Participant 7 21.11.23.mp3

Interviewer (I):	00:02	...convert the video recording to an audio and then destroy the video and then the audio is what gets transcribed . But unless you prefer , we tend to just keep the video on because it's a bit more normal . Right . I'll get on . So thanks . Thanks for agreeing to do the interview . You've been invited to participate in this research because you're involved in making changes in improvements to stroke care across the Northwest coast region . It's important that we capture the learning from what is being done to share this with others and support future improvements in the stroke care pathway . We're going to ask you a few questions about your involvement , if any , and your experiences of that in stroke and whatever part of the pathway you work are involved with . We're interested in your opinions about what you did , why you decided to do it , what worked well , how the service could be improved , any challenges and other comments you'd like to make . And then obviously , as you're aware , we hope to use the comments to understand what changes have been made within stroke care , particularly at a system level , and explore what went well , what could have been improved . And then the information from these interviews will be analyzed and used to inform focus group discussions to help develop a tool called the logic model . And then this can be shared and used by others to carry out improvements . It says the interview takes between 30 and 60 minutes . We find that generally takes the full hour . I apologize . Obviously it's voluntary . You can withdraw from the interview at any point . And as I've already said , the interview is going to be transcribed . Made anonymous . Your data will be stored on secure research drives , and only ARC Northwest coast research team members will have access to the data . So can I confirm that you're still happy to continue with the interview ? [**P:** Yep] . Have you got any questions before we start ?
Participant (P):	01:47	No , I don't think so .
I:	01:48	That's fine . And I've already checked . You are happy to be recorded , but just for the purpose of the transcription , that's fine . So can

		you tell me about your current role within the organization ? Within your organization ?
P:	02:01	Yeah . So I'm [ROLE] for the [PLACE]. So my role , it has three key areas , really , So I oversee our service delivery . We've got around 90 coordinators across the northwest , and that includes [PLACES]. I know this is north West Coast and all three of the north west ISDN areas . And it also includes overseeing our community engagement and volunteering approach . But probably most pertinent to this conversation , it involves and working with and engaging with the system as a whole to try and improve stroke services and from a whole pathway approach , at a more local level .
I:	02:52	Fabulous . So can you discuss any stroke care intervention or change that you're aware of that has been made or is currently being made ? So I'm sure you've been involved in quite a few . So for the purposes of this , we're happy here to talk about all of them or focus on one and give examples , whatever things . So it's about what the intervention was , why the change was needed .
P:	03:19	And yeah , I mean , probably a good example . I'm less involved in this now , but was more involved at the beginning . Is the engineering better care for Thrombectomy ? And is that the type of thing that you're looking for ?
I:	03:31	Yeah , yeah so something a system level that you were involved with and we want you to tell us all about the processes and then we can learn from your experiences .
P:	03:40	Yeah . So obviously , having been introduced thrombectomy rates were bobbing along below the target that the long term plan had set and there was a focus once , so it became more of a priority area for the ISDN and probably around 18 months ago , probably the beginning of 2022 . Into much as previously , they've tried to make progress in improving thrombectomy rates , but they decided to implement the engineering better care quality improvement process from Cambridge University into something else and that takes into account a whole system approach and the complexities within a system and goes through a model described by them as understanding the problem , potential solutions , ensuring you're

