Douglas Hamandishe:

How you doing Richard, Have you been good?

Richard Wyatt-Haines:

I'm very good thank you Douglas, how are you this afternoon?

Douglas Hamandishe:

I'm very grand thank you, it's a beautiful day outside and we have a great guest.

Richard Wyatt-Haines:

We do, and what's exciting today, I think is we're coming at this from a, uh, from almost a different, a different routine. Maybe that's the way to look at it. Yep. We're going to start with John obviously understanding who he is, what he does, but looking at a project that they've been working on and what do we learn from that and what came out of it? And that's a really practical way of looking at this. So I'm, I'm really excited about today.

Douglas Hamandishe:

So with no further ado let's bring in John from KCC, John, how you doing?

John Craig:

Hello, both. I'm very well, thank you. Thanks for having me. As you say, John Craig, chief executive at care city. We are an innovation center for healthy aging and regeneration, uh, based in barking, co-founded by the London borough of barking and second and Northeast London foundation trust, um, uh, hosted in the hospital, um, for, for, uh, for a period and now spun out as an independent community interest company. Uh, we have about 12 people on our team and we work across research innovation and development, which is really, really a theme focusing on, uh, workforce and regeneration. Um, and, um, our work is about transforming health and care services, but also trying to make a significant difference to the determinants of health, um, in east London. And London's poor poorest horsepower and showing that better care can help to transform a city like London.

Richard Wyatt-Haines:

John, that, that mix of a local authority in an acute hospital trust must give you a much wider perspective than many people would normally have must not having those two stakeholders on board.

John Craig:

I mean, I just describe it as trying to have our cake and eating it. Um, it's about having a, being a social enterprise, but also having a foot absolutely inside the public sector with these ready-made public sector partners, our co-founders and their partners, too. Um, so I divide my time between running our social enterprise, but also serving on leadership forums of our integrated care system. And it says in the terms of reference innovation partner and that notion of an innovation partner to an integrated care system, I think is really exciting and powerful. And you're right, it does give us that breadth of perspective of if you like that the independent sector beyond the public sector, but also understanding how we can work in partnership with those incredible leaders and clinicians in Eastland.

Richard Wyatt-Haines:

Does that make you, gosh, I was thinking at first, when you described it, you're subject to them, but actually I get a sense of you driving agendas in there as well. It works both ways, doesn't it?

John Craig:

It does. I mean, so I think I have to wear on my sleeve in that partnership that I have no formal authority decision-making power. Um, I sort of hold a budget, but on a, you know, on a good year, it equals my expenditure. So, so it's, we are subject to them, but part of what we want to do is to attract to east London, new ideas, innovations, resources that can help to make a positive difference. Um, and so at times that gives you a little bit, little bit of leverage to say, because you think, you know, what idea or what innovation are we going to introduce? What partnerships can, can we, can we broker? And so of course, yeah, we're trying to, we're trying to shift the needle for the better, um, but always conscious that that is an absolute privilege just to be around the table. Um, and we can really only mess that, those relationships up once. So, so I guess we do that really cautiously. Yeah.

Douglas Hamandishe:

And it's refreshing that you have that sort of relationship. Um, what do you do to actually cultivate that environment whereby those bright ideas can, can, can be worked upon what's the, what's the process for doing that?

John Craig:

Uh, I mean, you can read, you can read lots of innovation articles currently about building the right culture. And of course, I think that is about, it is about being honest, about not being scared to try things safely and being, uh, being open to failure. I also think though it's about building a social business that depends on finding new ideas and building a reputation for being able to test them rigorously and safely and scale those to succeed. Um, so I genuinely wake up every day excited to work for care city, but also a little bit worried about where's that next idea coming from where's that next project coming from. And I don't think there's much of a substitute for the, for the urgency that comes with, uh, a business that has to chase its mission and to survive and thrive. So I think it's, it's partly that culture, but I think it it's, it's partly that's what care city does. That's the job. Yeah.

Richard Wyatt-Haines:

John, just, if we can get into the specifics then of this project you were working on and what it started to aluminate for you, can you give us a bit of background and then the journey you went on, please?

John Craig:

So I didn't create Cassidy, but I am their first chief executive because I arrived shortly after they landed some big projects and they are fantastic. They too. Oh. Um, so my first day in the job was in, uh, uh, an office of NHS England, trying to explain where it tested. So few gadgets. And so few people as part of a big innovation program called the tech program, which is run and funded, um, by, and it just England and the office for life sciences taping, high potential innovations approve and better outcomes and experiences at lower costs. And, um, that was a fantastic opportunity really for care city. We set out a whole portfolio of different, interesting gadgets, if you like. And the exam question was what pathways and systems can these, these transformed for the better. And so just to give you a sort of feel for what that program was like, and also how Cassidy has evolved.

