Participant 6 9.10.23.mp3

Interviewer [I]:	00:04	So just for the purposes of recording , can I check that you're happy to go ahead and be recorded for this interview ?
Participant [P]:	00:12	Yes . Yeah , of course . Yeah , yeah .
I:	00:13	Brilliant . Thank you . So thanks again for agreeing to the interview it should take about 30-60 minutes . As I said my name is [*interviewer name*] . And you've been invited to participate in this research because you were identified as someone that has been involved with making changes or improvements to stroke care across the north west coast region . [**P:** Yes] . The idea is that we're capturing the learning from what's been done , share this with others and support future improvements in the stroke care pathway . So I'm going to ask you a few questions about your involvement and experiences of that work that you've been involved with . Obviously were interested in your opinions around what you did , why you decided to do it , what worked well , how the service could be improved , any challenges and other comments you'd like to make . And we hope to capture those comments to understand what changes have been made within stroke care , particularly at a system level , and explore what worked well and what could have been improved . And then , as I said , the information from these interviews is going to be analyzed and used to inform focus group discussions to help develop a tool called a logic model . And then the logic model can be shared and used by others to carry out improvements in stroke care . Is that alright ?
P:	01:23	Yeah , that's fine . Yeah .
I:	01:24	Okay . So can you tell me about your current role within the organization ?
P:	01:31	Yeah , of course . Yeah . So I'm a [ROLE] , so . And I cover Cumbria , a Lancashire area . So we have three areas in North West Ambulance Service . We will have a [ROLE] in each area . From my perspective , what that means is I currently cover Lancashire and South Cumbria ICB and North East and North Cumbria ICB . Previously I've worked in both of other areas as well , but obviously

		before the ICS or ICB were setup . So I worked in Greater Manchester . That's where I start my career as a [ROLE] and I was an [ROLE] in [PLACE] for a number of years before becoming a [ROLE] for [PLACE] and I worked there for three years , about just under three years before I transferred over to [PLACE].
I:	02:23	Brilliant . And your role has involved and involvement with stroke care services ?
P:	02:30	Yeah . So from the pre-hospital perspective . Yeah . Well , I say from a very pre-hospital . So sitting within the various groups . So in Cheshire and Merseyside , I was involved in some of the work that was done around the Mid Mersey stroke reconfiguration and some early conversations about the North Mersey reconfiguration and some discussions around Thrombectomy pathways . In South Cumbria and Lancashire I've been quite actively involved and still am in the stroke reconfiguration work that's going on there , currently . Well , that's currently on pause at the moment .
I:	03:12	I didn't know that , but I'll try not to ask . And so can you describe . Thinking about any of those any stroke care intervention or change that has been made or is currently being made , and tell me what the change was , how you were involved , how you decided on that change . I mean , you can use multiple examples , but sometimes people find it easier to pick one .
P:	03:36	Yeah , of course . So I think that actual change is predominantly around pathway from a pre-hospital perspective . So our assessment tools tend to be fairly, we look for a validated assessment tool . So we currently use FAST , which could be enhanced and there are suggestions of how that could be enhanced . And you know , ideally we look at how that is enhanced from the pre-hospital perspective in the future . But we have designed assessment tools , we've done some work around what stroke mimics can look like as well to try and filter out . So that's been it's been a journey from a pre-hospital perspective from about probably 2008 , 2009 where we have evolved into a position where we actually have hyper acute stroke unit pathways . That was predominantly around getting patients within a four hour window to Thrombolysis , so to the services that will provide Thrombolysis . I

		think the evolvement of stroke care and , and you know , I think the licensing around Thrombolysis as well has led to an increase in that window . So we've done some work to consolidate some of our pathways across the northwest because [ROLES/CONTEXT]. So you know , you could start in one area , you could be in another . So it's about trying to align the pathway so it looks very similar regardless of where you are . And also that factors in some of the inter-arterial procedures that are currently done and your CT reperfusion as well . So we're trying to move with the system around that so , you know , as fellow providers . So when thrombectomy being a big area where we we're looking at how we might be able to identify the right people to go to thrombectomy centers , you know , and when we look across the northwest , we have different challenges around that so , you know , in Greater Manchester it's fairly , you know , on a blue light it's quite good that you can get to a central place and you've got the draw of the staff who want to work in that environment . So setting up a stroke center there that delivers 24/7 thrombectomy means that your pathways are pretty aligned and you can have these tertiary centers that do some of the Thrombolysis but would all filter in to the center for the Thrombectomy Service . Merseyside , Cheshire and Mersey had a few different challenges around that and still continue to do so . So South Cumbria and Lancs , geography is a massive challenge there . And what we've been involved with is looking at some of the video teleconferencing and so that's been a big , it's been a big national driver on video teleconference for stroke . So this is where the using the [[CONTEXT/ROLE] can be involved in a consultation with somebody at a stroke centre and decisions made about [CONTEXT]. That predominantly for us has been in Greater Manchester and in Merseyside . In South Cumbria and Lancs we're currently taking part in the speedy trial , which was part the optimist research . So that was looking at , initially what we're looking at is being able to identify a pre-hospital tool that would filter out the right patients to go direct to Thrombectomy . And I think what speed is now doing is it's still an arm of that . But it's also looking at whether a telephone consultation with the appropriate . So you know , you've got the control , you've got your intervention . So the intervention arm would have a telephone conversation with the Thrombectomy