		working at whole system level to try and find a solution , implement it , test it and learn . And so from my perspective , I was in the initial conversations which were trying to get engagement , which we're trying to do scoping work and now that it's become very sort of clinically based and driven by the provider trusts , the hospitals , that I'm less involved in that work . Also we did a bit of work while we were influencing around and thrombectomy and the business case to improve the services . So that's one piece of work that I have sort of sat on the periphery of . Do you want reflections ?
I:	05:37	We can go through those . I'm just trying to look through my prompts to see if there's anything you have not . So can you talk me through the development process ? It sounds like you use this Cambridge University approach . Was that sort of like a is that a framework that was used ?
P:	05:54	Yeah . So it was , I believe the ICB are looking to use it . The ICB level systems and process improvements . And [*participant 4*] mentioned that like it could work with stroke . Obviously with thrombectomy , it's such a multitude of factors . So from the ambulance trust , the different acute stroke units , the Comprehensive Stroke Unit in Preston . The fact that it spans A&E , the stroke pathway and radiology . Its complex in relation to workforce but also in relation to estates and all of the work that needed to be done around making sure they had everything in place scanner wise and estates wise and that they had streamlined processes . Considering the each trust has its own processes . So it was a really example of bringing together a sort of a whole system approach . And the difficulty is , I think a lot of the focus previous had been on just Preston because that's where the Thrombectomy Center was . But obviously we know that the 75% of people generally arrive at a non-thrombectomy center . And so it needed to be more of a system wide approach and it needed to have NWAS in , the ambulance trust involved in that for us to make any sort of progress in that area . It was led by someone within the quality team at Lancashire teaching hospitals and still is .

I:	07:37	I think you knew what I was going to ask next . I was going to ask who led it . So they took the lead on it involved the key stakeholders . You know , how they were identified ?
P:	07:48	The key stakeholders ?
I:	07:49	Yeah . Obviously you've described how many there are and how complicated it is .
P:	07:53	Yeah . So and through a number of methods , really , obviously . Some of them were fairly clear . So it would have to involve stroke clinicians , key radiology clinicians and NWAS . There was the initial part of it was to look at , so one of the questions was who needs to be involved in this work and to make sure that we've got the right stakeholders in the room . And I think that that was a challenge for perhaps the acute stroke units so the transferring hospitals to release capacity to be part of the work . But it was taken back via the ISDN meeting and then escalated there to go to execs to get that buy in from there to release the staff to be part of this work . So and I think that again , that's a benefit of having something like an ISDN board that you can take back when those blockers or barriers to that board , which on it sits the executives and yeah , hopefully unblock that and got some good engagement then from across the patch . And there's also the what was SIG which is now COG the collaborative oversight group who are looking at . And they're looking at particularly the acute pathway so the pre-hospital and urgent treatment and the first four hours on onto the ward part of the pathway . And so they've also been looking at things that will support some of the thrombectomy work .
I:	09:39	Excellent . Thank you . I feel like I'm going backwards a bit , but it's one of the questions . Were you aware of any kind of information or evidence that showed whether or not this intervention would work in your setting ?
P:	09:51	And so the idea of using this intervention of using the engineering better care was brought to the ISDN by [*participant 4*] as a proposal of a way of working . It is a policy improvement methodology that has been tested in the NHS originally for engineering but tested in the NHS . And it's particularly useful for when it's complex and

		cross-sector and moving part type , complex , wicked problems . So I believe it had previously been used . It was signed off by the board to use it for this . And I think the Lancashire teaching hospitals were already using it as a quality improvement tool . It was a , certainly they'd been down to Cambridge to learn about it and implement it so .
I:	10:42	Brilliant , in terms of choosing the intervention . Do you know what was the what were the drivers for the introduction of Thrombectomy ?
P:	10:55	What were the drivers for prioritizing thrombectomy ? [**I:** Yeah] . So it was in the long term plan and there's obviously it's a well , it's one of the most , well evidence based procedures . It's cost saving . So if we get it right in Lancashire there's a , there's a huge return on investment of £47,000 over five years per person . I think all of those things and with the push from a national level . So there was obviously the GIRFT report that came out that highlighted it , there were the quality reviews of Thrombectomy services that took place in 2022 . So I think there were a number of different factors perceived to be priority . At the Stroke Association , we chose it as something to campaign on . So we did launch a campaign in a saving brains campaign to push for systems to focus on it . And again , the rationale behind that was if you can get thrombectomy right , then you sort out a lot of the early part of the pathway . So you're scanning people quickly , you're getting them to the right place , quickly , you get into the right stroke care , quickly , you reducing disability and therefore reducing the need for the rest of the pathway . And so that's why we chose it as something that's got a huge evidence base behind it and cost effective . It's well below the numbers that can benefit from it currently . So it felt like something that should be being prioritized .
I:	12:31	Brilliant . Thank you .
P:	12:33	Is that okay ?
I:	12:34	Yeah , that's perfect . I kind of knew that but I needed you to say thank you . That's brilliant . So in terms of the implementing the change and the team , it's quite a big team of staff that are involved .

