Participant 3 11.05.23.mp3

Interviewer (I):	00:06	So just for the purposes of the audio , can I just confirm that you're happy to go ahead and be recorded for the purposes of this interview ? Brilliant . OK . So can you tell me about your current role ? It says within your organization , but I know that's more complicated .
Participant (P):	00:24	Yeah . So I have a [ROLE] between[ORG] and [ORG]. So I'm notionally 50 percent [ORG], 50 percent [ORG] And my role , I guess sometimes it overlaps . Sometimes it's got separate elements to it . So the bits that I think are relevant to stroke care are my research around stroke rehabilitation and within the trust I am responsible for supporting predominantly [ROLES] , but it is wider than that in terms of [ROLES] more generally . wider than [ROLES] wider than just ELHT to increase their research capacity and capability . So helping people with sort of the clinical academic journeys and getting funding themselves and doing projects within the team to support them .
I:	01:26	Brilliant . So can you discuss any stroke care intervention that you're aware of that's been made or currently been made ? So I know you've been involved in several , so I don't know if you want to pick one or talk about a couple or…
P:	01:42	I mean , the obvious ones to talk about is NROL, neuro rehab on line , because that's been very much trying to do that at a systems level . [**I:** Yeah]. So it's an example of an intervention . So it was delivering neuro rehab online in addition to face to face care that that was instigated through COVID initially and some funding , whereas the pilot project happened at UCL in London . But it was a standalone service so not as part of NHS rehab . And it was also back in the lockdown when face to face wasn't possible , but it had good outcomes . It had good feedback from both patients and staff and so it was felt to be a good initiative . And because of my clinical academic role , I secured funding with them to see if this was something that we could deliver in the NHS . So that was with the same charity and we did manage to instigate and set that up to deliver that within one trust and initially so within my trusty ELHT . And then because it went well and because we're thinking about things that systems level , we then looked at how we might deliver that across the integrated stroke and neuro delivery networks across Lancs and South Cumbria . So we have now been doing that for a year across the four other trusts involved in community delivery of neuro rehab .
I:	03:03	Excellent . So you've been involved throughout . Can you tell me about your role within those changes ? And so give an idea of time dedicated and…
P:	03:18	So I guess I call myself the project lead , but I have other project leads within the trust , for example , who are fully embedded within the trust and within all the strategies and senior management groups and

		steering groups and the like who sort of need . know all stakeholders more because I think it is really important and we've really been conscious to involve all the trusts and also the commissioners right back from the beginning , because our kind of the whole point of it , is this something that we can carry on and we didn't want it to just be a small scale , short term project , then fizzle out . So we've been trying to work from the beginning to find out who we need to speak to and what information and data they need to be able to commission the service . So my roles really are kind of to navigate all the different people and keep them together , trying to speak the different languages of the clinical staff , the management staff , the commissioners , the academic , you know , meanwhile , doing evaluations that's robust enough to be published and to create an impact case study , so it ticks the academic boxes as well . So I guess I'm the kind of instigator of it , but also then the person who sits between both camps and sort of has awareness and oversight from that level . So I know what's going on the ground , I know the patients that are in and all the staff delivering the services and where the staffing challenges , et cetera . But I also know the wider landscape and how I can then pitch this if you like to commissioners . So it fits the strategy and we're more likely to get funding for it to carry on and have secured the funding so far . So we have got more funding now from NHS Catalyst monies , and we've currently got four new NHS positions that have started for a 12 month contract with the hope that we can do that until we get the commission sign off for long term future .
I:	05:15	Brilliant . So you talked about a little bit . Is there any more you want to tell about the development process of the intervention change ? I know you said it developed within COVID. Was it…
P:	05:29	It was kind of put to me as an idea . And then I brought it to our first of all to the clinical lead and discussed it with her to see if it fit within the objectives . Because I guess within my role to increase research capacity and capability of staff , that doesn't feel very tangible unless there's a specific project . So I think nobody on the ground argues that they know they should be doing more research or more research savvy . But how to do that is the challenging thing . So this felt like a project that would fit because it was something that was new . It was a way of trying to increase intensity . It was a way of looking at things differently . But it was tangible from that point of view , but we could also look at the data side of it . And from a strategy point of view , when I spoke to the people within ELHT and wider like [*name – Clinical lead L&SC ISNDN*] and the strategy people , if you like people across the ISNDN the fact that it involved the digital aspect , it looked at the workforce aspect, it looks at community of practice and shared learning across the trust and also a consistency across the system , which I know is another

