Participant 4 29.03.23

Interviewer (I):	00:02	So just for the purposes of the transcription , confirm you are happy to be recorded and take part in interview . [**P:** I am] . Great . And I've got a little bit of an introductory blurb to read . So my name's [*name of interviewer*] and we've invited you 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 stroke care pathway . I'd like to ask you a few questions about your involvement and your experiences of stroke care and whatever parts of the pathway you work in or are involved with . We're interested in your opinions around what you did , why you decided to do it . What worked well . How a service could be improved . Any challenges and or the comments you'd like to make . We hope to use your comments to understand what changes have been made within stroke care , particularly at a systems level , and explore what worked well and what could have been improved . The information from these interviews will be analyzed and then used to inform focus group discussions to help develop a tool called a logic model . And the logic model can then be shared and used by others to carry out improvements in stroke care . Is that OK ? But I think you know probably more about it than me to be honest . So can you tell me about your current role within your organization and stroke care services ? Oh , you're on mute sorry [*name*] .
Participant (P):	01:28	I'm on mute sorry that is not helping is it . So I so my role as the [ROLE] and [ROLE] at [PLACE] , but I've also got a role at the moment , [*interviewer name*] working across our [ORG] . And I head up the stroke strategic improvement group , which is just changing its name to the clinical oversight group . But it will still do stroke improvement , and I'm also a member of the [ORG] .
I:	01:54	Excellent . OK , 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:	02:05	Yes . Well , it depends on how far you want me to go back . So my first involvement with the stroke group , we started to run a breakthrough series collaborative that we were trying to work right across our ICS to bring providers , organizations and community services and paramedics together to really work differently and look at how we could improve stroke care through a breakthrough series collaborative model . We did do some work with colleagues at UCLAN at the time who did a review of actually what the contribution of a breakthrough series collaborative can be , which was really helpful work . And then we've basically been doing a number of things since then . Unfortunately , we were doing the breakthrough series collaborative in COVID , so we had to move

		from a face to face model to a virtual model , which did have an impact , I think , on what we were able to deliver . But we've also since continued to work together to really look at how we can work together with groups of clinicians and ops leads , really looking at and delivering those pathway level improvements . So some of the things that are underway , there's been teams of people working on developing standardized ambulatory care pathways , and we've got a standardized thrombectomy pathway , which we're just doing some work now through an improvement framework called Engineering Better Care to look to see how we can really identify patients early , improve the referrals of patients who need a thrombectomy , streamline the service that they get , and then repatriate the patients early . So there's multiple different improvement approaches and methods going on across our ICS . And then we've also internally here at LTH we've also got a stroke big rooms so the flow coach and academy methodology is an improvement methodology where you bring team members working across a pathway together . And we've done that for stroke , so we've got a stroke big room that meets on a weekly basis .
I:	03:58	Excellent . Kind of makes me want to ask , how do you how do you decide on which methodology you're going to use and also which interventions are you going to target ?
P:	04:09	Yeah . So it depends on the problem we're trying to solve . So what we do try and start with [*interviewer name*] , is a really good diagnostic to really understand what the problem is because that will determine the most appropriate improvement methodology . So if you've got quite a small scale problem , you might just be able to use the model for improvement and do some small , small scale testing to improve something . Whereas if you're trying to improve an entire pathway , then you want a methodology that looks at end to end pathway redesign . So the way we try and organize our improvement here at LTH is we've got macro level improvement . So we'll use specific methodologies like engineering better care or a breakthrough series collaboratively if it’s across the whole organization or a whole system . If its pathway level improvement , like the stroke pathway or the thrombectomy pathway then we will use the often used and flow coach academy program . And then we also use Micro System Coaching Academy here so to improve our stroke care on the stroke ward and our stroke leaders have been through the Micro System Coaching Academy program and our ward leaders coach a daily improvement model to really identify what our patients and their caregivers want us to improve , but also what our staff want us to improve . So we've got quite a structured approach to how we do improvement here .
I:	05:31	Excellent . And how involved are you in these changes , what's your … In terms of time and dedication to these ?

