Transcript

30 May 2024, 02:10pm

Interviewer started transcription

Interviewer 0:04
There we go. Brilliant. OK. Looks like we're to go. So Paddy, first of all, do you want to tell me a little bit about your current role in your organisation and your links to stroke care?

Participant 0:13
OK. So until December, the 31st of last year, I was on a consult position, initially trained in care of the elderly, went in Preston for five years, then came to Southport in 2003, helped to set up the stroke service in Southport.
I mainly did stroke from.
Well, did I did general medicine, elder care and stroke, but stroke became more and more.
Predominance from from around 2006, seven and probably from 2004 when the straight units opened and then from went thrombolisis really took off and then we had the Telestroke network with Cumbria and Lancashire and then I've done stroke mainly until 2000 till the end of last year and then I retired. But I've come back and doing frailty now because one of the geriatrician at heart and two, it's a slightly easier job to be absolutely honest.
I don't know old, so that's why I've come back. So I do. I I still do. Monday to Friday, 9:00 to 5:00, but it's.
It's a two 2/3 of what workload I did previously, but it's about the job's about 1/3 of what I did previously. So that's so I'm you know I've I've come back to help the NHS but not quite as hard as I did beforehand and I've been I've been an AMD and I've done some management roles within the NHS as well.

Interviewer 1:25
Right.

Participant 1:38

Within the church. So yeah. So I've done stroke and I was very much so. The two main things I've been involved in in sort of transformation projects where the Cumbria actually Teleshop network which is around 2009, 2010 and then the North Mersey stroke transformation for about 2015-16 to 2000 and well, until I finished really, but it it was established in September 2022.

Interviewer 2:11
OK. But that was like a an ongoing sort of.

Participant 2:11
So it didn't work as well as here, yeah.

Interviewer 2:15
OK, OK, that's brilliant. Well, I don't.

Participant 2:18
And the other thing with studies show is that I've done a for my appraisal. I've done AI did a reflection on on on the North Mersey transformation. So if you ever wanted that, I've done a written thing. I'm more than happy to share that with you. I can send, I can send them to you because it probably has a lot of other, you know, stuff about what I thought about it. And you know the goods, the positive, the pros and the cons.

Interviewer 2:34
And that would be priceless, yeah.
I mean, I would absolutely snap your hand off for that, actually, Paddy, if you're willing to share that.

Participant 2:48
Yeah, I'll send them to you. It's my personal. It's my personal opinion. So you have to take it as my personal opinion.

Interviewer 2:53
Sure, sure.

No, but that would be great. And if you know any any additional information like that is always useful to us. So I I don't mind.

Participant 3:01
Yeah, I'm. I'm being honest. So three of the best things I've been involved in as a [ROLE] are the [CONTEXT].
The [PLACE] stroke transformation ultimately, although it was like.
As you'll see, it was that was quite hard and I I'm a [ROLE] as well, and I quite like that. But [CONTEXT] and [PLACE] for lots of reasons ultimately were really good things to being involved in within the NHS.

Interviewer 3:30
Sure. No, that's brilliant. I don't mind whether you want to talk about one in particular or multiple sort of broadly, but if?

Participant 3:36
So I'll just tell you about this so quickly. So tell me show counts.

Interviewer 3:38
Yeah, you want to give us a background on, you know why it was needed? What actually happened? What about the implementation?

Participant 3:41
So, so so basically so basically.
But but [ROLE] delivered thrombolysis across Cumbria, Lancashire and everyone's got either one or two stroke [ROLE]s in those trusts, so there was about those ranging from Carlisle down to us and we got in it because we're Southport and Ormskirk in Lancashire. But it was useful for us because we didn't really know how we were going to deliver thrombolysis in a very small trust.
And so we've delivered it through Telestroke we can actually.
It was a very good collaboration between all those trusts, mainly because it was done by clinicians and the other main reason was the guy who was the IT expert was a can do person and it was like I can do this because they looked at all options, the options were to try and go alone, but how to provide 24/7 service was impossible with the workforce we had. They looked at or they considered.

Air ambulance and transporting people. And that was just a no-go because the air ambulance doesn't always fly all the time. There's lots of reasons why it can't fly. And then thirdly, this was the only real solution and it was, you know, there's there's pros and cons. There was some technical issues about so you gained.
In some ways, from people going to their local trust rather than moving them to a big hyper acute centre, which is where things have moved to and I'm not really sure where Lancashire's got to with that but.
The Telestroke for that, for that period of time, is a very much a collaborative process with between consultancy all. It's all a very much a can do thing and it was one of the things I'm proud of being involved in and I was involved in from the start. There was certainly some people who were the main drivers who was a guy called [*name*] at Carlisle and [*name*] was very much involved at Blackburn. And I think you know it delivered as you know in you know, OK, not as perfect as maybe some services but it and particularly as Lancashire had a very rural or big area to cover. You know how you got someone from Barrow to somewhere as a hyperacute centre. It's like a major problem and anyone in the Lake District. So actually it was really good. So I'm very proud of that. And that was that was done very in, in, in high compared to what happened with the North Mersey transformation that was.
Done very quickly and sort of at pace and certainly relied a lot on [ROLE]s, but also on stroke nurses and A&E's in the various places and I thought it was a really good collaboration with it and they did audit and have meetings etcetera, etcetera, etcetera. So I thought there's got a lot of buy in for that and that was that was really good and we carried on that till 2022. So for us we carry on that 20, they're still going I think but we kept we were involved in actual 2022 so.
And it also had a good administrator.
And yeah, so that was a really I think that was a really positive thing, OK, not absolutely perfect. You know, you could compare it to London and London, we'd say, oh, we're much better, but they probably had a lot more money thrown at it. But overall.
In trying to solve something, it was a really good solution.
And I said it was collaborative. It wasn't. We're better than you. We were all probably in the same boat, really. You know, Blackburn probably had a few more [ROLE]s as a bigger area and stuff like that. And also it was done very equitably. So the amount of slots on it for each tipped for each trust depended on what their population of stroke patients were. So like, for example, blackburn would have more slots than maybe we

would because we'd have a lot less patients. So overall, I thought that that was the other it was equitable and fair and.
I think it was a really.
Really good thing to be being involved in and it and it was because it was a can do person that I remember the guy called he was gussy was and he was you know he wasn't a young guy he was he was quite he was probably as old as I am now to be fair but he was very very much a candidate when he can do this if you want to do it they'll do it and there was a lot of that kind of attitude.
So that was good. That was, yeah. So that that was a transmission. But yeah. And and a really good transformation.

Interviewer 7:51
No, it's brilliant. I mentioned. Well, I heard you mention about how quick of a turn around it was. I think you mentioned before 2009, 2010, is that you also mentioned about coming on to the project. Was it something that was sort of already ongoing when you joined or?

Participant 8:04
No, no, no. I think I was. I was involved in it from the start. Really. I think because I think what I can remember, the national stroke strategy came out in 2007 and you know all the adverts for whenever you might not remember, you might be too young to remember, but there used to be an advert usually and in Coronation Street. So just get the whole population about.
Where someone's head goes on fire for us to indicate a stroke and.
A fast test and.
And to douse the fire and do it very rapidly, the thing that was hard about that was it was the adverts were going out before all the services were actually set up in the UK. So, you know, they expect to take the assault and they didn't. They didn't give the population, they didn't manage the population's expectations really, particularly for 24/7 care. So that one of the big problems until we got tally straight really was that there was like a well post code lottery plus.