		Can you tell me anything about the steps that were undertaken to inform and/or train , organize and its cross organizational in this case in these changes ? So how people kept informed , those kinds of things .
P:	13:07	Yeah . So and they've used a number so they've had to face to face meetings and regular online meetings and they have a program lead . So as well as [*name*] , who facilitates the sessions , [*name*] updates people on the progress of the program , both those who were involved , particularly in that work . But then they go back to the ISDN to update people on the progress of the piece of work . And they did some work at the beginning to understand what metrics would show that it was being successful . So what are we looking to change and how will we know when we're making change and they chose the metrics and how they would measure that . And yeah , they use Myrow [?] as a sort of a Myrow board , as an online collaborative platform to enable them all to continuously input . So after meetings , there's generally tasks for teams to take away to input data on to the Myrow board , which is analyzed in between times , which then leads to the next step in the process and moving it forward through the sort of quality improvement process .
I:	14:17	Okay . Do you know anything about the costings ? The budgeting behind ?
P:	14:22	I haven't got a clue I'm afraid .
I:	14:23	That's fine . No , that's fine . No problem at all . And were there any pilot processes within this particular system change or any that you've been involved with before ?
P:	14:36	Hmmmm...
I:	14:40	I don't think there are...
P:	14:41	So there are . Again , it's difficult when , how far you go . So , for instance , they did look at implementing the pre-hospital triage for ambulances , which is being piloted in other areas . They looked at . So I know they looked they went to the Walton Center to look at their rapid repatriation for this process . So they looked more widely at elements of the stroke pathway where it's being done well or

		differently . But in relation to piloting this methodology for improving Thrombectomy , I'm not aware of that being done anywhere else .
I:	15:19	No , that's fine . Can you tell me anything about any meetings , training or planning that was conducted to discuss and develop the plan or proposal for these changes ?
P:	15:35	Mm hmm . Yeah . So I say the main ones that I'm aware of is that there was a proposal put forward by [*participant 4*] , [*name*] then came to the board to demonstrate what , what it was , the engineering better care , what it , what it was . And during the what was the SIGG group then , which was strategy improvement governance group or something like that . And we looked at what they would like to use this quality improvement for and agreed that it would be best to use it in Thrombectomy . And so there was a process of deciding and yes , we want to try this methodology for improving stroke treatment . Which part of the pathway we all agree thrombectomy seems to work best . So that went through that governance group and then went back to the board to agree that was okay with the board .
I:	16:26	Okay . In terms of setting goals or targets for like the implementation of Thrombectomy as a whole . How were they set and decided upon . You've obviously talked about lots of interconnecting factors . So was there a way that that was decided on ?
P:	16:46	Yeah . So they predominantly use the national guidance that exists . So implementation of the NOSIP [?] , the neuro and the ... Optimal imaging pathway ...
I:	17:01	I know which one you mean , the optimal imaging pathway . Yeah .
P:	17:05	And so looking at what the guidance for that was and being able to measure the metrics against that . They looked at metrics for so they looked at the different stages of the process that they looked at door to referral times , referral to transfer times , door to needle times , door to link to site times to try and basically capture that whole pathway . And they looked at the metrics in relation to that and they used the guidance , which is in , as I say , in the GIRFT report and in the national stroke service model which is where the

