Participant 1 23.03.23

SPEAKER1	00:02	I will try not take up the full hour , so .
SPEAKER2	00:06	Is it distracting because it's inside of my head on the front of my head ?
SPEAKER1	00:11	Doesn’t matter , honestly. [Alright] Wherever you are comfortable , I won't be, I won't be offended . Whatever's best for you . And OK , so thank you for agreeing to take part in this interview which should take between 30 and 60 Minutes hopefully, and you are happy for it to be recorded on teams? [Yeah] and you've agreed with the consent, that's fine so you know me , I'm Alison and I've invited you to participate in this research because you're involved in making changes and improvements to stroke care across the North West Coast region . It's important that we capture the learning from what's been done to share this with others and support future improvements in the stroke care pathway . So what I'm going to do is I'd like to ask you a few questions about your involvement and your experiences of stroke care and what other parts of the stroke pathway you work or are involved with . We're interested in your opinions around what you did , why you decided to do it, what works well, how the service could be improved, any challenges and other comments you'd like to make. We hope to use your comments to understand what changes have been made within stroke care , particularly at a system level , and explore what worked well and what could have been improved . The information from these interviews will be analysed and then used to inform focus group discussions to help develop a tool called a logic model . The logic model can then be shared and used by others to carry out improvements in stroke care. Is that alright?
SPEAKER2	01:33	Absolutely , yeah .
SPEAKER1	01:35	So can you tell me about your current role within your organisation?
SPEAKER2	01:40	So I'm the manager of the Integrated Stroke Neuro Rehab Delivery Network in Lancs and South Cumbria , which has evolved from the original stroke program , which was running probably from about 2013 onwards across Lancs and South Cumbria . So my role is , is to enable all different stakeholders pulled together to transform the stroke services across the patch So we set this up , probably, the ISDN was setup from September 2021 formally and went proper live in April 2022. As I say , we transferred a lot of the previous stroke programs and workstreams across into that ISNDN , and we were carrying on with what our plans were . So in September , sorry , in July 2021 , we had a successful business case , and we call it the enhanced acute and stroke rehab business case and which is a three year phased business case for development of acute stroke centers and comprehensive stroke center in Lancs and South Cumbria . And as part and parcel of this business case , which had taken three years to come to fruition with numerous

		checks and challenges from the ICS finance teams. Prior to that listening to our clinical , I suppose this is where our lessons learned came from Greater Manchester and London and asking them the question around their reconfiguration of acute services . What, what, if you had to do it again, What would you do ? And they said we would do the community element first . So that's what we did before, as part of that business case , community was not part and parcel of it, because we had already done that community step prior. We had a regional commissioners meeting and pulled everyone together to look at community first . And we did, we did a separate business case at that point in time for each CCG , for an integrated community stroke teams . And we were successful in all areas across Lancs and South Cumbria , and I say across all Lancs and South Cumbria because West Lancs is a bit of anomaly, it sits between us and Cheshire and Mersey , and most of their patients flow to Cheshire and Mersey . So the CCG's over in West Lancs in particular , had made the decision that all stroke related stuff would go to Cheshire and Mersey and not to Lancs and South Cumbria so all the other CCG's successfully got business cases passed for integrated community stroke teams that we have been starting to build on those teams would recruitment wise and process wise since 2020. I think it is 2020, 21 . Yeah. Am I just rambling there?
SPEAKER1	05:23	No , no , it's good . No , it's fine . I'm just trying to, you are already ahead of me on some things , so I'm trying to just make notes so that I don't miss carry on . That's fine .
SPEAKER2	05:32	So just tell me if I'm rambling. So the integrated community stroke teams obviously were a big element , but also from our perspective , there was a big element around capacity and flow within the trust and and we'd already as a regional team decided that we were going to use the ambulatory care model to help the front door capacity and also to ensure that patients won't be admitted inappropriately and that , you know , help would reduce with ward capacity as well . And so we've started up, setting ambulatory care up in each of our trusts . So it and now we're in 2023 now , but we've got a fully fledged ambulatory care service in East Lancs , which is 8-8 seven days a week and is run by Consultants , non medical consultants , so consulted nurses , and that works really well and has showed to reduce admissions for up to about 40 percent of their patients that they receive at this point in time. They've only been running it properly seven days for since last November , so they can they can definitely see an improvement there . And it should improve 0-4 hour target as well and reduce the number of admissions and that's what that's what it has done so far at East Lancs. The other sites, Blackpool have had an ambulatory built as part of the business case and done in the first year , and they opened their doors to ambulatory care , probably about two months ago . So it's not

		been it's only been going that that period of time . They're not fully resourced , staff wise and at the moment are only working five days . And then the other trusts do have ambulatory care , but it's not as robust, they're sort of setting it up slowly but surely . And obviously , what this recruitment process as well because some of the people are doing all AMP's and they are training AMP's at the moment . So they're going through that two year training . And so that's where we're at , I suppose , with ambulatory . But the idea was that we would look at our front door and our back to door , and that's why we're up to. We've got seven day and 24 hours triage nurses at the front door for three of our sites . But those three sites , will be the two acute stroke centers and the Comprehensive Stroke Center. So Blackpool and Blackburn will be the key stroke center and Preston is a comprehensive stroke center due to having the neurology department there . Yeah , (yeah) . And I think and so at this minute in time and this 'what would we do better ?' Obviously , the big thing for us when we're looking at all of the improvement work is that we, every single solitary piece of learning , doing everything virtually had to go to about seven different committees , and if one committee didn't agree with it , it was back to the script and then we had to go around the whole rigmarole as well , which is where the business case came from and had with so many checks and challenges on it . it must have, I can't remember how many iterations it was . And we were backwards and forwards , you know , and to all the committees in the ICS. And it was it was really , really frustrating , to say the least . And one good thing , obviously , for us in the in this as well was the fact that we had a finance work stream and we had finance people from each of the organizations with an ICS finance lead . And basically that one person had the lead for that, did all the work in pulling together what we currently spend , which is it was not an easy task to understand what we currently spend on stroke and because with so many different parts all over the place . And then it was the question of what do we need going forward ? But also it was around , you know , looking at our workforce and why we were going with our workforce . And , you know , using the RCP guidance as our recommendations for that . And that's has flow throughout the business case and continues now as being like the recommended safe staffing level for stroke . And that was our aim to get to was and again , obviously in South Cumbria , our workforce is well , has been pretty dire . And in particular , you know , around stroke consultants , which is why we had to look at what we could do differently around this. We had also , I mean , we started this piece of work even before then when we started to look at tele stroke , you know , within the region because we were, we should have had 20/21 stroke consultants . I think we had 8 and that was substantive with stroke , with locums as well . I'm saying

