Transcript

3 June 2024, 12:03pm

Interviewer started transcription

Interviewer 0:04
Brilliant. That is recording. OK. So I guess to start off with [NAME], if you could just tell me a little bit about your current role in your organisation and how your role involves stroke care and stroke care services.

Participant 0:15
OK, so I recently switched my role. I've been working in at [PLACE] as an [ROLE] for about [DURATION].
And I've recently moved to the [PLACE] [TEAM].
Where my role is [CONTEXT], [ROLE] and then the other part of my job is working with [PLACE] [TEAM] as one of the [ROLE].
And I do that one day a week.
4
Interviewer 0:53
Is that that's the ISDN, isn't it? Brilliant. OK, lovely. OK, so. Well, we'll start with then is you can pick any at all that you've been involved with in the past, but I'd like you just to talk about maybe any stroke Care service intervention or change that you're involved with. Talk a little bit about it, what it was, why it was made. Some of the background and obviously the processes that you were involved in with that as well.

Participant 0:55
Yeah.
OK. Gosh. So I guess one of the biggest system changes that I was involved with was the mid Mersey collaboration. So when the acute pathways.
Were quite radically changed, really. So whereas Warrington and Western have both had acute units and taken patients with thrombolysis, it became increasingly apparent that that wasn't.
Sustainable model. And so there was a degree of centralization and thrombolysis and hyper acute care went to Western Hospital.

And then patients were repatriated for rehabilitation part of their journey to Warrington.
Or were discharged into straight into early supported discharge, which was the team that I was responsible for. So although it was particularly focused on the acute.
Under the pathway.
My role being on the mid Mersey Board was to ensure that the rehabilitation under the pathway was considered and the impact that the changes would have.
So that was a fairly major change and then not long after I've been involved in that, I took on the role with the ISDN as their [ROLE].
So they're my role has been around scoping all the services within Cheshire and Mersey region in terms of rehabilitation.
Impatient, but particularly community as our remit, was about trying to improve.
The the delivery of the integrated Community Stroke Service model. So we've been involved in scoping where teams are currently and how far away they are from being compliant with that model.
And putting together a case for change paper for the ICB.
And then trying to push that agenda forward.
And then my shift enrol to Chester at the moment has been very much about looking at.
I suppose smaller quality improvement projects across the entire rehabilitation pathway from acute through to community and looking at.
Sort of marginal gains approach.
And to basically ensure that we are meeting the national stroke guidelines across the pathway.
And that's kind of been without any investment. Just think about how we can do things differently.

Interviewer 4:02
OK. That's that's great. Yep. Sorry, carry on.

Participant 4:05
That's OK. That's. So that's probably in a in a nutshell, what I've been doing.

Interviewer 4:10
OK. So I'll I'll will I I don't mind if you want to bounce around different things.

Obviously, I know you've mentioned a few different changes there and obviously whichever you feel suits maybe the question better, I'm happy for you to talk about any of them.

Participant 4:25
OK.

Interviewer 4:26
So let's have a think about.
Maybe the the I think the did you say the mid Mersey collaboration so was that probably the largest one you've talked about there?

Participant 4:36
Yeah, probably.

Interviewer 4:37
OK, So what sort of support mechanisms were in place do you think for you to to be part of that change in terms of processes, stuff like that?

Participant 4:50
Honestly not very much really. At the time I was probably, you know, a lot less experienced. I think I learned a lot through that process.
Learning from doing really.

Interviewer 5:03
Yeah.

Participant 5:03
There was very little at the time around kind of leadership in stroke.
And I felt very.
What's the word? Not exactly lacking in confidence, because I think I'm fairly confident talking about my subject matter, but I was very aware that there was some very senior people around the table there and I felt a little bit like one of the jobbing clinicians really.

Interviewer 5:35
Sure. When? When was this change, [NAME], by the way? What? What? What sort of time are we talking?

Participant 5:36
Is that?
It's probably.
About 2013, maybe, maybe a bit later than that.
So yeah, it was a fair, you know, fairly long time. And I think I've probably grown in terms of my leadership skills and the jobs that I've done since then.

Interviewer 5:58
Sure.

Participant 5:59
But it taught me a lot about commissioning. It taught me a lot about kind of relationships between organisations and about some of the sort of change management processes.
And the challenges that there are.

Interviewer 6:14
Yeah.

Participant 6:16
But yeah, very little in the way of support.
And I suppose the most support came from. It wasn't the ISDN. Then it would have been the cardiac and stroke network.

Interviewer 6:27
Right. So.
Sorry, I'm just making notes as as we go here, we're sorry.

Participant 6:32
2nd.

Interviewer 6:35
OK. And in terms of that change that again talking about this?
Mid Mersey collaboration was it evidence based? Where did, where did the change come from in the first place in terms of that revamp of the pathway?

