Interview - Participant 2 29.03.23

Interviewer (I):	00:04	Excellent, thank you. So I just want to confirm I know you've done the consent form, but for the purposes of the transcription that you're happy to go ahead and be recorded for this interview. Great. I've got a bit of an introduction. And so my name is [***Interviewer name***]. And you know that you've been invited to participate in this research because you're involved in making changes and improvements to stroke care across the North West Coast region. It's important that we capture the learning from what has been done to share this with others and support future improvements in the stroke care pathway. I'm going to ask you a few questions about your involvement and your experience of stroke care and whatever parts of the pathway you work in or are involved with. We're interested in your opinions about what you did, why you decided to do it, what worked well, how the service could be improved. Any challenges and other commitments you would like to make so you can see there is quite a bit in there. We hope to use your comments to understand what changes have been made within stroke care, particularly at a system level, and explore what worked well and what could have been improved. The information from these interviews will be analysed and then used to inform focus group discussions to help develop a tool called a logic model. The logic model can then be shared and used by others to carry out improvements in stroke care. Is that all right? OK. So can you tell me about your current role within your organization?
Participant (P):	01:25	So in my organization I am one of the stroke consultant out of supposed to be five, but it's going to be five in June. So at the moment is four of us.
I:	01:38	That's fine, but you have it you have another role don't you, within the ISDN?
P:	01:41	Yeah I've got a few other roles here, so I've got a few regional roles. So regionally I am the [ROLE] for the [PLACE] and I do it jointly with [name] from Liverpool. I'm also the [ROLE] for the [PLACE] and I do it jointly with [name] in Preston. I'm also the [ROLE] for [ORG]. So, yeah, I think that's probably… but at the trust level at the moment in, I don't hold anything because I personally think it's a conflict of interest if I'm doing the regional role shouldn't be doing their local role as well , so .
I:	02:42	No , no , that's great . Thank you . So it's a regional thing . Yeah . So can you discuss any stroke care intervention or change that you're aware of that has been made or is currently being made ?
P:	02:57	Well , I mean , stroke has come a long way away , and that , I mean , when we were trainee actually , we had to really get a begging bowl out to the radiologist to do a CT scan . From there , we actually know quite a lot . So that actually says about my age as well as the

		improvement we have made . So they definitely have come a long way away and no doubt . I was the [ROLE] for the trust before taking up the regional role . So . Locally in Chester to begin with , uh . I actually introduced the stroke care in in the right way , and just so to begin with , Chester didn't have anything . From there , we gone into one of the , you know highest performing stroke centers in the country in that way , so it was quite a lot of change happened locally to begin with . I think personally , I think , you know what I personally say , you know , I was most likely to be a catalyst rather than in a changing things . One thing I learned , if you want to make anything change , I mean , as a specialist , you've got the special knowledge , you know the detail , you know the nitty gritty what had needed changing another thing . But if you don't have a group of people around you who you can convince that this change is necessary without getting into too much detail of it , like an executive summary type of things then a change doesn't happen . So obviously , when I started in Chester what I started doing in a building , that kind of and I kind of did it quite unknowingly because just become a consultant didn't have any idea how to make a change , another thing , etc . So I started building that consensus amongst the colleague of mine in medicine , the cardiologist , radiologist and other people , and it started coming back that so it's in a different medical meeting , presenting cases , a little bit of success here and there , etc. And I managed to convince a clinical group and actually it was waiting to happen locally . And they found somebody who could actually take it forward . I think that's a , you know , on the corridor stopped by the radiologist said , You know , I have to come in I mean , this time they had to come in in the middle of the night to do this , you know , CT scan for head injuries and I know they can't do anything about it . Why don't you start the thrombolysis ? Another thing of the protocol, I'd be quite happy to come in and help you with that , another thing . And that kind of clinical consensus actually puts the improvement very quickly that way . And any change you do , I think what I learned , you know you can, you want it desperately because that's what you know , that's what you want to happen . But unless you actually develop that kind of a support team around you , you know , things doesn't change and that probably is true for any project you do locally , nationally or regionally and other things , unless all the cogs of the wheel working properly , it doesn't get delivered really that way . So , yeah , I think that that's a general thing . Two things local things like, clinically , when the snap came in , we thought we are delivering a great stroke service in Chester . And we joined the snap and we came back , we actually bottom of the table . Bottom of the league , you know ? So it was a big shock to the whole team thinking why we are doing so badly . You know , so we actually did a project in 2017 , 2016-2017 , which actually won the

