Independent Review of AHSN Network Involvement in support to mental health trusts and police forces for the adoption of the Serenity Integrated Mentoring (SIM) model or equivalent.

Origins and Purpose of this Review

This Review was commissioned by the AHSN network to identify learning points for them emanating from their selection, implementation and evaluation of Serenity Integrated Mentoring (SIM) as part of their first 'national programme' of innovations. It was carried out by Mike Farrar CBE, FRCGP, FRCP, between September and October 2021

Background

SIM is a service model designed to enhance support to a small number of high intensity service users with a high level of contact with both health and police often when in crisis. The model aims to build relationships between health service and police staff and the service user when the service user is not in crisis. As a result, the intention is that over time the coping skills of the service user would be enhanced, reducing crises or, in the event of a crisis, giving them and health and police forces an opportunity to respond more effectively through the development of joint response plan shared with the user and health and police agencies. Between 2018 and 2020, the AHSN Network supported mental health trusts and police forces in England interested in adopting the SIM model of care. This support was commissioned by NHS England as one of seven programmes commissioned for national scaling between April 2018 and March 2020. AHSN Network support for adoption ended in March 2020.

Over the course of the three months May - August 2021 there has been a high profile "StopSIM" campaign, largely conducted through social media. This has called into question the SIM model and the roles of those agencies, including the AHSN Network, which have supported adoption of the model. As a result of these concerns, Professor Tim Kendall, National Clinical Director for Mental Health, wrote to all mental health trusts asking them to review SIM or other models of care for high intensity users. The results of these reviews are expected in Autumn 2021. One focus of the campaign is how the SIM service model support was selected as an AHSN national programme.

To complement the above reviews, the AHSN Network has taken a decision to commission an independently led review of its own support for SIM and equivalent models. The principle objective of this review is to provide a formal report to the AHSN Network that will provide an independent assessment of the AHSN Network's role and processes in selecting and supporting the programme and the associated contextual factors that influenced them. (**Specific Terms of Reference for the Review are attached at Appendix A).**

It should be noted that this is not a formal investigation of these issues but a learning review designed to elicit key points that can be considered by the AHSN network and AHSNs as they move forward to deliver their mission and purpose in supporting innovation within the NHS.

Methodology

The Review involved a desk top review of all the correspondence and information generated at meetings related to the matter of SIM, including that which related to the wider context of the AHSNs and NHS England's ongoing discussion about the development of a 'national programme' of innovations at the time in question. The information reviewed is contained in the following zip file - https://www.ahsnnetwork.com/freedom-of-information-foi-requests and can be accessed via the AHSN Network website.

The Review also involved a series of interviews with key individuals involved at that time in the decisions surrounding the selection, implementation, and ongoing evaluation of the SIM initiative.

Findings

The findings from the review are split into seven areas -

1. Contextual - matters affecting the initial establishment of a 'national programme' of innovations
2. Decision Making - in relation to the selection of SIM as part of this programme
3. Implementation and Evaluation - relating to the roll out and monitoring of the SIM initiative
4. Conclusions relating to the selection and implementation process of the national programme at its inception
5. Action taken or in train since the initial establish of the programme that relate to the conclusions drawn
6. Ongoing recommendations to AHSNs going forwards based on the learning review overall
7. Final Word

Taking each in turn -

1. **Contextual Findings**

A Question at that time over the future of AHSNs and the emergence of a 'national programme'

1.1 It is clear from the interviews conducted that at the beginning of 2017/18, the future of AHSNs as a vehicle for supporting NHS innovation was being questioned nationally. The general sense was that whilst AHSNs had some impact in individual areas and projects, there were a number of concerns

- their impact had been variable to that point and not all AHSNs had been able to establish universal support and commitment from their member organisations
- NHS England, as the sponsor body for AHSNs, held a view that innovation at pace and scale was still too slow
- NHS England believed that where innovations had occurred, these were still too narrowly felt within the NHS geographically and that whilst AHSNs had created new and helpful proof of concept for some innovations, there had been too little evidence of roll out and spread

- NHS England did not see sufficient correlation between the innovation pipeline and the national priorities

1.2. This was a genuine and legitimate question with regards to the future of AHSNs and whether, in their previous form and scale, they were the right mechanism going forward to support innovation. This was also a question fully recognised and acknowledged by AHSNs themselves and at strategic timeouts they held at that time, their leadership debated the causes and remedies.

