Participant 5 12.06.23.mp3

Interviewer (I):	00:02	Recording . Are you happy to go ahead ?
Participant (P):	00:04	Absolutely yes .
I:	00:05	I've literally seen you do your consent form . That's fine . Do you have any questions before we start or just want me to crack on ? [**P:** No] . That's fine . Okay . So can you tell me about your current role within your organization ?
P:	00:20	Yes . So currently I'm a [ROLE], it's a [ROLE]. So it was set up in addition to the [ORGS] . So it was additional funding from [ORG]. And the idea was that we would facilitate the implementation of the ICSS model because across the country teams were at different points with their development and their maturity and being able to do that . So they thought by having these regional posts that could support that facilitation and helped address some of the system level barriers that we have around developing services .
I:	01:06	Fabulous . So your role is purely in stroke services and it is across the pathway .
P:	01:14	Yeah , it is . Well , it's community pathway . So because it's the Integrated community stroke services model . There's been lots of work done in the acute side , so this post was to try and facilitate that implementation of that model that was released last year .
I:	01:28	Okay . So can you discuss any stroke care intervention or change ? I know you'll be aware of a few that has been made or is currently being made .
P:	01:39	Where to start ?
I:	01:41	Yeah . Yeah . So we're going to try and unpick something so you can pick any of the system challenges really that you've been involved with and use the other examples as we go . It might be good to have a visual of one in your mind .
P:	01:54	So you are thinking of different projects I'm involved with currently ?
I:	01:57	Yeah . So we're going to we're going to explore that intervention and what you've done and what worked well and what hasn't . So that'll inform the logic model , if that makes sense .
P:	02:06	Okay . So I think for me the best one probably to focus on because there's so many is probably the vocational rehab work that I've been doing because that's across the three networks . Does that work ?
I:	02:15	Yeah , yeah . And like I say , you can bring in other examples as we go , but it just it makes it so can you tell me what the intervention change is ?
P:	02:23	Yeah . Okay . So in the ICSS model there are different elements of the pathways so in the life after stroke pathway . There's a vocational rehab

		model , so that's about supporting people to get back into useful activity . And that could be voluntary work or paid work or in a wider sense , it could be around just getting it back into activities of daily living . So if somebody looks after their grandchild , it might be about supporting them to get back into something practical from that point of view , etc. . And there's a national agenda . So the national team is working on this as well and they currently just released some work this week as a tool kit , would have been helpful to have earlier . That's the way these things work . So what we were looking at really was we've done some work with all three areas because Greater Manchester had started some of the work . They've gone ahead and done some of their own training . But the others hadn't . So it was something that all three areas needed to work on . So we set up a working group . And I'm supported by … I've got [ROLES] working with me in two of the network's identified people which has worked well . Greater Manchester have spread the money across a number of people . That's been a challenge because I don't have somebody specifically I'm working with . That's been a real barrier . So our working group , we have done some work around looking at current services that they were delivering . We did a training needs analysis and we have been involved in developing training from an external provider . That training has been delivered . And then we've done some work with the teams to assess their pre and post learning . And we're just doing a McKendrick model we're trying to use , looking at the impact of that training on the patients and pathway . So that is our four or five month post training . We have also involved the wider [*inaudible*] stakeholder group . So we've got people , we've got clinicians largely , we've got third sector , we've had DWP input . And in terms of our patient voice , what we do is go out to the groups . When we first started out , I approached Lancs and South Cumbria patient group and they work in a way quite formally where you have to ask them for help and you take the projects to them . GM were restarting their group . So I think I've spoken to them now and they have a formal group again and I've taken the work to them around a pathway we deliver in a patient pathway . And then Cheshire and Mersey it's a brand new patient group , so they don't feel that groups at the maturity needed to be able to take work to concurrently . So we've developed the pathway based upon best practice , a patient pathway and a staff pathway and principles . We did a data collection to look at the number of patients because nationally we didn't know the figures , or locally we didn't know the figures , patients needing VR . So we've done a data collection tool , got support from our data analyst to analyse that . And we are looking then at what workforce we need to deliver that and also models of delivery for it .
I:	05:56	Okay , Fab . So can you just , I know you kind of discussed it , but in