P:	05:46	Yes , it depends , though , certainly the changes that we're trying to do across the whole ICS , I suppose my role is to sort of lead them . So I'm leading . So I chair the group and I'm sort of leading the design and delivery of some of the improvements . But some of my team are supporting that because obviously it's quite a large , significant scale improvement . So some of the others . So things like our stroke ward , I don't know , my role is to make sure we run the program . So once the ward team have actually been through the program and had improvement coaching from some of my team members , then actually they can now just get on and deliver it . But we still connect into them to just make sure things are going okay and provide some support . So there's the sort of role that I have really does vary from making sure that we deliver the building capability program and through to , you know , leading sort of the design and delivery of some of our larger-scale change programs . But really , I suppose I would summarize my role as making sure that we set the vision so we know what we're trying to deliver , have a really clear global aim , so we know what we're trying to do with some specific objectives , making sure we've got the right improvement methodology for the change that we want to see and then actually providing some support for my team on things like the data and the measurement and the design of the program . And then really , the bit that I think makes the biggest difference for us is having some improvement advisors attached to the program . So the frontline clinical teams are supported by people whose job it is to facilitate and coach improvement at the front line .
I:	07:23	Excellent . You've already , apologies if you've already mentioned it , so how do you how is it that you identify what it is you're going to change what kind of information sort of makes you target a specific change ?
P:	07:37	So it depends on the level we are working [*interviewer name*] . So if we're working at a whole system level , so if you take the work we're doing at the ISNDN Program Board , that actually what we did there was we got together . So we have an annual work plan basically . So we got together and held a workshop and said , what are the national priorities ? What are the expectations of both us and the ICS ? Actually , which of those are the priorities for Lancashire and South Cumbria ? Because some of the things may be more of a priority than others ? And what the national … so we were joined that morning by [*name*] who's the clinical lead for national clinical lead for stroke . And actually , what [*name*] said to us is it's impossible to deliver all of this . And I mean , don't obviously quote [*name*] in the findings , but that was the gist of what she said . So actually , we were really targeted in how do we identify what the priorities are that we need to work on ? So we found a really sort of sensible way , I think , to be realistic about what we can achieve . The next thing we do is we look at the data , so we

		benchmark ourselves . We've got the GIRFT data for stroke . We've also got our internal data , we've got the snap data . So we look to see where we are and how we compare to others . And then we basically have a number of ways that we design what we're going to work on , but largely that is through consultation and co-production and co-design with our patients and members of staff . And then we will often use tools like drive a diagram to be able to have clarity about this is our aim . This is what's going to drive delivery of that aim . And then these are the secondary drivers that we need to work on . And then we get the ideas around what we're going to test first for more staff and patients .
I:	09:20	Fabulous . That kind of leads into how do other staff colleagues and patients feel about the changes that you're making , how do you consult them ?
P:	09:31	Yeah . So we basically so I've been doing some work directly with our Patient and Carer Assurance Group . So one of the things we committed to doing in the ISNDN we always have a patient on the board with us , we have a patient who's on our stroke steering committee here at LTH too and we basically make sure that we engage with them to say , you know what matters to you , what's working well that we need to keep doing ? What do you need us to improve ? And it's really interesting when you do that work [*name*] , because we tend to , as clinicians will often get hooked into , we need to deliver the clinical elements of care . And the last time I went to the patient and carer group , they were talking to me about handrails on toilets . Actually , let's get the things that really make a difference to the experience . So what they were describing is if you've had a left sided weakness and the handrails are not fitted on the right side for you , then you're not going to be able to be independent . So we've done quite a bit of minor works in terms of estate that you know , really matters to patients , but wasn't necessarily on our radar . It might have been on the OT's radar or the physios radar , but it wasn't necessarily on our radar in terms of the clinical improvements that we want to see . So we tried to make sure that we really do focus on what our staff want , but also what our patients want .
I:	10:48	Excellent . And obviously , we're not quite sure how this fits because it will depend on the intervention or change that you're thinking . But does complexity play a part in terms of what you do and how you manage it ?
P:	10:58	It does , because obviously we work in very complex adaptive systems and depending on what we want to change will determine actually how you approach it . So some of the change we want to see delivered like the thrombectomy service improvements we know will take us at least another nine months to deliver because we've got some recruitment

		and workforce challenges . So actually , it's about being very sort of realistic about what you can do and making sure that we work very closely with our ops colleagues too . So for this thrombectomy improvement , what we're doing , we've actually got an engineering better care program , which is around how you engineer care differently and how you make sure you've got a reliable pathway and , you know , are designing to deliver the same level of care to all patients . So you're really driving out the unnecessary variation , but actually , you can't just do improvement because of the complexity in which we work . There's also a task and finish group , which is our clinicians and our op's leaders actually doing the work around getting those basics in place that we need around the right workforce , the right estate , enough access to the interventional radiology rooms , et cetera , to be able to deliver the improvements that we need to see . That's very , very different than if you've got a nurse on the ward trying to improve one aspect of stroke care for her patients .
I:	12:20	Yep , that's fine . Can you tell me about the support that's available to help you put into carrying out change ? What support have you got ?
P:	12:30	So , yeah , so I head up a team , so I've got a continuous improvement and transformation team , so the support we've got internally as a team is around . So I've got some senior program managers to help us track the deliverables . I've got improvement advisors to really work with the teams to do the improvement . We've got a really comprehensive continuous improvement strategy that we are delivering , so it lines and fits into the priorities of the organization . And then we've got broader support that we can draw on . So there's always key enablers to improvement work . So I've got access to our comms director and team . I've got access to digital so we can redesign things differently within our electronic systems . I've got support from our estates team , so we basically just pull in the support [*interviewer name*] as and when we need it .
I:	13:27	Excellent . [**P:** Sorry I am just going to have a drink if that's OK] . No , no , no that's fine. You are that's good . Can you discuss the steps that are undertaken to inform and/or train the staff and teams and other organizations involved in the changes ?
P:	13:42	Sorry , [*interviewer name*] , I missed that , can you ?
I:	13:44	Sorry . So can you talk about the steps that were undertaken to inform or train staff and teams involved in the changes ? What strategies do you use to keep people connected and informed ?
P:	13:56	OK , so it depends on the program , to be honest . So if we're doing something like within the Micro System Coaching Academy , that is a standard program that people being trained and , you know , coaching others to deliver improvement go through that they actually have a