		National Patient Safety Award in 2018 . We the HSJ so again , we formed a team . We sat down , we looked at , you know , what is the problem ? How do we do it ? It's a kind of a quality improvement project . And I actually was leading that project , but I actually put quite a lot of my own time in there . So one thing we realized that what happened in snap there publishing the results in a four to six months after what happened ? So if you do a change , you have to wait for four to six months to see whether the change made any difference in the score or not . So what we needed was an updated live database saying This is where we stand . We made a change . Is it making any difference on this particular area or not ? And SNAP is a very complex score . I think probably got 10 domains and probably three to seven subdomains in each domains anyway . So we started doing that . We picked up the quick wins . So I actually build and I have got no I.T. knowledge . So it's all , you know , 'Dr. Google' support . Uh , I built an Excel spreadsheet , which is probably very complex because it's actually built by an amateur who hasn't got any I.T. knowledge at all . But if you download the data from Snap , the current data pasted there , it will calculate your current score , you know , and it took me two or three months to build it. So , you know , in the evenings , I was working hard fixing one thing , another thing , etc . And then we started meeting up every week , you know , therapists , nurses , doctors and other things like representation . We picked up the things like which are the quick wins , which are the things we have to do in the short term and the mid-term and which is the most difficult one , we need the corporate involvement , another thing . So we identified those areas , we approached the people we needed to be there . We started correcting it and we started seeing the results from there . So within 14 months , we actually gone from the bottom of the pile to top of the pile . Just by doing that in stepwise fashion and each step , we improved a little bit there with marginal gains and sometimes this thing . But the corporate involvement was quite important , really . So we came up with these things . So middle grade , sorry middle management , top management involved and saying , you know , if you want to go from here to here , we need this . But that particular spreadsheet thing , the data analysis things was actually helpful to actually show them you know, 'If you want to go from there , I need this . Can you help me out with that ?' So were you going with the specific questions and specific answer there. So yeah , I think we've got huge help . So we actually . So that's the project . We had a huge success with it . We have a change up the management , the COVID time , everything falling apart . We've gone down to D again . So you restarted the project again , but I am helping them out because we've been through that and we managed to within four , three/four months . This time we've gone from D to B in . So

		we're going to the corporate now saying if you want to change it , we need to sort out these phases in a way , so it's because we have done it before, it's quite easy for us now to say we can do it again and we've got the confidence with because when you do it first time , you don't have the confidence that you know that that will work or not . So that's how this thing. Regionally , we have done quite a lot of work . We actually do it in a step wise , we identify people who needs to be there in the room . We invite people in there . So since become the [ROLE], we've gone to 24/7 for thrombectomy , which is probably we are the second or third centre outside London . Stoke and London was doing 24/7 and we had the third centre in Walton . But you know , we have to spend quite a lot of time with the guys in Walton to sort out another thing , etc. So we got 24/7 in October 2021 , so it's more than a year now . It's running . It's been a success . There is definitely some fragility in there . We had a huge problem in, still got a problem . So you need to go into the detail of it again , isn't it. So yes , running a service is fine , but is it producing the goods you expected to produce? And I still don't feel it is in a way . So we had a problem on case selections . People have a learning curve and other things that are four or five trust , different consultants , different personality . I kind of my approach . I try to identify the problem areas , try to meet them beforehand before we actually meet up as a group . So when you do the final meeting or discuss things , quite a lot of work goes on the background to say . This is our agreed pathway , our agreed policy . And I kind of identify people who might create trouble in the meeting to actually have an agreed part there . So we move ahead really , because otherwise we are just wasting time in the meeting , really fighting with each other and everybody becoming very defensive . So we had a problem with the case selections . Walton had lots of calls , unnecessary , etc. So we are putting a second opinion things there so that this is will be coming soon . Everybody agreed . So we do [inaudible] calls , but we probably have somebody dedicated second person who will take calls from other persons on that day , saying , Is this patient right for thrombectomy and thrombolysis ? Another thing because it's quite difficult area . Sometimes it can be very difficult and niche as well . So you're building that with neuroradiology , so everybody is trying to work together to sort out problems . And again , my role is a catalyst here . You know , I try to identify people who will be my friend there and will change it together at another thing , etc . Scanning is an issue the national's clinical in optimal stroke imaging pathway came up . So we in Chester , we do a lot of research because we are one, we were one of the eight hyperacute stroke research center in the country now that is one of the 13 now because it's expanded . So we do a lot of scanning , you know , like C.T. Perfusion . [inaudible] and other thing . Right from the

