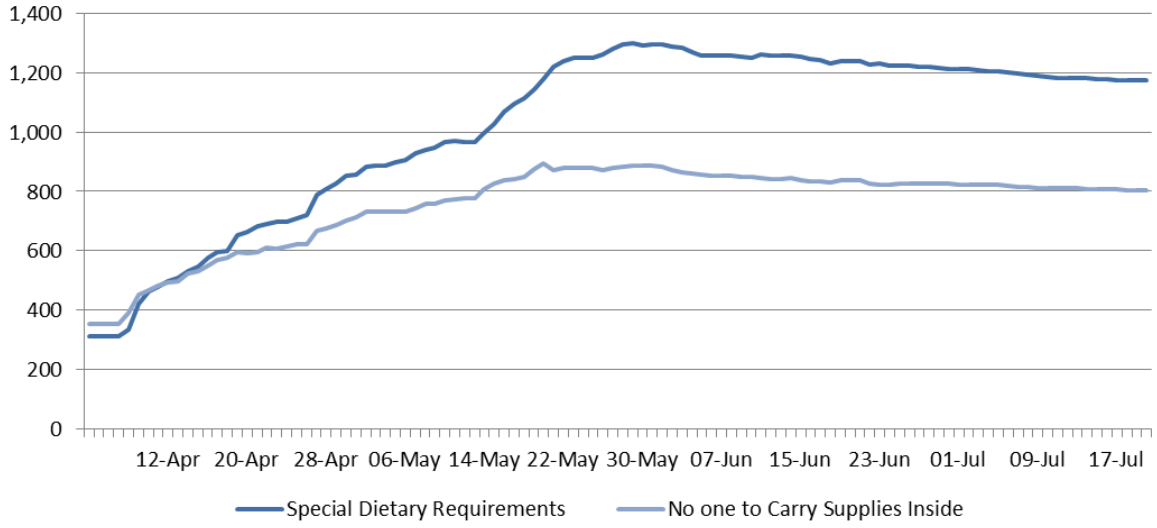
2.4.8. Over the shielding period the total numbers of patients registering for help at some point in time are:

- Help with essential supplies: 3,453
- Help with basic care needs: 751.

2.4.9. The local outward bound call centre prioritised all of these patients for a call and therefore these numbers are a better indication of the number of patients contacted for these reasons.

2.4.10. The numbers of patients who have additionally indicated that they have special dietary requirements or have no one to carry supplies inside their house are shown in figure 4

Figure 4 Patients Flagging Additional Needs



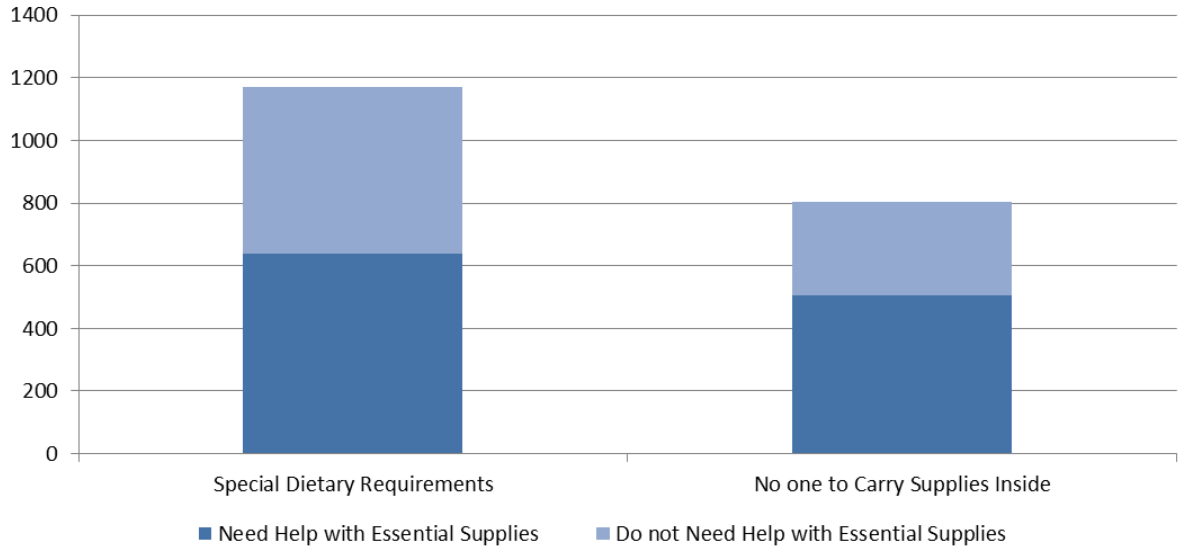
Source: Daily Shielded Patient List downloads

2.4.11. The numbers of patients flagging additional needs also peaked towards the end of May and has been steadily falling since then.