		terms of leading the change is that you that's taking that leadership role ?
P:	06:09	It has for this one . It's this is a sort of strange role in that sense . And it's taken quite a … There is probably more useful stuff around the information you're trying to find out as well is that some of the challenges I've had around that role and how it's worked . So I've taken the lead on this one . Often the role is around facilitating work with other people so it can be one of those jobs where you feel you're not achieving a huge amount sometimes because it's quite woolly . A lot of it is about influencing people , having an impact upon things and it's lots of lots , so the large scale change approach where people go off and do pieces of work based upon what you've spoken to them about . So that's not always catchable , measurable in terms of the impact that you're having . So that can be quite tricky sometimes . So I've chosen this one because it's easier for me to measure the impact that we're having . So I take a lead on chairing the meetings and taking the direction , but we do work quite hard at engaging the other people in the group . So we've had for the data collection tool , we had a small working group to look at that and to develop it for the patient pathway . We took that off to patient groups and [*name*] from GM's helped me with that and [*name*] and [*name*] in the other areas . So and then for the workforce we've taken it out to small working groups to make sure that we're developing , they've got a working group now looking at models of delivery as well .
I:	07:49	Okay . That's great . Thank you . So can I just kind of clarify in terms of this and other system level changes you made , what makes you choose the interventions that you pick ? I know you said it was a national priority on this one .
P:	08:09	So in terms it's evidence , we're trying to look at the evidence that we're working with as well . So we are looking at what's the national agenda ? What's needed from a national point of view ? What targets have we got to meet ? So it's measured on SNAP . So we haven't got we're not meeting on SNAP so that's another issue . Whether it's being addressed for my role , whether it's already being addressed with the ISDN's and in the local services or whether it isn't . So when there's a gap . I've tried to do it as a value added role . So I'm not duplicating work . That's not always been easy because it's quite tricky to find out exactly what's going on , to be honest . So I've tried to do it as a value added and it's also been done in consultation . So we did . We looked at the workforce , we've looked at the strategy of the workforce to identify what the needs of the workforce were . So why wasn't VR being delivered anyway ? And that's where we identified the challenge around the skills , the training needs of the staff and the confidence and competence to deliver that . So we did some scoping work around

		the discussion we had before around , you know , what are you currently delivering , what are your training needs , etc. . So it was based on all of those , those things . And then looking at the data we gathered , we use that to identify what level of service was needed . So from the data we now know we didn't before , which patients actually need a specialist level , which the NHS doesn't currently provide . So we're having to look at how we move that forward in the future .
I:	09:48	Excellent . So you've talked about the scoping work that you did . [**P:** Yeah] . How have you sort of captured what people thought of the intervention change ? Is that been captured as you go along with staff , colleagues and patients ?
P:	10:05	Informally only probably through the meetings . And I think that's probably one of the things reflecting on me as a marketer of myself and the work I'm doing and how we need to work now . I think that's one thing it's not my strong point . And so I do engage people , but I'm not very good at sharing what I'm doing , in a sense of formally . So I think the feedback I get from the groups I'm working in is positive and someone did give some good feedback in the meeting a few weeks ago about how it was being managed . But I think when I see other people nationally promoting their work , that's where I'm not particularly good at getting the message out there to a wider audience . And part of that is around my confidence in using different tools to do that . So making it look pretty is a big challenge for me . So some of the IT skills , so things like using Sway or one of my colleagues uses doodley [?] and there's lots of other things I'm not very good at . So I know how I'd like it to look , but it doesn't always come out the way I want it to . So I think that sometimes limits … I think about it , and I don't always do it because I don't know how to do that . So that marketing is not a strong point for me .
I:	11:21	That's fine . I'm just interested so you're aware of colleagues that do do it . What do you think they gain that you're missing by not doing that engagement ?
P:	11:30	I think I do engage patients and I do engage people and I do engage with the stakeholders . I just don't perhaps record it formally . [**I:** Okay] . So in terms of reporting it , maybe that's what I don't do . So I think what you can gain is when you're consulting with other people , it's that other perception , especially from patients and other agencies , external agencies , they just give you a fresh view and a realistic view of how it could look . And they very much bring you back to . So what does that mean ? So you're doing this so what does that actually mean in practice ? So I think that makes a massive difference . It brings it back down to why it's important and focusing on what you need to achieve .
I:	12:19	That's fine . This one , it is a tricky question , I think but in your opinion