Participant 6:48
I think it was the the agenda about trying to kind of centralise hyper acute care and the sort of numbers that would be required to make a viable service, but also a workforce challenge in terms of consultant workforce. So it wasn't sustainable to have a rotor on 2 sites. And so that kind of necessitated the change really.

Interviewer 7:12
Right. OK. OK.
What did sort of colleagues, what did? What did you think? What did your fellow staff think about the change either when it was in progress, when it was implemented finally as well was it was the reception of it good or positive negative?

Participant 7:31
I think yeah, there was a lot of fear, a lot of.
Negativity, particularly from the trust that felt more vulnerable. I think so. I think there was very much a sense of.
Rather than it feeling like a collaboration, perhaps it feeling a bit more like a takeover.
And I think that could have been handled differently.

Interviewer 8:02
Did you say so? Is that received that reception was from the site? That kind of lost the centralised edition. Yeah, yeah.

Participant 8:07
Lost their acute services. Yeah, yeah, yeah.

Interviewer 8:10
And that was without Warrington. So yeah.

Participant 8:12
Yeah. And I think there's probably a sense of, you know, people were very pragmatic about why the change had to happen. But I think there was a nervousness around finances and that acute tariff being lost.
And I suppose.
You know what, what came to be was that you lose control of the repatriation process in that very much becomes something that the acutely admitting trust and have more control over.
I didn't particularly feel that in my service from an ESD perspective, because that was one of the exit routes out for patients from.
The acute trust and to maintain flow that has to happen.
But I think some of the kind of have to. It probably did feel a little bit political at times.

Interviewer 9:10
OK.

Participant 9:11
And as a clinician in the middle of that, you kind of it's quite frustrating because what you really want to do is the best for the patients. You don't really want to get caught up in that politics.

Interviewer 9:16
Yeah.
Absolutely. And I know you. You mentioned that feeling you had feeling like you were that sort of clinician that maybe didn't have the seniority experience in that sort of process with the people you were surrounded by. Were there other clinicians involved? What was that? What would the sort of what's the word I'm looking for here, what was the expertise of the people involved in that change, I guess?

Participant 9:51
So they were around the table, there were senior commissioners, there were finance directors, there were director of OPS.
The not particularly the board meetings, but you know.

The chief execs would have were involved in it, and they weren't particularly around any of the board meetings that I was at.
Consultants were there.
Sometimes some radiology involvement.
And there were therapists there, but sort of sporadically. I was probably the person that was often the consistent person, and particularly from Warrington, because we had quite a lot of change in our directorate management structure at the time.
And so there needed to be somebody there who had the history of the meetings really.

Interviewer 10:45
Sure. In terms of, you know, I, I I've heard it from others as well about this. You know, as a clinician you have that focus of really wanting it to be patient LED and and those outcomes being the main driver for a change in your opinion. Obviously you've talked about those other people around the table. What do you think their focus was was it was it still a bit of that? I assume you know I'd hope, but was there a different priority?

Participant 10:59
Mm hmm.
No, I think I think absolutely the the patient pathway was at the heart of it. I and I do I do think that across the board but I think there was also a lot of kind of nervousness about finances and loss of finances and tariffs and clinic payments and which obviously there needs to be.
But it sometimes it feels a bit like.
You've got to be so careful that you don't destabilise 1 organisation.
And the rest of the pathway and I think.
I think it perhaps just needs to be a little bit more.
I don't know. Sometimes I it feels a little bit like that gets lost.

Interviewer 11:59
OK. We'll talk about finances. I know you've mentioned that a few Times Now. So I guess first of all, in terms of that change, let's you know we're on, we're consistent with this with this implementation at the moment. How was that funded? What what,

what was the funding like? Was it funded to be implemented? Was it funded to be sustained like what? What did it look like?

Participant 12:20
So.
The tap the acute tariff went to Western and the we continued on a block contract at Warrington. Now I don't know whether that's been reviewed since I've not been there.
There was lots of talk about unbundling tariffs and the rehab tariff and and it as far as I'm aware, that never happened.
Whether it's happened since I've left, I don't know.

Interviewer 12:53
OK, I was actually gonna ask as well. I just, I meant to just slightly earlier. You talked about this change being 2013, which obviously predated the ISDN Reformation, which sort of 2019-2020. How have these changes that were made then how you know this isdm was a look at the whole network as a whole and that pathway is that change, has it been consistent through the new sdns or is that changed since then as well?

Participant 13:21
Sorry, I'm do you mean in terms of the tariffs and the finances and engage?

Interviewer 13:26
So no, in terms of the implementation itself. So where you have that centralization in Western for like your thrombolysis and things like that, has that been maintained through the the new ITN? Yeah.

