Healthier Greenwich Partnership meeting in public

Date: Thursday 12 May 2022
Time: 11:30 – 13:30
Venue: MS Teams - Click here to join the meeting
Chair: Sarah McClinton (RBG)
Questions: Please submit any questions in advance by emailing alex.harris2@nhs.net

AGENDA

	Item	Page no.	Presented by	Time
Opening Business				
1.	Welcome, introductions and apologies	Oral	Chair	11:30
2.	Declarations of interest	Oral	Chair	
3.	Minutes of the meeting held 7 April 2022	3-7	Chair	
4.	Action Log and Matters Arising	Oral	Chair	
5.	Update on Local Care Partnership Developments	*To follow*	Sarah McClinton / Jackie Davidson	11.35
6.	Update on Healthier Greenwich Partnership Workshop & Next Steps	*To follow*	Sarah McClinton	11.45
7.	Health Inequalities Funding Proposals	PPT	Jackie Davidson	12.00
8.	System Development – lessons learned and look forwards	8-29	Robert Shaw	12.15
9.	Communications and Engagement in Local Care Partnership	30-34	Iuliana Dinu	12.30
10.	Public Q&A Session	Oral	Chair	13.00
Closing Administration				
11.	Any other business	Oral	Chair	13:20
12.	Next Meeting: 9 June 2022 (11:30-13:30)	Oral	Chair	

Meeting closes at 13:30

Healthier Greenwich Partnership

Healthier Greenwich Partnership
Minutes of the meeting held on Thursday 7 April 2022, 11:30 – 13:30

Members	
Sarah McClinton (Chair)	Deputy Chief Executive & Director of Health & Adult Services, Royal Borough of Greenwich
Jackie Davidson	Acting Borough Director, SEL CCG
Andrew Scriven	Head of Business Strategy & Performance, Royal Borough of Greenwich
Christopher Dance	Associate Director of Finance – Greenwich, SEL CCG
David James	CEO – Greenwich Health Ltd.
Florence Kroll	Director of Children's' Services, Royal Borough of Greenwich
Lisa Wilson	Integrated Commissioning Director (Adults), Royal Borough of Greenwich & SEL CCG
Nick Davies	Adult Social Care Director Royal Borough of Greenwich
Robert Shaw	Director of System Development – Greenwich, SEL CCG
Sandra Iskander	Deputy Director of Strategy, Lewisham & Greenwich NHS Trust
Steve Whiteman	Director of Public Health, Royal Borough of Greenwich
Tuan Tran	Local Medical Committee Chair, Greenwich
Richard Rice	LAY Member, SEL CCG

Also in attendance	
Alex Harris	Corporate Governance Lead (minutes) – Greenwich, SEL CCG
Sam Hepplewhite	Executive Director of Vaccinations & Primary Care, SEL CCG

Apologies

David Borland	Integrated Commissioning Director, Children & Young People, Royal Borough of Greenwich & SEL CCG
Iain Dimond	Chief Operating Officer, Oxleas
Ify Okocha	Chief Executive Officer, Oxleas
Joy Beishon	Chief Executive Officer, Healthwatch Greenwich
Krishna Subbarayan	GP Clinical Lead
Lisa Thompson	Director of Children & Young Peoples' Services, Oxleas
Naomi Goldberg	Director of Strategy, Metro Gavs
Niraj Patel	GP Partner, Thamesmead Medical Associates
Sabah Salman	GP Clinical Lead, Greenwich

1.	**Introduction**
1.1	**Introductions and Apologies for Absence**
1.1	The Chair welcomed the attendees. Apologies were noted as above.
2.	**Declarations of Interest**
2.1	Attendees were asked to declare any new or existing interests in the context of agenda items. None were declared.
3.	**Minutes of the previous meeting**

3.1 3.2	The minutes of the meeting held on 10 March 2022 were approved as an accurate record subject to the below changes. It was noted that a number of job titles were incorrect on the previous minutes. Alex Harris would correct the minutes and send around an updated version along with the minutes of this meeting.
4.	**Action Log**
4.1 4.2	Updates on the action log were provided as part of the agenda pack. **08/07/001** – Jackie Davidson would follow-up with Russell Cartwright on this action, as the due date was April 2022.
MAIN BUSINESS	
5.	**Update on Recruitment of Chair**
5.1 5.2 5.3 5.4	Jackie Davidson introduced the item. She noted that we had circulated a paper previously outlining a series of questions circulated aiming to generate discussion. Most respondents had indicated that the Chair should come from a clinical or practitioner background. We had also updated the JD / person specification based on feedback received. Opinion was, however, divided on whether to have an Chair. Two people had indicated that the Chair should be independent to minimise Conflicts of Interest. There were two people, furthermore, who strongly indicated that the Chair should not be independent as they would have less of a connection to the local Greenwich area. Our recommendation was, therefore, to aim to recruit from a Greenwich partner organisation in the first instance. It was agreed: ➢ **Chair to come from a clinical background.** ➢ **To be recruited from a Greenwich Partner organisation in the first instance.**
6.	**CCPL Update**
6.1 6.2 6.3 6.4 6.5	Robert Shaw introduced the item. We had interviewed for the Phase One roles and we were in the process of recruitment for the medicines optimisation role. Other roles were being interviewed for or interviews were being set up. Accountability and delivery on this would sit in the HGP as this board would shape and define our partnership relations prior to us becoming an Integrated Care System (ICS). Sarah McClinton asked what the relationship would be between the SEL roles and the Greenwich roles. Robert Shaw responded that this was still being worked-through and the detail was not yet set. Sandra Iskander asked what level of response we had received. Robert Shaw responded that we had a low number of applicants for Phase One, however given the specificity of the roles it was not surprising. With Phase Two recruitment, we would need to think about how to proceed if we received a low number of applicants. Lisa Wilson asked if we had a role based around patient and public engagement. Robert Shaw responded that there was and this as an oversight in the papers. David James asked if he could be kept in the loop in relation to the workforce role. He also asked what the distribution list was for the applications. ➢ **Robert Shaw responded that he would check the workforce role with Russell**

	Cartwright and respond to David James. ➢ **David James further requested that all the Phase 2 roles be sent to him as a matter of priority.** ➢ **Sarah McClinton requested that this be discussed at a future meeting.**
7.	**Primary Care Delegation**
7.1 7.2 7.3 7.4 7.5 7.6	Sam Hepplewhite introduced the item. She noted that we may have different answers as to how we discharged responsibilities in different boroughs. This was fine, so long as the responsibilities were themselves discharged. Richard Rice noted that there could potentially be time commitment issues in relation to the meetings themselves. There were also potential conflicts of interest in relation to the Chair themselves being clinicians. Sam Hepplewhite noted that the decisions on composition of committees would be left up to boroughs themselves. In relation to CoI, there would be many interests that would have to be managed by the Local Care Partnership and these interests would need to be managed rather than necessarily being seen as an inherent conflict. Jackie Davidson noted that we would start from the premise that everything was delegated and the detail of how this would be worked-up would be left to local place to determine. She added that we needed to consider whether the HGP would hold the reins on this or whether we would convene a smaller sub-group to take some of this work forward. A number of colleagues supported this idea and put themselves forward to be on the sub-group. Tuan Tran added that we needed to consider whether we had – as a partnership – the resources and support to make effective decisions. There were a lot of changes coming imminently and we needed to make sure we discharged our responsibilities effectively and appropriately. Lisa Wilson added that we should have a phased approach to this, as there wouldn't be a single answer for every borough. Sarah McClinton noted that there were colleagues who had sent apologies and this paper should be circulated to them for their input, for this item to be brought back to the HGP at a later date.
8.	**Draft Inequalities Funding Proposals**
8.1 8.2 8.3 8.4 8.5	Jackie Davidson introduced the item. She noted that we had discussed this matter at the February meeting of HGP. Since then, there had been further work done within the system to identify new funding opportunities. Some of this was non-recurrent funding, and there was also £5m of CCG charitable funds. There was a relatively tight timescale in relation to this – with a deadline of 13 May. Sarah McClinton suggested that we therefore develop our approach in terms of how it relates to ongoing funding. We should also co-produce some of this work with partners from the voluntary sector. ➢ **Sandra Iskander stated that she would share the LGT paper on this item.** Steve Whiteman noted that it was very positive that some of this investment was recurrent. He also noted that the pandemic had highlighted serious inequalities matters. Richard Rice noted that he was the chair of the charitable fund. They were not used to managing this type of money and would be utilising the services of fundraisers to assist with how to allocate the funding. ➢ **Florence Kroll also added that the Mental Health Equity Group had done a wide range of work on this and that she would share this with the HGP.** The Healthier Greenwich Partnership agreed to establish an Inequalities Task and Finish Group

