Participant 10 30.05.24.m4a

Interviewer (I):	00:02	It's about your involvement and your experiences in stroke car and whatever part of the pathway you work in or involved with . And I know that's big for you , so there might be multiple examples . We're interested in your opinions about what you did , why you decided to do it , what worked well , how the service could be improved and any challenges and comments you'd like to make . So the idea is we'll use your comments to understand what changes have been made , particularly at system level , and explore what worked well and what could have been improved . And then the idea is that the from yours and the other interviews , they'll be analyzed and inform focus group discussions to develop a logic model . Which can then be shared and used by others to carry out improvements in stroke care . I know your part of the stroke roundtables . You probably were involved in the development of this where I wasn't , so apologies for that . So , okay . Can you tell me about your current role and involved in stroke care services ?
Participant (P):	00:57	So I'm a [ROLE] [*name*] and I have been a [ROLE] on the [*location of work*] hospital since 2005 and I have had a [ROLE]as the [ROLE] since 2017 and the [ROLE], getting it right first time . And then since 2019 , I've just completed [PERIOD] as [ROLE] for [ORG] and then more recently as an [ROLE] with [ORG] just earlier this year . I still work 50% of my job is still clinical at [*location of work*] hospital and the rest has been around [ROLE].
I:	01:59	So thank you . Okay . So we're going to , I'm going to actually discuss any stroke care intervention or change that you're aware of and I know there's loads and talk about what the change was , why it was made needed . How you were involved in the changes , how it was developed . And you can use multiple examples if you want , but obviously with some people we would direct them to one example . But whatever you think and it's about , yeah , you talk and I'm sure I'll fill questions as we go .
P:	02:34	Okay . Stop me , [*interviewer name*] , if it's too macro rather than so . And we're keeping things to post 2020 are we [*interviewer name*] , as a focus .

I:	02:44	Well , I don't know . We're trying to gather anything . Really that's good in terms of what's worked well and things . So you can use historical examples . It's not a problem . So it's your opinions about what works and what doesn't , so that we can feed that into the logic model share . So yeah , it's fine to use whatever suits you though .
P:	03:02	So within my national clinical director role , it was clear to me from experience that good networks work and there's a good evidence base for networks and a distributed clinical leadership model and an economy of scale and not reinventing the wheel and the ability to have shared learning , you know the evidence was vast and from the GIRFT visits . So between 2019-21 , I and one other colleague met with every single stroke unit across the entire country , across 22 quality improvement days . And we combined data with meeting clinical teams face to face , not just the acute bit , but that whole pathway approach , which I think is pivotal . There's been far too much focus on the acute end of the pathway and not enough on from what our stroke survivors tell us , which is the fear of disability , living with disability . So I think based on those visits , that gave me a really good foundation for knowing the crux of the problem . What was , you know , people have lived and breathed on what the SNAP scores were thinking that they were the be all and end all and they are not . And too much focus , in my view , has been put on them . So understanding what someone with an A snap score , what their workforce looked like , what the vacancy rates were , what the culture and behaviors were within teams . What their HES , so the hospital episodic statistic data look like and what mortality look like on top of snap scores . So combining a chart , triangulating outcomes , cultures , workforce and behaviors with performance and delivery was important . So I think writing that national GIRFT report was a brilliant foundation for me to understand where the gaps were . And that led to 29 recommendations across the pathway from prevention , all the way through to end of life support and stroke . That was a good footing to go to develop the [GUIDANCE]. So it was clear from the GIRFT visits there was way too much unwarranted variation across the stroke pathway and people thought they had a brainwave and it had been done for 15 years in another part of the country so . Sharing that learning was important . The National Stroke Service