Interviewer 8:45
Right.

Participant 9:04
A time lottery as well, depending on when you had your stroke.
So I think that's all you know, being able to get 24/7.
Cover was probably the main thing, you know, avoiding burning out for consults. I mean, you know, it was just impossible in most people to run a one in two or one in one service. It was just like.

Interviewer 9:16
Right.

Participant 9:25
Main mainly in Lancashire, probably the Max anyone had was four people and the geography was you couldn't send [ROLE]s from one place to another because the job was too too large. So. So from that point of view it sort of came up around 2007 with the national stroke strategy and delivering thrombolysis. And then how were you going to do that? So it did take a few years to get done, but when it was actually. When he was actually thought of and and everyone joined in it, it happened very pretty rapidly, including the technology, including the Curtin inclusion. Everything else because you know, obviously kids were going into [ROLE]s houses or the sort of technical stuff and everything along those lines. So you know, that was pretty pretty good. And also the tally stroke kit for the hospitals and the A and then the education and training etcetera. And also it's obviously a different way of working working with. And sort of telemedicine. So that was something. But, you know, I think everyone picked up that quite quickly and that relied a lot on, you know, trust.
Both, you know, trust within the trusts themselves and trust within the people who are referring to you, et cetera. So you know from that point of view it was, it was good and it wasn't too own recently and the and the rotors were fair. So I think it was, you know it was a good thing really.

Interviewer 10:47
No, that's that's brilliant. I'm just making notes, by the way, as as we go here, Patty, obviously, I know you're covering lots here, so I'm just.

Participant 10:49

Welcome.
Somebody. Somebody. So there was some, there was some sort of downsides, like sometimes the technology wasn't quite as good and it can be delays and getting the scans et cetera. So there was some delays in.
In, you know, making those decisions about thrombolysis and the type door to needle time, but that was probably offset when we looked at it a long time ago. It was offset by if you'd had to go to another trust. So the travel time. So actually what you really wanted to do was not the door to needle time. You wanted to look at the onset, to needle time because that was performed more important than the door to needle time. And they and the onset to needle was probably did I think.

Interviewer11:23
Mm hmm.

Interviewer 11:26
Yeah.

Participant 11:35
Even with technical factors, it did sort of. It equalised. What would have happened if you got to another another site?

Interviewer 11:42
Yeah. In terms of this work, was there an evidence base that it came from or was there past research? It leaned on sort of to?

Participant 11:48
So does she speak? Yes, I don't telestrope networks, I think, particularly if I remember rightly in Germany and the US, where they'd have a hub and it was probably more there related on a hub and spoke model where they'd have a central hub and smaller district generals around around the site.

Interviewer 12:06
OK. And then that led into this, this sort of Tele stroke sort of project, right?

Participant 12:11
Yes, I'll take that lesson to town. The straight yeah.

Interviewer 12:14
Brilliant. I also noted, and I might be jumping around a bit for your sake here. Joe, by the way.
You mentioned about funding and and London obviously having their different routes potentially with more money available to them. What was the funding like with with this work, where was it, how was it funded?

Participant 12:27
Yeah.
I'm that's where I'm not an expert finance.

Interviewer 12:34
OK.

Participant 12:36
I don't think you know because the funding was probably that each trust did the funding themselves to be honest. And then there was probably overarching. So the trust then probably puts some money into a central pot in order to have the admin team and the the governance and management. And it was the other thing about it was it was a managed system through Virgin.
And that was different to lots of others. So you know, for technical problems, there was virgin with their 24/7 a day as on a helpline, etcetera. And that was pretty useful as well.

Interviewer13:09
Hmm.

Participant 13:10
So it was a managed system and that probably helps. I didn't really understand all the insurance and outs of it, but financially wise.
I don't think we ever had any major issues about the finance from a trust perspective,

partly because it was delivering. We were mandated to deliver it. Therefore, I don't quite know how the funding came, but it must have come from through the CCGs or whoever it came through, I don't know.

Interviewer 13:35
When you said mandated to deliver it, where did that come from?

Participant 13:37
So, so, so, so, so strokes was mandated, wasn't it? Through the national stroke strategy. So. So so yeah.

Interviewer 13:41
Through the stroke strategy, right? Yeah.

Participant 13:44
So we had to deliver it. It was. How are you gonna deliver it?

Interviewer 13:48
Great. OK.
In terms of this change and obviously looking at implementing it through the different sites and the and through staff was there, what sort of training was, was sorted, what sort of I guess planning process about the actual going from the implementation of it?

Participant 14:07
It's so it's so, yeah, so there's obviously governance and that was all set up.
So there was governance, there was and within the governance was the education, training and the documentation et cetera.
The training probably was how to use the kit, mainly because the [ROLE]s because it was we were already. We already were probably delivering thrombolysis 9 to 5 direct face to face, so it wasn't such a big issue. So the training was really about.
Maybe, but having a more structured structured process like ensuring that we did the nhss that we did all the inclusion exclusion criteria that the stroke nurses who were main, most of the trust had stroke nurses 24/7 and who were the mainstay of are being trained with regards to the tally carts within the trust, but also some of the

A&E staff as well would be involved. So the [ROLE], so that would so.
There was training that went on before you were allowed to start, and that happened through the networks and the network delivered the training, so it was through.
The whatever the stroke network was called, Cumbria, Lancashire, Stroke Network. So that's how it was delivered. They were the main. They were the overarching organisation.

Interviewer 15:30
Yeah. And that was prior to the obviously the ISNDN's and stuff that we have now, yeah.

Participant 15:34
Yeah, yeah, yeah. So I think they'd be, yeah. They'd morphed into that. As far as I can that I can bring. I get very lost on what it's like to being deck chairs on the Titanic. People move around things.

Interviewer 15:38
Yeah, yeah.

Interviewer15:43
Mm hmm.

Interviewer 15:46
Now that's that's that's great.

Participant 15:46
Yeah, but yeah, we had and we had some and I think there was a lot more. There was a lot of stability there and I think we had some really good people in the in the network who were the drivers for it, so.
Whoever the chief or whatever, whether they call the chief exec or not, and then there was so-called Elaine Day, who you may know or may not know, and there are lots of people who are real drivers for it and facilitated all that. So there was I think there were quite a number of [ROLE]s who were very positive about it. So I think it was a lot of positivity about it, but there was also a good organisation but also stability, which I think is really important.

An organisational intelligence as well, which I think is again is quite important, as you'll see when I talk about what happened next.

Interviewer 16:34
Well, I mean, yeah.

Interviewer16:34
Just the four. Sorry. I was gonna say just before you get on to that, what happened next, you you've talked about how the leaders were involved. Really. Well, thank you. And particularly the [ROLE]s and them being quite encouraged to buy into this by the sounds of things.

Participant 16:48
I'm sure this drug this is as well.

Interviewer16:50
Yeah, I I was going to say the rest of the stuff with the strict nurses as infused about it. And what did the patients think about this change?