Participant 13:32
Yeah.
Yeah. Yeah. So and actually it's extended. So mid Mersey was first and then N Mersey have centralised so.
Liverpool at Aintree is kind of the hub now, the acute hub and that fits with the thrombectomy.
Care as well. So the only part of the region that doesn't have any kind of centralised

model is South Mersey. And that's probably something that you know is in the process of starting to be looked at geographically. It's a little more difficult.
But yeah, that's that's probably the direction of travel. And then I guess.
The bit that's quite frustrating for me as a as a [ROLE] is that we've looked at the front end of the pathway, we've reconfigured that and then it's sort of come to a bit of a standstill this by our work on scoping out the pathway.
Looking at how far away we are from acss looking at.
What needs to happen in a step change approach to be able to improve the rehabilitation offer across the region?
And they're just, it's flat. There is no money. We have very little engagement.
With the ICB around that, even though we are constantly banging the drum.
So most so, you know, as an ISDN [ROLE], we do an awful lot of work with teams on small scale quality improvement and doing the things that are within our control to make things better.
But it there comes a point where you've you've kind of reached the limit of what you can do.
We've been had some really sort of successful squiring catalyst bids with some region wide projects.
And they've been, you know, really useful tests for change for different ways of working.
But we're not getting the buy in in terms of picking up those projects. So that's quite frustrating really is that we've kind of poured money into the front end and nothing into the back end. And actually I think myself and my colleague who works on rehab feel very much that, you know, rehab is part of the solution in terms of patient flow.
And and support of the solution for the front door. Really.

Interviewer 16:06
Yeah. Whereas like said, right now you're seen as sort of just on the end kind of thing and not not feeling like you considered as much sure, OK.

Participant 16:13
No.
Yeah.

Interviewer 16:16

You mentioned just to jump on something you said there, you mentioned about these sort of at the moment you're focusing on sort of small improvement change, quality improvement projects. What's the funding like for those who's forgive me if I'm wrong here, is that from things like the [CONTEXT] and the [CONTEXT] or is that funding you by yourself essentially internally?

Participant 16:32
Lots of different things, really. So the square and the catalyst funding.
Has funded some of the projects, so we had I think we had five or six projects in Catalyst One and two in Catalyst 2. [NAME] and I have been acting as temporary [ROLES] because we lost our [CONTEXT].

Interviewer 16:39
OK.

Participant 16:55
So we.
In in round one we had one region wide project which looked at.
Ecology provision. And then we've had and I think it was another four or five that was smaller team based projects that were funded looking at that tech in rehab.
Speech and language therapy, splintings spasticity management.
Think they were the four and then the last two that we've been involved in in Catalyst 2 are both region wide. One is looking at specialist VR provision and one is looking at neural rehabilitation online.
So extending the East Lancs model in Cheshire and Mersey, so again region wide, so fairly big, fairly meaty projects.
That will definitely help with some of our our issues, but it but to to sustain them, they're going to need long term investment.
And so we've, because we've had limited engagement and buying from the ICB, we've tried to ensure that those projects have some legacy element to them. So even if they don't get taken up, we get left with some form of skill or product at the end of it that we can take forward.
But then in other teams we've had lots of kind of Qi work.
That that's not been funded at all. It's literally been, will and motivation, a very dedicated rehab staff who just constantly look to see if there's something different

they can do without funding.
And you know, we're lucky that we have a, you know, despite the challenges we have from funding and icb engagement, we do have a really motivated workforce.
In a very active clinical reference group that [NAME] and I run and we try to do as much as we can in terms of free training in that.
And she brag and steal events.
Yeah.

Interviewer 18:54
It must be frustrating, I guess when you've got that workforce and they're all ready to go and it's sometimes a bit harder to do anything with it, yeah.
You mentioned focusing on making sure that these projects have some form of legacy, at least for for a period of time. How do you? So you talk about investment as well. How do you go about that sort of stuff? Where would that investment come from? I mean, I know maybe hypothetically a little bit here, but what what would be your target for for those sorts of things to fund those sorts of things?

Participant 19:25
So things like the VR training that's happening at the moment so.
The VR model looks at sort of piggybacking on what the rehab network are already doing, so they have a centralised specialist level vocational rehab practitioner.
And what we've done is seconded somebody from within Cheshire Mersey region.
NOT who is receiving that specialist level training, so she's going to maintain those skills whether she stays in that role and the ICB fund it for stroke, or whether she goes back to her clinical role that she was seconded from.
We're also working at training up through a communities of practise group.
Various clinicians. So we're raising the skill level across the network and there's also an education.
Module that's been designed by the rehab network specialist VR practitioner and that's been designed to to perhaps be part of a master's module if that, could you know. So we'd be targeting that with higher education institutions.
And but also it can each of those bits of that module can stand alone as individual pieces of training to.

Interviewer 20:51
Yeah.

Participant 20:53
But ultimately, you know we we're trying to publicise it all the time with the ICB as a very it's not a huge amount of money to sustain a region wide service really.

Interviewer 21:05
Hmm.