1.3 AHSNs reflected that part of the cause of any concerns regarding their effectiveness had stemmed from their own inconsistencies in terms of the balance of their operating models and priorities of members. They also agreed that there were problems caused by NHS England's history of adding new responsibilities and redefining the expected outcomes from AHSNs (eg the addition of patient safety collaboratives to the AHSN role, and an introduction of job creation as a key performance metric). As a consequence they resolved that going forward there needed to be greater clarity and consistency of their mission between themselves and agreement on this with NHS England (this included a commitment to propose and agree a national programme of innovations to which all AHSNs would be committed).

1.4 Consequently, two key initiatives emerged and were proposed -

- the proposal to work with NHS England on a small number of innovations that would be agreed, adopted and rolled out by all AHSNs as a nascent 'national programme' (these would be also be aligned more to national priorities)

- the proposal to boost the work of the National Network of AHSNs to support the collective working between AHSNs that such a national initiative would imply

1.5 There was an additional aspect of this debate in that whilst many of the key leaders at that time and most of the relevant policy officials expected AHSNs would be given a further period of time to demonstrate their value and impact, it was by no means certain what level of funding they would receive in the next period, should they be granted a further license to operate. There was also uncertainly about what any new funding would be expected to deliver, and what, if any, additional locally derived monies and flexibilities AHSNs might have at their disposal

1.6 It is clear, in my view, that**,** not only does the Government have an ongoing democratic right to review its policies and priorities, NHS England, as its most important arms length NHS management body, also had and maintains a right to review its approach to enacting and delivering these policies under its mandate with DHSC.

1.7 Crucially also, in attempting to strengthen innovation capability within the NHS, any review would include the consideration of the wider general evidence on 'innovation support' per se. This evidence reveals that, in promoting the development of effective innovation partnerships with suppliers, it is beneficial for any health system to -

- specify the problems and areas of concern to which the system is seeking innovative solutions
- provide sufficient 'scale of market' within that system for suppliers to encourage them to see the full commercial opportunities available to them if successful
- offer a guarantee of consistency of approach within the market to the adoption of any proven innovation

- enable the conditions for the system and its potential suppliers to engage in co-creation of solutions and shared ownership of any subsequent roll out and measurement of success

This evidence supports the direction of thinking that both the AHSNs and NHS England were heading in as they considered the next phase of healthcare innovation and the approach that AHSNs (or any potential successor structures) might be asked to take, and the development of a national programme.

1.8 The operating context within which SIM was identified and selected therefore stemmed from **an entirely legitimate policy and implementation question**, which both NHS England and AHSNs recognised. It was also clear, given the state of NHS finances at that time, **that funding levels and deliverables would legitimately be under review.**

1.9 **It served however to set an important tone in relation to the development of the first 'national programme' of innovations and coloured the development of that approach, including the specific approach to selecting the innovation ideas and reporting on their progress as national initiatives.**

Impact and Consequence of this Context

1.10 The process which then ensued to establish a 'national programme' was clearly the first of its kind and as such was built without precedence or experience from previous years. The AHSNs, working through their Network, as a consequence, designed a process based on their understanding as to how best to select, implement and monitor progress of any innovations adopted. Whilst AHSNs had local experience of this, the lack of practical operation of this *at national level* however, meant that it was always unlikely that the process created would be 100% fit for purpose, or error free, and it was acknowledged by those involved in this at the time, that it would need to be a learning process.

2. Findings Related to the Selection of Innovations and the Initial Decision Making Process

Issues Related to Process Design

2.1 The AHSN Network created a thoughtful process with regards to selection of potential 'national programme' innovations. It was built from comprehensive consultation with all AHSNs, with clear criteria for nomination and appraisal of potential candidate programs. The process also had a democratic scoring process that meant the views of all AHSNs were material and influential.

2.2 The process in its first iteration did however have a number of important elements, which affected the first round of nominations -

- it favoured areas of previous investment and supplier market development eg major disease areas, simply because historically these areas had received more innovation funding and attention,

- in terms of the stage of development of any innovation, the evidence required for an initiative to be selected was likely to favour more mature and developed innovations that already had a higher degree of proof of concept,

- the process lacked precision in terms of whether it was designed to be a national spread programme of existing innovations with proof of concept already demonstrated, or whether there was any intention, through this programme for a more early stage innovation to be tested across the country in order to establish proof of concept, or both,

- the desire to apply this process with rigour and discipline tended to establish a more scientific and empirical approach than may have been warranted given this was a first year of its application. The process may have benefitted from a rather more explicit weighting to be given to AHSN leadership judgment for example,

- the process lacked qualitative assessments alongside quantitative measurement and this excluded some important quality measurements. Instruments such as patient reported outcome measurements (PROMs) and patient reported experience measurements (PREMS) would have given the AHSNs a greater richness of understanding of the candidate programmes and a better basis for judging the programme's successes. This would undoubtedly have helped the AHSNs assess the relative merits of different innovations including SIM.