2.4.12. However, the numbers in figure 4 are **all** of those patients flagging these additional needs irrespective of if they have also requested help with obtaining essential supplies. Of more relevance are the numbers of patients requesting help with essential supplies who also have special dietary requirements and/or need assistance to bring supplies into their house.

2.4.13. These numbers are not readily available from the national information, and can only be obtained by further local analysis of the data. Figure 5 shows these numbers. **[Key Learning Point 3]**

Figure 5 Additional Needs and Essential Supplies Analysis



Source: Further Analysis of Daily Shielded Patient List downloads

2.4.14. Our local outward bound calls have prioritised calling those patients requiring assistance with essential supplies rather than those flagging additional needs but not requiring assistance with essential supplies.

2.4.15. Our local approach to supporting patients is discussed in the remainder of this document. It falls into two broad areas of work: contacting patients in priority order to identify specific needs; and providing local support to address these needs.

3. Our Approaches to Contacting Patients

3.1. This section describes the approach we took locally to contact patients on the shielded patient list and includes how we prioritised which patients to contact and the methods we used to contact them.

3.2. Prioritisation

3.2.1. The number of patients on the SPL and the amount of time required to attempt to contact them meant that this process would take a considerable period of time. This was further complicated by the growth in SPL numbers during the process, the need to establish systems and teams to do this work, and delays, omissions, and complications in receiving information on the patients on the SPL.

3.2.2. We were effectively developing our systems and teams as we went along as there was no time to develop and pilot these prior to 'going live'. In order to help manage this we used data from a range of local sources to help prioritise which patients were most likely to require contacting earlier.

3.2.3. This required us to take data from GP records and in order to do this we established an Information Governance Framework that allowed the CCGs to extract the relevant data with GP consent and share this with the Council. We also matched the data with other data held by the Council.

3.2.4. We also developed a prioritisation framework which combined this information in a logical way and provide a prioritised order in which to contact patients. In doing this we were mindful of the need to contact those patients who had registered for help on the national system as well as also contacting those who had not registered on the national system and therefore we had no information on their needs in case they had not received or not understood the guidance on how to register for help.

3.2.5. Broadly our approach to prioritisation was to contact patients in the following order:

- Patients registering for help on the national system
- People with mental illness, autism, learning difficulties, dementia and severe frailty
- A combination of other risk factors, age, sole occupancy, if in receipt of social services support.

3.2.6. Patients registering on the national portal and indicating that they did not require assistance were not contacted locally (although if they subsequently changed their status on the national system to requiring assistance they would then be prioritised for a call).

3.2.7. As the SPL changed over time, we re-ran the prioritisation matrix and figure 6 shows the number of patients in each category as at 16th April 2020. More information on the prioritisation process can be found in the document 'COVID-19: Vulnerabilities Prioritisation'.

Figure 6 Prioritisation Categories as at 16th April 2020

Prioritisation Stream		Not Registered with Portal								Registered with Portal
		Not currently receiving support from Social Services				Currently receiving support from Social Services				
		Risk Factor		No Risk Factor		Risk Factor		No Risk Factor		
		Sole Occupant	Multiple Occupant	Sole Occupant	Multiple Occupant	Sole Occupant	Multiple Occupant	Sole Occupant	Multiple Occupant	
Age Category	70+	97	229	264	861	17	34	30	47	*(This group should already be accessing council support)*
	50 - 70	79	280	190	898	7	15	6	20	
	30 - 50	34	81	62	413	Suppressed	Suppressed	Suppressed	6	
	18 - 30	Suppressed	18	11	171	Suppressed	12	Suppressed	Suppressed	
	0 - 18	Suppressed *	Suppressed *			Suppressed *	31*			

*212 blanks in the U18 category

Source: Council/CCG Prioritisation Work

3.2.8. Our intention at the start of the process was to contact all patients on the SPL, but we were unsure if this would be practicable as the resource implications of doing so were unknown. A decision was taken to work through the SPL in priority order and review on an ongoing basis the level of work involved in doing this. Ultimately, we did attempt to contact all of the patients on the list either by phone or via a welfare visit.