		beginning , from 2016 onwards , etc. But other trust in the region wasn't doing that . So we kind of built a program implementing C.T. perfusion was a big challenge . The people, particularly my stroke consultant colleagues are not very keen to read something completely new . So they asked for a training . I approached [name] from Glasgow because he is probably the best guy in C.T. perfusion in the country . So [name] did an online to our stations for us and the perfusion . We have got lots of perfusion scans there . I sat down with one of the neuroradiology colleague and one of the vascular neurology colleagues at Walton . We built a online training program , so we look at 20 cases . They are very challenging cases with their scans and other things . We built it online so people can go through the cases and other thing , etc . We got a four hour CPD from Royal College of Physicians , Edinburgh for that . It's actually , you know , who got a lot of positive feedback about that . So now we actually have implemented CTP across the region there , but it's practically asking people , what do they need from different levels in the radiologist , this thing , etc. So we did a couple of surveys before that as well on their requirements and other thing , etc . So , yeah , I think it's practically , you know , working with people on what they require . If it is logical in your mind , you actually then say , OK , I will fix it this way . If you think it's not a logical request , you actually go back to the people and say , You know , how do you ? What do you think this is? and other things. But , you know , my approach is , you know , I try to be more adult approach to actually talking to the people , giving them the feedback to try to see whether they can come up with anything rather than , you know , child adult relationship where I tell people , you go and do this and expect them to do it , really . I think adult relationships , you actually move forward faster and because you know you are trying to engage actively , the other part , or see they want to be engaged , but not really rather than this thing . So you've done that . We had done some work on the MRI part of it as well . So there's still a lot of things needs to do . You know , the TIA service we have got particular interest in identifying the etiology of the stroke , cryptogenic stroke , so you have got a system in Chester where if you haven't found the cause , we sit down together with the vascular neurologist or a radiologist . We discuss the case and come up with things . I want to extend it across the ICB in the other patches . So currently in discussion with other trust and other things . So yeah , if you try to pick up things , one thing I notice is that , you know , it's a . It's endless list of things you can change in a way.
I:	18:18	I was going to ask you about how you kind of choose them . So obviously you've talked about certain things have been identified by individuals within the trust , and obviously Snap was a key driver for a lot of your pathway changes if it . Do you ? Is there other evidence or

		information that you use to decide what are your targets or changes? Are there other things that help drive those changes , I suppose , is what I'm trying to…
P:	18:45	Well what we did actually we sat down together . Uh , we have got a little bit of things in at least all the junior doctors have to do the quality improvement project , then audit and other things . So each six months we come up with the Stroke Department Quality Improvement Project and programs together . [**I:** Wow] . So instead of each consultant saying , I'm going to check this, we have got a departmental program and the junior has to pick up , you know , they're allowed to pick up one of the many things going on , but they are not coming up on their own little project , which is not helping the department there . So it kind of made it corporate or , you know , helping the trust because trust is paying for the time for that in a way . We are working on a few things like , you know , we are working on a quality improvement project to develop a scale to support the decision making of stroke referrals , because the referrals to the stroke coordinator has gone up through the roof really. That will help ambulance video triage program , which I am also involved in the region to build it and other thing , which is another big program I'm currently involved in and it is totally in a mess and I'm not sure how whether I can actually deliver it or not with NWAS. Practically you know , neither fast nor rosier or any of the stroke scale are actually good enough to pick up the specificity of stroke , so there's lots of impurity picks up . So we are building a scale based on the probability of the stroke likely to be . And that's a quality improvement project there , the juniors are doing at the moment and practically , if the probability of the stroke is less than point 2 or a 20 percent chance , they shouldn't be referring to the coordinator . If the probabilities above point 6 or 60 percent , then yes , there should be referring to the nurses because they need to act to the scans and other thing , etc. That same thing true for the ambulances as well . And if the probability is sitting in the middle , it's a point 2 to point 6, they shouldn't be calling the nurses , they should be calling the consultant because there is lots of uncertainty in there in the data , in the patient's presentation . So . So we are building that scale . We want to make it regional and probably if he comes to national and other thing . But that will feed into the video triage project . So we are doing it in Chester and Whiston , and we are comparing the data and other thing , etc , will come up with that . But the whole idea is to develop that incorporate into a artificial intelligence based , some kind of app or something . So that will help with the video triage and also help who the call goes to as well , because what I notice the paramedics level of knowledge on stroke is quite variable . So if you… [**I:** *inaudible*]. Yeah, So if you cannot keep on training each of them for the whole region , it is quite difficult . You can

		actually do some training , basic training , etc . But it's probably an area you can actually use precision medicine , and AI and other stuff in there . So I'm working with some of my colleagues in Southampton , Nottingham and in Chester and Whiston together try to come up with a solution which will be built into delivering the hopefully the ambulance video triage project , as well as the referral to the coordinators and other things. Because everybody's got the same thing like my colleague in Southampton says our referral number going up to 3500 from 2000 in a year without any extra personnel or beds , you know , how do they expect me to manage and if we actually don't support it , yes , you all talk about the problem but if we don't try to find the solution for the problem , then we keep on talking about the problem without coming with it really so yeah , I think little thing here and there we are trying to build there . So in terms of choosing the project , yes , I think . When I was I became a consultant , I mean , these things never get taught in the medical school or in the training program and other things , etc. When you become a consultant , you probably you go above the threshold , clinical knowledge wise . But how do you manage project and other things ? It , they never get taught . So you get very enthusiastic about things and you take too many things on your plate and then you struggle . I think that's the thing I learned . So I try to now space it out . So , for example , the secondary prevention thing is I'm involved in the CBD prevention board and other things , etc , but probably putting it for the next year rather than this financial year, put it as 24-25 rather than 23-24 , or we actually proposed to them to get somebody in who can deliver the job, role and do that way if you want it now , because it would be quite difficult for me to deliver within my , you know , current workload and other thing , et cetera . So yeah , I think one thing I learned very well , it's better to be honest at the beginning and not take up the roles rather than take up too many and fail . I think that's the problem . Uh . In NHS , I think we put quite a lot of our own time into it , no doubt . I think I've got , you know . I must admit my partner , she doesn't mind me working over the weekend , sometimes another thing , etc. But , you know , so I'm quite lucky that way . But it's if you take up a project , it has to be delivered in a timely manner . That's the key there . And that's why the project planning at the beginning is quite important there , no doubt . Yeah . So so I think that's probably the things I can tell you.
I:	25:21	So you're talking about planning , and so do you have implementation plans for each of these projects ?
P:	25:29	Yes, I always write it down and get it agreed with the rest of the team saying , you know , these are the work packages . This is how you want to deliver . Are you happy with the time scale and the work packages , really. Because you knows practically I may be very enthusiastic about

