NOTE – THE COMPLETE APPENDICES ARE IN THE LIBRARY COPY OF THE UNIVERSITY OF BATH AND THESE INCLUDES THE DVD

Appendix 1

"Breaking down the walls of silence"
Improving care for people with dementia

Report from meeting held on Friday 28th September 2001

Improving care for people with dementia in West Berkshire

Timetable *All Lead facilitators in Bold* *Notes in Red*

	Doctors / all	Nurses / AHP's	Practice Staf
12:30	Registration - All delegates will be asked to fill in a questionnaire. Lunch	Results to be given out before Action Plan Session	
1:00	Welcome **Patrick Brooke**		
1:05	Break out session – all Shaun Naidoo	The Clap Exercise	
1:20	Video	Coldplay Presentation	
1:25	Overview of Dementia Patrick Brooke		
1:40	Care pathways Marian Naidoo	The pathway- its development	
2:00	Creativity and complexity	Initial Presentation of Theory including	Followed b Complexity Game &

	Roger Bullock and Shaun Naidoo	Flocking Birds	Debrie *Roger Bullock Maria Naidoo* & **Shau Naido**
2:45	Tea		
3:00	Uni-disciplinary groups Focus on West Berks **Patrick Brooke & Roger Bullock**	Assessment Focus on West Berks Marian Naidoo	Understandin dementi Focus on West Berk Shaun Naido
4:00	Feedback from uni-disciplinary groups ➢ Action plan ➢ -Influencing the local care pathway ➢ putting theory into practice	Feedback led by group Spokesperson Roger Bullock *Marian Naidoo* *Patrick Brooke*	

This event was organised jointly by Kingshill Research Centre, Swindon, Newbury PCT and the Department of Old Age Psychiatry, Fairmile. Participants included General Practitioners, Consultants, Nursing staff and Allied Health Professionals (AHP's) from both primary and secondary care and a wide range of managers and administrators from primary care.

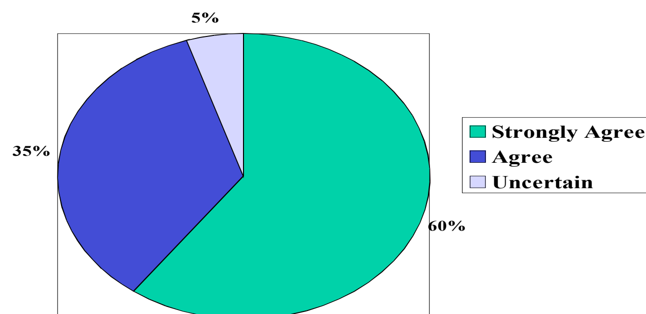
Objectives of the day were to: -

- Challenge the way dementia is perceived
- Challenge the way dementia is managed
- Gain commitment for the development of integrated local care
- Identify local issues and concerns
- Identify solutions and individuals with a commitment to take the work further

Dementia is an important disease that affects approximately 1 in 120 people in the UK, ranking it in prevalence alongside Diabetes Mellitus and Stroke. A report produced by the audit commission (Forget me not - Audit Commission 2000) identified that only 48% of GP's surveyed felt that they had received sufficient training to help them to diagnose and manage dementia. Only 54% of GP's recognised the importance of actively looking for the early signs of dementia.

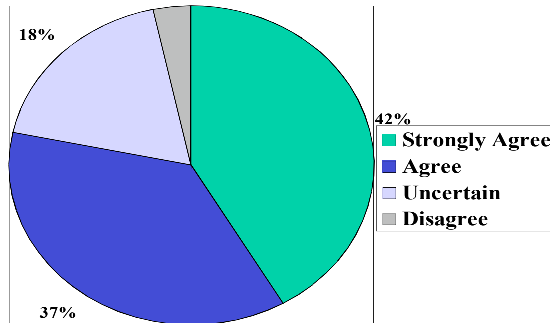
The participants completed a short questionnaire:

Q1: It is important to identify the symptoms of Dementia as early as possible.



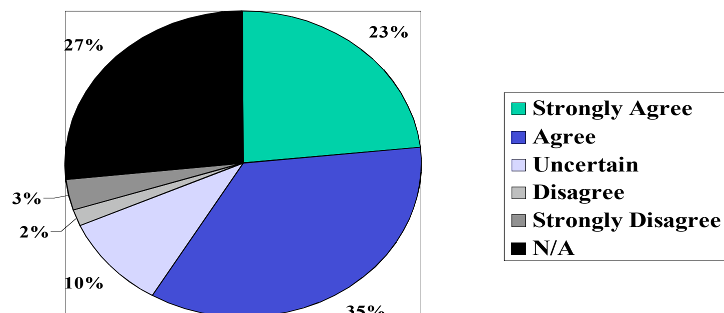
The results from this question show that 95% of the participants felt that it was important to identify the symptoms of dementia as early as possible.

Q2: An early referral leads to a better outcome.



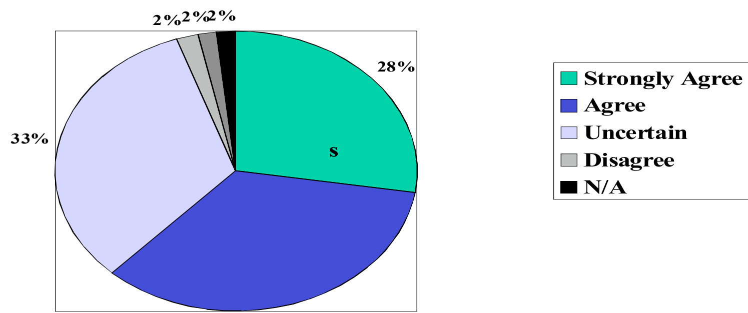
Question 2 indicates that 21% were either uncertain or disagreed that an early outcome results in a better outcome. 79% either agreed or strongly agreed that there would be a better outcome.

Q3: I use a diagnostic tool to assist my diagnosis.



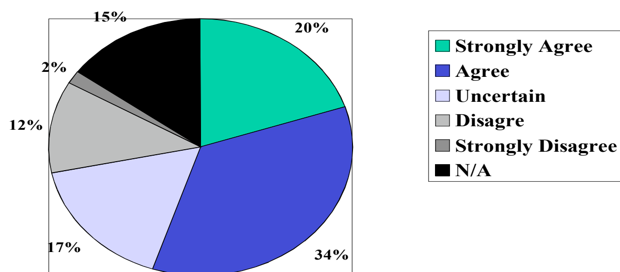
58% of the participants were using a diagnostic tool. There is an indication of a need for a specific tool to aid with the identification of dementia. This was also identified in the afternoon session.

Q4: There are effective interventions for people with Dementia



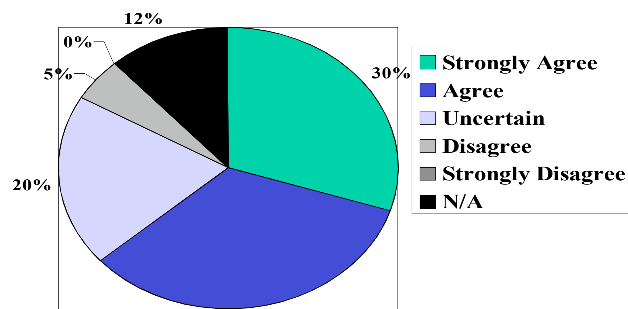
41% of participants were either uncertain or disagreed that there are effective interventions for people with dementia. This is an indication of a need for further education and development. This was also reflected in the afternoon session.

Q5:I have information for patients relating to Dementia.



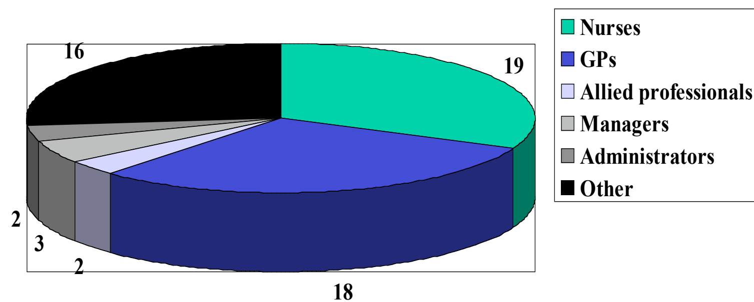
Almost half of the participants do not have information for their patients relating to dementia. This indicates a need for the development of appropriate information.

Q6: Improving services for people with Dementia is one of my priorities.



37% of the participants felt that dementia was not a priority for them. This also indicates a need for further education and development.

Your professional background.



Total number of delegates =60

The purpose of the early part of the session was to give the delegates some background information about the work that is being done in other areas to improve services for people with dementia. Also to introduce the delegates to the aspects of the methodology used in the development and implementation of an integrated care pathway for dementia. This methodology included the use of evidence based practice, complexity theory and creativity.

The delegates then worked in uni-professional groups with a facilitator in order to identify specific issues and possible solutions to identified problems.

Group 1

Group one was made up of nursing staff and included nurses from primary community and secondary care, and Associated Health Professionals.

Identified the following issues:

- Problems locally with early recognition and diagnosis.

- Long wait for specialist services resulting in delay in hospital discharge and inappropriate admissions
- Limited respite available resulting in increase in carer burden
- Some respite inappropriate for people with dementia
- Lack of resources all round
- No services for younger people with dementia
- No flexibility in what is available

Possible solutions / suggestions / requests

- Would like a fully integrated community team
- Would like to input creatively into respite homes in order to develop staff
- Would like to know more about dementia and suggest Community Psychiatric Nurse input into other professional groups.
- Would like someone to lead locally
- Would like to undertake a similar project (care pathway)
- Care pathway would enable greater understanding of each others role

Group 2

This group included Receptionists, Administrators and Managers

Identified the following issues:

- Need to bridge the gap between NHS and Social Services
- Would like access to the same information
- Need to improve communication and make it effective
- Need to find solutions to the problems of confidentiality
- Need effective leadership
- Carers need as much help as patients

Possible solutions / suggestions / requests

- ❖ Redesign primary /secondary care interface.
- ❖ Put patients at the centre

Group 3

This group included, General Practitioners, Hospital managers, Pharmacists, Psychologists and Public Health

Identified the following issues:

- ❖ Lack of resources financial and staff
- ❖ Lack of EMI beds
- ❖ Need access to a screening tool
- ❖ Faster access to old age psychiatrists
- ❖ Needs faster access to crisis intervention by specialists
- ❖ Lack of effective interventions
- ❖ Need for greater communication between primary and secondary care

Possible solutions / suggestions / requests

- ❖ Skill mix
- ❖ Better use of Community Mental Health Care Team for Elderly
- ❖ Increased Out patient: Home visit assessment ratio
- ❖ Greater focus on mild-moderate dementia by old age psychiatry, with Community Mental Health Care Teams taking the lead on managing moderate – severe dementia.
- ❖ More information on memory clinic
- ❖ Information about 6CIT

Conclusions

Reports from the Department of Health through the Audit Commission and Nat
ional Services Frameworks have highlighted the need to develop better-integrated health and social care for people with depression and dementia in old age. The National Service Framework for Older People discusses the need for a comprehensive integrated service model with a community mental health team at its centre.

The NHS and councils should:

- Review the local system of mental health services for older people, including the arrangements for mental health promotion, early detection and diagnosis, assessment, care and treatment planning, and access to specialist services.
- Review current arrangements, in primary care and elsewhere, for the management of depression and dementia, and agree and implement local protocols across primary care and specialist services including social care. In time, this should be extended to cover all mental health problems in older people.
- Review current arrangements in primary care and elsewhere for the management of dementia in younger people, and agree and implement a local protocol across primary care and specialist services, including social care. (The National Service Framework for Older People – Standard 7, 2001)

The findings of this meeting confirm that we still need to develop and integrate our services. A means of doing this is through the implementation of a care pathway for dementia across the Newbury Primary Care Trust, local voluntary sector services and the Department of old age psychiatry, Fairmile. In 2000 The Kingshill research Centre in

Swindon started work on developing an integrated care pathway for dementia, which was published earlier this year. Newbury Primary care

Trust in liaison with The Kingshill research Centre and Berkshire Health Care Trust have agreed to work together to implement and research the implementation of this care pathway locally.

The meeting on the 28th of September was the first step in implementation of this pathway and enabled us to identify needs and solutions locally. In the next few months as we move forward with implementation we will attempt to answer individual practitioners and practice's needs as identified. The bringing together of approximately 60 people to examine local services was thus a huge success and one that few if any other Pico's or service organisations have been able to replicate.

We shall be contacting you in the near future to communicate progress, identify further needs and offer help in achieving these. If you would like to send representation from your practice or organisation to develop a small working sub group we would be happy to work in this way. Though if you like many, feel overloaded with external work commitments and thus unable to, we will keep in close communication with you as to what is happening.
Thanks once again for your support.

Marian Naidoo
Patrick Brooke

Appendix 2

<u>Study Protocol</u>

The implementation of a care pathway for dementia across 2 neighbouring primary care sites.

(April 2001)

Marian Naidoo

Introduction

Rationale for the study

Dementia is an important disorder, with Alzheimer's disease alone being the fourth most common cause of death in the Western world. The number of older people in our society is growing and the number of over 65 year old people is predicted to rise by 10% in the next 10 years. The greatest increase will be among those over 80 years of age. Of those over 65 years of age 6% have dementia and this proportion rises to 50% for those over 85 years of age. (Naidoo & Bullock, 2001)

A recent Audit Commission for Local Authorities and the National Health Service for England and Wales report (2000) entitled ***Forget me not*** found a wide variation in practice and in the kind of resources that were available and identified that:
"Services for older people with mental health problems are patchy and inconsistent throughout the UK. Older people and their carers have often not received the help they need when they need it." (Audit Commission for Local Authorities, 2000).

Early recognition and diagnosis of dementia are essential, yet fears of diagnosis result in late diagnosis. General practitioners and other primary care staff are often the first port of call and should be alert to early signs of memory problems, confusion or depression when older people seek their advice for any health problem. A recent survey of 1000 general practitioners carried out by the Audit commission (Audit Commission for Local Authorities, 2000) identified that only about one half believed that it was important to look actively for early signs of dementia and to make an early diagnosis. A similar number stated that they did not routinely use any diagnostic tools.

The publication of this report and local anecdotal experience resulted in the decision by the team at Kingshill Research Centre to develop a care pathway for dementia that would address this problem.
The pathway was developed using the principles of Action Research. Following wide consultation and identification of all stakeholders a local workshop was held. The purpose of the workshop was to create multi-disciplinary teams with representation from every stage in the care process. These teams looked into five stages of the care programme: Recognition, Assessment, Care Management (including guidelines for medication), Review and Coping With Changes.

An extensive review of all relevant research was then undertaken and the project facilitator provided each group with research evidence in a format that was accessible and appropriate for their needs. The teams reviewed the evidence and discussed their own experiences in a knowledge workshop format, the purpose of which was to produce or elicit new knowledge. The workshop was facilitated in such a way that inequalities were addressed and minimised. The main objective was to bring forth experiences and knowledge from people who are not usually heard or allowed to exert their influence. At this point the notion of storytelling was introduced to the groups as a way of confirming the research evidence with the realities of each individual experience. The use of creative approaches enhanced the abilities of the groups and the individuals within them to communicate their understandings of their experiences more effectively. The telling of individual stories helped to reinforce the experience of the individual within a complex system and the impact that the system had on each individual. It also enabled the groups to identify strategies for improvements based on a combination of researched evidence and the abilities of each group to identify how every stakeholder could contribute towards a more coherent programme of care. The aim was to identify and agree best practice.