		Center and would bypass and take the patient direct to Thrombectomy . And that's that's been going on since June in South Cumbria and Lancs . So lots of work they're looking at but prehospital stroke care doesn't really massively change . It's about getting patients , identifying the right patients and getting them there very quickly , getting them to the right place very quickly . And that and how we evolved that and how we make sure that we are utilizing the best approaches towards identifying the right patients is key . And that is , you know , it's a bit of an evolving process really . And I think the other side of that then is , you know , there's a lot of work we have because the role of a [ROLE] has massively changed over the past 25 , 30 years and how we ensure that [ROLES] are identifying certain patients where less is more , so not doing observations that perhaps are not needed and making sure that they're moving very quickly is part of what are the key things that we try to promote . The other side of some of this from an ambulance service perspective is the movement of vehicles . So when we move vehicles longer distances , what that means is that we are potentially depleting another area of a resource . So we have to factor in the impact that does have with regards to our resource mix and our profiles . And that becomes further challenged when we start looking at repatriation .
I:	09:27	So is that so you've talked about obviously different ...
P:	09:30	I have talked about loads haven't I .
I:	09:31	I know you have those loads in there and I'm going to try . And so you've talked about different areas and different challenges and that's great , but can you talk to me about the development of these intervention changes and why you choose to make them within the areas ? So obviously there's resources issues and geographical issues you mentioned , but is there other things that and who's involved in that decision making process in terms of making those changes at a strategic level for you ?
P:	09:57	Okay . So do you mean from a the implementation of , for example , like so you know , I talked a bit about video telecom but that that pilots so there like short term and we will trial this in one area and I think what happened is there was a funding opportunity so people

		could apply , the ISDN's could apply for funding to support that but the application came from the is the ISDN's . Now we had initially we from an NWAS perspective we thought well what would be great and Greater Manchester were very keen but Cheshire Mersey put one in and in Cumbria and Lancs we did look at it . But I think what we decided in Cumbria and Lancs was because we had multiple things going on with the speedy , we were already in the throws of a bit of a reconfiguration at the time as well . We thought , why go down that route when we've got something else ? Because well there would have been a conflict , there would have been a conflict with what we were doing with the trial , and what we would be doing with the video teleconferencing set up , that was why we couldn't proceed in that that route .
I:	11:10	Okay , that's fine . So actually it's getting the evidence to decide what you should be doing as much as anything .
P:	11:18	Yeah yeah, well , the thing is as well it if , if the trial in Greater Manchester , for example , proved that video teleconferencing was brilliant and we should roll out across the northwest , that's proved it's proved in what you know it's not going to tell us anything different in South Cumbria and Lancs from what it's telling us in Greater Manchester , because it was about using doing the same thing , like you would phone ahead to speak to someone who would say , yes , this patient should come straight to you or no they shouldn't . So that would have been exactly the same . You know , we would just all be doing it for the sake of doing it .
I:	11:57	Sorry . My phone keeps going off .
P:	12:00	No it's okay . Yeah , I mine keeps doing it as well .
I:	12:03	I think it's somebody ringing me about telephone , believe it or not .
P:	12:08	Yeah , mine is my boss trying to get a hold of me so .
I:	12:13	Oh , I'm sorry .
P:	12:14	No it's okay it's fine .
I:	12:14	That's fine . So , um . So when you , if you are going to make a change , you obviously , you just we've talked about lots of different

		things and some changes and some are things that you're exploring . But if you were going to make a change or put an intervention into place within the setting . What , how would you go about that ? What would you need to support it ? Who would be involved , What staff and colleagues ? What would drive the change ? Would it be the evidence from things like the Greater Manchester Project ? Obviously you've mentioned funding might have an impact .
P:	12:52	Yeah . So I think that it depends on the change really . So for example , when we looked at increasing the window for pre-alerts . So we're , we're going from 4 hours to 6 hours as a window for pre-alerts the impacts on us as an organization with that was pretty much you know it wouldn't have had any ... so we would consider what impact it has on our core function for emergency case because obviously we provide broad emergency care for a range of patients , including strokes . So what we would consider is , well , what does this mean for us ? You know , does it mean we're going to be spending longer on scene with patients ? Does it mean that we're going to be taking patients further distances ? Because all the impacts on our ability to respond to other patients . You know , does it mean we'll be waiting outside hospitals for a longer period of time ? Are we taking them somewhere where that they're currently really struggling with regards to ambulance handover's because that would just add to their pressures . So they're the kind of things that we might factor in . But with regards to the sorry , back to the window , that would have no impact on any of that . It was just the case of asking [ROLES] to fore-warn a bit patients from a broader window . So that was a fairly straightforward and go to the ISDN's , present it with the ISDN's and agree with the ISDN's . This is what we'd like to consider doing . And if all five ISDN's that we currently cover are in agreement , I say five , the three main ones being South Cumbria and Lancs , Greater Manchester and the Cheshire Mersey . I mean we touch in Derbyshire with Glossop and Northeastern so .
I:	14:38	Choosing doesn't it , but yeah ...
P:	14:40	Yeah , so we would we would inform them all but they would be the main three ones . And if the big three you know you might not hear anything back from the other ones , but if the big three are