Participant 16:59
Yeah, I think I think, I think everyone's a tease about it because.
In lots of ways, we had a lot of concerns that we were delivering a less than perfect service.
And also we were we were delivering a time related service as well which was you know what was going to happen at the weekends, what was going to happen out of ours. And as you know a lot of strokes happen out of hours. So it's about it's at least 6040 in stroke outside hours at least at least.

Interviewer17:22
Yeah.

Participant 17:29
So you know, so it I think there's a lot of enthusiasm for it because you know previously there been a sort of nihilistic approach to stroke in some ways apart from the stroke units, et cetera. So this was, you know this was the start of you know and

it'd been, you know been delivered in a lot of other countries a lot earlier than we did in the UK.
Although when you looked into it, they weren't quite as good as people said they were. You know, they were, you know, the percentage of the small in other countries as well, but I think.
And obviously there's a lot of concern. There were concerns from the [ROLE]s about how big an impact this was going to be on, you know, work life balance on you know, so the other things like as a [ROLE], you didn't get the day off after you've been on call. So you could be wrong up all the way through the night and you'd be going back into work the next day. So it was very much like the old system, but you probably had quite a lot of [ROLE]s who were used to having been junior doctors where they did 110 hours a week. And I'm not saying that's the right thing. I'm just saying that culture was still probably there.
So you know that that probably still had an impact really, but I think it was enthusiasm, it definitely was enthusiastic and I think it that's why it got buy in and you know on the whole people and I think other things is that people have had good clinical outcomes and good clinical experiences with thrombolysis as well. So therefore that was again you know we haven't been able to do anything and we saw people who got better sometimes at the very end of the needle. So it's like you know that was you know not everyone did and we did have complications and all those kind of things.
But I think you always think about the positive outcomes rather than negative outcomes. So I think that again.
Again supported that change.

Interviewer 19:14
And the patients as well themselves or were they not necessarily aware that there would be a change?

Participant 19:21
I don't think the patients, the actual patients were aware who were having it, who got into the service. I think people it might have been before, it might have been aware and that's an interesting thing that happened when we when we talk about the North Mersey transformation that was one of the interesting things about what we

did in North Mersey because the patients I can maybe we could move. Do you want to move on to that or do you want to ask any more questions.

Interviewer19:30
Mm hmm.
Hmm.

Interviewer 19:47
You talked about saying what happens next is that reference to North mode? Yeah.

Participant 19:50
Yeah. Yeah. So. So what happened next was that.
You know the big game changer I think is being thrombectomy. So that is a big game changer and that was, you know, I think this one of the big trials have been around 2015.

Interviewer19:59
Mm hmm.

Interviewer 20:00
Yep.

Participant 20:09
And certainly centres in London and Stafford were starting to do thrombectomies and it was starting to move across the country again a very time limited.

Interviewer20:22
Mm.

Participant 20:23
And.
And then obviously we've got the Walton Centre in Liverpool and we also had, you know, we had challenges here. I was at some stage as to single [ROLE]s here. So there were challenges here.
And how we were going to be, you know, how we can make future proof the service

etcetera and how we could look at out of hours and making sure there was seven day services for people etcetera, you know, not just from a licence not just thrombectomy.
But also ensuring people got reviewed appropriately, decisions made that, you know, senior decision making etcetera. So in 2016, there was a lot of pressure from initially the CCGs and then through the trusts to.
Look at a N nursing model between Aintree, the royal because they weren't merged at the time and us.
And and we had meetings in 2016 and yeah, there was a little bit of reluctance initially on and and not I don't think on both I think on both sides really I mean we were a little bit concerned about.
Particularly we there's a lot of concerns about mimics. Stroke mimics initially cause we've got a very frail older population in Southport which have a higher.
Prevalence of mimics and instance of mimics and we were concerned that we're gonna be sending people down to Aintree, which had a very busy A&E department which was, you know, full and overloading them. And then it's not really good for that population group who may have a lot of other multi mobilities to move around everywhere and you know it's not good for things like delirium and such. So we had a lot of concerns about how many people were going to be transferred into concern because they didn't have the capacity, didn't have a new unit, didn't have the staffing etcetera.

Interviewer 21:48
M.

Participant 22:18
And what was this going at all look like, but I think you know as everyone so clinically everyone you know it was very easy to write a pathway of what you would like to happen, right? So when myself Claire Cullen aintree and Nick Sharma print the royal map right and and and the stroke nurses and and some of our therapy managers.
You could write a very hyper acute pathway in about 5-10 minutes. It was like you know this is what should happen. You know. Admit that recognised stroke.
On set time.
Ctct and Joe and then decide treatment options and you know, so that was so that all started 2016, but then it sort of got bogged down.

Meetings got cancelled because the CCG were leading on and people weren't able to go all the time, time pressures etcetera, etcetera, etcetera. So it it, it's sort of bumbled along.
And as I said, I'll send you. I can send you because I actually, I've written it down in more detail.
Exactly dates, times and how everything happens.

Interviewer 23:25
Mm hmm.

Participant 23:26
And then it bumbled along, and then we sort of think thoughts about the sort of dripping ship model we went to look at Scarborough and York and how they worked and stuff like that. And then.
And then, you know, we weren't really. We were getting there, but it was slow. It was very slow. And then the most important thing that helped drive that was we got a project manager specifically for this, for the, for the Someone who was actually.
Very good facilitator. He's been a chief Operation Officer operating officer somewhere. So although this was his project.
He had some degree of seniority. He wasn't sort of just from the PMO office where you can get. I'm not being critical. You can get relatively young people who don't have that knowledge, et cetera. And the big difference there was he could write, you know, obviously with a big transformation. There's a lot of part. There's a lot of. Stakeholders, there's a lot of financial stuff to consider. There's, you know, there's N was primary care, communication, all those things that are really important, how to drive it, and you need someone to be able to write the business case. And then also there was a public consultation, et cetera, et cetera. And all those things take quite a lot of time. So that you came on board, I can't remember it's 2018 or 19, I think it was around 2018.
Teen a guy called Jeff Johnson and he made a massive, massive difference because, you know, all of all the clinicians. So there's me, Claire and Nick and.
Martin Wilson from Walton Centre. We've all busy clinicians. We were also we, you know, we did a bit of management. We did a bit of clinical leadership, but we also did a day job of you know clinics.
In patients etcetera, etcetera and.

And there's a lot of boxes you gotta take, and there's a lot of things that you gotta do, and you gotta be able to write it.
And I don't think that's always a doctor's skill set to be absolutely honest.
And one per time. I'm not saying you can't do it, so I'm just saying the time needed to do it and he was able to go and have those conversations to facilitate that. And then we had a lot of workshops. So there was a lot of, you know, there's a lot of bureaucracy involved. You know, you had to, we had about 42 shortlisting options, one stage and then we whittled them down.
What I was talking about the patients were.
We had workshops, the Stroke Association organised for patients to come to the workshop.

Interviewer 26:11
Mm hmm.