John Craig:

I thought I'd tell you about just one of the innovations, which I think we'd be news to many, to many people, but I still think it's interesting and perhaps still underused. Um, we worked with a company called AliveCor. They have a product called Kardia mobile, which is that credit card sized ECG that talks to a smartphone or a tablet. And it can screen people for luckily atrial fibrillation. It's not as good as good as having a 12 ECG, 12 lead ECG, but it's, it's pretty good if it says you've got likely atrial fibrillation, get it, get it checked out. Um, as I say, it's not novel, Simon Stevens took them on the one show. So we were like, we are beyond peak, right? It's old news, but it was important news for candidates. So we said, look, first of all, let's test test a hundred things.

John Craig:

Let's just, let's just play around with it. You know, like they do on Brighton Dragon's den where they just try and break it. Let's just mess around with it and test it in lots of different places. One of the places that we tested, tested those devices was in high street pharmacies. Seeing if we could strip screen over 65 and spot likely atrial fibrillation. And we could, it kind of works really nicely. I mean, people come in and to get their repeat prescriptions as the, you look at their age and you say, oh gosh, you don't okay. The 65 as you are, would you like a free heart check on the right? This just works. And it's quick. And it's easy apart from because it's a pilot, you've got to fill in forms for 20 minutes, but let's, let's pretend it's not a pilot. It's really smooth.

John Craig:

Um, so we did that and it worked, but what we ended up doing was sending lots of worried people to their GP, um, which, you know, GPS are busy enough already. Um, it's really great to, for them to have lots of unmet need banging at their door, but as a system, and this is the innovation partner. This is sitting around with GPS, pharmacists, um, secondary care specialists from Bart's commissioners, really racking their brains. We said we can do better. So we built a prototypical AAF pathway that involves screening in high street pharmacies, but then a direct referral to a ideally one stop appointment in Barts health, the director secondary care within two weeks. So you got to go for a blood test in that two week window and go to Bart's have all the tests, get your diagnosis confirmed and get some treatment issued to reduce that very high stroke risk associated with, with atrial fibrillation.

John Craig:

So we did all, we did all that and got the pathway going. We brought all the pharmacists. Then we gave them amazing east London, Curry, brilliant training. They stuck around for three hours. They did a great job. And we even had one of those proper AUSkey exams at the end, we felt great. We've done a receipt. And they went back to Walton forest. And this isn't there because they was great working with the pharmacist. Okay. But my version of this story is they love these gadgets at the counter assistance and said, look, it's dead intuitive. Can you do some screening, please? I've been trained. It'll all be fine. Of course it wasn't all fine because people are incredibly creative in ways to mess up using a piece of technology. They haven't been there. We had all kinds of errors in the system, all over wealth and forest.

John Craig:

And my amazing colleagues in Magento who happened to be a pharmacist, which gave her a lot more credibility than me drove round Waltham forest as a mystery shopper, catching people out for limitations and sort of retraining them there. And then in the shop one by one. And that was a big deal for us because it was a mistake and people talk a really good game about mistakes in innovation. Don't they,

they talk about failing your way into success and we should celebrate mistakes. And we should, you know, I guess I sort of get that. I mean, it's just that the number of things that won't make public services better is infant. So if you're trying to go through the things that don't work one at a time while, and as we all know in public services, it doesn't, you don't have to favor often before you've used up the oxygen of trust and legitimacy, right?

John Craig:

So it's, I think the point that really matters is if you mess up, admit it, frankly, learn from it and do better. That's the discipline. I'm still not quite there to celebrate it, but it was important for us because we said these counter assistants are interested. John didn't really think about the characteristics, but there are, pivotally important. And we're an innovation center for healthy aging and regeneration. And these are generally young people, or though it is a mix, who've got a job in a shop. They could be working in the news agent next door. And a little gadget just meant that they might have helped save a life, which is interesting for that in east London. And it's interesting for that counter system, isn't it. So what did they think their career was going to be? Did they think that they, they could, that they were good enough to work in the NHS to be part of our health system, but they didn't.

John Craig:

Cause we young people in east London think that the health system has doctors and nurses now incredibly special people and most people don't think that's special. Um, so that has actually that mistake has actually been pivotal for us thinking isn't that interesting that a new piece of technology has changed the capability of what a counter assistant could do. Um, they don't really change the capability of a cardiologist. They could, they could give you a better ECG, then that device can from the golf course, they are amazing red. Yeah. Um, but for a counter system, it made them dramatically more, um, capable and it was inspiring for them. And so we've more and more now as, as an organization focused on projects like that, where we can combine a digital innovation with a workforce innovation to unlock benefits simultaneously for the patient or the services there.