		absolutely committed then that's what you do . You know , you just and that's what we did with that with that change . When we start looking at wider change , like , well , the reconfiguration stuff that was going on for South Cumbria Lancs that involves and you know there was an options appraisal . So there was a scoring exercise that was done and this wasn't NWAS introducing a change . This was us a collective . Yeah , yeah . So as part of the network , it was decided that , you know , stroke care is very difficult to deliver in some of our district general type sites . Some of our challenge geography , where the challenge to , you know , recruit and retain the right calibre of personnel . So we would look at how we might want to reconfigure . And then there's a scoring exercise that was done and there was a public engagement piece that was done as well . And then as part of the options appraisals , what we what we would do from an ambulance perspective is we would look at some modelling around what the movement of vehicles would look like and the impact that has on our resourcing , because like I said , when you start moving ambulances , from our perspective in South Cumbria and Lancs , you know , we're not talking small distances . It's not like it's a 20 minute journey . We're talking an hour and a half . And so it starts to become very difficult from some parts of the patch . And that's what we did . We considered that modelling we put in that these this is the additional resource that we need . I think the , it becomes even more challenging because more influential factors come into play and that sometimes throws the modelling out . So you end up that in discussions . I think the biggest challenge we faced within South Cumbria and Lancs is the pre and post Covid position because that's very , very different with regards to health care delivery . And I think what that has done is for us as an organization but as part of a system as well , all the provider sites are feeling the pressure with regards to the complexity of what types of patients are presenting and length of stay and the impact that's having . So with that , we're in a situation now where we we're on a hold and we're reviewing what that looks like , really .
I:	17:32	Okay . So can I just check with the modelling when you talking about the ambulance moves , it sounds like that's an internal thing

		that you do within , you don’t have other stakeholders that get involved with that ?
P:	17:39	Yeah . So we do .
I:	17:40	Have all the stakeholders that get involved with that .
P:	17:43	We can do I mean , what we did with the and we modeled it about 15 times it feels like it wasn't that many . But what we did when we were looking particularly around one of our sites was we because from an ambulance perspective , you see a patient that looks like they could be having a stroke . And what we what we find out is you get them to a site and actually they're not having a stroke . They could be a number of other things . And , you know , mimic’s being a prime example . But even when you start identifying the , you know , the key conditions that can mimic , the key differentials of a stroke , what you still get is a group of patients that will not be filtered out , prehospital care . We don't have C.T. studies on the back of ambulances . So , you know , it's very difficult sometimes to identify them right patients . So what we did was we did some work with the one of our acute sites to identify what their numbers looked like . And this was based around treat and transfer . But they we changed the dynamic in one site as well , where it was going to be a direct from their flow , which was a short notice change from our perspective and we hadn’t modelled that . And that was a big risk for us . And I think ... sorry go on .
I:	19:07	No , that's good is fine . So you do liaise with acute ?
P:	19:12	Yeah . We liaise with the acute for some of that data . And I think what we were what we found as well is that the number of self presenting strokes was slightly different than was expected as well . And I think that has an impact as well on the flow because you're not factoring them into what ambulances are taking into our site . So , you know , there is a whole other level of complexity that wasn't based around ambulance modelling then that was based around what the sites would say .

I:	19:43	Okay . And when you say we , I'm just trying to get some like nitty gritty stuff who obviously yourself as [ROLES] . But who else in the organisation did that sort of stuff .
P:	19:56	As the this would be as part of the integrated stroke ... ISDN's .
I:	20:02	So it is done with the networks ?
P:	20:03	Yeah yeah yeah yeah . So we would work , yeah . So we have like an operational implementation group that were focused on these components .
I:	20:14	Okay . And was that was that big group . Small group . Who was in it . How did it work ?
P:	20:19	It was a fair size . Yes . So every acute site affected would have representation there . And what we would do is we would you we had we were on a three year trajectory for implementation . We got to the end of year two and we're on a hold at the moment .
I:	20:35	Okay .
P:	20:36	Which was the ambulance side of things .
I:	20:41	Okay , so in terms of implementation changes , obviously that's . That's in the planning process . And you're on with that . But I know you said it was a simple one but the change for the pre-alerts from 4 to 6 hours . What strategies do you use to implement that intervention within the organization ?[**P:** Okay . So what ...] Are you just getting the [ROLES] to do that . But I know it won't be that simple .
P:	21:06	Yeah . Yeah , it . It's not . So it's about communication isn't it . So and , and try and showing people to understand why and that that's been a bit of a challenge because well communication is always a challenging such a nomadic organization . You know , we move around so that , you know , it can be very difficult to pin people down to communicate . So what we tend to do is we send out clinical bulletins which inform of the change . They are uploaded onto our guidelines app , which is called JRCALC . So the Joint Royal College Ambulance Liaison Committee has an app location which is holds all ambulance UK ambulance guidelines and we have a