		thing . So it kind of ticked lots of boxes . And so it seemed like too good an opportunity to not try and pursue . So , yeah , it's just kind of snowballed from there , really
I:	06:51	Excellent , and where did the idea come from originally ? Was it evidence led in terms of …
P:	06:57	Well , there is systematic review level evidence that tele rehab isn't inferior to the face-to-face . And as we on all things change really rapidly in COVID . And so that's kind of where the proof of concept , if you like , was able to happen because of the bureaucracy and the systems that make it challenging . Some of those were easier to get through than they are normally sort of . We were able to get approvals for use of teams , for example , for consultations . And so we have lots of things that we were able to do because of COVID . But then we had to adapt the intervention . So we went through sort of a... We used the MRC framework to underpin what we were doing . And that involves getting all stakeholders together , trying to put a logic model together about what we thought NROL was bring it back with the UCL people who delivered it to say , Is this what you think it is ? Because they said , here have the intervention , but actually we have very little detail of what that was . If that makes sense . And I think it was often the people say , “Oh this worked for us , you do it” . And then you think , But what is it ? What did you do and how does that fit in our context ? And within the , you know , ours was very clearly embedded within an NHS system . So within existing stroke and neuro rehab . So how does that then fit ? What are the processes in the systems that you need to do ? So we had quite a few . So working group meetings and we have regular weekly working group meetings now where we're constantly reviewing how the intervention is going and what the content is and modifying that . And in addition , we also have public advisers on that and a patient volunteer . So we're very keen that it comes from working with patients to say , is this something that you think is helpful ? And if it isn't , let's change it . So it's kind of how you deal with that uncertainty and that sort of ever evolving thing makes it challenging from a delivery and an evaluation point of view . But I think the important bit to make sure that your intervention fits and continues to fit . If that makes sense .
I:	09:11	Yeah , yeah , so this one was almost completely new . Have you been involved in other interventions ? How do you choose which interventions you take forward I suppose is what I’m asking.
P:	09:24	Well , there's different ways that happens , and sometimes it very much comes from the staff like they have various working groups or areas that they're working on . So , for example , within ELHT we have been thinking about what we do for the upper limb . Clearly , my research area has done quite a lot around upper limb rehab , so I feel like I could

		be in quite a good place to support them on that . And so then they have themselves chosen areas that they want to focus on . So some of those are around specific interventions , and some of those are around things like outcome measures . So it has come from them . But I do try and steer that to a degree because it has to be manageable . And you know , we can't take on too much at once . So we do sort of have discussions around where we focusing now . But I feel it should come from them telling me , not me telling them , [**I:** OK] . And I have to say that's not all gone very swimmingly . You know , I've been trying to get to look at outcome measure use , for example , since for three years now , and is it done regularly and consistently ? No . Have I done training sessions ? Have I bought our out kits ? How you know , but you know the challenges of the time available , it's just it is an uphill struggle . So not everything happens . And I feel a fraud sometimes when I'm talking about those things , like in research conferences and I know full well that my team aren't doing it regularly despite all the help I give them , if that makes sense .
I:	11:04	Yeah , no , no , it's fine . So it's you struggling with getting the outcome evidence to support the intervention ? [**P:** Yeah] . Yeah . But you're doing a lot of work . How often did you say you were meeting?
P:	11:17	For the working group ? That meets weekly . Well I mean , I have stepped back because that's a lot of it . Now we've got the staff . But , you know , during transition points , then I try and get to those more regularly
I:	11:34	And is that across all five trusts ? Those working groups .
P:	11:37	Yeah , yeah . And then we have champions meetings on top , which each trust has a nominated champion or two .
I:	11:46	What are they championing ?
P:	11:48	Well , they need to know more about the processes and their referrals and so that the wider team know what an NROL is so they can refer into it . And so they kind of they are the point of contact if we're struggling with anything but also to know what's happening so they can feedback to the teams because I guess as it gets bigger . That's the challenge . So we've got about 70 therapists who've been involved in delivering NROL now . So it's quite a lot of people so trying to just manage that and the communication aspects of that are a challenge . So that's why we've got our most nominated champions who are , you know , keen on NROL , know what it is and also have the contacts within the team to share it wider and do their own , sort of , I don't want to call it marketing , but you need to …
I:	12:35	It sounds a bit like advertising? [**P:** Yeah , yeah] . Just to make sure people know it's there . Yeah , I know what you mean . And you said nominated . How did you go about choosing your champions ?