		, how complicated is this intervention change ?
P:	12:29	It's more complicated than it looked on the surface , put it that way , I think . But that's always quite often the case . So it was we chose it initially quite early on in the project because a lot of the things it was unclear where we were up to . Had to do a lot of finding out from other places , some the other areas of what we needed to do . This one looked simpler on the surface , but it's as with everything when you get deeper , it's not . So it is complicated because you're having to look at … Well we've got a workforce that doesn't have the capacity , in their opinion , to deliver what's needed . We've got recommendations because the stroke recommendations and British Society of Rehab and Medicine recommendations . Their workforce recommendations are huge , and it's almost like having a whole new ICSS just to deliver VR , vocational rehab . So that's a challenge because that's identifying a whole team of people to deliver this service , including psychologists , you know , speech therapist , physios , OT's , etc. It's identifying a whole team of people . So there's challenges there about the expectations of it . It's complicated as well because of the , there's issues that people just haven't got confidence around . So things like AHP's are now allowed to do fit notes . So some AHP's are now allowed to do fit notes or the old sick notes but trying to get people to change their practice has been a challenge and the barriers have been around well our organization doesn't want us to do it or , we haven't got access to the information that we need to do it . So there's been quite a bit work around challenging some of those processes with changes as well . So it's also complicated because you potentially in terms of your delivery model having to look at it's not just going to be an NHS delivery , it's going to be a collaboration likely with a whole range of people . So you're having to scope out who are your stakeholders from a provider point of view , and you've got a whole range of charities involved in different areas . And because we're working across the three networks . So for example , GM's got 13 teams , Lancs and South Cumbria's got five and Cheshire and Mersey have got ten and they are just stroke teams . You are working with a whole range of teams that are all at different points , different capacity , different knowledge , different skills , different pathways , different local needs , population needs , etc. So it is quite a complicated piece of work . So on the surface it looks like it was going to be slightly easier than it turned out to be , which is why it always takes longer than you think .
I:	15:06	Always . Always . So can you tell me a bit more about supports that have been available to help you put these changes into practice ?
P:	15:17	Support for me ?
I:	15:18	Just generally , what support for you ? Support that's helped the project ?

P:	15:23	Supports come from the national team . So because [*name*] was looking at it from a national point of view and I've been able to link in with what they were doing and they although I wasn't involved in their working group , they shared their resources with me at quite an early stage . There's also clinical experts around the country , so that support have been helpful . So [*name*] from London , she set up a service a few years ago , so she's been really supportive as well . There's been support from the networks in terms of taking it forward . But again , in all honesty , I think they saw it as a thing that I could do that would keep me out of their hair and that's me be very honest . We will give [*participant name*] that to do because we're not doing it and it's something that she can get on with and it's not going to impact upon anything we're doing too much . So support has been , I suppose that has been more of a challenge from the ISDN point of view . It's sort of like on their agenda , it's not top of their agenda . So I felt it was a little bit like , let's just keep her quiet to do that bit . There's been quite a lot of support from the clinicians because they've wanted to move things forward . And also from the patients because they recognized the need for it . So patients are identifying that this is a problem and that staff weren't asking the question about work . So I think there's been also been support from the evidence that's coming out . So things like the UKSF stroke conference last year had a session on vocational rehab . So again , a patient presented at that , that's the powerful voice that people hear then to say , actually , we do need to think about this . And she identified that it should be included in the TIA pathway as well . So patients who had TIA weren't being asked about work at all when actually it was kind of going to be quite a big impact on them because the first thing you think about when something goes wrong health wise . Yes , I think there has been a range of range of support . I had support from data analyst as well and the teams that work together on sharing resources .
I:	17:39	Excellent . It's quite a lot you've covered as we've gone through . So the next things around implementing and staff . So you talked about you working groups , patient groups and strategies for keeping people informed and connected . Can I just ask either in this or in anything have you had experience of carrying out pilots of changes before you roll them out ? I suppose in a strange way , you are here , aren't you ? Because it's going in one before another but I suppose it is not a formal pilot .
P:	18:08	Yeah , so there's often lots of pilots in other areas , so I worked in [SERVICE] beforehand , so I have done stuff in that setting where we did research and pilots in that setting . I suppose all of the catalyst projects are pilots in some respect . So there's 14 projects going on with lots of different implementations or tests of change happening .