		local agreement where we can put our clinical bulletins on there so that's available electronic to our [ROLES] . We also have a display screen in every ambulance and we could put up a message to inform them of the change on the display screen as well . In every ambulance when we make the change . And so , you know , a few approaches and we have the contact shifts in north west ambulance as well so we would use them where a supervisor goes and works with a member of staff and could have , would have conversations about these kind of changes . People still slip through the net though . And , you know , that's that's life , isn't it ? I think the other thing that made it a little bit more complicated was there was a perception that this was a change to the thrombolysis window . And it wasn't . It was a change to assessment for stroke patients . And I think there is a big communication piece and we still ongoing with around [ROLES] understanding of what is provided for patients when we get to a hyper acute centre because we've done so much work from all in the benefits of thrombolysis for stroke patients and [ROLES] can relate to Thrombolysis because we used to do it for cardiac patients . So I think that relationship sort of like bound them a little bit stronger and when you start trying to explain that Thrombectomy is like a PPCI for the brain and , you know , trying to put it into a language that they might understand a little bit better . So but some of that is about just getting out and speaking to people and making them aware .
I:	23:26	But they definitely need that wider understanding stuff because it's changed , hasn't it , In terms of thrombectomy windows have changed , haven't they , with all the wake up stroke work and everything else that's been done ?
P:	23:36	Yeah , absolutely . Yeah . You know , and the CTI stuff as well , which none of our sites do currently but well that's but again , massive changes for the future and I think it's just that evolvement of treatments , you know that are available for patients . And I think some of it is about getting the right messages out there , you know , and patient stories are really powerful in this space . If you can get some really good patient stories where they've received thrombectomy , you know , that kind of thing really works well . So ,

		you know , it's about finding them nuggets and using them to your advantage if you can .
I:	24:14	Yeah . No , no , it's good . It's so it's about them understanding why the change is rather than it just being a change .
P:	24:19	Yeah , exactly . Yeah . Yeah . You know , and I think obviously so certain change does affect people's lives as well ? So , you know , when they're on a late finish and they've got to go further with a patient , you know , that , you know , affects on home life , it affects you if you're tired , you know , say it's about them being confident that it is the right thing to do for that patient .
I:	24:45	That's right . And I was going to ask you about piloting of changes . You've already discussed that you do do piloting of a change in like the tele video stuff for the iPads ?
P:	24:55	Yeah . Yeah . I don't like the name pilots , though .
I:	24:57	No , No , you don't like it .
P:	24:59	Someone said to me , you've got more pilots than British Airways . You've got to be careful you'll have more pilots going on the British Airways , so . Yeah . Yeah . No joking aside . And yeah , we do . We do . So we would I mean , it depends Again , it depends on the change . I think . I think the video conferencing is . The video conferences is one of them areas for me where it could expand on scene time for patients . And I think currently we really , really push the fact that you should be minimizing that time you're on the scene with strokes . So it feels a little bit like you're going completely in a different direction when they're waiting for a callback and somebody on the end of a tablet device is asking a lot more questions and assessing the patient in a lot more detail than they would . And again , it's about the evidence to support and be able to sell that as the right thing to do . So I think , you know , it was and it is very popular . And I think , you know , I completely understand some of the data GIRFT data around and the and it that video teleconference suggests that it does really benefit for patients you know , getting them to the right place and identifying the patients who shouldn't be going . But I think you know , to just to go out and pilot three sites and just , you know , unless we are implementing ,

		you know , let's say we're implementing , which is different . I think we just need to understand what impact it could have and from various different angles as well . Because the other thing is that , you know , you are limited with times . So so , you know , there'll be 8-5 Monday to Friday . And [ROLES] work [CONTEXT] so . You know , it's things like that which impacts on it as well .
I:	26:52	Fair enough . Can I just ask , though , what you'd call them if you didn't call them pilots ? Do you have a term that you prefer ?
P:	26:58	Yeah . So we do use trials occasionally or tests , you know , try and try to we we what we do try and at least do stuff alongside QI methodology . So how we can we could build on it from a QI perspective . I mean , I'm joking aside with the term pilot because we still use that term as well . I just it just it just does make me feel that , you know , it's . And the other thing is some of these things just don't change that . You know , whilst you are putting it in as a pilot , you still doing them in 2 years , three years time . So it's how do you you know , I do like the concepts of you're doing it through a QI approach where you actually building on the success of it or you know that you agree that it's got to a point where it's not going to continue . And , and , you know , with the video conference and I think some of that and it well not from an ambulance perspective particularly , but from a having a stroke physician or a general practitioner , it becomes that there is a funding component to that .
I:	28:07	You led me straight into where I was going to go into that . So what what sort of how are the costs that are incurred managed . So it sounds like most of the work that you do is linked with the ISDN . So is the funding come through their sources or NWAS sources or ?
P:	28:26	Yeah so and it tends to come through their sources . So with the video conferencing, it was it was NHS England funding , the short term funding that was available to be applied for and that's how the ISDN's agreed that funding . And in the end with regards to reconfiguration , it would absolutely try and factor in , I think it starts to become a little bit more complicated . So . So we would factor it in through the ISDN's , you know , and we would expect it to be part of the business case . With regards to a reconfiguration , I think the these other elements that start to become a little bit more