		launch event . They get some pre-reading . They then go through the program and we connect them in and we've got a program of executive support . So our director of nursing and myself will actually go and see the work in action and we'll have a celebratory event at the end . So there's lots of connectivity for people going through programs like that . We do the same for the FCA program , so they very much are connected in . It's a longer program . So they come together for 14 and a half days over a year . So there's lots of work around how you deliver that . And sort of structured approach and connection and do the comms . We also ask the improvement work to be reported , so we have a mechanism to feed the progress of the work through our divisional boards that we're trying to connect in , the work that happens in the big rooms or the other improvement programs , to the divisional management teams . And then we basically feed that up to … So there's a report that goes on a monthly basis to finance and performance committee . Some of the work and ICS level is a bit trickier to get the comms as good so that you can manage to reach everyone . But there's a stroke newsletter and there's some other work underway that really tries to make sure we've got some clear comms that are distributed to some of our teams who don't attend all of the meetings . So [*name*] and her team will try very hard to make sure we keep everyone up to date .
I:	15:40	That’s fine . Do you ever carry out pilots of the changes before rolling it out ?
P:	15:46	We don't often call them pilots , but yes , we do . So basically we would call it a small test of change and then we might do a slightly bigger one and then we'll come up with a plan to scale up and spread . We did do a formal pilot for the ambulatory care pathway for stroke patient . So yes , we do . But one of our criticisms of pilots is that they often get going and then they get stopped . And actually , you don't then necessarily continue to get the benefits . So we try to plan for the Scale-Up at the start of the program .
I:	16:17	OK . So rather than it being an opportunity to tweak and bring change , actually , sometimes it can be a blocker to it , actually .
P:	16:27	Yeah , well , it could actually be really good , so you do the pilot , you deliver some great work , you see some real benefits , but then the pilot stops and people move on to other things . So that's what we need to try and guard against because otherwise , you know , you end up not sustaining the improvement .
I:	16:44	OK , so it should it should be a step rather than a stand alone process . [**P:** Exactly] . OK , well , that's fine . And in terms of cost , the whole resource issue and things , how are these considered in terms of the changes that you make and how are ongoing recurring costs managed ?

P:	17:03	OK , so that again depends on the level at which we're doing it . So the ISNDN programme board is obviously we have a stroke team who are funded and a lot of the improvement work is supported by them . But they obviously also have a broader remit to do some of that work . And internally , we work closely and are working more closely now with our finance team to really try and identify the cost benefits so that we can absolutely demonstrate the financial impact . So in terms of the actual cost of designing and delivering the improvement work most of the time that is basically delivered from the frontline teams we've got and the improvement teams so we are not often going to ask for additional resource to be able to do some improvement work , although obviously depending on the size and scale of what we're aiming to do , sometimes there are some costs associated with that . The way that the stroke team have done is to really look at . So [*name*] team have brought together a sort of business case for what you need to do in terms of stroke improvements , and some of that has been around capital investment to be able to right size our stroke beds and units , although that has hit some challenges [*interviewer name*] in terms of the latest wave of financial , and I'm sure you can imagine the financial constraints that the whole NHS is under . But it is largely developed through those programmes of work .
I:	18:36	So you've already described about planning from the start , but can you describe the planning process in terms of what you do to plan how you organize meetings , training that kind of thing to develop that plan proposal in the first place ?
P:	18:53	OK , yeah . So that basically if we're doing this sort of system level work , then that forms . So when we do the … so you'll remember I talked about the planning workshop for the annual plan in which we had in December . The team then take that away . So [*name*] and [*name*] and others basically do a detailed program plan . So we have an outline of who's doing what . So we have a number of groups set up for stroke and we allocated the priorities to each group . So [*name*] who is our chair of the ISNDN program board was really clear that he wanted to be able to have a group , one of our established stroke groups responsible for the delivery of the different priorities so then that gets put into a project plan and then it gets tracked . Each of our organizations will also have their own stroke improvement plan , and we've got a mechanism through sync to track the progress that teams are making .
I:	20:02	Reading ahead really quickly sorry . You've already mentioned . Let me just check I have not missed anything here . So you've already talked about the fact that service users are embedded in the development of the stroke changes . [**P:** Yeah] . And you've given an example of where needs and preferences , but can you describe the strategies you used to include them ? How you've gone about getting that involvement ?