		So what we're doing there is looking at … It's slightly different because we sort of seize the moment where the money's become available . So one of the catalyst projects , just going back to the vocational rehab , we have the Catalyst Project going on in another area where they've used Catalyst money to prime this . We were actually looking at this in the northwest area , but it got pulled at the last minute because the staff couldn't support it . Yeah . So ran the pilot with the catalyst . It's those sort of tests of change , of trying something to see if it's making a difference and then broadening that out and that's been the same with the NROL project in Lancs and South Cumbria where they used it in East Lancs initially and then supported the other services to take that on board .
I:	19:25	Okay . So have you , you said you've had experience before with the [SERVICE] . So in terms of making changes as a result of the pilot , do you think the , I suppose do you think piloting is useful ? Or does it vary ?
P:	19:41	No , I think it is useful . I think you do need to because that's where you find out how things can go wrong . I think if you made a massive change straightaway , you know , you're not going to learn from that process . I think you do need to try it out on a smaller basis because you don't want to waste everyone's time . And you also need to get that buy in as well . If you're going to pilot something , it's useful to have people who are interested in it in the first place , and that could potentially go against you further down the line where people are less interested . I think if you did it with everybody , you could have quite a scatter gun approach to the uptake of it . So , for example , in the past , when I was working in [SERVICE], holistic needs assessments for [SPECIALTY] patients . There is , you do a bit like the stroke six week and six months reviews . So you do the same thing for the [SPECIALTY] patients at different points in the pathway and it had been implemented and it was mainly nurses doing that intervention , but it wasn't working very successfully and the numbers were quite low . So we had a whole range of AHP's in the team , there was another 5 or 6 AHP's in the team . There was some resistance to the nurses for AHP's picking that up they felt it wasn't our role . So initially my colleague and I were specialist AHP's on the brain tumour team picked that up and started to pick up some . So we did a pilot of I was sharing out some of that work and we increased the number of patients being able to have the assessment and also we asked patients experiences of it and we didn't find differences between the nurse doing it or the therapist doing it , which I think surprised the nurses and the patients were satisfied with us doing that . So we were then able to , because we tried that , we've been able to broaden that out into other settings . So our radiography colleagues then picked that up , our pharmacy

		colleagues have picked that up . We had ACP's in those areas , specialists in those areas . So they were then able to take up some of that work at the end of patients treatments , etc. , or during treatment . There was an evidence base there to do that , then rather than just saying , Yeah we can do it .
I:	21:54	Yeah , no that's good . But proving its value and then its non-inferiority , if nothing else , isn't it ? [**P:** Yeah] . Oh , the big question I want to discuss about costs considered and incurred in carrying out the change . So what costs are incurred ? Have you got ongoing recurring costs ? How complicated …
P:	22:15	How complicated is it ? So again , we probably chose this one earlier on because it didn't have in terms of cost , the cost is further down the line . So actually doing the scoping work and identification the cost then is of the teams meeting and the time of people being able to meet . So we've had costs around obviously the training . We wouldn't have had money to do that training . It was just that we'd put in a bid . HEE do an annual pot of money that they put out . So we got funding for that for Lancs and South Cumbria and Cheshire and Mersey . We wouldn't have been able to do the training otherwise because I don't have a budget which is again slightly different to the other Squires . So the Squires started their role with themselves on a pot of money to do QI projects . I started my role with me and the money was split between three areas into the [ROLES] . So I've had people rather than money to do projects . So where the others have had money to do that , we didn't . So HEE funded the training for staff and then it's been done and we're going to prepare some bits for the data and analysis . I've not been charged extra for that [*name*] has done that for us as part of the ISDN work . The biggest cost now is in workforce . So we can train people up but then once they are starting to look at what that model is going to look like , that's where the barriers are going to be because we've just being told there isn't any money to take that forward . So we're probably going to get to the point . My aim currently is to get to a point where we can look at a model that could be used and if we're going to probably have three different levels of model in terms of , say , the ideal model recommended , you know , the gold standard model , intermediate model and probably the model that we're going to have to go with because there isn't any of the money to step up to further down the line . So I think we're going to have to take a pragmatic approach to education and training as the way of being able to deliver that rather than the all singing , all dancing services . We're also looking at different ways of delivering that so for example NROL are looking at putting an element of their program into vocational rehab so it can be delivered online . So where we've got those options and patient support group . So for example , Third Sector Stroke Association are