		complicated , such as repatriation , because I think that that is a massive area where we you know , I . Well , I don't know of any up and down the country really . I could be wrong because I haven't gone into detail looking for it where there's robust repatriation policies in play . And that is a big challenge because everyone's capacity is challenged . And how that how that works , you know , from because obviously from an ambulance perspective . You know , for example , some of the conversations we have had is and you take a patient on a blue light for an hour , you get into a site which is where the specialist stroke centre is and it turns out it's not a stroke . So you'd take them back an hour and a half in normal driving conditions to the day that they should . And that for me is just not good patient care .
I:	30:07	No , no , I can see that . Just to quickly clarify again , I will try and move on , so you said for some of the things that you've done , it's been like small pots of money , like the NHS England money . But how's the decision come about to go ? Is it because the money's for testing teleconferencing or is it that you've decided that's a good intervention to trial and you've gone for money to trial it . Do you see what I mean ?
P:	30:34	So I think the I think from a national perspective , there is good evidence coming online to say that it does work . In the early adopter sites , so I think it's [*name*] who has led some of this work . [**I:** I think it is through the GIRFT stuff] . Yeah , through the GIRFT stuff . I think that . That extrapolating that into busy systems is , you know , is something else a little bit . And I think that's where there probably is an element of caution from from all parties .
I:	31:09	You have taken something that's been shown to work in early adopter sites and decided to pilot it ...
P:	31:15	Yeah yeah .
I:	31:16	And then had gone for external funding to be able to do that .
P:	31:19	Yeah . Yeah . So it was NHS England provided the funding for that . We haven't implemented in any of our two sites where we've , I think , I think Cheshire & Mersey might still be going on in some form at the moment , but I think it's still considered a short term measure

		whether they as an ISDN have agreed to continue funding it . I think they had some a few teething problems with getting it up and running initially . That probably means that , you know , the timescales are slightly out .
I:	31:50	So you discussed the importance of patient stories in terms of getting those that implementation and examples . Can you can you discuss whether the needs of service users were considered in other ways ? So how have you involved service users in in the changes that you've brought about within stroke care do you think ?
P:	32:12	Yeah , I mean , we do have service users and as part of the group . So the ISDN has service user representation , as does the clinical oversight group , and they , they attend regularly and they provide regular updates at their meetings as well . And they've they've also I say , you know , as an ISDN , we've been going out . So when we do decide we're going to propose a change , they will go out and they will speak with Healthwatch , speak with public engagement groups to try to understand what their concerns are , you know , how they feel about proposed changes . And as part of overview scrutiny committees as well , they would go to that level . So the representations , you know , they get the council representations for the public at that represented there as well , and they're able to voice a concern or , you know , ask questions and try to understand the impacts of the change . I think more locally from an ambulance perspective , you know , it can be quite challenging actually , to get the patient stories and to get the patient's view because , you know , obviously we get there at a time of , you know , emergency where their world is falling apart . Try and put some sense of like normality in play and get the moving to where they need to be and then hand the patient over and then , you know , never see them again . So , you know , in many cases , quite recently because it's World Stroke Day at the end of the month , we've just been looking at some patients where we've had complements . So where stroke patients have complimented the crews and reaching out to some of them to just try and speak and see , you know , what we can use with regards to getting some messages out . So doing that kind of thing , really . And I think . The other thing , you know , it is interesting because from an ambulance perspective , we have clinical quality

		indicators around stroke care . We have clinical quality indicators for a number of things . But it's all very much like a bundle of care that you deliver for every patient who you suspect is having a stroke , which we tend to do anyway quite well because we never drop below 98% . So , you know , it's not really telling us anything . It's just things that we do . And then it's all about time . So it's all about , you know , we get there , we need to get there very quickly . So it's you know , our CAT2 standard is 18 minutes , you know , but we're in a situation where it's slightly different because we're in a recovery situation and they're in urgent emergency care but we should be about 18 minutes . And we with strokw we tend to have a call to door of an hour . So what we try to do , we you know , we don't hit it . We think the closest we've been is probably , you know , just going into 2019 where we were about one hour and 12 , I think . So , you know , it's a really challenging target . And some of the reasons for that is because , you know , someone's worlds fallen apart and they want to look after the doctor , make sure the husbands or phone , you know , and we are trying to usher them along so , you know , and then you've got difficult extrication and all these things that impact . And I think it's sometimes when you look at the stories that patients give you , actually it's , you know , times important . Certainly when you get them to that treatment and they get the right treatment . But that's not the only thing that they want from us , it's the compassion that they want it’s the care that , you know , there's so much more to that package . And I do wonder sometimes when we look at our quality indicators , whether we should factor that in a bit more rather than just look at , you know , the quickness , the speed , which speed of response is important . And I'm not saying it's not , but there are other things that we perhaps should be factoring in really .
I:	36:22	Do you or in the work that you've been involved with , do you think health inequalities are considered as part of like change in intervention things ?
P:	36:31	Yeah . Yeah . So we , we have the stroke association in our ISDN as well . And it is a real I think that , you know , health inequalities are a real factor that we want to bottom out . I think we , like a lot of areas , I don't think we are anywhere near where we should be with this ,