	to take this work forward. Sarah McClinton noted that the priority for this group would be based on building capacity within the system.
9.	**System Development Update**
9.1 9.2 9.3	Robert Shaw introduced the item, noting that the next meeting would have a wider update on system development including some patient experience stories. He noted that we had successfully recruited to a series of diabetes roles, however we were struggling to recruit to a clinical diabetologist role. We had successfully landed support through the elective recovery fund to enable the funding backlog to be addressed. A lot of our work was still at system-level, aiming to manage challenges that we had and looking at our front door offer. He offered thanks to Rebecca Moore for her work and she was an example of how someone could come in from primary care and utilise the right skills and relationships. He also thanked Nick Davies and Lisa Wilson for their support. Sarah McClinton noted that there had been a significant challenge in the past few months, and we should recognise the hard work of the team in rising to the challenges faced. Robert Shaw noted that we could use the existing primary care forums to open up some of the discussions and conversations on this. We currently had roughly 80 ambulances come in every day at QE. Over 450, however, come in without an ambulance. We could potentially use existing primary care forums to open up discussions and conversations. Jackie Davidson noted that we still need an understanding of people who turn up at the front door. We also needed to think about what is meant by “system” work and how we could enable this to focus on Greenwich.
10.	**Forward Planning**
10.1 10.2	Sarah McClinton noted that we were in a transitional period awaiting the outcome of legislative changes. Alex Harris noted that we would be looking to firm-up our forward plan at a forthcoming workshop in May. Tuan Tran requested that we change the time of the Healthier Greenwich Partnership going forward. Sarah McClinton responded that it would be challenging to change the time of the May meeting, however for meetings beyond Alex Harris would survey HGP members to find a time appropriate for them.
12.	**Any Other Business**
12.1	There was none.
11.	**Date of Next Meeting**
11.1	The next meeting will be held on 12 May 2022.
12.	**Meeting close**
12.1	The meeting ended at 12:48.

Action Log for the Healthier Greenwich Partnership – May 2022

Updated 9 May 2022

OPEN ITEMS						
Meeting date	**Minute Ref**	**Action no**	**Action**	**Action Owner**	**To be Completed**	**Comments**
11 November	7.2	11/11/04	Work to be undertaken among the Integrated Commissioning Directors to look at the delivery plan and identify any areas of overlap and duplication.	David Borland	May-2022	Workshop was held on 4 May 2022. Update for May HGP meeting – action can be closed.
7 April	6.5	04/07/01	David James further requested that all the Phase 2 roles be sent to him as a matter of priority.	Robert Shaw	May-2022	Completed.
7 April	6.5	04/07/02	Sarah McClinton requested that CCPL be discussed at a future meeting.	Alex Harris	May-2022	Future date TBD.
7 April	8.2	04/07/03	Sandra Iskander stated that she would share the LGT paper on inequalities funding with HGP.	Sandra Iskander	May-2022	Completed.
7 April	8.4	04/07/04	Florence Kroll also added that the Mental Health Equity Group had done a wide range of work on this and that she would share this with the HGP.	Florence Kroll	May-2022	Completed.

AGENDA ITEM: 8

Healthier Greenwich Partnership

Date: 12 May 2022

Title	System Development – lessons learned and look forwards	
Executive Summary	The purpose of this paper is to provide the regular update on system development, but also reflect on the process thus far undertaken.	
Recommended action for the Committee	• The HGP is asked to note the report.	
Potential Conflicts of Interest	• None.	
Impacts of this proposal	Key risks & mitigations	• None – this is a reflective document, not a proposal.
	Equality impact	• None arising from this report however equalities impacts of the changes will be addressed as and when they arise.
Wider support for this proposal	Public Engagement	• None as this is a discussion document.
	Other Committee Discussion/ Internal Engagement	
Author:	*Robert Shaw – Director of System Development*	
Executive sponsor:	*Jackie Davidson – Acting Borough Director*	
Clinical Lead	*N/A*	

This is going to be different – our look back over the last two years as a System Development Team in Greenwich

"Ask not what your country can do for you, but what you can do for your country" is often attributed to the American president JF Kennedy. Whilst this is true, it has its origins in the bible (Luke 18:41). When we communicate and keep our messages alive through stories whilst it can be both enlightening and powerful its is also an effective way of describing how to work as a system when most of what you do is to help others succeed.

Rather than write a formal report, we wanted to reflect what we have all achieved together through a series of stories from Greenwich patients, clinicians, members of the teams we have worked with as well as members of the systems team. During the summer of 2018 we held a series of meetings and sessions with key leaders across the system to test the appetite for transformation. There wasn't support for transformation, but there was support for System Development. The reason for this was because transformation infers "being told to change" whereas system development is more about working with people to help them change where they own and have the ideas themselves. We gained support from The Healthy Greenwich Alliance (now Healthier Greenwich Partnership), together with executive support from both Oxleas and Lewisham and Greenwich Trust. We then went through organisation change where we set about changing a core group of our commissioning team into a jointly and system owned System Development Team.

Whilst we are a joint team, our work is vested in and originates in our individual borough with focus on systemic issues and opportunities. Given financial constraints we are a shared resource across the two boroughs of Bexley and Greenwich, but as I say our genesis as a shared team is within each borough. These stories are from a Greenwich perspective.

In February 2019 we met as a team for the first time as we started to come through the CCG reconfiguration. Our ambition was to work in system to support and enable change, to break down the commissioner / provider split heading into integrated system space ahead of time. In March our ambition was to be put to the test, in ways that we didn't know at that time. But, in difficult times can come opportunities which as a system we took together through three very different waves of a pandemic, a realisation of the impact on our environment and another organisational change as we move away from commissioner provider split with internal markets and competition into Integration with collaboration as South East London Integrated Care System / Board.

Health and social care is all about people, about humans, and so we adopted an underlying approach with System Organisational Development techniques. We learnt these techniques and have refined them together over the last two years together as a system with three elements;

- Developing relationships of Trust
- Working in co-creation and collaboration not competition with winners and losers
- "Break through" to help us innovate and move into the unknown

These elements have served us well on multiple occasions. We hope that you enjoy both enjoy the stories and look forward to your continued support to keep evolving as the world around us changes at an ever-increasing rate of acceleration, and not always with in our gift to control.

Robert Shaw

Director of System Development

Greenwich borough (SEL CCG), Bexley borough (SEL CCG), Oxleas NHS Foundation Trust, Lewisham & Greenwich NHS Trust.

May 2022.

Contents

We are in a relationship 4
Who's decision is it anyway?..5
Trying to move from cost mindset to an investment mindset..6
How do we engage with clinicians, social care, operational and commissioning teams 7
How we improved our flow around the Urgent & Emergency Care System and help our Greenwich residents to get back home ? 8
How can I get better access to Urgent & Emergency Care 8
How we help make diabetes work for our patient than the other way around 10
Skin Matters..11
So, what can we do different for workforce 12
How we helped to support Covid vaccination..13
What can we build differently ? 14
How can I get my bloods done 15
Neurorehabilitation 16
So, what next …. 17

We are in a relationship

As humans, having connections and relationships with others and our environment is the thing that we value most. When we meet new people for the first time, whether that's new friends or meeting that "special person", our first instinct as humans is to find commonality and ways of connecting with others; -through talking, sharing experiences and opening ourselves up. All this lays the groundwork for trust. So why in the NHS and social care when we look to deliver a project, or a programme of work we do so by immediately setting out terms of reference, make our position clear, and demand formal reporting structures with the expectation relationships will take care of themselves!

Resplendent story

In May 2019 a directive came out from NHS England that set Community Providers as the lead organisation to co-ordinate wider system response to the first wave of the pandemic... This was the start of our Bexley & Greenwich silver group. We came together as a system into an environment where normal restrictions of finance were dropped, and governance relaxed. This meant we had one focus on a common enemy … Covid. As governance slowly found its feet again and the return of financial restrictions, as a group we decided that we wanted to keep the way of working and so along with a request to have a different name for the group …. Resplendent was born. A *relationship system* is any group of people that shares a common identity or purpose – this is absolutely the starting point for Resplendent as we continued to work together to tackle the challenges of the Covid pandemic. But as we worked together through this unprecedented phase in the history of health and social care we recognised that the way we worked together really works.