		model was the first time , there had been an attempt with a national stroke strategy years earlier . But the national service model was the first policy document . And what I learned was if something isn't in policy without political backing , you can't get newly formed systems to deliver . And so I think having a national stroke service model was important with key themes for what teams should focus on . Giving them our teams and systems away to benchmark their delivery . So delivering the right care tool kit that was relatively rudimentary , but it meant that people could benchmark where they were against the delivery of the National Stroke Service model . So that was helpful . And then subsequently to that , the Integrated Community Strike Service model again gave a framework for high intensity specialist stroke rehabilitation delivered in the home . And it was a needs based , not time based model . So again , that was relatively good guidance for commissioners . And then as a slight bolt on to that with feedback from our service users and stroke survivors was the integrated life after stroke model that and published in addition that looked at how we work with our voluntary sector , how we looked at services that already existed to make sure that people returned to living , not just surviving , but I think more recently , some of the subsequent work that we've done on thrombectomy has been very powerful . So setting up six communities of practice again , communities of practice is a model for improvement work extremely well , but need a lot of nurturing and light and support . They often don't just thrive on their own , especially not in the current environment where clinicians have absolutely no time to do anything other than the bare minimum , but creating again publishing in 2022 , The national GIRFT thrombectomy best practice report again gave a framework for how to improve that pathway approach . The northwest , the northwest including greater Manchester rather than just northwest coast community of practice had already , I chaired that group for a while before we set up the other five communities of practice and that's worked to some regard but again , with anything , we've got different populations , different communities , different personalities , 2 or 3 ISDN’s . And so that was interesting to see and play out , which it was across the rest of the country too . Something else I think changes that have been made that I'm particularly proud of and I think delivered is the [CONTEXT], so this is the stroke quality improvement

		and rehabilitation . So this was a regional lead post and I there were seven of them across the country . This is the positive bit but being honest while we're talking about it the North West Post didn't deliver quite as much as some of the other regions , but I think some of that was because of the amazing work that two out of the three ISDN's had done already in the delivery of the Integrated Community Stroke service model . And I think it was also related on personalities too as many leadership roles are , or the success of them . And then the north West Coast has done particularly , well , we've had 75 funded catalyst projects to deliver quality improvement and the North West Coast bids were , I know I'm biased and I didn't score them but they were brilliant . And the North West has been particularly successful in securing quite a large amount of funding in the terms of millions of pounds to deliver some of these projects so that's been brilliant . Some of the other things that , again , pivotal to the north west but have been implemented across the country , national optimal stroke imaging pathway so the nosip and the northwest coast has with great vigour taken that on and moved that forward absolutely brilliantly and they said they didn't have any CT perfusion in 2020 . Now every single hospital has CT perfusion . Most didn't have a stroke to CT angiogram pathway now all of them do . None had AI support tools now all of them do . So the big bit now is around the other side of the pathway , which is MRI scanning . But that's been brilliant but always still work to do . There's been some good work delivered on prems , obviously we've had our national patient reported experience measure survey , first one last year 6500 responses . Wealth of information from our service users . And again , the north west , Lancs & South Cumbria particularly , have really taken on the results and made sure that they felt its service users and trusts in terms of how they use that really , really rich , patient reported data . And I suppose one other area that I think is an area of change is around their Leadership Academy . So what came through very loud and clear from our brilliant stroke team . So we met them face to face in 2019-20 was a lot had been on leadership academy or leadership training , but none of it was stroke specific . They weren't with their people their tribe . And I think if people put into a situation where there's a shared goal that accelerates your leadership learning massively . So I'm extremely proud of that . UCLan were brilliant in supporting [*UCLan colleagues*]

		were part of the initial faculty , so that was great . And now that's in partnership with The King's Fund and Royal College of Physicians . It's the first ever stroke specific , or speciality specific leadership training so that's good . And all of the things I think have just listed have all been deliverable because of creating integrated stroke delivery network [ISDN's]. So 20 of them across the country in the north west , greater Manchester and London were the only two that had continued with an old style of ODN networks so operational delivery network . The ISDN's was different to the ODN's because we had a very clear vision how they would integrate with the new NHS England operating model of ICS's . And because Lancs & South Cumbria was one of the first wave early adopter ICS's we knew what that footprint would be and we use the GIRFT visits to infrom what those footprint should look like , because it's very clear to me when you set up a network , you need to look at patient flows , commissioning boundaries and , yeah , also the population that you're trying to deliver quality treatments for . In some areas you can just fudge it , smush people together and get something from it . But if there's that commonality of population , people you serve , challenges and a shared challenge is often a massive borometer , isn't it , to , you know , judge people's interests to make a change and do something different . So I think getting your right tribe together is important and being completely frank , not for quoting , but hey , we're being recorded [*laughing*] , people were sick of hearing from London or Greater Manchester about how brilliant their stroke services were . So nothing gave me greater joy than on a national level , bringing people like [*participant 1*] or [*name*] or [*name*] to a national meeting and getting them to present the brilliant work . I mean , some of the brilliant work that's been done around workforce gap analysis in Lancs & South Cumbria or service reconfiguration in Cheshire & Mersey was a real coup to be able to do that so yeah . [**I:** Excellent] . I could talk forever but I won't because you will get bored of me [*laughing*] .
I:	14:22	No , it's great . It's absolutely brilliant . And obviously you have covered quite a lot already , so you've talked about the importance of gathering information and evidence around interventions and change . Is there anything you'd like to say about how that was done or how