The methodology used enabled a number of significant outcomes to emerge. The dynamics of communication between carer's and professional groups identified areas for improvement, particularly with early diagnosis and ease of referral. The group also recognised the need to develop clear and simple flow charts with information that can be given to patients and carers so that they can be fully informed about the way their care should proceed.

By enhancing the quality of communication and understanding that emerged from the use of storytelling techniques, decisions relating to care, both clinical and non clinical, contributed to the development of an integrated care pathway for the whole disease from early diagnosis to long-term care. For all the stakeholders involved in the project, the process of continual transformation and development had begun.

Aims of the study

This study aims to take the care pathway "Breaking down the walls of silence" (Naidoo & Bullock, 2001) and apply it to two neighbouring Primary care sites which are at different levels of attainment. Explicit aims of the care pathway were identified as: -

1. Ensure an early diagnosis.
2. Give appropriate information to all involved in the subject, especially the patient and those caring for them.
3. Provide equity of care based on evidence.
4. Enable individuals to remain independent and at home for as long as possible.
5. Provide an educational resource for all in the field.
6. Produce a template for service improvement.

The project will seek to implement the care pathway using action research methodology. Hart and Bond (1995) argue that the current ideology of reform and improvement in Health Services points directly to action research and Holter and Barcott (1993) that action research was designed specifically for bridging the gap between theory, research and practice. The intention of this project is to demonstrate the structural and cultural changes needed by all stakeholders involved in the implementation of the care pathway.

Methods to be used in investigating the problem.

The project will follow the principles of Action Research to guide the implementation of an integrated care pathway for dementia. Action Research requires the participants to ask, "How can we do what we do better?" Implementation of the care pathway will require facilitation and will use the structure detailed below.

1. Stakeholders will be identified following a stakeholder analysis.
2. All stakeholders will be involved in an evaluation workshop, the aims of which are to identify problems and issues, barriers to change and ways of overcoming them.
3. Stakeholders will develop an implementation plan starting with diagnosis through to long -term care.
4. Case study data will be collected in order to identify how much change has occurred and in what way change has contributed to an improvement in services.

The data for this project will be collected by the use of a combination of observation and in-depth interview. The purpose of collecting case study data is to collect "stories" from individuals of their own improved

understanding. This information will add to the construction of collective knowledge. This process is described by McNiff, Lomax and Whitehead (1996) as "a culture of independent thinkers each willing to submit their claim to knowledge to the critique of others, to ensure that the claim is robust and legitimate…. ensuring that claims to knowledge are validated by the most rigorous standards."

References

Audit Commission for Local Authorities and the National Health Service for England and Wales (2000) Forget me not: mental health services for England and Wales. London. Department of Health.

Hart E, Bond M (1995) Action Research for Health and Social Care. Buckinghamshire: Open University Press.

Holter I M, Schwartz-Barcott D (1993) Action Research: what is it? How has it been used and how can it be used in nursing? Journal of Advanced Nursing. 18. 298-304.

McNiff J, Lomax P, Whitehead J (1996) You and you action research project. London. Routledge.

Naidoo M, Bullock R (2001) An integrated care pathway for dementia. London. Harcourt.

Appendix 3

Excerpt from Letter sent to participants of Swindon workshop

17th October 2001

"The purpose of the day is to explore current service provision, what we do well, what we do badly, and how we work together and put these findings together into creating a systemic service across all organisations…….It is a long day but is designed to be participatory, stimulating and thought provoking. At the end of the day I hope we will be planning to work across existing barriers rather than patrolling them and that we will have a plan to provide new and exciting services for those unfortunate to have this devastating condition."

The letter also included the programme for the day

Swindon Older People's Services – Modernising Dementia Care
Bowood House, Chippenham
Tuesday 27th November 2001

09.30 Myths and issues – chat show

Is dementia a mental health problem?

What is the advantage of early diagnosis?

Do drug treatments work?

What is person-centred care, and what does that mean in Dementia

Can we give carers what they need?

Can care homes survive in sufficient numbers?

Can the acute hospital agenda fit into the National Service? Framework aims?

Can we really work together in an inclusional way and be truly responsive to the people using our services?

11.00 Coffee

11.20 Care pathway

The work done

Who make up the bits of the jigsaw of care in Swindon

11.40 Single organisational groups

Themes from the chat show

Task: *What 10 aspects of dementia care do we do well and what 10 Things we could do better?*

Feedback

13.15 Lunch

14.15 Identification of themes from the first session

14.00 Mixed organisational groups

Task: *Can we create ways to develop the identified themes – simple rules and bold aims.*

Team building exercise

Perform the task

15.45 Tea and feedback

16.20 The creation of a dementia action team for Swindon

17.00 Close

Swindon Workshop

Out come from group work

Group 1

What can we do better?

Access to services

Quality of life for users and carers.

Support for carers is not joined up. (e.g. carers register)

Need better and more appropriate information at Primary Care stage.

More integration of specialist services e.g. Health visitors and district Nurses.

Communication of research findings – theory in to practice – good ideas

We have a culture of silos

More education

More pooling of resources.

What do we do well?

Early identification is better

Team approach

Community support (When you can access it)

Recognising carer's role

Carer education

Memory clinic

Good assessments

Good clinicians

Research and development

Forget me not

Commitment

Professional satisfaction

Where do we go next?

Need for education – clinical, carer and user – Drugs MCI Early symptoms, behaviour

Change in culture

Need to learn in groups

Memory clinics in each location

NVQ for care home staff

Partnership with private sector, offer education service

Implementation group for pathway, need to be empowered from the top.

Need to change the way people think

HIMP

Group 2

What could we do better?

Quicker response

Local training

Liaison service to acute unit

Forced patrol of boundaries

Need common image /standards / voice

Keeping sight of goals under pressure

Promoting services to moderate/severe as well as mild

No clear inventory

Supporting staff ourselves and others and organisations

Clarity of what is and isn't included

Who does what?

Planning blight

Independent sector planning

What do we do well?

Care about our patients – patient centred and carer focused

Dementia service

Identifiable lead

Strong component parts

Team well – common goals

Many disciplines

Want to do better – concerned about service

Invest in training

Desire for continuous improvement

Active research

Think beyond box

Think ahead of the game

Good at crisis

Make a little go a long way

Where do we go now?

Develop good information at ground level

Open access for memory clinic

Develop clear criteria

Early diagnosis Primary care

Universal entry point

Joint working

Education to change culture

Group 3

What can we do better?

Develop our approach outside our sphere

Engage across boundaries

Explicit criteria for within the system

Support private sector

Develop better understanding with GP's

Work with acute unit

Train everybody concerned in system

In patient services / environment

Clearer response techniques

Earlier intervention in moderate/severe dementia

What do we do well?

Holistic / patient centred philosophy

Integrated team with single assessment process / open access / CPA

Improvement / learning environment

Forward thinking / creative

Strong carer emphasis

Truly MDT working

Good at making a little go a long way

Service development focus

Active research unit / philosophy

Place standards above volume

Where next?

ACCESS –	When I want it
INTERACTION –	What I need when I want it
RELIABILITY -	Exactly what I want when I want it
VITALITY -	Can give exactly what I want when I want it

IDENTIFIED THEMES FOR AFTERNOON WORK

Group 1

Eliminate competition

Increased private / public

Proactive not reactive planning

Develop a new approach

Indicators that relate to quality of life

Create a new local model

Group 2

Set common goals

Develop standards matched to resource

Phase 1 implement ICP

Develop out of hour's service

Who does what when where and why?

Induction across all areas

Create common language / paperwork

Group 3

There is commitment across all areas but

Tension regarding budgets, culture, control, imposed changes

Misperceptions

Misunderstanding

Poor information

Communication

Lack of criteria / standards across all

Knowledge

Learn from each other

Training

Resource Pooling

Clear lead

Identification / inventory – *Create a new service model together*

Appendix 4

Study Protocol

The Newbury Memory Clinic Project

September 03

Proposal

The development of a more holistic approach to dementia care. To trial the development of a multidisciplinary chronic disease style clinic for dementia patients that would diagnose, initiate and manage treatment of people with mild to moderate dementia within a community setting.

Marian Naidoo
Patrick Brooke

Introduction

Rationale for the study

Dementia is an important disorder, with Alzheimer's disease alone being the fourth most common cause of death in the Western world. The number of older people in our society is growing and the number of over 65 year old people is predicted to rise by 10% in the next 10 years. The greatest increase will be among those over 80 years of age. Of those over 65 years of age 6% have dementia and this proportion rises to 50% for those over 85 years of age. (Naidoo & Bullock, 2001)

Dementia affects roughly 1 in 120 people in the UK, thus ranking it in prevalence alongside conditions such as diabetes mellitus and stroke.

Dementia causes social isolation, disability and depression for both the patient and carers

Only 25% of patients with dementia access specialist services in the UK

Non Cholinesterase intervention

Multiple evidence based interventions exist for patients with dementia besides cholinesterase inhibitor medication. They have been shown to reduce patient and carer stress, slow progression of the disease process and/or delay institutionalisation

- Carer support delays institutionalisation Brodaty et al.
- Modification of cardiovascular risk factors for Vascular Type Dementia
- Needs Assessment
- Benefits Assessment
  - Access to information and education
  - Access to respite care
  - Review of compounding medical factors including drugs

Cholinesterase inhibitors

- Cholinesterase inhibitors have been shown repeatedly to improve cognition, function and behaviour in mild and moderate dementia. *NICE Technology Appraisal Guidance No.19*
- Cholinesterase inhibitors have been shown to work in Alzheimer's disease and Vascular Type dementia *Pratt et al. 2002* and case independent reports show benefit in Lewy body dementia also.
- **Current international surveys show a delay of approximately 1 year from first referral to initiation of drugs.**
- Considerable evidence supports rapid intervention to treat and manage dementia, in that **delay in assessment and treatment by even a few months has a direct negative impact on patient outcomes**. Clinical trials data confirms that those patients treated initially with placebo never catch up with those on cholinesterase inhibitor *Doody et al. 2001*
- Even in environments with relatively open access to these drugs only approximately 10% of patients with dementia are on them.

- Cholinesterase inhibitors have substantial data to support their safety
- Cholinesterase inhibitors have been shown to reduce time to admission to nursing care by up to 2 years *McRae et al. 2001*
- Cholinesterase inhibitors have been shown to be at least cost neutral. *Bosanquet at al. 1998*

Models of Care

The National service Framework recognised the need for greater integration of mental health services for the elderly

- NSF targets

  "Older people who have mental health problems should have access to integrated mental health services, provided by the NHS and councils to ensure effective diagnosis, treatment and support for them and for their carers".

- NICE does not recognise GP's as able to initiate and prescribe anti cholinesterases at present
- Integrated Care

  'The Forget Me Not report' noted that *the number of elderly people with mental health problems is growing rapidly, with the older patients requiring most help. They recognised the need for carers to get help and advice rapidly yet found that many GP's are unable to provide appropriate advice, with specialist services for both users and carers being patchy and often uncoordinated. They stressed the need for health and social services to work closely together to be more flexible and responsive in meeting the needs of both users and carers.*

Problems

- Current models of care are often lacking integration, being based on multiple sites with rigid service provider boundaries, there is often no clear single point of access and subsequently they have poor communication.
- Patients find referral to secondary care stigmatising and access more difficult
- Current systems may delay and impede access for patients with dementia.
- NICE currently requires cholinesterase inhibitors to be initiated by specialists only

Hypothesis

Joint multi professional / multi agency clinics including General Practitioner Specialists (GPwSI) as part of the team will increase access for patients and carers to a comprehensive model of dementia assessment and care without negatively affecting the quality of their care.

Proposal

To develop a more holistic approach to dementia care. To trial the development of a multidisciplinary chronic disease style clinic for dementia patients that would diagnose, initiate and manage treatment of people with mild to moderate dementia within a community setting.

The clinic will provide a comprehensive ‘one stop’ style service, using multidisciplinary concepts to organise joint working with voluntary sector (Alzheimer’s Society, Age Concern, Citizen’s Advice Bureau, St John’s Ambulance, Admiral Nursing etc.),

practice and district nurses, psychology, social services, primary and secondary care.

Aims

1. To improve access to comprehensive multi disciplinary, assessment and management for people with (or suspected of having) dementia.

2. Development of a model of care that seeks to integrate the services currently provided by primary, secondary, social and voluntary care organisations, by providing them in one location, so that they are available in a comprehensive chronic disease clinic format.

3. To improve communication between care providers, the patient and carers.

4. To develop a model of care that encourages the emergence of a 'Community of Practice', and to develop a care pathway to include the GPwSI role.

The project will seek to develop The Newbury Memory Clinic using action research methodology. Hart and Bond (1995) argue that the current ideology of reform and improvement in Health Services points directly to action research and Holter and Barcott (1993) that action research was designed specifically for bridging the gap between theory, research and practice. The intention of this project is to demonstrate the structural and cultural changes needed by all stakeholders involved in the development of the memory clinic.

Methods to be used in investigating the problem.

A collaborative inquiry using action research techniques. Action research requires the participants in the study to ask the question “How can we improve what we do?” Although this is an emergent process it is anticipated that the project will include the following.

- Community based service
- Collaborative approach between primary, secondary, social and voluntary sector care
- GPwSI to be enabled to assess, diagnose, initiate treatment and follow up people with dementia.
- A holistic approach to dementia management and diagnosis (where services are not available on site the patient or carer will be ‘sign posted’ to the correct agency with subsequent clinic review monitoring that needs have been assessed and met).
- The study will focus on newly referred people with mild to moderate dementia. Existing dementia patients will be excluded from the research.
- Quality of care will be monitored through review by involved secondary care specialists.

<u>Some quality markers that may be used</u>

1. Speed of assessment interval between referral and first assessment
2. Time to treatment interval between referral and starting cholinesterase inhibitor if appropriate
3. Quality of diagnosis random sampling and review of patients by consultants
4. Percentage of patients discontinued from treatment having completed a therapeutic trial.

5. Patient and carer satisfaction questionnaires and interview.

The project will follow the principles of Action Research to guide the development of an Holistic multidisciplinary memory service for Newbury. Action Research requires the participants to ask, "How can we do what we do better?" Development of The Newbury Memory Clinic will require facilitation and will use the structure detailed below.

Client satisfaction Questionnaire for patients and carers to be administered at intervals determined by the collaborative enquiry.

Interviews will be held with all participants, members of staff, carers and patients. The purpose of this will be to collect "stories" from individuals of their own improved understanding. This information will add to the construction of collective knowledge. This process is described by McNiff, Lomax and Whitehead (1996) as "a culture of independent thinkers each willing to submit their claim to knowledge to the critique of others, to ensure that the claim is robust and legitimate….ensuring that claims to knowledge are validated by the most rigorous standards."

Project Timeline

Start - Report one

Interview with all those involved in delivering the service prior to starting the new style clinic. Discussion about the service they currently provide and how they would like to see that change /

improve with a new way of working. Includes some baseline statistics (eg: current waiting times etc).

November 2003- April 2004

First 6 months to review existing services and to evaluate how role of GPwSI, voluntary and social sector care can best fit into an integrated service model. Dr Brooke to develop and review knowledge necessary to diagnose and treat dementia. Development of patient held records, integration with voluntary and social care organisations, early development of care pathway based on integrated clinic model

April 2004 - Report 2

The second interim report to be prepared in time for NICE deadline. This should include some initial change data, collected in the first six months (probably largely in narrative form).