P:	20:30	Yes , so I haven't been that closely attached to this , so that's something that the stroke program team have done . So they basically , I think , worked in partnership with the Stroke Association and others to identify patients and carers , though obviously we've got a database of people who've had a stroke who we have been working with , and I think that they definitely do work really closely with the Stroke Association , though the exact strategy they've used to identify individuals , you'd need to talk to [*name*] about and but we just tap into the group of stroke users that they've already got . The other thing is , UCLAN have also got a PPI group for stroke research . So there is a couple of different groups that we've got depending on the work that we're doing . So if it's the stroke research work that we're interested in then we will use the PPI group , but they're not exclusive , so we'll quite often go to both groups for input .
I:	21:31	You've said about like locally it has made a change in terms of you have said on some minor estate changes as a result of that . What is it about the service uses that makes a difference to what you do ? Is it ?
P:	21:46	I think it's the focus on experience ? So I think for me , the work often when you when you're design improvement work with clinicians , most of the time the greater emphasis is on the quality of clinical care delivered , the equity of access , the timing , health prevention , sort of reducing health inequalities and then making sure that the outcomes are as good as they can possibly be . The thing that patients often bring to the co-designed element are a focus on their experience , and I think that's one of the things we've seen in COVID . With the increased pressures in demand , it's been more difficult to maintain that focus on patient experience , though engaging with the patients around what is it that makes the biggest difference . You know , we've had great feedback on things like the quality of our [*inaudible*] modified food . Our catering department have done some great work to improve that based on feedback . And we've obviously got some of the estate work I've talked about . But then there's also things like the patient passport that we've been doing to try and make sure that the relatives have got all the information in one place for standardizing some of the works of the Stroke Association have done a brilliant piece of work on that . So I think it is more about making sure the experience is right and the communication is as good as it needs to be .
I:	23:08	Excellent . So it sounds like you when you try and ensure that the interventions are meeting the needs of the service users . [**P:** Yeah] . And that you thinking of that broader experience rather than just service level . You've already kind of reached on , reached on ? You've already touched on it but health inequalities . How do you consider those as part of the change ?
P:	23:31	Okay . So that's something we're doing an awful lot of work on as an

		organization at the moment . So we know from on-call 20 plus programs that we've got , we are part of a national collaborative On-Call 20 plus that we've been doing some data analysis [*interviewer name*] that really looks at how do we identify those groups of our population who are least likely to access care . But when they do access , they present late so their health outcomes are not as good as the people who access early . So the way we are doing that in stroke is to really look in at … Well , there's a number of things that are ongoing , so there's some things around prevention so how do we really target those speculations to make sure that they are focused on stroke prevention ? And then actually , there's some work we're doing to look at our data to say , is there something we need to do to really make sure that the patients who present later and do have the ability to , you know , really recognize the stroke symptoms and present at the same time ? Because we've got a piece of work underway through the SIG [?], which is really looking at the prehospital phase and there's a massive amount of work going on in terms of prevention , which we're trying to bring together with other areas of prevention . So it's not so we're not targeting just stroke in one area and then CVD in another and then , you know , something else in another . We're trying to sort of really work together across the patch to really make sure that the coordinated and culturally competent is the phrase that they keep using for is on-call 20 Plus to make sure that actually we're getting the comms to the right communities in the right way . We've got more work to do on that . I think that's something that needs to be a focus as we go forward .
I:	25:21	OK , so can you describe around the networks and relationships within and outside of your organization that help or hinder implementation of change ? It's a long sentence .
P:	25:34	Yeah . So I think I think the stuff that's really helping internally is our board commitment . So we committed as a board to adopting continuous improvement about four years ago now . And we've seen that absolute commitment from senior system leaders , clinicians . We were on the delivery of our second CI strategy . We've got the commitment . We're now working much more closely with our OD team . So we're running a joint OD and CI program for leaders , which has been a really positive step forward . Some of the enablers for us have been around comms , so we've definitely had support from our comms director and her team in terms of just making sure some of the work has been presented . Some of the barriers , I think have been related to COVID so we had planned and it's something we're looking to re-setup . And just how we share the information more widely . So in the early days had the celebration event . We were planning the conference that just had to get stepped down . And so there's

		something around how we connect more of the organization in that I think would be really helpful .
I:	26:47	And when you talking about the broader regional things , are there specific networks that are helpful ?
P:	26:55	Yeah . So I think we've got a stroke high impact roundtable , which is good because that allows that to have the conversations about what the priorities are . And again , we've got patients on that group and researchers . So that's been a really helpful forum to challenge our thinking in terms of what stroke improvements we should be doing . I think the national focus on stroke care has been really helpful . So we've seen a real clarity about what we should be doing through the ISNDN networks , which is good . I think some of the challenges have been around just the financial context within which we're working . And so whilst we all know what excellent plan looks like for stroke patients , it's been really difficult to be able to secure funding to deliver , you know what we all recognize as the gold standard service , especially for some of the elements around things like psychology . Although we are making improvements and we have had some investment , so it's moving in the right direction .
I:	27:57	Excellent . I think you kind of touched on this , but what do you think's helpful in bringing about change ?
P:	28:06	For me there's probably four or five things that are really key . So the first one is a shared , it’s all the stuff that's about to come out in the National Improvement Framework . So the first one for me is a shared vision and purpose , because if you can align everybody behind a shared vision , everybody knows what they're aiming to deliver . The second one is around how do you build capability ? And by that , I mean , making sure that people have got the right skillset and some protected time to be able to do the improvement work so they know what their role is in delivering improvement , but also how they can coach others . Got that saying from [*name*] that improvement is 80 percent human and 20 percent technical , I absolutely agree with . So it's building the relationships and being able to work well with people . There's something for me about clarity of design of the improvement program or intervention you are trying to deliver , because if you get that bit right , then you can really deliver more . And then I think the something to me about having a quality management system that allows you to do the planning , deliver the improvements , have the control element right so teams can see in real time how they're performing and how they're doing . So they can make improvements while the patient’s still with us . But we've got some really good examples of that that we've shared across our patch around things like the snap data be invisible in real time so teams can intervene if patients haven't had the care that they need in a timely way . And then how did