3.2.9. Towards the end of the shielding period, some of the staff undertaking welfare visits were re-prioritised to take part in our community protection work to help manage potential local increases in COVID-19 infection s. This was felt to be reasonable as the remaining patient were lower priority and the outcomes of previous welfare visits had not found any serious cases of un-met need.

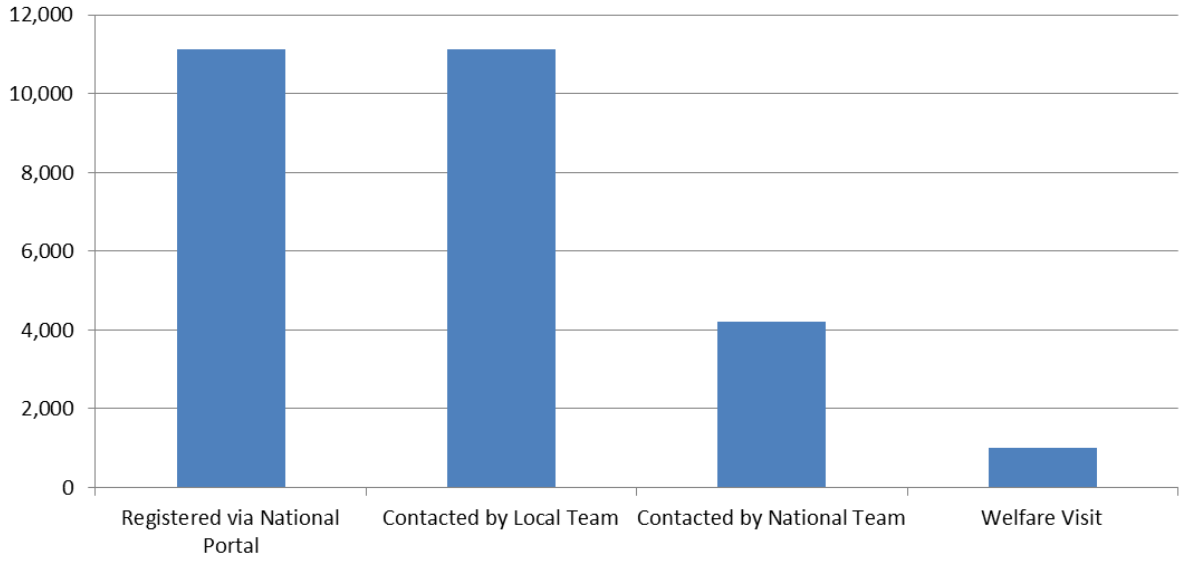
3.3. Different Approaches to Contacting Patients

3.3.1. There were 4 ways in which patients were contacted:

- Patients were called by the national team
- Patients were call by our local outward bound call centre
- Patients received a welfare visit from the Council's Community Response
- Patients contacted the Council's COVID-19 helpline.

3.3.2. The number of contacts made via these different methods are shown in Figure 7 (note that we do not separately record the number of patients contacting the Council via the COVID-19 helpline). Patients may have been contacted more than once and Figure 7 shows the number of contacts not patients. The number of patients registering via the national portal is shown for comparison.

Figure 7 Contact Methods



Source: Local Data

3.3.3. When contacting patients via telephone the initial number we used was the one on the national data download. We also put into place a system t extract patients' preferred contact numbers from their GP record and share this with the Council. Where this was a different number this was then used to try to contact patients where the one in the download did not result in a successful contact. Although it took some time to put this in place, it was helpful for a number of patients, and in future now that the system is in place this could be updated more quickly if needed. **[Key Learning Point 5]**

3.3.4. Where it wasn't possible to contact patients via telephone they were passed to Community Response for a community visit. For a small cohort of people, GP practices were contacted for help in making contact with patients. These were primarily patients with dementia, learning disabilities, and autism. However, this was a time consuming process and had only limited success in helping to contact these patients. In future, using a welfare visit is likely to be a more effective approach where these patients cannot be contacted by phone.