		you think it should be done ?
P:	14:45	Well , I think it's important that whatever evidence if it's data driven . It needs to be data that clinicians trust and believe and their not questioning . In the past that had been a problem with SNAP . I think we've got to a point where SNAP on its own now doesn't tell the full story and it hasn't done for a long time . And that is being addressed . So that's , I suppose , one thing , one of the changes we've made is we've looked at the , or I've looked in the service specification when that was rewritten for the recommission of the SNAP audit that the questions that are asked and then how the scores are generated because it means nothing if everyone get's 100 percent on a score . I mean what's the point of even measuring it so I think what's important is what you're measuring is meaningful . And the question is , who is it meaningful ? Is it meaningful to the clinician , is it meaningful to the service user ? Is it meaningful to commissions ? Is this meaningful to all three ? Brilliant . But that's the Holy Grail , I think , around what we measure and what we're trying to improve . I think stroke is phenomenally lucky because our evidence base compared to many specialties , is extremely strong and robust . I think having the nice guidance is fine , but obviously that looks at things in a financial lens , which clinicians generally are not interested in . They're looking in a patient outcome lens . So that's why having RCP consensus guidelines , so 2016 and then the 2023 ones are great . I think on top of that , because again , we were lucky in the last four years to have had a James Lind alliance demand signalling review for stroke , which is obviously again has a lens of evidence from a patient perspective or strokes survivor perspective and carer . But we also had the NHS england demand signalling work . So stroke was the first programme to go through the innovation Research sciences demand signalling . Why that is important is that's generated quite a few research calls by the NIHR and SPRO and a few of the research groups to have a real spotlight on stroke . So I think having evidence based national guidance , clinical consensus with GIRFT guidelines , a community of practice across the stroke networks and that , weirdly , as terrible as the pandemic was , at least it drove us to being able to work virtually remotely and connect people across the country . So from a QI perspective ,

		although I do truly believe you do have to be in the same room as people , and if you don't know individuals , you don't get as much out of relationships virtually . But the ability to , I think , do rapid improvement workshops virtually has been good . And I think the utility of some of the platforms used has been good . And so , yeah , but I think having that shared vision and shared goal with the data behind and a clinical consensus is pivotal .
I:	18:05	Excellent . I was going to say that links in with your shared vision for like . Yeah . Excellent . Obviously you've been involved in lots of different interventions and changes and some are more complicated than others . But is there anything else around support that's available or would be available to help put intervention changes , is it ... I know you've talked about lots , so you've talked about the data and the ...
P:	18:36	So the positives are some of the fundamentals of what should be there and aren't always there . So the positives are if you , if the stroke networks ... so the staffing that was created within the ISDN's and the governance to enact policy evidence based change , if that exists then that's fine , but obviously you need the resource behind it . You also need people across the system to understand who's driving the improvements and people to take ownership . And a massive reflection and a sadness I've had over the last 12 months is with the new operating model that we've got for the NHS with ICS's , 42 ICS's across the country . And the footprints don't make sense for many patients with flow . They do for some and we're lucky really lucky in the Northwest , but others aren't . But with this new operating model , many of the ICS's are very naive . And so naive leadership , lack of QI [*quality improvement*] expertise and no money , again , talking about the Holy Grail or the triad of doom , I prefer say . So you can have the best written reports or business cases or intentions and right now it's almost impossible to move anything forward because of , you know , add a general election year onto it .
I:	20:19	We can't talk about anything either .
P:	20:22	But the other challenge as well , which I've seen get worse , not better in stroke . Not universally across the country , but certainly Lancs & South Cumbria is a particular example of the northwest