		delivering something , but it's going to fail if the others are not on board so.
I:	25:52	Do you include service users in those targets setting or involved in any way?
P:	25:58	Not on the proper planning part of it , but when we used some of the things , you know , when he planned the project itself . Yes , we've got a very , you know , vocal PPI group of around 20 people who actually support some of the research project , which we are building on the back of some of the things etc, and also that this thing we actually [inaudible] point of view , we actually appointed those people after interviewing another thing , etc, with Stroke Association . They are very active group . Sometimes they come up with things , this thing on demanding things . So you have got a quite active patient partnership group there.
I:	26:52	Okay so they may come up with ideas for service change as well? (Yes, yes) Do they, can you think of a time where they've made a change in terms of your planning and things all that ? Are their goals difference to yours and do they make changes in what you do as a result of them being involved ?
P:	27:12	Well , from the clinical delivery point of view at the moment , we take it to them and take their opinion rather than take it . So , but from the research point of view , they are pretty actively yes , they change quite a lot of things there , no doubt. So at the moment , the clinical delivery but what you are suggesting , I think , you know , that gave me an idea . I think we have to move forward to actually see what they want from the clinical delivery point of view rather than taking it to them saying we are planning to do this or do you think in a way ? So that relationship probably need to develop and mature ?
I:	27:55	OK . That makes sense. And have you, have you considered any health inequalities when you're making these sorts of changes ?
P:	28:10	Yeah , so the cryptogenic stroke , or the secondary prevention thing is a very . Health inequality type of thing , because this huge inequality amongst the region . And that's what we actually told to ICB . The ambulance video triage project is also very health inequality , things in terms of service delivery . Say for example , if you are in Liverpool , they've taken you to Aintree . Then he needed somebody needed thrombectomy . They moved the trolley from Aintree to Walton . If on the other hand , somebody is in Chester , we have 40 minutes away from Walton . Even if we do things the same way , I cannot literally push the trolley to the INR and to do the thrombectomy there . And that's why we need that inequality sorted . And that's why the NWAS has to be very proactive in getting the people in another thing . So my dream success on that project is patient coming in . They tell me

		they're patient . They told me before the patient coming in . We do the scans and everything . If we need thrombolysis , we thrombolyse . The ambulance crew is waiting . We take put them on the ambulance . Go to Walton on the same ambulance within 20 minutes . So that's my target , dream success and the whole thing . At the moment , it's taking between one hour to an hour and 20 minutes on an average to do that job . So I want to cut it down to 20 minutes so they know, that is their target may not be able to achieve it straightaway . But if you don't do that , it's a inequality between , say , Chester and Liverpool in terms of this thing . So yeah , I think these are the things we actually putting through the healthcare inequality part of the ICB . I'm also obviously my colleagues in the therapist also working quite a lot on the health inequality of ICSS program . There is a huge inequalities in terms of this therapy service provided across the patch . I actually support them rather than directly involved on the ICSS programme as this thing , etc. We are trying to get some of the . I know technologies and other things with my other hat on with because there in stroke , there are lots of . Small and medium sized companies who has got a product for stroke , rehab or something , but they don't have the funding actually to test it out properly or they don't have the , you know , the manpower and they don't know how to do it either . So I actually kind of a building a program for their nature , for the SMEs to support that , which will support some of the inequalities in the therapy side of things like , you know , there is quite a lot of speech therapy program there on iPad , another thing , etc. I work very closely with another company which is developing the VR based cognitive rehab and other thing . So . So we are building it in the region . And this thing to support those as a research program and this thing . So I actually support them for the application , get the CTU and other people in . You know , to do that , PPI group is very actively involved . But some of it , you cannot keep on going to the ICB saying we need extra funding because there is no money anywhere . So you need to save somewhere to get the money in a way . And so , yeah , we try to do it separately , but there is huge inequalities among the therapy services as well in the stroke . The problem is hopefully [name] told me there is a lot there in the new stroke guideline coming up on 4th of April . So I'm looking forward to read that document what they're coming up from RCP and Snap . But the problem with the therapist is that . Is quite difficult to define what is ideal . Then what is minimum service for therapy ? And I don't know about your background , if you ever go to therapy background , you probably know it very well . Say , for example , upper limb therapy . What is the normal upper limb therapy ? How much time you give ? Do you use the mirror therapy ? Do you use the constrained based therapy as a normal therapy ? Do you use the bullbut[?], this other technique ?