P:	12:45	Well , some of them were kind of almost obvious as in they were ones who were showing interest from the beginning and then otherwise , we've sort of worked with the groups and asked them to nominate , and some have changed over time . Some staff have left . And all the teams are all set up slightly different in different trusts . So some are stroke and neuro . Some are supposed to be together , but are very separate . Some are on different hospital sites . So we kind of . So , for example , we've got somebody at Furness General , and we've got somebody at Lancaster because they actually don't know each other . So some of it is this this by itself is help teams within teams to know each other , and the same with ELHT . Stroke vaguely knew who neuro was , but they didn't know really who they were other than maybe an occasional meeting , but by delivering sessions and having these regular contacts , we've definitely seen . Sort of bonding from that point of view and not . I'll give you an example of our fatigue group , for example , which is one of our most popular groups and it's always full . And then we had when [ORG], came on board . There's an [ROLE] who's got a must see that specially focused on fatigue . So then she fed into the content and shared , and then she's been doing sort of discussions with the team to develop the content . So it's a really good way that then it organically , if you like , has become a vehicle for staff to get to know each other and to share best practice .
I:	14:18	It's been much larger than the intervention . [**P:** Yeah , yeah , yeah , yeah] . Moving to how complicated was the intervention or change . It sounds really complicated and continues to be complex .
P:	14:30	Yeah , but I suppose I think of NROL as the delivery method and the sort of bit higher level and the actual content I can’t influence all at once , all the groups are running with staff that are changing . So I kind of have to leave that in my mind they would be delivering face to face therapy and I don't always know what that is . So if the delivering group therapy , it's exactly the same , but there is an opportunity to share more easily by the fact that it's online , by the fact that it's groups and the fact that we can observe each other's practice . I mean , you would , you know , occasionally people do visits to other stroke rehab unit or what have you , but you wouldn't do a… Well , it's very rare that you'd spend a day doing community visits with people , and it's , you know , it be a one off thing where with this you can dip in and out and watch a group session . And then in a nice way of saying , Well , oh you did more sensory stuff in that upper limb than I expected . We don't really do that . Why did you do that ? So it's kind of , you know , in a supportive way . I hope .
I:	15:34	Excellent . We will come on more to feedback on what staff think of it . Well , can you tell me what you found ? The support that has been available , what's helped you ?

P:	15:48	And the connections between trusts and the network that was already there , so the ISDN was already there , and I think Lancs in south Cumbria is probably advanced compared to many other regions in the UK so my sort of discussions in that it's a small world , relatively . Lots of people already know each other . There was already like a stroke rehab steering group set up within that . There was already those connections there . So that helped . Ironically , the fact that we've become more online and went on to teams has helped . When I first started , I remember within the NHS , I remember saying as I'd gone from Pendle to Blackburn to go to a meeting which , you know , took me all afternoon , couldn't find anywhere to park , everyone else was the same coming over . I was like , Do we not do online meetings ? Because this feels like a lot of time . And oh no , no , no . But obviously now we do , so it is much easier . We would never have been able to do the regional , probably even the local , but definitely the regional level that we've done without the help of online communication and meetings because we can connect and it's a lot more flexible , and realistic to expect people . You would never do a weekly meeting from somebody from Furness , Morecambe , Blackpool , Preston , Burnley . It's , you know , it's been a real enabler .
I:	17:24	Excellent . So we've kind of talked a bit about this already , but . I was going to start with this , so obviously you were . Can you discuss the steps that you undertook to train and inform staff ? Across well within and across the organizations in the changes.
P:	17:51	Yeah , so I guess we've got a few key people myself is one , but [*name*] was the other who's in the steering group and also the some of the most strategic level meetings with . She's got a relationship with the commissioners . So I guess firstly , all of us knowing what was going on and the opportunities and then having the opportunity to influence/share the information that we've collected , but also check the information collected is what we need . If that makes sense . So I think having visibility at that high level and getting the buy in and we have then have sort of in effect a memorandum of understanding , which is being trying to be formalized between the different trusts to get buy in at that level .
I:	18:43	OK . And is that at a strategic level or is the memorandum cover ?
P:	18:49	Yeah , that's at the sort of therapy directorate level for each of the trusts . But then each of those have also then had discussion with the NROL champions and with the wider team in the first instance to say , Is this something that you want to be involved with because you can't really , you need the buy in from people . But we have to be flexible with that with staffing , you know ? You know , there's been a mass exodus of SLT's in one trust , for example , just the way these things seem to happen . So they've said , sorry , we have to step back from

		delivering the speech groups . So we tried to be flexible and accommodate for that . And other trusts say , well , we'll do this , but you can come back in six weeks , eight weeks or whatever it might be . So I guess we've got that kind of with trying to be supportive to each other and because if you were to tell every trust was in a perfect position and every team , you would never run it because there is never such thing as a perfect time . There is always staff leaving . There is always staff sickness . And obviously , we've had various waves of COVID . We've had industrial action . You know , there's all sorts of things that have influenced the actual delivery of it . And so I think the other thing we've tried to do with that is keep highlighting the fact that this has been a trial and we're allowed for things to go wrong and give people that permission to try things and see if we can make it work , rather than sort of think people get too scared to even try . Because unless it's perfect , they won't try it , if that makes sense . Just the culture , I guess , around being supportive , dealing with uncertainty because we don't always know what's going to happen and having each other's back . So if something is to happen within staffing or what have you , you know , we have random things like five alarms go off within a section or , you know , there was an IT upgrade this week and all of a sudden ELHT teams weren't working . And you know , so I guess these are the things that happen . But . Because there's the different people in different locations and different organizations , people have helped each other out , which is really nice to see . And it's got to the stage now where people help each other out without us doing it . They do it themselves . If that makes sense .
I:	21:11	Yeah , yeah , it does . I'm going to ask a really silly question , so do the group's run and any… Do the organizations run groups for their own patients , or are these all open ? Yeah , that's what I thought . But I was just checking I hadn't misunderstood . So while the trust has not got speech and language therapist , the other trusts support in that delivery ?
P:	21:37	Yeah , there is , you know , we do have caveats and limits to that in terms of we don't want to be seen as like a stopgap for all vacancies and waiting lists , and there's got to be oversight by the team . So [**I:** the right sort of people in the group ?] Yeah . Like because if you flag up a challenge , you need to have a therapist you can refer back to because they're still being seen face to face or certainly on the books and can be seen face to face . So even if they've sort of step back for this time . So we are quite clear , like , you know , for example , we do anxiety and depression screening . We have some living well group run by our psychologists . Some trust don't have much psychology at all . Well , we don't , but some have even less than we do . But if we flag up an issue , we need to have someone who can follow that up so we can't have