4. Local Support

4.1. Results of the Outward Bound Calls

4.1.1. Figure 8 shows the outcomes from the outward bound calls.

Figure 8 Outcome from Outward Bound Calls

Outcome	Number	Percentage
Emergency food parcel	151	1%
Community Response food support	182	2%
Medicines Management Team support	151	1%
Community Response medication support	86	1%
Community Response social support	294	3%
Gateway to Care referral	81	1%
Welfare visit made	96	1%
No support required	10,084	90%
Total	**11,125**	

Source: Local Data

4.1.2. The table shows that the vast majority, 90%, of the patients contacted did not require any further support. .

4.1.3. Where it was not possible to make contact with patients via phone, these were passed to the Community Response for a welfare visit – more information on this is provided in section 4.2 below.

4.2. Results of the Welfare Visits

4.2.1. Patients were transferred to Community Response in stages. The first group of patients were those from the high priority categories – those with mental health, autism, or learning disability flags in their primary care record. These

were transferred in May. Subsequent patients were from lower prioritisation categories and these were transferred in late June and early July.

4.2.2. Over 1,000 welfare visits were undertaken and around 58% of the welfare visits resulted in a successful contact with the patient. In the majority of these cases (99%) the patient did not require any support. Where the patient did require support this was provided through referrals to Local Area Co-ordination, Gateway to Care or other support mechanisms.

4.2.3. Feedback was generally positive with patients appreciating being checked in on. Some patients reported initially struggling with accessing food and medicines but that this had been rectified by the time of the welfare visit. These patients were mainly being supported by friends, neighbours, and family.

4.2.4. Where visits were unsuccessful the main reasons were not being able to get an answer, patients not being in, or patients moved away/staying elsewhere. As shielding was relaxed success rates dropped as more people were out and about. In these instances information was posted through the door providing information on how to contact the Council for support if this is needed.

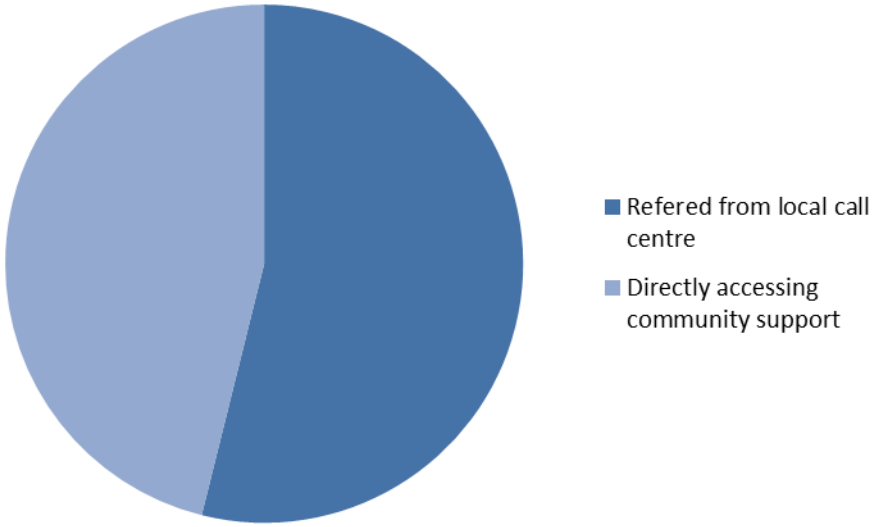
4.2.5. Staff also noted a sizeable number of cases where addresses appeared to either be out of date or premises appeared to by unoccupied.

4.2.6. In a sizable number of cases, staff noted that patients had issues with answering the phone. These included hearing difficulties, poor mobility and unable to reach the phone, avoiding answering calls from unknown numbers. Given that the focus of the national and local communications approaches have been via telephone this is worthy of note to inform future work should it be required. **[Key Learning Point 6]**

4.3. Wider Community Response

4.3.1. As part of its broader response to COVID-19, the Council put in place a Community Response and COVID-19 helpline. A number of shielding patients used these to pro-actively access support. This means that the Community Response provided support to more shielding patients than just those directed to it following a local telephone call. Just over 1,000 shielded patients are on the Community Response data base and Figure 10 shows the breakdown of how patients accessed this support.