		you get the assurance right ? So how do you really look at your data and do the benchmarking well around things like GIRFT and create opportunities to learn together and learn from each other ? So I think what we see when we bring our teams together to work collaboratively across the ICS is just a sharing of learning and best practice with the focus on leveling everyone up to the level of the best that you don't always get if you try and work on your own .
I:	29:53	Excellent , excellent . Describing an absolutely wonderful process . Do you have and can you explain how others come on board , are there issues in terms of engaging other people ? Or is that sort of set up in the clarity of design ?
P:	30:11	Yeah , I think it's getting better . I think we're trying really hard to make sure we've got the right team members in the room . So in the early days , it was largely the SIG was mainly operational leaders , and we did recognize that that isn't enough to really drive and deliver change . So now we're changing the name and changing the formation of the group . We've got some of our real clinical leaders , so we're actually meeting less often but more focused on the delivery of the work . And that's been a real enabler for us in terms of getting the right people on board . I think some of the things we struggle with are getting enough sort of digital support and comms . So there's something we've been talking about around how do we engage those members of staff more with us . So we're doing some good stuff , but there's more that we could do . I think one area we do find difficulty with [*interviewer name*] is engagement with primary care because they are under so much pressure at the moment , and it's actually been really difficult to take some of that work forward .
I:	31:18	Yeah , I can imagine that . Done that one . So can you tell me what you think the main barriers are to implementing change ?
P:	31:25	So for me time , I think , would be one that I would call , and I know that often sounds like an excuse rather than a reason but out teams are so job planned now to maximize the frontline care delivery . But actually , if we're going to design and deliver change , that's radically different . You do need some headspace and capacity to do the thinking . So I think that's the first thing . I think the second thing is probably around getting access to the data and measurement in a way that enables you to have that data in real time to drive the changes . It can be really difficult to get the measurement for improvement right . Although we've done some good work on that and we're making some real progress .
I:	32:08	How do you go about doing that , making it right ?
P:	32:11	Well , it's making sure that you've got a measurement subgroup for the large scale design programs that you've got . So making sure that

		you've once you've got an aim and you know what you want to deliver , then it's about how you designed the measurement strategy for that vision and the aim that you've decided . So quite often we do that the wrong way round . People will start by looking at the measures , and it's always the wrong thing to do . So what we tend to do is we get the teams to set an aim . We're really clear about what we want them to deliver or what they want to deliver . We then really take our time to design to driver diagram so that if we do focus on those primary drivers that will deliver the change and then actually get the secondary drivers right . For me in any change program , you need measurement , at least at two levels . So one is tracking those overall process outcome and balancing measures that you need and an improvement program so you can track whether you're delivering those outcomes . What you also need , though , is measures for the test of change that you're doing . So actually making sure that you've got the measures so just say you're trying to improve the four hours standard , actually , you know , waiting the outcome may be more patients on the stroke ward within four hours . There's an awful lot of things that make up that , whether you're successful or not . So designing measures to test the impact of the tests of change is really critical . And I think that's what we don't often do well enough in improvement programs and so trying to really focus on that is key . So you really take the learning from the test that you're doing .
I:	33:40	OK . And you've talked quite a bit already about how the progress of plan changes have been recorded , so you've talked about the data measurement , reporting back to the divisional board and the monthly reports . Is there anything else that you have not mentioned that you want to describe in terms of how you ? Do you use that to sustain ?
P:	34:07	Yeah , I suppose the only thing I would say is those individual conversations you have in building relationships , that's a key element for me because that's what actually drives the ability to do the work and to be able to , you know … So you can write the papers , but that doesn't bring it to life . So really , what you need to do is have the conversations and make sure the teams are connected to each other and that you find a really good way of getting the teams to present their work in some of the forums . And I think in terms of sustain , that's a real challenge for us in health care improvement . One of the things I particularly like about the Flow Coaching Academy program is that it's got a focus on sustainability in it . So actually , as well as doing PDSA's , you do SDSA's , which is sustained . So instead of plan , do , study , act it's sustain , do , study , act . And that's actually a really helpful way to make sure that you're designing the processes and the systems that if that group of people who've been working on it leave , you've actually got a sustainable way of keeping the work going . So