		somebody with no psychological signpost if we're going to have an escalation . We've got to have a plan . So as long as we can make a plan around it , then we can make that work .
I:	22:40	Excellent . Excellent . You talked about different languages before . [**P:** Yeah] . And different levels and things . And obviously you've got these the regular team meetings . And it sounds like from what you've described it's very much across the clinical , about more communication . But is that how do you support the communication between the levels ?
P:	23:01	So within the wider teams , we try to encourage the teams and they have now got NROL as a standing item on , you know , general MDT meetings so that it's part and parcel of existing , you know we don't want extra meetings , and it doesn't offer the needs to be very long , but it's just a regular prompt or reminder . And we also have the staff where the T-shirts that deliver the sessions , which also raise some visibility sort of on the ground , then talks a little bit already about [*name*] already got involvement in lots of the both internal and across organization meetings . So she's been really , really key at making sure it's regularly on those agendas . And we myself and [*name*] so at the university side , we support her in terms of giving her data , giving her pretty pictures and graphs and those sort of things . And I remember we did a presentation to the chief exec at ELHT he was like , Wow , I'm blinded by this science . It was fantastic and I was thinking there was no science in that . So I mean , you know , for us , it was not just science , it was , you know , let's put things on graphs that look pretty rather than , you know , let's worry about whether it's a T test and the P value and the minimal clinically important difference . So I think that's what I was mean about language . You have to tailor the audience to that . And then other things from a visibility of things like submitting posters to conferences . Media press releases were quite a few press releases and webinars and then awards as well , like the North West Coast Research Implementation Award that we were shortlisted for and things . So some of those things , sometimes you think , is it worth doing those things ? But I think they all help with the visibility and actually some of those things , they're not from an academic point of view . I mean , you could argue the more the more relevant now with impact than they ever used to be but from an NHS point of view and trying to get commissioners on board , it becomes harder and harder , and we are now in the clinical guidelines given as an example . So we're using sort of all those levers with the commissioners to say . How can you not fund us and they want to and they were about to sign the dotted line until the economic was just chaos , and then suddenly things got a little bit less secure , shall we say , but we have other funding for this next 12 months . So that was good that we've managed to secure that .

I:	25:32	Okay . So is there a plan behind all this visibility and . In terms of which stakeholders you engage with and stuff ?
P:	25:42	I'd like to say I was well organized . I mean , there's a bit of an idea and we do kind of recap and we do feedback , but it's also being opportunistic when something comes up . So …
I:	25:53	I'm sorry , go on no go on .
P:	25:56	Just , you know , sometimes it's been because of the [*inaudible*] charity . They've had their own events and webinars and so they ask us . We're just about to put a symposium suggestion into the stroke forum . Got that ready to go . So I guess we know that's coming up . We'll see if we can get sort of on that agenda there . But it's not , as , you know , don't have a clear tick box . I do capture it all , and I've got sort of because I'm thinking of impact case study and I do write it all down . But it's not , Oh we haven't spoken to the commissioners for a while . We'll speak to them .
I:	26:32	Have you identified so you talked about key stakeholders , so commissioners , trust boards . Obviously , the clinicians , PPI , all that kind of thing , are there stakeholders that you hadn't planned for or is there …
P:	26:47	Yeah , at the beginning , I had no idea around who I needed to contact around systems , support around data protection impact assessments around some of those governance issues that particularly with the restructuring in the ICB's and the timing of that meant we didn't even know who was in the roles and they themselves didn't know . So that was quite difficult knowing that you need to speak to these people , but they themselves don't know who they are , if that makes sense . So we even now , there's a bit of uncertainty around who the commission is going to be for I think the specialist neuro , it's clear for … I can't remember which way round it is . But , you know , people have to reapply for jobs . Yeah , they're not sure on the scope . So that really that's challenging .
I:	27:36	OK . That's fine . I'm going to ask you about pilot processes in a way you have done a pilot haven't you because you started it in East Lancs . Did you ? Was that always the plan to pilot it in one organization or was it ?
P:	27:51	Well , I mean , it wasn't when once we started at ELHT and it was working , it was kind of the next logical step because of the ISDN set up to think how we could do it consistently . But it wasn't like we definitely set out because we didn't know if it would work . So we kind of not look too far ahead , [**I:** OK] . But I guess , you know , we thought the more we thought about it and also with sort of capacity and maximizing efficiency of groups and things , we were like , Oh , we can't run the speech this time because we've not got enough patients . But we know there is , you know , within ELHT , we've got a pathway where