		What is normal and there is no consensus , I think , amongst the therapy team say . So this is just an example of this .
I:	33:35	So it's harder to implement a change .(That's right). When there isn't the evidence or consensus around what's the best thing we should be doing . It's much easier when you've got something like thrombectomy . We know they have . (Yeah) okay . I know that's fine . And can I just ask , have you ever done any piloting of any of the changes before rolling out ?
P:	33:56	Piloting things, I think the snap things we are rebuilding it. So what we have done , and it's actually with the . You know , the [name] ARC thing , etc. So we actually nearly finished building on the power bi platform from Excel . But you can actually . You can actually question the data . A lot of different ways , just clicking some box sets there . So for example , you know , if you are having a problem getting into stroke unit , if this thing is it a problem on a particular day of the week on Saturdays because the trust is extremely busy and that doesn't happen . So do you actually need to focus on a particular area something ? So the plan is to roll it out in the region. And I've spoken to my colleagues and other things , so we probably just roll it out , but the whole thing is from there . We are building a screen for the region . A performance there in that way , which will be completely anonymized and other thing . So that would be our dashboard for the ISDN that way . So it's not only Snap , it may be other data as a little bit from the snap and other thing . So we are building the snap part of it as a part of a carrot to get the big data . And that's where [name] support from ARC came in . And are a couple of people from Liverpool University are quite interested in the big data part of it. So we will . We have a live feedback on the big data on certain things we feel is important for the region there . So yeah , we are building that as a pilot things that way.
I:	35:58	Okay, and you making, I presume you're making changes as you go in your testing . (Yes) . So interestingly , you talked about almost using the Snap data as the carrot to get all the people involved , that's another way that you involve people is kind of, entice them and something that will . (Yeah) OK , that's fine .
P:	36:18	Yeah , unless people see it's benefiting them , there is no way people will be involved . I'm pretty certain about it .
I:	36:25	I'm not sure a catalyst like you .
P:	36:27	Yeah , we need a catalyst here . And I always try to be that catalyst and try to identify what will excite people .
I:	36:36	It was going to go back to that, it's interesting . So you obviously are a massive catalyst . Do you think these things would move forward if you weren't there to drive them ?

P:	36:46	Well , if I'm not there , somebody else will do it anyway , isn't it ? So . I'm sure there were . So what I've started doing now since I became 50 , I started to try to find people who would be I can develop to take up the things from, succession planning in a way because , you know , the things needs to move on , really . And I have got a few people , you know , like [name] from Aintree , one of a new consultant . They are coming up very well . So we kind of , so what I'm trying to do is to give some of them , some of the program saying to you to test this out and see how it goes , etc. So this is not an empire , really . I don't look at it as an empire . I just look at it , each individual project and have we successfully delivered it in some way or fashion or not ? It's not my project , it's the whole team's project , and I'm part of it , you know ? And you know , it's my role really so . And so I never try to build an empire that way . And if you try to build an empire , then you create a conflict there no doubt so .
I:	38:06	I'm sorry , and costs are at the root of all evil and money , but how do you consider costs in terms of making these changes ? What are your processes or considerations ?
P:	38:20	Well , I mean . I think it's probably how I personally look at my personal finance as well . You know , I actually look at the NHS . I mean , the reason actually , I mean , I'm originally from India and I stayed back in the UK was practically NHS because I didn't want to do business with health care . So practically the NHS money , I personally think it's actually my money as well . I pay probably not went , you know , naught naught naught naught so many , naught one percent of that money . I contribute . So yeah , I think , you know , value for money is always the important part there . Personally , when I take a business plan and one thing I learned as a part of my initial role as a consultant is is the business plan for NHS . And I probably got it somewhere in the archives . I probably know from going from no stroke service to these . I probably done more than 50 business plan written for , you know , for the trust , another thing , etc . So I kind of get very good at it as they keep doing it . But one thing I know . It's much better to take , I mean , that's what the business plan is , isn't it , you take certain options , but do you know the options you are providing is the best options to you and you try to project it to the others you want to convince this is the best option there . And that's where I think the finance things comes in really know the cost and other things . So practically you just say if you do , nothing is costing you more than you do something that way . And that's one of the technique I use quite often in terms of try to convince people at the top . Who has got power and control over the money.
I:	40:22	Excellent . Okay . And we've talked about so much joint if I've got any , and I might nip back to some of them in a bit because you've talked about quite a lot of it already . And can you overall tell me what you