		building the work into our processes and systems is a really important part of what we need to do .
I:	35:17	OK . Is there anything that you'd change in relation to this process , if you could ?
P:	35:23	The process of sustainability ?
I:	35:25	And recording progress , do you think it's …
P:	35:31	Yeah , I'd just I'd make it more mainstream , so it feels at the moment as though lots of our measures for what you need to deliver in health and social care are determined at a national level by outcomes . And actually , there's still an awful lot of performance measurement in place . Although , to be fair , we are changing it and we've changed ours , so our board reports are now SPC charts like many organisations are . So I think what I'd like to see is a real focus on making sure that we are using measurement for improvement really effectively .
I:	36:07	Excellent . Do you feel others have been supportive of the changes that you've been involved with or are involved with ?
P:	36:17	I do . So we've got great support from our chief executive , got really good support from the Provider Collaborative Board , we've got really good support from our clinicians and ops leads and people internally in the trust and trust boards . There's probably other places we could get support from , but I take responsibility for that because I don't think I've asked them for it . And again , it's finding the capacity and time , isn't it ? You end up working with your closest stakeholders to make those changes successful . I think there's probably more we can do with wider communities and especially some of the patient groups , some of the voluntary sector . So we work really closely with the Stroke Association . But I suspect their role with the voluntary organisations who may be able to have an input and so we could scale that up and do more .
I:	37:06	Okay . And what do you think that would bring having that wider support ?
P:	37:10	I think it would just bring diversity of thinking . And actually , it would bring some different solutions , though at the moment . You know , you tend to think and feel that the NHS and social care have to provide all the answers and of course , we don't . So how we get that shift so that local community groups , patients own relatives , families , friends network and some of those , you know , voluntary organisations in primary care could be more engaged and more part of the solution . And that's not because they don't want to be engaged . I think it's a case of how big do you make the improvement programs ? And it's always a balance because if you try and make them too big , you don't deliver anything . I learnt that a long time ago . So actually , you've got to incrementally improve and just increase the engagement as you go .

		But I think we probably are at the stage where we could really think about taking that next step .
I:	38:09	Are you asked for feedback or do you give feedback on the changes processes ?
P:	38:16	Yeah , we certainly we are asking for feedback so I get asked for feedback all the time from people like our board , the Safety and Quality Committee , the Finance and Performance Committee . We get feedback from some of our sort of patient groups , especially if they've helped us in the design of things , we'll go back and give them feedback and we'll ask them for feedback to on how we're doing . And I think making time for more feedback would be good , and I think we could formalize it more if I'm sort of , you know , just reflecting on where we could do better . And I don't know whether we spend enough time really evaluating what we're doing in the way that , you know , I used to work at UCLAN in the way that you do if we're doing the kind of work that you're doing . So I think that is a development opportunity for us .
I:	39:06	Do you record in any way the sort of the feedback that you give is that .
P:	39:12	And we do sometimes , but it doesn't tend to be a formal .
I:	39:18	That's what you mean about formalising it ? [**P:** Yes] . That's fine . Obviously , you think that better feedback will have an impact . Can I ask why you think it would be useful to develop that ?
P:	39:30	Yeah , because I've been involved in numerous programs where we've paid more attention to feedback and it's always been really good . So to give you an example , we did the harm free care programs that I was involved in a national program with a hundred and thirty two organizations , and we basically worked through the SHA's . We asked both the organizations and the SHA's for feedback . They asked us for feedback on how they were doing and actually what that does is throughout the program of work it enables you to just take just a bit of a pause to say , Are we on track ? Are we delivering what we need to ? Is this meeting all of our stakeholder engagement needs ? And so , building that into the work is really , really important . It's actually really challenging , though [*interviewer name*] because the pace at which we are asked to deliver changes in the NHS at the moment is phenomenal . And actually , that's sometimes because you're so driven by hitting standard benefits , KPIs , whatever you want to name them . You actually end up focused all out on the delivery rather than necessarily building in sometimes the time to just take pause and get some of that feedback . But it is really important as when we do it , we highly value it . So just as I'm talking to you , I'm thinking I will have a refocus on that .
I:	40:47	Yeah , no , that's good . It's almost like the key drivers and things that are pushing the change . But sometimes those can hinder the process is

