**Douglas Hamandishe:**

How you doing Richard?

**Richard Wyatt-Haines:**

I'm very good. Good afternoon, Douglas. Good to see you.

**Douglas Hamandishe:**

Well, you know what? I'm always happy to see you today. And, um, I'm super excited to have this conversation cause we've got somebody in the house that's going to really bring the conversation to that human level.

**Richard Wyatt-Haines:**

Yeah. Yeah. Up to now we've been sort of more about technology and system today. We come at it from the patient perspective and absolute, really, really important piece in this jigsaw. Um, and so for the first time we can go dig into that with Jonno broad, um, from NHS England, should we get him on stream and get him going reckon let's do that straight away Jonno. Good afternoon. And welcome to think big act now. Absolutely delighted to have you here. Um, quick intro, who are you, John? What do you do?

**Jono Broad:**

Uh, Richard. Good afternoon. Absolutely brilliant to see you. Great to be with both of you today and thanks for the invite. God, who am I? And what do I do now? That's a question and a half. Isn't it let's start with the easy. Um, my name is Jonathan board, but everyone calls me Johnno. And the easy way to remember that is just think of my mother. All I ever heard was John. No, I just thought it was my name. So that's me as an introduction at what do I do? I have the great joy and privilege of working with NHS England here in the Southwest. I live and, uh, Harold from Devin, uh, and have the brilliant joy of working across the whole of the Southwest region. And I worked specifically with a group called the integrated personalized care team. And we literally look after everything thinking about the patient experience.

**Jono Broad:**

What's the patient going to get the most out of. And the reason I have the, I call it a great privilege is because I am somebody who will say I'm game turned gamekeeper because for my entire life, I myself have had a long-term health condition. I have cystic fibrosis. Um, I have had the privilege of both being killed by the NHS and revived by the NHS. So they're on a good record so far because I'm still here. Um, and I transitioned over 25 years of being a volunteer, doing things for the NHS as a volunteer, and then somebody was silly enough to offer me a contract. And so I decided to start working with them formally. Um, and so, yeah. Um, and funnilly joined NHS England on the 1st of April. So you might as well say it is an April falls that I'm actually working with them.

**Richard Wyatt-Haines:**

So what are, what a patients think from what you're seeing of what's gone on over the last year, particularly backlog, the rollout of technology at speed. What's the, what struck you? What are the headlines?

**Jono Broad:**

So the first of all that the headline has to be how grateful people are to the NHS that under such struggle under such heavy workload, they were still there for us. Things may have changed and yes, we've moved much faster in the ways of technology, the way that we engage via things like this, this wonderful video conferencing or telephone conversations with our clinicians and with our GPS. Um, and for some people that's been really scary for some people it's been an inconvenience rather than a convenience, but for others it's been an absolute joy. Uh, the realization that you don't have to go somewhere, spend hours on the road, uh, in order to get to a hospital appointment. But actually you can sit comfortably in your own home and have those conversations openly. Um, and the importance of course, is that those conversations are held in a, in a way that's supportive and caring. Um, so for me to, to those that have cared for me personally, I love you dearly. Thank you ever so much from your patients. I think the overall response would be, we are overwhelmed and grateful for every second you've done for us.

**Richard Wyatt-Haines:**

You, you touched on something there that, uh, issue about doing something from your own home and connecting with your carer in that way. You almost imply a greater intimacy, but I'm not, I don't know if that's what you intended or not, but that's because a lot of people would say technology actually removes intimacy and treats everybody the same, but is that so

**Jono Broad:**

In some ways I remove some of that intimacy. You you'll see my background today. It's got the logos of places that I work and organizations that I'm proud to be a part of, but that hides something that hides the fact that I'm sitting in my garage, um, off for some people who don't have that we are actually now inviting healthcare professionals into our own home because they can see our living environment. And actually that's unusual. That's not how we used to do it. We used to go and attend and be in a very clinical environment. So it has changed the dynamic. It's changed the dynamic of how certainly for me as a patient, I feel, um, and I'm welcoming people into my world, not being welcomed into theirs. Um, and so for me, it does change that dynamic and, um, it is more open. You

**Douglas Hamandishe:**

Feel that there's, this changing dynamic has also changed the patient clinician relationship. Um, we will, the energy has its own spotlight all the time. I have a lack of resources, um, people to actually deliver care and the patient is an untapped resource for want of a better word or expression. So it's a two-fold question one, in terms of some of the technology that's been brought in through the COVID pandemic, um, home consultations, which are consultations, do you think that's going to stick and also the role that patients will then play?