		this off the top of my head . That was about like 11 years ago , but actually it's not changed since it's , you know , the recent workforce and we now have a workforce work stream . And that's work that we've commissioned the TU to do . And I got some money from Health Education England towards the workforce development role . And basically we're developing a workforce strategy that should be ready for May 23 . But as part and parcel of looking at our stroke consultants has been very little change in the boat . But what I can say is that we we have 8 substantive stroke consultants , but now we have 9 non-medical consultants that we didn't have before , and that was the process when we were looking at . So that's what we've been building towards over the last few years . So we've been upskilling our staff , you know , to get to that level , knowing that we've got a severe shortfall and it's not going to get much better and . So our plan that was a workforce decision made probably 2011/2012 , something like that , so we've been working on that across the patch for a while , so we're actually doing quite well in that regard . And we're just in the process of taken well , trying to get a couple more into the region , and so that is like a real positive bonus for us . And one of the big issues that we had across the region as well was rehab workforce and rehab numbers . And that was both in community and in inpatient rehab , and we had and if you if you look to all snap squads , we were constantly in the low probably D's and E's for a lot of the rehab elements . And that was because we didn't have enough staff . But the business case, basically , there is a business case , and part of the business case was around and 6 day working and then 7 day working a case as part of a phased approach and so 6 day working was last year . And basically each staff was that we did a big scope across the patch and we decided what was in the, rather than giving it per trust as we originally intended . And all the AHP leads within the region got together . And decided it would be better to have safe staffing across each of the sites and in the community as well . So despite the fact that we'd have separate business cases for community , we were still lacking in some teams within community as well to be a safe staffing level . So we've utilized we pooled all the money for the rehab element in the business case , and we've basically gone with RCP guidance and sort of split it across everybody and that this is a ladder or up. This is where we're going . This is what you need to get within your region to pull it up . So that's where we've been . We've been on a journey recruiting now and all those spaces and teams. Included in the workforce , as well as orthoptists . And we have an alliance in Cumbria with an orthoptists group , and we have a north west coast orthoptists group and is run by the national clinical lead Fiona Roe , who basically wanted as a gold standard and as a model to use something, and also again , it was

		lessons learnt from Whiston Hospital . Basically having their orthoptists on the ward , having full time orthoptists as part of the team . And then that that all stopped us looking at the patients on the ward on a daily basis and running the outpatient clinics. But also actually having a octopus machine on site on the ward so that the patients , basically when they were going to go to the orthoptists , they were literally wheeled from their bed to their room . So it was like an easy , easy process for them . So obviously , that's a big , big ask because it's not that much room on each of the wards . So in Lancs and South Cumbria , we joined together , we pulled together a business case that the shared basically across each of the patches . So it was like a single one that everybody uses template and then we went and took it and put it and added it as part of the enhanced business case . And so now each of all sites have got a gold standard level , so basically it's enough orthoptists moneys and three sites, those are the three sites, are the ones that the acute stroke centers and comprehensive , so they've actually put moneys in for the machine or one of our trusts didn't and so they start to take theirs down to the ophthalmology department . But we've actually got quite a good orthoptists service now that been generated and is ward based and has made, or is starting to make a difference . And that's only happened in the last 6-8 months since the business case came out this year as part of 6 day working .
SPEAKER1	17:54	Excellent . Right . And I knew this one was going to be complicated because you're involved with so much , and so there is the enhanced business case , which is covering multiple changes and interventions and the ones that I have picked out ambulatory care safe staffing the 6-7 day working is that for therapists , particularly here ?
SPEAKER2	18:16	Yeah , because I mean, nurses already worked seven days.
SPEAKER1	18:19	Yeah . Yeah , yeah , yeah . I was just double checking . And it wasn't .
SPEAKER2	18:22	The money, the monies that are there are for the enhanced business cases , so obviously nursing will be in there because it's enhancing the numbers up to the safe staffing levels
SPEAKER1	18:36	Yeah , yeah , I know . Yeah , I was just double checking it was not like consultants or something . And seven day triage at the front door . Are they the sort of major interventions that are covered by the business case?
SPEAKER2	18:51	Yes , they are. Well , it is , but it's also like equipment for their comprehensive stroke centers . It's also ward reconfiguration in those three , in those three centers . Trying to think what else I mean , there was some medical staff that would taken on as part of that as well , [name] , because from a comprehensive stroke center element , it was also the enhancement, in the first year it was five beds for our hyperacute services at LTHTR . Which meant that they needed some

		seven day working for some medical elements as well , so it needed to be like , I think it was a think it was two registrars and as well . But obviously it was to enhance the thrombectomy service as well because those beds were, two of those beds were for thrombectomy .
SPEAKER1	19:54	That's fine is there is the documentation available that sort of outlines all this
SPEAKER2	20:00	so that the business case is available . [Is it? Excellent] if you want the business case you are more than happy to have that.
SPEAKER1	20:07	It's just because it's asking about the changes you're involved with . And can you explain why the change was made and needed ? And I think that's why I let you speak , because I think you've done a lot of that for it .
SPEAKER2	20:15	So it's kind of there is there is that , obviously . But there was also we've also got the case for change for the region as well that that fed into that . Obviously running concurrently to this is thrombectomy . And that's like one of the major things that we are trying to improve as well and obviously towards our thrombolysis rates were low . And so one of the things that we did , obviously for us was when we implemented the telescope out of hours service . Because of that , we didn't have enough stroke consultants to do it 24-7 . So we have to think outside the box around how we would deliver that . We only had one site at the time when I first started in the network that actually delivered thrombolysis at all . And it was , I suppose , the build from that was and it was get everyone to run, to do thrombolysis Monday to Friday , then let's think about the out of hours service . And then it was , which is where we came up with tele stroke and tele strokes been running 11 years now , and it's been really successful . I know it has been really successful , but from a national perspective . We weren't the only ones doing that , but we were the only ones that had managed service and we . And literally we're the only ones that got set that we've got probably got 24 hour service that we don't use 24 hours . It's only out of ours that we use it , but we can use it and we do use it . And it's been part and parcel of our mutual aid during COVID . To be able to do that across each site to support each other . And so we are we have obviously we have . parts in our A&E departments and , you know , and in our stroke wards in some areas and tips so consultants can remotely access the patients of high definition cameras on those carts that are really beneficial . We have a rota of consultants from across the patch , but it's not just Lancs and Cumbria tele stroke that's also North Cumbria and what was West Cumbria and Southport but this year, Southport has gone to the Royal [Okay] , and they've all joined together in Cheshire Mersey . They've got a reconfiguration of stroke services over in Cheshire Mersey . So now everything , we don't need to do that for Southport anymore because they've got support from the Royal and