Our covid debriefing session was emotional and uplifting – we could not have got through the pandemic without each other. We agreed that the successes of our covid response was an approach we did not want to lose – this was something bigger than organisations working together to manage demand, we had created a way of working that encourages true system thinking. We have achieved flexible and resilient thinkers who are cognisant of the impact of decisions on all system partners – and most importantly on the service user.

We challenge each other continuously – what needs to be done differently? Is this the right thing to do? Conflict is not a problem – it gets the best from us.

Confluent story

Following the success of Resplendent we looked to establish the same relationships in the planned care space….. and so Confluent was born.

Confluent is an informal planned care partnership forum – the group meets weekly and there is no decision making or formal reporting. Instead, the weekly touch point is about connecting all those working in service of planned care (clinicians, commissioners and operational managers), building relationships and supporting the sharing of information, issues and opportunities across community, primary and secondary care.

The group has worked on local pathway issues, initially with radiology but moving into other diagnostic pathways, gynaecology and dermatology. The group is also used by SEL Planned Care and the Acute Provider Collaborative as a way to work with the local system for the local pathways and helping them come to life. Again it's a testament to the way of working that Confluent, SEL Planned Care and the APC is very much a win, win ,win rather than a winner and a looser.

Confluent is informal, facilitated and focused equally on task (the work that needs doing) and relationship (through which the work will be done). Participants have an equal voice in the meeting and a check-in at the beginning helps define the agenda. Actions agreed are taken away by participants and picked up at a later meeting. Decisions / recommendations are deferred to borough / provider governance processes as needed.

Both Resplendent and Confluent have no budget, no decision making authority and no hierarchy. This was, and remains key in our success as decision making will always technically reside in statuary bodies, but as humans if we have the right relationships we can make them together across organisations from within organisations. We use both Resplendent and Confluent as our system relationship vehicles to lead through relationship whilst remaining equally ruthless to task.

Who's decision is it anyway?

Who makes decisions in an environment when there are both limited resources and multiple layers within layers within the system of systems rapidly becomes both a focal point and if not careful a bone of contention that can rapidly bring things to a halt as everyone tries to chew on the bone! Within our Greenwich system we have multiple providers (Oxleas, Lewisham & Greenwich Trust, Care Homes, Primary Care, Hospice and GP companies) in addition commissioning System of Systems with Greenwich standing in its own right and being part of a wider system at multiborough level with our providers and South East London with sector level commissioning …. So, lots of opportunities to become unstuck! To compound this further, when we became a Systems Development team not all of our previous commissioning tasks were transferred over to other commissioning colleagues both at South East London and boroughs.

In order to maintain credibility and hold our licence to operate within these systems we need to remain agnostic and support the collective combination of organisations in different permutations depending upon the work to make their own decisions as part of the System of Systems ….. so we became advocates for change.

Therefore, to help us advocate and remain agnostic our two system meetings, Resplendent and Confluent deliberately have no hierarchy and no decision-making authority. However, it is testimony to the great work and trust built through these groups that they are often seen as decision making rather than advocating for the statutory organisations which they serve.

We extend this approach in all our workings so examples in Home First Board, Skin Matters, Gynaecology as a Systems team we have no decision-making authority …. Instead, we are part of the groups / boards to advocate and be catalysts support change owned by the people who want to deliver the change(s).

In relation to our commissioning portfolio, we have managed through relationships to keep the decision making separate from our System Development work by taking all decisions through our existing decision-making forums such as the Integrated Commissioning Board, Senior Management Team, Healthier Greenwich Alliance (then partnership).

Accountability for delivery of System based upon decision making within organisations in the system has further to evolve. Over the last two years we have got better at co-developing proposals within our Greenwich system and presenting proposals across multiple organisations. However, when it comes to then looking at outcomes off these proposals it can be come very variable.

It is testament to our advocacy approach that we have been successful working collaboratively with colleagues from South East London. In the Planned Care space for example we were able to move towards win wins by joining up SEL network initiatives with our Greenwich local pathways between primary care referrals and outpatients. A space that historically has been purely acute centric.

More recently with the advent of the Integrated Care System we had the creation of the Acute Provider Collaborative (APC). The APC were tasked by NHS National team to submit proposals for funding for Community Diagnostics, initial discussions with the APC Diagnostics SRO who had heard of the system working approach we have in Greenwich we were able to secure Eltham as a centre for diagnostic funding at the current stage of the process. All the decisions around this were made solely through the APC framework, yet through our advocacy approach we managed to gain the respect and support for our local system and influence the decision.

Trying to move from cost mindset to an investment mindset

Within the NHS and social care there is an underlying driver of efficiency and effectiveness which lends itself to a cost mindset. When this is set within our historical context of internal markets with competition this often ends up with continued reduction in costs with “winners and losers”. When we want to work in “breakthrough” and innovation our mindset has to move to investment, and, arguable in order to maintain efficiency and cost effectiveness we still need innovation and breakthrough.

We realised we need to set out a multiyear, multi provider case for investment in our Home First Projects, Neurorehabilitation project and Diabetes projects. All these projects were previously funded through a mixture of recurrent non-recurrent monies and contract baselines in different organisations. All of this made for a challenge when it comes to investment in sustainable workforce.

Our first experience of this was in the development of three investment proposals that covered SEL Bexley, SEL Greenwich, Oxleas and Lewisham and Greenwich Trust. We developed three proposals for;

- Home First (Greenwich, Bexley)
- Neurorehabilitation (Greenwich, Bexley)
- Diabetes (Greenwich, Bexley and Lewisham)

These covered up to three years recurrent investment and all of this at a time when the NHS planning guidance was fragmented and changing due to Covid with impact upon funding and we didn’t future year allocations. It covered both Oxleas as well as Lewisham & Greenwich Trust across multiple boroughs.

We took the proposals through the local partnerships in each borough, Oxleas, Lewisham & Greenwich Trust then aggregated position into South East London. Having developed the proposals collaboratively as a system across Greenwich alongside the wider SEL system this enabled SEL Commissioning & Contracting team to enact these borough recommendations into annual contracts, and annual uplifts in future planning cycles. With huge thanks to the skill and energy of the Sel contracting and commissioning team we achieved in a three increased recurrent investment in all three programmes for our Greenwich system. For us in Greenwich this was an example of how we can make financial investment decisions at a combined borough and sector level for the benefit of our residents. We are the first part of SEL to successfully land multiyear, multi provider investment in this way. As you will see from stories in this paper, we have successfully implemented the first year and about to start the second.

At a specific Greenwich only level, our relationships between the CCG and Royal Borough of Greenwich continued to develop in a positive way. In the past finance had often been a sticking point, mainly driven by cost savings and result cost mindset in both organisations. Together, we recognised that this had the risk to influence decision making in a way that was not helpful. So, we decided to take a leap of faith and move to making decisions on investment together then how to align the financials together, rather than starting with the financials. Taking this more evenly balanced approach enabled us to move forward investments for Greenwich to deliver improved outcomes. Our approach was implemented through both our Better Care Fund joint meeting then Home First and now into a combination of Home First and Integrated Care Board. In January 2022 we were able to secure additional £1m for workforce investment which we hold in a fund for the Greenwich system to invest in completely new system approach to workforce. Without the leap of faith, we would never have been able to either secure the funding or take the joint approach together on investment.

Ben Sturgis - SEL Director of Commissioning Finance and Planning
Chris Dance – Greenwich Associate Director of Finance

How do we engage with clinicians, social care, operational and commissioning teams

From the very start, the system development team has committed to a radically different approach to transformation- while we are ruthless on “task”, the work is always led through relationship. Practically, this means that we attend to the “how and who” as much as we attend to the “what”, as we are clear-and have seen- that focusing on the people side of change is the key lever for sustainable change.

The way we work is supported by our Organisation Development (OD) lead who partners with SD programmes leads to ensure all pieces of work are approached using OD methodology and practice. Her role stretches outside the programmes to provide OD advice/ coaching to any system leader who feel they would benefit from access her support.

