Participant 9 19.01.24.mp3

Interviewer (I): 00:02 Thank you for agreeing to participate . As you're aware , you've been invited because you're involved in making changes and improvements to stroke care across the northwest coast region or other regions in your case [*participant 9*] . It is important that we capture 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 , if any , and your experiences of stroke care and what other parts of the pathway you work in or involved with . We're interested in your opinions about what you've done , why you decided to do it , what worked well , how the service could be improved , any challenges and we are open to any other comments you'd like to make . So the idea is that we're going to use those comments to understand what changes have been made within stroke care , particularly at a system level is what we're interested in and explore what worked well and what could have been improved . And then the information from these interviews is going to be analyzed and used to inform focus group discussions to help develop a logic model , hopefully . And then the logic model can be shared and used by others to carry out any improvements in stroke . So I just want to check for the purposes of the recording . You are happy . I know you've done the consent form . [**P:** Yes] . That's fine . Okay . So can you tell me about your current role within your organisation ?

Participant (P): 01:16 So I have a [ROLE] . So I work two days a week at [PLACE] as a [ROLE] in [CONTEXT] and three days at [PLACE] as a [ROLE]. Couldn't even remember what I was then . Sorry [*interviewer*] . And I also have an additional role as [ROLE] for [ORG.

I: 01:41 Excellent . So it's quite a broad one to start with . But can you discuss any stroke care intervention or change that you're aware of that has been made or currently being made ? So you can you can use more than one example . But if you think of it like a system wide change that you've been involved with , and can you tell me about what it was , why it was needed , how you were involved ?

P: 02:05 So well there are two , there is one local want to here , which I would say is the regional Thrombectomy service where Preston is the comprehensive center . And then the other one that I've been involved in my past post is the , which is probably more right from the beginning , is implementing early support to discharge for our local region . So two ends of the spectrum .

I: 02:34 Yeah . That's fine . So maybe if we focus on the one that you were involved with from the beginning , early supported discharge . But if there's things that … so can you explain why the change was needed and how you were involved in those changes and the amount of work you dedicated to it ?

P: 03:00 So why was the change needed ? So that was twofold . Firstly , we had been aware for a couple of years about the new evidence come out saying that rehabilitation outcomes were equivalent using the early supported discharge model as the current at the time inpatient rehabilitation model . And we really wanted to implement that because we saw it as a better way to deliver rehab for a specific group of our patients . And the second thing was then it became part of the NHS policy . And so we worked with commissioners to work out a model of care that would be applicable for our region . At that time it was primary care trusts , that was a long time ago .

I: 03:50 So can you can you talk me through like the development of it ? Who led it ? Was it led by the commissioners or the trusts ?

P: 03:58 I think it was I would say it was it was a joint effort . So the commissioners identified that it needed to be done . I would say it was probably done sooner because it was driven by the clinical specialists who were at those commissioner level strategic meetings saying this is a priority . We think we can do this and we think we can save you money . So it's a win-win . And that definitely brought it up the agenda . I think we also had a priority that we wanted to make sure that it was evidence informed . And the specialists who understood the evidence wanted to make sure that the commissioners provided a model that was based on the evidence and not just one that was going to save them money and be determined by the funding envelope that they had available to them .

I: 04:59 Excellent . And can I just sort of get a feel for how many organizations and teams were involved ? So obviously , you've talked about the commissioners and you as the clinical team . Was that just one trust ?

P: 05:08 No so it was , so it was two acute hospital trusts and then the three overlapping community NHS trust providers as well as the commissioners for , for that region . Also at that time it was a stroke network , wasn't it ? So they were , they were there supporting us in achieving that change and planning it .

I: 05:35 Excellent . And that's fine . So what sort of colleagues , staff , patients were involved in the intervention change ? What were they consulted about what they thought of it ?

P: 05:49 And so it was a time when there was less patient and public involvement and so there wasn't any . [**I:** Okay] . Although we as clinicians brought back patient stories to the group as to illustrate how and why we would think it would work . People that were involved , so as always in stroke and because of the nature of what it was , there were physicians . There were therapy leads from the community and the inpatient services , as well as the service managers for each of those areas and the commissioners and the network . I think I was a bit of an anomaly in the early support to discharge team down there because of my [ROLE], I was sitting on that group . I can probably bet on it they wouldn't have asked for a [ROLE] if I specifically , if I wasn't there because the nurses weren't considered to be key for early support to discharge .