		Aintree . So that's that's where we're at with the Southport and we used to do Whitehaven as well . But Whitehaven and North Cumbria have joined together, they are a single trust anyway . But now that they've gone into just having that one , that does , and they're doing that in remote consultation between the two sides themselves . So we don't, where it was over eight sites , it's now over six and which is fine , and we still have that that rota of stroke consultants that do it out of hours . So thinking about it , despite that our thrombolysis element is still low and what have you so one of the things that we've put into help that as well is the artificial intelligence brainomics with stroke . So that has been live in our region since July 21 and then obviously thinking about it , we're trying to . As part of the national picture for NOSIP[???] we've been , you know , the national optimization imaging program and development of an front door , so everybody going for CT then to CTA . It's been developed and we had a regional policy around that. Now , obviously , there is CTP and basically we had a separate research program that was going on as part of the digital ICS digital team and that was to implement artificial intelligence and to enable all CT scanners to have CTP perfusion facility. We basically , all that money that was part and parcel of this was taken as part of COVID. So that was really and that was not a good time . We had to basically pull together rapidly a business case for the ICS finance team to see if they could fund it for us . And and they were happy to fund the artificial intelligence , but actually at that point in time and National policy were running it out across England as part of COVID . And as part of a resolution for COVID , so we got the money from them instead . [Right]. But the CTP element finance, it wasn't part of that , so they basically said from a finance perspective that we would have to take evidence that the ai was working and that then they would give us the money for CTP moving forward . However , due to COVID and we had quite a number of new scanners put in across the patch , and all of those scanners have CTP perfusion facility , so we don't have to pay for it . So that is a bonus . So one site only has it already , which is the comprehensive stroke center , and they've been running with it for a while . And every single site now is apart from East Lancs who we're waiting for that . That's got a delay on the scanner that comes in , but should have been here in April but I think it's a bit delayed and there will be a phased rollout of CTP across the other elements . We've done quite a bit of training around the INR lead , which is [Name] at LTHTR . She's been going around with somebody from the ISDN to each of the radiology sites to discuss CTP and what's needed , and obviously from her opinion because she works all the time , but also the reporting mechanisms because there's a massive thing regarding particular and Lancs and South Cumbria around the radiology time we are from a

		workforce perspective , short on radiographers , intervention radiographers and the radiologists . You know, don't know enough about CTP because they have not used it and some big training elements around that and also around reporting .
SPEAKER1	27:28	There's just so much going on , isn't there ? I'm very aware of time and keeping you so it is right for so it's great that you're telling me about the loads of different things , but I want to kind of get a bit more about some of the strategies and get down into that , if that's alright . So obviously you're massively involved in all these changes . Yours is a full time role . And are you do you lead in terms of directing these business cases and plans ? What sort of time do you dedicate to it?
SPEAKER2	27:59	Right , so I suppose for me, no , no , I don't do the business case and plans . What we've done is because I don't have the time to do it . [That's fine] I've not had the time . So we've got numerous work , obviously work streams , and that's all mobing at this point in time . But the big business cases is we've commissioned the TU to do it , but that's , you know , from an ICS perspective , the from an ICS perspective . So I suppose just so . From a perspective of what is good , I suppose , is that stroke was put down as a vulnerable service in 2017 when the ICS was first built . They bought in the acute and specialist work stream and the acute and specialist workstream had underneath it stroke and maternity, head and neck, vascular something else I can't remember and as part and parcel of that it was deemed that stroke would be an ICS priority , it was like one of those disease areas, 'Right ? What is going to be? and it was classed as a priority for Lancs and South Cumbria, just because we , despite all that being put in , our figures weren't improving because our workforce etcetera was still so limited . And so we came under the remit of that . And so there was a directorate in the acute stroke specialist workstream , that sat over us , and we reported to them . And obviously for us that person had got the TU involved to write the business cases because it was a regional business case , definitely didn't have the time to do it because I can't tell you how many iterations they had and but it was , yeah , it was it was definitely worthwhile bringing them in to do that type of work . So we're and business cases now you've got to have a green, think it's called like, I want to say its like a karate type thing , like a green belt type of training that you've got to do this and they are only accepted as the business case if the person who's written them has got that particular type of training.
SPEAKER1	30:31	So in terms of that development process , obviously all the trusts were involved and yourselves and you've talked about the ICS . You talked about seven committees . Who else is involved in this development ? That we have not…

SPEAKER2	30:44	So when I talk about the seven committees that you go to , that is that is that is like there was provider collaborative boards . [Yeah] right . There was clinical reference groups . [Yeah] there was an ICS system leaders groups . And then there was ICS execs groups , so there's like lots of different all of them across the patch I suppose . And then and we also has our own , I suppose , our own board as well that we've now got the ISNDN board . And that is chaired and the exec lead for is the chief exec at one of our trusts , and he holds all of us to account for what's happening across his patch in regards to that .
SPEAKER1	31:34	OK , so we got the strategy thing in terms of development , what went in ? So the ideas that went into all our safe staffing and things what ? What information or evidence made you, was there information or evidence that made you pick the… because obviously you say it's a big pathway in so many different things that you could have chosen ? What was it that made you pick the interventions that you were going to change ?
SPEAKER2	31:58	I suppose it was . It was all the modelling that we've done , which is we do such a lot of the modelling around it . When looked at , obviously of everything looking at your activity numbers , what comes through the door . And then it was like , what would you if we had we had quite a number of workshops around , you know , strategy workshops around how many , you know, modelling it down to get how many stroke centers we would need in this area for a kickoff ? What would that look like ? We also have obviously had to go and visit all the local hosks [???] and we have to do that , probably, twice a year , we have to go and update them where we are with our stroke program and also and the business case went to them all to , you know , as we were building that business case and going to them , that's fine . And now that we've got the business case , we go to them with where we're up to the implementation on what's happening . And then obviously listening to them around that as well . I suppose the decision on how things were made , we look to the numbers of patients if you, if you did... We had I can't remember how many variations of models I think it was about 19 that we started off with, is if you went, if we had one single stroke center that the numbers for that , how would that look ? If we had two , Where would that be based on what would the numbers look like for that ? And they've carried on like that and it was light . And then it was like , Do we have direct divert , do we do triage treat and transfer so we'd done loads and loads of modelling over the years we went to , we went on and lots of trips to go to different places in the country to have a look at what they were doing and how they were doing it , how effective it was . We took people with as though from NWAS from stroke association from each of the site disciplines . So we think we