		NOSIP sits at the minute as their sort of guidance for what good looks like .
I:	17:52	Okay . Excellent . So can you tell me and I'm sure they were , but can you tell me whether the needs and preferences of service users were considered when discussing stroke care changes and what strategies we use to include service users ?
P:	18:08	Yeah . So firstly there are , so there is a patient care representative patient care assurance group who the chair of that sits on the ISDN board . So anything discussed in the board he's aware of , he takes back to the group and there's a two way flow between them . So and that group are instrumental and involved in all decisions by the ISDN board . So that was part of it . They also sit on the SIGG and the COG groups where it was discussed and patients stories were used in relation to where it's at as a ... seeing the impacts of not getting it right . There were patient stories and I don't know whether it has , but they were very keen that they got patients involved in the process , but I haven't been there for the last few meetings , so . But that was the plan , to involve patients who had both been through the pathway and hadn't been through the pathway and to check their views on it . There was also obviously quite a big piece of work , consultation piece of work that went into looking at how our stroke services are configured in Lancashire & South Cumbria , and that involved a lot of patient engagement going round to patient groups . And part of this work was discussed at those as being one of the priorities the ISDN would have .
I:	19:39	Okay . Sorry , just to go back , so you said there were plans , I know you don't know , but there were plans to involve it . To what extent and in what way were they planning to involve patients ? And obviously the stories of ...
P:	19:54	Yeah , I think they wanted them to be in the meetings , the engineering better care meetings to make sure that any quality improvement was also quite patient focused in relation to their needs and whether you know , not looking at the system needs , but what would that mean for patients .

I:	20:19	And just to clarify as well , you said there was a there was a two way link with the patient assurance group . So were the voices of the patients , if there was communication both ways was that listened to and acted upon within the service level change ?
P:	20:36	And I think so in that the patient group were advocating for Thrombectomy to be prioritized . And were concerned at the rate of improvement of it . And so they fed back about that . And particularly the chair at the time was particularly keen and vocal about the need to prioritize this and take action . So in that sense , I think so , yeah .
I:	21:05	Yeah . No , that's great . A bit squeezed in , this feels a bit random but do you know if health inequalities have been considered as part of the change , and if so , how and why ?
P:	21:17	So I know they have been considered , I think from a perspective of this being something that should be available for everyone , not looking at the areas that it's not currently received . I don't know if a health inequalities impact assessment was carried out . If I'm honest .
I:	21:37	That's fine . But it sounds like something that you have been involved with before ?
P:	21:42	Yeah . Yeah .
I:	21:46	Okay . Can you describe how relationships , networks and relationships between the organizations have helped or hindered the implementation of these changes in your , from what you've seen ?
P:	22:02	Yeah . And so I don't think this... I don't think you could make this type of change without a network approach because it crosses so many boundaries . So I think having the ISDN or ISNDN board has been massively helpful in driving the change forward , in releasing capacity to engage and get people engaged with this piece of work and to be a vehicle to go back directly to exec boards where there wasn’t engagement . So I think that's been really important . Again , I think there's been quite a lot of work . So I think the [ROLE], the [ROLE] at the minute , [*name*] , has been hugely instrumental in the

		work and she's done a lot of work directly with clinicians going out to trusts , understanding the barriers for them which again , has been really important . And I think having the stroke nurse consultants there has been important . I think one of the meetings where it felt that we made a lot of headway , as I say , it's a really difficult one is thrombectomy because it comes under the stroke portfolio , but it's very much at the discretion of the radiology department . And it was unclear who was responsible for improving it previously , whose targets were we meeting and who had the power to make change . And I think during the first meeting , it was clear that that became more of a shared ambition as opposed to which was important , I guess , for making any progress . But I think that that's probably something that hinders other areas and that sort of sharing between stroke consultants and radiology .
I:	24:04	That's fine . You talked a lot about key influential organizations and individuals . Are there any key steps that you think were taken to encourage individuals to commit to this change ?
P:	24:23	So there was quite a lot of communication about it . I think . Again , where it made it changes , where there was pressure from executives and support from executives to take part in it . I think it's been I think it's been a combination of the goodwill of the clinicians wanting to improve this process . I think that could still be , it could still have progressed faster with more executive prioritization of it because they were still , you know , within the trusts , they're still battling against a number of other priorities that have to be pushed up and so that kind of ties with that I guess that's the NHS .
I:	25:27	That's good . So obviously , the support from the exec teams you've said . Is there anything else you thought was helpful in bringing about changes ?
P:	25:38	I think all the background work that the ISDN had done for the case for change , to be able to see , for people to really see the difference that they were striving for and the need for it . Hopefully some of the work that we did around the saving brain sort of won the hearts and minds of people as well . On why it's important as opposed to just the data , but the human impact . And that did raise public and political awareness of it . Yeah . I also think it's possible , and this is