I: 06:57 Okay , I will probably come back to that bit .

P: 06:59 Yeah .

I: 07:01 So in your opinion , how complicated was it and I know you've described , you've said about the network , but what other supportss were available to help you put this change into practice ?

P: 07:15 So how complicated was it ? I think stroke is always a bit complicated because even though , for example , I'll jump back to the thrombectomy one , even though you think it's , for example , a very medical focused intervention and really you only need medical informed people around the table . No matter what it is in stroke , it impacts on the rest and the wider MDT as well . So you have to negotiate their presence for people who don't understand that . And then once they're in there , in a way you have too many cooks . And so then it's a bit of a challenge to drive things forward when you're trying to absorb and implement all these different perspectives that are coming in and extras add ons that come as a result of involving wider people as well . So it does get quite complicated and you need to have some really skilled facilitators and chairs who can work through that and navigate through that so everybody feels like they have buy in and they're aware of how this change is going to impact them and

how they need to work differently , but also do it in a way that is still going to push it forward . So the early supported discharge team we had . I think it was key around that was one consultant position who was very MDT focused , so that was [*name*] , who could understand more about stroke delivery being about skills and competence rather than which profession base you were from , which was really helpful in designing the model . And then we also one of the commissioners , and again , we've talked about this in the ARC about she has that organizational memory . She had worked in the Primary Care Trust , the PCT for a long time commissioning stroke services . And so she understood where we'd been as a region and where we were aiming for . And so she was great at putting what we were trying to do within stroke in that wider commissioner arena about what other priorities they might have and how they were going to convince the other commissioners in the PCT that stroke was more important , for example , than learning difficulties or mental health . So I think it was confirmation of the two of those people that really helped us to push it forward . [**I:** Excellent] . Does that help ?

I: 09:45 Yeah , definitely . It's really good . Yeah , it's brilliant . So you've talked about already , you've talked about the importance of involving people and things . So were there strategies that were used to keep people connected and informed about the changes ?

P: 10:03 So you're asking , were there formal processes in place to keep people engaged and informed ? So I think it was it was mainly through those meetings . It was through the meetings and the minutes and so if you weren't at the meetings , you really didn't get an opportunity to contribute . But we were all committed and those meetings were really well attended .

I: 10:28 Okay . That's fine . Did you do any sort of piloting or anything [*participant 9*] ?

P: 10:35 Yes . So we did a test of change . So the model was a bit different in that it had started off with one of the acute trusts seeing it as an opportunity to release their bed capacity . So one of the acute trusts , the one that I worked with , went first and decided to fund their own community team to pull people out earlier so that we could increase the flow through our stroke service without increasing the number of beds . So we tested it out there and could see that it could save us money by not requiring so many inpatient beds . And so that's how we funded it initially . And then we use that evidence then to build on that model and then widen it to incorporate the other acute hospital trust and the other community service providers . Oh you have gone . Are you still there ? [TECHNICAL DIFFICULTIES]

I: 00:02 We were talking about tests of change weren't we , so you piloted …

P: 00:06 Yes so we piloted it at the acute trust got some data through about how it was going to be cost neutral , if not saving some money for the acute trusts . And then we could take that to the commissioners and then look to expand a similar model out to the other acute NHS trust in the community teams in our area .

I: 00:29 And you were describing how you costed it initially and then so when you went to recurring ongoing costs , how were they covered once you got to that point ?

P: 00:38 So it was , I think the biggest challenge for us and whenever it came to rehabilitation , this kind of elephant in the room came up that if you do rehab well , the main cost saving is to social services because patients are more likely to be going home and independent than they are requiring care packages of care , institutional care . And we regularly had that debate in that commissioning room about that and there was no solution . And I think the thing that kept us driving forward was that it was the right thing to do for our patients , even though economically we weren't necessarily going to benefit from it . The way we costed it was through predominantly through shifting acute funds into community , so shutting stroke inpatient beds and using that money then to fund early supported discharge . And at that time we had . So the acute service that I was working in , 10% was commissioned by one Primary Care trust . And the other 80% was commissioned by the other because we had an overlap of areas and we were , the smaller one was on a block contract and our larger one was on a tariff . And so there was , I wasn't so involved in this , but I knew what was going on behind the scenes is that tariff was being renegotiated for our supported discharge patients , that funding could be given to the community services to provide early supported discharge .

I: 02:32 Excellent . And was there like an overarching plan throughout or was it flexible ? Can you remember ?