Figure 10 Shielded Patients Accessing Community Response



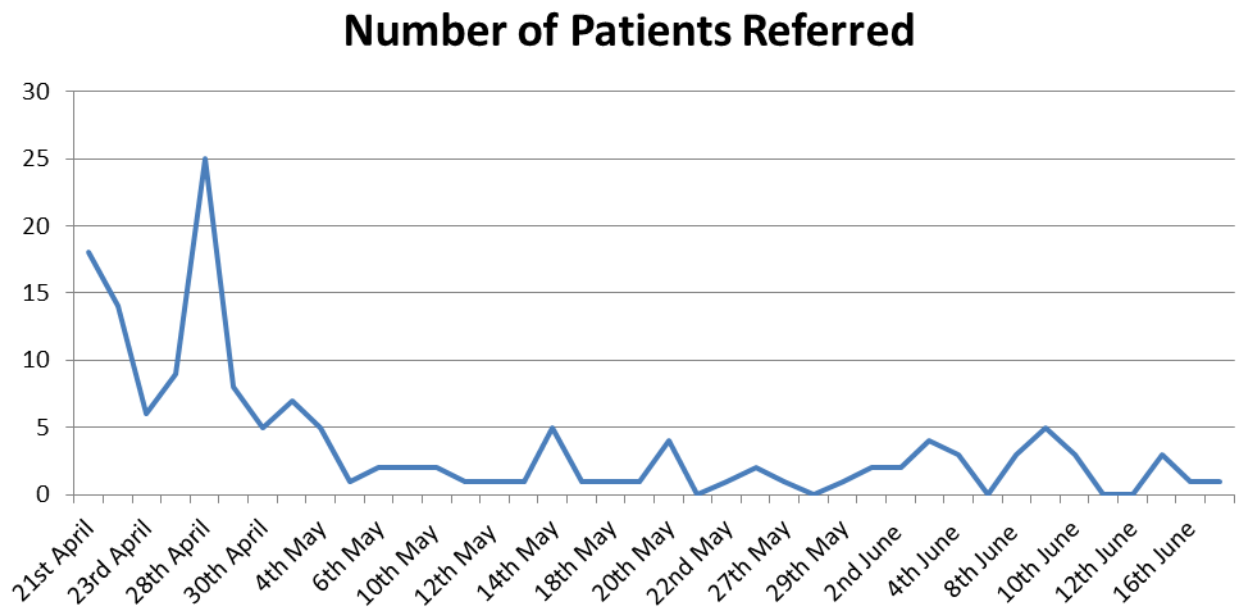
Source: Shielded Patients Dashboard

4.4. Medicines Management Support

4.4.1. At the start of the process, where the outward bound call centre identified that patients required assistance with medicines, they were advised to speak to their GP practice for advice. However, a system was then put in place whereby these patients were asked if they were happy for their details to be passed to the CCGs' Medicines Management Team so that they could contact them to provide support. **[Key Learning Point 7]**

4.4.2. The first of these referrals were made on 21st April 2020, and by 17th June 2020 151 referrals had been made. Figure 11 shows the pattern of these referrals over this period.

Figure 11 Referrals to Medicines Management



Source: Medicines Management Records

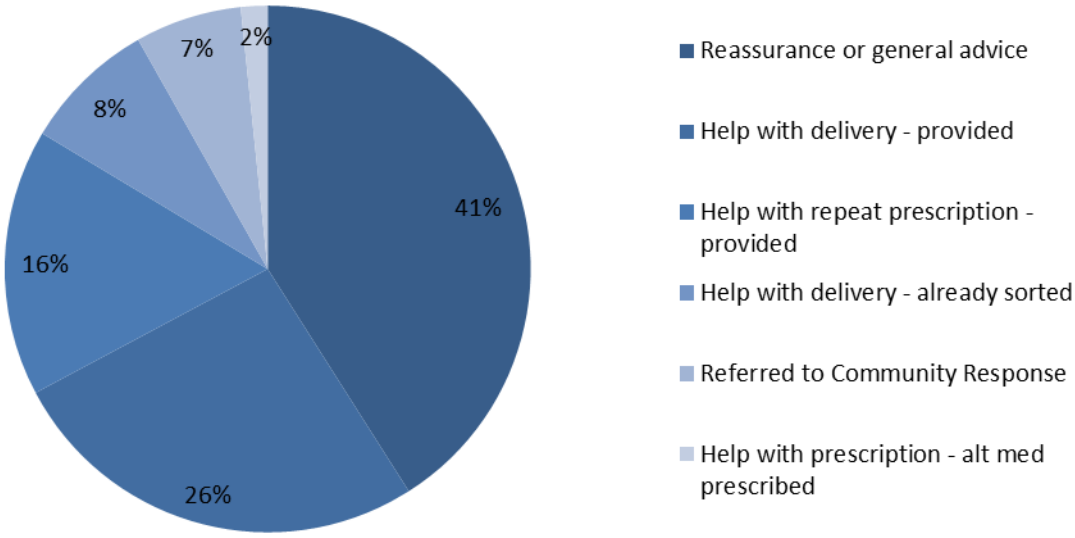
4.4.3. Figure 11 shows that initially a high number of referrals where received and some of this is due to the 'holding' of referrals by the outbound call centre whilst arrangements were put in place to provide support. Over time the rate of referrals has fallen and no referrals have been made since the middle of June.