		with with addressing health inequalities and reaching the populations we should . I think from an ambulance perspective , one thing that and one of my well , a [ROLE] who works now within the GM (Greater Manchester) ISDN , so he works within their ISDN but he's part of the national group working on ambulance measures and looking at SSNAP . And one thing that we we're looking at getting in there is are time of patients , time of onset of symptoms to calling for the ambulance . And I think that's a massive area really with regards to health inequalities and try to understand what you know , why certain people will phone a lot quicker than others and try and address some of that . And so , yeah , you know , I think there's lots of really interesting work there . I think from from our perspective , the , you know , the ambulance data is not it's not as reactive as you'd like it to be around health inequalities . We do have some , which is helpful , but I think we look at that national ambulance data set which will link in to some of the patient data that the hospitals hold as well , and that will give us outcome data for [ROLES] . But it will also link because in with some of the and the ethnicity monitoring and that will help . But we can look at geography , you know , we can certainly look at areas of deprivation and try and understand why , you know , we're just not reaching certain communities .
I:	38:34	In terms of implementation of changes . Can you talk to me about , Can you describe how networks , organizational relationships , colleagues within and or outside of your organization ... It's very complicated ... help or hindered the implementation of the changes . So what key influences good and bad in terms of that sort of cross organizational stuff , I suppose ?
P:	39:05	Yeah . So that's an interesting one , isn't it ? So I think . The . I remember . I remember one where we were in a situation that I'm not going to name any sites . We're in a situation where we had real issues with regards to stroke cover at a site and it was going to be and you know , there were going into repeated periods where they had no cover at all and we were taking patients in and they were having to transfer to another site all the time . And , you know , that that was the situation . And , you know , we decided , look , you know , enough is enough , you know , whatever the ISDN were

		called back then . And we , you know , we decided enough was enough and we need to do something differently . So we put a pathway in and we modelled it and decided looked at the movement of ambulances there was , you know , a small uplift in our resources . We were all set to go and we sent out , I sent out loads of comms to my staff saying , this is what we're going to do , we're going to go there and it's going to start from this date . And it was I think it was a Monday morning . And on the Friday afternoon , the chief exec at one of the sites said that's not happening and stopped it . And they all stopped .
I:	40:32	So was that because they weren't involved or they hadn't engaged properly or ?
P:	40:39	Well , I think there was they weren't they clearly weren't aware . For him to react the way they did . So , you know , I think the brief that they'd had was clearly lacking . But my understanding is it was to do with finance . And we eventually did do the you know , it did eventually happen , but it was , you know , a really frustrating situation to be in where you were back peddling and then trying to tell everyone that the thing that you were telling them was starting now wasn't starting . And yeah , so , so yeah , so and I think that I think the difficulty we face in a lot of areas is the capacity to accept patients . That is one of the key things for me and you know , from an ambulance perspective because , you know , at the end of the day , we're fairly flexible really . You know , we you know , it's not a big ask really to put more ambulances on the road , although you need a lead in because qualifying [ROLES] now it takes a few years . It's not , you know , as quick as it used to be and ordering ambulances . But pretty much we could do that fairly , fairly , you know , well within a decent plan timeframe . I think where a lot of the challenges are , we have some really , really challenged estates which mean that their capacity just isn't there . And I think what you end up with is in a situation where everything's going to go to a side that's fit to burst and they just are going to struggle and you can see they're going to struggle before we even get to the point of implementation . But we seem to go down the line of well we're going to do it anyway and then get to a point where it just doesn't happen .

I:	42:33	Okay , that's fine . So can you tell me about things you think are helpful in bringing about change , at a strategic level that you maybe haven't already discussed ?
P:	42:46	Yeah . I think that having a really good collaborative group , I think having a group of individuals who are ... Work together and do try to understand each other's problems , even though sometimes they do not strictly align to your own . So I think that that level of maturity in a group is key for me . And I think , you know , I've worked with some really good people at the moment , certainly within the ISDN that I work in , that helps . It really does because , you know , whilst you get frustrated with each other and you do , you know , they will not all have the same priorities . You know , you do your best to understand each other and to be empathetic and supportive . And I think that really does work . And sometimes , you know , just reflecting on that a bit further , I think sometimes having the knock-backs helps with having the occasional knock-backs can help with that because you're all in it together if you like . [**I:** Okay!] . So you grow . That's just me on reflection on some recent events really .
I:	44:02	Okay , that's great . And within these collaborative groups , are there key or central people to plans or is it is it very collaborative or do you have leadership within that ?
P:	44:14	Yeah , I think we have we have leadership in there . Absolutely we have leadership . You know , so we have people we have directors , we have a chief executive who chairs the ISDN , and we have directors who will attend that . The national clinical leaders attend our ISDN occasionally as well , which does help . And so we do have key individuals . I mean , we I think collaborative wise , we absolutely bring our patient reps in as part of that . They are part of our group and they are as represented as everybody else in the room , really . And I think that's key . So whilst you get the structure or format is put in place by , you know , the leadership , you know , and one of the directors of quality and improvement from one of the sites looks after the clinical assurance group , for example , the sorry the clinical advisor group . So she , she , she chairs that and we do a lot of quality improvement side methodology work around in that group . But ultimately that is just to guide us in that process ,