**Jono Broad:**

Yeah, absolutely. So let's take those two things slightly differently. Um, will the technology stick, I think it has to, and the reason I think it has to is that let's, let's think about both the human experience of healthcare and the wanting of people to, to be involved in their care. Um, but also let's think about the planet on which we live. Can you think of the carbon footprint that's been saved to stopping patients and staff, having to drive to certain units all the time and the fact that actually we've got an environmental saving by doing it the way we're doing it. Um, and as far as the other technologies, um, a lot of people

are saying these technologies were introduced due to COVID actually, these were there beforehand, but hadn't been as widely used or widely introduced. Um, one of those for me are the access to the care records that patients now have.

**Jono Broad:**

They were there pre COVID, but we've used them so much more. And it enables me to be properly involved in the, uh, looking after my, my care record, my notes, understanding the medication that's being given to me much faster ordering of medication. Um, as an example, this week alone, uh, ordered medication one day pharmacy phones, the next is ready and done that used to take five days to a week because it used to go via fax and get sat on a side for however long lost it. Wait, know all of the technology advances we've got to keep because of the benefits that they really are giving. And the key for me will be how we keep them and ensure that patient experience is improved by them rather than keeping them just because they happened to be nice.

**Richard Wyatt-Haines:**

Excellent. In general, I hear clinicians, healthcare professionals at times say, oh, well, my patients won't use this technology. Uh, and they sometimes make an assumption about age or their socio economic background or whatever. It makes no words. I worry that that's an assumption, but who who's who's right. Who's wrong. What's your sense of what's going on?

**Jono Broad:**

So let's get right back to personalized care. Um, I believe that the future will be a personalized choice. Has this worked well for you? Do you like it let's use it did the previous way of doing things work well for you? Why can't we have choice in how we attend? Do you want to attend digitally? Do you want to attend by phone T want to attend in person let's give option and choice to patients in all that we do and not make the assumption that it's for one, that's also remember that in the UK, somewhere between 13 and 20% of the population do not have either capacity or access to digital. Now we have to understand that you cannot shut out a part of the population by making a choice to only do things in a new modern digital world. So we have to ensure that we are caring for everyone equally and with equity. And for me, that's about choice and about ensuring that the discussion is had openly with patients to ask them, what is it that matters to you? How am I going to serve your needs best? And then we serve them in that way.

**Douglas Hamandishe:**

Sure. And all in all of those, those things you mentioned there almost reshapes the patient relationship, being the word patient. I think you touched touch upon consumerization of health, where you view people as consumers, as opposed to patients per se.

**Jono Broad:**

Uh, I'm very conscious of the, of the word consumer, because it immediately brings people's thoughts to an Americanized system or to a financially based system. I would much rather be talking about patients as partners within their healthcare. Um, that the classic for me in the old medical model is when we talk about, um, the, the way in which we get, um, uh, teams together to discuss patients. And it's the clinicians that get together or the support teams and the person that's missing always is the patient. And actually I'd rather be looking at multidisciplinary teams and saying they should be occurring with the

patient at the center of them. Actually in-person present able to be a true partner in their healthcare. So for me, it's much more about we've become partners in what is making our health better, that, and the, um, maternalistic, motherhood and apple pie, old style of healthcare, which was, I am the clinician I trained for however long to learn this stuff. So I'm going to tell you what to do. And I often like to point out to the people that try and do that. And there are still some, unfortunately that do that whilst they trained to become a clinician. I trained to become a patient say for 50 years now I've trained to be the patient I am. Yes, yes. Which is an awful lot longer than you train to be a doctor.

**Douglas Hamandishe:**

Yeah, yeah, absolutely. Absolutely. That's a good to be a partner. Yeah. And just, just to underscore the partner side of things is partners based upon eco 14, as you were saying, at least because, um, patients by lived experience and condition by academia, if they're both respected equally, only would yield better outcomes. Moving forward.

**Jono Broad:**

Douglas, I'll ask you a question. Have you ever been on a Seesaw with your kids?

**Douglas Hamandishe:**

Yes, I have. Yeah. Yeah.