		actually looked at things and done things properly and obviously be based on areas like what we are, not on urban .
SPEAKER1	34:15	Yeah , yeah , yeah . So you've consulted staff , colleagues and patients throughout making these changes .
SPEAKER2	34:23	Yeah. We obviously we settled the patient and carer assurance group as part of the ISNDN but prior to that we did have patients that sat on all of our boards , etcetera and were part and parcel of it . But it's only since we developed the patient and carer group in the ISNDN that we've had real success with actual , you know , total patient voice in all in everything that we do . Now they're involved in all decision making , and they are involved in the options appraisals . They are invited to everything that we do so, and they are listened to they start off our program boards and they end our programmed boards . It reminds people all the time , well , with that , what we are doing it for.
SPEAKER1	35:28	Excellent. In your opinion , how complicated are the intervention changes ? They sound extremely complicated to me . **BOP**
SPEAKER2	35:37	It's it's like one of those things when you start off , you know , you , you work program each year , you think you've got your priorities right . And we have got our strategic priorities for like 23 , 24 . And as much as , you know , like our programs were massive . And you know , the director who sits over us now , she sits over something like five or six different programmes of work like yours , but the work our stroke program is bigger than all of theirs . All the others are quite tiny , quite small , quite niche . Where as the stroke one it's just it's like an iceberg , you know , when she came into power , she thought she was taken . She was she was just to help implement the business case . She had no idea that underneath it all , we had all these work streams and that we had everybody working on different things, do you know what I mean , because we talk about the stroke development , it's not just about putting something in it's about everybody working towards it as a consistent approach, and we work collaboratively to do it . And . By doing that , it makes it that much less complex . If we didn't have that this complex . You know , because you have to go to every single site where we don't and we're really lucky that we… I suppose it started when we had tele stroke and we started pulling everyone together and it was really great and start to us and it's been easier to do that . I mean , when we write when we wrote the service specification originally . And you know , like when it was , it was it was prehospital, there was sorry there is primary prevention and theres prehospital . Then there was hyperacute phase, acute phase, rehab, there was TIA elements in it separately , there was specialist assessment , so this is when you're going to assess them for thrombectomy . Then there was stroke rehab , and then there was community rehab , and then there was life after stroke , and all of those sections were written by those people in those

		areas . So in primary prevention, and second prevention elements were written between GP's and consultants , and the prehospital was written by NWAS staff and the hyperacute was written by the stroke consultant , as was the acute and the TIA. Special assessments was written by the INR's at Preston and . Rehab was written by therapists . Community was written by therapists and life after stroke was written by Stroke Association . So it was like a true collaboration , right way across when we were writing the service specification but that service specification as we wrote that service specification back in Twenty Thirteen about what we wanted . And obviously the RCP guidance is throughout the whole of that element and now the service specification that we got now and . Is the same, is aligned to the national one , but the national team utilized our service back as one of the best within the country . for collaboration , etc. So we didn't have to, when they say the national service that came out , we didn't have any alignment to do because we were already doing that . I suppose then the other element of it is as well is the clinical lead that we have for our area . You know , is actually the national clinical lead [Name]. So actually , having her as our clinical lead . And what have you, we just knew that what we were doing was right and that we were following whatever was being done , probably before all the people . So I can feel that our service spec is good and we utilize this service spec . You know , it's not not utilized . It doesn't sit there gathering dust like some do on it . And the other thing we actually make people benchmark against where they are in the service back on a six monthly basis . And I was part and parcel of service improvement . And every single site has got a an action plan , which includes GIRFT recommendations to move forward . So we've had some trials and tribulations over the last couple of years with , you know , stroke units and being on section 31s and things like that and being investigated for different things across the areas but the staff are still picking themselves and getting on . So it's , you know , it's about supporting them in that area , I suppose .
SPEAKER1	40:52	And… sorry go on? [No sorry go on] . I was going to say , you've described lots of things that have supported you so like the service spec, the business case , consistent approach , the RCP guidelines , the recommendations are that are there any other sort of supports that are or were available that you think have helped you bring about these changes ? I know you've described loads as you've spoken .
SPEAKER2	41:15	Well , just I suppose for us it's, having the national, the way the national clinical team runs now is , it's made an improvement for us , and obviously because our clinical lead that used to run is now the national clinical lead we're , you know quite close to that element . And obviously having the having the networks so the integrated stroke delivery networks now that peer support across the patch across

		England is great . We do an awful lot of sharing collaborative work in regards to that , having the futures website that you can tap into it to get your information and stuff . It's great . We work really , really well with UCLan and we've done quite a lot of , you know , joint working and also they also feel because they listen to what's not . What we haven't got , we are able to , you know , we've set up bespoke courses for our assistant practitioners . that's part and parcel of our workforce strategy , and we're thinking as the AHP leads across the patches that well , from a pragmatic perspective , what's missing for us is the clinical leadership and people doing the job , and that's what those are the posts that we need . So we are invested in our ACP's . So we've got ACP's in training at each site now and we've got we've invested in and . The fact that we, each site's now got in at least two or three assistant practitioners on the bespoke course at UCLan , and that's carrying on its a rolling course . So as we as we're going through and we've got a six day working and we started those courses , we start those courses in a UCLan and yeah , so that's what we've done , so local university has been really supportive, clinical teams , national clinical team has been really supportive . Our ICS has been very supportive because I looked at my counterpart in Cheshire and Mersey , who really has no support like I have in Cheshire and Mersey and struggles to get stroke as priority on the agenda . And so , you know , and we definitely don't have that , whereas ours is a priorities recognized as a priority across the patch , we do have more, oversight of all our programs , you know , we obviously have to write highlight reports to the program boards and clinical reference groups , etc . We also have to attend them . Like I say , we also have to go to the HOSKS[???} as well to let people know where we're up to . So there's all of those things I suppose keeps us on the straight and narrow and makes us you know , make sure that we've got a proper reporting systems in place and things like that really.
SPEAKER1	44:22	Okay, and can you tell me about again , you've mentioned some of it as you've gone along , but the steps you take to ensure that that people are informed that the staff are trained across the teams , in other organizations ? What strategies do you use to keep people connected informed ? You've talked about some already said about you go back to them twice a year . You report back to them on the business case .
SPEAKER2	44:48	Yeah . And the, we have monthly highlight reports that go to the teams . We also we also have the ISNDN board and that's on a monthly basis . It's just bi-monthly . But each team , each trust , has to do a highlight report to the board on certain elements of , you know , a reporting across the patch . So they're keeping us informed of what they're doing . We also attend each organization has its own internal stroke governance group . And I'm a member of that group , so I feed back to them around what the ISNDN are doing and they feed me with what