April 2004-April 2005

Further development of care pathway, refining and developing existing services through feedback from carers, patients and staff using interviews, questionnaires and reflective journals. Monitoring of service indicators such as access times to assess change. Documentation of care pathway for publication and review of learning needs for GPwSI

End - Third and final report (at 18 months)

Full write up of project for publication including summary of project and its conclusions, together with comparisons of auditable data. Aiming to produce a care pathway for GPwSI's and Integrated clinics.

After Project

Dissemination of findings through publication and presentations.

References

Audit Commission for Local Authorities and the National Health Service for England and Wales (2000) Forget me not: mental health services for England and Wales. London. Department of Health.

Bosanquet N., May J., and Johnson N. Alzheimer's Disease in the United Kingdom - Burden of Disease and Future Care. Health Policy review Paper No.12 Imperial College of Science, Technology and Medicine, University of London 1998

Doody, R., Geldmacher, D.S., Gordon, B., Perdomo, C., and Pratt, R.D., Open label multicenter, Phase 3 extension study of safety and efficacy of Donepezil in patients with Alzheimer Disease. Arch Neurol 2001. 2001[58], 427-433

Hart E, Bond M (1995) Action Research for Health and Social Care. Buckinghamshire: Open University Press.

Holter I M, Schwartz-Barcott D (1993) Action Research: what is it? How has it been used and how can it be used in nursing? Journal of Advanced Nursing. 18. 298-304.

McNiff J, Lomax P, Whitehead J (1996) You and your action research project. London. Routledge.

McRae T., Knopman D., Mastey V., Ieni J., and Provenzano G. Donepezil is strongly associated with delayed nursing home placement in patients with Alzheimer's Disease. Poster Presentation XVII World Congress of Neurology 2001. London UK

NICE Guidance on the use of Donepezil, Rivastigmine and Galantamine for the treatment of Alzheimer's Disease. Technology Appraisal Guidance – No. 19. The National Institute for Clinical Excellence Jan 2001

Pratt R.D., and Perdomo C.A. Cognitive and Global effects of Donepezil in Vascular dementia. The Donepezil 308 VaD Study Group Eisai Inc., Teaneck, New Jersey USA.

Appendix 5

Outline of Royal College of Nursing Workshop

Part one (Morning)	Part Two (Afternoon)
Skills development Range of practical Exercises	Devising Creative Dynamics

The objectives of the workshop are outlined below. There will be ample opportunities for both workshop participants and organisers to debrief in order to support the development of understanding and application of skills as the day unfolds. A summative evaluation of the day's progress will also be made at the end of the workshop.

Individual Skill Development	Group Skill Development	Representation of contradictions (Stage one)
Multitasking	Teamwork	Devising Solutions
Competition & Cooperation	Leadership	Developing Creative strategies
Communication		
Trust	Group Interaction	Creative problem solving

Physicalisation	**Competition & Cooperation**	**Physicalisation**

All workshop participants will be required to take part in practical exercises. These will involve elements of 'personal ' risk taking, in addition to the use of good and fluid communication skills. We always aim to base the workshop on information that you can give to us about each individual group and the work that they have already established to date in order to tailor the workshop to the individual needs of each group.

<u>RCN Workshop One</u>

Aim

To help Clinical Practitioners to develop an awareness of and the use of creative practical skills in order to utilise creative processes and techniques to develop practical understanding of communication, leadership, problem solving, group interaction, team work, trust, and multitasking.

We all have an interest in investing time and energy towards the development of a more wholesome approach to the way we interact as practitioners.

The arts can play a major part in making us become more effective in our tasks by helping us focus on the way we as individuals interact as both people and professionals.

It does this by developing transferable skills that can be utilised in the workplace. It can enable us to understand how we can become better communicators. Better people centred professionals. Understand how best to become effective leaders. Deal with pressure efficiently. Think laterally.

Part One – morning session

Multitasking, Communication, Competition and Cooperation, Group Interaction, Physicalisation, Taking Risks, Concentration, Self/Group awareness, Observation.

1. Passing Ball/Maintaining Momentum – (energy transitions, flow, self awareness, group interaction, taking risks).

2. Fuzzy Duck (verbal communication keeping the mind sharp).

3. Change place dominoes - Communication -Eye contact. (Non verbal communication and reaction under pressure, working to a brief).

4. Slow motion races- Slowest wins (Physicalisation awareness).

5. Walking and Leading with parts (observation and self awareness, reading body language, group/self appraisal).

6. Competition and Cooperation - (Physical Interaction, Competition and Cooperation - how do you deal with both).

7. Pass the pulse – (Concentration exercise – unity and team work, rhythm).

8. A which and a what. -. (Multitasking using systems, concentration, communicating, physical transactions.)

9. Improvisation. Objectives exercise- (communicating and identifying objectives, subtext, taking risks).

Part Two – afternoon session

1. Trust Exercise – (Just close eyes and run supported by designated catcher at other end. (Trust, taking risks).

2. Paired exercise – tell each other a story about a family event, getting to workshop, getting out of sticky situation to partner. Partner needs to retell the story to rest of group. (Re-communicating information, listening, re-enactment).

3. Discussion – think in pictures – 'Yellow pram'.

4. Devising of montage- Series of pictures. (Image Theatre)
   Groups to show each other their montage. Whole group to identify the nature of the concepts.

<u>What do we want out of the workshop?</u>

We want you to recognise the importance of the creative arts as a tool that can be utilised to help us think differently and consequently deal more effectively in your professional capacity. We want you to develop the basic skills to enable you to do so.

We also want you to look at the process that you have experienced and develop you own appraisal of how you felt and about how you 'performed'. The small range of questions below are by no means exhaustive but may act as a starting point from which you can build your evaluation.

- What if anything did you discover about yourself?

- In what way was it easy or difficult for you to carry out the tasks?

- What, if anything, stood in the way of you interacting effectively within the group?

- What have you learnt about the quality of your observation skills?

- How did your behaviour alter when you felt vulnerable? Why?

- What risks did you take? Why?

- Did the need for you to rationalise get in the way of you working instinctively?

- In your professional role would you operate in the same way? If not what would the differences be?

Debrief.

Discussion / talk about codification and de-codification process. Link in with the thinking in pictures and part one of the workshops.
Talk about recodification how exploration can raise awareness may assist in finding solutions to the complexities of professional experience and the need for change.

Talk about the use of re-enactments how systems can be analysed through the use of theatre to explore operations, procedures and the ways in which people can interact professionally, multi-professionally.

Identify from groups ways in which experience can help them tackle the issues that they have in their workplace.

Looking for the signs (reading the code):
Understanding the contradictions: (identifying the problems,)
Developing clear communication strategies for change: (recodifying for change management)
Utilising the Arts as a tool towards gaining better clarity of people and how they behave within their professional context.

Evaluation

As well as undertaking a thorough debrief of each exercise and again at the end of the day, we would like participants to have the opportunity to undertake a written evaluation. This is essential for us so that we can undertake a process of continuous quality improvement on the workshops we are creating in order to ensure that they have fully met your needs.

Report on RCN Workshop.
(Clinical Leaders Programme)
15 Dec 2000.

Workshop Aim

To help Clinical Practitioners develop an awareness and use of creative practical skills in order to utilise creative processes and techniques to develop practical understanding of communication, leadership, problem solving, group interaction, team work, trust and multitasking.

Introduction

The Problem-solving workshop held at RCN Headquarters in London on the 15th Dec 2000 was very successful. Although the initial response to the workshops was less than expected - we had anticipated twenty-five participants. Those who took part felt that it was worthwhile and that they could take much of what they had gained back to the workplace.

In line with our policy of reviewing the activities that we engage in we have produced below some details of the evaluation that occurred at the end of the session. This enables us to implement our policy of quality improvement and also gives an indication of where these improvements are needed. I have also included some of the statements that the participants in the workshop made to help gain a clearer non-measured response to the outcomes that were experienced on the day.

Expectations.

There was some consternation regarding expectations from the workshop. Although nearly everyone stated that they did not have any expectations, general tension was evident at the beginning of the session. Pre -conceived ideas were prevalent such as, "***I came with no expectations except perhaps I was going to learn to juggle.***" We had anticipated this. We clearly thought that it was a good idea to introduce the theoretical framework from both Don Berwick and Paul Plsek to root the rationale behind our activities in a paradigm that was 'cerebrally safe'. The response to the expectations question on the evaluation form to a great extent reflects this dichotomy.

The participants were asked if the workshop had met their expectations. 46% of participants stated that the workshop met their expectations. While 36% did not know what to expect. If you combine this figure with the 18% who said that the workshop did not meet their expectations then over 50% (54%) of participants had clear problems with expressing what their expectations from the workshop were. This is reinforced by one participant who said, ***"I felt obliged to come…but you did it very well".***

Organisation

All the workshop members felt that the workshop was organised effectively. 100%.of participants said that this was the case.

Challenge Perceptions.

A major stated aim of the workshop was to challenge the perceptions of the participants. This was achieved to a significant extent. 73% of participants felt that this was the case. A further 18% felt that they were not sure yet.

Appropriateness of Content

A great measure of the success of the workshop can be identified as a result of the response to the next evaluation question. The use of Theatre skills as a tool to change thought processes and readdress the ways in which professionals engage in their work has been tried and tested for many years. Introducing the same approaches within the Clinical Leadership Programme at the RCN reaffirms the value in the use of the arts as a means to enable individuals to think and feel within the systems that they work within in a more lateral and subsequently effective way. The workshop was designed to relate much of the connections with the workplace and in doing so made the links between the workshop experience and the issues within the workplace more tangible for the participants.91% of participants felt that the approach and content of the workshops was appropriate with the remaining 9% unsure or with no particular opinion.

Ability of the Facilitators

We were very pleased to note that 100% of the respondents felt that they had confidence in the facilitators. Indeed one workshop member wrote,

“The competence and facilitation was remarkable.”

New Skills

We asked the workshop participants if they had acquired any new skills. The feedback is interesting.64% felt that they had with 18% not sure. 18% also felt that no new skills and been acquired. A more thorough analysis of the in-house evaluation may provide a more detailed response, and identify the learning outcomes and future needs. Either way we are pleased with this result. As an introduction to problem solving using the arts we would expect this level of response at this stage. More detailed work and a growing confidence and involvement will of course reap better and more sustainable outcomes. This is indeed something to look forward to particularly in the light of the kind of change development currently taking place in the health service.

Work related workshop?

The evaluation surrounding this question was for us the most significant. We used many of our skills and experience of Theatre/arts, management development and the health service to ensure that the workshop made the connections where it mattered. We were pleased with the success of this strategy as it reinforces the value in the interdisciplinary approach to the development of individuals, teams and application of problems solving skills. 91% of the workshop members felt that they were able to take much of the new skills back to the workplace. 9% were not sure. The great value in the workshop was spent in debriefing the activities in order to ensure that participants felt more confident about being able to implement the skills that they had newly acquired. Much value was perceived and gained from debriefing. We feel it is important enough to continue to feature debriefing of this quality in the subsequent workshops that we do.

Appropriate Venue

There were mixed reactions to this question. However there were some exercises that we could not do properly because the room was too delicate. Lovely room for talking but not really practical for doing theatre based exercises. Over 50% (54%) felt that the venue could have been better

Conclusions

The creative problem Solving workshop proved to be of enormous value to the participants. It enabled many of the workshop participants to re-assess the way in which they may deal with people situations in the workplace or systems designed to improve healthcare outcomes. Clearly the use of the arts in such management development situations depends on the leaders of organisations such as the Royal College of Nursing continuing to support such initiatives. At Kingshill research centre we feel that the use of the arts in such context will do more for the effective development of teams and individuals than just the presentation of new paradigms. Steps towards finding ways in which to use these skills and implement new management development philosophies is crucial as we prepare professionals for interdisciplinary team approaches to care.

We know that we may need in the future to support our work with further references etc. We are currently preparing a handout and reading list (which was requested by participants) for the next workshop. However much you read, we also know that the use of experienced practitioners with knowledge of the workplace is invaluable. Most of the learning outcomes result from structured workshop activities that are subsequently debriefed in detail.

Marian Naidoo

Dec 2000

Appendix 6

Workshop Example

Belbin's model for team roles

Team Role	Strengths	Allowable Weakness
Plant (PL)	Creative, unorthodox	Ignores incidentals
Resource Investigator (RI)	Enterprising, develops contacts	Over-optimistic
Co-ordinator (CO)	Good chairperson, clarifies goals	Manipulative
Shaper (SH)	Challenging, dynamic	Provocative
Monitor Evaluator (ME)	Discerning, judges accurately	Slow moving
Team Worker (TW)	Cooperative, diplomatic	Indecisive

Implementer (IMP)	Efficient, disciplined	Inflexible
Completer Finisher (CF)	Conscientious, painstaking	Reluctant to delegate
Specialist (SP)	Single minded, seeker of knowledge	Contributes on a narrow front

Team Development Workshop

26th July 2001

Workshop Outline

Aim

The aim of this workshop is to bring together a multi-disciplinary group of people who will use the arts to explore through the creative process the dynamics of team work, team building, group interaction, problem solving, communication, advocacy and leadership.

9.30 Preliminary written assessment - on arrival will be carried out by H.R. (30 min)

10.15 Initial warm up – Voice work.

Group interaction. (30 min)

10.45 Theatre Workshop (105min)

The task outline (Stage 1)

The group will be split into two halves and each will be given the same objective but with significant differences. The objective will be to produce a small 'theatre' performance for the other group. Both groups will have their own facilitator assigned to them who will also be able to offer additional theatre expertise and support (if requested).

An additional facilitator will offer support to both groups as well as note the development of the dynamic as the process unfolds. This facilitator will lead the debriefing session at the end and, if possible, use any data from the preliminary Belbin assessment within the debriefing session.

The Story

Each group will be given the same story upon which to base their performance. The story is essentially a tragedy involving a simple

narrative. Each group will take a different approach to the delivery of their theatre piece. One group will use a different form of theatre than the other.

Devising

The groups will then engage in the 1st stage of the Theatre workshop. They will devise a performance using specific criteria.

It will be this process of devising that will enable the teams to be formed and the team dynamic to develop. Particular emphasis during observation will be given to how well the group interacts.

1. How creative and imaginative are they at finding solutions to the task?
2. In what way does each individual make a contribution to both the task and the dynamic of the team that they belong to?
3. It will also be worth noting any reticence at having to take the personal risks to perform or try out new ideas through the rehearsal process.
4. How do they handle the specific brief that they have?
5. How well do they listen to each other as the process unfolds?
6. What kind of rationale dictated the decision making process?
7. Who led the group, if anyone?
8. How do/did they feel about testing their work through a performance?

Performance and Preliminary Debriefing

Once the two groups have performed their short piece a comparative debrief will take place. The aim of this debrief is three fold.

1 To celebrate their achievement
2. To re-enforce team identity via the original brief.
3. To highlight the merits and differences between the two pieces of work.

Stage Two Outline

After the 1st performances and initial comparative debrief the groups will merge. They will carry out the task once more and be given a new brief

designed to create degrees of conflict between the two old groups. Despite this they will need to continue to work together in order to complete the task.

Facilitators note

The group through default will make a series of assumptions about the characters and events in their story. In particular as the process of devising their theatre develops, they will apportion blame on some of the characters for the tragedy in their story. Finding consensus and deciding to agree the detailed content of their story is one of the first tasks. What happened and why in relation to the tragedy will be the focus for some of the discussion.