**Jono Broad:**

Okay. Is there ever fun being on a Seesaw and making sure that the other person's feet never touched the ground and you don't change position? Yeah, it doesn't work. And I've got to admit, there are times in life where I want the clinician to take over and to give me the cow I need, because I don't feel well enough to engage in it. That's me at the top, at the bottom of the sea. So with the clinician supporting me and equally, I want times where I want to be in that power position where I can say, Hey, look guys, I'm doing really well at the moment. Can I make amendment to X, Y, or Z within my health care plan? And so we, we flex, um, our position, but it is equal. It is pivotal and equal. And for me, that is key to how we need to start dealing with each other. It's no fun being on a Seesaw when somebody else's is keeping your feet off the ground

**Richard Wyatt-Haines:**

Jono though, that's very demanding. What you've, what you've touched on there is, uh, a switch to make digital available alongside all the other medium for engagement that may exist, the ability to engage with the patient and discuss their options of which medium to use, and then to bring the patient in as an equal partner, as opposed to the matriarchal subservient model that we often operate. Now, that's a hell of a shift for the system, if you don't mind me saying and for patients. Um,

**Jono Broad:**

So as far as the end, the change from digital to physical or the, or the balance between the two, have you ever been in a doctor's office where there hasn't been a computer? Not me personally, or certainly not for a very long time. So the shift is easy for them, if they are able and willing to learn the technology, as well as the patients are having to learn that technology. And if they're willing to engage in it, I see no

issue with the shift to digital for clinicians. And actually I think they, they are doing a very good job of shifting very fast. Um, I think more likely they're likely to go, why do I have to go back to clinics and, and have people trailing into the room every time. Um, and, um, as far as other issues go, um, for me, if you want to get the best outcome for your patients, you have to involve them. You have to ask those questions of engagement. Again, I'll use my own experience. When I come up against doctors that don't want to do that, I actually stopped engaging with them. I then pull back and I'm more likely to have a worse outcome because the relationship's not like

**Richard Wyatt-Haines:**

The nub of this, which is the relationship then, is that the w we, we tend to talk in this series. Don't we about tech think big act. Now we think about tech, but actually what you're saying is no, it's something else that makes this work. Tech might be there, but it's something else

**Jono Broad:**

Technology can only ever support it. It is there to give emphasis to an ease of access, but what is it giving ease of access to? It's giving the ease of access to another human being who is going to look at you and care for you in a supportive way, and offer you the support that you as a human being need. Um, when I, when I used to work, um, with the Southwest academic health science network with other organizations, uh, we constantly talked about what's the patient experience or what's the staff experience, or even well, what's the whole community experience. I'm working with a wonderful organization now in the states called the Bowen Institute, and they've decided to let's crush those silos. And let's actually talk about the human experience. Let's transform the human experience of healthcare and stop siloing people and actually deal with each other, human to human. Everybody has an interaction with health care at some point in their lives. And if we only did it as human to human, rather than siloing people, we would see outcomes which would far outweigh any cost or negative benefit that would be happening. And I think we've got a great opportunity. Um, COVID forward its horribleness has given the NHS and the population of the UK, an opportunity to do it differently. And we've got to grasp that way.

**Douglas Hamandishe:**

I was going to ask you very quickly in terms of, um, the opportunity that you're talking about and also education, because you, you know, the example you gave of a condition, being resistance to the, um, changes in patient empowerment, is there room for re-educating the educators so that, you know, the new breed of conditions come in with a different ethos, dif a different philosophy that can really embrace innovation.

**Jono Broad:**

Yeah. So I really think there is that the difficulty with the way that the system is currently set up is that the educators of clinicians are clinicians. And quite often it's older clinicians with a lot of experience sharing their experiences. What I would like to see is, again, a partnership between patients, families, carers, the community, and having them involved in the training of GPS and the training of doctors and the training of nurses. And in every single course, we should be placing before these people, large swaves of people that are experiencing healthcare in the present right now and asking them to share their experiences. We really shouldn't be all about the degree or the, or the university time we should be about the people and what the impact and the outcome is. We have to mix and measure those two things equally good as

**Richard Wyatt-Haines:**

Well. Can I take the other side of education and engagement, because I think there's a, there's also, uh, a factor that points to the patients and the patient's role in this less matriarchal, as you say, how does that shift John? Because actually that helps us in a way to get through the backlog, to deal with these numbers that we're facing, because I think you're alluding to a different model altogether here. So where's your thinking on that?