		coast around workforce challenges . Stroke is seen as a hard speciality . And I think a lot of the QI work that people haven't been focusing on because it's in the too hard to do boxes unless we're very clever and we start as part of a QI work and singing from the rafters about what a brilliant speciality stroke is , its diversity , what it offers to you as a clinician , you know the difference you can make to attract people into stroke ? We're going to be in a really difficult spot and it's going to get worse before it gets better . So although we've got this brilliant foundation that I've talked about already , about why we could tomorrow deliver all these brilliant QI changes , I think off the back of a pretty burnt out workforce post pandemic who did brilliantly . And again , the level of pride I've got for the stroke workforce for , stroke was one of the few specialties nationally that over the pandemic everyone carried on delivering all of the acute services across the country when others were folding in other specialties . And more than that , they grew , a lot of them grew and , you know , developed some of the virtual rehab models that have been brilliant . So but I think , separates to the pandemic I think now we're in a position where the networks have been decimated really in the last 12 months in terms of their staffing . And it's heartbreaking and shows again , just a lack of respect for the importance of organizational memory . We keep trying to do the same thing over and over again , but we lose brilliant staff who then go , 'well get lost if I'm not valued I'm off' so what would be great to see is nothing new needs to be reinvented now . We don't need any new evidence , but we need a commitment to some investment for stroke . We need the workforce to deliver the models that are evidence based and we need the network structure to support QI work because no one else is going to do it . And I think we've not been as good at linking our academics our researchers our quality improvers altogether to get that clear voice , yeah . That sounded a bit downbeat . I didn't mean it to be . [**I:** No , no , no , no . It was good!] . Talking about politics! [*laughing*] .
I:	23:30	Well , you've got to be honest . And at the end of the day , that's one of the big things , isn't it , around resource . And so you've said quite a lot so this talks about managing teams of staff and it's talking about strategies to keep people connected informed . And what you've just

		said fits into that anyway , because you've said it's important to link up the academics and the clinicians and things . You've talked about , various things like the ISDN's and the communities of practice . Are there other strategies that you think are useful or you've used to keep people connected and informed ?
P:	24:07	So I mean , certainly across the national team we have monthly drop ins , which is information sharing , a bit on research updates , a bit on other relevant audits , for example , you know , CBT prevent . So there's that update element and then there's national and all of our ISDN's , most of them do newsletters to share with their clinical teams what's been happening and , you know , highlight research project of the month or sharing successes . The face , done lots of face to face work because it was really evident that post-pandemic when you could get back together , people really valued that personal connection seeing the whites of someone's eyes and that yeah , that's been really powerful . So certainly the away days for the networks have worked and also the individual networks have had their own QI days across the country . And I think in terms of other connections , a lot of networks have tried to do , but it's been a much harder , and northwest coast is a perfect example of the relationship with the ICB's and ICS's . So because of the way that South Cumbria had an early ICB and ICS they were able to get relatively good tight relationships with their ICB and ICS leadership team . 25 miles down the motorway , an equally skilled network manager has got an almost impenetrable ICS and ICB where you can barely have a conversation . And when you do you present the same thing over and over again . And it astounds me why it should be so different . When both regions have identified stroke as one of the three clinical priorities . So , I mean , that's just you could write a book on it . Yeah . So that's , that's a problem that we have and I can't work out whether that's , well I know I've got my own personal views why it is , but I think when ICS's aren't held to account within their own principality , it's cowboy country and we're going to lose a huge amount of momentum in delivery , and delivery of great care shouldn't be personal dependent , and that's really frustrating . So you should have clinically led decision making by experts that , you know , as we talked about , that's backed by evidence and with a good QI methodology behind it .