A core ethos of the team is learning and capability development-both with partners we work with and within the SD team. Over the last two years, we have benefit from learning new OD skills through a series of micro learning from our OD lead and external specialist consultancy support. We also sought knowledge and experiences through workshops and sessions with TedxNHS, Newton Europe sponsored events with key leaders from various walks of life. This has enabled us as a team to deepen our practice, and to support our system partners to shift their thinking.

Some of the ways we have done this include:

- A regular “OD microskills” blog sent to system leaders to provide simple practices that can be ‘experimented with’ in their own areas
- An OD Tool kit which creates the foundation of our work including
    - Infinite game (Simon Sinek), Elephant & Rider (Chip and Dan Heath), System change (Cynefin model for system decision making (Dave Snowden), Breakthrough methodology (Nowhere), Leading for change (Brene Brown)
- Professional Development half days that have been open to all partners and employees across our Greenwich system where we invite international speakers to explore future possibilities together (e.g. Using technology; imbedding sustainability, etc)
- Regular slowing down as team (within SD and our programmes) to reflect on our work, what we have learnt and how the learning can be fed into future work

Lisa Hancock – System Organisational Development lead

Guest presenters:

Jonathan Smales – Greenpeace / Natural Spaces

Joshua Newton – Ellen MacArthur Foundation

Dr Nicola Millard – Principal Partner BT Innovations

How we improved our flow around the Urgent & Emergency Care System and help our Greenwich residents to get back home ?

An non-covid example of system success was our winter planning. We came together as a group in March 2021 to consider our options with an overlying principle that all parts of the plan should be truly system owned and would not disproportionately disadvantage any organisation, team or individual. We knew that Winter 2021 was going to start early, that we would see people more ill than in previous years as a result of the pandemic and that we had limited resources (money, people and space) to put extra into the system – we had to be creative!

As a system we agreed to focus on admission and attendance avoidance as the core of our Winter plan and move away from a traditional focus on the bed base. We wanted to maximise flow through existing pathways as an alternative to hospital attendance. We agreed we would:

- focus on prevention and admission avoidance schemes
- create the capacity to meet increased demand
- maintain good flow through our pathways
- ensure we have the capacity and capability within our workforce – opportunities for colleagues to work in other organisations to support at times of peak demand
- robustly monitor the system to maintain quality, activity, safety and experience – and provide a framework for escalation and resolution
- be agile to the changing need

Eventually the winter plan began to be enacted in June and together as a system we agreed which elements would have the biggest impact in response to changing needs and when they would be "switched on".

… together we survived two winters!

> "It's a privilege to be part of this group-I have never met anyone in person, but am respected. Its always a space I look forward to. Its well led with good humour. It should be bottled up and sprinkled over London"
>
> **Dr Mike Robinson**

> "Now we understand together-all problems are our problems. In the group there is respect of our responsibilities and positions. Together we demonstrated the power of partnership and created a different type of trust and that matters" **Kate Heaps**

> "Wouldn't have been able to get through it without this. This team of faces as been a massive support without judgement".
>
> "We are no longer defensive-together we work out what we need to do to fix things. We don't have to do things alone"
>
> **Kelly Lewis-Towler**

Mr Gn is a 74 year old Greenwich resident and living an independent life when he experienced a fall which resulted in a hip fracture. He was taken into the Emergency Department by Ambulance and was admitted. During his hospital stay the ward team diagnosed a delirium which presented as difficulties retaining information. During Mr Gn stay in QEH he received care from nursing, medical and therapy staff to support his recovery from the hip fracture, the Mental Health Liaison also visited him to support with the delirium. As Mr Gn was unable to weight-bear he was not able to return to his home which was a private arrangement above a pub, this rendered him homeless and may have resulted in an admission to a care home.

To enable further assessments to be undertaken Mr Gn was discharged to one of our Discharge To Assess beds (D2A) at Riverlee Nursing Home. He stayed there for five weeks where he received ongoing input from the community Physiotherapy and Occupational Therapy teams, Greenwich Social Care, and the Irish Community – all with the intention of maximising Mr Gn's independence. During his stay here an application was submitted for Extra Care Sheltered Accommodation.

Greenwich Social Care have commissioned the use of void properties in Langton Way for the purposes of short stays (usually around one month) for people with minimal health needs who are unable to return home for social or housing reasons. Mr Gn was able to stay in Langton Way whilst his application for extra care sheltered accommodation progressed, he also continued to receive therapy input from the Reablement team, and support from Social Care and the Irish Community. Mr Gn's tenancy agreement has now been signed and he awaits his moving in date.

Jayne Mason – System Development

Kelly Lewis-Towler – QEH, Nick Davis – RBG, Iain Dimond - Oxleas

How can I get better access to Urgent & Emergency Care

The overarching objectives for urgent and emergency care in Greenwich is

- To provide better provision of peoples needs in the most appropriate setting
- Create a sustainable U&EC system across health and social care
- Improve performance across the U&EC system underpinned by a more cost effective, productive and more efficient pathway.

When restriction measures were put in place at the start of COVID (March 20) activity at our ED and UTC provider declined. We supported our UTC provider by ensuring they were not penalised financially for the reduction in activity and in turn they supported the wider system by leading and participating in several Covid Management Service schemes. The pandemic also meant that our procurement process for a new urgent care provider was put on hold and subsequently stopped. An extension to the current contract was agreed to provide stability.

During 21/22 activity has returned to pre pandemic levels and we are now focussing our attention on service improvement. In January 2022 a pilot was put in place at the front door of ED (using winter monies and provided by the Greenwich GP federation) focussing on our see and treat model. The objectives of the pilot were to

- Facilitate timely early assessment and senior clinical decision making
- Improve/reduce times to 1st assessment by a clinician
- Facilitate early referrals to specialities and early discharge

The pilot is continuously reviewed to assess impact and to explore further work that can be done at the front door to improve flow.

As the pandemic eases we have turned our attention to the procurement of a new UTC service for Greenwich with an anticipated start date of April 2023. We will be hosting a co-design workshop in May 2022 and several system providers have been invited. The purpose of the workshop is to co-design what the front door urgent care offer should look like, focussing on

- Flow
- Collaborative working
- Patient experience

As part of our preparation for these workshops we will be having conversation with system partners patient groups and designing an online survey to understand

- What works well
- Current challenges
- Areas and opportunities for improvement

Our objective by the end of the workshop will be to have a co designed urgent care front door which we can include within our service specification for the new service commencing in April 2023.

How we help make diabetes work for our patient than the other way around

Diabetes is a long term condition and our ambition in Greenwich is to enable people to live well with the condition, supported close to their home wherever possible, so they can live their lives to the full!

Greenwich has been successful in gaining new recurrent investment of £733k over three years into the borough to enable more specialist diabetes staff to be recruited as well as funding to provide diabetes education to GP Practices, including being able to initiate insulin where required. This will mean that more patients who would have attended Queen Elizabeth Hospital or the Community Diabetes Team will be able to have their diabetes care and medication reviews carried out in their GP Practice.

Type 2 diabetes can be reversible for some people, particularly when they are in the pre-diabetes stage. Reversal can be achieved through dietary changes together with exercise. The National Diabetes Prevention Programme (NDPP) is a 9 month course of 13 sessions which supports people to make positive lifestyle changes and no longer be in the pre-diabetic range. Moses Zikusoka completed the NDDP in 2021, this course was a group, online programme, which he found informative and interactive. Since completing the course and following the advice given, Moses is no longer pre-diabetic which is a great success story

The clinical roles being recruited to include a Consultant Diabetologist working in both the hospital and the community, an additional Diabetes Specialist Nurse, Dietitian and Psychologist. Whilst we have just come to the end of the first-year implementation this together with NDDP programme is having some impact. Although the more longer-term benefits will take longer after the second and third years implementation.

Diabetes is not just about medication, it is a long-term lifestyle change and as part of the diabetes programme we are working with Public Health, Parks, Leisure and Live Well Greenwich to promote activities that are either free or low cost for people to join, for example, healthy walks, cookery classes, exercise classes and weight loss programmes. The aim is to support people to enjoy what Greenwich has to offer, have a family friendly approach to fun and exercise together and learn new things such as cooking healthy meals together. All of this information will be included on the diabetes pages on the new NHS SE London Integrated Care System website being launched in Summer 2022

Greenwich resident Ana has vivid memories of when she was first diagnosed with type-1 diabetes. She was in her native Portugal, nearing her thirteenth birthday, facing the loss of her grandfather was offered as possible cause for changes in her eating habits. “Sometimes I was vomiting after eating food or eating too much food and drinking too many fluids,” she says. “We had no history of diabetes in the family, but before the diagnosis, my mother began to suspect that may be the reason for what was happening.”