		the Blackburn with Darwin patients go to a separate community team . So it was an obvious that we knew there was some patients who we had been seeing within the rehab unit were then on a waiting list for Blackburn and Darwen community team where as if they'd been in East Lancs community team , they would have , you know , so we are like why can't we just add them in ? We need some . Let's have them in .
I:	28:56	Fair enough . So actually , the pilot probably encouraged the rollout in a way . [**P:** Oh yeah , yeah , yeah] . Yeah . And it sounds like you're making changes all the time , not just because of the pilot as you go on things are changing and the weekly meetings you described . [**P:** Yeah] . Obviously , you've considered costs and you're trying to you've got ongoing funding for 12 months . [**P:** Yeah] . Is there anything else that around costs that you , you think would be useful for other people ? What's going well or not ?
P:	29:30	We're trying to work out what is realistic for there to capture going forward and what our minimum dataset should be , if that makes sense . Because while we have my , the university team supporting , we've been able to be quite rigorous and consistent with our outcome measures pre and post . We have overall outcome measures , but there are , for example , some group specific outcome measures , but they've been done less consistently . And other things like the different electronic note systems in different trusts . So we're trying to work out how we can work if we can put templates on EMIS and Rio , which are all in slightly different versions in different trusts to make the data capture more routine . Like we've kind of found what we've what we've done is we've found workarounds and we've done our own data capture on top of existing data capture , but we need to find a way that's consistent and doable going forward . So that's what the point where we're at now is . We're thinking , how can we streamline this and how can we do this better ? And we're trying to find out if and work with the ICB digital people to work out . Do they know yet where to go into a systems level was the things there and resources there that we can tap into ? But that's still not that easy . I thought something else but it's gone out my head now . Well , just the other thing is we've not done things like capture , mileage and travel time , but we know that's an important part of potential efficiencies . We've looked at staffing ratios . So we're now that's another because we've just had this kind of transition period where we've gone from more university staff to completely NHS staff . We're just finding our feet from that point of view . But seeing if there's capacity to look at say mileage data because , you know , otherwise , if you were doing face to face to these people , you'd have to find your car and drive for some of these in Cumbria , like you know , really rural places might be a good hour drive . And then the same back , but we haven't got data to capture that at the minute . So

		we want to .
I:	31:50	I think you definitely show efficiency well , if you can …
P:	31:54	Yeah , exactly if we are showing efficiency now when we've not got that , but it's just not that easy because mileage doesn't show you travel time particularly rurally .
I:	32:01	really .
P:	32:03	And it's hard to say , would you have gone to see them face to face anyway ? You probably wouldn't . So we're doing like a heat map with postcodes of where people are . Which in itself looks pretty cool . [*Laughter*] . Just again , I guess that's in different languages , is that having some visual feedback of that rather than saying our staffing ratios point four , which means we can offer over double the capacity of therapy sessions than we would if it was first office , one to one that doesn't really mean a lot . In some ways , it doesn't have the same impact as showing a heat map of the number of travelled , you know , if you had done them all face to face we would have travelled , I don't know the length of the UK or something . I'm sure there'll be some fact that we can find .
I:	32:55	Excellent . Excellent . See , you've talked about meeting training and planning and stuff . Can I try and , did you set goals and targets ?
P:	33:08	We had an evaluation embedded within the ELHT version , which was around specific implementation outcomes around is NROL appropriate , acceptable and sustainable . And so then we had specific quantitative and qualitative measures that we aligned to those . And now with our catalyst funding , we've got specific deliverables around the number of blocks we'll run , the number of patients we'll see the number of sessions we'll offer . So we've got quite specific deliverables now that we have to do this year . So , yes , but we didn't know what they were at the beginning . And I think you … yeah .
I:	33:47	Yeah , no , no , that's fine . You had a rough idea of what it would be , but you've had to do the work and tweak it to get there .
P:	33:56	And I think that's the real problem is you need a bit of time to trial these things and sort of work out what they are and what they should be and what support you need before you can then ask for funding for them . Because how do you know what you know ? We didn't know that we need . We were going to put in four Band five tech support post , we didn't know what tech support looked like to support staff and patients to get online . There wasn't any in the trust or in the , you know , it's not a common thing within the NHS , but now we know what that is . And now we've got a job description and now we've got someone employed on that role . But you wouldn't have been able to do that from the outset because you wouldn't know what to put in the job description .