		Which again , goes back to why the ISDN's are so important . So yeah I think the power of connection networks , communities of practice , a clear governance structure for what you're doing and why you're doing it . A clear reporting structure against delivery and a clear narrative around vision . And the other thing I think is highly important that we do relatively well stroke , but I think cancer maybe , cancer networks have managed to do it better is capturing hearts and minds and the public and patient voice . So how do we and again , Lancs and South Cumbria have done this , particularly well with that PPV [*public and patient voice*] representation on the ISNDN board . So how do we make sure that our service uses are actually the biggest jumping and making the biggest noise about lack of delivery or in fact successes as well rather than just the negative .
I:	27:58	Excellent . You kind of , your answering all my questions as you go . Sorry if I flip a bit but while we're talking about service users and stroke survivors . So you've talked about they're obviously represented on ISDN board , you've talked about the been involved in terms of prems and even down to the James Linden and making sure that those things are listened to . Is there anything else that you want to say ? Do you think the interventions are delivered in a way that's meeting the needs of service users ? How do you involve service users in other ways ? And also the big one about do you think any health inequalities are being considered as part of the change ? And if so , how ?
P:	28:44	I mean certainly on a national level , health inequalities , they're a , you know , vein that run through all of the projects and decision making within warranted variation that we see across populations and communities . And ISDN , one of the first things that was brought in was some specific funding around projects to ensure everything was looked at with the health inequalities lens . And that was done variably but not because of a lack of will , but a lack of structure I think at ICS level and some ICS's I think maybe paying a bit of lip service to inequalities rather than really knowing what they wanted to focus on . A lot of inequalities work has in the past focused specifically on prevention because that's where the biggest gains , which is great , but it's not the only the only issue . I think some of the digital exclusion that we've seen around , you know , offering virtual

		follow up or virtual rehabilitation or whatever else is huge , especially in some of the more deprived areas . And , you know , there are obviously huge pockets in the northwest coast that fit into that . Some of the ethnic diversity that we see within the northwest coast is not as marked as some other connobations , but it's still very real . But again , it's very different across all three ISDN's and we've seen very different approaches , which is good to support some of that work . Yeah . I don't know if that answered your question .
I:	30:34	No , that's good . So you're thinking that they're using different strategies based on their populations , and that's appropriate because obviously everywhere's different and it kind of fits with what you said about geographical differences earlier .
P:	30:46	Yeah . Yeah , absolutely . I mean , I think one good example is around Covid when , you know , access to blood pressure monitoring . So a lot of the stroke teams are going out and doing blood pressure monitoring just after they've done the therapy work because they already gained trust and they are in a patient's home . So it's understanding the community you work in and the clinicians that have access . But some of the work , I suppose , specifically was done within Greater Manchester around linking with service users , their churches , their community centers , you know , the people that are trusted within the community that aren't medics or associated with the NHS is really important . I think how we link in the public and patient voice into our research is important too . So we've done quite a lot of work with the national CRN . It has just changed its name , but I can't remember what they changed it to now ... [**I:** They have not quite changed yet so you're alright] .
I:	31:46	Not quite change yet . So you're all right ?
P:	31:48	Okay . I have not done a heinous crime ! So I think how we've had lots of discussions with our PPV leads at ISDN level and the patient voice leads at CRN that seemed to go , why are they separate , why are we separating things and not having a much more detailed conversations that link policy , research , innovation together and bring in our research and academics . I think we've gone backwards a little bit in stroke over the last five years and actually I'm not really sure why and it might just be because everyone's gone backwards

		because of the pandemic . But I think bringing research and innovation into the forefront of people , understanding that if you've got a research active unit , by definition an evidence base , you usually deliver better care . We've lost some of that and I know why we've lost it because people are just burnt out and tired and don't have , they perceive it as a nice to do rather than an essential .
I:	33:01	Yeah . So I'm just going to bring you back to a big one now around , well actually I'll start so in terms of any of the changes and stuff , have you been involved with piloting of any of the changes within services and making any changes as a result ? Or has it been much more strategic in terms of we know the data's there ?
P:	33:21	No so a lot of the things we chatted about were brought in as pilots . So the AI work initially in stroke that was , we brought that in as a pilot before we did the formal procurement . Rehabilitation pilot . So three massive national pilots , again with multimillion pound funding that went to Northumbria , Northampton and north east London after multiple bids had come in to look at demonstration that you can deliver the integrated community stroke service model so I think piloting is good . The problem is the word pilots used inappropriately a lot of the time and sometimes if the evidence base is there just get on and do it and stop calling it a pilot but the NHS is caught up in this ridiculous merry go round of we'll call a pilot and then we'll be able to do it and we won't have to do all of the governance and ethics and bells and whistles . So I've got a slight bug bear with calling things a pilot when we just need to do it . But within the stroke programme , it served a purpose around rehabilitation because we demonstrated you can deliver something and it's cost effective and it delivers better outcomes . The commissioner seemed to like the term pilot because it makes them feel comfortable with giving time limited funding . And in my mind , if you can just get it done and deliver better care for patients and demonstrate a better outcome , if you want to put the word pilot in front of it then crack on but I think it's a misnomer sometimes . The work that we've done around pre , I've not mentioned it pre-hospital telemedicine . So they were classed as pilots . We had 16 pilots , they are pilots I suppose , across the country to demonstrate different models of delivery of pre-hospital assessment . Northwest Coast is being backwards with that because