When she was diagnosed, her blood sugars were discovered to be the highest that her doctors in Portugal had discovered in a conscious person, so immediate treatment was vital. This led to her staying in hospital for a week to receive insulin and relevant dietary advice. She took on an upbeat philosophy, even though her diet would be restricted, and she would have to take daily injections. “It wasn’t easy,” remembers Anna. “But there are worse things in life, and I was very well- supported as a child. The approach was quite focused on me doing everything – such as the injections – for myself and taking responsibility, which was empowering.”

Ana then moved to the UK where we had a slightly different way of managing diabetes. She adds: “In Portugal, the focus was more on empowerment, but in the UK, it was more about, ‘I’m a doctor, I will treat you’.” But it wasn’t long before mutual trust developed, and the clinicians she saw in the UK realised that Ana was in control of her diabetes conscious of its management. “I’ve never had a problem,” she says. “I established a rapport, which made everything more plain sailing, and now I go to the Queen Elizabeth Hospital in Greenwich every six months for a check.”

Ana - now married, and a mother of two – says she has learned to live with diabetes in the UK as she did in Portugal. “You’re aware that having diabetes in pregnancy is high-risk,” she says, “and sometimes I did feel like there wasn’t enough information available for those with type-1 diabetes, rather than type-2 or gestational [pregnancy-related] diabetes.” She adds: “When I was pregnant, it was big shift in perspective, and you can feel guilty and worry about something going wrong.”

Ana is convinced that her determined outlook has enabled her to cope with her diabetes and ensure that the condition hasn’t impacted her life negatively. “The way we deal with things is very individual. The weight of responsibility was hard to understand, initially, but I decided to make diabetes work for me, rather than the other way round.”

Michelle Barber – Systems Development
Dr Kishna Subbarayan, Dr Tremble

Skin Matters

Within our Greenwich system we had a challenge to develop a sustainable dermatology pathway which addresses current and future patient/staff needs for Greenwich within a wider system across Bexley, Greenwich and Lewisham and the SEL Dermatology network. Prior to starting the programme, secondary, and community dermatology services worked in isolation of each other, patients were waiting for more than a year for routine appointment, and we were breaching our 2 week wait targets. AS well as long waits there is significant inequality with much shorter waiting times for GSTT and Kings. The services had been through several change programmes, which were not able to address the issues, and staff were demoralized.

In July 2021, we began a dermatology project across Bexley, Greenwich and Lewisham (BGL). Using a co-designed breakthrough question: How do we develop a sustainable dermatology pathway which addresses current and future patient/staff needs within an ICS context …? Dermatology clinicians and operational staff across BGL from acute, community and primary care embarked on a journey to co-design what was needed to achieve this goal and to implement the co-designed 'blueprint'. Over a 9 month period, the group came together over 5 workshops (3 design workshops, and 2 implementation workshops) to co-design Skin Matters, an outstanding dermatology service across BGL**,** and to start implementing the blueprint for change. The implementation blueprint focused on 3 core areas:

- **Back log reduction:** reduce the backlog, with an aim of all patients to wait no more than 14 weeks for routine appointments and less than 2 weeks for cancer pathway (2 week wait) appointments
- **Managing demand differently:** new and different ways of collaborative working across acute, community and primary care to increase the overall capacity and capability of our multidisciplinary team
- **Long-term systemic change:** develop a collaborative, clinically-led Skin Matters service across BGL with a valued workforce and high quality, seamless pathways for patients

We worked with a specialist OD consultancy to employ breakthrough methodology. Given the frailty of the service, we knew that the enabler to this work was the development of deeply trusting relationships to ensure we could maximise the dermatology resources across primary, community and secondary care.

Much of the work was done outside the workshops, where the SD team spent time understanding the different realities of each provider, enabling people to come together to honestly explore their assumptions and biases, and to help people shift their narrative from "hopelessness, and "broken without end" to a sense of collectively hope, ownership and clarity of what is needed.

The breakthrough for this group happened in workshop three when the group was exploring what success looks like and Angelika Razzaque, our GP lead for Lewisham Community Dermatology Service said: "Isn't what is important to all of us is that skin matters?"-in this moment, all the historical organisational boundaries fell away with the collective insight that their commonality was greater than their difference. And so, Skin Matters was born: a collaboratively led dermatology service across BGL which is seen as one team at multiple sites.

> The greatest difference however is how staff feel about their service now. At the beginning we heard staff feeling "hopeless, unvalued and cynical about the possibility of anything changing".
>
> "this is the best thing I have ever done in the 16 years of my career".
>
> **Dr Marie-Louise Daly (Consultant Dermatology)**

Since the development of the Skin Matters implementation blueprint, the team have achieved significant changes in less than 3 months and are collaborating in ways that were considered impossible at the start of the work.

Gemma O'Neil, Lisa Hancock – Systems Development
Marie-Louise Dal Consultant Dermatologist QEH, Nadim Niman GP Communitas (Greenwich)

So, what can we do different for workforce

A key theme in all of the work we have done within the System Development (SD) team are our people. The overriding blocker of our ambitions for system transformation is our people-the ability to attract, develop and retain a workforce that can sustainably care for the people in boroughs. While this is a common issue across all of health and social care, in Greenwich we have experienced additional challenges due to our geographical footprint which means that we fall outside of inner London weighting, a lack of transport links making commuting more difficult for our staff, and the pull of our partner organisations such as Guys and St Thomas and Kings that compete for a small pool of staff.

As a system leadership group, we identified the need to commission SD programme to explore what is needed to attract, develop and retain our staff. We decided to focus on AHPs as a first cohort, and this was a critical workforce group that was preventing us from achieving our Home First ambition to sustainably supporting patients in their own home.

To understand what was needed we ran a series of sessions with Allied Health Professionals (AHP) leads from across all health and social organisations in Bexley and Greenwich to co-design what the focus of the work needed to be. This co-designed paper enabled us to secure funding for 6 months to commission the work, focusing on the identified areas that our AHP leads felt would have the biggest impact in developing our AHP workforce, namely:

1. An AHP system leadership group to work through workforce issues and opportunities on a system rather than an individual organisational level
2. Explore what is needed to develop a robust career development pathway for all AHPs so staff could spend their entire career within Greenwich system, while continuing to progress and develop
3. Operational processes to enable AHPs to work across the system more seamlessly to enable a more agile workforce. This included a development programme to ensure our AHP workforce was equipped and enabled to work in different settings.

To ensure all parts of the system were represented, and that we were able to address issues systemically, we recruited 3 AHPs -all working in different part of the Greenwich system (including acute, community and adult social care) to complete a diagnostic to understanding what is needed to enable a sustainable workforce.

Our AHP workforce leads have spent their time with all levels of AHPs to deeply understand the different needs of people dependant on their organisation, role and grade. The outcome of this work is an insights-based diagnostic which describes the multiple determinant impacting workforce retention across Greenwich, with a range of actions needed to address this in the short, medium and long-term. The success of this diagnostic lies in the approach: focusing on the lived experiences of people that work in our organisations to draw insights to what will truly make a difference. The recommendations offered reflect national recommendations but are nuanced to the people that work in Greenwich. The next step of this work is to implement the recommendations. While this will not be without its challenges, through this work, the AHP workforce team have built the relationships, networks and trust of AHPs which has laid the conditions for success in implementation.

Lisa Hancock – System Development
Kate Leszkowski – Royal Borough of Greenwich, Emily Corrigan – QEH, Emma Woods - Oxleas

How we helped to support Covid vaccination

In the last 2 years, COVID pandemic is triggering the team to reprioritise their work to manage increased demand by pausing QIPP plan but attending to the need of the system focusing on:

1. Supporting vulnerable patients
2. Managing out of hospital demand
3. Vaccinations

We have seen the pandemic accelerated collaboration in some areas, as services came together in creative ways to support shielded patients, care homes and more complex care needs in the community. For example, we worked with local authority and community pharmacy to set up COVID delivery services to ensure shielded patients continue receiving their repeat prescription alongside with their groceries. It is the first time we have every stakeholder primary and secondary care, health and social care, physical and mental health care, who met and decided to establish borough based COVID-19 community pathways and COVID-19 oximetry @home remote monitoring in a short period of time.