		if you like , to keep us on track because otherwise it be a bit like herding cats . So I think it just keeps us all on track . But we all absolutely work together and respects each other's views . And I think what we've done is we've split down each theme and we've brought individuals from other representation into each theme as well . So , you know , for example , I am pre-hospital , obviously I sit in the pre-hospital , but within that group there is also one of the well , one of the patient reps sits in that group with us as does one of the project managers and one of the acute sites managers as well . And what we do is we , you know , we all work together and set out what our improvement goals will be and try to work towards them .
I:	46:09	Okay . So it's bringing in all those perspectives and , [**P:** Yeah , yeah] . And all the stakeholders that will be affected . So for pre-hospital , it's the acute providers , yourselves , the patients , yeah .
P:	46:20	Yeah , yeah , and everyone's views follow too , you know that they absolutely have a view and are entitled to bring it , bring the challenge basically to each other to make sure that we are thinking of things a little bit differently . We're not just on not , you know , narrow thinking .
I:	46:35	Okay . And so obviously you've got these people involved , but how do you how do you keep that group moving and how do you keep each other involved ? Is it just meetings or are there other strategies for ...
P:	46:48	I mean , it is predominantly meetings , you know , because obviously we're all very busy as well . I mean , I mean , I do see people in other settings as well . So , you know , I might meet with one , you know , the one of the directors for unscheduled care . I might meet them in another forum , but I know them through the stroke group . In the main , you know , it's doing the business . But what we do try to do is make sure that there is a variety of elements . So we would go to meet up at one of the sites and we might do a walk round the stroke ward and things like that . So just understand how their people work . And you know , that's quite useful because you get to see other things like , you know , posters that staff on a wall and identifying , you know , you can identify like superstars who

		work on the wards and things like that . And you can pick that organically from the energy that you see . And that gives you a chance then to look back at your own organization as well .
I:	47:44	Do you have those within your organization like Superstars Champions ? Do you have that sort of system ?
P:	47:50	No , we we do . And we don't I don't think we formally do . I mean , championing things and ambassadors and things like that , we might have we don't have any any specific for stroke , but we do have people who take the lead on certain clinical topics . And I think what you do is you know , you have to recognize anyone in them kind of situations where they don't want you because you get some people who will just do that naturally and not really want to take that mantle on . So it's important to recognize where you have those people but to not put them under any undue pressure to take on a role or responsibility that they might not be comfortable with .
I:	48:33	Okay . Can I ask you about the way that plan changes are recorded ? So how do you sort of monitor , record , evaluate change processes ?
P:	48:49	Do you mean as an ISDN or ?
I:	48:52	I just mean generally within changes . But yeah . I suppose it’s useful in terms of the stroke strategic stuff .
P:	48:59	Yeah . So from a stroke perspective , we have a working plan . So there's a project manager who is involved and we have a work plan and an action tracker that will , you know , pretty much be ... we've chase down for actions that we've not we've not delivered on . So yeah , we tend to have a project manager would oversee some of that . And I think what the ... that would sit with the implementation group and then what the implementation group do is they report into the ISDN board . So they would regularly provide an update report to the ISDN board .
I:	49:36	And do you think those systems are helpful or do you think theres things that ...

P:	49:41	Yeah , absolutely . You know , I'm primarily a clinician , so keeping me on track can be quite challenging at times . So yeah , it's I think yeah , it's quite it's very useful .
I:	49:53	Fabulous , that's fine . Generally in terms of implementing change at a strategic level . And what do you think are the main barriers ? That you know of or have come across .
P:	50:12	I think the main well , there's a few things really should be the main barriers to a general change as well as to specific to stroke . I think ultimately I think capacity is a massive issue . I think at the moment within the NHS , and I think the capacity to be able to be innovative is probably really , really challenged . I think there is that theory is that on the edge of chaos , you see , you see like effective change . So you know that that opportunity to try new things where there's a challenge there's an opportunity . And I think you've got elements which should prove that such as the and you know , the recent industrial action , certainly from our perspective , where we had the industrial action at the beginning of the year , you know , that enabled us to try some things differently from an organisation perspective and see what works but you are doing that at risk . And I think , you know , you can probably justify some of that risk at that time whereas you can't at other times , but it allows you to evaluate how effective things could be . And I think the and the capacity currently where you've got so many other pressures and that opportunities not always there is it so you know , it can be things like industrial action for example , can be quite crippling can't they as we see with some of the doctors strikes currently . I think the impact that's happening on the wider patients , certainly elective care and then the impact that has when there is no industrial action , I think it's it really does feel that we're quite restrictive with regards to capacity to do things differently . And I think that that doesn't help really . That is a barrier to change , I think . Obviously funding is always a bit of an issue , but I don't think he's just about money . I don't think , you know , with certain things you don't need a lot of money . I think you just need the commitment . And I think the other thing there is that commitment , because the trouble is we it feels sometimes that we have too much change . And I think we should build on certain things that we currently have . I think we you know ,