		they're doing . So I got it from attending them and on teams meetings , we're going to see them face to face . And I also . Get their highlight report as well . And from an ISNDN perspective , I'd feed back all the local governance meetings every month of where we are and what we're doing . And I feed, we have the patient and carer group. [Yeah] right , so the patient and carer group , they, what we have set up for them is that they what we have for that is an ISNDN group . But every single member that is on that group is from a different area within Lancs and South Cumbria , and they attend also the local governance meeting . So that they partake in that what's happening from a regional perspective in there in that organization , back to the patient and carer group as well . So it sort of feeds in different elements , different ways , really . And we hold we have a monthly commissioners meeting . So and that's . It's sort of like or everything that we're doing in our workforce, sorry in our work streams , gets that back to them around . This is future commission intentions . This is what we're working on. You know , this is what this is , what's needed , you know , or vice versa , that the commission will come and say , you know , this is coming and this is what we need . This is what we need to look at or whatever . So there is that up and down element there and we have commissions that sit on the ISNDN board as well . So we have a commissioner update at that board and all the work streams . They each have their own individual , either working group , steering group , etc . But the clinical lead for that group will sit, will facilitate them . But then they also report back to the ISNDN board so they'll do a highlight report for the board . But they aren't expected to speak every single time because obviously it would be mental if we did that , so yeah , so obviously from our prevention element as well , that's slightly different because we had a separate prevention group that was actually run by the Lancashire County Council and that was a region wide prevention group . But it was just stroke prevention . They set up and produced a stroke prevention strategy, five years stroke prevention strategy , which comes to an end in 2023 , which was around the ABCs . So , you know , AF blood pressure , cholesterol etc , and as part and parcel of that , they developed a reactive dashboard across the patch rather than having to wait a year for CVD , fingerprint type things . So we did have that element now they've joined together with the cardiac network and we are we've set up now the CVD prevention group in Lancs and South Cumbria , and we're working on those targets , which is around . And it will be a 10 year strategy . And what have you and it also now ? As of last week , has expanded to have diabetes and to have renal in it as well , and it's like true CVD prevention group . And so we're part and parcel of that from a prevention perspective .

SPEAKER1	49:30	Can I can I ask you , you talked about the full patient voice . Can I just ask whether there's been any changes in terms of their involvement or [So we] I mean , have they made any changes to the way things have moved . You know what I mean ? Do they do you feel interventions met the needs of service users , have they sought of fedback on that ?
SPEAKER2	50:00	And I think yes they do . And certainly they can sort of see that that will . But because of the way that they're doing it is so for instance , Our psychology is virtually nonexistent across the patch and we've been working on, we've got a psychology workstream , so we've done quite a lot of modelling , quite a lot of stuff out there and what's what we need to do , what do we need to see ? And obviously they've been heavily involved in that as well , you know , because obviously , as far as they're concerned , that's what's missing . It's one of the health inequalities that we have in our area . And one of numerous health inequalities . One of the things obviously , that they'd be involved in is actually choosing the type of model that they would want and being a part of that group that they've worked through all options up wise and that we're doing same with in neurorehab as well and neurorehab sits there , we . neurorehab joined with the ISNDN because of such similarities between our therapies and what our, what's delivered to them is very similar , isn't it ? And so basically it was picked up at a ICS CCG meeting that if we were doing it , then neurorehab should be part and parcel of it . However , we have had, we don't get any funding for neurorehab . The only time I say we don't have any . The last year we actually managed to get half an 8-8 post , which is funding the person who's working on the neuro rehab work stream . And you know , all that additional work with LTHTR that they have that they do across the patch . So it's, it's trying , everything that we do is clinical that with a patient voice in it . So that's you know , It's a strong , consistent message that we're trying to do our best for everybody by following , you know , having the right people in the room , I suppose
SPEAKER1	52:18	You're answering so many as I go and keep diping between . You mentioned health inequalities . [Yeah] .Obviously, considered as part of the change , can you say , if so , how and why you've considered those
SPEAKER2	52:31	As part and parcel of if you think in the case that it's part of the change process , if you look at the case for change , it's what's missing across your area . And what's so obviously missing across our area was prevention elements you know, and so obviously one of the things that is, we got £50,000 from the national clinical team for health inequalities and it was a one off payments . And it was a question of what do you do with it ? And so when you sit down and think , what are the health inequalities that we've got across our patch ? We've got so many and we do have so many , but you chipping away at it, what we're going to do is going to take years . It's not a change tomorrow ,