As part of the largest vaccination programme ever in the NHS, this is critical work to support the health of our population and the wider prospects for SEL. The vaccine programme has continued to require a considerable commitment from our workforce in all sectors and further established the valuable contribution of all Medicines Optimisation team pharmacists and pharmacy staff in the safe and secure handling of medicines. Within two weeks, we have set up and assured three local vaccination service sites across Greenwich, staff also worked as vaccinators, while more are trained up to the role, with the PCNs and GP federation.

Staff has been redeployed to work at GP practices to help keeping the medicines supply chain functioning and supporting patients with medicines related queries and setting up electronic repeat prescription request. More recently, pharmacists are at the heart of delivery models for Covid 19 treatments including monoclonal antibodies and antiviral medicines through the SEL Covid Medicines Delivery Unit.

In the summer of 2021, there was a drive to run significantly increase the number of people with second dose. Many systems turned their attention to mass vaccination events within their Integrated Care System, to with South East London was no different. We were asked to help set up and run some mass vaccination events with some very short run in times.

As a SEL system we often work well together as a single system in the face of common challenges …. And this was a challenge ! so we co-developed a proposal for gold that identified multiple sites across SEL with a short list of three to take forward. These were Millwall Football club, The Tate Modern and the Oval. As you can tell none of these were in Greenwich, but given our skills and experience in working through relationship we were able to provide leadership to getting these events of the ground.

We had the complete privilege to work with some fantastic people in Southwark, Lambeth and Lewisham where the medicines and primary care came together and we delivered the three mass events. These were done at very short notice, for example within two and a half weeks we started and delivered the event at the Tate Modern. This event soon became not only a mass vaccination event, but also raised the profile and energy of our population to get their second dose with support from the mayor of London but also a huge thank you to all six of our South East London borough teams for all their incredible work in the programme.

What can we build differently?

The last two years have been both challenging and exciting in respect of our built environment across the Borough and against a background of service transformation; the securing of resources; the COVID – 19 pandemic; and an extensive new agenda around creating sustainable environments.

Our "flagship" development, the Kidbrooke Village, Block D Health and Well Being Centre is scheduled to achieve Practical completion at the end of July this year and to become operational in early August following the final commissioning phase. This is "flagship" development not only for Greenwich but in the wider South East London and Greater London context and is one of the first projects that has represented genuine joint and integrated working between Health and the Local Authority from inception through to completion. The Project is the first Project to be procured through a Section 2 Non Works Contract Agreement (which ensures the long term safety of tenure for the NHS in respect of the use building) and is the first building in South East London, and indeed Greater London, to be procured and commissioned though this route.

The strategy for the Kidbrooke Village, Block Health and Well Being Centre was co-designed by South East London Clinical Commissioning Group – Greenwich and the Royal Borough of Greenwich with emphasis being upon health and wellbeing; service transformation; reducing hospital admissions; providing care closer to where people live; and within a built environment that will enhance the experience for every individual.

Sustainability, and long term sustainability, has been one of the key objectives for the Project and has achieved a rating of BREEAM excellent.

We have exciting opportunities ahead to transform out built environment across the Borough and in conjunction with our partner organisations as follows:

Gallions Reach Master Planning Project

Having secured funding through One Public Estate in March 2021, we are now in the final phases of producing the Master Plan for the Gallions Reach site in Thamesmead. The opportunity to develop the whole of the Gallions Reach as a multi-use provides significant added value in respect of not only being to develop a further health and well being centre within the Borough but with the added to potential to deliver affordable / key worker housing. The Gallions Reach Master Planning Project is also significant and is providing the focus for our sustainability objectives which are extending far beyond the built environment and into sustainable communities and the circular economy.

Feasibility Studies / Options Appraisals

We are currently engaged in two Feasibility Studies / Options Appraisals relation to the Millennium Health Centre and Plumstead Health Centre and expect to be reporting on both over the course of the next three to six months. The Millennium Health Centre Feasibility Study / Option Appraisal is against the background of the Lease on the Premises expiring in 2029 (at which point the Health Centre will be 25 years old) and the number of new developments planned for the Peninsula through the same period where we have the opportunity to secure new Premises or to secure s106 funding to support Primary Care infrastructure Projects.

The Plumstead Health Centre Feasibility Study / Options Appraisal has been designed on a similar basis , to look at the site as a whole and with the potential to view the site as a multi-use site where value can be added. The existing Plumstead Health Centre, and whilst it has served the community well, is now very dated and does meet any of the expected standards for modern Primary Health Care Premises.

We are working very closely with the Local Planning Authority in respect of major Planning Applications being presented to the Authority and where there are significant opportunities to work alongside developers to secure premises or s106 funding as mentioned earlier in strategically important locations within the Borough ie/ Charlton Riverside / Peninsula

The development of Primary Care Networks is a key theme running through the built environment and has been identified as one of the key enablers to deliver the extensive additional services planned to be provided under the Primary Care Network banner. Initial survey has now been completed and it is the intention that this initial work be built upon over the next 12 – 18 months.

The Greenwich Local Estates Forum (LEF) has been revitalised over the last 12 months and with a new and challenging Agenda replacing what was Forum where Estates people reported to Estates people. The new Agenda is principled upon integration; joint working; joined up strategic thinking to inform the future of the build environment; and sustainability

How can I get my bloods done

We were asked to help resolve the challenges patients were facing with accessing phlebotomy within our system. It was clear that the work was around short-term recovery, to ensure that the immediate clinical risks could be mitigated – the central SEL planned care team had indicated that they would lead the longer-term strategy around phlebotomy. There were three underlying issues;

- Mismatch between demand and capacity – demand difficult to measure
- Overwhelmed telephone contact service (space constraints, volume of calls)
- Lack of pathway for urgent blood requests – reliance on patients to advocate the urgency of their referral
- Lack of community phlebotomy in central Bexley.

There was also an inherited view that this was a Lewisham and Greenwich Trust issue "So what are they doing about it" which was fuelled by multiple complaints via MPs and local councillors.

The first step was to identify the right people across the system to support with the rapid change that was needed. A small group was convened with representatives from primary, secondary and community care alongside commissioning colleagues.

From there, weekly meetings were informal but focused on understanding the root causes of issues and the opportunities for improvement available. There was a light agenda and, as the work developed, an action plan that was populated and reviewed in the meeting.

The work delivered;

- an increase in capacity of 10%, by working together to find space to host phlebotomists in the community
- The offer of a next available appointment within 72 hours to all patients (from a median wait of 7 days – but often much longer) – negating the need for a separate urgent referral pathway
- The introduction of an online booking system for phlebotomy which eliminated the call centre step in the pathway
- Commissioning of the Bexley Health phlebotomy pathway to increase the phlebotomy community offer in Bexley.

What made the difference?

- Clarity around the focus of the group (short-term turnaround of the waiting time position)
- Broad membership of the group and a keenness from all sides to find a solution
- Context setting – it was made clear from the outset that this issue was a system issue, not an organisational issue. It was also explicit that the history of phlebotomy, and how and why this situation had arisen, was not to be a focus of the work (given the unique situation we found ourselves in during the pandemic). It simply wasn't helpful in finding a solution to the immediate issue.
- Dedicated time – having someone to coordinate the programme and to spend time working with members of the group in between meetings to make sure action was taken swiftly and to monitor the impact.
- Respectful behaviours and challenge within the group.

Neurorehabilitation

Within Greenwich we have faced significant challenges in delivering our neurorehabilitation services this was mainly due to lack of investment in the service over several years together with increases in demand and acuity. In 2021 we were successful in working with South East London colleagues to secure additional recurrent £1.1m investment into Neurorehabilitation services over three years. We have had successful recruitment and on track to deliver phase one of the South East London Neurorehabilitation network plan.

The following is a reflection from Annie Norton who led this piece of work.

"It was a pleasure to get to know the Oxleas Community Neuro Rehab Teams and to support them in driving things forward within Phase 1 of the Neuro Rehab Core Offer. Despite the prolonged period of dealing with COVID-19, which was very tough for front line staff, team members remained absolutely committed to do undertake the best possible work to improve services for patients, much of which was centred around recruiting to increase capacity, as well as building stronger working relationships with local acute partners, to reduce waiting times for patients and to respond to needs in the most effective way possible. I felt very privileged to be a part of such important work and to be able to facilitate and enable those on the front line, as well as in management roles, with their role in delivery against respective elements of the Core Offer.