I:	34:36	There's an element of flexibility in when and on the job . On the job . [**P:** Yeah , yeah] . Yeah , that's fine . See , you talked about having service users involved in your meetings as a public advisor . Did you have I mean , I know you always intended to include service users , but was there a set strategy to include service users in developing the changes ?
P:	35:04	Well , we kind of we looked at all stakeholders back at the beginning , we did a bit of a stakeholder map and patients were very , you know , we're obviously on there if that makes sense . [**I:** Yeah , yeah] . We've had slight changes over time in terms of , you know , we used to have within the ELHT monthly focus groups that were called with patients to get feedback and discuss things , but they had all stopped in COVID . So then they've actually not restarted face to face as far as I know anyway , I suppose maybe I haven't found out they have . We've been doing online things and I guess because it's an online intervention that kind of lent itself to that . So we've always said to patients right at the beginning , this is new to us as it's new to you . We might mess up our tech getting online like you might mess your tech up . But with those , give us feedback . And then we have set feedback sessions at the end of the each six week block to sort of say , How was it for you ? How did it go ? And then we have patient satisfaction questionnaires as well . And , you know , tell us one thing you liked about NROL tell us one thing we can improve . And so we have like a mixture of things if you like . And we did qualitative interviews as well .
I:	36:23	Have you made changes as a result of any of this ?
P:	36:25	Oh , yeah . Yeah , lots of changes .
I:	36:27	Can you give me an example of one ?
P:	36:32	Yes . So we used to we tried at one point having a sort of a follow up session four weeks later , so we had the six weeks and then a four week sort of follow up . But what we found is that at that point , a lot of people were kind of , what are we ? We didn't know what it was for , if that makes sense . And life had moved on , and some people can do a second block . So we've ended up stopping that because people just thought it wasn't that helpful . We've changed the way we feed send out invites , for example , because they told us that they were getting bombarded with different invites and it was all too much for them . So actually , now we've got it all in one email with all the different links in .
I:	37:17	And you've got your key patient involvement stakeholders , as well at the meetings and stuff how did you come about identifying them ?
P:	37:29	So the first few people who were involved . It was really it became a goal of their rehab that they wanted to be involved in some kind of volunteering or there was somebody wanting to get back to being employed . And so they needed to get more confident with speaking in

		different groups . So it kind of became and we've had this discussion , when is it rehab and when are they a volunteer ? If that makes sense , because we've , you know , I mean , the one guy who got a job so we didn't volunteer anymore . So that was fine . And then we've got a particular patient who is , I guess our most active , patient volunteer in that she co-facilitates a session . [**I:** Wow] . Although she's just fallen and fractured her femur so slightly and we want to do more of that and have more people like her role because we know we need more than just one person involved with that . But the challenge for that has been the infrastructure to support her . So she had to do 16 mandatory training modules to be signed up as a module as a volunteer , including mandatory training . She's predominantly in a wheelchair , or she can walk short distances . She's never going to be on site . She had to do fire alarm training that she had to submit a CV , and the whole thing was ridiculous . But there was no computer says no . If you were a volunteer , this is what you must go through . And so we've been looking trying to get that again if it can be supported at an ICB level because our volunteers have been predominantly ELHT but we don't want that if that makes sense .
I:	39:13	Yeah , no here for different things . Excellent . And have … how have you ? Or have you ? Have and how have you considered health inequalities ?
P:	39:25	Well , we've just got an ARC intern who is about to specifically focus on that aspect . We have been looking at things like our attendance rates , referral rates for peoples like level of deprivation , trying to do ethnicity . We've had lots of discussions around how poorly ethnicity is captured . It's not on our routine EMIS system . It's the way something to do with how it links up with the GP system , it gets wiped . So we have to manually collect that separately . So we have been doing that now and we are aware that we are more white British than our , we should be if that make sense . Yep .
I:	40:10	So . Are you able to map that against ?
P:	40:16	So we're looking why that is , and that's why it's good , we've got an intern , because that's going to be one of their specific projects . And also , we've got some funding from the clinical research network around health inequalities and specific groups . That's for research more generally rather than linked to NROL . But we've got people who are going out to some of the mosques in Blackburn and various other things . So we're going to kind of try and link the two projects together to find out . Why is this , what should we be doing , should we be designing and then a separate or a spin off NROL that's more tailored to particular ethnicities , for example , or particular timings ? Because that's some of the feedback we've had as well , that sort of . Just the family support and culture might mean that we need to do this at a