		what I'm kind of … [**P:** Yeah] . Yeah , that's fine . So overall , and across the board and $64 million question , if you could do anything differently , although you've have reflected as we've gone along . Is there anything that you would add at all and from what you've said ?
P:	41:10	Yeah . So I think if we could do things differently , I would , I think the main thing for me is how we connect in our patients and service users , our researchers , our improvers , our clinicians and really make sure that we've got that comprehensive plan at the beginning that's ambitious , driven by the best research evidence and we are all working together to the same time scale . So we do try our very best to do that , but I think there's more we could do in terms of how we really work together to deliver that and it does feel if I'm being really honest , it feels as though sometimes I'm in a parallel universe . So I've got an [ROLE] at [ORG] and when I sit in research meetings , I was in one yesterday . We were doing the work around writing a bid for end of life care for stroke . So part of a writing group around how do we do that . That time and capacity that is in our university colleagues to think , to write , to do the detailed planning , just do the million miles from where we are in health care . And that's not a criticism of either of us . I just think there are … [**I:** Need to be a bit more symmetry] . Absolutely . Yeah , yeah .
I:	42:30	Okay , that's great . Interesting , you say about common timescales . Do you think there's commonality of understanding in what you're trying to do in the work ? Or do you get ? Because you've described how relationships are important .
P:	42:44	I think largely there is commonality about the ambition and the vision about what we're trying to do , I don't always get a sense that there's a dose of realism in terms of what we are working in . And I think sometimes we just need to call that out [*interviewer name*] . We'd all love to be able to deliver a gold standard Rolls Royce service to every patient who walks through the door . However , the demands around the increased pressures , the backlogs as a result of COVID , the financial context in which we work means that we absolutely have to prioritize the things that we are being asked to deliver at the center . And that sometimes causes us real conflict because , as you'll know , if something is on the national radar , then the whole of the NHS and social care will focus on it because we have to . It's part of what we have to do in the priorities that we set for the organisation . You cannot possibly have every single patient group a priority . So it's how do we deliver the best possible service within the resources we've got for all patients and really maximise the contribution that everyone can bring , including researchers , primary care , our clinicians in the acute care are ops leads , etc. And how do we redesign those clinical models to be really fit for the future within their work that we're trying to do around

		reducing health inequalities , keeping patients while at home , only having patients in the acute care who need to be here ?
I:	44:18	It doesn't help that we don't know what the gold standard of care looks like across a lot of things does it , let's be honest. [**P:** It doesn't] . It sounds like there's a lot of pull then within what you do . [**P:** Yes] . But you have key things that sort of keep you . So it's that agreement , those prioritizing what you look , at being realistic about what you do , involving the right people , having a strategic plan . [**P:** Yeah] . So it's very structured in terms of the way that you kind of yeah , that's fine .
P:	44:52	Absolutely but bearing in mind that improvement is never ending in the reality . So it ends up looking like a spaghetti diagram rather than a nice flow through . But we try and keep that flow through in terms of planning , the test of change , the delivery , the measurement for improvement and the outcomes . The other thing I would say [*interviewer name*] , is I think we often underestimate the complexity and the sheer amount of hard work and effort that goes into working with the teams to actually design and deliver the improvements . So I think there's often a mismatch between the people who work in health care and , you know , are at the frontline and are trying to support that change through our organizations absolutely understand how difficult it is . I mean , sometimes it can feel like wading through treacle . Sometimes we find people in other parts of our system . It's really easy to say , can you please have an A in your snap data for all of the domains ? It takes 30 seconds to say that actually to deliver it within the estate constraints , the workload constraints , all of the other things we're trying to deliver when that is one priority in a whole plethora of priorities . You know , there were 31 asks of systems in the organizations in the national planning , with pages and pages of more asks in the detail . Actually , how do you deliver all of it is the current leadership challenge . [**I:** Got any answers ?] . Yes , answers on a postcard .
I:	46:20	That's fine . Is there anything that we haven't discussed or that you haven't had the opportunity to speak about that you'd like to ?
P:	46:28	I don't think so . The only thing I do think is and I do have a optimistic view on what the opportunities are , though I do think there is an opportunity here to do something really differently . And if we can take the learning from the best global health care systems , if you take places like the Nuka health system in Alaska , they have redesigned their system really well , achieving a very significant reduction on their urgent and emergency care services because they have done that co-production with patients . So if we can do this and really realize the vision that we've got at the moment for our system , then I do think there is something really significantly different that we can do and we are obviously all focused on that . I think the key challenge for us will be

		making sure that we bring all of the system partners along with us and really do that in a way that really does focus on delivering better care for patients .
I:	47:27	Yep . Keep coming back to the focus . [**P:** Absolutely] . That's what keeps you optimistic , I think , isn't it ? That's fine . Have you got any questions or anything ? Thank you so much for taking part . I've just got a few more things to go through .
P:	47:43	Yeah , no , no , that's fine . I suppose the other thing that would be good to understand a bit more of is when do we , you know , what are your plans once you've interviewed everybody and how do we get to sort of see the results really because I would be …
I:	47:54	That's what I was going to ask you about , So is it all right if I , well , it might help a bit . Is it OK if we follow you up if we need to check anything ? [**P:** Of course] . And then obviously the idea is we're going to do the interviews and then take that , we'll analyze all the interviews and then take that to a focus group . So is it all right to contact you to be part of that focus group in terms of designing that actual logic model ? [**P:** Of course] . So we'll bring what's come out of the interviews to that and then the group within that will formulate what the output of that logic model is . There's some commonalities and some interesting things coming out , I've only done three and I've kind of been swooped in . But it's interesting what's coming out . Is it alright just to contact you via e-mail ?
P:	48:39	Of course it is , that's absolutely fine .
I:	48:41	So then the other thing that I've got to do is ask you if there are other people you feel should be interviewed as part of this process . We are supposed to be doing a snowballing effect .
P:	48:53	OK , so just remind me , is this . Because it's a while since I filled out the consent form is the focus on whole system improvement for stroke ?
I:	49:02	So its system level changes , the exploration of the implementation of system level changes in stroke care across the north west coast region .
P:	49:09	OK , yep . So I don't know whether you've got [*name*] , but she's the national clinical lead that I talked about . She's fantastic . If you can interview her , that would be brilliant . I think interviewing [*name*] would be fab , so he's the chair of our ISNDN program board . And I think if you haven't got [*name*] on the list , then she'd be really good because she pulls together for us all the plans that I've made reference to . If you haven't got [*name*] , she would be amazing because she's our clinical lead for stroke . I'm sure you've got [*name*] on the list . There's also a consultant stroke nurse . I think she's or she might be a therapist actually called , oh what was the name I might have to send it to you [*interviewer name*] ? And she was part of our SIG group for the first time last week . [*name*] . [**I:** Oh [*name*] ? Cool] . Yeah , she was amazing