		just a personal view . I don't know whether this is helpful , but I think it is useful , [*name*] who is the clinical director who we see often comes to the ISDN meetings and I think having that . Linking with the National Stroke Program Board and that quick way of sharing innovations and new ideas and supporting the team and guiding the team is also very , very helpful . Not that she could do it for all ISDN's .
I:	26:44	No , it's excellent though , isn't it ...
P:	26:48	And some things were in place and some things were ahead ... so like AI was already in place and Lancashire & South Cumbria have been quite proactive in a lot of areas of getting some of the groundwork done .
I:	27:03	Yeah , in terms of the scanning and various things , you mean . [**P:** Yeah , yeah] . Yeah , yeah , yeah . That's good . Are you able to tell me about the ways that people and organizations involved are kept up to date with the progress on the implementation of change ? I know you've talked about regular meetings , but there are other other ?
P:	27:22	Yeah . So I don't know when the last comms was , but the ICS comms team do and send . So somebody from the ICS comms team who links in with the stroke program to make sure that the external comms go out . And I know the program team from the ISDN once a year go out to engage with stroke survivors in the community to try and update them on plans . And there are strokes survivors and carers on the different clinical reference groups at each of the trusts who get updates about this so there's a few ways to share what's happening .
I:	28:08	Excellent . So on the other side of things , can you tell me what you think were the main barriers to implementing change ?
P:	28:17	Yeah . I mean , workforce has to be the number one barrier . So predominantly having the right workforce to enable this procedure . And that's not something we can't just suddenly magic . Radiologists so the workforce . Estates . So again we can't just build a purpose built stroke emergency assessment unit like they have in Aintree just because of the age of the site . And I think having the

		new hospitals programs , I don't know the details , but I'm worried that that prevents any progress being made on existing sites . Definitely the external pressures . So the urgent and emergency care pathway and the impact of the pandemic , but also the winter pressures and staffing levels there . So all the normal pressures also impacted on this piece of work and possibly I think , going back to trust level exec buy-in throughout . So I think that can move something forward very quickly or it can mean it drags its heels and that's to sort of enable things like creating the space , just having the space to have a second bi-plane scanner those types of details and in some areas , people make it happen and then in others it's taken a lot of work so I think that's a barrier . And I do think there was , so I think it took a while for wider engagement . So it was raised and escalated at the ISDN meeting that there were a couple of teams who consistently weren't getting engaged with it and that it would only work with all teams engaged . So I think that's been ironed out now but that engagement from all teams was a barrier .
I:	30:32	I suppose you have mentioned some throughout , but in terms of like system level change that you've been involved with this and other things . What helps ? So you've talked about exec things , you've talked about business cases , you've talked about having lead organizations like the ISNDN . But are there any other barriers or facilitators for this or other projects that you think are useful in terms of bringing about this sort of implementation ?
P:	31:05	Any other projects ... So I don't know whether this is , whether I'm answering the wrong question . I think the biggest , or one of the biggest factors in it all is people and relationships and having the time to engage , help people to understand , help people to get on board , keep them up to date . I think without that , nothing's going to change or move . So I think that's one of the again , some of that is done from goodwill of the people involved as opposed to just ... I think that is around culture as much as anything and in the organizations ... I haven't , yeah , I'm trying to think . I mean , some of the work that I do there , I haven't been involved in it , but some of the work that does seem to be having quite an impact and scaling up is some of the population health work and looking at stroke prevention . And again , that seems to be one of the things , the