I anticipate that each group will come up with different versions of content (story) since at some further point they will need to make decisions as to what it is that they are going to communicate in their performance.

The facilitator will need to seek clear confirmation from the group that it is their intention to portray their version of the story content.

Group One Brief.

Your group task is to work together in order to create a small theatre performance from the story outlined below. You will have to construct your performance in a certain way details of which follow after the story outline below. You will be assigned a facilitator with performance training who will at your request, offer help advice and guidance – however the core role of the facilitator is to help you gain clarity of purpose as a group. The facilitator will consequently seek group clarity at certain key stages of your devising process and seek to move the process on when necessary.

Do not worry about the quality of your performance; it is immaterial. We are more interested in how you seek and find creative solutions to the group tasks and individual responsibilities that you assume as the process unfolds. To this extent a third facilitator will observe the team working in both groups and will feedback with the other two facilitators in the debriefing session afterwards.

The Scene. (Outline)

Your story is set in the street. Three characters are involved in your story. 1) An old woman with a dog on a lead. 2) A driver. and 3) A passer-by.
The driver is driving along the street
The old lady crosses the road.
The passer by anticipates an accident and shouts to the old lady.
The old lady does not hear.
The driver avoids the old lady but hits the dog.
The dog is dead.
The old lady mourns the loss of her dog.
The three characters come to terms with the incident.

Your task is to tell this story by playing the characters involved. You will have time to work out your plot and casting and to rehearse and develop your Theatre Performance.
You must explore through any means the events of the scene as this will give you the useful information that you may need in order to get the story clear for the group and to help you with your characterisation. You can further embellish the story but only within the criteria set below.

- You can only play people.
- You must perform your theatre as if it were true.
- You must tell the story through the characters action and words.

- You must, through your characterisation, emotionally involve the audience.
- You must start your story at the beginning and work out a plot.
- If you decide on a number of scenes each scene must follow another logically.
- You must choose one character that the audience will identify with. Either a victim or a hero or both.
- You can use music or song but only to help the characters express their emotion.
- You must bring your theatre to a conclusion by devising a suitable ending for your story.

Good luck!

Group Two Brief

Your group task is to work together in order to create a small theatre performance from the story outlined below. You will have to construct your performance in a certain way, details of which follow after the story outline below. You will be assigned a facilitator with performance training who will at your request, offer help advice and guidance – however the core role of the facilitator is to help you gain clarity of purpose as a group. The facilitator will consequently seek group clarity at certain key stages of your devising process and seek to move the process on when necessary.

Do not worry about the quality of your performance; it is immaterial. We are more interested in how you seek and find creative solutions to the group tasks and individual responsibilities that you assume as the process unfolds. To this extent a third facilitator will observe the team working in both groups and will feedback with the other two facilitators in the debriefing session afterwards.

The Scene. (Outline)

Your story is set in the street. Four or Five characters are involved in your story. 1) An old woman with a dog on a lead. 2) A driver. and 3) A passer-by. 4) A Narrator OR 5) a Dog. Or both if you can manage it.

The driver is driving along the street
The old lady crosses the road.
The passer by anticipates an accident and shouts to the old lady.
The old lady does not hear.
The driver avoids the old lady but hits the dog.
The dog is dead.
The old lady mourns the loss of her dog.
The three characters come to terms with the incident.

Your task is to tell this story by playing any of the characters involved. You will have time to work out your plot and casting and to rehearse and develop your Theatre Performance.
You must explore through any means the events of the scene as this will give you the useful information that you may need in order to get the story clear for the group and to help you with your characterisation. You can further embellish the story but only within the criteria set below.

- You must as a group demonstrate an opinion as to why what happened happened.
- You must interact and or consult with the audience; they must know that you are only acting in order to tell your story.
- You must devise more than one scene in order to tell your story. Each scene must be self-contained. ('Stand up' to audience scrutiny on its own merits).

- You must show and comment on, through either the narration or your characterisation the choices that those involved in your story have made and possibly even why they made those choices.
- You must ensure that at least one of your characters is made to face the consequences of their action.
- You must not start your story at the beginning and work you story through to the end. You can jump from one any point in your narrative.
- You can use music or song but only to enable the characters to express their thoughts and move the narrative forward.
- You must get the audience to think about or react to what you are performing without going over the top emotionally.

Good luck.

Stage Two Brief.

Now that you have successfully performed your Theatre piece, your groups will merge and carry out the final stage in the task.

Using the same story as before devise a new piece of theatre to perform. You do not all have to perform but you do all have to participate. Some of you could either direct or write or devise a specialist insert. Your brief for this task is out lined below.
You are to devise a performance for your audience. You are already familiar with the events and the characters involved in your narrative. This time you will as a whole group form an opinion as to how the events came about and why whatever happened happened.
Your aim is to come to an agreed version of the 'truth' surrounding the events and the people involved in your story.

In delivering your truthful version of the story to your audience you will agree and make a conscious decision as a whole group as to what you want your audience to experience during your performance and what responsibilities you have as a performer.

There are no other rules. You can do what you want and how you want, as long as you find group consensus.   Good luck.

Appendix 7

Outline Proposal for National Patient Safety Foundation /Charlie Victor Romeo – Kingshill Research Centre ~ Facilitation.

I have put together the following suggested structure for the CVR project. I have little information yet about time, group size etc. I will need to talk to you about this at a later stage.
I have included a section on rationale and aims to help try and focus the desired outcome of the project. This may need to be altered as necessary and should form the principal terms of reference for the project. Please feel free to alter and/or comment.

Rationale

The use of Charlie Victor Romeo (CVR) at the recent IHI 12th Annual conference at San Francisco reinforced how theatre (and therefore storytelling and re-enactments) could be used to enable health practitioners and patients to identify some of the fundamental issues that relate to patient safety and medical error. The Theatre Programme draws key parallels with the kind of complexity theory approach to operations that are applied by people and people working in teams. Unfortunately although the impact of the Theatre was profound, little was done to take this reaction forwards and apply many of the issues to a Health Care context.

Time in any case would not really have allowed this process to take place. One of the main functions of the conference was to provide inspired vision for health care improvement using approaches that were progressive, alternative and effective. It certainly did this! From many of the discussions afterwards and over the three-day period, it became clear that this outcome was achieved. Many of the delegates

were clearly 'fired up' by the thought of using complexity theory approaches in order to improve their health care practices. Placing the patients at the centre of these paradigms reinforced the need for concepts like inclusiveness, teamwork, honesty, and effective communication.

Aims

With this clearly marked as an area that needed further work in order to exploit the development opportunities that CVR had, it was suggested that the Let's Talk - 3rd Annenberg Conference in Patient Safety at St Paul Minnesota in May 2001 would be a suitable place to do this. The aims for this project are set out as follows:

- **To fully exploit the value of CVR to enable all interested stakeholders to develop reactions to identify key issues, present further analysis and problem solve effectively.**

- **To provide facilitative support to enable delegates to take the experience of CVR forward and use it as a means to help contextualise the systems, people, safety and error issues within their own professional experience.**

- **To develop and present re-enactments based on delegates' experiences that highlight the issues and provide some suggested solutions to some of the issues presented.**

- **To take back to the workplace skills and approaches that can be used to help colleagues and teams to improve their care and practice as professionals.**

A draft delegate development structure involving the use of CVR, experienced facilitators and members of the Theatre Company has been designed. It has four distinct stages to it.

1. Exposure to Charlie Victor Romeo – Theatre performance.

2. Deconstruction of the Theatre stimulus. Identification of Health Care parallels.

3. Reconstructing the parallels within a Health Care Context to storyboard.

4. Presentation of Health care re-enactments.

<u>Charlie Victor Romeo – Theatre Performance.</u>

It may be useful to video the audience during performance. This could be played back to groups in order to demonstrate the power of storytelling.

<u>Deconstruction</u>

Using delegates' recollection of CVR will provide the ideal platform to raise some of the principal issues. Video play back could be shown to demonstrate how the audience reacted to the story. It is also important that discussion takes place in order to enable delegates to develop an analysis of what the issues of the CVR story were, particularly with regard to systems, procedures, communication, relationships, teamwork and risk. This is in many ways a safe exercise as it allows discussion of a series of re-enacted events that are not

contextualised within a health care framework. This process is called 'deconstruction' as delegates will be encouraged to think about the content of the theatre in order to identify the issues. Good facilitation at this stage is crucial as many of the delegates will be able to relate to many of these issues from their own professional experience as health care workers. These will act as important markers for the next stage in the workshop.

Reconstruction

Once the process of deconstruction has been completed, delegates should move on to the activity of openly sharing with their group their own professional experience situations and anecdotes that highlight similar issues. Using some of the previously identified markers from stage one will be vital to encourage discussion. The facilitators will encourage discussion, support analytical development, focus discussion on issues and help identify common patterns of interaction that have led to error and subsequent risk. In this way delegates will start the process of reconstructing their own stories: but this time within a health care context. This could use an amalgam of anecdotes or focus on one story that will raise a number of significant issues. The facilitators will use the group's experiences and ideas, and help create the scenarios for the next two stages.

NOTE: Previously written case studies could also be used at this stage. (Although ownership is an important part of the reconstruction process) These could be devised and written by the facilitators and designed deliberately to highlight clusters of issues that have been responsible for medical error in the past. These would be works of fiction should there be worries about liability issues, and could serve as a short cut to the reconstruction process outlined above.

Storytelling – Re-enactments - Issues and Solutions

The facilitators will subsequently ask their groups to develop a practical re-enactment of their story - twice. In the first re-enactment (Story One) delegates will highlight the problems that they have shared and show this through the use of their story. (Not every group member will need to perform – some could write, advise and record.) In the second re-enactment (Story Two) delegates in their groups will use the same scenario, re-run the story but this time provide evidence of solutions to the problems that they have identified in story one. This is important since identifying the problems without developing solutions is only part of the task. We would want whole development to take place. The re-enactments would be either performed live or recorded on video and shown to other delegate groups.

This workshop structure has the following benefits.

- **It uses the safety of the CVR stimulus as a means of stimulating discussion to enable people to draw the parallels.**

- **Reconstruction positively encourages discussions between health care professionals across disciplines about the similarities within a health care context.**

- **It also develops team interaction and should as a matter of course include patients.**

- **It helps to develop the practice of sharing of issues from experience and may identify common themes.**

• It develops the skills required for re-enactment that can be taken back to the workplace and used as a tool to encourage localised healthcare improvement.

• It offers the opportunity to use creative approaches to problem solving.

• It reinforces patient centredness.

• It encourages discussion and sharing of the need for patient safety and its relationship to medical error and risk.

• It promotes systems analysis through the process of re-enactment.

• It offers a means whereby solutions to problems and issues can be identified and applied within a health care context.

• It reinforces the special communication dynamics needed within a multidisciplinary team.

• It introduces delegates to the use of technology for self and professional development.

Clearly there is still much to discuss and structure and prepare for the Minnesota Conference in May. The use of the CVR cast will be crucial. We know that the project is exciting in its approach and delegates will gain a great deal from participating. In addition finances will need to be raised to ensure that the project is resourced properly.

Appendix 8

Mary and Sue

Scene 1 Mary's lounge early evening

Mary is alone putting on her make up.

She sings softly to herself…………

Diddle diddle dumpling my son John went to bed with his trousers on…one shoe off and one shoe on……Diddle diddle dumpling my son John……diddle diddle dumpling my son John…….my son John………my son John.

John was such a happy baby, he used to lie in his crib and smile and sing to himself, he was no trouble at all. He was the same all the way through really, no trouble at all. He's married now, she was his first girl friend… oh what's her name… it's so annoying….it's on the tip of my tongue…never mind. (pause). No babies yet though, to tell you the truth I don't think they'll ever have any, they're only interested in work……they work so hard… not here though….down there…..you know…erm..oh London way. They've got their own business…they do, erm, houses you know….for….men and women….houses..you can buy

them…or sell them… Oh these words, they just don't come… they're all in here (points to head)..but they just won't come out of here (points to mouth).

Where was I, comb my hair……my hair was blond when I met Ted….and he used to hold me so tight….I can smell him, his special smell….lemon…tobacco…but I can't see his face….I can't see his face…..Did he die?

I worry about Liz….so far away….(laughs)…she sent me some beautiful erm…..oh…erm…snaps…lovely babies…tiny, tiny little things. (pauses) Sometimes I wake in the night and I don't know where I am….I get so afraid. Come on Mary snap out of this, this won't get you anywhere, what was I doing, (points to make up) this is here, was I doing my face? (hears noise from the hall)

Ted….Ted……is that you Ted……

Scene 2 Sue at her GP surgery

No….no doctor…I'm fine, I'm fine, very well actually, maybe a little tired…..stresses …you know, but who isn't these days. No Olivia's great, that last inhaler seems to have done the trick, touch wood, no she's fine. No, actually, actually…..it's mother…no nothing

physical….well nothing I've noticed……no …..no……she just seems to be acting a little strange, and I just wanted a chat….some reassurance really, that it's nothing serious.

It's quite hard to explain ….there's nothing drastic, she seems to have no confidence, in fact she gets quite anxious if you suggest she goes anywhere different, or if she meets anyone new. She's also a bit forgetful, she's forever losing her keys, or her bag, or her purse……….and words…she seems to be having trouble with words……she can't find the right word. Sometimes she repeats herself…she tells you something as if it's new, and you've already had a long conversation about it. The other day she told me she never hears from Liz, my sister in New Zealand and then the next minute she's showing me photographs that have obviously just arrived in the post. Last Wednesday I went round, as I always do, every Wednesday, without fail. We have supper together and I drop her round to the community hall, to one of her committee meetings, on my way home. Well you know what she's like, mother would rather die than miss one of her committee meetings…when I got to the house everywhere was in darkness…well I panicked for a moment.. I thought perhaps something had happened..you know with me finding dad that way. I let myself in….well she was just sitting there in the dark, and I'm sure I heard her calling dad. She just laughed it off…said I was hearing things…said she had a headache and couldn't face the committee meeting, but do you know…I think she'd forgotten all about it.

I just want to know if you think it's anything to worry about…could it be anything serious? I mean she seems well physically.

Oh I'm so glad doctor, so happy you don't think it's any thing to worry about. I suppose you're right, she has lost dad recently. Yes I suppose we do all get a bit forgetful as we get older. Well thank you so much doctor, that is certainly a weight off my mind. Anyway I must dash, thanks again, goodbye doctor.

Appendix 9

Welsh Assembly Notes for 30 Minute Theatre Introduction

Theme = Identity

The purpose of developing a piece of theatre is to use the opportunity at the conference to explore the nature of the identity of the nurse, and the function that nurse education has in shaping that identity.

We hope to create both a stimulus and dialogue with the participants at the conference. The aim of the theatre piece is therefore to raise the issues and controversies that surround the changing roles of the nurse within the health sector. We will use the initial 30-minute slot to provide the theatre stimulus for delegates at the conference in order to highlight some of the issues before the presentations from the nursing profession that deal with the developing and different roles that nurses have.
We will also present a series of comments for nurses and other health care workers, in video format, that will add evidence from others as to the perceived role of nurses.

The programme will follow a 'countdown form (game show).' and use the principles of the game show to help demonstrate the issues that the theatre will discuss. This format will also enable more active audience participation.

Narrative- The journey of the nurse.