4.4.4. Medicines Management staff rang patients to establish what assistance the required: with ordering, delivery of medicines, or both. In some instances patients only required advice on what to do, or reassurance that existing arrangements for ordering or delivery of drugs would continue. On occasions, patients had already made their own new arrangements for delivery.

4.4.5. However, for a significant number of patients the Medicines Management staff provided help to ensure that patients continued to receive their medicines. Often this required staff to liaise with GP practices, Community Pharmacies, and secondary care. For some patients, a referral to Community Response was made either for a visit because the patient couldn't be contacted by phone or in one instance where assistance with food was required.

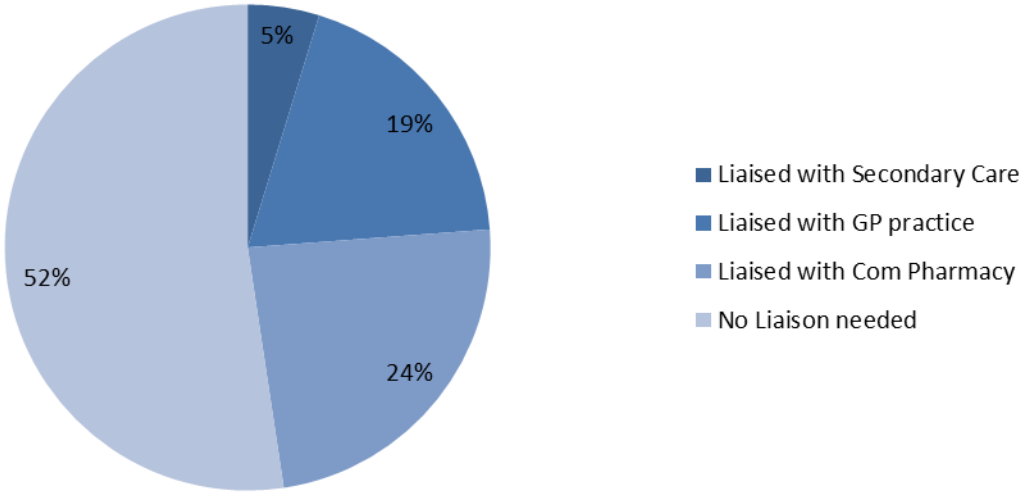
4.4.6. A summary of the actions taken by Medicines Management staff are shown in Figure 12 and Figure 13 The medicines management staff also provided contact details to patients so that they could get directly back in touch if they required any assistance in the future. Although this option was not used by any patients, it was appreciated by them.

Figure 12 Summary of Medicines Management Actions



Source: Medicines Management Records [sample of records]

Figure 13 Summary of Liaison



Source: Medicines Management Records

4.5. In providing support during this period, the Medicines Management team highlighted the support they received from elsewhere in the CCGs, from the Council,

and from volunteers. Lines of communication have been excellent and any concerns raised by technicians about the welfare of patients were always been acted on promptly.

5. Reflections of the Team

5.1. Over the past 3-4 months a number of people from across Kirklees came together in a team to help to co-ordinate the work required to support the shielded patients. The core team consisted of staff from a range of functions across the CCGs, Council, and Third Sector. In addition, staff from Locala and SWPFT attended the meetings where needed and/or remained involved in the work in other ways.

5.2. We captured the teams' reflections and learning using a short survey, a summary of the response in included as Appendix B.

5.3. It is clear from the feedback that people recognise that collaborative, partnership working has been really strong and beneficial. Within this:

- People focused more on outcomes rather than roles.
- The team adopted ways of working that were structured, focused on actions, supported by frequent meetings, with pragmatic decision making.
- Individuals demonstrated a real desire to get the job done and overcome difficulties. They also felt valued and able to contribute to the work.
- The impressive speed with which the work was done.
- Individuals feel proud of the role they have played in this vital piece of work.