		because a lot of it is like it is a system wide change , like having no psychology to thinking about what a model would look like and doing this, that and the other . And it's like neurorehab . we didn't have a single service that had neuro rehab . We had two services that we were working against each other per say , we have . Lots and lots of stroke patients in neuro rehab beds for no reason other than the fact there wasn't any community beds to go to . And yet those neuro rehab bed are really precious . So now , you know , we've virtually got a single , you know , rehab service , which across Lancs and South Cumbria we've now got , you know , we've obviously got a clinical lead leading on that we've developed . core standards , inpatient standards and community standards for neuro rehab , they are all benchmarking against these standards at this minute in time and then the next processes that we're going to do that service specification , which those standards will . Influence and guide , I suppose it's going to be similar to our stroke one , I think , but that's the next step for neuro rehab was it's taken us a long while to get there . And you know , people, because the work had not been done before , that was . It's been a frustrating , frustrating element in the fact that we don't have any money for that so, I've got additional money from the ISNDN last year and that's made then I could actually physically pay a clinical lead to come and do it and get some backfill for it . So that's made a difference and we have moved on a little bit and that's where it is for neuro rehab . So and that's one of the big health inequalities across the patch , and again , is that there isn't community staff out there , but that builds in that case towards getting a business case in the end around what that looks like ? And psychology , like I say , we didn't have anything like that . So we've been working on that as a group with patients psychology elements from across the patch, all multiple stakeholders . And we've just gone through an options appraisal for what model we want and the way that we want to run it . So that's the preferred model , etc. as well . There are coming through at this moment in time and then running concurrently to that is a, being developed at this point in time is a business case to move that forward . And like I say , the business case at the moment is being done by one of the people in the TU .
SPEAKER1	56:07	Thanks so much , [name] . Have you got another meeting at half past ? [No , no , that's all right] . If you need to finish , do let me know , Quite a lot that you've covered and I don't want to . And you've talked about the economic cost at the start and you've described where you've got money from as you've gone along . And so obviously , you've described that there are costs in carrying out the changes and . Is there anything else you want to say in terms of how you cover those, are there recurring and ongoing costs and how do you cover those, and across, I

		know you talked about the pots of money that you've drawn , but how is the overall cost…
SPEAKER2	56:46	The overarching thing is not is, at the moment in time , from the ISNDN perspective , we have national monies . [Okay] . And the national monies they gave us was they gave us the ISNDN's £100,000 a year and . but and out of that . The majority of the time I paid for things like clinical leads and things like that , etc. But then . When it came to ISDB , so out of that clinical funding now comes my wage, clinical leadership monies of which we've got three or four/five clinical leads and also and . I have a band 7 and a band 8a as well . So I don't have any monies for this because a hundred grand doesn't go very far , [I was going to say that I'm surprised it covers that!] that so it doesn't cover any of that really got increased to £140,000 last year than we had . there is a new, a squire role . And from across the patch , which , you know , that was for an 18 month role , and that so we got monies for that 8b , but that was divided between three ISNDN's . So it's not very much . And then on the back of that , we also got some service improvement money to go with the squire monies , which funded the band 7 role . So that's where we got our band 7 from and that is like, that was extented to 18 months . So that's only up to watch over this year . And we got half an 8a monies which came from specialist commissioners towards neuro rehab . And then what I've done as well is I've asked the Northwest Clinical Network because we're part of that , obviously part of the North West Clinical Network . And if they've got any and if they could fund the other part of the 8a . That's what I do , fill loads of posts.
SPEAKER1	59:06	And in terms of the actual intervention changes , how are they sort of?... **BOP**
SPEAKER2	59:10	Well , the business case that we had the business case was we were given just £19.5m for the three year intervention , and that's how it's been done . And a lot of the lot of the training , a lot of the interventions in the past , a lot of the stuff that we've done at workshops , things like that we use , we do is pharma , you know to support our events . Obviously , that was then stopped . Obviously , we use our local universities as well . You know , we need things to be done . So we try and think broadly and we used to utilize like the business centres and the CCG areas for external meetings , so we are not having to pay for meeting rooms and things like that . So we have been quite frugal now has been some creative thinking going into that. We got in health and the health inequalities money that we got was split between prevention and psychology because we didn't have clinical leadership monies for that . And this is not cheap clinical leadership monies because you pay them at the band they are at and it's , you know , it was really , really expensive and training and education wise , I do a beg, stealing and a borrow . And I usually , if

		there's any HEE monies we put in bids for the monies and were successful with doing that. Nursing wise not so , not so good . And the HEE monies now seems to have dried up . We've managed to split monies for like therapy and doing a lot of stuff like that . And we… So I've had to go back to the educational elites within and within our region , and they held a monthly meeting of all the leads , and normally I haven't asked them for any money for training and education for years and years because I've been so lucky to be able to get health education monies . But I have to go back and say , you know , please can we get funding because we can't do it . So we've had to go back to them and do a bit of a beg and steal . And I used therapy money last year to send people 17 people, 17 or 18 people went on and the stroke forum this year and that's, from our perspective yeah , we will take up as many opportunities we can , I suppose that's free and we offer out free , yeah. The training education element as well , obviously from all perspectives thinking about future workforce , etc. and all the training , and stuff that goes on , we obviously do cross sites working and cross site training . So and I'll say cross site , we've just got the first regional post , which is a workforce development lead post , which it's speech and language therapist , and she is based across the whole of Lancs and South Cumbria , and she goes and delivers dysphagia training to band 7 SLT's because we have we don't have many SLT's and we certainly don't have senior ones . So we've basically been using [name] to go and do training education across the patch . But she also , to be honest , was the clinical lead for our rehab for a long , long time . And we've just taken on another clinical lead . So we don't pay [name] now for that lead . She still maintains that lead and as part of the workforce development role , but we've just taken on another person to help move on a load of rehab projects that we've got , which are service development projects , and it's around looking at those service specs and trying to find out . What's missing and what we need to be working on next as a group. So I think . I don't know . Did I answer your question? I don't know.
SPEAKER1	01:03:40	Honestly , I could speak to you for about four hours , I think the way it is . Can I just ask going back to changes and interventions that you've made ? Have you done any pilot work for any of them?
SPEAKER2	01:03:50	We obviously we've done we've just done and NROL , which has been rolled out across the patch and East Lancs was a pilot trust for that . And so , yeah , they have done quite a bit of work around that and obviously work in conjunction with UCLan to do that . So I suppose that's one of the interventions that we've been rolling out and that's that definitely had a pilot. We did have a pilots , and I was trying to think for the neuro rehab element . So we piloted , as you said , the beds at [inaudible] not just for [inaudible] patients , but as a region. So