John Craig:

And for that member of staff. And there's, there's, there's no acceptable accepted term, but who we're focusing on, but they're just people who aren't paid so well and our health and care system. And generally aren't so skilled across such a broad range of areas. So they might be administrative staff in hospital receptionists in primary care. And actually we've done a lot of work in social care now thinking about both care home staff and, um, home care staff, um, who do a huge amount of, um, incredibly valuable work around personal care and support. Um, but aren't really yet the eyes and ears and hands of the health system as systematically as, as became the case for those capture systems. So thinking about how digital innovation and workforce innovation can work together to transform some outcomes, but also transform some careers and tell a story about how to regenerate a poor part of east London, that's sort of become what gets it is about. And to an extent it came from, from a, from a mistake, although I would say it came from the admitting of it, frankly, and trying to learn.

Douglas Hamandishe:

I think, I think that that example is fantastic. And I was just wanting to talk to you, talk to you about the mindset. Again, you talked about this being the mistake mistake, and I think it's a journey. It's a must take a must take journey and you've managed to untap on value in a workforce that was under appreciated. Is

this something that you, you fully impaired moving forward as part of the transformation or a rolling road journey as it was to seek out these, these groups a lot earlier and bringing them into the projects?

John Craig:

Yeah, I mean, first of all, I think you're right that probably seeking to implement complex innovations does involve inevitably some mistakes and some, some learn. Um, and I know that for leaders and certainly politicians, there's a frustration that great innovations don't scale and the come adopted quite as quickly and uniformly across, uh, across our system as they should be. I think that there's a lot of truth to that, but we do have to remember that all of those adoptions and implementations are themselves creative acts and give people the space to do, to do some of their own learning and the prepayment in the process and help them expect that to be part of the process. I think that's important. And yeah, absolutely. That is, that is now a really strong theme for us, um, that it is easy to, underappreciate the significance of support staff in all different guises across our health and care systems.

John Craig:

I actually think the COVID 19 experience has also helped to shift the dial on some of that. If you're a GP who's locked down, that's an incredibly stressful thing for, for a GP to deal with. Um, I think it was just in survival mode trying to look after your patients, aren't they in a way that you've never had to before. And so any assistance you could get from health or care colleagues who are, who are boots on the ground, if you like a home care in, in someone's living room worried about their health, then I think you switch on to that more so, more so than ever before. So I think increasingly this is, this is a language that, um, senior, senior clinicians are learning to speak. They're sort of learning that they actually lead a virtual team that's getting bigger and that, that helps them a great deal, but it brings with it lots of leadership challenges.

John Craig:

And I think digital innovation and workforce innovation will play, play a big, big part of that. Um, if you'd like, I can tell you about some, some of the things we're doing in care sort of, sort of off the back of that, but there is something really important about the moral that really remembering just how many people work in care, absolutely enormous work. And that each one of those has done an HCA has done an incredible job, um, and is, is able to learn and develop and do more is a really important ethic for us.

Douglas Hamandishe:

Yeah. So, um, I remember we were doing a remote, an exercise in a trust I was working for before and we spoke to some patient groups and to ask them who is the most important person to you? Bear in mind, this is a mental health trust. And now we were like, she thinking that we'll say, you know, the psychologist, the nest, and it turned out to be the receptionist. And then we had a few that maybe if you upscale uptrend the receptionist, they can also add value. So how much of this work that you're doing? Are you seeing it being technology driven or human under the end of the human potential?

John Craig:

I think it can't be technology driven, partly because that isn't, that isn't right. That takes up too easily, takes you to slightly misanthropic space, but also I'm not going to, I'm an overgrown politics student. And so that the exciting and I faint at the sight of blood. Okay. And I'm safe to say it, but it happens to be true when everyone near me needs to know, I, yeah, I can't do this on my own. I can only do this by getting alongside amazing clinicians who say, oh, that's interesting. How often home care staff and district

nurses pass each other on the like ships in the night, the NHS spends 8.3 billion pounds on wound care. That's like nearly half the entire budget of social care. I wonder if there's a way that, that district nurse and that member of home care staff can collaborate. Now, I might be able to have that insight that's far, but what the form of that collaboration might take us down the line is it's beyond that.