Introduction

The narrative will involve the career progression of a nurse from small child to 'senior nurse' status. Throughout the narrative the Theatre piece will look at the relationships that exist at each stage between the nurse and the other healthcare professionals that they interact with in the workplace, including patients.

The nurse character will be able to comment on his/her situation directly to the audience and or the game show host. The same character will also be able to engage naturalistically with other characters within the theatre programme.

Three stages of the career journey have been selected to enable the developing self-awareness of the character and the points of career change where many of the issues and controversies can emerge. The team have, after much research, concluded that the relational sating point is the same as the end point i.e. no change on both the relationships that nurses have with their co workers. Indeed parallels are drawn between the perception of the old style dictatorial matron and the emergence of the concept of a new matron. More importantly is the premise that the politic involved in the relative status between the nurse and the doctor have not really changed that much and that the realities of this politic has had a detrimental effect on the pace of modernisation within the health service.

Stage One

Childs perspective.

- ***Young girl who wants to be a nurse because she is a girl.***
- ***She wants to care – or has been conditioned to do so by the sex role models that exist in society.***
- ***She may have spent some time in a hospital and experienced directly the care of a young nurse.***

- ***She could describe how she watches mum take care of daddy when he returns from work…or even how she has to because mum is also too tired so this gives her an opportunity to practice.***

- ***She talks about wanting to take care of others like she had experienced in hospital.***

- ***She talks about the animals she has or the teddies and dolls that she has taken care of.***

- ***She talks about dressing up and looking pretty in her nurse's uniform.***

- ***She talks about making people better; curing them of the diseases that they have.***

Stage Two

The Student Nurse

- ***Young student nurse talks about why she is doing nursing.***

- ***She talks about the training and the differences between expectations and the reality.***

- ***She talks about her degree and the difficulties in the theory/practice experience.***

- ***She talks about the expected role model that she has with doctors and patients.***

- ***She talks about the need for more practice based experience.***

- ***She talks about her experience of the dynamics of teamwork and wanting to care for patients.***

- ***She describes the clear demarcation lines that exist between nurses and other staff delivering care and services.***

- ***She talks about her maintained ambition to continue with nursing because she still believes that it is a vocation.***

- ***She talks about the need to maintain good relationships with other staff involved in the delivery of care.***

- ***She talks about the jobs that she wants to do but cannot and the jobs she does not want to do but has to.***

Stage Three

The Experienced Nurse

- ***She talks about her long experience of working in a hospital.***

- ***She describes the changes in the health system that she has experienced and talks about the impact if any on the relationships between her profession and other professionals.***

- ***She talks about the need for better management and care systems based on evidence and further updated professional research.***

- ***She talks about the weaknesses of the leadership that she has experienced and what she would do to rectify this.***

- ***She talks about needing new challenges and bigger rewards and that being a big nurse is one of the only ways that she knows to achieve this.***

- ***She talks about the role of the modern matron and the irony in her perception of the role of matron dating back to the good old days of the NHS.***

- ***She talks about the need for a better and more robust and professional identity for nurses but how this can only be achieved through a long journey and profound changes.***

- ***She talks about identity and the fact that it arises out of the relationships that are developed with other.***

Appendix 10

Script for the National Nursing Conference of Wales

I am because we are.

Introduction

After the initial intro the 'host' introduces the concept of the game show and the fact that they are going to play a special version of countdown. We hear the music from the game show and the and invite the audience to solve an anagram of the word 'identity'.

Added pressure is introduced with the countdown theme.
The 'host' thanks the audience and then introduces the first contestant.
"She is a very special guest for this very special version of countdown. She comes from Cirencester in Gloucestershire where she currently attends Powell's schools. Her hobbies include Barbie, Ponies and anything with Diamonds. Her favourite colour is Pink and her favourite Pop Idle is Gareth who she intends to marry when she grows up. Ladies and Gentlemen a big round of applause for…..

April….

Stage One

A little girl dressed primarily in pink moves on to the stage and sits on the table.

Her finger is bandaged.

She looks nervous and excited.

She looks at the audience- (establishing an initial relationship)

She takes time to peer, possibly using her hand to see if she can see someone that she knows.

She can identify someone in the audience. She waves to them excitedly.

"So -------- How old are you? What happened to your hand? Are your mum and Dad here today? ………Here are your letters you know how to play the game you have sixty seconds to see how many words you can make from these letters……?"

Audience word – Identity
Contestant word – Nurse

I'm not really very good at spelling, and anyway I don't have to do what you say, you can't make me do it if I don't want to.

[makes a point of showing the audience her bandaged finger and waits for a reaction}

I have been to the hospital 'cos I hurt my finger, well I didn't do it, it was my stupid brother's fault, he hurted my finger. Mummy said "Thomas be careful with the car door" but as usual he just wasn't listening and it went slam, on my finger, and he cutted it very badly and all of my little blood was coming out on the floor and all over my bestest Barbie T shirt, and he got a smack. Mummy had to bring me to the hospital, but not in an ambulance, just in the car silly. and I didn't cry and I was very very brave and I had to wait and wait and wait and I got a certificate and it said, April was very brave, and I could choose a colour and I chosded pink.

I liked the nurse who putted my bandage on me, and she didn't hurt it like that nasty old doctor did, and she was very pretty and her hair was blonde and it was very very long and she had pink bobbles. But she didn't wear a pretty dress like the nurse in my book. The nurse in my book wears a pretty dress and a white hat and it's all frilly and when I am a big girl I am going to be a nurse and I will wear a pretty dress and I will grow my hair so it is very long like Kate's and I will put pink ribbon in like this and then I will wear a pretty hat. When I am a nurse I will make all the people better, cos when my dolly was very poorly I looked after her and made her all better. And I won't be mean to the children, I will make them all better with medicine but all on a spoon, not medicine in a needle, because that is very mean and nasty to do that to put the medicine in a needle and stick it in your bum, unless you are naughty, like my brother. I will put all the medicine on a spoon.

Are you all nurses…..naw….I don't believe you and you is not a nurse because you is a daddy and daddies do not do nursing things. You are a very silly man, you are.
Can I go and get my mum now 'cos I need a wee.

(April rearranges her letters and runs off obviously rather desperate.)

Stage two introduction to May

Audience word =Caring
Contestant Word =Vocation
(Very happy, bubbly and up beat. She is clutching an envelope in her hand and waves it around.)

Do you have any idea what this is in here? Do you have any idea what this means to me? 3 years of hard labour over, finished that's what… but guess what….I've passed…yeh…..not only have I passed….I've got a 1st…smartest nurse of the year that's me. Tell you what though you wouldn't have put money on this, I mean me and nursing, sick people, blood and guts and vomit…no way…beautician maybe but nursing never. That is until I met the gorgeous Joshua Browning, talk about

fate. I wasn't even invited to the party but Gemma was going and she had no one to go with her, and you know me, never turn a party invite down. It was all a bit boring at first and then he arrived with all his mates; he looked so cool, like a cross between Brad Pitt and Jamie Oliver. You know what I mean, sex on legs, but he can also cook you a lovely dinner! Get in there girl I said to myself and then ha ha May Roberts pulling machine extraordinaire, I mean, he didn't stand a chance did he. When he said he was a medical student I was gob smacked well I mean, generally got them down as geeks haven't you, but geek he was not. And then I met his mates and a couple of them were nurses. I didn't know you went to university to be a nurse, they really liked it and they said it was challenging and made you feel really good when you did something for someone and it kind of grew on me. And anyway it's a degree isn't it and even if you don't end up nursing it was still a useful qualification, that's what mum said anyway, she said it would be a good thing for me to have under my belt. Josh and I went out for nearly 8 months all together; mind you we didn't actually get to see each other very often. There was always one thing or another, we never seemed to be off duty at the same time, it was almost impossible to meet up, and then…well…. you kind of move on don't you. Actually I saw him a couple of days ago, I took a patient down to theatre and there he was, god he's still gorgeous, but you know there's something about scrubs isn't there they kind of all manage to look really sexy in them don't they, even the ugly ones, or is that just my fetish? He's just as arrogant though, so it's just as well really. He's going out with that new South African anaesthetist, yeah that's the one, blonde with legs that go right up to her neck, thinks she's gorgeous she does. Anyway good luck to them I say, they deserve each other.

3 years though, you know it's gone really quickly although there were many times when I thought I wasn't going to make it. The pressure gets

to you you know, and no matter what they teach you at uni, they can't prepare you for that. There have been times when I have wanted to say shove it. Remember that awful sister on geriatrics, it was my first day on the ward and she gave me these suppositories to do, well yeah of course I knew what they were for, but I had never given them to anybody and she just took off on me and said oh you know stuff like "student nurses are no use now, what's the use of a nurse who can write a book on constipation but can't give a bloody suppository" She shouted this at me all over the ward in front of everyone, I felt so embarrassed. I felt like telling her where to shove her suppositories. It is like that though isn't it I mean like at university they drum it into you about the importance of research and evidence and not just doing things because that's the way it's always been done, and then you get onto the ward and you get told Oh no Mr so and so likes his ladies to bath in milk and stand on their heads after surgery, well you know OK slight exaggeration but you get my drift don't you.
But there's also the good bits, the rare occasion when you do have time to hold someone's hand or you make them feel better, or someone goes home, better, and you know you really did make a difference. A lot of the time though you just don't have the time to do the things you know you really should be doing and that gets so frustrating.

There is another thing too. I went to an infection control conference last week and I got talking to this woman on one of the stands. She was saying that her company were desperate for people like me, with a nursing degree, and also because I did A level theatre studies I was a good communicator. I thought she was just giving me the spin but I got a phone call this morning and they want me to go and talk to them this afternoon. They've got this job in their healthcare team, they are offering me a starting salary of £32,000 and a car, can you believe that,

it's a bit tempting isn't it. I mean, how long would I have to stay in the NHS before I could earn a salary like that.
Oh god…what am I going to do….well what would you do?

(Rearranges letters to make her word – vocation).

Stage Three introduction to June

Audience word = Career

Contestant Word = Relationships

(A Nurse sits at a table. She pours herself a small drink. During the course of the speech she pours subsequent drinks for herself as necessary. She talks to the audience using silence and pause to underline aspects of the speech.)

To know to really really know is so important to me. I've always cared, ever since I was a little girl, I used to drive my mother mad. Every sick pet, every injured animal, anyone with a problem, I brought them all home. She used to say to me "For god's sake June will you stop bring the problems of the world to my doorstep." I needed to help and wanted

to help. For me though, I had to know that I could……help people feel better.

I've been a nurse for more than 20 years now…. I've experienced the cut and thrust (usually the cut) of the NHS at its best…I have seen my profession go through enormous change …….shortages….lack of esteem and poor wages and do you know, there is nothing right about any of it….we never get it right and I don't suppose we ever will…..but that doesn't matter. It doesn't matter because whatever we get wrong - we can put right……and if we harp on for long enough and keep the pressure up in the appropriate places we will eventually get what we want……but that is not enough. I know believe you me I know.
You see, it doesn't matter what you do; how you tweak the systems…..the bottom line is always there……I know, that to do my job properly caring is not enough….and anyway not everyone that I work with cares the way they should.

I have worked in some places where we all knew that there was something wrong…like the system itself was flawed. And nobody did anything about it ….and that's when people are suffer more that they need to…Patients don't get the right treatment or they get the right treatment at the wrong time…..and that is where I start to detest my work…detest my job…my profession ….detest myself. And it starts to get to you and they keep the pressure up and the pressure builds up and it wears you out and you get tired and it builds and it builds until you just get pissed off with the pressure, you get pissed off with work pressure, pissed off with doctor pressure, pissed off with patient pressure… manger pressure…hospital pressure and your just pissed off, pressured out and knackered …and I know I care….. I really do!

Shame and blame that's what we're good at ….. Shame and blame. (Change of tact) I was on a course recently….I wanted to try and do something… The NHS is awash with them. Modernisation……Service Improvement….patient centred caring…..Leadership….Medical Error…Mentoring……great ideas lots of energy THE NEW NHS….modernisation for real! And I wanted to do them all. More than anything else I was looking forward to the break from the ward, a break from the pressure…..but you can't even do that can you, because I know when I'm away some other poor buggar's picked up my work load. And then you feel guilty, you feel guilty about being away. When you're on the course you get lots of ideas, you get energised and when you come back you want to change things but your workload is up to here and you've got to deal with that, and everything you've learnt's gone out the window.

At the time the hospital was going through a crisis, oh not your normal every day kind of crisis, I can deal with them, no this was crisis with a capital C. This one had hit the press big time; it was even on the telly. You know I'm a good nurse and I've got a good team of nurses but when the shit hits the fan you all get splattered. Oh…listen to me…I'm doing it now…shame and blame…we were a good team but when we they put the pressure on we all run back to our own professional groups, and we blamed each other…we all knew something was wrong…but not one of us did anything about it. Well when I got to the course they were all talking about it there, I couldn't go for a cup of coffee without it being talked about…and I got through two and a half days without telling anyone who I was and were I worked because I didn't want to answer any of their questions. I did great until the last afternoon. We had one of those happy clappy external consultants. Come on we'll start with an icebreaker… let's go around the room and tell each other who we are and where we work. Well I started to sweat…and as they went

round the room one by one my head started to swim…I started to panic. Its bad enough at the best of times ..but I was going to have to tell them where I worked…and when it came to my turn…I tried to whisper…I couldn't say anything..all I felt was shame…shame…shame and guilt and now embarrassment. Pause

Give her her due, she dealt with it very well, she stopped, she threw away what she'd planned, and she got us to sit down and to talk about what I was feeling, and she asked if anyone else had ever felt like me. And do you know there wasn't one person in that room that hadn't felt the same. The more I reflect on that, the more I think about what happened, the more I realise that the problems not with resources, not with shortages….yes they're there, but they're the things we can put right, we can fix them. ….No……what we don't do is think about the way we treat people and I'm not just talking about patients, I'm talking about the people we work with, the people we work alongside, the people we work for. We don't trust each other, we don't respect each other. And I know that if we could get that right, if people really matter and we know that it's people who really matter and we can get the relationships right, the rest will follow. That's the starting point, that's how we modernise. I know because I care.

Stage Four introduction

<u>Audience word= professional</u>

Contestant word=what do all these words have in common?
Well done, it's good to see that you are all on the ball this morning. Now moving swiftly on I'd like you to give a warm welcome to our final guest this morning…..Oh…..erm…….I don't appear to have a name for our next guest….perhaps you could begin by telling us who you are and where you come from.

(A masked figure enters into the space.)
Well that's where I thought you could help me.
Sorry.
You see that's the problem…I'm not sure who I am.

Look I haven't got time for any of this nonsense, let's just forget your name and get on with the game. Here are your letters….

Countdown music.

Perhaps the answer is here, out here, with you, perhaps you know who I am.
I know that I care for people, or at least that was my intention, that is what I want to do. That is where I started, from almost the beginning of time, when communities began to form I nursed the sick. When society became more industrialised I adapted and cared for the sick and the poor in workhouses and voluntary hospitals. Sometimes I had to sustain my own existence by stealing from the patients.

I improved myself and sought education and training. During the Crimean war I saw the need for more reform and laid down the foundation for modern nursing.

I brought together women from working class backgrounds and ladies with breeding. I fought off the attacks from the medical profession when they felt their profession was being impinged by me. I was responsible for the cleanliness of the wards as well as the cleanliness of wounds. I fought for registration to give me autonomy and status and enrolment to deal with a crisis in nursing numbers. I allowed men into the profession.

But who am I now?