P: 02:42 So we . Yes . So we had a business plan that was put together . I suppose it wasn't quite as networked as what I have experienced up in lancs teaching . So we would individually do our own business plans for our own organisations , have that agreed by execs and finance in our organisations and then bring it back to the wider group rather than what tends to be done at lancs teaching now , which is those kind of processes , policies and business plans tend to be drawn up more by the network and then given to each of the boards for approval .

I: 03:30 From your experience , which one do you think ? Is one better than the other ?

P: 03:35 I think they both have benefits … [**I:** Yeah , yeah] . So I think I like Lancs & South Cumbria approach because I think it gives you that more network model of care , which is what we're aspiring to now , isn't it ? And that really wasn't a priority back in the day when early supported discharge was being set up . But I would say having that network approach means that the people who will be implementing and delivering a leading it have less engagement in that whole production of the policy and the business plan . And therefore I don't think they have as much buy-in . So the actual implementation of it takes longer . [**I:** Okay] . I think .

I: 04:20 No , no that is interesting . So you've said you didn't have formal PPI [**P:** No] . But you did have goals or targets set by service user stories . Is that right ?

P: 04:35 Yeah . So because there were clinicians round the table , so clinicians with a strategic responsibility , I suppose , but they were still seeing patients every day . We were , we knew it was important and it could really drive through some of the key messages that we wanted to get across . And so we would bring , you could you just pull them you didn’t have to prepare them , you could just pull them out from your experiences . [**I:** Yeah] . And that's what we did , we would bring them to the table . And I think that was very helpful to ground why we were doing what we were doing .

I: 05:09 Okay , that's fine . You talked about the meetings and planning and things we've talked about service users . Were health inequalities considered as part of the change that you were involved with ?

P: 05:26 Not within the specific … No , not within the stroke agenda . Often the commissioners would talk about we have other health priorities within our region and they would cite some of that which would be linked to underserved communities and socioeconomic deprivation and that was key for their priorities around the community health of their region . But in a way , justifying why they couldn't give us as much money as what we wanted . But no , not within stroke . [**I:** Fair enough] . And I would say that was probably the same for our thrombectomy services now . We have never , I've never heard that conversation be had about , we know that people from underserved groups are less likely to access urgent care as quickly as other groups . And we haven't really addressed that in access to Thrombectomy services .

I: 06:33 That's a whole other conversation about what you think we should do there isn't there ?

P: 06:37 I don’t know whether I'm the right person to say am I really ? Because we don't see them . That's the issue . We don't see them , so we don't really know what the issues are .

I: 06:46 Yeah . And so you've described about some of the key players , but are there other key influential organizations or individuals that it was important to have on board or is important to have on board I suppose ?

P: 07:06 So I think the stroke association was the commissioner for services at that time down there . And so they were also around the table . And I think they were important to validate what we were saying . And I think it was important that it was also referred to in policy . So I don't I don't think it would have got the priority nor the funding if it hadn't been referred to in policy , even though it was in the kind of guidance . Okay . [**I:** So that was the key thing ?] . But I think that was the key thing , yes . I think it also helped that there were quite a few of us around that table who were involved in developing the policy . So we were at an advantage that we could say to our commissioning group , listen , we're involved in this in six months time , this is what is going to come out . And so in a way , we were , that gave us a bit permission to be a bit more innovative . Do those tests of changed because they knew it was going to come anyway and they were going to be asked to deliver that service anyway . We were just giving them the heads up and give them a bit more time to do it .

I: 08:16 Excellent . What about well , you talked about one of the issues is maybe having too many cooks kind of thing , but are there other things in terms of relationships or networks that you found hinders implementation of change ?

P: 08:32 So I think for me personally , the biggest challenge was . I was , there was another colleague that really set up that initial test of change to pull all the evidence back as to why we were saving money and why it was credible and possible to develop early supported discharge services at no significant extra cost . And the commissioner , [ROLE], I can remember her [CONTEXT]. And it was in a way I felt a bit , a bit like she was … What's the word I'm looking for ? A bit like a traitor for the [ROLE], really . I felt like I shouldn't have to explain why you need a [ROLE] in patients who have just left hospital having active rehabilitation who are going to have loads of secondary prevention , continence , cognitive , sexual function , loads of different problems that they need to work through and that why there

shouldn't be a nurse support in that role within there . So I found that quite challenging and in a way I have to park that agenda and try and objectify it and put it through in a language that a commissioner would want to understand rather than professionally , why shouldn't we be included ? There's a huge amount that our role could contribute to the community rehabilitation of those patients . And it's taken a long time to actually get nursing in the national clinical guideline , hasn't it , for early supported discharge .