John Craig:

Ken and I, I, I think the challenge to social care colleagues is to say absolutely sort of, hopefully you kind of take what I'm saying, which is everyone in social care is incredible. They can do more, but, um, let's also not be too tribal and care and say, um, it's okay for health to lead on some things. Cause, cause they know about some stuff. When you can work remotely with a physio or you can get MDT support in your care home, you know, it it's, it's incredible. And, and the clinician can, can lead on clinical questions. Um, and everyone can, everyone can benefit. So I think it has to be clinically led. It has to be led by the evidence and it has to be tested carefully. Um, but, um, what's, what's undeniable is that because they're being produced for the mass, for the consumer market every month, an interesting new capability emerges. That's smart, easy to use cheap mobile. Um, and we get excited about middle-class patients using it, frankly, if they can do it, every single person in that health care system can use it for the, for the patient. They're standing next to the services, the best of things. And to me, there's still more that we can do to, to realize the potential of those innovations for our least trained least for pit stop.

Richard Wyatt-Haines:

Um, and what you're saying in here though, is the workforce that's available to us in a world of a shortage of healthcare professionals, as we used to talk about them in your world, that that population is enormous because they are people anywhere and everywhere, every corner.

John Craig:

Well, I'll give you an example, partly because it's taken me two years to make it happen for only four people. So I need to tell you, um, we, um, we have been looking at, uh, Prentice, nursing associates and nursing associates. Um, if you ask residential care homes who don't have a nurse, if they'd like a nursing associate, they say, yeah, loved one. That'd be really useful. Cause I'm gone nurse. And of course, as it stands, they can't have one because a nurse, an apprentice nursing associate rightly is apprentice to a nurse. So there's just a lovely catch 22 problem. Now the people isn't based, one, one can't have it. Um, but acuity and complexity and care homes is rising all the time. It's it's really high right now. Um, and more and more they're being care homes are being digitized. That remote consultations going on from that care home to a GP or to a hospital, or maybe, maybe some remote diagnostics alongside that.

John Craig:

We need to think about the workforce innovations that, that supports that and enables. And we've been working with a huge long list of partners, uh, but including university of London, east London and Northern standard foundation trust to provide some remote supervision, to support members of staff in those, in those care teams to become a princess nursing associates just as they might, if they worked for the acute hospital down the road. And I think that's an interesting example because they were already key key members of staff. You can liaise with those district nursing GP colleagues. And of course they want to know if they're in the buildings, they want us, they don't want to miss a bit of clinical practice. They can observe, right. That can go on their record. Um, so they're taking a load off for their managers. They're driving a lot of these new routines around remote monitoring.

John Craig:

So when the GP comes on for their weekly virtual ward round, they're not just the face being carried around a care home on an iPad, which is a pretty daunting thing to try and make sense of clinics. And they've got a dashboard they can say, right? I want to talk to these five people, but they can also talk to that apprentice. Who's clued in who's part of that clinical routine and can help them translate action nets and next steps into reality into the room in terms of the routine of the care. So again, that's, that's lovely for the GP, as you say, saves them some time and they haven't got much time. And even if we want more GPS, we can't happen tomorrow. So it's hopefully good for those residents. Um, but for me, it's great for those members of care team staff, because the story about progression in social care is, well, maybe become a manager and then become an owner and that's either unrealistic or unattractive to a massive proportion of those people. And he's like in east London, some of those staff where a nurse in another country, and they just can't find a routine for a, for a career based on clinical skill. So let's unlock it for them. And my point is digital tech doesn't drive this, but it's the missing bit of the chicks or the constructing some different stories about how we work together, how we save some time of exhausted hard-pressed clinical staff, um, and also different careers career rates for our staff.

Richard Wyatt-Haines:

We were going to have to break we're well over. We're going to be in trouble with everybody for running over, but that riff, that reflects what you've provided the wide way of insight today. I don't know if in a 22nd burst you can say, look, these are the two things. One thing that people should just bear in mind as a takeaway, um, just to wrap us up, which feels unfair given the scale of what you've covered.

John Craig:

Um, in your health and care system, wherever you are, there is a of clinical leads thinking about remote monitoring, remote diagnostics from Etsy provisions and taking a lot of the expertise of hospitals and the health system and getting it out there into our community. There's another set of people who are thinking about quality of work for challenges out there in primary care, um, in social care and they are your ally allies. Um, if we could bring those two groups of people together, I think we have a better chance, both of improving outcomes for patients and for changing the lives of some of our most types of stuff.

Douglas Hamandishe:

John. Thank you very much. Very informative.

John Craig:

Thank you. Pleasure. Thank you.