		things that make me think it's working is one , we are seeing a change , but also , there's a lot of information about that , there's a lot of communication about it , there's lots of sorts of ways in which people can get involved and they're working out loud . There's nothing sort of behind closed doors .
I:	32:29	Excellent . Brilliant . Can you describe ways that the progress of any plan changes have been recorded ? So I suppose , are there ways to measure that changes are happening ?
P:	32:44	Yeah . Yeah . So a report is given to the board regularly and they , as I say , they , they've identified the metrics and then monitoring those metrics to , to show whether improvements are being made .
I:	32:59	Excellent . Is there anything you would change in that if you could ?
P:	33:07	I guess I don't know what the consequences are . The governance back . So if we aren't seeing improvement , then what the escalation process is and we've sort of seen that by the ISDN but I suppose ... Yeah , I don't know whether there's something .
I:	33:33	Like the Plan B ? What do we do if we don't see a change ?
P:	33:36	Yeah . Yeah , I think it is there . Yeah . But no , I think I think it is clear , it’s transparent that they are happy to ... the only difficulty I think they found is that SNAP , which we use for a lot of our metrics , doesn't collect the metrics that would be helpful in this . So there has had to be a lot of individual gathering of data and some assumptions being made . So that's obviously time consuming for the people involved . And so an easier system to collect that data would be great , but I think SNAP are on it . Data sharing is probably another one that's impacted on that . Way back when the ISDN had to get data sharing agreements and I think appeared in other areas where that doesn't exist , they struggle with system level change because they can't see , they haven’t got oversight of the data across the area .
I:	34:41	So it can be some of the governance things that slows it up , not necessarily the will of the clinicians as such ?
P:	34:47	Yeah . And having to again , having to sometimes go through hoops to progress things to take a case of change and get that agreed . Get

		a business case , get that passed 18 different committees to agree that they will that ... all of those behind the scenes things can be frustratingly slow .
I:	35:09	Do you think that's clear in terms of the process ? So when they started , do you think they knew that they had a business case like , say , the 18 different committees ?
P:	35:20	I think they are , they were aware . Yes . But yeah , I think it's just that it takes a lot of patience to continue to keep pushing at different doors .
I:	35:32	Yeah . You know , I'm just thinking of projects I've been involved with where you suddenly get an out of the blue stakeholder that you've not even thought of , and then you've got to deal with that on top that's all . [**P:** So , so , yeah ...] , I mean , they had a clear trajectory .
P:	35:44	They did . Although it has changed in the interim period with the change in the ICB and again the change in NHS finances have impacted on the initial business case , although also so has changes within the hospital . So there's been some quality improvement work done in some hospitals . We've seen rise in stroke and that sort of impacted where things might go next . And so , yeah , those external pressures that you can't mitigate against .
I:	36:17	So it's had to be adaptable as it's gone through . And was that , do you think that was built in that adaptability or do you think it's something that's come through the process ?
P:	36:27	Yeah , I don't think it was built and this is looking at it like this is more than just the thrombectomy and the engineering better care ...
I:	36:34	No no , that is fine .
P:	36:35	That has had to be , I don't think that was built in in that there was a business case , we were on track for it , but then there was a pause whilst there was a reassessment of what was actually needed with the changing circumstances . So rather than being able to continue and just yet we will iterate and iterate and iterate , there has had to be a hard stop and a reflection and then a progress forward hopefully .