**Jono Broad:**

So, um, the joy of working with NHS England is we like to name things and we like to give things titles. Um, and currently the discussion is about, uh, waiting. Well, we know that the backlog has been caused that we have a ma I mean, 5 million people currently on the waiting list for non-urgent elective care. Um, do you want to wait, do nothing? And by doing nothing more than likely be worse by the time we actually get around to helping you and dealing with you by what you need now, or can we help you as patients to really grip the problem, help you via things like therapy, physio, physio therapy, occupational therapy, uh, talk, talk therapies, give you tools as a patient that if you actually work with us as health professionals, we'll actually be able to make your waiting period and a positive experience rather than a negative and more than likely stop the deterioration from where you are now to where you will be when we do have an opportunity to really give you what you need. So waiting. Well, I think you'll hear a lot more about, um, and I think it is about educating patients, but also educating staff to ensure that we're giving all the opportunities, all the information, everything about safe, reliable, effective health care, and about how you can do the most for yourself in the period of waiting between now and when the healthcare service can deliver what you really need as a final outcome.

**Douglas Hamandishe:**

Pretty super. And you still see that in other walks of life. When you see people waiting to engage in other activities, why wait till the GP surgery, if you even have to, when you can be filling in the questionnaire a bit, making better use of your time over the last 12 months, have you seen any initiative, anything that's stood out within the health innovation that says, okay, that was something that was really good and you know, it just blew your mind.

**Jono Broad:**

Um, so I've got to say that the Beryl Institute and the Hume, the transform human experience has really impacted me, but on another again, pre pandemic. So before we even got into this, I was really infused by, um, a project called 1530 and that, that project I've got some detail here. So forgive me for looking down. All right. But, um, it came from, uh, Daniel Wadsworth and Rachel Pelling, uh, from the Bedford teaching hospital. Um, and their entire emphasis was can you, as a member of staff or, or a patient do something that takes 15 seconds that can save a colleague 30 minutes now, the classic, and forgive me for how this might sound. But the classic is you as a nurse, give the patient the last sick bowl from the cupboard, the patient uses it. You take it away, but you don't take the time to a place that stock or that stack the poor person who next feels sick, has to wait.

**Jono Broad:**

And unfortunately is sick all over the bedsheets because they've not had a bowl available to them straight away. That means a colleague of yours is now having to change a bed care for a patient. Look

after them. What could have taken 15 seconds to walk down a corridor and help your colleagues by replacing the sick bowl. Stock has now taken somebody 30 minutes, 40 minutes, whatever it is because of that, are there small, incremental things that we can do in 15 seconds that will support our fellow colleagues in 30 minutes? And that blew my mind in the sense of, yeah, we just need to think a little bit more, be more supportive, more team players, and more about how can I help and support my colleagues in the work that they do. And as patients, how can I support health professionals to really do better for my health outcomes?

**Richard Wyatt-Haines:**

Yeah, because there's a patient I can collect, gather my symptoms. I can look after my health day in, day out in small bite size chunks that enable a better diagnosis that enabled me to be in better shape and I'm easier to operate on, or my disease hasn't deteriorated as badly as it may have.

**Jono Broad:**

And again, uh, projects like ask three questions when you go to a GP instead of thinking, oh, when I get there, I'll just tell them everything. Think very clearly about, um, describing the problem, asking three questions about it and asking for those things to be, um, given to you really clearly for advice. Um, it's often the way that we as patients myself included at times, got into the GP, had a conversation and as you're walking out the dog, oh, but the real reason I came was, and then it takes, it takes up so much more time. Um, and actually we really need to be thinking poor out overloaded GP. He needs me to get to the point, how can I help support that? Here, here is a quick way of doing it, make sure I've got my three questions in advance that I can ask and get the help I need as quickly as possible.

**Douglas Hamandishe:**

That's great stuff. And cause again, you've got innovation technology that can help you relieve some of that pressure of remembering all the things that you want to convey to a GP in that small snapshot window that you have. So again, we know your time is limited and there's so much useful information that you're distilling patient empowerment is not going anywhere. It's just going to increase and rightfully so. There's technology out there that needs to be, um, embraced, um, to Quicken that process and think big out now as I'm, um, taking, does it really mean as such, just, um, acting out there steps that you can take to bring around that change. So we're thinking big, right? To now through small incremental steps, then you were talking about education, which is fantastic. So I was fully behind the a hundred percent of the way. Cute

**Jono Broad:**

Jonah. Thank you very much. And of course we, uh, we only do a journey by one step at a time. Thank

**Douglas Hamandishe:**

You so very much. Thank you very much,

**Richard Wyatt-Haines:**

John. I thank you. Thank you.