I always felt very well-supported by the whole System Development Team in terms of being able to ask for help with specific things, as necessary, and in the wider well-being sense. The safe space to talk things through was particularly welcome and a refreshing change Such a great team to be a part of – leadership as its best (relationships) with great results to-boot (task)."

A Greenwich patient story from Amy (Rotational Therapist within Neuro rehab team)

A retired Greenwich gentleman who was fully independent prior to his stoke on 9th October. He spent 28 days in Lewisham Hospital and was discharged home with package of care 4 times a day to support with personal care and meals. He was seen by the Early Supported Discharge (ESD) team and identified goals to be able to cook for himself and to be able to walk to his local shops and his local barber for a haircut. On assessment he was able to walk indoors with a quad stick but was not walking outside. He had muscle tightness at calf's, scoring 2/5 on Modified Ashworth Scale which impacted his walking. He scored 3/6 on the modified Rankin Scale.

The team (Physio, OT and Rehab assistants) worked with him on ADL practice, cooking prep, mobility practice, exercise prescription (strengthening, stretching, coordination, and balance). Equipment was provided to help with bathing. The team provided an ankle foot orthotic to help manage foot drop and a resting splint for his shoulder. The team liaised with gentleman's GP about his needs due to his muscle tightness and were able to reassess this after his medication change. Unfortunately, his tightness was still problematic and so the Team requested that the GP refer to a neurologist for specialist management of his muscle tightness

Upon discharge from the ESD team the gentlemen regained the ability to cook basic meals for himself and was able to live independently without need for any carers. He was able to walk to his local barbers to get the hair cut he desired. He was able to walk outdoors with a normal walking stick. He scored 1/6 on the Modified Rankin Scale. Referrals were made to the GP for medication for spasticity management and referrals for review by consultant neurologist for longer term spasticity management.

So, what next ….

As well as developing and refining our skills the last two years have presented us with multiple opportunities to move further into system quicker that we had initially hoped for. We were able to secure additional funding both recurrent and non recurrent across multiple work streams, see improvements in our performance, and start to reduce some of the inequalities that still reside within Greenwich. We hope that you have seen the benefit of these both within your teams and the stories that have brought them to life. We now continue to evolve our approaches and strategy for the next year, with the agility to be comfortably uncomfortable together as we go through a series of unknowns to get break through in our wicked issues. As we move into the next year we will be focusing on tackling in equalities, improving outcomes and performance through;

- Year two implementation for Home First including Eltham, Neurorehabilitation, Diabetes programmes
- Next stages in our Confluent areas:
    - Completion of Skin Matters business case
    - Start Gynaecology and possibly Neurology
    - Completion Community Diagnostics for Eltham
    - Next step on Cancer with SEL Cancer network
- Next stages in our Resplendent areas:
    - Re-procurement and development of Urgent Care
    - Next steps in respiratory including long term respiratory initiative funding; End of Life
    - Very excited to be implementing a new approach to Allied Health Professional workforce in conjunction with Home First, Oxleas, Queen Elizabeth Hospital and the Royal Borough of Greenwich.
    - Get ourselves ready for what ever winter 22/23 and covid is going to throw at us !
- We have terrific untapped and talent resources in our neighbourhood programmes of work through both our populations and teams that support them. As public health data has shown us for over twenty years the top wider determinants of health have nothing to do with health! We would love to bring our approach into the neighbourhood programme so we can get great system working for our residents of Greenwich with the combination of health and care through our neighbourhoods.
- Follow up on initial conversations about some System Development work for Integrated Children's, Oxleas and Queen Elizabeth Hospital.
- Our Integrated teams in Greenwich have expressed an interest in, to quote one of my colleagues, "sharing the love" of our approach so we can get greater benefits and outcomes for our Greenwich residents.

We continue to see increased financial pressure across health and social care as well as within our population. This will undoubtedly mean we will be asked to deliver more for less money in an uncertain and everchanging world. We recognise that this will mean increased pressure on cost savings which drives a cost mindset. However, to deliver this on a sustainable basis we still need investment and innovation ……. All this means we want to build on our advocating experience to strengthen our capability to become more catalytic in supporting systemic change across both the Greenwich system and our wider ICS System of Systems.

We look forward to continue to work with our colleagues across health and social care to keep building from neighbourhood into place and scale where appropriate. It has been a real privilege to be given the license to work in this in service to the residents of Greenwich.

Systems Development team May 2022.

System Development team look back for Healthier Greenwich Partnership

Robert Shaw

	Greenwich						Bexley	Lewisham
System development programmes with a non urgent care theme for Greenwich residents and patients. Given common providers, these schemes are delivered in collaboration with Bexley and Lewisham through system meeting Confluent. The main focus is the interaction between primary care, secondary care and community with referrals.	Confluent							
	Phlebotomy	Skin Matters	Gynaecology	Diabetes	Diagnostics	Cancer		
	Community diagnostics	Neuro rehabilitation						
	SEL Planned Care Board (awaiting new TOR)							
	SEL diagnostics modality meetings and boards							
System development programmes with an urgent care theme for Greenwich Residents and Patients. Given common providers we work these schemes together with Bexley through system meeting Resplendent	Resplendent							
	Respiratory	Waves of Covid	End of Life	Home First	Intermediate Care	Urgent Care (UTC)		
	ED and emergency flow	Allied Health Professionals						
	SEL Urgent & Emergency Care Board							
The system development team retains some commissioning responsibilities for Greenwich.	Hospice	MSK (Circle)	Urgent Treatment Centre	Primary Care for Care Homes	Adult community Services (various)			
Pure Greenwich system development programmes in isolation from other boroughs	**Pathways**	**Estates**		**Medicines Management**	**Clinical Leads**			
	Lymphoedema	Gallions Reach		Covid Vaccination support	Management of clinical leads. Recruitment of new system leads.			
		Local Estates Forum						
		Kidbrook Village						

System Development programme leadership

Who	Greenwich programmes of work	System meeting	SEL ICS
Gemma O'Neil, Deputy Director	Skin Matters, Gynaecology, Phlebotomy, Cancer	Confluent	Planned Care; Cancer
Jayne Mason, Programme lead	Home First, Eltham, ICB, Commissioning (various), PC for Care Homes	Resplendent	
Michelle Barber, Programme lead	Diabetes, Respiratory		
Erica Bond, Programme lead	Urgent Treatment Centre, Commissioning (various)		
Annie Norton, Programme lead	End of Life, Neuro Rehab		Neurorehabilitation
Lisa Hancock, OD Lead	Organisation Development, Allied Health Professionals		
Joanne Hare, Programme Support	Diabetes,		
Kirsty Nash, PA and project support	PA support, Home First, Lymphedema		
Kirsty Ayton, Project Support	Respiratory, Diabetes,		
Malcom Brydon, Estates lead	Gallions Reach, Kidbrook village, Local estates forum		Estates forum
Jin On, Medicines Opt lead	Medicines Optimisation, Covid vaccination		Medicines Mgt
Robert Shaw, Director	Director, Community Diagnostics, System flow and covid waves.	Resplendent; Confluent	A&E Delivery Board; Diagnostics Board; Community Provider Network

Is there one golden thread ? …. Yes ….. Organisational Development ….

Where we hold ruthlessly to task BUT *through* relationships

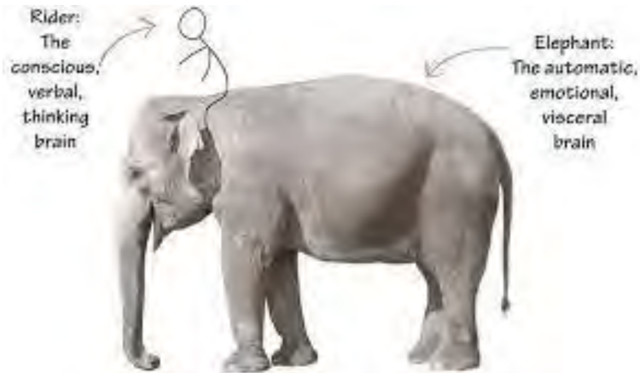
The system development approach is underpinned by theory, tools and an approach to enquiry;

- Tool kit – Infinite game, Elephant & Rider, Break through, relationships of Trust
- Ensuring OD is embedded within all work programmes and available to all stakeholders in system
- Professional Development Days for wider system and Micro learning for system
- New & emerging methodologies
- Evaluation

So …. we use a series of OD tools that help create relationships that allow us to work across the system, to go on a roller coaster of innovation and co-development together where we are truly accountable in a system rather than as a group of organisations…

…and most of all work differently through "Breakthrough" which gives us insights, supports us to re-pattern behaviours and beliefs such that we can no longer think in the way we thought before.