		there wasn't a commitment from Northwest Ambulance , which is unfortunate . So how we are not anchor draggers and have a better working relationship with our other stakeholders is really important . But again , that's the interest for me in terms of how you can have 15 I think it's 15 different ambulance trusts that have all got different personalities and leadership and delivery of great care should not again be personality dependent and it is so yeah . So pilots are okay the catalyst really I suppose those 75 nationally funded projects , they are pilots to demonstrate that delivery is possible and also to fund some of the QI work that's needed to yeah , just demonstrate deliverability to what is a really hard and climate and environment right now .
I:	36:15	Yeah . Okay . So it's more about showing feasibility and acceptability potentially . [**P:** Yeah] . Fair enough . So the big one that I said I was going to go back to , funding . So you've talked about it in snippets of things and so how have things been funded and how were recurring costs and things dealt with and what can we do and learn from what's come before ?
P:	36:42	So we were lucky , I say lucky but it was a huge amount of lobbying , but we are lucky in stroke that we were part of one of the national programs . We were lucky that we had a disease specific national program . We were lucky that we had a national director , and I was able to build a team around me because not all specialities were . So with that comes funding and the SDF funding , which is the central funding that goes to region and down to ICS . And so the networks had that funding , but every year you have to fight for it . So the idea that every year you have to do your budget sheet and there's a top slice every single year off everything . And then came last year when it was all because of the new operating model , they've decided to shrink NHS England and push the money down to ICS . ICS's aren't ready for it and are in a deficit before they've even begun . So suddenly all of this money that is meant for stroke disappeared into the ether . That is a massive problem obviously , because now we're in a position where it's not even about how we do great quality improvement and deliver evidence based care is how we can maintain the services we were delivering five years ago . So we're in this dreadful , difficult situation at the moment . What's positive for

		the northwest coast specifically is that stroke has been identified in the top three clinical areas for both Lancs & South Cumbria and for Cheshire & Mersey . But that seems to come with a can you please just deliver improvements and no commitment to funding and Lancs & South Cumbria specifically and the sadness again that they've been going again around and around with getting funding and support and feeling like they got somewhere . And then it being pulled so it's that constant rug pulling that's desperately unhelpful . I think until we've got some stability in operating models and budgets , it's very difficult and I think working on a year on year budget is ridiculous . A minimum of three years is needed , but probably five if you're going to do decent QI work and improvement . We've got a big problem in the NHS at the moment that there is no money for capital . And any money that goes ... So a lot of our hospitals to deliver , for example , 24/7 thrombectomy in Preston , you need a big capital program . There is no capital budget . I think the way we fund workforce . So that obviously is revenue based , not capital and you need recurrent funding because the way we treat our staff is really poor . Why anyone would move to be promoted into a post that's a fixed term and then they might lose a substantive post is beyond me . Very few businesses treat people so poorly , so and that all comes down to HR [*human resources*] and funding pathways and it has to stop . I mean , what's been positive about the networks is , well , it's positive except northwest region have behaved less well about it than other regions . So the money for networks was made recurrent in the baseline for staffing . The money for the SQUIRE post is recurrent baseline and then the region go and take care of 50% slash and burn and then say the money's gone . So that's even when at national level you say it's a priority , you have to do this . And an ICS line you say it's a priority . You have to do this . An ICS board prioritize something like stroke and then you still can't deliver . So I'm not confident with a new government that it'll look and feel any different . In fact , it may feel worse if they put all of their eggs into the primary care basket , which I'm not saying is a bad thing , but acute services still need to be delivered . We in stroke haven't done a good enough job in terms of cost benefit analysis works that we've done a bit for Thrombectomy we've done a little bit thrombolysis in terms of cost savings . We haven't done it for the ICSS [?] model and it's not for