		later time point for some of our South Asian communities . And there's obviously language issues and various things , so yeah , so we've got we know we need to do better . I'd say we're at the stage where we've been capturing data as to where we're at and we want to tweak that going forward . We have had issues and discussions around digital inclusion and thinking around devices and Wi-Fi accessibility and how that might exclude certain groups , particularly around Blackpool . There was quite a few issues with people who couldn't come to NROL because they didn't have access because they didn't have a device and things . So we've been linking with , like various charities who can help and support and loan out devices . We did look ourselves whether we could look at loaning iPads , for example , and dongles , and very soon realized the whole , so we could become a whole project in itself to look at the safeguarding , maintenance , et cetera , et cetera , around devices that I had not even thought about . So we decided against that .
I:	42:17	Fair enough . From what you said before , it sounds like you have quite a few governance issues anyway so . [**P:** Yeah , yeah] . So you have talked a lot about networks and relationships . [**P:** Yeah] . I think we've covered more about helping . Are there any that you've not talked about that have helped or hindered implementation and are there any that have caused ?
P:	42:39	Think the governance issues and the patient record type things and trying to find those people have been the real challenges and . You know , when you send emails and get no response , lots of times , there's kind of nowhere to go with that if that makes sense . So then you try and escalate and you find who you can escalate with . But that is a real challenge . That's one something we've really struggled with , and I've never seen an auto reply on emails before that says I am experiences a large volume of emails . I will not get back to you in time I think , I mean , how that's even allowed , I don't know , I'm not naming any names , but I just I was like , I've never seen an email saying that kind of where do you go with that ?
I:	43:27	It's just , well , yeah , well , what are you doing then ?
P:	43:33	So I guess , you know , I would say that we tried to be creative and flexible and think about who we can link him with to get round challenges . Who are our key allies .
I:	43:48	Yeah . And you've talked about . It asks here about key steps to encourage individuals to commit , but I think that you've talked about that in terms of the different levels and making the visibility in a way that suits the different stakeholder groups . [**P:** Yeah] . And you've talked about involving training and stuff . Is there anything else particularly that you thought was helpful ?
P:	44:21	I mean , talked about the teams from electronic communication . But

		we have also used that we use that as a repository . We call it the NROL hub , and that's got all the resources and shared documentation with various channels that are locked . So some teams are not locked to others . And that's how we've got around sort of trying to work together and have like version control , for example , on referral forms . It's just an example , but you know , you make one tweak and if everyone has saved their own version . And we're talking , you know , five different trusts and how many sites you can just imagine how quickly things get out of control . [**I:** Yeah , totally] . So I think the fact that we've been able to have that , although it's clunky in places , it's not what you'd choose . I think that's been helpful , but at least we've had that as an option . But it will be really good if we had a better option on the same for timetable and again , we've created our own version , but you know , some kind of system level support would be really helpful .
I:	45:22	Are you aware of a better option ?
P:	45:26	We are aware of hypothetical better options from where the ICB wants to go
I:	45:34	So what would that look like ?
P:	45:37	Well , there's this talk about having a shared patient record where you can put things on and then you can , you know , so those kind of things would be really helpful rather than trying to . You can imagine sharing notes between different organizations and all those kind of things when we can't use . We don't really use email because that's not secure and we end up with . It just becomes , we found ways around it , but it's time consuming and clunky . So if some things like that did happen , that would be really helpful .
I:	46:10	That’s fine . Are there any other barriers that we've not discussed ?
P:	46:16	I mean , I think you can't run away from the workforce issue . And that's not getting any better and morale , time and those kind of things , so I suppose we try to highlight that this although there is some outlay of time that it ultimately will give you more time back . But also the career
I:	46:41	career
P:	46:42	development/just job satisfaction part of having something new upskilling in being able to do online rehab , upskilling across trusts because I think there is a real appetite still for that to happen . And you know , yes , people have , you know , there's definitely , definitely fatigue set in across the workforce and those kind of things , so we try to this to be sort of a , I don't know , a beacon of brightness or an element of something new , something positive , something that people can be doing that feels manageable , that will support them with rather than stand down all your meetings . Look , whatever next

		crisis is . Oh yeah , you want to go on that training course while there's no money and no time and you can't go .
I:	47:27	Yeah , yeah , yeah . So you had talked about ? Recording progress of the changes , yeah . And how are you trying to ensure things are embedded ? Can you just briefly describe your process in terms of what you're monitoring and if it's helpful ? I suppose measure the embeddeding is what the …
P:	47:57	We've talked about at some point trying to do more around defining the context and how things change over time . So we have collected some sort of field notes , if you like , if you call them of all the different trusts and where they are , where they were in terms of readiness , organizational readiness . Yeah . And we have been looking at using the ISAT tool , which is about scalability assessment , which kind of links in with the consolidate framework for implementation research as well . So just thinking about what are the elements around the organizations in terms of their culture , their staffing , their connections , their networks , their priorities . And so we've got that data and we want to have some time to think how we might write it up because I think it is a really important point of , you know , at some points , organizations or teams within it just aren't ready to do this . And so it's almost you need to work that out because you need to support them to get there , but you can't . There's only so much resource , so you've got to decide it's going to build , where do you start ? And how do you build ? And some of that information we've got , I think , would be really helpful for thinking around those things . So we have thought about it . We have captured lots of information . We have not yet processed it and done anything with it . If that make sense .
I:	49:33	Yeah , no , that's fine . And then I said I would come back to feedback . But what sort of feedback have you given and how is feedback recorded , so I know you talked about you get feedback from the patients , we've disclosed that and then there's the opportunity for staff to feedback into the weekly meetings . [**P:** Yeah] . But do you do a more strategic level as well ?
P:	49:59	Well , we've got the champions meetings and we've got . And then with the other wider meetings that we've done , say to the chief exec and wider voice or to whoever whatever meetings are going on , we always put together PowerPoint presentations for that . So just at the minute , for example , we've just had the end of Block six of our regional . So we're just at the point where we that's what we do as a team . If you like the university team , we get all the patient outcomes measure data , we get all the service level data , you know , attendance rates , who's coming from which trust how many staff have we got involved , how many patients we got involved , etc. And then we feed it back to the various groups and again put them on our shared hub so that people