How we make decisions



Psychologist Jonathan Haidt – Elephant & Rider concept

+

How we work together

Finite Games	Infinite Games
Known players	Known and unknown players
Fixed rules	No agreed-upon rules
Game ends at a certain point	Game never ends
"Winners" and "losers"	No such thing as "winning"
"What's best for ME?"	"What's best for OTHERS?"
Focus on stats (followers, fans, $$)	Focus on legacy (quality writing)

Simon Sinek

+

How we breakthrough to something different

Ashvin Sharma
www.now-here.com

Healthier Greenwich Partnership

AGENDA ITEM:

Healthier Greenwich Partnership

Date: 12 May 2022

<table>
<tr><td>Title</td><td colspan="2">Public Engagement and Communications discussion paper</td></tr>
<tr><td colspan="3">This paper is for discussion and approval.</td></tr>
<tr><td>Executive Summary</td><td colspan="2">The paper sets out options for the Committee to discuss for holding future meetings of the Healthier Greenwich Partnership in public and other ways of engaging with Greenwich residents. It also has proposals for future partnership communications and public engagement.</td></tr>
<tr><td>Recommended action for the Committee</td><td colspan="2">The Committee is asked to discuss the areas outlined in the paper, consider how to make best use of the Let’s talk health and care SE London platform, agree the preferred option for future HGP meetings, and approve proposals to:
• establish a HGP Public Engagement Steering Group
• transform the Greenwich Covid Comms group into a HGP Communications Steering Group</td></tr>
<tr><td>Potential Conflicts of Interest</td><td colspan="2">None arise from directly from the report.</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td rowspan="3">Impacts of this proposal</td><td>Key risks & mitigations</td><td>The major risks are that HGP:
• doesn’t meet it’s legal and statutory requirements for public engagement
• fails to engage with and adequately involve our diverse communities to reduce health inequalities.</td></tr>
<tr><td>Equality impact</td><td>Not required for the direct purposes of the report, however the proposals outlined will help support work to reduce inequalities.</td></tr>
<tr><td>Financial impact</td><td>There are likely to be some financial implications eg to carry out the branding work and implement the HGP Communications Strategy. These will be outlined at a future meeting.</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td rowspan="2">Wider support for this proposal</td><td>Public Engagement</td><td>The paper outlines details of activities to engage with patients and the public have been engaged and consulted.</td></tr>
<tr><td>Other Committee Discussion/</td><td>Not Applicable</td></tr>
</table>

Healthier Greenwich Partnership

	Internal Engagement	
Author:	Russell Cartwright	
Clinical lead:	Not applicable currently – a clinical lead for this work may need to be identified.	
Executive sponsor:	Jackie Davidson	

Healthier Greenwich Partnership

Public engagement and communications discussion paper

Public engagement

The Healthier Greenwich Partnership is keen to engage with Greenwich residents in a more meaningful and coordinated way. This will enable us to make better decisions and to take positive actions to improve health and wellbeing outcomes and reduce health inequalities.

SE London engagement infrastructure and resources

In Greenwich we will link in with and draw on the support of the south east London engagement team as well as wider partners. Our local HGP work has informed the development of ICS working with people and communities strategic framework and our proposed approach set out below reflects and fits in with the framework. We will explore methods and approaches currently being developed including the Let's Talk Health and Care South East London platform.

At an SEL level there are established groups such as the Engagement Practitioners Network and the Engagement Assurance Committee. There is also likely to be an additional System Level Engagement Planning Group which will be chaired by a senior leader from the ICS. We will ensure the links between local and system level work are joined up and make the most effective use of our resources in line with the principle of subsidiarity.

Let's talk health and care in SE London

The SEL engagement team have developed a digital platform to engage with residents which brings great opportunities for use by HGP. The Let's talk health and care in SE London platform is being promoted to all SEL residents and includes functionality such as surveys, open and closed chat forums, question and answer function, quick polls, maps and can include video clips and photos and discussion questions.

On the platform there is a Healthier Greenwich Partnership Hub which we could use for HGP projects and developments. This also gives us an opportunity to engage with residents to provide insight to the HGP meeting. For example we could post about topics to collect insight ahead of their discussion at HGP. We could also ask questions about agenda items in advance of meetings and use the platform to ask residents to tell us what is important to them. This insight could be reported to the HGP meetings.

The HGP is asked to consider how it may wish to best use this platform

Healthier Greenwich Partnership

Working together to plan and deliver engagement activities

In Greenwich we share the SE London need to shift from sporadic, set piece engagement to continuous dialogue building on the good foundations that have been built in partnership work in response to the Covid-19 pandemic. We would like to achieve active, continued involvement in our work, building on the strong local foundations through initiatives such as deep engagement work (neighbourhood champions and communities of interest) and Community Champions.

In many HGP partners public engagement and involvement activities aren't carried out directly by staff from the communications teams. As part of the south east London approach we are developing toolkits, how to guides and templates to assist all parts of the system to carry out engagement work. We are also developing criteria for assessing how we decide the level of engagement input.

The proposal to the HGP is that a HGP Public Engagement Steering Group is established. This group will enable partners to plan ahead jointly, increasing collaboration and coordination, share good engagement practice, share insight and to align plans and activities where possible. This will also ensure that we better use the intelligence gathered through these engagement activities and minimise duplication.
The HGP is asked to endorse this proposal.

Engaging around the HGP meetings

Guidance for local care partnership boards in SE London has yet to be released however we expect that there will be no formal requirement for HGP to meet in public as the constitution doesn't prescribe this, however it is likely to be expected that partnership boards are held in public to be open and transparent.

Greenwich Borough Based Boards have been held virtually in public for the past two years with opportunities to ask questions at the start and the end of the meeting. Typically these are attended by a small number of well informed and passionate residents. As a partnership we would like to achieve more local accountability to members of the public and broaden our reach whilst remaining open and transparent. It is difficult to encourage people to attend formal meetings and it is challenging to make the content of meetings accessible and meaningful. Engagement reports should form a key part of programme board papers to support decision-making. Engagement planning should also be built into programme initiation and documentation.

Options:

1. HGP meetings adopt a similar approach to Borough Based Boards previously – meetings held in public (virtual or a mixture of virtual and in person if possible) every three months with opportunities for residents to ask questions
2. HGP meetings are held in public (virtual or a mixture of virtual and in person if possible) every three months with no opportunities for interactions with the

Healthier Greenwich Partnership

public at the meeting. Members of the public will be invited to submit questions beforehand which will be responded to at the meeting.

3. HGP meetings are held in public every three months with no opportunities for interactions with the public at the meeting. Engagement will be carried out beforehand on the Let's talk about health and care in SEL platform and we will explore setting up quarterly informal public open forum sessions where people have the opportunity to raise the issues important to them away from formal meetings at an accessible time. This activity will be reported to the HGP.

The HGP is asked to choose a preferred approach from the options outlined above and then a group will be set-up to develop this in more detail.

Communications

Promoting the HGP Local Care Partnership

As we move to the ICS/ICB it is important that we develop, build and enhance the HGP brand within our communities, and with key stakeholders and use this to communicate the local work of the partnership.

The proposal to HGP is that some work is done to develop the branding of the partnership and use this to raise awareness of the new joined up approach to healthcare for residents.
The HGP is asked to endorse this proposal so work can start with an update to come to a future meeting.

Collaborating to communicate about partnership working

In Greenwich we have a well-established Covid communications group which is jointly chaired by the CCG Comms lead and a Council Comms lead. The group was set-up during the pandemic to share and align key messaging and support each other. At one stage it was meeting twice weekly. Currently, the group is meeting monthly. Membership includes: CCG Comms, RBG Comms and public health, Oxleas, LGT, Greenwich Health, Healthwatch Greenwich, MetroGAVS, Chamber of Commerce, Charlton Athletic Community Trust, University of Greenwich and London South East Colleges.

The proposal to Healthier Greenwich Partnership is that this meeting becomes a HGP Communications Steering Group. This group can then oversee the development and delivery of the HGP communications strategy and plan.
The HGP is asked to endorse this proposal.