		want of trying because the expertise doesn't exist in NHS England for health analytics or economic health analytics . So you have to always go out to procurement . And when there's no money in the system , spending money for an academic institution to do a cost benefit analysis work , they just don't want to do that . But it doesn't mean it doesn't need to be done . So it may , we may get to the point where ICS's rather than it being done at a national level , which would be the right thing to do because it would be an economy of scale for funding . We might get to a point where each region or ICS needs to look at its population and say , if we delivered X , Y and Z , we would save this but that's the problem because at the moment the funding , people don't look at the overall cost of stopping someone becoming disabled from a stroke . They look at little bits along the pathway that they're responsible for . So until we get to system level health economics , we're stuffed . **[HERE]**
I:	42:09	Well , I totally agree . Wow . And . You talked about clear reporting structures earlier . So can you describe the way that planned changes have been recorded and sustained . Any ways to measure the embedding of the changes ? I know it kind of fits in with the fact that we haven't got cost benefit analysis and we don't do that . What works well , what doesn't what would you change if you could ?
P:	42:43	And in terms of reporting and governance ?
I:	42:46	Yeah , I think so .
P:	42:49	Well , I mean , as a national program , you monitor as to how many hours sleep you get at night virtually . I mean , it's all very , you know , all of the budgetary flows are heavily scrutinized . Everything has to be related back to patient outcomes . So the rehab pilots , for example , we incorporated the EQ-5D into snap so that we could look at functional based patient centered outcomes . We delivered the prems survey so we could actually demonstrate is the patient experience changing ? We've re-looked at the SNAP score , so we're actually monitoring things that are evidence based and currently aren't being delivered rather than just measuring the same old , same old . Within the rehabilitation pilots as well we piloted a new web pilot which again , we looked at new scoring systems . Incorporating bartell[?] looking at consistency around ranking reporting . So there

		are hard outcome measures obviously . We look at mortality across the stroke pathway , so we do ONS [*Office of National Statistics*] case mix adjusted mortality and then feedback to mortality outliers . On a more people based level , we do a lot of leadership development and support people to be their best selves and support the communities that they are meant to be leading . And help them to support and understand the systems that they work in so that's positive . So but yeah , I think some of the improvements that are needed really are around , we just need some consistency . We need to stand to stop constantly moving , consistency of workforce , organizational memory , people to be able to have these consistent posts , people to know their community , who to go to to make things happen , who are the decision makers and at the moment we don't . [**I:** Excellent] . [*Interviewer name*] , just so you know . So I've got I've just messaged to say , because I had a call at quarter too , I've just delayed it but I'll probably have to drop off at five two . Right .
I:	45:20	Yeah . No , that's not a problem . [**P:** Is that okay?] . I'm just trying to make sure , because you've covered loads of it . So it's a big interview schedule and you've covered loads but I don't want to miss anything . So apologies . [**P:** That's okay] . So I suppose I want to , you talked about a clear vision narrative , capturing hearts and minds , and I think that links into the stakeholders stuff as well . How do you go about developing that clear vision narrative and where you can engage in those identifying and engage in those stakeholders ? What are the key steps in that process ?
P:	45:55	Well creating a story that is patient centered and probably having patients and carers delivering some of that narrative and certainly always in the room with , you know , co-creation co-production of products and the narrative not being too medicalized in the way we speak . Understanding your audience and understanding who you stakeholders are . Often if , as everyone knows with any leadership work , if you don't get the right people around the table right at the beginning , they feel extremely disappointed when they're invited later on and often are disruptors and not necessarily positive disruptors . Respecting the positive disruptors , though , because a negative voice is not necessarily a bad thing . And having the conviction of what you're trying to do to know that you can change