Participant 21:08
And that kind of is similar to our the psychology catalyst project from Catalyst One. It was a very much a hub and spoke type mode of delivery. Knowing that it's hard to recruit psychologists and B when you do if they're stand alone.
It's hard to retain them because they've not got that kind of peer support, whereas if they're part of a bigger hub and then outreach to teams, that might be a better way of delivering the care.

Interviewer 21:27
Yeah.
That makes sense. That makes sense. OK.
Let's switch a little bit up here. So again, I don't mind which project or change you want to talk about here. I'm going to sort of open this up again because I know we've talked a lot about the the mid Mersey collaboration.
Service users. So how were needs and preferences of service users included or considered in these changes you know, can you talk a little bit about the strategies you might use to include?
Users as well.

Participant 22:11
Yeah. So I think I, the midmor say that was a very formal process and there was. Events at the various town halls that were publicised so more like public public consultations, really.
And when I say consultations, I kind of use that term loosely, because I think the way

that it was described.
Was very much that. This is a not.
Consultation in in as much as there's a choice in the matter, I think things have become so unsafe from a consultant workforce perspective that it was a change that had to happen to improve patient care and safety, but it was about communicating that in the right way to the public. So that was done.
And I have to say that the I the wasn't the ICB, then the CCGs took a lead on that at the time.
And the Stroke Association were also involved in it, and the communications teams at both hospitals.
So that was a very formal process.
There was a patient Rep on the board.
I'm trying to think was there two? There was definitely one.
And then our other group, so within the asdm, we have a patient and public voice group.
And they meet regularly.
And.
Although that that's been a bit a bit on hold at the moment because of the NHS England restructure.

Interviewer 23:51
Right, right.

Participant 23:53
But the idea of that group is that we kind of know who in that group has certain interests in certain areas of the pathway or their own experience sort of lends itself to certain projects. And so when there's something that needs to be consulted on, we take it to the group. But often there will be somebody who who thinks that that fits with my interest.
More and so that's a bit more of an informal group really.
And then within our teams, most of the local teams within the Cheshire Mersey region do have patient reps within their own boards, so.

Interviewer 24:31
OK.

Participant 24:33
It can be at various different levels, really, and I've also been involved in the past in Stroke Association engagement days.
Where we've had.
An invite for them to come along and round table discussions on various different themes, and that's been quite useful.

Interviewer 24:53
Good. OK. And do you think again any of the changes really, do you think the needs of the services were met, were they were they sort of it's obviously it's one thing let's say.
Having those outreaches having those workshops, those consultations, do you think those voices were heard and put on board with with the work?

Participant 25:06
The.
Yeah. I mean, I think I think the large scale mid Mersey, I think yes, they were, Matt. I think you can't, you can't. Patients are obviously much more aware and much more.
Savvy about what?
They should be getting what kind of acute care they should, and those missed opportunities I've jumped on now, and rightly so. And so I think.
You know, they were very much listened to because we it couldn't carry on the way it was. There would have been, you know, serious incidents if it had carried, if we hadn't have had that acute transition.
I think with regards to the rehab, I know I don't, I don't think things are changing really.
But it's very difficult to.
How? How? How do you get anywhere when you're flatly being told there is literally no money and there in deficit and the decommissioning it when they're not decommissioning stroke, but neither are they investing in it either because there's nothing to invest.

Interviewer 26:22
It's almost just rolling along with no momentum kind of thing, yeah.

Participant 26:22
So.
Yeah, yeah.

Interviewer 26:27
OK. And sticking on this, this sort of topic a little bit in terms of health inequalities as well, were those considered, were they improved upon, should we say with with some of these changes, I guess with the mid Mersey one given that it was essentially needed?
Hey, there, [NAME], I think I'm at a loss you.

Participant 26:58
They lost the connection I'm I think.

Interviewer 26:59
Oh, I think you're back. I lost you there briefly.

Participant 27:05
So for example, when you centralise the pathway you take care often further away from home. And I think that was considered, but I think it was a necessary evil. And I think wherever possible, we tried to get people back to a more local hospital or out to their home. And but I think what would have made that easier is if the Community services had been invested in at the same time as the acute care.
I think they they missed that and now we've kind of missed the opportunity because we're in a much worse financial position.

Interviewer 27:44
Yeah.

Participant 27:45
So I think.
Ish. It was taken into consideration, I think in terms of our [CONTEXT] projects, I think health inequalities are very much taken into account and there's, you know, a large impact.

Risk assessment done on each of those projects. When they do the pids, so things like like the digital tech stuff we've had to have things in place whereby if people haven't got access to Wi-Fi or haven't got access to.
Tablets or.
And iPhones, we have to think of a different solution for those patients, whether it's a lone piece of equipment or whether it's a different offer of face to face instead or whatever it is you have to consider it really so I think.
I think it is something that's very much in the fore of people's minds when they're doing any kind of change now, which is probably different to how it was maybe 10-15 years ago.