		we ... Well , ISDN's ... we've got this system which looks very much like a system we had 20 odd years ago . And , you know , I'm not sure by the time we settle down , we'll probably change it again . So it's , you know , I think at that strategic level , I think sometimes that having a top structure that is stable and able to look down and focus on delivery , I think that is probably a barrier . So I'm not thinking about , you know , change being from a negative perspective at an operational level , I think that change at a strategic level means we're unable to focus down and deliver what we need to .
I:	53:21	Yeah , you just get used to the way things go and then it all goes ...
P:	53:25	Yeah , exactly .
I:	53:26	So you can't you can't actually focus on implementing change at the ground level because everything's changing at the strategic level . [**P:** Yeah] . And thinking about any of the innovation or interventions you've been involved with , is there anything that you would have done differently thinking about them ? And that's , you know , things that you would advise other people if they were thinking about making these sorts of changes ?
P:	54:00	That's a difficult one really , because I think I think there's lots we would've done differently in all of them . I think , you know , I think there's so much we want to do differently . I think you know ... ? Yeah . Yeah . I don't think I can answer that . Really .
I:	54:22	And I suppose . The following question then would be . Maybe , what have you learnt from one that you've brought forward to another maybe ? I mean , there's always going to be things you can't envisage . I've been involved in projects where you get assigned for and it's something you hadn't planned for at all and it knocks you out of the ballpark . But yeah , that's informed what I've done next time I've thought a bit wider .
P:	54:51	Yeah . I think , I think we've , I think some of the modelling for different scenarios I think is probably a key one . From our perspective , I think looking at every single scenario that could play out from a situation because I think what certainly what we did with some of the recent modelling was focused in on what the outcome

		from a scoring exercise . So we were told this is what's going to happen and we went out and modelled against what was going to happen . And then in the 11th hour we were told , you know , there's been a review done here and that's not happening now . This is going to happen instead . And we hadn't modelled for that scenario . And then we just spent the rest of the time back playing . But that said , I think even then , I think we were all in the same boat with regards to what the activity looked like pre-COVID as opposed to what it looks like post-COVID . So even with that , you know , but it did take a lot of time . So we'll have to revisit , revisit and revisit to try and get the right the numbers right . And even then , you know , I think everybody else was under such pressure and just couldn't really quite really get the structures right . So it was yeah I think I think you've just got to be flexible . The other thing things as well I think you've got to focus in on the people . I think that's probably one of the biggest learning things I've had is that it's about the people that you're dealing with , both at , you know , in relationships where you're trying to collaborate and the patients , because I think sometimes it's dead easy to just focus on the business and just try and push the fact that , you know , as an ambulance service , this is my core business and all my ambulances are queuing outside your hospital and you're not giving me back and all this and that that actually , whilst that is what I'm paid to deliver for patients , I think , you know , people are not sat there doing that on purpose . It's happening because of factors that they're trying to deal with as well . So I think focusing in on people is probably the biggest learning things I have taken .
I:	57:10	I'm just very aware of time . So , is there anything that we've not covered around the strategic level change that you thought you'd want to mention that you haven't ?
P:	57:23	No , I don't . I feel like I have waffled a bit really .
I:	57:25	No , no , no , not at all . I've made notes . It's been really interesting . I'm a nurse , stroke nurse , my background . So it's really interesting for me .
P:	57:35	All right .

I:	57:37	So , yeah . No , you haven't . It's been really good . I have to stop myself . Asking questions that aren't relevant to the interviews .
P:	57:42	Yeah . I'm sure .
I:	57:44	I'd like to thank you for participating in the interview and sharing your experiences . Have you got any questions at all ?
P:	57:51	Yeah . So ? Well , what ... When will this be published ? Will I be able to review it ?
I:	57:57	Yes , course you will , that is what I was going to ask you next . So are you happy to be contacted if there's any follow up needed ? And like I say at the start , the plan is to do these interviews , which are taking a while and then kind of get the key points from them and develop a logic model that can be taken forward . And the idea is that we're going to get a focus group , too . So are you happy for us to contact you at that point to be involved with that ? There's no there's no pressure either way at this point . And I obviously we will contact you when we're at that . Are we best just to give you an email ?
P:	58:31	Yeah , yeah , yeah , probably best .
I:	58:33	I'd love to say when we'd get it published , but yes you will be kept informed . It’s slow going to get in individuals at the level that we need to and then get in there and approvals in the background . But we will get and we will be in touch if you're happy . I'm just going to stop the recording .
P:	58:53	Yeah , no , that's fine . Yeah .