		in the group . I think she'd be really good . If you haven't got a patient then I would say [*name*] , you've probably got [*name*] on your list already . I can't imagine you haven't . Or there's a guy called [*name*] , and I'm just struggling to remember their surname who joins our steering group . I'm sure [*name*] would be happy to do it too , because actually getting the patient input into the logic model would be really good . And then what I would say is and someone from our finance community . So I'm actually sat in an office next to [*name*] . And so [*name*] may or may not have time to be interviewed , but I'll connect you to him because I think dropping [*name*] a line to say who would be best to speak to , he might nominate someone like [*name*] , but actually really understanding the financial context within which we're working and [*interviewer name*] is really important to me . And one of our therapy leads , if you haven't got a therapist down already , so someone like [*name*] or [*name*], how many interviews are you doing ?
I:	51:07	Well , this is this is the interesting thing in that I think we said originally that we do up to 30 . So I've done three and then I'm doing a snowball , some names are coming across some names I already had on my list . And so some names , and there's some commonality in the names that are coming out . I think it's just about so . As I said to the person I interviewed earlier , I'm sort of doing a first raft of the ones that were identified from this roundtable as key . And then . I will reassess , probably with the group who has been recommended and then pick who else we need to focus on so that we get that sort of group last ? That's my plan at the moment . I need to take it back . I don't know what we actually said in terms of whether there'd be some shared agreement on that , but I think that makes sense rather than me just randomly going out and interviewing everyone that's been suggested . I think we should be a bit more strategic about that across the patch .
P:	52:00	I think that makes perfect sense .
I:	52:02	So that's my plan at the moment .
P:	52:04	But yeah , but I think that would give you a good sort of broad section of people .
I:	52:09	Yeah , yeah . No , it's good . It's good that several people have mentioned about patients and bringing them in , which is good to see . And the other thing and I believe you've got lots of documents .
P:	52:24	Yeah . So what do you need ?
I:	52:26	Well what have you got and what can you share with me ? I'll have anything and everything . So I know you've talked about your driver diagrams . You've talked about all kinds of stuff .
P:	52:34	I can share it all , [*interviewer name*] . So what I'll do is I will put you in contact with one of my team . So [*name*] is leading the thrombectomy into new and better care program and he was instrumental in

		delivering the first breakthrough series collaborative that we did . And then in my team is involved in the stroke big room . So we'll just send you a selection of things over and if you need any more , let me know . What might be good is to share with you some of the updates that go to the ISNDN programme board . So I'll send it to , I'll copy [*name*] in and ask her to send you some of those updates because she's just got a record of them all . So you'll get the final version that went in rather than some of my working drafts .
I:	53:15	I think it'd be great to get anything we can because it's about that , that sharing of practice and if we can , if we have got good examples of things that other people can learn from quickly , you know , like those strategies for dissemination and how you plan , across the entire pathway . So yeah , anything and everything , because we obviously would come back to you before we did anything with it or shared any further . And you're going to be directly involved in how this is developed and goes forward .
P:	53:42	Yeah and to be honest [*interviewer name*] we have the sort of view in the improvement world that , you know , we've all got an obligation to share it . I'm quite happy for you to do whatever you want to do with it , because the more we can share the learning across our patch , the better . I mean , we've taken some really good learning from East Lancs and some of the other trusts across the organization . So we've already got that commitment to work together and share it . So I'll just make sure you get some of the key documents .
I:	54:07	Excellent . That would be brilliant , apparently . Yeah [*name*] told me I had to ask you .
P:	54:15	Yes , that's fine . We can definitely make sure . Obviously , if you need any more information , you know where I am , let me know and I'll fill out that electronic consent form this afternoon for you . So you've definitely got that as well as the word one .
I:	54:27	Brilliant . Thank you so much for your time . [**P:** It was a pleasure . Good luck with the rest of your research] . Yeah , I look forward to speaking to you in the future . [**P:** OK , thank you [*name*] . Thanks bye] .