		interested in running VR work as well . And in Cheshire and Mersey , we've got catalyst funding , catalyst two funding . So Cheshire and Mersey there bid didn't go through last time . They've now got more capacity within their neuro rehab team have a specialist VR service . So their lead now has capacity to support a project for them . So they are putting a bid in for catalyst funding . So that would be funding to deliver that service . But whether that's then maintained is the challenge .
I:	25:18	Okay . So there's challenges with costings and , I'm going off on a tangent a bit , but I'm just wondering do you think the budget is more important than the people or do you think it varies depending on the project ? But the future barrier potentially for any of these system wide changes is that future costs , especially with things like this ?
P:	25:41	It is . And that's where I suppose I've been used to as a clinician , I qualified in [YEAR] . So I've worked for a long time on a shoestring . And we all we make things happen on a shoestring . So to actually put bids together in my experience , because we … I suppose we get used to working around it a lot of the time .
I:	26:04	I was going to say so you've got a specific skill set then . Thinking outside of the box and how you can do things in different ways ?
P:	26:11	I think so because we don't have money , we often don't get …. I am a [ROLE] background particularly and an ROLE] , you're not on the top of the list to get things . So even if strokes on the agenda , then it's acute stroke that's on the agenda . So even when we were with stroke services , when we're setting up dysphagia trained nurses and screening , etc. . We did that across Pennine acute across small trusts . And it was literally the speech therapists who made it happen . We didn't get funding to do that . We did it . We made it happen . We developed the tools , we delivered the training . We did all of the competency work . We did all of the governance of it , etc. On our own . We were obviously you worked within the organisation and systems that you work in in terms of governance , but we just did it . We made it happen from peanuts really . So I think we just got used to doing that . So when these opportunities come around , I find with the catalyst stuff now that when these opportunities come around , people don't know how to put bids together as clinicians and maybe that's our role . Maybe it's not as I think there's an argument for that . But I think people are less sure they don't always have the skills to do it because it's not something we're used to doing .
I:	27:23	Okay , that's fine . So you discussed the training and things that you have going on . I'm going back to the beginning . Did you have like a formal plan for implementing these changes ?
P:	27:35	For the vocational rehab one yeah , for any of them , for all of them .

I:	27:37	Do you always , always have a formal plan . You kind of intimated that things evolve ?
P:	27:45	No , I do have a plan . So I've done project management training and I started an apprenticeship four years ago , 3 or 4 years ago now . So I do understand some of the project management tools and implementation , etc. . What is a challenge is everyone does it slightly differently in different organisations . So sometimes people ask you to report things in a different way . So that's a challenge . But no I have a project plan myself , so I work with updating that with the [ROLES] that I'm working with .
I:	28:19	Okay . Excellent . So project management skills and , that's fine . I think you've discussed this a bit anyway , but to what extent were goals or targets set ? I know you've talked about national priorities , organizational goals and patient goals , but were they formalized ?
P:	28:41	Yeah , I suppose it would . Yeah . So it was linked into the project plan and then what we were doing and what our work packages were against that . So we broke it down into what we were going to deliver . So being able to deliver the outputs from that . So for example , being able to do the training needs analysis , being able to deliver the education , being able to evaluate . So all of those pieces of work are the outputs and measures that we've done . So I would say my goal is to have a plan for each of the three networks in terms of how they look because of the role I'm in , it's not a management role where I can then take it back and say , okay you've got this , now you need to implement it . So we've got a model , all I can do in my squire role is offer it to people to say that we've discussed this as a network and this is what we've come up with . This is what you can work with . Now , some teams will run with that . Some teams are already ahead . So , for example East Lancs are already ahead with doing their delivery . So they're already looking at virtual rehab . They are already looking at having a standard operating procedure , etc. . Other services aren't it's not just East Lancs , different teams are looking at taking it forward . So it's about how . Yes , it's a strange role , this one , I have found it a bit weird in that sense because I'm used to working in something where I have responsibility as well . So again , we're talking about whether you've got that power , responsibility and authority . So there's some power with the squire role , with some perceived power with it , with some level of responsibility and some level of authority . But I don't have the say-so to go into a team and say right you need to do this . These are your key performance indicators . This is what you need to do . So it's a little bit of a slightly removed in that sense . And I suppose that's been a slightly weird . Situation for me from the other posts that I've done where I've been ultimately responsible , been able to make those changes myself .