		think ? What was what you think was helpful in terms of making changes like these ?
P:	40:42	I think it's the key there is the engagement of different people , and because it's such a complex, you know change is always complex and there are certain effects , known effect , but you need to be ready for unknown effect as well . Quite a lot actually depends on the personality of the people you're working with . Do they like change ? Do they don't like change ? If they don't like change , how do you convince about the changes , another thing , etc ? I personally think each of my colleagues are an asset to the NHS rather than the way saying , you know , they're the troublemaker . But I faced few troublemakers as well . I people usually don't call people troublemaker unless , you know , I reach a certain stage . The problem is , if there is one bad Apple , which is spoiling the whole thing in a how do you actually manage that part ? It's quite difficult in NHS to . Even in the UK , probably in terms of moving people , if they're not happy with their job and other thing etc or even , you know , had a private concern , they would have sacked that person long time ago and the NHS is very difficult to go through that as well . But yeah , I think it is quite a lot of it's actually non-verbal , quite a lot of background work . You probably develop a kind of ability to assess the personality of the people you are working with . Can you work with them and other thing , etc. So it's quite complex process in my mind , really . And . I think it's quite a lot of psychometric work should have been done at the beginning in terms of forming the team and other thing , etc , to match up people according to their psychometric profile . To move forward rather than . You know , this is my default role . I mean . So , for example , you know , I've been a doctor for so many years now , is great . And it's a long job . In a long period of time , long span job , really , if my psychometric profile didn't fit into it , I shouldn't be doing this really , so I should be enjoy doing it rather than , you know , I do it as a part of my job . You understand what I mean in the way…
I:	43:28	Yeah yeah, you know , it's about getting the right people that have got that mindset to do this.
P:	43:31	Yeah , and there is, a lot of precision technique should have come in and will come in in the future with the AI and other thing , etc , to do this because you know what you want for a success for any project a group of people , as I said , all the cogs working together as a whole.
I:	43:53	Yes , I know about that whole team relationship being for you that most important thing to be able to implement change .
P:	44:02	Yes, but that should have been . I mean , we do it all the time . When you talk to the people , we are doing lots of non-verbal assessment , lots of body language and other thing . We are probably doing it in

		subconsciously . But I think it should be done at the beginning . For any project to be successful , for any research project or this thing and that one thing I don't know , I probably wouldn't be , but I'd be quite interested to work on it when I retire as a consultancy project .
I:	44:33	I see you've already got that planned , oh my word. And can you think of any of the facilitators or barriers to implementing change that you've come across other than people or relationships ?
P:	44:47	I think it's quite a huge percentage of the people , so , if you are interested , people go out of their way to find the way to be successful anyway . Obviously , the UK's biggest problem which is a problem the official line of Brexit as well . But there are the processes . So my, and this is something I talk to people all the time as well . If your process is taking longer than the actual project itself , then you are inefficient . And the productivity and other things in the UK , particularly in NHS , is so low . Part of it is the process itself really ? No doubt . And that is a barrier for any success , really . Some of the things you need to exist for research and other things you need the regulatory body , you need the MHRA and other thing , etc. But say , for example , this SMEs I am working with . They have to pay to fill in 80 pages form for MHRA . Another 100 pages form [inaudible] And this thing for the FDA and other thing , etc. So why do we have so many duplication of processes there ? And that's the bit . I think as a society we need to ask . But that's the biggest one of the biggest period of productivity in the UK you know unnecessary processes . So people who are actually the regulator , they should all look into their processes to see is it necessary to go through each steps or can they cut out the steps ?
I:	46:40	To streamline and (streamline the whole thing , yeah , yeah) okay , that's fine . And can you tell me about ways that you track progress ? How do you how do you record or track progress in any way ?
P:	46:56	Well , the should be a project plan there and can you actually deliver to the project plan , if not , why not ? And this thing , I think . Personally , I am more of more of a facilitator and innovator rather than governance person , so I tried some of the governance role and I don't like it at all , really , you know , like , you know . Governing things , delivering things , etc, individual project is easy because you've got a proper plan , gant chart type of things , etc. , you're trying to deliver accordingly and you've got monitors coming in , etc. if you have a funding from external bodies . So I try to do that way for the project and I actually try to do it on each project . And actually , you know , you have to be very honest with each other saying , you know , if we are not going according to track , do you actually park it there ? That should be an option rather than trying to struggle to deliver in a way . I think that's one thing we learned quite a bit from the COVID crisis that way , saying , you know , is it necessary ? Do you park it there?

I:	48:22	OK . So , yeah , it's not about always things improving , because sometimes there are things that you I will say it , I'm interested in changes and how they have sustained . I think you've got a brilliant example with the Snap database . So there was organizational change , in it, but because you'd got that, because you'd built that way of measuring it, you could come back to it . So for you , that piece of tech was a way of ensuring that embedded in practice and when things changed , you could readdress it . (Yeah). Are there other examples of things that you do to make sure things are embedded and sustained?
P:	49:00	Well , we are building a , you know , one of the things with the thrombectomy part of it as well about the outcome . So yeah , I mean , we have got a service , but is it actually providing the necessary outcome to the patients and other things ? So there is lots of there's another little project of trying to build with the Walton Center and there's lots of area in the Walton Center still , there is to build that sustainability , right cases and other things . So basically , what we're trying to do is to measure the ranking at three months . Of these people has been to the thrombectomy , you know , so practically that's the bottom line . And that probably will probably giving the sustainability for the thrombectomy service , really , because if we don't control it ourselves , I'm pretty certain the [inaudible] team will come up with some of the data and that's what happened quite recently . [Name] did a visit for the northwest thrombectomy . They presented a data showing that the Walton Center has got a high mortality rate from thrombectomy higher than expected nationally or something like that . They didn't realize what they did so there we have a thrombectomy process , so we have got a thrombectomy MDT . We meet every six weeks . We discuss cases , refused cases as well as the new cases in other cases they have done if we need to discuss . On that MDT after the [inaudible] visit . So we have got something like two to one or two point five to one thrombectomy versus decline cases . Suddenly , it becomes one to one . So the decline cases number suddenly going up , you know , hugely , and it's actually the knee jerk reaction from Walton and saying , well , if the mortality is high , yeah , yeah , I should be choosing cases more carefully , another thing , etc . So yeah , I think sometimes the external factors , if you will , build something and sustainability become a problem . So you need to plan for it . So you're building that thing . So if you have a regional database and the regional listing with this , then we can go back and tell them how you're performing , really . So these are the sustainability thing we're trying to put in in terms of delivering the service rather than somebody come up with something , maybe national team and you get a knee jerk reaction . So it's a learning from it and working from there .