Interviewer 28:43
OK. Thank you very much. I'm just catching up on where where I'm up to here. So, OK, so let's talk a little bit now about the process itself and the actual process of those implementations from beginning to end.
What sort of things? People, maybe other organisations? What? What sort of things helped or hindered that process in terms of going from an idea and an issue maybe or a change that wants to be implemented or needs to be implemented in this case? What sort of things help and hinder that journey?

Participant 29:22
I think organisational boundaries really hinder it?
And by that I don't necessarily sometimes it's it's a kind of a process issue of an organisational boundary that's the problem.

Interviewer 29:51
But what do you what do you mean by organisational boundaries, [NAME]? Sorry, just so I can make an answer.

Participant 29:57
I suppose I mean two, two or three. Well, two things really. One is kind of people's affiliation with an organisation. And their loyalty to that organisation?
And it becomes a little bit territorial. And then the other is the kind of processes that surround each organisation and it drives me insane because we're supposed to be 1NHS1 organisation, but actually.

When we're absolutely not, and so something as simple as sharing data or patient information across 2 trusts becomes this horrendous monster that you're trying to sort out with dpias and IT systems that won't talk to each other. And actually, no, we're not going to give you permission to look at that even though you've got the patient's welfare at heart and you would be doing a much better job if you had that information to hand.
But actually I'm going to make you jump through 15 hoops to get there and we won't really get a satisfactory solution at the end of it. So there's kind of those sorts of mechanics of working across systems and that's that's not even working between NHS and local authority or that is literally between NHS organisations.

Interviewer 31:08
Yeah.
Right.

Participant 31:24
And you know, we're having that that problem is is not getting any better. So the enrol project that we're working on at the moment.
The the red tape around DPIAS is just ludicrous and it it's a real barrier to doing something innovative and different. Totally safe. The governance is in place, it's all there.
But it it just it stifles any kind of creativity and when you are limited anyway because of the financial envelope it just is another frustration that people don't need and probably gets to the point where a lot of projects fail because people give up.

Interviewer 32:07
Yeah.

Participant 32:11
I think the kind of territorial bit the people, the personalities, the politics is another huge frustration really.

Interviewer 32:22
Strong personalities. Yeah, agendas. Stuff like that, yeah.
Just for my notes, is it dpia? What what's what?

Participant 32:33
It's kind of data sharing, it's yeah.

Interviewer 32:34
Data sharing. I thought it would be. I just wanted to speak brilliant.
Right.
Are there any specific organisations, obviously within or outside the NHS, that that you would maybe want to get on board? Sort of. You know, you always know helper project.
I mean, there's an example I can think Stroke Association obviously usually would be pretty good any any others?

Participant 33:07
I mean, I think I've been very clear that things like early supported discharge, we need to engage with local authorities with care organisations.
We do work really closely with the Stroke Association and we're really fortunate in our region that we have good representation. They come to our CRG meetings, they come to our catalyst projects, they're part of some of our catalyst projects.
And sometimes that that is a really easy tick in the box in terms of patient and public involvement. They can really support with that.
We've done work with things like I'm trying to think of. Some of the ones [NAME] has used, so some of the Community sports foundations with some of our rehab projects. So she's worked with Everton Football Club, there's been work with Warrington Wolves Sports Foundation.
So we try and use local community groups. We've done some work with some of the social prescribers.
Age concerns with some of the community connectors.

Interviewer 34:21
All of that again? Yeah, it ties in with that public involvement. It ties in with health inequalities. Yeah, absolutely. OK.
How how is progress measured in terms of the implementation? So not just necessarily once it's implemented, how do you see change and how do you measure

that change but also while while that implementation is in progress, you know, how do you make sure things are on track goals, targets, stuff like that?

Participant 34:50
And.
So for our ICSS work, looking at trying to improve the pathway and where we are, we we have two dashboards. One it looks at kind of.
The different things that should should be part of.
The ICSS model of care in terms of staffing disciplines.
Amounts of staffing, whether they've got certain services within them and that's lifted straight from the GM.
And work. And then we also do the.
Right care tool Kit dashboard as well.
And we use that. That's quite hard hitting actually because it's it shows, you know they were kind of jumping up and down. Oh, look at those, aren't we great? We've got A's in all our acute trusts and it's very green on the dashboard. And then you look at the Community dashboard for the right care toolkit and it's pretty much universally red and so few oranges don't think there's any green.

Interviewer 35:51
OK.

Participant 35:54
And we deliberately didn't water that down. So even if there were parts of it being delivered, if it wasn't being delivered in totality, we marked it right.

Interviewer 36:04
Yeah.

Participant 36:05
Because you we're not doing half measures we need, we need it to be hard hitting.

Interviewer 36:11
And that toolkit, so that right care toolkit that covers that whole pathway, does it in terms of all the care provided, right?