		can then use them within their meetings as well .
I:	50:42	Excellent . Overall , do you think that others are supportive of the changes ?
P:	50:50	Yeah , I would say so , I mean , I think generally people think it's a good idea they can see the relative advantage of it that can see it's a good idea . They're scared of how much work and effort it's going to be to make it happen . But by us supporting it in the background and trying to make it as easy as possible by saying , Oh yeah you should be speaking to your team . Here's some information you can tell them . We make it as easy as possible for them . So I think that's what we're able to do to make it happen . And we have now got the relationships and know who each other is , if that makes sense , which I think is really , really important , people can . I know they can always pick up the phone/teams me or whatever , you know , and we'll sort it out .
I:	51:36	Is there any support that's been missing or you would have liked to have received ? Do you think during the process ?
P:	51:46	Well , you know , you know what it's like trying to apply for funding and get funding because we have , you know , there's always gaps and ebbs and flows within that . And then you end up with lots of paperwork to do behind the scenes from a contractual , legal , invoicing and all those kind of points of view . So anything that could be done to streamline those would be helpful .
I:	52:04	Fair enough . I know the answer to this one . Do you think these changes would have happened anyway ? [**P:** No] . I just thought I'd check . But no . [**P:** Absolutely not] . And the $64 million question , Can you tell me about anything that you would have done differently in retrospect ? Looking back , is there anything you'd change ?
P:	52:30	What would I have changed ? I mean , it's kind of , you know , it's been it's evolved , so it would have been if we'd had known at the beginning we were going to look towards upscaling perhaps we would have captured more data around that and if we had more resources to do some evaluations around that than we would . But we didn't . So we are sort of retrospectively for some of the information , especially when it becomes obvious in the different trusts now we're like , Oh I wonder where Blackpool were in that , but we didn't ask that in a structured way at the beginning . The timescales I wish , had a pre-printed one of the articles we submitted a little over a year ago that's now on its third revisions from a visibility point of view and those kind of things . But now , you know , I think I feel fortunate that I've been within , I've been able to get the funding , been able to work with the teams and been able to see it happen and see the patients involved with that and see the staff has been a real privilege .
I:	53:37	Fair enough . Is there anything else you'd like to add at all or do you

		think I'm very aware of time ? There's a few things I want to just quickly … [**P:** No , I think that's all good . I'm sure I bored you enough!] . So have you got , and it's whether you have and whether you're willing to share it . But if you've got any sort of like the tools that you've used or plans or matrices or anything that you've got that you think might be useful to feed into the logic model , would it be alright to share that with me ?
P:	54:09	Yeah , I mean , I can show you like MRC framework diagram we've done with what we've done in the different phases .
I:	54:16	Yeah , that would be great . Anything like that that you are willing to share . Obviously , it won't go wider than this project without coming back to you and obviously we wouldn't do that . And obviously , I'd like to thank you for taking part . And I have to ask you , are you happy to be contacted if there is follow up needed ? So if there's anything I need to check back on . Also when we come to do the focus groups , is it alright to contact you to see if you want ? But obviously there's no pressure ? [**P:** Yeah of course] . But yeah , because obviously it would be useful if you could help inform that logic model at that point . Yeah , that's great . And then the other thing I have to ask you is , is there anyone you think I should be interviewing
P:	54:56	I am assuming you're interviewing [*name]* , [*name*] , [*name*] , if you want wider AHP , you might want to ask [*name*].
I:	55:13	Sorry , was that [*name*] ? [**P:** Yeah] . It went it bit dodgy then , OK ? Could you put me in contact with [*name*] ?
P:	55:24	Yes , she has retired , but she's returning on a couple of days a week to see through NROL .
I:	55:30	OK , great . That's fine .
P:	55:34	Yeah , [*name*] . Yeah , if you have not met [*name*] you need to meet [*name*] .
I:	55:37	Even more so than if they're on a retired return can you , would you do an introduction ? So I'm not yet . [**P:** Yeah , will do] . The others obviously that's brilliant . And anybody , obviously , these are very linked to if if you think of anybody else across stroke care improvement interventions that you think it would be good to talk to , please do just drop me a line , that's it . Thank you very much . I'm going to stop the recording . [**P:** Yeah] .