I have improved my education and developed complex technical skills – yet I feel inadequate. I rely on my colleagues but appear to be invisible. I am knowledge based, I am committed and dedicated, innovative, yet I stand in isolation.

I want to take your hand but the demands you place on me pull my hand away. I am a professional - but it is me in here – that dictates what kind of professional I am.

I

I am me.

You

You are you

We

We are us

I am because we are.

END

Appendix 11

Modernisation of Older People's Services Conference.

Agreed Brief

- ***Collect and record qualitative evidence through research with a wide range of service providers for Older People to ascertain perceptions in relation to change, improvement, experience, and modernisation.***

- ***Collect and record qualitative evidence from the wider community including service user's perceptions, stories and experiences of the NHS and Social Care provision.***

- ***Analyse data for use in the creation of a theatre piece to be developed for the older people's conference in November.***

- ***Through the means of devising and writing, create a piece of theatre that explores many of the issues identified by the research in order that the theatre piece can 'set the scene' for the conference.***

- ***Edit and prepare some of the recorded evidence for use as an integral part of the theatre presentation. (Video, slides, pictures).***

- ***Develop and perform the Theatre piece at the conference.***

- ***Ensure that the Theatre piece is structured to take into account the learning objectives of the conference in an active way.***

- ***Align the theatre presentation to active and discrete learning outcomes during the session.***

- ***Structure, develop and facilitate a warm up session for day two of the conference.***

- ***Facilitate the plenary session of the conference by using an agreed 'chat show' format.***

- ***Participate in the planning and development of the conference through membership and attendance of the steering group meetings as and when scheduled.***

NSF- Older Peoples Conference – Bristol Nov 2002.

Research Based Theatre/Video for NSF Conference

Steering Group Report

Initial Brief

- ***Using drama and video to represent the perceptions of older people and their carers as service users.***

- ***Include positive images of older people to challenge stereotypes.***

- ***Possible theme – "Older people are part of the solution not the problem."***

- ***Research evidence that challenges the burden of care for older people.***

- ***Develop Chat Show Format***

- ***Breakfast session day 2***

Outline for programme of work

Aim: to elicit perceptions from the public as to how they value older people in society and as users of the NHS.

A series of in-depth interviews using video/audio-tape and note taking will be undertaken. Interviewees will include; members of the older population, older service users, carers, health care professionals, and members of the public.

The purpose of the interviews is to encourage individuals to tell their story. Following analysis of the data the research team will use this material to create a narrative, identify issues and record onto video items to playback to the conference.

The purpose of the narrative is to inform the audience at the NSF conference and also to challenge current perceptions of older people for health care professionals and others who provide services for them.

Progress to date.

47 interviews in total have now been undertaken. Each interview is essentially a detailed story from different individual viewpoints about Older People and/or the Health Care Sector.

Thirty-eight of these interviews have been in-depth with the remaining 9 providing anecdotal evidence that has been recorded onto video and will be prepared for the conference. It is intended at this stage to use video recorded material at both the opening stages of the conference to support the theatre narrative and at the end of the conference during the 'chat show'.

The evidence will be used and amalgamated to form the basis of a narrative piece of theatre that will be used to initially 'set the scene' for the conference.

<u>Form of Narrative</u>

The form of the narrative is not yet known; it may be interactive, use video as an integral part or just stand alone. The criteria for the 'form' will be dictated by three separate factors.

- ***The content of the narrative.***
- ***The required impact on the audience.***
- ***The nature and size of the venue.***

<u>Content.</u>

The narrative will raise a number of different issues some of which are critical of the quality and expectations of health care, and others that highlight a very efficient and effective relationship with areas of the health care sector and the people who work within them. Throughout the conference these issues will re-emerge and be discussed – any new learning can be shared and discussed further during the 'chat show' at the end. We feel that it is important to finish the conference on a positive note having moved forward in some way

The stories that have been collected are real and represent a valuable form of evidence. Permission has been requested from the interviewees and obtained by Kingshill to use part or all of their stories. We have also agreed to change names and other identifying information to protect those involved.

<u>The Devising Process</u>

The video footage and the stories we had gathered from the research was very powerful and we didn't want to lose the potential of its impact on the audience. It was also important that the very bold and sometimes very brave statements that some of the healthcare professionals we had interviewed had made were also captured for the delegates. We decided to edit the video using the themes identified by the research and to then underpin this evidence with the use of a real person who was experiencing these issues.

Identified Themes from the data collected

Getting Old and Positive Attitude

Ageism and Equity

Resources

Access to services

Leadership

Relationships.
Specialist services.

Systems Failure and Whole Systems Design

Perception of Health and Social services care.

Final Script for National Service Framework for Older People's Conference

Decision Day

Intro to the session

This session has been designed to help to set the scene of the conference.

All of the material that you will see has been researched by gathering stories, opinions and experiences both from individuals and from focus groups in various parts of the country.

Some of the evidence you will see via video - and some has been created and condensed into a fictitious story of a patient's journey, which in itself is based on the evidence gained from the research.

We also want this to be an opportunity for you to celebrate the success of the modernisation projects that you have been involved in and to offer your experience of these achievements to others during the conference.

During this session we will be asking you to use your workbooks and record what you feel are the important issues for you. Your expertise is invaluable.
We will pick up some of the themes again as well as your responses to this and the other sessions during the chat show and the end of the conference.

Decisions are something we make every day…they shape our complex lives in profound ways, they affect others- sometimes in ways we are not aware of, and they reinforce our values and beliefs and sense of community.

Intro to Getting Old and Positive Attitude

We all get old – some of us anticipate our old age with dread – some with more positive attitudes.

Video Tape 1 (3.32) >>Getting Old/Positive Attitude

Most of the time we learn what it is like to be old when we are old and when we experience how society responds to our own old age. The people we have talked to share this mixed view.

LFX 1 (Lights Down for Screen)

Decision Day Logo LFX2 - XFD Presenters Area

Ageism and Equity

One of the outcomes of the research recorded perceptions of discrimination toward older people as service users. We were surprised however at the high percentage that did so. 83% of those who took part said quite categorically that ageism exists and that equity of access to services was desirable but in reality rarely perceived. These were the most common reactions…

LFX 3 (Lights Down for Screen)

Video Tape 2 (5.06) >>> Ageism & Equity

Decision Day Logo LFX4 – XFD Presenters Area

Joan 1 (Theatre)

It is now time to introduce you to a 'patient journey story' and the theatre piece performed by Marian Naidoo.

LFX 5 Lights up Half State on Acting Area

Marian will play Joan Simpkins, who like the video evidence, starts her journey at the point where she begins to recognise what will come to us all.

LFX 6 XFD Lights Down Presenters Area & Full State Acting Area

Joan 1

I was doing my shopping one day in town, ooh it was freezing cold and there was a bitter wind, and I saw this poor old woman, she pulled her coat around herself to keep warm, I looked at her and she looked back at me, and then I realised, (Pause)… I was looking at my own reflection in the shop window!

Getting old is just like that, ..it creeps up behind you when you're not looking and it grabs you by the throat.

But inside, I feel just the same as I did when I was 16; it's just your old body that lets you down.

You don't really take much notice at first – just a couple of aches and pain, oh you know, and then you notice you're a bit stiffer than you used to be when you get up in the morning, and every now and then y'get a couple of funny turns .. it all builds up gradually and then you realise, you're on your way down the slippery slope.

I was determined it wasn't going to get the better of me, and anyway I've got a good family and a good doctor. Doctor Wilson is very good to me, he's always got time to listen to my problems and he has the most wonderful blue eyes. I've known him for a long time now…he's getting on a bit himself now although I don't think he's quite my age just yet!

Dr Wilson says that he can't understand why I want to stay living on my own, but I'm used to it. My boys are grown up now with their own families and My George died suddenly17 years ago - I've been on my own ever since, George loved the garden. Everybody used to compliment him on his roses...he was the envy of the whole road. He died in the garden you know, it was a beautiful summer evening, I thought he was having a doze on the bench, well he liked to do that, used to crack on he was reading the paper, he was only 61 (laughs) and he still had that twinkle in his eyes.

I do try and get out and about as much as I can. Not at night though, not when you're on your own, it doesn't feel very safe especially when the nights start drawing in. It's different if you've still got a husband, or if you can drive.

I go to the pensioners on a Tuesday afternoon, I used to walk down to the end of the lane and catch the number 23 but I can't manage the walk that often now- not with this hip. I miss that walk and I think it makes you feel worse when you're used to walking. So I have to catch

the little bus from round the corner and then get the number 12 and if you miss 1 of them, well, you can wait for ages and by the time you get there it's time to get back. That's why I don't go to Marks any more, I used to go on a Monday after I'd collected my pension, I'd jump on a bus and I'd be there in 20 minutes, well you can trust their meat can't you, and you can buy just a little piece, just enough for 1, you can't do that in the Supermarket, and anyway I don't like the look of their meat - it doesn't look very fresh and you don't really know where its come from. There isn't a proper butcher round here anymore, there used to plenty of them on them. Isn't it funny how quickly things change.
I used go to Marks to buy liver - I thought I might be a bit anaemic, but Dr Wilson said my cheeks are too red and rosy for that, but I thought, if I have, a bit of liver will soon sort it out

.

I'll feel much better when I get this hip of mine done, I'll be able to get out and about more. Dr Wilson said it shouldn't be long now, mind you he's been saying that for a long time. I've been in once already, just before Christmas, but there was a flu epidemic and I got sent home again. We can't cope with a crisis in this country any more can we?

They do need to sort these waiting lists out, it's not right having to wait all that time is it, particularly when you're my age. I mean take poor Bert from the end there he's been trying to get a stair lift because he can't manage the stairs during the day, but because he owns his own house and he's got a pension he's got to pay £2,000! Irene his wife, she's 82 herself; she has to put a bucket with disinfectant in the garage for him to wee in. It's not right is it? He was a prisoner of war you know; but he said to me" Joan I didn't let the Japs get the better of me so I'll be buggered if I'll let the NHS.

LFX 7 XFD (Slow) No state in Acting Area & Half State Presenters Area

Power Point - Slide 1 - On Screen (Decision Day Logo)

Power Point - Slide 2 –

LFX 8 - House Lights On

<u>Activity</u>

Please take the next 10 minutes to discuss at your table the kind of decisions you feel would be needed to address any of the issues that you have identified.

LFX 9 XFD House Lights Fade Down & Full State- Presenters Area

<u>Intro for Resources Access Leadership and Relationships.</u>

One of the most common shared perceptions of both service users and service providers is that more resources will resolve many of the issues that surround older people's services. It was a recurring theme. However when the evidence was more closely analysed a number of related issues became more evident. They raise more questions than answers but more significantly they can provide the basis for the kind of challenges that modernising services for older people could address.

LFX 10 Presenters Lights Down.

Video Tape 3 (2.44) >>>Access/Resources/Leadership/Relationships

Decision Day Logo LFX 11 – XFD Presenters Area.

Joan 2 (Theatre).

As Joan continues her journey, we discover that like the weather life is sometimes unpredictable and that small changes can have big consequences.

LFX 12 XFD Presenters Down & Acting Area Full State

Joan 2

I'll be glad to see the back of this place – I've been in here far too long - although I'm not going <u>home</u> just yet!

They're sending me to what they call an 'intermediate care home' for rehabilitation. Well, I came in in a panic! (Pause) I had a bit of a fall.

(Telling the story) - Fireworks night it was, there were a few boys and girls messing around like they do. They have me pestered sometimes you know, I don't mind them having a bit of fun, but they were setting off fireworks right outside my front door. Well- you read about them putting

them through your letterbox and setting your house on fire don't you? So I went out and I chased them.

I must have just lost my footing because the next thing I knew I was on the floor, in an ambulance and then in here. I must have lain there; on the floor for at least half an hour before the ambulance came. I suppose it was one of their busy nights.

Casualty was heaving with people, so I expected to have to wait for a <u>bit</u> but not on a blinking trolley for hours. What made it worse was that they parked me right by the door. Everyone was going outside for a smoke and do you know, not 1 of them closed the door behind them, I was freezing. I don't know what they're doing letting them smoke in a hospital. I'd put a stop to that if were them. I was there for 7 hours before they sorted me out.

I hate hospitals at the best of times, if you want to catch something this is the place to come. Anyway at least I got my new hip and d'you know I felt really guilty because I jumped the queue.

I thought that I'd be up and about and then I'd be able to go home. Things are never that simple are they? I've been in for nearly 11 weeks all together! I asked the doctor if I would have been in this long if I'd had my operation when I first came in before Christmas. He said that I had picked up one of those hospital infections which didn't help and that the delay after the fall had weakened me, well it can't do you too much good lying in the cold for do long can it? The operation went very well and they are very pleased with my new hip, and so am I, but I had to spend so much time in bed my muscles are a bit weak, and I'm just a little bit wobbly still, but they're going to sort that out. I have to be able to walk to the toilet by myself before I can go home.

Ooh I can't wait, I can't wait for that 1st cup of tea and slice of toast by the fire – my evening paper and Inspector Morse….god rest his soul. The tea in here is awful, it's either weak and hot or stewed and cold and the toast is like Ryvita by the time it gets to you.

Those poor nurses are so busy – they work really hard - you don't really like to bother them. See this old lady here next to me, she doesn't speak any English, they don't understand what she wants, she's been banging that plastic cup on her locker for about half an hour. She does that when she wants a drink but there's no one around. If I could just reach a little bit further I would get her one myself. God love her, poor old thing.

I wonder if I'll get a stair lift when I go home? That would be handy; I could wave to Bert on the way up. (laughs).

LFX 13 XFD – Acting Down & Presenters Half State

Power Point - Slide 3 - On Screen (Decision Day Logo)
Power Point - Slide 4 –

LFX 14 - House Lights On

Activity
Take the next 10 minutes with those at your table to create a short list of things that you can do to improve the relationship between you, the service you provide and the service user.

LFX 15 XFD House Lights Fade Down & Full State- Presenters Area.

Intro to specialist services.

Specialist services are in many ways an expression of the desire to create better more effective provision for any area of work. The response to perceiving a need to develop specialist services was very positive. The research also indicated a number of systems issues in relation to specialist services.

LFX 16 Presenters Lights Down.

Video Tape 4 (1.51) >>> Specialist Services

Decision Day Logo LFX 17 – XFD Presenters Area

Intro to Systems Failure and Whole Systems Design

We gathered a lot of research that recounted numerous stories of negative experiences, and the need for change. It is the nature of that change that you as Health and Social carers need to identify.

LFX 18 Presenters Lights Down.

Video Tape 5 (4.41) >>> Systems Failure/Whole Systems

Decision Day Logo LFX 19 – XFD Presenters Area

Joan 3 (Theatre)

In the final part of our small trilogy Joan Simpkins is under pressure to commit herself to making a decision.

LFX 20 XFD Presenters Down & Acting Area Full State

Joan 3

I really do look forward to them coming to see me…. But they wear me out…I don't know where those kids get all their energy from- eh it would be alright if some of it rubbed off on me wouldn't it. I could do with a bit more energy right now.

My oldest 2 grandchildren, they're both in their teens now, and they are not keen about coming in here on a Sunday afternoon. I bet they've got better things to do. It's not as if they even had very much to say for themselves, when you speak to them they just grunt back at you. They don't like this place anyway – they said that it smells like cooked cabbage in here….and the music they listen to boom boom boom. full blast, it's a wonder they're not deaf.