Participant 36:16
Yeah.
Feel really happy.

Interviewer 36:18
Really.

Participant 36:20
So we use that for the ICSS for our [CONTEXT] projects, we have the interim reports and each project has the paid which they measure against.
We also have regular check insurance with our teams in the [CONTEXT] project and kind of action plans that we measure from meeting to meeting.
The.
And mid Mersey, collaboration had an action log similar really.
Meeting to meeting what was going to achieve what's not been achieved and then the KPIs were designed at the end of that project about you know what needs to be measured against.

Interviewer 37:01
That's cool.

Participant 37:04
Most of our teams are inputting to snap from an inpatient rehab perspective.
A lot of our community teams are, but not all, and so.
We have collected some specific data on dosage and frequency of therapy.
But we are really looking to move all our teams to be in pot, into SNAP Community data set. They all inputted onto the organisational audit.

Interviewer 37:37
OK. Just one question I had about that.
You talked about the interim reports for the first [CONTEXT] projects. Where do they go? Where do they report to?

Participant 37:45

M.
So we feed them into the national teams, so they go to Rebecca Fisher.

Interviewer 37:53
OK, come.

Participant 37:54
So the national team have oversight of all the projects.

Interviewer 37:59
Brilliant. OK.
All right, what's next? What's next? We're we're getting there. [NAME]. We're getting there.

Participant 38:05
Mm hmm.

Interviewer 38:06
In terms of these changes, how how, how well do you think these changes have been sustained since implementation to now I get that some of them are longer sort of standing than others in terms of when they're implemented, but do you want to talk a little bit about that as well?

Participant 38:23
And.
Well, the acute, I mean the acute collaboration obviously is now an accepted model of care and the pathway is well established.
They have regular sort of stakeholder meetings just to iron out any issues. Usually it's around repack when there's pressure on beds.
They're looking at doing things like ambulance video triage.
Pilots to improve the alert times, etcetera. And they, you know, constantly looking at the thrombolisis and thrombectomy times.
I don't think really anything has moved forwards in terms of looking at the rehab and the pathway.
So the when I was there, I had an extensive dashboard looking at performance and

looking at referral rates, which had gone up about 25% since the acute amalgamation of the pathway.

Interviewer 39:23
Right.

Participant 39:27
No extra staffing.
No change in how we did anything. No amalgamation with the Bridgewater Neurosciences team to become a seamless integrated pathway. Big gaps in the Halton area.
Big waits after ESD.
No maternity leave covers, so there was a time where ESD had a way of about six weeks, you know, totally ludicrous. That's come down since the staff have come back. But there is still a small wait.
But it's just not being addressed and it's not being.
It's kind of it's. It's almost like, oh, we've got ASD. Well, we have, but it isn't fit for purpose. And can you really call it ASD if you're not getting in early and you haven't got a speech and language therapist in that team and you haven't got a nurse in that team?
Become a nonsense to call it ESD when it isn't really. And that's not just there. That's across the whole of Cheshire and Mersey. Most teams have got gaps in terms of disciplines or staffing levels and ratios or they're not integrated. So they might get ESD. But then what happens after six weeks, they drop into a black hole just further down the pathway.

Interviewer 40:26
Hmm.

Participant 40:46
So I just don't feel that the rehab element is being picked up and it.
It's quite frustrating and as a [ROLE], you feel very responsible for that. You feel, what are we doing? What are we not doing? What should we be doing differently?

Interviewer 40:56
Yeah.

Participant 41:05
The reason I've done some leadership training, we're not on the.
The the glass training.
But are ISDN manager is on it?
I sort of felt like there was a time I wondered about applying for it, but I'm probably, you know, four years away from retirement. So it felt like it was perhaps something that somebody else who's going to be in this for longer would benefit more from.
But it is frustrating and I think we are.
We bound the drone. We tried various different methods of flying the flag for rehab, but ultimately, you know.
When you're constantly being told that there just is no money, what else do you do?

Interviewer 41:56
Absolutely.

Participant 41:57
And I would love it if someone could come up with a great idea for us, but I don't. I pragmatically, I don't think there is a solution for that.

Interviewer 42:11
Some some big questions now.
In terms of these implementations, what if you could go back in time and change something in terms of the process in terms of that implementation that change what what would it be? What would you want to change if you or would you change anything, would you do anything differently?

Participant 42:33
I think with regards to the mid Mersey collaboration, I would have engaged more with the staff on the ground.
I think there was a lot of meetings that happened that were quite high level and I think the communication to teams was poor.

Actually, that was quite unsettling and I think it led to a lot of conjecture.
And I also think that actually if they'd spoken to teams, they'd have come up with.
Much simpler solutions to problems, and they'd have been more engaged in the change and I think they wouldn't have perhaps thought it in the same way. I think I think it would have been.
I don't think they felt like they were all part of 1 pathway and I still don't think they think they're all part of 1 pathway, if I'm honest.