Participant 26:12
And we went, we weren't really supposed to say what our preferred option was. Our preferred option was it should be at Aintree. It should be Co located with the Walton Centre, where that's where the thrombectomy was. And we should have our own stroke admission unit.
That was what the preferred option was from the clinicians.
But they said, I don't know why you're messing around with all this. This is what you should do. So they they didn't see why we're having all this bureaucracy. And then we had to go to, you know, the scrutiny committees for NHS England. And, you know, I I had a meeting with them where, you know.
They were all at home and I was at work and I found it really quite interesting that they were worried about Whiston, which had a really good stroke service and we had a really poor stroke service in in, in comparison and you know, and they were worried about the knock on effect of Whiston. I'm sitting there saying, well, I'm not really worried about Whiston, to be honest. If I was, you know, I'm worried about my population of people, I said. But so there was a lot of bureaucracy we had to go to Council meetings. And you know the second one is relatively easy. I didn't go to the Liverpool One, but the Nikki went to Liverpool. One got quite a hard time because there was a lot of politics involved.
And stuff, and then the royal and Aintry merge into Luft and there was a lot of, you

know, I wouldn't say it was a marriage made in heaven, so, you know, so and a lot of change from Danielle going to entry. So again, it was all a lot of things that were going on, which I've written all down but.

Interviewer 27:38
Hmm.

Participant 27:41
So.
It wasn't really to to that, so COVID then hit in 2020 and April and that really and and we got to where we got the pre business.
Case all written and then COVID happened and that put a big hiatus on us. And then. Probably later that year, maybe 6 to 9 months later. I think it could have been in 2021.
It got revisited and then you know, there was a lot, you know, new people because they'd, they they didn't keep on the project manager, which I think in hindsight was either, I don't know if he wanted to stay on or not, but we lost that that intelligence. And then everyone's criticising his numbers and his figures and how did you get that and then, you know, everyone revisits and thinks they know something different, et cetera. And there was a lot of the other. The other issue I think was.
It's obviously been formed and whereby you had, you know, we'd have ancient the royal. Previously there was one managerial team who again.
Didn't probably have that intelligence and Ella was a little bit. There's a lot of mistrust, I think at the time as well, because new people came in, you didn't know what their agenda was. There was talk about having a new, the stroke unit at Walton Centre, which would not have worked because.
What we were concerned about the stroke [ROLE]s is that.
The stroke, but they these patients are often have a lot more other multi morbidities and also have a lot of other medical General Medical.
Conditions which need to be managed, et cetera and whereby someone like with all three of us are geriatricians. So we're all general physicians and geriatricians, but we also do stroke.
That skill set the Walden neurologist don't really have that. I don't think there's a criticism there, miles, but locating lesions and really, really good at, you know, neurology. And they were really good for the mimics. And and that actually.

Interviewer 29:39
Mm hmm.

Participant 29:43
Two or three of them have come into the rotor and they're fantastic assets, but I don't you know they would find it difficult to run a ward because they're not used to that to running that kind of patient ward, whereas we are.

Interviewer29:52
Mm.
Mm hmm.

Participant 29:57
So so ultimately it took a long time because it took 2016, we started.
Then you know there was a lot of hiatus at the beginning. Then it sort of took off end of 2018 to 2020. Then there was a hiatus due to COVID.
And then and then 2021 to 22, it's sort of it must have been 21 when it sort of be relaunched I think.
And then the the business case had to go up discussion and it'd be agreed. And then we had to sometimes repeat the scrutiny that has happened to it because it had been so long previously. So there's a lot of duplication and new people came on and then we also had a merger of a trust and our chief exec had done a merge between Whiston and Warrington and didn't understand why or should be any more complex when it actually probably was more complex than Western and Warrington.
It was probably bigger. You know, you're talking about 15-16 hundred stroke patients a year, which is like.
One of the biggest numbers in the country.

Interviewer 31:07
Hmm.

Participant 31:08
And that's not taking them in. That's just that's just a stroke. So that's not counting the TIA's and also any minutes that they turn up and also we have you know the

other thing was we had to turn back to the centre right next to us. So ultimately you know.
It it happened in September 22.
And I one of the things I did, I was going to return September 22, but I decided to start felt like I should stay for another year, keep see how it went well, it wasn't. Mm hmm. When the new stroke unit initially it was like, you know, the stroke patients went to A&E and they had a pretty bad experience in Aintrys A&E because it was like, you know, firefighting and there was no space, there was corridor care, et cetera, et cetera. And once it got to hassle, that was great. There was no problems with the housing.
And and getting the imaging and all this sort of initial test was very easy, but sometimes patients could spend 24 hours on a corridor and you could be doing the assessments in a corridor. So, you know, that wasn't great care but. And for some of my patients, I did think they might have got better care in Southport, particularly if they didn't need hyper acute care. But overall, once the CAC wants to stroke at emergency centre opens, which was to be in around middle of last year.
That that's like a Rolls Royce service that like, you know, they got a front door, they've got loads of stroke nurses, they've got the well staffed like well, really well staffed. They've got act. You can do CT angio and I think they're going to be able to do CT perfusion, you have to do CT perfusion elsewhere.

Interviewer 32:43
Where's that again, Paddy? Sorry.

Participant 32:45
So ancient. This is all that aintries you got door entries they got what's called the strip. It's called C at stroke Emergency Assessment centre.

Interviewer 32:47
That's that's at Aintree?

Participant 32:53
So you know, overall, they're trying to get anyone who's fast positive with the paramedics recognising a stroke, especially within the 1st 20, you know, 2448 hours to go direct there and that and that's a much better you know for that hyper acute

care is so much better.
I think there's still things that need to.
Improve in stroke care but.
Transformation to that hyper acute centre was really good and ultimately, although it took a long time, I think it's pretty state-of-the-art and pretty, pretty, pretty Rolls Royce service actually I would say they've they're it's really nice it's like.

Interviewer 33:25
Hmm.

Participant 33:32
You know, they've got four, sort of.
Phase. So you know, as a [ROLE], they've got no staff I could actually. And the way I work, I could see three or four people in the same go really and make decisions. One people did what I wanted them to do, they go scans, etcetera, review the scans and we can make decisions. We can make decisions pretty fast. Plus it also takes all the boxes in the snap national snap data. So it's it's it's because they're right in the stroke Centre service straight away. So that's really, really good.

Interviewer 33:52
Yeah.

Participant 34:05
Things that need to be, I think.
Improved is how maybe.
That sense of source of supports thrombectomy across the region, so that's the next step. So they've got, they've got ideas how to do things like that. So and then, you know, the other big thing in stroke is community services, rehabilitation, et cetera, et cetera, which are really important. I think the Cinderella service. So when we did the transformation. One of the things that kept getting mentioned was how we were going to improve rehabilitation services, particularly community rehabilitation services, early supported discharge discharge. I think that's still got a lot of.
I still at. That's still I think post covid a little bit and so I think that's where people have got to sort of start to think about how we can improve that. So that you know all this good treatment at the start. People still, you know, even if you did 10%

thrombectomy and 20% thrombolysis, you're still going to have a significant proportion of people who have who are stroke survivors who need ongoing rehabilitation and that can be quite prolonged and that sometimes pushes people into the private sector.
And that's, you know, you know, some obviously some people can afford and some people can't afford and you know, so I think that's something that.
I think needs to be an ongoing.
Yeah. So I think the energy that was there to deliver that if that could energy could then be used, especially the energy towards the end could be then used to how we could improve.
The rest of the stroke service would be really good because some things are really good, so I think Tia has definitely improved over the years. Access to carotid endarterectomy is definitely improved. Hyper acute care is definitely improved. I think it's and you know how soon is definitely improved. I think it's steps. I mean I think inpatient rehabilitation is not too bad. But you know in our trust we've got a inpatient rehab world, but there's a lot of pressures on it.