I:	30:44	Fair enough . And can I just say so those differences in teams . Because they're at different levels . How have you managed that across the project as a whole ? Are there strategies you've got for …
P:	30:56	Yeah , I think it's about the communication , the collaboration . So I've tried to make sure that teams haven't felt that they are failing miserably if they've not thought about it because it's , you know , it's one of those things in the North . Greater Manchester sort of quite good at selling themselves . Lancs and South Cumbria , East Lancs always come up as the people who are taking things forward so the certainty , and Cheshire and Mersey are doing some cracking work but they're just like me they don't sell it very well . So it's trying to recognise . So I've been trying to be inclusive and collaborative and engender that feeling within the group that this is the starting point for all working to the good of the patient . We've got the patients at the centre of it and it's about how we can develop the services for patients and develop the staff within the remit we have , what we're able to deliver , what we'd like to deliver and what we're able to deliver . And so I've tried to be inclusive in that sense . And engender that sharing of resources as well and that ownership . So having people involved in the working groups , having them involved in the ownership of the work . So it's not me doing the work they actually produced that work . And we've also set-up a community of practice for the teams . So again , that's about them getting something out of it so they get an education out of it . They're getting that support and that ongoing moving forward . So that's how I've tried to sort of equalize it . And thanking people who have shared it as well , I suppose rewarding them for the fact that they are willing to share . But also making sure that all of those teams that don't always step forward , if I've noticed that they are doing something , I like asking them to feedback on the work they're doing as well as the approaches they've taken . And provision to sharing any problems that they are having within those community . I don't facilitate community practice , [*name*] does that for us . But we've spoken to her about trying to encourage some of that solution focused work as well , thinking about how do we fix those things as well . What are the approaches that people have taken in the hopes to sort it out ?
I:	33:05	Okay , that's fine . Loads of useful stuff so I'm fussing about a bit but in terms of you talked about engaging service users . How well do you think the intervention is , have you made any changes as a result of the service user involvement in terms of the intervention or how you deliver it or anything ? Or is it more a consultation exercise ?
P:	33:29	No , we have made changes , because we asked them to be involved in the sort of the pathway as well . We have the best practice pathway but we have asked them to be involved in looking at what that pathway looks like from a patient point of view . So they have yeah , they've

		made some comments about things . So one of the important things is I went to one of the groups and most of them were self-employed . So actually the pathway didn't really meet some of their needs . So there was some impacts in that conversation with them about how we perhaps needed to think about self-employed , because there's lots of talk about [*inaudible*] . And they said “well I run the business , so that's not relevant to me” . So that was important . And I think again about the reassurance from patients that they wanted to have that conversation early on . Clinicians were quite hesitant and didn't talk about work until there were a number of weeks or going home , which is totally useless for people who are still working . And so again , having that feedback from them and I fed back … So when I go to the meetings , I always feedback at the formal meetings with the working group , what's being said and what the changes are . And so I think it is invaluable and think that in terms of the presentation of it , the colours used , the language used , etc. and they've been able to be really helpful as well .
I:	34:47	Okay . And have health inequalities been considered within this ? Or do you consider health inequalities in your work ?
P:	34:59	Yeah , I probably more so in this role than I did previously . Not because it wasn't in my brain , but I think it's become more on the agenda in terms of I am more aware of the tools to use now as well like the heat tool [?] as well . And also working in NHS England , you have more access to people with that knowledge so that when you're a clinician , a jobbing clinician , trying to get that information or knowing where to find it is a real challenge . And having access to those resources within your trust is difficult . So I think being in the NHS England role enables me to ask those questions and know who to go to . Don't always get the answers because they're absolutely pulled out , but at least they might signpost you to where you need to go or the different tools that you can use . Yes , I suppose in that sense , looked at , around the data we would have looked at age profiles as well . And we kept hearing that certain areas were saying , well our area because we've got a lot of poverty , we've got more need . But actually when we looked at the profiles , we got [*name*] to look at the data . The background for the populations are actually quite similar across the three areas in terms of of age , only Lancs and South Cumbria had a higher age profile and they had quite a lot of patients that were still working , albeit they still wanted occasional rehab . So that was sort of the only tweak there . So yeah , I think it's challenging that thought that people don't need to work past a certain age . That's helped to make a difference in this project as well , I think . And also challenging one of the things that's come up from the findings which haven't take forward with [PLACE] yet but I think it's interesting . When we did the data collection because

		[PLACE] were doing part of their own thing , they didn't send all of the data in . They only did with some partial buy in but the other two trusts have had brilliant buy in and all of the teams have submitted data . And it's easy to see across those two areas what those patterns are quite clearly . And so you can sort of start to draw some information from it . So both areas for all of the patients that had a stroke about a third needed vocational rehab … [*Recording ends*]