Interviewer 43:24
Yeah. Do you think that, I mean you you mentioned before about that sentiment that it didn't feel like a collaboration. It felt like a takeover from from that side. Is that what you mean? Is that what you think contributed to that? Do you think that poor communication that maybe lack of transparency?

Participant 43:43
Yeah, in part. And also I think you know this, the whole sort of SNAP rating.
So instead of having a pathway SNAP score.
It was organisational.
And.
I think then you're not working.
A patient centred snap.
Rating your your working for an organisation weighted snap and so.
It kind of breeds this competition between two trusts that are essentially working for the good of 1 patient doesn't make sense to me.

Interviewer 44:24
Because they're each gonna want to improve their own snap score, which is independent per per organisation. Yeah. OK.

Participant 44:29
Yeah.

Interviewer 44:34
Alright, sorry, I didn't mean to interrupt.

Participant 44:37
And.
Yeah, just tell me the question again.

Interviewer 44:46
Yeah. So it was about that. What would you maybe do differently? So you talked about the communication.

Participant 44:52
Yeah.

Interviewer 45:04
Can be any any of them implementations as well.

Participant 45:07
1.
I think with the trust I'm working with at the moment, we've very much done a kind of launch about quality improvement, been very open and very honest about the climate that we're in.
But that doesn't mean that we can't make changes and that sometimes you know, thinking differently, thinking outside the box, harnessing an entire team's ideas, but also thinking about. So I've where I'm working at the moment. We've now got very clear.
Communicated processes to the staff about what it is that we've you know, we've audited against the national strike guidelines and the rehab guidelines. This is our RAG rated position. These are the things we have to work on 1st.
These are the things that we will be working on. Any idea is not a bad idea, but we need to log it. So if you whoever it is in the team sees any area of waste or you know, ways that things can be done differently, there is a very simple form that they just pull out of a Poly pocket on the wall in the staff room, fill it in, hand it in. If we haven't got the scope to do the project or look at the project at that time, it gets parked on the dashboard till we have everybody.
Can be involved in Qi.
Continuous improvement and it's that idea that we might do a project, but it doesn't

mean that's the end of it. We'll keep reviewing it and see if there's anything different we can do.
And almost like no idea was a crazy idea. Let's just throw it around and see if there's something that comes out with that.
And I think that's led to a real sort of rejuvenation in the team as a real buzz about it. And we've had no money to do it.
I think my post, although I do have a clinical case load, it's not huge and so I have the time to do it and to support people.
And I think they feel like they're being listened to. There's someone that can take this stuff to the governance meetings and to the Directorate meetings and take it to comms and actually get them on a map, be heard and I think.
That's that is, you know, sort of raising the profile a little bit.
And it it doesn't necessarily mean that there any money coming with it, but what it does mean is that if that part of money that we know NHS England likes to do quite a lot, you know, you can, you can have this little bit, but you can only do this piece of work with it. You can't. You're ready to go with something.

Interviewer 47:53
Yeah.

Participant 47:55
And I think that kind of enthusiasm engender in that that positive culture really.

Interviewer 48:05
I can say so. I mean, you mentioned before that you you're fortunate to have that engaged workforce that doesn't surprise me given what you've just described in terms of that culture essentially that you've that you've got in that. That's fantastic.

Participant 48:16
Hmm.

Interviewer 48:21
OK.
I will pass to Alison in a minute, just in case she feels I've I've missed anything, but is there anything else you want to share in terms of, you know, barriers facilitators,

those those changes you've gone through in terms of that you've been involved with? Is there anything else you'd like to share?

Participant 48:38
I think the biggest barrier for me at the moment is lack of named people within the ICB to engage with around rehab, so I feel the change to Icbs has set us back in mid Mersey in terms of rehabilitation no end. So I feel when [NAME] and I were first in post and we were working with CCGs, we knew all of our local Commissioners.
We knew which teams worked with which Commissioners they knew was we would have regular check insurance with them. We could bring up various different problems within teams. We could start to have a look at them. Now I feel like some of those people are the same people, but many have changed and they don't know what their portfolio is. And they, you know, we we go to different we were having. We're not having them at the moment, but we were having. Some regional boards. And so we'd have place directors at each of those boards and you would get very different steer depending on who you were speaking to. So for some people looking at the ICSS was a transformational change across the whole ICB and it was something that they felt should be being led on centrally.
Other people felt like we weren't getting that stay essentially. So let's look at it in a place by place.
Sort of basis.
But it varies depending on who you're speaking to, and there's there's just no consensus at all. We had a meeting not that long ago with the chief exec at the ICB. And The upshot of that meeting was that they were going to identify somebody, but we're still waiting for who that person will be. And it's just creating this absolutely hiatus.

Interviewer 50:40
Yeah.