Interviewer 36:10
Mm hmm.
Mm.

Participant 36:23
So our stroke rehab, we have the sort of hub and spoke model so people would come back wrong going rehab to Southport from Aintree after.
It could be 24 hours, it could be up to 72 hours. It could be a bit longer depending on their medical condition.
But I know for a fact since I've left.
This, you know, the pressure's not bad, so there's people in the middle of bays on there, which is not. It's not helping with rehabilitation etcetera, etcetera. Put more pressure on nursing staff and therapy staff, which is not good. But what do you do with an overcrowded A&E It's like you know. Where's the balance so?

Interviewer 37:00
Mm hmm.

Participant 37:02
Overall, again, I'm pretty proud that I've been involved with it. As you can, you'll see what I've written a few things. So there was some tensions we had. We were really good at the beginning.
And then there's a bit of change in management and and that didn't really help, I don't think. And again I think.
One of the things that I would say, one of the learning points is to have.
Someone senior as the project leader, and that's all they do.

Interviewer37:30
Clinically, senior or.

Participant 37:31
No, no. I think we have the clinicians, it wasn't the clinicians, it's more management and precipitation and you know you can have the cheap exact same, but you've got to have someone who's going to be and how accountable that is you know and and there's an awful lot of bureaucracy. There's an awful lot of bureaucracy to get anywhere like you know.

Interviewer37:34
OK.
Alright.
Mm hmm.
Mm hmm.
Mm hmm mm hmm mm.

Interviewer 37:49
Yeah.

Participant 37:53
Which, if that could be removed?

Interviewer37:57
M.

Participant 37:58
That would be fine. I mean, most of the concerns was that was to be an independent judicial review, which there wasn't. Because I think somewhere else, I think Kennedy had a lot of problems with, you know, you know, save our NHS, etcetera, which I think is, you know, I understand that. I mean one of the big things that we had when we were doing the public consultation at the end was about the ambulance services and you know, people waiting for ambulances.
And we're telling this is a time specific decision about from and you've got to get there as quickly as possible and and the reality was, would the ambulance get to?

Interviewer38:32
Mm hmm.

Interviewer 38:36
Yeah.

Participant 38:37
Yeah. So, you know, I think there's a lot of concern about that. And then obviously, there's also the concern about saving your local services, but actually what we were trying to say is and and actually the people who'd had strokes were saying the same thing. That was a good thing, was actually what they really wanted was to go to the right place at the right time.

Interviewer38:56
Mm hmm.

Participant 38:57
And then if they needed local services after that to go back to those local services and ensure those local services.
Had the resources that were necessary. So actually the days coming back to the rehab here to it, you know us, we've gone from. So the other proof that well, maybe proof of putting is that snap.
Aintry went from a C/D to an A.

To one of the top performing.
And we went from there, we usually.

Interviewer 39:26
Mm.

Participant 39:29
Went what went longer? DNA. We got to AB.
So so.

Interviewer 39:33
So the evidence is there that it that it's had that impact and had that success.

Participant 39:36
That was one of the.
That was one of the outcome measures that we wanted to to do. That was one of the reasons behind what we did. OK, that's a process measure. Their process measure is an app. But you know, it's hope that they would have the clinical outcomes as well. I don't know how people are going to look at them in future but that's so process measures definitely improvements and you know.

Interviewer 39:43
M.
Mm hmm.

Interviewer 39:49
Yeah.

Interviewer 39:54
Mm hmm.
Come.
Mm hmm.

Participant 40:04
Overall, I think people you know, I I enjoyed working at ancient. You know, as soon

I'm you know old I'm you know I managed to you know quite enjoy it and get on with it I you know I had to go and learn a whole new computer system to actually get onto it. So I expect about 6 hours doing the computer learning which I felt like telling I'm not a house officer anymore thank you very much but I was a stupid avatar saying oh do you want do you want to know your scores no I just want to pass the damn thing.

Interviewer40:22
M.

Participant 40:33
So you know it, and I did that and I went to work in a different trust with different people and in a team. And you know, I I, you know, I enjoyed it and they were really good overall. You know, I hated Aintry A&E because it was just like I never knew where I was. It was like at Warren and I didn't really, you know, the corridor care was hard. But, you know, you have to do it. So that was you just ended up doing it. But ultimately they've got something that's good. Definitely. That's something they should be proud of. And I think we should be proud of people who are involved. It should be proud of. That was the only sad thing at the end.

Interviewer 40:49
Mm hmm.

Interviewer40:59
Mm hmm.

Participant 41:08
There was sort of a new there were like new brooms and the people who'd done all the real work at the beginning didn't get the recognition.
When it opened and I think that left a bit of a sour taste for some, some of us, I think, and I think you know, that's something that could also I think be a learning thing. So I've written all that. As I said, I've written a reflection. It's like my personal reflection, but it's it. It gives you the timeline as well because I actually went when I did the reflection, I went and looked at all my all emails and stuff like that to see when things actually happened because. As you can see, over that time period everything blur to

when was, you know, like COVID happened in the middle of it all and OK, that helps you 'cause you've got a timeline to know where things are, but it's very blurry.

Interviewer 41:45
Yeah.

Interviewer41:48
Mm hmm.

Interviewer 41:53
Sure. Yeah.

Interviewer41:54
Mm hmm.

Participant 41:54
About how everything happens.

Interviewer 41:57
Yeah, I'm conscious of time.

Participant 41:57
I didn't understand the other thing I think is it shows that it took a long time, probably took a longer time than it should have done.

Interviewer 42:04
Yeah. Yeah. Do you think I mean on on that point?

Participant 42:05
What the government?
There were reasons for that.

Interviewer 42:09
Yeah, I was gonna say on that point. Do you think COVID was quite, I assume COVID

was quite a big impact on that given the delays that that caused as well in the middle or?

Participant 42:17
So I think COVID had some some delay to it, but actually.
Probably, if we're being honest, the delays were before that. I mean I think.
I think the delays were before that.

Interviewer 42:33
Was this before? Is it Jeff you said before Jeff got involved essentially?

Participant 42:33
Bad.
Yeah. Before Jack came, I think there was like we sort of, you know, went to meetings. Nothing really got decided. We didn't really have any sort of focus or we didn't have any drive. I don't think and we didn't have sort of like God do this by this. We didn't have milestones. I don't think it was just like I think it's like you know it was just like we went to meetings you have to find the time to go to the meetings. It was very much led by, I think once once Jeff came and the clinicians were in the room and we had a sort of more clinical driven Pathway group.
Or what we called it. We'd call it something else. I can't remember what we called it. Uh, a clinical reference group. I think once we have that, things got a little bit better when you know Jack was writing stuff and then we were sort of moving, I think more and you know, we got the workshops up and running. We got the short. We did all the sorts of bureaucracy around the shortlist, the long listing, the short listing, etcetera.