5.4. It is also clear that people want to take these ways of working and apply them to other areas of work.

5.5. The main difficulties have been around working with national guidance and data flows and working at the pace required. These hampered the local speed of work and created some difficulties that we had to overcome. However, because of the points outlined above the team were able to overcome or work around these difficulties. **[Key Learning Point 4]**

5.6. Some areas of improvement were also identified mainly in relation to wanting to be able to involve the shielding patients themselves more in the work. This is something which should be borne in mind should shielding been un-paused in the future. **[Key Learning Point 8]**

5.7. The Key Learning Points from this are summarised in Appendix A **[Key Learning Point 9]**

Summary and Conclusions

5.8. The local work to support shielded patients has been a genuine cross organisational and departmental team effort. Staff came together to help support shielded patients and work in dedicated and innovative ways

5.9. Whilst there have been some difficulties to be overcome, the aim of supporting shielded patients has been achieved and the staff involved should be proud of their efforts.

Appendix A: Summary of Key Learning Points

National Arrangements

1. The national portal has no specific question relating to if assistance is needed with the supply of medicines, even though the letters received by patients and the national guidance talks about support being available for this.

2. The national portal asks patients if they have special dietary requirements but does not allow them to specify what these requirements are.

3. The national portal allows patients to flag that they have special dietary requirements and/or require assistance to bring supplies into the house even if they have not asked for assistance with essential supplies. Of more relevance are the numbers of patients requesting help with essential supplies who also have special dietary requirements and/or need assistance to bring supplies into their house. These numbers are not readily available from the national information, and can only be obtained by further local analysis of the data.

4. The main difficulties have been around working with national guidance and data flows and working at the pace required. These hampered the local speed of work and created some difficulties that we had to overcome.

See also point 5 and point 8 below.

Local Arrangements

5. The system we put in place to extract a patient's preferred contact number from GP records was helpful for contacting a number of patients. Although it took some time to put this in place in future this could be updated more quickly if needed.

6. In a sizable number of cases, staff noted that patients had issues with answering the phone. These included hearing difficulties, poor mobility and unable to reach the phone, avoiding answering calls from unknown numbers. Given that the focus of the national and local communications approaches have been via telephone this is worthy of note to inform future work should it be required.

7. The system we put in place with the CCGs' Medicines Management Team was valuable in helping patients to continue to receive medicines and to provide them with guidance and assurance. In providing support during this period, the Medicines Management team highlighted the support they received from elsewhere in the CCGs, from the Council, and from volunteers. Lines of communication have been

excellent and any concerns raised by technicians about the welfare of patients were always been acted on promptly.

8. In future we would want to be able to involve the shielding patients themselves more in the work. This is something which should be borne in mind should shielding been un-paused in the future.

9. The following learning points highlighted by the staff involved in the work are ones that are relevant to other areas of work and can be applied elsewhere.

    a. *Collaborative Working:*
        - Common goals strengthen teams
        - Focus on outcomes not roles
        - We are more than the sum of our parts.
        - The value of integrating clinical care with a place based community response – so important to work together.
        - Trust one another, listen, and hear.
        - Make the absolute best use of networks and relationships.
        - The positive impact that working together has for patients.
        - Investing in relationships is always worth it.

    b. *Ways of Working:*
        - I will apply some of the new ways of working back to my usual work streams
        - Applying the wider picture and crossovers that I have gained.
        - How quickly things can be turned around when needed.
        - Seeing the real benefits of joining up data sets and the value this adds in action.
        - Inequality is a real issue and needs to be a cross cutting them in everything we do.
        - Using some of the processes developed in wider ways – particularly around data sharing.
        - Collaborative working via video conferencing can really work effectively.

Appendix B Summary of Team Feedback

Twelve members of the team completed the feedback questionnaire. A summary of the responses is provided below.

The Strengths and What Worked Well

Partnership Working:

- Collaborative working between organisations, sectors, and teams has been really strong.
- Collective systems leadership helping to form a collective partnership.
- Excellent partnership working.

Meetings:

- Regular, focused meetings – helped people understand the range of issues involved.
- Well-co-ordinated meetings, focused on outcomes and actions.
- Given a high priority with senior leaders taking part – especially at the height of the pandemic.

Decision Making:

- Sensible and action focused decision making.
- People came together very quickly to solve problems that ordinarily would have taken weeks.

Individuals:

- Real commitment from people involved.
- Everyone trying to make things work.
- Impressive speed of working – solution focused and wanted to move forward quickly and pragmatically.
- Everyone identified with the task/goal.