I: 10:17 Well , yeah , definitely . So we have talked about networks and organizations . And I know you've already covered some of this , but broadly , can you tell me what you thought was helpful in bringing about change ?

P: 10:33 Having … So having a vision was really important . And the key enablers buy into that vision . I think having that multi-disciplinary perspective . And at different levels because there were clinicians who were also around that commissioning table . Like I've said before , I think it really helped with engagement . And then when it came to the implementation aspect , it was easier to do .

I: 11:09 Excellent .

P: 11:12 And I think that's change now . And I think a lot of that is because of clinician capacity to be released , to be in those conversations , even if they're not invited , you use to invite yourself . And so I think it would be really good if we were there and we would be welcomed . It wouldn't , we wouldn't be told that we couldn't come . But now it's easy for them not to be there because the clinicians haven't got enough time . And it just well , I think the commissioners , etc. think it's easier without us around the table .

I: 11:47 Yeah , but like you say it has a knock on impact in terms of that ongoing implementation .

P: 11:53 I also think , sorry one more point , as a result because the clinicians aren't involved as much in those kind of conversations now , I think they're losing the skills on how to have those strategic conversations . So we have different meetings in lancs teaching and in one of them is our steering group meeting , which is supposed to be more strategic . And the way that the clinical teams frame their arguments and their discussions , they don't change it for that type of that type of meeting . So I think there's something around that as well . Learning different ways to communicate your message depending on who it is you're speaking to .

I: 12:31 Yeah , definitely . I suppose looking at you more recent ones , then how , how do you go about engaging clinicians if they're not involved at an early stage ?

P: 12:50 I find it really challenging , actually . And I think the other thing I find challenging about up here is having those long term networks , which I don't feel like I've established yet . If I went anywhere in the Southwest , I would know several people in each of those stroke services and it was a bit like a family . You'd bump into them and you've got those professional relationships with them . And I don't feel like I could confidently say that for all stroke services up here . I think some of that's probably because we work more virtually now as well . So it's not as accepted to go and pop down the road and go and see someone else's services , what it was before the pandemic , because that was really the only way we met people and got to know and have meetings with them . So I think there was something around that . What was your question ? I know I haven't answered it properly .

I: 13:46 It's about those relationships and things are key . It was about how would you sort of address that lack of engagement of clinicians ? Well , anyone that's involved in the change , I suppose , not just clinicians , if they're not involved at that early stage .

P: 14:05 I think there's something about some of those key leaders saying it's important we have them there and have them at the table early on . And I feel as if there is no one at the moment saying that . And the ones that are there . I'm not gonna mention any names . I don't necessarily have such a wider MDT perspective of stroke delivery as others would have . They've got more of a medical model .

I: 14:39 So where your examples of it working well , and what you'd recommend would be a multidisciplinary approach from the start . And having key leaders who understand the systems and have real working relationships across that team . Is that right ?

P: 14:57 But yeah , that's informed on the evidence and is driven forward by the policy . And I think within that that over complicates the whole process . I genuinely think it does . But when it gets to the implementation stage , it will really help . And so it's having some really skilled chairs and facilitators who can actually get through that whole planning and commissioning and implementation process . While keeping everyone engaged .

I: 15:30 Simple .

P: 15:33 It’s really simple yes . You'll have one person , I can remember our stroke manager saying her whole role was communication . She just needed to communicate the whole time because and I totally agree with it because as soon as you stop doing that , you've lost everyone .

I: 15:48 Yeah . So think it , suppose it does link in with communication actually . So can you describe the ways the progress of the planned change is recorded , how it's recorded as you go along .

P: 16:02 So we had at those strategic meetings , we had our dashboard . Improvement dashboard that were linked to SNAP when it came about and the key national policy objectives that we had . And those were the responsibility of the network to update those and check progress and facilitate progress as well . So those were brought back to the meetings , and that's what we used to monitor our progress .

I: 16:37 Excellent . And do you think that was helpful ? [**P:** Yes . Yes] . Yeah . There isn’t a change you'd make or other things you'd include ?