Interviewer43:13
Mm hmm.

Interviewer 43:30
Yes.

Participant 43:31

Yeah. So I think COVID had a bit of a delay in it, but I don't think COVID was the complete reason for the delay.

Interviewer43:40
M.

Interviewer 43:40
Yeah, it just added added to it.

Participant 43:40
Twist your head. Just add it to it. Yeah, yeah.

Interviewer 43:44
A couple of things I want to pick on 'cause. I'm conscious of time and I don't want to keep keep you longer than longer than needed, but.

Participant 43:48
Oh, that's a that's OK. I'm doing alright. Quite interesting.

Interviewer 43:52
I'm I'm going to go back to something you mentioned about when you have the community outreach and you put the proposal to the community.
In terms of that, when you say Community, what what, what did that involve, what what was that process like?

Participant 44:04
Oh, you see my workshop? Sorry I'm, I'm.

Interviewer 44:06
Yeah. So it was when you were referring to like you had council meetings as well, whether it was politics involved and stuff like that.

Participant 44:11
Oh yes, so so all the stakeholders. So yeah, so, so. So they organised well we had, right.

Interviewer 44:13
Yeah.

Participant 44:19
I'm trying to remember what actually happened. We had some workshops where it was mainly the clinical staff think.
And then we had workshops where there was clinical staff and.
Stakeholders.
Yeah. So we had, we had to go from a short listing to a lot to to. So we had to, we had a long list, we had 42 options at the start I think. And then we went down, we whittled that down. So we had a workshop in order to whittle them down.

Interviewer44:34
Does that include patients as stakeholders?

Participant 44:49
We had a number of workshops with people from all the trusts.
Some people were not on board. Some people were on board, so there wasn't. There wasn't buying from everyone. In fact, there wasn't buying from all the [ROLE]s at the royal, for example, who have no come on board, they had some buy in but not all buy in.

Interviewer 45:01
Sure.

Interviewer45:09
M.

Participant 45:10
And then.
We had Stroke Association we had.
Community teams we had.
Probably some management people as well, some from the trust management. They were always consistent. The trust managers weren't always consistent.

And we had, do you, I think the big thing that we didn't really.
Two groups that we probably didn't buy in early enough where nwas.
Who payment at the end and.

Interviewer45:43
Mm hmm.

Participant 45:45
Well, they threw some financial issues into it at the end, which were a little bit challenging. How much they should get paid and how much it was going to cost, etcetera. Then they took an opportunity. If I was being honest.

Interviewer45:55
Mm hmm.

Participant 46:00
And then and then the other group, we didn't really buy in with the radiologists. Which were a really big, important group of people that we should have probably noticed in earlier. And because we were asking for a lot of work to be done on the entry site, and particularly around radiology and radiography. So I think that was a group that we should have probably got in earlier.

Interviewer46:15
Mm hmm mm.

Interviewer 46:24
Was there was there a public patient involvement in this as well?

Participant 46:27
Yeah. Yes, I'm probably busy. So then we did then so that the workshops at the beginning were mainly patient involvement. You could call the public, but they were patients. So they were mainly through the Stroke Association. Then when we did the public consultation, they did do meetings, but because it was COVID, I certainly did the meeting. But I certainly did a meeting on teams or what, at zoom or whatever it

was at the time. I think Zoom was the big popular one. When it was done. And so we did a meeting on there.

Interviewer 46:34
OK.

Interviewer46:36
Mm hmm.

Interviewer 46:36
Shop.

Interviewer46:53
Mm hmm mm.

Participant 46:59
And I don't think I had a lot of, I don't think I had a big uptake of people really. And I think we all did it on top team teams then. But we also have some Council meetings that we went to. So I suppose that councillors were also acting as surrogates.
Public, et cetera. So the gaping out meetings with September 'cause, I went to the Sep Tim Council meeting.

Interviewer47:21
Mm hmm.

Interviewer 47:21
OK.

Participant 47:27
And actually they were. You know, I thought I'd get a quite a hard time from the Southport councillors, but I actually got a real good buy in from them. Not been a hard time for someone from Crosby, but that was to do with tight ties, et cetera. And then somebody just waxed lyrical about aintry because they'd had personal

experience. So anyway, that was quite that was OK and then I know Nick went to Liverpool.

Interviewer47:39
Mm hmm.

Participant 47:50
And we sort of had to go to Knowsley as well, because there's a little bit of carryover as well.

Interviewer47:55
M.

Participant 47:57
So I think Nick got a much harder time at those at Liverpool cause Liverpool was much more political about. It was eeo.

Interviewer48:04
M.

Participant 48:06
They were all councillors in Sefton, especially N Sefton saw the advantages for their patients, so they they got the bit of being in the right place at the right time.

Interviewer48:13
Mm hmm.

Participant 48:15
In the Liverpool councillors.
I can say that services would go from the royal to Aintree.

Interviewer 48:22
Mm.

Participant 48:23
Don was, you know, political.

Interviewer48:25
So it was more about infrastructure for them rather than like local health inequalities being balanced.

Participant 48:29
I think I think so. I think it was. I think it was politics, to be honest. It was a bit of politicking going on. From what I understand, I I wasn't there. So I'm just saying.

Interviewer48:32
Hmm, OK.
Mm hmm.

Interviewer 48:37
Yeah.

Participant 48:39
Then you know.
That was Nick Sherman, who went to that I'm pretty sure. Or Claire Nico or Claire went to those.

Interviewer48:44
Can I ask you one question very quickly because I I'm aware at a time you mentioned about Jeff before and being able to put in place a project manager and but was all and the fact that it became established in 2022 the transformation project so?

Participant 49:02
So, so the stroke services moved to Aintree in September 26.

Interviewer49:05
Oh, OK. I'm just wondering, was all the funding designed to end at 2022 or was it anticipated to be ongoing costs or there were just like one off to get them started?

Participant 49:12
But it's I think it's all coming.
Yes, I'm going go down to business. It wasn't an end. So I think that's when the funding was gonna start.

Interviewer49:20
Yeah. OK.

Interviewer 49:21
Right.

Participant 49:21
So. So he stopped doing being project manager in April 2020, just as COVID happened.

Interviewer49:30
Mm hmm.

Participant 49:31
So that's when we stopped the first. So it was like and then it got.
It got restarted. Now I just can't remember whether that was.
20 or 21.

Interviewer49:47
Mm hmm. OK.

Participant 49:49
It might mean to mention.

Interviewer49:49
I'm just wondering if it was funded to be sustained or funded just to be established in the first instance.

Participant 49:54

No, no. It's been funded to be sustained. OK, but I I'm not. I'm not close to the figures and stuff like that, so.

Interviewer50:00
Yeah. Thank you.

Interviewer 50:01
Yeah.
Again, you know.

Participant 50:04
I'm not. I think that's another important point because.

Interviewer50:07
Hmm.

Participant 50:08
We could. Explanations Can tell you what's the best pathway and they can tell you what's the best care and what we think would be the best options. We don't really think about money when we do that. We just think about this is the clinical evidence. This is the best.