I:	37:05	Excellent . We are flying through it you'll be pleased to hear . Do you feel that others were supportive of the change and what sort of support was given or , would you have liked to receive during the process ?
P:	37:28	I think , I think there was general again going back to the person leading this is sort of sits in the quality improvement team . They don't have the authority to force anybody to do anything . So I think if anything , that loop could have been maybe easier for them because when it was clear there wasn't engagement , they then had to try and go back to the board , get the execs to get the engagement as opposed to having the authority to sort of pull people there themselves . So I think that maybe to have an SRO for the project that was at exec level possibly might have helped . But that is just a personal opinion .
I:	38:30	No , no , it's fine . That's the kind of things that , and for the logic model thing , obviously we're taking ... it all is being anonymised and we are taking those processes that other people can use quicker and easier so it's all good , honestly it's all good . Do you think these changes would have happened anyway without this process ?
P:	38:55	I'm slightly doubtful in that we'd sat through probably 18 months of of a lack of progress . So it had been on the agenda and it seemed that it just kept coming back as no progress , no progress , no progress . So I do think that this created an impetus behind it . It created a focus . It had somebody moving it forward whose role was to move it forward as opposed to people with a lot of other work to do who were trying to pursue it in their day job . So I actually think having a sort of process to stick to , resources behind that process and that accountability definitely moved it forward more because it felt as if the ISDN were a little bit stuck in or the ICB sorry I should say , because it's not the ISDN , but it felt as if it was stuck at how do we move it forward ? I also think it made a big difference that the [*name*] taking on the clinical director role , and that sort of enabled some movement as well .
I:	40:03	I was going to ask you about that . Do you think it was because of her personal interest in it helped ?

P:	40:08	Massively .
I:	40:08	It's about having the right person . [**P:** Yeah] . With the right knowledge and skills to lead ?
P:	40:14	Yeah . And again , and I have said this to her , I think from an outside perspective , it feels frustrating that the clinicians know the answers and the hoops they have to go through . And I think if it was up to her and she was just given , you know , you make this work , she would . I think she made all the difference to moving it forward as well . I think she had quite a big impact on it .
I:	40:43	Excellent . Excellent . Do you recall being asked for feedback on this change process ? Or from you or from anybody ?
P:	40:55	Not formally . There is always the opportunity and they're always asking for continuous feedback as we go along on things . I think possibly because it's not completed yet , that particular project we haven't been asked for feedback .
I:	41:14	Okay so can you just from other examples then , what sort of have been good strategies for getting that feedback in ? Has it been impactful ?
P:	41:31	Feedback for ... ?
I:	41:33	Yeah , on the change process itself I think .
P:	41:41	I'm not sure there's been a big . Yeah . I know we did , and I can't remember the name of that one now . [*participant 4*] led a piece of work that started just the beginning of the pandemic . So that ended up holding a bit but that was on a change piece that we fed back into . I am not sure there has been very much feedback on the process itself , if that makes sense .
I:	42:21	Yeah , no , no that is fine so what sort of feedback did she ask for on that then just to ask ?
P:	42:26	So that was on each sort of session and we're running this ...
I:	42:31	Okay , so not about the whole process ?
P:	42:33	No . I'm recently the ISDN have come up for feedback on them and how they work and their program board . We've done feedback ,

		we've done exercises where we've looked at feedback of ways that we work as a network . Again , that was a very sort of rough and ready feedback , but it was given back to us . But that was using , I can't remember what they call it . Nuts and something else . Where we went into group to say the difficulties , the barriers and the enablers and yeah , that was a facilitated session to try and look at how we work together as a whole network and , how we can improve that .
I:	43:23	Excellent . So is there anything , I think we've kind of discussed this as we have been going along , but is there anything that you think could have been done differently in retrospect or should have been done differently ?
P:	43:39	As I say , I think it's that the overall responsibility from a senior level to ensure , which I think they could say was there . But it had to go through a process to get back to that when things weren't moving . So I think that could have sped things up . Perhaps more support for engagement with the teams that weren't Lancashire teaching hospitals . So obviously it's quite a big quality improvement team were based there . So more engagement from the other hospital trusts . And the only other thing which could be a longer term issue is the difficulty of ... So the ambulance trust is a completely separate trust . So ultimately they have their own , they're a pivotal part of this piece of work . But they have their own policies , procedures that are separate . So I think that's always a , that's a real difficulty of aligning priorities because their priority is a category one call , not a stroke repatriation for Thrombectomy that's category two . So the different priorities and when working in such pressure . For the model , no . I mean , again , the proof will be in the pudding . We are seeing increased rates . So that seems to be positive . And there's hope that that will continue and that the trajectory is that it should carry on . So , yeah , hopefully that will demonstrate it .
I:	45:30	Excellent . So yeah , that line of priorities and it sounds like this one's a bit more complicated because of the service thing , but involving all stakeholders and making sure they're engaged , [**P:** Absolutely] , no matter how big or small their involvement is ?