I couldn't live with my kids - oh they've offered, - <u>both of them</u>… but I've lived on my own for far too long, it wouldn't be fair on them, we'd soon end up falling out with each other..

I'm used to living on my own, doing my own thing; I could eat what I wanted, when I wanted. Even if it was 3 o'clock in the morning, well why not. Sometimes the night can be very long when you're on your own, so when I couldn't sleep I'd make myself a nice cup of cocoa, or sometimes something a bit stronger, and I'd turn the fire up high and watch an old film, well that's when they have all the best ones on, in the middle of the night. In here when you are awake at night you don't like to bother them, they've offered to give me something to help me sleep but I don't want to take anything. I take enough pills without starting on sleeping tablets and all, and anyway your supposed to need less sleep when you're older so it's quite natural, it just doesn't fit in with what they want.

They're very good to you in here you know. - but you do get used to somebody else doing everything for you. You don't have to make any decisions for yourself – nothing for you to worry about – you don't have to plan your meals or wonder if you've remembered to pay the electricity bill – other people do it all for you. Sometimes you do need that - although something is missing - I don't feel like me any more – ooh and you get that bored.

I've decided that I need to manage on my own more now – so I'm ready to go home.

My boys don't seem to be very happy with that idea though. They're worried that I might have another fall. They want me to go into a residential home, permanently, but if I do that I'll have to sell my house to pay for it, and I don't want to do that. I know it's only a little house but it's all I've got to leave them.

I know they want to do what's best - so I've even been to see a couple of them to keep them quiet, but it isn't what I want. Although I have been told that I have to make my mind up now so that they can organise everything…but it's very hard. Oh there's plenty of them to give you advice, but how do you know which one is telling you the right things, I don't even know who half of them are, they all ask me the same things and then you don't see the same one again. Do you know what I think, I think they should get those Almoners back, do you remember them, they used to have their own office in the hospital, and they sorted all that sort of thing out for you, it's a pity they got rid of them.

What a position to be in, you see I'm going to have to choose, aren't I, either I go home…..on my own…..or…..I give up my independence and do what they want and go into a residential home. Either one or the other. But you see I think I want both. and I don't see why I can't have both?

LFX 21 XFD – Acting Down & Presenters Half State.

Power Point - Slide 5 - On Screen (Decision Day Logo)

Power Point - Slide 6 –

LFX 22 - House Lights On

Activity

From the evidence given so far identify three ideas within your specialist area that you could develop (or have already developed) designed specifically to improve your services for older people.

LFX 23 XFD House Lights Fade Down & Full State- Presenters Area

Intro to the Perception of Health and Social services care.

It is worth celebrating the fact that nearly half of the people we talked to about their perceptions of Health and Social care for older people responded positively to the services that they either used or would be expecting to use at some time in their lives.

Good things are happening & there are certainly still issues that we need to address.

I hope that we can all use the opportunities within this conference to continue this process of improving services for older people.

Video Tape 6 (2.01) >>Perceptions of Care System - a celebration

LFX 24 Presenters Lights Down.

Decision Day Logo LFX 25 – XFD Presenters Area.

Appendix 12

Electronic Booking

The electronic booking team had produced the following paper for our guidance.

1 Purpose of Event:

- ***To highlight progress made since the Ministers initial commitment to electronic booking.***

- ***To present the 2nd wave of shadow communities and explain the roll out process for electronic booking.***

- ***To publicise and celebrate the achievements made to date***

- ***To raise awareness of the National Electronic Bookings Programme throughout the NHS.***

- ***To give a National direction, which will encourage Trusts to ensure that local initiatives are developed within a consistent framework.***

- ***To raise levels of interest and take up of the Shadow site roll out.***

- ***To share knowledge and experience, in order to minimise costly duplication of effort within the NHS.***

- ***To raise awareness of the place of electronic bookings within 21st century IT.***

- ***To give information on the funding mechanism and budget available for this project.***

2 Key Messages

- ***There is a National programme for Electronic Booking which Strategic H.A.s, PCTs and local Trusts need to be engaged in.***

- ***Electronic bookings is a key part of the overall modernisation of the NHS e.g. links to 21st Century IT, EHR, EPR, Choice initiative, NHSD etc***

- ***Electronic bookings is an integral part the National Bookings Programme.***

- ***Electronic bookings will only be successful within the context of redesigned services, which are supported by co-ordinated management of capacity and demand.***

- ***The involvement of Primary Care is key to accomplishing the goals of electronic booking***

- ***Activity has resulted in improved patient experiences.***

- ***Activity has resulted in better use of time for clinical professionals, and other NHS staff.***

3 Overview of key Messages

- ***How Electronic bookings fits into the overall modernisation of the NHS.***

- ***Who needs to be involved to make it happen, and what they need to do.***

- ***Why is it worth doing?***

4 Target Audience and Rationale for Inclusion

- ***Electronic Booked Admissions Project Board: As have accountability for programme***

- ***Trust CEOs: Key decision makers within organisations. Responsible for ensuring that Trust projects have national strategic fit. Need to influence/reinforce perception of importance of E'bookings as part of a national programme rather than solely a local initiative.***

- ***Directors of Modernisation: As above***

- ***DHSCs: Performance monitoring of overall programme***

- ***CIOs StHAs: Key responsibility for 21st Century IT, StHA will be responsible for monitoring performance of ECs and Shadow sites.***

- ***PCTs: Success of the project is dependent on Primary Care commitment and engagement currently projects are being driven by Acute Trusts therefore need to ensure inclusion at National events.***

- ***NHSIA: Project partners***

- ***NHSD: Project partners***

- ***NAGPC/RCS/BMA/Clinicians: Powerful accelerators or brakes to change/redesign need to hear (and believe) the messages around improved patient experiences and release of time for clinical professionals.***

- ***Patient organisations:***

- ***M.A/DOH. key people***

- ***Enterprise communities***

- ***Shadow Communities***

Max number of delegates: 300

Due to the limited number of places it is suggested that people are targeted on an individual level, to take into consideration those who have already expressed an interest.

5 <u>Media</u>

- ***It has been generally agreed that this will be a one-day conference style event, based on primarily plenary sessions.***

<u>My response</u>

<u>E Booking Conference – Draft Theatre Structure & Brief</u>

<u>Outline Brief & Context</u>

To develop some of the issues and complexities surrounding E-Booking in a 15-20 min Theatre presentation for the E-booking conference on November 21st 2002 .In response to the research we have carried out, we can identify some of the pertinent issues suggested by the evidence in relation to the E-booking agenda. These subjects are not exhaustive but in our view form the main foundations and if addressed, will help drive the E-booking agenda forward.

<u>Patient Centred Care / Ownership</u>

To emphasise the patients ownership of the process of booking.

It is pretty essential then to ensure that the patient centeredness aspect to booking – a fundamental component- is shown. We can demonstrate how technology can be a positive personal influence rather then a cold unfeeling tool for processing.

Improved Clinical Effectiveness

Evidence suggests that clinicians have been reticent in taking on board the value of e- booking.
One of our aims is to demonstrate by the use of theatre how clinicians and the patient can benefit from the process of E-booking. We would like to emphasise the 'effectiveness 'of the modernised process by showing how the whole process can benefit all the stakeholders concerned by demonstrating that;

- ***The patient can have more choice and have information on quality of services from various providers. (evidence-based selection)***

- ***The clinicians can use E-booking to speed up many of the clinical processes that have previously been victims of cumbersome administration systems. This will provide a smoother journey for the patient and a more coherent 'joined up' provision in terms of clinical care. It will also reinforce that although the E-booking process focuses on the patient it can be a useful means of developing the interface between resources, services in the relationship between the clinician and the patient.***

Whole Systems Approach

A whole systems approach is essential. The theatre piece will demonstrate through the narrative how a whole systems approach can streamline the use of resources and services and provide a quality of information that the patients, clinicians and managers can access and use to improve the quality of services provided.

Traditional Vs Modernisation

We want to show how two different systems can affect the individual stakeholders. Although embracing a new technology is not going to be a flawless process it can be fixed more easily and subsequently provide a more effective integrated approach for he patient.

We would also wish to draw on existing contradictions with expectations. I.e. you can trace the movements of your DHL parcel on its journeys – and would expect this quality of service from such a company but cannot do the same as easily with a patient journey.

Suggested Draft Structures for Theatre piece

We have come up with a number of options one of which at this stage is our preferred option.

Due to the complexities of the issues involved with E booking we feel that it would not be appropriate to take a 'naturalistic' approach to the theatre form. We feel that each narrative would be best served by using 'caricatures' rather than 'believable' characters. It would be much more effective to communicate the complexities described above by way of a short narrative for each component. This will allow us to develop very condensed forms of behaviour (cartoon like for comparison) to use in order to highlight the content. It will also allow us to lighten the subject by using comedy, comment on entrenched positions of some of the characters involved. We know that in any case the whole thing will tie up as part of the overall 'Theatre' experience. Each narrative will have a comparative approach.

Please feel free to add to this or make suggestions.

<u>The running order of the scenes need not be fixed.</u>

<u>*Option One (draft structure)*</u>

Is a 15 – 20 minute piece split into 3 or possibly 4 separate scenes? Each scene will focus on a different issue and run one after the other.

<u>*Option Two (draft Structure)*</u>

<u>(Our preferred option)</u>

<u>Is a 15 – 20 minute piece split into 3 or possibly 4 separate scenes? Each scene will focus on a different issue and run intermittently in between different stages of the conference throughout the day.</u>

Sc<u>ene 1 – The 'High Tech' Traditionalist</u>

No Set - Intro theme 'All creatures great and small' or 'Dr.Finlays Case Book'. A quiet country Yorkshire village –

We have a 'traditional doctor' (Tweeds & Corduroy) who despite his appearance is able to produce a laptop during consultation in order to:

1) ***Review the evidence on quality of services needed by the patient.***
2) ***Can book a range of pre appointments needed as well as the essential consultant appointment to suit the movements and time commitments of the patient.***

We see on the screens 'a mock system' in operation. Both patient and Doctor seem please with the new facilities and system in place. Particularly since it can accommodate all the patient and clinical needs

while at the same time provide information on quality of services. Everyone goes off pleased. Theme tune to end scene.

>Blackout LFX >Scene change >new theme SFX >

Scene 2 – 'Stuck' Traditionalist & Professional NIMBY

We meet a 'Young Doctor'– self assured to the point of 'arrogance' – very busy dealing with patients and devotee to the 'traditional booking system.'

He is talking to a patient about his skiing holiday and how he managed to book it on the internet to get the 'best deal'. He was even able to get info on the quality and types of hotel he could book. Before he left for the resort he was also able to check to ascertain the ski conditions on the slopes. Recommends the resort to the patient.

He tells the story of how on the way back he left his skis at the hotel. They have agreed to courier them back to him and he can also use the Internet to trace the stages of their journey back to his house. Just as well because they skis 'cost him a packet'. He is very impressed with the 'totality of the service'.
He then consults with the patient. Says he will write to the relevant specialist and who will then contact the patient to make an appointment. He should hear from the hospital in 4/6 weeks. Theme tune to end scene.

>Blackout LFX >Scene change >New theme SFX >

Scene 4 Tell me what you want, what you really really want. (Whole systems approach

Two cynical 'old boy' patients in the waiting room talking to each other. They are having a general 'moan' about how they have been dealt with by the system. They list their grumbles. They play 'one up-manship' with each other's grumbles.

Such as…..

- ***Having to wait to be given an appointment – no choice.***
- ***Having to then wait for further appointments for tests etc.***
- ***Having to keep coming back to complete a procedure that took 5 to complete and a whole days travel to achieve.***
- ***How they had to wait three weeks for the results of test already completed.***
- ***How they are treated when they get there.***
- ***How they lost some of the records, as they had not yet transferred records from the other department.***
- ***They conclude that it will be a while before they get their replacement hips sorted out.***

They switch their 'negative one up-man ship' to 'positive one up-man ship' by listing the things they would want desire in a service as a service user.

- ***Can choose their appointment to fit in the Local Bowls tournament or daughters wedding.***
- ***Coordinating of tests one visit-to do all pre tests…vs… one hour etc..***
- ***Results of tests our before their photographs were developed at the local Boots.***
- ***And so on…..***

They get so carried away until they look at the audience and decide that it is 'impossible'
Theme tune to end scene.

<u>E- booking Conference Theatre Presentation .</u>

<u>"Vision to Reality"</u>

<u>Three Scenes Back to Back.</u>

<u>Scene One – Smith & Jones – Two Consultants</u>

Why does nobody like me?

What do you mean - why does nobody like you?

I mean is it the hair, the accent, the attitude …….am I a bad consultant?

You must look on the bright side…the most that you have ever delayed anyone at your clinic is 15 months….it is not that bad. I've heard of a lot worse in other hospitals.

Yeah, but you seem to be meeting all the targets…your waiting times are down to 9 months and with any luck you can get those down quickly.

Look why are you behaving like this? Here you are at the pinnacle of your profession and you are sitting here with a gob on!….racked with self-doubt and insecurity. For gods sake pull yourself together!

Well it must be something.

It's the hair.

The what …what …what do you mean the hair>

When was the last time you looked in the mirror? …and when you did what did you really see? Did you see a consummate professional that has gained the trust and respect of not only his profession but also the organisation that he works for? The mover and shaker in the small but elite world of urological consultancy. A thriving firm dedicated to offer the most progressive and up to date service to his customers…….and you mustn't forget…

What?

At least you're not a gynaecologist.

Well I suppose that is a plus……and come to think of it I am pretty significant….. like being a big fish..

Yes, that's what you are a big fish…every time you walk down the corridor that's what I see a big fish. (Pause) Did you ever find out what happened to that patient of yours…the one that waited three hours after your surgery had finished?

(Thinking) Went home I think..saw him for weeks later. He had sorted himself out by then….any thing that was wrong had passed. (Instantly

remembering) I knew that I'd seen him before..he works at the club….drives one of those grass-cutting machines.

So …what happened there then?

Dunno!….given the wrong information I think….he'd already waited 13 and a half weeks for the appointment…so he wasn't well chuffed when I refused to see him.

On the way to the golf club where you?

How did you know?

Well it's what you always do after your Thursday morning clinic…you're a man of routine. You're more predictable than you think. Although I can still beat you when its comes to grief over waiting lists!

Not a chance – I have the biggest waiting list in the region,

But not the longest!….that one is mine..(remembering) and to add to that I'm the one who had the patient come in every day of the week for tests.

I remember that…a test a day every day for five days….. didn't it take him a whole day to travel from home?

Yeah

Awesome

I suggested that he should buy himself a weekly bus pass…it would have saved him a few quid…. Bad Planning!

Managers!

What about the time you lost the entire records and test results for your day clinic?

Ah! Sent them all home in the end. Can't do anything without having the notes in front of you can you!

What did you say to the patients
Systems failure…works well every time…if you pardon the pun.

They always get grumpy don't they?
Always…you have to be firm…like a rock!

…..a rock?…..what's that about then?

Look them in the eye…stand firm….instils confidence….

…. and blame someone else (drumming up the courage)…I was wondering…you know…..is that kind of behaviour a ....manly thing?

No…I don't think so..it's…it's …(thinking hard)..Professionalism. Yeah that's what it is it's professionalism!

Suppose it is. So…professionalism...(waiting a while after contemplation)..what's that then?

Well It's when you're good at what you do!

The following sequence starts slowly and builds up to a fast pace > crescendo!

Could it also be…. contemplating..that you're customer's get what they want…?