Challenges and What Didn't Work so Well

Pace and Scope:

- Pace of change and speed of work required.
- Scope and amount of people involved.

National Guidance:

- National lead in and response times.

- Lack of clear information governance advice around sharing of data
- Guidance to GP practices re identification of patients could have been handled better.
- Changing national picture.
- Delays in some patients receiving shielding letters.
- Difficult to understand the NHS Digital governance conditions place on SPL and changing position on this.

Data Flows:

- National data didn't flow as quickly as we would have liked
- Difficult to manage the changing national data sets.
- Lack of clarity and moving goalposts at the beginning of this process making it difficult to manage data flows locally.

Make up of Team:

- Didn't always have right people on calls to help with the knowledge resulting in some delays.
- Working out team roles – but resolved quickly.

What is Missing or is a Gap

Data/Information:

- Joining up the data that CCGs and Council have to get a full picture.
- Involving Information Governance colleagues from all organisations earlier.
- Our database doesn't allow easy reporting of some key figures.
- Still some lack of clarity about the use of data which could be addressed centrally in relation to secondary uses.

Engagement:

- Engagement with shielded patients.
- Primary Care Networks.

Utilising offers of Help:

- How to make the best use of offers of help within GDPR rules.

Opportunities to Improve What we Have Done

Future of Shielding:

- Prepare for future shielding.
- Make sure we have everything in place to do our local data linking.

- Establish a better way of sending data from CCGs to Council.
- Feedback from shielding patients on the support they have received.

Ways of Working:

- Embed place based working.
- More collaboration across all sectors and building on the partnerships we have developed.
- Formalising some of the processes and relationships we have put in place for future use.
- More willingness to think outside the box when solutions are offered.
- Networking opportunities to meet colleagues from other organisations.
- More overt involvement of social prescribing.

The One Thing you would go back and Change

Involving Shielded Patients:

- Communications directly with communities.
- Shielded patients included in the calls.

Data/Process:

- Better national advice on identifying high risk patients.
- Build the database first and in a way that allows key figures to be extracted.
- For shielding letters to have gone to patients at the start of lockdown.
- Being able to have started earlier – but we were responding to national direction.
- Council IG involved earlier.

Most Proud of

Supporting Shielded Patients:

- Supporting shielded patients.
- Being part of arrangements for supporting the most vulnerable patients in Kirklees – the area where I live and work.
- Being part of a system that enabled people to access food at a local level.
- Being part of a process and ensuring our most clinically vulnerable patients have been supported in difficult times.
- Feedback from patients knowing they were cared for in extreme circumstances.

Ways of Working:

- Team effort – no organisational boundaries.
- Whole process – got it working well, shared goals, overcoming obsticals.

- Being part of a system working collaboratively and having my opinion valued
- Collaborative working, high levels of passion and commitment from colleagues.
- Collaborative working to ensure patients looked after.
- Keeping going with good humour and kindness.
- The job got done and with speed.
- Exemplary teamwork.
- Playing a part in putting arrangements in place to obtain and use GP data.

Learning that can be Applied Elsewhere

Collaborative Working:

- Common goals strengthen teams
- Focus on outcomes not roles
- We are more than the sum of our parts.
- The value of integrating clinical care with a place based community response – so important to work together.
- Trust one another, listen, and hear.
- Make the absolute best use of networks and relationships.
- The positive impact that working together has for patients.
- Investing in relationships is always worth it.

Ways of Working:

- Apply some of the new ways of working back to my usual work streams
- Applying the wider picture and crossovers that I have gained.
- How quickly things can be turned around when needed.
- Seeing the real benefits of joining up data sets and the value this adds in action.
- Inequality is a real issue and needs to be a cross cutting them in everything we do.
- Using some of the processes developed in wider ways – particularly around data sharing.
- Collaborative working via video conferencing can really work effectively.

Other Comments

- Overall the work has demonstrated the best of team working and taking a collaborative approach.
- Really enjoyed the challenge – in particular the shared vision and determination to achieve the goals.
- Everyone felt valued and valuable.
- Short, regular meetings- where we can see the other attendees - are really helpful.

- Team stuck with the task and were well informed.
- Great Collaborative piece of work.
- Enjoyed working with teams and building relationships that would ordinarily take years/months to do.
- Really proud to have been part of this work.
- Although not all elements of the work apply to all members of the group, there was strength in including all members in the meetings, especially in the early days - it helps with context and in forming the team.