P:	45:45	Yes . Yeah .
I:	45:46	Okay . That's fine . We have whistled through so that's great . So if you have any further comments that you'd like to add or anything you'd like to discuss that we haven't already ?
P:	45:57	And no , I suppose the only thing to say is obviously that's a focus on Thrombectomy and just because that's front of mind , but there are lots of other examples that I could have given of where the ISDN's come together to move a piece of work forward . That I think having that cross organizational , cross sector working in that way , so working in a networked approach has really led from what was , because I've been working sort of in stroke for over ten years now and was frustrating to go to a number of meetings where everybody identified the problem and nobody found a solution . And it did feel that with the investment of the ISDN and with the support from [*name*] and the ICB , that's enabled delivery of change as opposed to just an understanding of what needs to change . So I do think and that being able to bring in teams from across the area and work more cohesively for stroke specifically with the type of the fact that it does need that group of people working together . And I think that , yeah , that's been really instrumental .
I:	47:17	Excellent . That's really good . Yeah , thank you very much for taking part and for sharing your own experiences . So have you got any questions before I go on to my other piece ?
P:	47:30	No , I guess just I think that was timescales wise was in the information . Have you got ?
I:	47:40	So I'll be honest . I think this project was supposed to have been done and dusted probably before I came onto the stroke round table . [**P:** Yeah] . And we are slow progress in terms of getting people to be interviewed . So we are very , very grateful to you and I am going to come on and ask if you can recommend other people in a second . And so at the moment we haven't got a timeline . We have extended the ethics , [*name*] probably will correct me if I'm wrong , but I think at the moment it's the end of … It's into next year , I can't remember the exact date .

Third Party:	48:13	I was just in the process of finding it to get the actual date for you .
I:	48:17	Yeah . Yeah , no , that's fine . So is a bit of a work in progress , but obviously as part of the stroke roundtable , we'll continue to do updates . We've had several people we were hoping to interview that haven't come back to us or haven't been available . And also we appreciate that the people we're speaking to at this level are often extremely busy and isn't always a priority . So we're going to keep trying . But at the moment , you are our sixth interview and we've been at this for several months . So watch this space , I'm afraid , is the answer to that one , [*name*] . Having said that , though , the idea is that once we've done enough of the interviews to get data together , we're going to come together and do some focus groups to help inform the logic model . And there are key things that are coming out . Relationships and communication come through every time for me , and I'm not sure how we put that in a logic model , but that will be what the focus group discussions will be around . And is it all right for us to contact you at that point once we're ready to see if you want to be involved at that point ?
P:	49:25	Yep .
I:	49:25	And is it alright just to contact you with the email that we already hold here ?
P:	49:29	Yeah .
I:	49:30	Brilliant . And so that just leads me on to the fact that we are trying to do some snowball sampling going forward . So are there people that you would suggest that we interviewed and you can go for anybody , we may have interviewed them , we may not have done .
P:	49:46	Yeah . I mean a key person for me is definitely [*participant 4*] . So I don't know whether you would also need to do [*name*] because [*name*] is leading the engineering better care process so I think he probably , and as I say , it's only one of the projects of the ISDN , so ...
I:	50:04	What was [*name*] surname again , sorry ?
P:	50:06	It begins with B , I can find . I will put his email in .

I:	50:11	That would be great if you could .
P:	50:13	[*name*] . Again , [*name*] might be one in that she's , [*name*] . Whether ... [ENDS] .