Yeah, yeah…I agree with you there…customers yeah…. they're important…I suppose.

Giving them ……..a good service

(quickly) a good service…

Our customers want a good service!

They want to get to us when <u>they</u> need to!

They want a choice of appointment times.

They want one-stop shops.

(quickly) ..(confirming the good idea) … one stop shops!

They want to be dealt with efficiently…(new idea)… back-to-back services!

Streamlined!..Planned in Advance!

They want to benefit from the electronic age!

Systems designed to serve!

Integrated WHOLE systems….seamless and smooth!

Staff dedicated to help!..to provide…to care!

No waste!

No Haste!

Just…(thinking)

Just…(thinking)

Just..quality!-

We're clever..aren't we?

Yes we are…aren't we……..(Pause) …My hair…what's that about then?…

SFX2 (Mics OFF)

LX2 (Slow fade Down)

VT 2 (30 Sec) Short video intro as lights up
Selection of holiday snaps – skiing in Whistler ...end as

LX3 (Slow fade UP of lights)

SFX 3 (Mic on)

Scene Two - Sophie's Surgery

Dr Sophie Green addresses the audience directly. She is self confident and energetic.

This is the hardest bit isn't it; I find it ever so hard to concentrate on my first day back at work after a holiday, don't you? Especially after such a wonderful holiday, it was marvellous; the snow was perfect and the weather glorious. We've never been to Whistler before, but I'd certainly go again. And do you know I organised the whole lot from here….on the Internet. I booked the hotel, I booked the flights and I even managed to book a car. I could even log on to their web site and check out the ski conditions before I left. I did have a moment of panic on the way to the airport in case I'd pressed the wrong button or something, but no, everything worked perfectly!

That isn't to say that it wasn't all problem free, oh no, no, no, not at all. I treated myself before we left, new skiing outfit, top of the range goggles and the slickest pair of skis I've ever set my eyes on. They were a little bit pricey but if you're going to take a sport up seriously, you really do need to invest in the right equipment. So you can imagine my horror when they didn't appear with my luggage when we landed at Heathrow, I was furious, I had to hang around for ages. It was the hotel's fault, they have this service they provide, they have all your luggage taken to the airport for you, supposed to lessen the stress, and somehow my skis were left behind at the hotel.

I really gave the hotel what for, they apologised and said they would have them sent to me by courier. I spoke to a charming gentleman,

Maurice…….He gave me a personal number, I can check exactly where my skis are just by logging on and entering my number.

Well I could hardly wait, I checked first thing this morning and it told me that my skis were in a holding bay at the airport waiting for their flight. I've just checked again and they are in the air above the Atlantic, it showed me the exact spot. Isn't technology marvellous?

SFX 4 (Mic behind set ON)

Tanoy. Your 1st patient has arrived Dr Green.

SFX 5 (Mic behind set OFF)

OK. Show them in.

SFX 6 (Mic for Mr Brown ON)

Ah Mr Brown, do come in and have a seat, make yourself comfortable. Now then what can I do for you today?

Well it's this knee Doctor; I still haven't heard anything from the hospital. It's getting worse, it's very painful, and every now and again it kind of locks. It's even given way a couple of times. I've been waiting a month now and I wondered if you could find out what's happening and hurry it up a bit.

OK, just remind where we are with this one. You've had an X ray, (looks at screen) yes; I've got the report for that.

I've had a look on the Internet Doctor and I think it's definitely my cartilage and (reading from a piece of paper) the recommended pathway would be to see an Orthopaedic surgeon who would probably do an arthroscopy. In the meantime some physiotherapy would be advised.

Very impressive, I agree with your diagnosis completely.
Look, I know it's very difficult having to wait like this, particularly when you have an active lifestyle like yourself, but I have written to the orthopaedic consultant. The problem is that they are very busy and it's not unusual for it to take 4 – 6 weeks before they get back to you.

Well that's not too bad, it's been 4 weeks already so they should be able to see me in the next couple of weeks then doctor.

Erm, no, sorry, I think you misunderstood, I meant that their reply will be with you in the next couple of weeks, I'm afraid the routine waiting list for orthopaedics is about 20 – 30 weeks.

What!!!

I know, I'm very sorry. I can refer you for some physiotherapy, which will probably help, but there again they have rather a long waiting list as well and I can't promise that they will see you before your hospital appointment. I'll do you a referral note and get that off to them ASAP.

And in the meantime?

And in the meantime, I'm afraid it's the same advice, rest the knee as much as you can, I can give you some more anti-inflammatory tablets and take the painkillers as and when you need them.

Well thank you very much for your help doctor.

No problem, lets hope it's not too long.

Bye bye then

Bye Mr Brown

Patient exits.
Doctor picks up phone.

Jane? Sophie. Can you have a look at Mr Brown's notes and let me know when his referral letter went off to the hospital? Thanks, and can you just give me a quick minute before you send in my next patient. I want to quickly book some tickets for Lord of the Rings on Saturday night.

SFX 7 (All mics OFF)

LX 4 (Slow fade DOWN)

<u>Scene Three - Doctor Finley's Laptop</u>

VT 3 (A Country Practice) (1.30 min) > end (Theme music from A Country Practice. Picture of Highland Farm setting. Title "Dr Finley's Laptop". Picture of Highland cattle on Scottish fell. Heading, " Somewhere near Leeds. A short time in the future". Music fades. Maggie is on the phone)

LX 5 (Lights fade UP)

SFX 8 (Mic ON)

Maggie

No, no Jeannie! I cannna gie ye the recipe noo! We've a visit frae Dr Finley to see Dougal … Aye Dougals' hernia. I'm awfy worried of what he'll have to say, the house is an absolute disgrace. Dougal's in the byre and I've no swept through yet … and there's a newspaper on the Doctors chair! I'll have tae call ye back Jeannie.

(Shouting outside)

Dougal, awa in and wash your feet! … Dougal!

SFX 9 (Mic ON)

(She picks up newspaper then takes a brush and begins to sweep. Dougal enters)

Dougal

Whit?

Maggie

Awa in and wash your feet.

Dougal

Ma feet woman? Its ma stomach woman, not ma feet!

SFX 10 (Mic ON)

Maggie

Wash them feet. You never know, and I don't want to take the risk of poor Dr Finley having to examine them in their natural state.

(Dr Finley's voice is heard)

DF

Hallooo! Maggie? Dougal?

Maggie

Too late! Now just you mind your p's and q's in front of the Doctor.

Dougal

Ma whit?

Maggie

Just remember we have an educated man in the hoose, so watch your mooth!

(Dr Finlay enters, he is carrying a traditional Doctors bag)

DF

Good morning! And how are we both today?

Maggie

Oh, we're fine thank you very much Doctor. Aren't we Dougal?

Dougal

Whit? … Oh aye we're fine … but I have this thing on my back Doctor.

DF

Yes I know Dougal and that's why I'm here isn't it!

Maggie

Oh what are we thinking of Doctor, please sit down. Take the weight aff.

(Dougal is sitting in the chair ear marked for the Doctor)

Dougal …

Dougal

Whit?

Maggie

You're sitting on the Doctors chair.

DF

No, it's alright, you stay there Dougal. Over here is fine.

Maggie

Dougal!! Oot that chair!!

(Dougal gets out)

Dougal

Er … aye here ye are doctor, I was getting up anyway. It's er … no very comfortable with ma back.

DF

Thank you. (He sits). Well …

Maggie

Before you start Doctor can I get you anything? Cup of tea perhaps?

DF

No thank you …

Maggie

A nice piece of shortbread?

DF

No really thank you I'm fine …

Maggie

A wee drop of something for medicinal purposes?

DF

No thank you Maggie …

Maggie

Dougal could slaughter some cattle if you fancied a bit of roast beef?

DF

No honestly, I've not long eaten breakfast …

Dougal

(Shouting) For God's sake woman the Doctor disnae want anything, did ye no hear him?

Maggie

(Shouting) Well I'm only trying to make the Doctor feel comfortable!

(Silence)

Maggie

Well Doctor, you were saying?

DF

Yes..Well Dougal, it's a straightforward procedure and you'll be in and out of hospital in a day. Basically you'll attend the clinic and you'll see a nurse who will prepare you for the procedure, the consultant will carry out the procedure and, after a short period of recovery, the nurse will discharge you from the clinic ….. now, do either of you have any questions?

Maggie

No, no, that all sounds very clear Doctor, doesn't it Dougal?

Dougal

Aye, you're the doctor, Doctor.

DF

Fine then we'll just sort out an appointment for you.

(He opens his medical bag and produces a laptop. Dougal and Maggie step back in awe)

Maggie

Is that one of thae computers you've got there Doctor?

DF

A laptop yes this is the modern National Health Service, we'll use it to book your appointment at the hospital.

Maggie

Jings! That's marvellous isn't it Dougal?

Dougal

Aye! Jings!

DF

Now, if you could just show me the nearest power source.

Dougal

Whit?

Maggie

Dougal awa and find somewhere for the Doctor to put his plug.

(Dougal hunts the room for a plug socket. He finds one and Dr Finlay sets up)

Maggie

And does your laptop have a megabyte Doctor?

DF

Its 30 gigabytes, 2.4 kilohertz, Pentium 4!

Maggie

Oh, is that so?

Dougal

She disnae ken what a megabyte is Doctor; she read it in her Daily Express!

DF

It's all ready. Now what dates are we looking at?

(Silence)

Maggie

Whatever suits you Doctor, whatever you're happiest with.

Dougal

Aye, you're the doctor, Doctor.

DF

No you see this is a list of which consultant is available when and where. For example Dr Riley is available at Kinch for a morning clinic on the 24th 9.30am.

(Dougal and Maggie look at each other crestfallen)

Maggie

Aye that'll be fine Doctor. He'll be there at nine thirty sharp.

DF

That was just an example. I'll put it in if you like… is there a problem with that date?

Maggie

No, no Doctor, no problem, our son Sandy can probably cancel the flights from Canada.

Dougal

Aye, and if the restaurant can book in another golden wedding celebration we may not lose the deposit on the cake.

DF

No, no, you see clearly that date is inconvenient for you. We have a choice of five clinics you can go to, you don't have to see Dr Riley, you can choose the time and the date. So you see its up to you as to when you come.

Dougal

Up tae me?

DF

Yes within the given framework.

(Dougal considers this)

Dougal

Give me a date.

DF

The 27th?

Dougal

I'm washing the cattle, it has to be done.

DF

No problem, what about the 2nd with Doctor-----------------?

Dougal

That's the week the bus disnae come.

DF

The 7th then?

Dougal

That's the most important day in the young farmer's club calendar. I wouldn't miss that! They line up all the single girls on one side and …

Maggie

Dougal! The 7th would be grand thank you Doctor.

Dougal

Aye the 7th Doctor. If you could arrange that please.

DF

Already done. That's the 2.30 on the 7th at White Rose Hospital.

Dougal

Whit?

Maggie

Ye've done all that on one gigabyte?

Dougal

I thought there would be letters involved.

Maggie

There's no paperwork?

DF

All done.

(He puts laptop in Doctors bag)

Good morning both. I'll see myself out. It's as simple as ABC. Access, Booking and Choice.

Maggie

Eeee Dougal!

Dougal

Eeee Maggie!

DF

No E Booking!

SFX 11 (ALL Mics OFF)

SFX 12 (Dr Finley's Casebook (Two End) Play 15 Sec Only and then Fade DOWN with LX6) (Theme music)

LX 6 (lights fade DOWN)

Camera OFF

Recorder OFF

END

Appendix 13

Liverpool Theatre Project Proposal

Aims

The aim of the Theatre Project is to stimulate an awareness using Theatre in Education, of Mental Health and Young People and the Services that are available to them.
This ½ day programme will tour Secondary schools in Liverpool over a three-week period.

Local Objectives

- ***To raise awareness and challenge the stigma about Mental Health and Young People.***
- ***To encourage an awareness, benefits and need for early detection.***
- ***To help identify the kind of services and pathways to services that are available.***
- ***To contribute towards the development of a collaborative inter-agency approach as part of a longer term locally driven strategy.***
- ***To share and collect through Action Research, qualitative and quantitative evidence to help develop strategies that will work with young people.***

Regional & National Objectives

- ***To lay the foundations for similar projects in other localities/communities. (NIMHE to coordinate)***
- ***To encourage longevity in each project by encouraging community and agency interaction. (NIMHE to coordinate)***

Location: ***Liverpool***

Target Group

The Theatre project will target Year 7 and 8 secondary pupils.

One of the objectives of the project will be to focus on early intervention. Current research indicates that there are a number of themes that can be subject to further detailed research locally.

- ***Depression***
- ***Suicide***
- ***Domestic relationships/Family Break-up***
- ***Social Exclusion***
- ***Stress***
- ***Drugs***
- ***Ethnicity***
- ***Bullying***

Many of these themes are interrelated although each one can have a differently focussed 'narrative' in relation to Mental Health and Young People and the experience /journeys that they have. They could also fit well into the pastoral/core skills programmes that the schools run.

Location One - Liverpool – the context.

In many respects the Theatre project and some of the existing provision in Liverpool could 'dovetail' quite effectively. Liverpool Education Department and its partners are currently operating a pilot in 4 secondary schools with the aid of central government funds. This is a collaborative approach to dealing with the relationship between education, exclusion, mental health and crime involving young people. Collaborators involved are; Liverpool Education Department, CAMHS, Liverpool Social Services, Merseyside Police, Public Health and Young Minds. The approach, methodology and collaboration that they are

involved in are both progressive and 'ground breaking'. The Pilot will run for two years initially and has already collected an impressive evidence base that the theatre project can use.

The Theatre Project

The project will be facilitated, managed and administered throughout the 24 weeks of its existence. Additional strategic support will be sought from NIHME and the Public Health Department.

The project will involve initial research and evidence gathering - bringing the collaborators together (including schools) and identifying with the support of teachers where and when, given our schedule the programme could fit into the schools timetable and the School curriculum. Ensuring the continued involvement and support of all the schools post-production is a major priority.

In order to ensure that the process of collaboration and the Theatre Project reflects the local issues and experience the Theatre project research and development process will take around 10 weeks to complete. This is important, as there is the need to encourage commitment, ensure sustainability and gather evidence from all the stakeholders' involved particularly young people.

Recruitment of professional devising actors/teachers will then commence. Again these skills are specific. We have already had interest from the Small Scale Theatre Sector who have indicated their willingness to support the project. Liverpool Institute of Performing Arts (LIPA) have also indicated an initial interest.

The 'Company (up to 5 actor/teachers including stage manager) will then commence the process of further research and devise and write a Theatre in Education programme for Liverpool Schools. Rehearsals will take place over this period. Support in locating suitable premises for rehearsals will be needed.

The theatre programme will be ready for launch at a NIHME conference expected to be held at Haydock during the last week of January 2003.By then many of the programme components will have already been tested with the Pilot schools in Liverpool. As in any work of art the theatre programme will try and reflect the specific needs of each school community that it visits.

A programme of follow up to assess the impact of the programme on young people will also be devised and will go into schools to gather evidence during week 24 (1st week after half term)

Appendix 14

An Integrated Pathway for Dementia

Best Practice for Dementia Care.

Marian Naidoo

&

Roger Bullock

Appendix 15

Complexity and Healthcare Organization:
A view from the street.

Chapter 15

Using the performing arts to facilitate emergence in organizations.

Marian Naidoo
&
Shaun Naidoo

Appendix 16

Creative Arts and Humanities in Healthcare