Interviewer50:13
M.
Mm hmm mm.

Interviewer 50:21
No.

Interviewer50:28
Mm hmm.
Mm hmm mm.

Participant 50:40
We can drive it on and I think that's another thing that people that Daphne was

done.
By so when we went to see the the politicians, it was very much sold as this was a clinical lead.

Interviewer 50:55
Hmm.

Participant 50:55
Service and transformation. This was a clinically led transformation because then I think.

Interviewer 50:56
OK.

Participant 51:02
The politicians would have it wouldn't have a strong would be very difficult to argue against something that's been.

Interviewer 51:09
Mm hmm.

Participant 51:09
And it was clinically, it was a clinical decision. So. So it wasn't they weren't being.

Interviewer 51:12
Yeah.

Participant 51:17
They will be in a hoodwinked, basically, but.

Interviewer 51:19
Mm hmm.

Participant 51:25
But they and and but they. But that was what was trying to, you know, to ensure that

they would buy into it. So everything would say, yeah, that was definitely a conscious decision, definitely a conscious decision. But but wasn't wasn't it wasn't hoodwinking them. It wasn't lying to. And it wasn't budding the waters it was absolutely true.

Interviewer 51:29
Yeah.
I was gonna ask was that a conscious decision, do you think? Yeah.

Interviewer51:32
Mm hmm.
Mm hmm.

Interviewer 51:47
Yeah.

Participant 51:49
I think then.
I know I don't know what happened about it, but afterwards there was the ICB came into being, right towards the end of this, and there was some concerns about how much I think it went way over budget for the IC based to be honest. But then they were sort of left with, they're going to have to do this because, you know, they didn't have any other option really. And and and. I'm not saying there was a blame game, but one one of the things that seem to be that there seems to be.
Yeah. Who? Why did it go way over budget? Well, one of the reasons why it went couldn't potentially go on a budget was there's no real managerial buy in. There was no real. There was no real person who was really overseeing it and ensuring within the trusts, particularly on the ICB.

Interviewer52:32
Mm hmm.
Mm hmm.

Participant 52:43
Ensuring that, to be honest, you know, if I was, you know, it was like we could write a client. As I said, it was a clinically it was clinically driven definitely.

Interviewer52:45
Mm hmm mm.
Mm.

Participant 52:53
Well, we didn't really think about cost so much. We just thought about what best options were, and I suppose the other thing that you know it's difficult is there might be upfront costs just that to save money from social care. Does that save, you know, how blessed people are disabled, more people who can go back to work?

Interviewer53:08
Mm hmm.
Mm.

Participant 53:13
All those things are hidden. Benefits might not see.

Interviewer53:15
Mm hmm mam.
Yeah.

Participant 53:19
Yeah.

Interviewer 53:19
Got a couple more questions for you, Paddy. And then and then we'll we'll we'll tie up. First one's a little bit sort of two pronged. You mentioned before, I sort of circle a few words, you mentioned positivity, stability and organisational intelligences like these three things that you felt helped move things forward sort of as terms and I obviously I'm following that you also talked about bureaucracy as the opposite of that and so one of the barriers you face. So essentially what I'm asking is what, what do you feel in terms of processes, so rather than the implementation itself?

Participant 53:22

You can talk.
That's a.

Interviewer 53:43
M.

Interviewer 53:52
In terms of processes and actually getting any implementation through the door, essentially what sort of things are important, do you think to you in terms of those processes? I know you've mentioned about Jeff, for example being a really having that central sort of management figure to lead you through as well.

Participant 54:07
Yeah, I think you need that, I think.
Think you gotta have milestones? I think you've gotta have an an idea where the project's going to and what your goals and achievements are, I think.
I think the problem is the health service is very politicised. It's also quite bureaucratic. I mean, you know.
The I don't. I don't. I didn't really see the point of NHS England to be absolutely honest. I don't. I've never really seen the point of NHS England. To me, it's just another bureaucratic organisation that's I don't really understand what they do. I mean, I think that that's what holds of people's accounts and ensure, but there would just be wrong, there's incredibly bureaucratic.
And they have. Yet I remember the meeting at hand. We had about eight or nine people, and it must have been sort of COVID times because they were all at home. And I was at work and I felt like, you know, thinking I've found an hour. And in my day to come and do this, and you're all sitting at home and you're pontificating away. And actually, you know, this is, you know, there's no arguments about what the clinical pathway should be. There's there wasn't, you know, all the evidence was there. It wasn't like we were going like some wild.
Fancy maverick idea? This was like all evidence based.
The reason why entry we chose entry was because all roads from sort of sect which I didn't say to before, we don't have travel times. We've done all those kind of figures et cetera. They all led to entry entry was easy to access already had an established stroke unit which had good you know good.

Reasonably good outcomes and and and the roads lead there and travel times were easy, you know, even people in sort of West lines could easily get there because the motorways went into there. So from Scan M 58 it was direct into Switch Island, etcetera, etcetera, etcetera. So it wasn't really.

Interviewer 55:58
Mm hmm.
Mm hmm.

Participant 56:13
It wasn't really rocket science. Most of the things you're saying.

Interviewer 56:16
Mm hmm.

Participant 56:18
So I did think it was quite bureaucratic and then you have to go the public consultation and yeah, that that again was like a lot. And then the the councillors, I mean it's just you know, what you realise is that you have to organise those meetings and you know weeks go by before you do the meeting, then you find out what happens, etcetera, etcetera, like a lot of sort of downtime between everything.

Interviewer 56:36
Mm hmm.

Interviewer 56:40
Hmm.

Participant 56:41
Yeah. So.

Interviewer 56:42
And in that downtime, as clinicians, you guys are also just chocka with your own workload and it goes to the back of your minds as well, yeah.

Participant 56:49
Yeah, so so you know, I think that was, yeah.
I mean to give credit to our our chief exec, she didn't want to push it, but she pushed it in a way that made it like whereby.
She wanted to go fast and it was it was all. So she came in sort of March, April and basically saying we were unsafe, which we had loads of mitigation to say we weren't unsafe, but that just added a lot extra work and and we got it all planned for September when Aintree would be ready now you know, you have to go when the team we were going to take all these patients and have the capacity to do that already. You can't just go oh let's go tomorrow because it's just not feasible. So you know I did think that was a bit stupid.

Interviewer57:12
Mm hmm.
Mm hmm.
Mm hmm.

Participant 57:33
But.
I think maybe.
Maybe if we'd had someone like her earlier in the day, things might have been a bit quicker. We had the we had the so we had a lot of change. Chief execs here restart and you know, so there's no stability really. And we had a lot of change in who, you know, our management teams changed an awful lot and and then also ongoing in the midst of this, there was the. So when I when I said COVID actually the other thing that probably caused a lot of sort of hiatus was the merger.

Interviewer 57:41
Yeah.

Interviewer57:41
Mm hmm.
Mm hmm.

Participant 58:07
To the royal age there she 'cause. That was obviously another massive reorganisation, massive transformation and that was going on. So even though stroke, we thought stroke was quite a big transformation in in comparison to the merger, all services in blocked. It was only it was.

Interviewer58:07
Mm hmm mm hmm.

Participant 58:26
Not, you know, it's not as big as that.