P: 16:51 No , I don't think so . No , I think that at that level , that's what you needed . And you'd have those then the stroke network would then come to the individual team leads within each of the different organizations . And we then have our own action plans for our own areas to drive it forward . But yeah , that dashboard was really helpful for the strategic drive even making sure everything was kept to time .

I: 17:17 That dashboard was developed to address key progress criteria of the change ?

P: 17:23 Yes . Yes .

I: 17:25 And whether the change was being embedded . So it was recording … [**P:** Yes] . Okay , that's fine . We have kind of whistled through it . But can I just ask you , do you think that others were supportive of the changes or do you think , or would you have liked to receive more support during the process ?

P: 17:55 So I think the only , I think the hardest challenge for us was that we had to close the beds to fund the pilot , so there was no pump priming of any funds . So there was this , we knew we were going to potentially compromise some immediate patient care for the greater good of future patients and the way those services were going to go . [**I:** Okay] . So that's probably the biggest one , I'd say , and we felt very uncomfortable about that . The ones who are actually seeing the patients . The commissioners didn't , they see the future , see what they were aiming for . And although it was acknowledged , it wasn't so much of a concern for them because they weren't actually having to deal with the person in front of them with the consequence of that happening .

I: 18:48 Okay . Do you think the changes would have happened anyway ?

P: 18:56 Yes . I don't think they would have happened as soon as what they did . So we were a bit of a trailblazer because of it . And I don't think we would have had the same model of care as what we had . I think they had a really comprehensive MDT team , including nursing , and we're still one of the few down south that actually have that type of team together .

I: 19:18 Excellent . And do you recall being asked for any feedback on the change process ?

P: 19:25 On the change process ? No .

I: 19:29 There was no feedback gathered as you were going along ? [**P:** No , no] . Do you think it would be useful ? To have feedback or do you think there were other things that …

P: 19:42 I wonder whether , it would have been yes . I wonder whether even though I wasn't involved in it , the Stroke Network were reflecting on and evaluating the process in the way that they went about it , because they were , of course , involved in lots of other projects around the planned delivery as well . So they may have had more feedback and evaluated that process . But I wasn't involved in it no .

I: 20:10 And what do you think the impact of that would have been , though , if you had got feedback potentially ?

P: 20:19 And I think it would have … So I think there's three things , isn't there , really ? There would have been the individuals who are involved in that process could have had some personal and professional development through it because they would have identified what their role was and how they could potentially have changed that in the future . And then I think there would have been something around the collaboration between the teams and , like you said before , the structures that are in place to enable those teams and those conversations and that communication all to work effectively but also efficiently . I think the final thing would have been the acknowledgement of the chair and the key consultant position who were driving forward and facilitating that process and acknowledging the skills that's needed in order for that to happen .

I: 21:16 Excellent .

P: 21:20 It is nice I am reflecting on stuff I didn’t even think about , it’s nice .

I: 21:23 Can you tell me about anything you have done differently in retrospect ? So I suppose , $64 million question , what do you think , what would you do or what would you have done differently if you could ?

P: 21:38 So I think I've talked about it before . I think the one would have been getting some pump priming funding that would have been really helpful . I think we hung onto the evidence base . So the one , the early supported discharge original studies that came out . We really hung on to that because we were anxious about other patients not necessarily getting the best outcomes if they were moved from community out . And I think in hindsight , that's happened anyway . So there are now patients being treated through early supported discharge that weren't in the criteria for the original trials . But that's never been evaluated . And I wonder if we were more open to looking at those because that's what the commissioners wanted at the beginning . We could have controlled that process and got some of the data around it earlier on as well . So we could have evaluated whether it's actually working for them or not .

I: 22:41 Excellent , always thinking . Have you got any further comments that you'd like to add or anything you'd like to discuss that we haven't talked about already ? I think you did go back and talk about all the things that I …

P: 22:58 No I just think these days we have reverted back to more silo working , and I think that was a nice time to be and transforming services down there because it felt like everybody had more capacity to collaborate . And I don't think we have that now .

I: 23:21 Yeah . Collaboration and relationship building and then a knock on impact that has for the actual implementation that’s come through strongly . So if there's nothing else , I'd like to thank you for participating in the interview and sharing your experience . Do you have any questions ? [**P:** No , no , no] . That's fine if its fine I am going to stop the recording and then explain about next steps . Don't press leave .

P: 23:52 No , we have already done that once .

I: 23:53 I didn't ! I didn't , it just crashed ! [END]