I:	51:44	Okay so you said a lot about support , about organizational support that you've received and built in those relationships , so there's everyone's supportive and you do a lot of work around that . Is there is the support that you would like to receive that is harder to elicit or you don't receive that would be useful? I'm just trying to, it sounds like you do a lot of work in that anyway but…
P:	52:08	Yeah , I think it's the background and other things . So I think last thing I even before talking about any project or anything . I try to assess in my mind , is it something deliverable or sustainable or not with the group of people I need to work with ? And these are the things before even talking to them . Then I try to individually interact with them , you know , either by email or some little bit of chat or something like that . And I'm not worried about it . It could be something I need to speak to the chief executive or , you know , somebody , you know , the chief operating officer of ICB, because there's no point putting it out and then making people frustrated if you don't involve these kind of people at the beginning , really . And I'm not worried about emailing them and other things , so they all know me that way . And you know , they are very honest with me saying , you know this , it doesn't look like going anywhere . Don't do it fine . You know , I'm quite happy to do that . And I'm always that kind of kind of personality in that way . So for example , when I was looking for a consulting job , I actually sent my CV to few of the chief executive of different trust . I wanted to work . You know , one of them is in Preston , one of the main Aintree and Stoke and other thing I didn't send it to Chester chief executive so that was a default for the same position I ended up in anyway afterwards for some circumstantial thing , but I actually sent my CV to that chief executive six months before I was becoming eligible for consulting , saying I will be this thing . This is my CV . I'd like to work in the institution . Would you be interested in me or something like that ? And I had reply from them , quite a lot of them saying , You know , this is very unique because they can , and I really appreciated your honesty and other thing , etc . But we don't have a post now or something like that in a way . So they do respond to it in that way . So , yeah , I I always yeah .
I:	54:19	Personal relationships as well as team relationships . That's the idea .
P:	54:24	That's right yeah . I mean , without that , it wouldn't work .
I:	54:26	OK , so it is for you as you as the catalyst in that, somebody overseeing and being that driver and engager, that is key to the success of the projects for you . OK , yeah . Do you give, I know the answer to this because you've said you have regular meetings and stuff with project teams , but do you give that feedback or are you asked for feedback on the change processes by anybody ?

P:	54:50	We do, yeah , yeah . Simple things like we do quite a lot of I mean , since I've taken up the regional role , I do quite regular surveys and other things with my colleagues to see what's coming out like that . I think the [inaudible] we installed for the C.T. perfusion , to get the C.T. perfusion on the things we have done two different surveys with bigger group radiologist , stroke consultant, and I think I've headed back to the companies as well , saying this is how things are with your product . So , yeah , I tend to do more, very, in a straightforward face to face feedback and other things , and see people's opinion rather than talking about it behind people's back , I think I had doing that anyway . You know , the gossip part , I tried not to, try to avoid that , and that's fine .
I:	55:47	Well , it kind of fits in with everything else that you think is important in terms of engagement and ensuring that people are on board . And so if you obviously think that has an impact in terms of implementing change. Million dollar question , if you could do things differently in any way , what would you do with it ? Or would you not ?
P:	56:09	No , no , I'm I'm quite happy the way I am , you know , I was trying to get into a University hospital as a consultant , but ended up in Chester because , you know , this circumstantial reasons , really . So I went for an interview , didn't get the job , didn't go to the other interview because of the other things that said about it anyway . So initially , when I became a consultant , I actually put a target and it's always me saying in five years down the line , if I don't go from this point A to point B , I'm going to look for a new job at that point . In that way , but I actually spoken to my clinical director before taking up the job , saying , This is my intention . What do you think ? And he said , Yeah , that sounds quite good one .
I:	56:57	But from an implementation of change perspective , not from a personal perspective . Is there anything that you'd do differently ?
P:	57:06	Yeah , there's no point . I mean , I , as I said , I try to take it more and I don't take things with my heart and [inaudible] that kind of personality saying , Well , if I don't do that fine , we'll have a mutually agreed divorce in a way . That's how I am as a personality anyway . So I don't take anything personally or by hard get upset or anything like that . And , you know , it did work really because my legal director helped me hugely with getting from A to B and other thing , etc . But , you know , even before taking the job , I actually told him , you know , this is what my plans are, what do you think? And I'm always thought…
I:	57:52	It is that the belief in making things better ? (Yeah , yeah) . Early on for you was like identifying where the gaps are and where things were missing and not right , and that for you was key and making changes to address those . OK . And that's fine . Is there anything that we haven't