		to make it as part and parcel of that first, you know , as being a single service trying to see what that looked like and whether the beds were utilised . So we've done that as a pilot and all ambulatory all sites have done ambulatory pilot to sort of see what that looks like . They have all done that
SPEAKER1	01:04:59	And have changes been made as a result of these pilots . Do you think or do you know?
SPEAKER2	01:05:04	Yeah , yeah , definitely . I mean , I suppose when we did the pilot originally , when we first started up , we thought , Right , okay , what do we want and how do you want it to work ? And everybody in their custody is slightly different and they use different staff . But on the basis of that , when we actually came together to sort of talk about the pilots in different ways , we have a region . We developed regional ambulatory policy so that everybody works to that . And we have and I suppose it's from a thrombectomy perspective when we look at the thrombectomy pathway trying to think , what does that look like ? How do we measure things and how are the pathways working. We went to it, well , we have study days all the time , and we're looking at how that works , but obviously it's a bit like the AI for stroke it was put into , you know , one trust first and second , then third. It didn't have to do a pilot because they'd already done national pilots on it. It was more of an implementation . But again , everybody's , you know , it was working differently . And so we've got a regional SOP for that . And then and the regional SOPs were written by everybody , you know ? I would lead on it and would sit in a room and would write it together . That's how we how we've always done it . So somebody from every trust would be involved in that element and then we would then feed it back across the whole patch . And what else… are there other pilots ? I don't . I'm not saying that it's a pilot , but we tried to put in an ACP into one of our community teams over in East to see if that makes a difference . And it did and that enabled part and parcel of the work force to think about clinical leadership and what we would want for our community teams .
SPEAKER1	01:07:10	So what way it made a difference ?
SPEAKER2	01:07:13	Yeah , I suppose just more around the organization of the team and what have you and that clinical leadership around the whole of that , that person that's in there ? And they also extended to the neuro rehab team that they have as well . So and I don't know much about that , I suppose , but they've been quite involved with the national process of . What does an ACP do or in that [inaudible]? What you know , the job descriptions and roles , they'd been as a region to be quite involved in getting , you know , in that process . And I suppose that's made a difference because now we've got we've got an ACP in every community team that's bringing up clinical leadership was missing . And there was no career progression you know , within the community

		teams as well , you know , you literally got to a band 7 and it stops. There was nothing there else . So there is there is a bit more of a career progression now .
SPEAKER1	01:08:21	Brilliant , I'm very aware of time I'm really sorry , can I just ask you that kind of leads into how you record progress ? Kind of thing so how do you monitor and record your intervention changes ?
SPEAKER2	01:08:41	So I suppose obviously we . Do in you have to fill in smart sheets as part of the ICS element . So we fill in smart sheets and obviously when we think about it , one of the things when we look at the intervention is how do we monitor it ? And obviously we will we obviously looking at . What SNAPs telling us about activity numbers , we're obviously monitoring it through SNAP , we're obviously monitoring it through our local KPIs and things like that around our service specifications . Understanding what that looks like. Implementing six months reviews , because that was a big thing . We didn't have any six month reviews , but now every site , apart from East Lancs commissions stroke associations do their six month review . So we've gone from being down here to being up here , but you can see that through our, you know what I call our SNAP toolkit , but actually , that toolkit, then that toolkit grows and you can see that that toolkit is not just about SNAP we've put ambulatory care in there now and every single site , every patient that goes through ambulatory care has to have a form filled in and that form is then put onto a database and databases sent to us at the same time as when the SNAP results come out we then get that overarching 'this is what's happening with ambulatory care in the region'. And then the same thing as well , monitoring wise for thrombectomy as in the pathway we know, so we have a form that follows the patient and, at the moment in time , it's a paper form . It's not set up electronically that way . but from each site it's filled out in the A&E departments by the staff , you know , getting the patient ready for transfer if they are going for thrombectomy . The form goes with the patient , and it's then picked up filled in by the staff at LTHTR and then the LTHTR manager collects it when the patient leaves , when the patient leaves , the form goes to that person , and she puts it into a database for us , it actually gives us the information around thrombectomy , you know , door in/door out times , NWAS it gives us all of that type of thing . And that's… [sorry go on]. That form is meant to been going into the SNAP toolkit as well .
SPEAKER1	01:11:10	So it sounds like the SNAP toolkits like your overarching record in and you use that and then you pick what you record in terms of evaluating each intervention separately . [Yeah , yeah] . Is it helpful? [It is] Would you make any changes , if you could? [To that toolkit?] Well , to the way that you record so yeah , the tool kit for you?

SPEAKER2	01:11:32	I suppose for us its the paper , but the paper based systems clunky , we know it's clunky , we're happy , you know , we don't, we do have [name] who is our business analyst , but [name] is , and she is paid for by the Northwest Coast network to do some of the work for she does all our modelling , everything . So she's based , basically , and she's meant to be between Cheshire and Mersey and Lans and Cumbria , but I use her a lot more than Cheshire and Mersey, I use her all the time . But yeah , and you know , from my perspective , like from the snap element , that toolkit, when you say you got a picture over time , we've got one since 2013 in regard to SNAP and where it is. So we were able to see at a glance what each trust is doing separately and we've got that vision per trust over time . We've also got the benchmark against everybody together . What does it look like together , or we can then filter and then do it as a this is a Lancs and South Cumbria position . So . It's it is working and it works well , and I've taken it… when the national team were looking to think about what they need to think about ISDN's and where we're at and what we're doing . And I've shown our toolkit numerous times and it's been the basis of it has been taken and utilized across England . So people find it really helpful to have it all in one place because the good to think about it , is we've got SPC charts in there as well , so you can pick it up and use it for any presentation, for any business case . It sits on NHSFutures , so it's accessible to all . It is not hidden you know , there's not . It's there . So commissioners use it and you know , for their local reports that they have to provide . Yeah , so it is a good thing . I can't say would change it , would we do anything ? I think it is evolving all the time because it's does get bigger, it's hard work to manage and obviously also collects community data it collects numbers, it collects everything and then from an ISDN perspective , we built an ISDN tab in there so that an . what ISDN's are saying is, we want to know what thrombectomy rate is or thrombolysis rate ? Want to know ? And you know , 0-4 targets, 90% stay certain things that they want to know as the region what we do . So from an ISDN perspective , we set that up as well . So we have that . Or ISDN reporting as well ?
SPEAKER1	01:14:34	Excellent . There's so much you've told me and so much… can I just ask you , you've talked a lot about what can be helpful in terms of bringing around changes like learning from other places , the supports , the having the right people involved . But in your opinion , can you tell me what are the main barriers to implementing changes ? And what are the most helpful ?
SPEAKER2	01:15:00	I suppose the implementing changes and is local cultures , that's been quite difficult in some respects . You know , that's . And in particular , sort of like I'm thinking on community teams and on neuro rehab teams because there are out in community they're not always under