Participant 50:42
You know who'd you go to? We've tried every. Which way we can. We've had workshops where each table each place had their representative there. We've had. High High Level Board meetings we've had, regional board, sub regional boards, just we're just not getting it.

Interviewer 51:05
So I'm not banging your head against the wall, isn't it?

Participant 51:08
Like how many more ways can we go at this?

Interviewer 51:10
Yeah.
What do you think is what do you think is stopping that? Is it a lack of engagement? Is it just lack of the funding to to fill that post or put that person forward or?

Participant 51:23
I think originally it was the, our ICB was very immature in its formation, so it hadn't. It was one of the later ones to become an ICB.
There was a lot of it took them a long time to actually appoint people to posts, and so there was this like.
Stall in any kind of work for a long time, and then it was kind of for quite a number of months. We were getting there kind of well.
Building in and nobody quite knows what the role is yet, and it's like, OK, that's going to wash for so long and then it's not going to keep washing.

Interviewer 51:59
Yeah.

Participant 52:04
Now I think it's money.
And people losing those jobs that they were put into.
And just no money to Commission services. And they're actually in the process of what can we decommission? Never mind anything else.
So I just think the climate that we're in is is really tricky.
We're, you know, we go on the national community call and you hear of other trusts, other other regions where things like the SDF funding has been devolved to the various integrated Community stroke services and they've had there because within the SDF funding, there is supposed to be a line that identifies that there is a chunk of

money for ICSS delivery.
And some trust. Some regions have had that we haven't and we're not getting any kind of sense of we're going to get any of it or it's almost all just in the mix in the pot and it's not been ring fenced.

Interviewer 52:57
My.
OK.
Thank you for a start. You've covered so, so much there. I am gonna just let Allison, Allison, if you feel I've missed anything or anything you want to jump on in terms of comments or anything, feel free.

Interviewer 53:29
An interesting to listen to. Thank you, [NAME]. Very aware of time as well.

Interviewer 53:31
Yeah.

Participant 53:33
Is that?

Interviewer 53:33
It won't.

Participant 53:34
Is that the kind of thing that you were?
Which are expected.

Interviewer 53:39
Absolutely. Yeah. So I mean, one of the challenges we are gonna face with this is is we're trying to be as open as we can with everybody we've interviewed in terms of the changes they're discussing what level those changes are at because what we want to do is just discuss the actual processes involved, not necessarily the changes themselves. It's more about the processes involved in implementing them, the

people involved, the organisation involved and that sort of thing. So yeah, it's it's, it's more.

Participant 53:59
Good.

Interviewer 54:06
Today, the idea is we learn from what you've done well and what's not gone so well so that we can develop the logic model that can be used in the future. And it's it's interesting. A lot of the stuff that comes out is that is that soft stuff, that planning, that relationship stuff alongside those. Yeah. Sorry. I was trying to be quiet. Sorry Joe.

Interviewer 54:09
Yeah.

Participant 54:14
Hmm.
No, I think you've I and I think the reason I feel that very much because we were, there's a point where they're looking at whether the [ROLE] post will continue. And I think.
Our our take on that is actually if you don't have those people that have the relationships with the staff.
Who? The staff have a kind of.
A respect for because they walk the walk with, you know, [NAME] and I had job in clinicians as well as [ROLES]. So we know the pressure those teams are under. We feel it day, day in, day out. We're very in touch with it.
And we have some credibility because of that.
And I think when you don't have that. It doesn't quite sit right with teams.
I think we are very much about sharing we we're not, we try to foster a culture of if you've got a good idea, don't don't sit on it and keep it all to yourself. You know, let's share it around because we've made some great changes with no money because of that.

Interviewer 55:34
Yeah.

Participant 55:35
And it's it's really quite, I mean, [NAME] is a classic case. So she.
I don't know whether you saw on BBC Northwest Her walking group.
They did a piece on it not that long ago, which has just been about, I mean, it literally cost her nothing. They just engaged with a local park cafe.
And the Rangers there. And it's been almost becoming self running. So the patients do their own quiz now. Stroke Association go along and do some blood pressures. They get to meet people all in one place. All that befriending stuff. And so that's been shared as a model.
So increasing their activity levels falls and reducing confidences of loneliness is down. Depression is back. You know, all that sort of stuff. And so now we've got three teams in the region that are all doing one and another two about to go. No one's had any money to do it.

Interviewer 56:34
Mm hmm.

Participant 56:34
But the benefit of it is huge.

Interviewer 56:37
That's that's brilliant. And that's that's the thing, isn't it? It's money is a massive issue across the board as well as staffing, but stuff like that at least it shows what's possible, not necessarily having those resources and that there are still things things have done. That's brilliant, [NAME]. If there's anything else you'd like to share, go ahead. Otherwise, I'll, I'll stop the recording.

Participant 57:01
No, no, we're good. Thank you.

Interviewer 57:02
I'll just stop that then.

Interviewer stopped transcription