		discussed that you'd like to mention in terms of implementation of change , anything to do with organizational factors, training ?
P:	58:20	I think the training part comes in later on any of the changes . No doubt if you don't put the right training in , then change becomes very difficult . So any change you need to have a whole package on training there , no doubt , as we discussed about the C.T. perfusion and other thing , etc etc. As I said before , personally , I think . It should have been . You know , we shouldn't end up by default to do things , really . And that's the bit , I think the people at the bigger post , another thing needs to see . And we should get a lot of psychometric things in there . I mean , I have seen it happening because , you know , I have involved in a . You know , I was doing a disciplinary to somebody for the trust . They asked me to do that and I would never do it again because it's such a stressful thing . But when I got into the detail and that person , you know , I saw the behavioral problem , which was the disciplinary all about of that particular person . You go back . I actually went back all the way since that person become the consultant in that way . And I had taken out all the feedbacks and other things that person had as a trainee , at the trust and other thing . And the point we actually identified 10 years down the line , or 12 years down the line was identified 12 years ago by different people giving feedback, the only thing we didn't have that data when there was a person was appointed . So I recommended to the trust and it actually they followed it, that when you actually doing the interview and employing somebody instead of asking for references , you asked for their feedback from before , so you'll know about the person before . So that's what came out of the disciplinary process , you know , couldn't do anything other than that know , change the person because it's actually imprinted in that person's personality , and it's very difficult to change that they can temporarily change . And I think we should introduce a lot of psychometric things in that kind of team structure . Otherwise , you know , you are actually working in the dark , a bit of it and that dark it should go . As I said when I retire that will be my consultancy process .
I:	01:00:50	Yeah , no . I look , I look forward to it . And I'm very aware of the time I was going to ask you a little bit more about whether any particular networks that you felt were beneficial in terms of change?
P:	01:01:06	Well the ISDN definitely changed a lot . I think the CRN part of it from the research point of view the NIHR definitely made a change in terms of research delivery , no doubt . I think ARC is doing some of the things quite important , but again , it's practically . Everybody thinks they are part of it , really . How do you actually join up this network ? So one thing I try to do with my two hat’s on in the [role] and [role] . I actually got the two institution joined up with a lot like , you know , we actually have a joint newsletter and other thing etc which improve the research

		interest and everything there , no doubt . I think we need to think about how we join up all this institution together because there is a common interest between them and that hasn't been implemented fully yet.
I:	01:02:09	So we need to harness that commonality . (Yeah) . OK , that's fine . I'm very aware that you will have something [name], so thank you very much taking part . I need to check , are you happy to be contacted if there's any need for follow ups ? (Yeah sure no worries) and there's a potential to take part in a focus group to help inform the logic model . Obviously , there's no obligation, saying that you're happy to be followed up doesn't mean that we expect you to take part , but is it all right for you when we get to this point?
P:	01:02:38	Yes, I'm quite happy to help yeah .
I:	01:02:40	And are you happy for me to do that by email ? (Yeah) And then the only other really quick question I've got is if there's anyone else you'd suggest that you think we should be speaking to in terms of this .
P:	01:02:51	Well , I think speak to a [inaudible] [NAME] in [PLACE] , I think he's coming up as a rising star in the region . You can speak to my colleagues in the ISDN [NAME] as well , he has done quite a bit as well . But it's probably not the colleagues , you know , probably maybe you are thinking about some of the , you know , the unspoken people like the therapy type of lead and other thing , etc . So there is a lady called [NAME] fom Witham from Warrington she is a [ROLE] . She has done quite a lot for the region as well . So if you want to speak to Ruth who seems quite helpful . I don't know whether the patients group we want to speak to as well . So there is a chap called [NAME] [inaudible] . He's a rising star for the PPI group, he did help with lots of research and other things . If you want , I can email him asking his permission for you to contact him . If you want to , I can send it .
I:	01:04:00	Well , I'll come back to you, so I'm I've got kind of my first raft of interviews and I'm asking people and then obviously we've got a limitation on the amount we can do . So I think I'll be running it past people as to who they want me, who is coming in the second half , but I will come back to you . That's very kind of you . Thank you very much . OK . And I'm extremely grateful for your time . (Okay) . There's a lot in there and keep being a catalyst . It's been amazing . I could have spoken to you all day .
P:	01:04:28	[Laughter] I don't know . That's how I pretend to be . I'm not a catalyst or not . I don't know if that’s others.
I:	01:04:31	It sounds like it, sounds like within the stuff that you've been , you've been very much a key driver in terms of driving this forward . So , yeah , thank you very much .
P:	01:04:41	All right . Take care . Bye .