		the umbrella and they see the service spec , but they don't always want to work towards it . So we've had we have had a couple of problems like that . Trying to implement that has been a bit of a bugbear and what have you . One of the other issues that we've had is Blackburn with Darwen community team cannot provide early intensive intervention , can only really provide ongoing rehab support and the monies, each CCG as you know , say they would give moneys for their community teams , and they've spent an awful lot of time deliberating on East Lancs and Blackburn with Darwen joining together, and in the end , the CCGs just gave all the money to East Lancs and didn't give Blackburn with Darwen any . So we did make sure that as part of the business case , that there was money in their to uplift that community team, but it had to come from the CCG , and it was agreed and they want to work as a single service together , but the two trusts execs Well , it's causing so many problems and this has been ongoing for years , and we thought we agreed that we a single service and what have you , but because of the process and because it's so on hold because it's now gone had to go back to the ICB into the new commissioning thing . And it's put their recruitment on hold , so they're all ready to go out for recruitment, they are waiting but now that they're holding the monies again , so they're not even… the decision to join together has been really frustrating . And again , this is this is the overarching thing . This is around very much the ICB and having to go back time and again . And then it being disappointing every single time when you go back , that's, I know this, we're in a massive change and transition around ICS's ICB's at this point in time and commissioning , sorry , I'm messing with my fingers, but that has proven so frustrating , so , so frustrating and not good for patient outcomes for patients in Blackburn with Darwen . So that's a big health, that's one of the massive health inequalities that we've been working on and trying to get through . And it is so frustrating because it's just their ready to do it, the staff are, you know that they're going to be a single team but it's that exec hierarchical decision making that actually slows everything down . That's the biggest bugbear I suppose .
SPEAKER1	01:18:31	So they're the biggest barriers you've come across so it's that cultural thing or where there's a relationship that maybe isn't as conducive at a higher level…
SPEAKER2	01:18:40	I think it's just that is their governance processes that are the issue, it's the governance processes that have to go through and you know , you're jumping through hoops all the time . But their governance processes , but then the governance processes change all the time . So you think you're doing the right thing ? And then you're not obviously , it's that thinking I suppose. Yeah , I think… And obviously , workforce and recruitment is a massive thing , you know , because despite

		because of where we are and how we it , we tend to fish from the same pool . So you think you're doing okay , you think , Oh , that's great . But then you realize that , you know , like , for instance, LTHTR as of now , has got five speech language therapists, a year ago they have none. They have now got to five and you think , oh , that's fantastic , but now blackpool have got none, they've taken, exactly . So they've taken one from Morecambe Bay, they've taken one from , you know , East Lancs and so we are depleted on the other sites, do you know what I mean? Speech and language is a has been a nightmare and that's been one of the big things for us is around trying to recruit OT's speech and language therapists and , you know , all therapists I suppose in regards to dieticians and everybody . And in the fact that we've not been able to have a local supply , but now we do have speech and language courses run locally . So we're hopeful that we might get people coming out of that . We have tried to grow our own. So as part and parcel of that AHP strategy is now that we have every single site has got OT's on the apprenticeships , the OT apprenticeship . So we're waiting for the same for a physio and for speech and language as well when that comes out , if we can , you know , we'll start to build our own from that because we know then that they're not totally out there . We also obviously move into seven day working . We were a seven day working within the acute trust , within the acute , within the rehab element of it , but a six day working in community, we will never get seven day working in community like that , and we don't need it . We don't need that . So that's been modelled. Dietitians, you know , again , so OT's and speak and language therapy are on the at risk register , you know , because there is not that many people going to them. And so we struggle to get senior bands , but saying that, we had, one of the big things at Blackpool recently is that their community stroke team has been ongoing , and they've been recruiting into it for quite a while . However , and the working process , the way that the work and the way they've been doing it wasn't following the service spec , it wasn't doing what we wanted it to do . And they've had some issues around leadership there and we had a mass exodus from the community teams at Blackpool and some of them are not staying in stroke , some of them have gone elsewhere and so it's like , oh , grief , but when I went to the meeting this week , they've recruited a band seven OT a band seven physio, a seven SLT , so they're absolutely pulling together again . And I suppose this is part and parcel of the cultural change that we talked about . That's been difficult . So to deal with . It wasn't dealt with by us doing that, it's been dealt with in some ways by people leaving and gaining new staff in .

SPEAKER1	01:22:46	So if you are going to implement another change or any change , what do you think would be the most ? I know you've described lots , but what would be the most helpful things in your opinion?
SPEAKER2	01:22:55	I suppose the thing for me is that if you doing it, that you use a proper methodology and you work through it because otherwise you get gaps and you go back and you think , Oh , not done that , not done that , not done that , we need to do that . Whereas if you use the proper methodology , then it absolutely does . You know where you are up to you tick yourself off as you're going along , you know , use it , use a proper project methodology , yeah. And have that clinical managerial ownership and buy in to whatever you doing and make sure that everybody is involved . And I think that's what we definitely do that really well across our area .
SPEAKER1	01:23:37	Excellent . Is there anything you'd do differently or change in retrospect on any of the ones that you discussed ? I think you've kind of talked about it , but broadly?
SPEAKER2	01:23:58	I suppose . It is more the difficulties , it's more like the governance that we find that is difficult . That's one thing that you would change is system governance is just, to onerous I think is the word .
SPEAKER1	01:24:20	Is there anything else that you'd like to add that we haven't already discussed ? I'm sorry to take up so much time .
SPEAKER2	01:24:27	I don't know , honestly there is so much .
SPEAKER1	01:24:29	I know there is . And do you have any…
SPEAKER2	01:24:31	You got the worst , the worst person to interview ?
SPEAKER1	01:24:36	No no no no, in a way , it's good for me because you've given me a massive , broad overview and caught me up in a way that I couldn't have done with anyone else . Are you happy to be contacted for a follow up if needed ? [Course yeah] and are you happy to be contacted to take part in the focus groups that were planning further down the line because I think you would be integral to that.
SPEAKER2	01:24:57	I'm happy to do that , but you have to understand , although it's a full time post I actually only do work three days a week .
SPEAKER1	01:25:02	Yeah , yeah , it's fine . Obviously , if it doesn't fit [name] there is no . But it's just , are you happy for me to contact you ? And if it works ? [Yeah , yeah , absolutely]. Yeah , right ? If it's all right with you I'm going to stop the recording.