		course is very important . Making sure that whatever narrative you're creating isn't creating more health inequality so that it speaks to your varied population , whether it's from a language or culture or a level of education or digital access , you know ? I think , knowing who your cheerleaders are , knowing how , you know , if it's hitting the fan , how do you access your medical directors , chief executives , MP's , the people that can help you and profile raise . I think knowing your strengths and your communication style is important and we don't do enough of that in the NHS to help people develop that . Yeah and I think just having a story that is compelling but kind and compassionate and accessible . And then going back and accepting that once you've done something one way , working out whether it's worked before you just keep doing it over and over again . But that's expensive and it's time consuming and it's again , not something the NHS necessarily does well .
I:	48:28	Okay . I suppose that kind of links back into feedback . Do you give feedback to all stakeholders and how have you , how do you do that and are there good ways of doing that ?
P:	48:40	Yeah , so possibly not as much as I would like to , but that's the weirdness of NHS England . It's a very hierarchical organisation to work in that I don't and didn't enjoy many elements of . And so it's really , really important , especially the public and patient voice . So it needs to be done in a very respectful , sensitive way so we have PPV representation on a national stroke board and after the stroke board , I always have a catch up ... well I have a pre brief and a debrief with our PPV group to make sure that they're comfortable about what's going to be spoken about . And then we reflect whether there was any language used that wasn't useful in the board or how they felt the board went . And we don't expect necessarily them to question in the same way that some of the medics or op's leads or exec people on the board might do . So I think allowing for people's communication style is really , really important . As a [ROLE] so I managed as [ROLE] over [CONTEXT] so I would have 1 to 1 catch up with all of my [ROLES] on a relatively regular basis and then we'd meet as [inaudible] across the ISDN's . Going to meet people face to face is really important . I don't , you can't do it all virtually . Being very accessible across different modalities . So I've been able to be called

		or emailed or just be present , but also to understand what is important and what isn't , because I think many of us get pulled into lots of meetings that never even needed to happen . So understanding your impacts and your value and your worth , but knowing that if you say yes to everything , there's just not enough hours in the day . Yeah , so feedback is very important . But also , I think what's important is allowing yourself the time to be kind to yourself too when you're doing any of these roles and I think you can get on quite a brutal conveyor belt that makes it hard to do that and also be willing to accept feedback for yourself too . Yeah so we do a lot of 360 appraisals , strength scopes . We use some validated , certainly in the leadership academy we use some validated Franklin-Covey , yeah , different models . I think using stuff that is validated and structured is important .
I:	51:34	Excellent . I'm very aware of time . So are there any of the comments that you'd like to add or anything that we haven't discussed that you'd like to mention ?
P:	51:43	Strokes the best speciality ever and I do know working across with multiple national clinical directors across the country , there's something uniquely wonderful about people that work and are interested in stroke and I think the non-hierarchical MDT approach that , and more rigorous across research and evidence and also very holistic in the approach that we have . It means that we've managed to deliver stuff over a really difficult , yeah , global health situation that many other specialties have not . I don't view this parity of esteem . I think the NHS is profoundly ageist in the way many people view delivery of health care and as a geriatrician that , I said a rude word , *** me off . [*both laughing*] . But it does . And I think how we communicate with our politicians , our policymakers and help people especially now we've got this demographic shift . We've got the baby boom coming . Every one of the baby boomers now just turned into a pensionable age . So the next 30 years , we are up a creek without a paddle if we don't start understanding the complexities of older age and frailty and stroke , I think is the testbed to demonstrate how if you look at an evidence based clinical consensus , policy driven , research active dıfsease speciality , and you deliver a pathway and two-ended[?] approach , you can actually

		deliver a cost effective health care that doesn't cost more . You can do it . Yes , some stuff needs pump priming , but you can do that . And I think if I had 1 or 2 , if I had a wand and some wishes in acute hospitals just let some of the stroke leads demonstrate how it's done in other specialties and in the community , let the rehabilitation specialist do the saying because there's lots of transferable brilliance in stroke and transferable QI work that's gone on that if it was just filtered across , would be massively impactful .
I:	54:14	Totally agree . Aware it's five to and aware you , I could talk to you for hours but aware you're massively busy . Is it alright if we keep you in the loop with things like the focus groups and the development of the logic model ?
P:	54:23	Oh yeah . If I can ever fit in the diary , I always will .
I:	54:28	Yeah . No , that's brilliant .
Interviewer 2 (I2):	54:30	I was just going to add to that actually , I'll send through a doodle poll to yourself and [*PA*] and if you can make any of those that would be brilliant
P:	54:37	Brilliant . Okay thank you .
I:	54:37	Thank you so much for your time [*participant name*] .
P:	54:40	You're welcome . Nice to meet you both virtually , take care .