Interviewer58:27
Being dwarfed, yeah.

Interviewer 58:33
Have you got something, Joe? Go on.

Interviewer58:34
Yeah, if that's OK. I was just going to ask, it's doing the further question that I've got for for you. But so you've said right at the start that you produced this reflection on how the process of the transformation project had been for you and like you've put all this detail into that and you've shared loads of it. We're with us. I'm just wondering, other than you performing that reflection for your own appraisal, was there any kind of reflection or were you ever asked for feedback?

Interviewer 58:36
Yeah, absolutely.

Participant 59:05
Oh, so so. So yeah. So it was a bit disappointing so.

Interviewer59:07

Sorry.
Yeah.

Participant 59:10
We did have.
We did have a meeting afterwards whereby because it was way of a budget which seems to be the main thing for driving a reflection now, I don't know 'cause I've I've not involved for the last 5-6 months, so I don't know. So obviously. Snap has gone very well.
So but I don't know if there's been a a sort of, you know.
One of the things I think that happens is people don't have always time to reflect. So you know or as an organisation you move on, we've done this. It seems to work. We're very happy with it, et cetera, et cetera. And that's probably what you think. But they they did have where there was someone in the icb i think.
One of the medical directors, I think, or who was supposed to be taking things forward, we had one meeting and nothing seemed to happen afterwards, but I think that was possibly because.
There's probably a little bit of.
Disharmony about that really, because I think you know.
Why? Why does it cost so much? And then I think particularly the clinicians found that a little bit difficult 'cause we were the only people who were constant throughout the whole thing. So the only people who were constant throughout the whole process.
Were.
Clinical stuff.
And mainly me, Nick and Claire, we were the only constants, right? Right. Till the really till it's transformed. Then it changed a little bit with some new CDs et cetera. But until that happened, we were probably doing cousins. So it seems to be a little bit like well you know the doctors have just spent too much money. Oh oh, it could be if you just start when. Actually what? It should have been was Oh my God, you. You were there all the time. You you did a clinical pathway and actually we should have been there to ensure the costs or say what what needs to be done et cetera. And there was no constancy of that really they had to they had to scrutiny committee and somebody was who threw the PCTs was drawn but you never felt you never felt that.

Interviewer1:01:19
Mm hmm.

Participant 1:01:22
Especially, you know, you never thought anyone was really overall in charge?

Interviewer 1:01:27
No. Taking that accountability essentially.

Participant 1:01:29
Yeah, yeah. I never really felt that ever.

Interviewer1:01:31
So the scrutiny Committee and the the way that you you were able to reflect back to them.

Participant 1:01:36
I think what we what we call it not gonna called it now, it was called it is either steering committee or the IT was the oversight. It was whatever whatever the the main committee they had things underneath that I think they they they changed their names all the time so Carol.

Interviewer1:01:43
Hmm.
OK.
Yeah.
I was just wondering, do you think that that feedback will be acted on? Will anything happen to the feedback?

Participant 1:01:57
Because no, I've never said I've not sent this. I've sent it to you. I've not sent it to anyone. Actually, I've just written it for my appraiser.

Interviewer1:02:04
Right. That's interesting.

Participant 1:02:05
I've sent, I might have sent it to Nick and Claire. I might have sent it to them, but I've I've not really sent it to anyone else. I just use it for my appraisal.

Interviewer1:02:09
Mm hmm.
Mm.
Yeah.

Participant 1:02:15
Well, no one really asked and no one. No one. Yeah, we had one meeting and then I don't think anything's happened after that. So I don't know.

Interviewer1:02:22
Mm hmm.

Interviewer 1:02:23
Yeah.

Interviewer1:02:24
Ha ha ha.

Participant 1:02:24
But it was it wasn't. It wasn't the best meeting because it appeared to be.
It it paints me that that they were really looking to see.
It wasn't supposed to be, and I know nothing's ever supposed to be a blame kind of culture, but it seems to be a little bit like that.

Interviewer 1:02:43
They're almost finding finding someone or some organisation or something to.

Participant 1:02:46
So thank you again. Other than thinking about it as a, but they may have done something. I'm not sure because I've never heard anything after it, so I'm not really sure if they ever did anything or didn't do anything.

Interviewer1:02:56
OK. Well, thank you. It's helpful to know that in itself.

Interviewer 1:03:01
OK. So I guess just to close off it, first of all, you know, thank you for everything you've shared today. It's unbelievably content rich and we're going to obviously go diving through it. If you can share that reflection with us as well, that'll be amazing. Is there?

Participant 1:03:13
Yeah, yeah, it's fine. It's not. It's not unique. You should have to take it to my personal view on.

Interviewer 1:03:19
Absolutely. Yeah, absolutely.

Participant 1:03:20
Yeah. So I I may be critical of something, but that's my personal view of what, how I perceive stuff.

Interviewer 1:03:27
Yeah. No, that's fine. And and you know if if we want to have a discussion about how much you want us to use that as well, we can have that chance as well.

Participant 1:03:34
Yeah, you can't. Again, I'll. I'll use it and see what I did say. Oh, I don't explain this. I don't think it's lively, so that we'll get dump.

Interviewer 1:03:38
Yeah, yeah. And and you know.

Interviewer1:03:42
M.

Participant 1:03:44
As I said, my personal reflection.

Interviewer 1:03:47
Is there anything else you want to talk about? Any, any things you want to mention?

Participant 1:03:48
That actually was. I'm done. Yeah, it's quite. Do you know what it is useful because I don't think we've had, you know, it would be, you know, the only thing we haven't really had a debrief on. What we actually I think overall.
Your feel that ultimately something good came out of it and that's I think that's what and and ultimately a really good pathway and really good care for patients, which was actually the real driver about everything.
As actually miles better than what all three organisations had before this. Yes, there's some things that could be done better. This think it's not perfect by any stretch of imagination, but a lot. Lot better than what we all had previously. A lot more access to things like thrombectomy and, you know, and thrombolysis better care at the very beginning for patients. And I think that's really important. So ultimately, despite all those things that I've said. Ultimately, it did lead to, I think, a pretty something that to be proud of.
Us and the other good thing I think, which is both have in common, is they both had collaboration between clinicals teams from different trusts and not about competition and stuff like that. And I think that is also something.
That the NHS must a little bit somewhere along the line, but it's maybe that's something that is an important thing about the NHS.

Interviewer 1:05:15
Yeah.

Interviewer 1:05:17
'Cause like culture amongst individuals rather than the organisation.

Participant 1:05:21
Yeah, yeah. But it's also about collaboration, I think, and about think about what is important and and that ultimately what you're trying to drive is better care for patients and well patients. You mean your public or your population or anything along those lines.

Interviewer 1:05:22
Yeah.

Interviewer 1:05:37
Yeah, that is absolutely amazing. Patty, thank you very, very much for for all of that today. I'm sorry. Obviously, we've run a little over.

Participant 1:05:40
OK. OK. Mr Thomas, yes.
No, no, no. Ice course wasn't you talking? I was doing the talking.

Interviewer 1:05:50
So if it's OK with you, I'm gonna stop recording. First off, actually, I'll just do that now.

Interviewer stopped transcription