2.3 The consequence of this process being developed and applied was therefore the generation of a long list of innovation candidates. For the reasons outlined above, this did not initially result in the widest range of areas and programmes that the AHSNs themselves might have hoped for as an initial long list, (although a small number of mental health initiatives did make this initial list). AHSNs were then invited to prioritise this initial list to arrive at a proposed long list for discussion with NHS England.

2.4 It was not surprising or illegitimate in my view therefore that there were further rounds of discussion, both internally between the AHSNs and externally with NHS England, prior to a final selection of programmes.

2.5 This iteration of thinking was also warranted by the fact that at the early stages of selection it is clear from the meeting notes, that there was still uncertainty about the total quantum of the money that would be available to fund this programme.

Issues relating to the inclusion of mental health schemes on the candidate list

2.6 Throughout the subsequent process of iteration of the candidate list, there are some key developments that impacted on the selection of a mental health innovation -

- it is clear that the absence of any mental health schemes emerging from the first round of prioritisation was of concern, not only to NHS England, but also to the AHSNs themselves. At that time mental health was a growing national priority and it is legitimate that this was raised as a concern with regard to the prioritised long list of candidate innovations.

- it is unsurprising that no mental health programmes made the prioritised long list given the initial more empirical criteria for selection and so the next iteration of the selection process would always have been the stage at which a mental health innovation would have had to be proposed

- the tone and nature of the discussion between NHS England and the AHSNs at that time with regards to mental health innovation and its absence on the prioritised long list, and the ensuing request to consider adding such an innovation to the list going forward, was appropriate, constructive and not coercive

- there was still uncertainty for the majority of this time on the level of funding available and so adding in more candidate programmes with greater variety of focus (ie mental health) was sensible and rational.

- The absence of a clear budget placed added emphasis within the process and criteria for selection on one metric - Return on Investment (ROI). As a consequence this measure dominated the selection and created in some cases, of which SIM was one example, a need to extrapolate or hypothesise national ROI figures based on low levels of actual cases and evaluation (see later para 2.9)

Issues relating to the selection of SIM as a chosen innovation

2.7 There are also a number of important points that are raised by the specific selection of SIM as a mental health programme as a part of the first 'national programme'

- SIM had been first piloted on the Isle of Wight in 2013 and 2014. It had built on a multi-agency street triage programme introduced in 2012 which CQC referred to in its 2014 report on the IoW Acute Trust as good practice. In 2016 there was a positive economic evaluation undertaken by Wessex AHSN using data supplied by Hampshire Constabulary . (The data was assumed to be reliable although subsequent emails from Hampshire Constabulary in 2018 revealed there may have been inaccuracies in it). SIM's initiator was subsequently supported by Wessex AHSN and Hampshire Constabulary to become an NHS Innovation Accelerator fellow.

- This was followed by subsequent interest and adoption of the scheme in 2017 in Surrey and four London MH Trusts where it was supported by the London MH Transformation Board. In 2017, IoW Acute Trust also employed the initiator as part of a contract with NHS Right Care to roll out the SIM approach.

- It is unsurprising therefore given this background and association with national schemes that the SIM approach came to the attention of the AHSNs at the point they were looking to strengthen their generic approach to roll out. Therefore it was logical and legitimate at that stage for SIM to be put forward as a candidate for the emerging national innovation programme.

- it is less clear that the evidence base for SIMs effectiveness was fully understood. Work in 2017 by the team supporting the evaluation element of AHSN selection process made it clear that SIM, as a specific programme delivered on the Isle of Wight, was based on the experience of a very small number of individual cases.

- It is clear that the fact that the initial assessment of the scheme was based on a small number of cases *was* pointed out by the evaluation team to the team managing the selection process but it is unclear that this was understood by *all* AHSNs.

- As is clear, SIM was not prioritised by the AHSNs in the initial process of selecting from the initial long list to the prioritised list. However, following the discussion between NHS England and the AHSNs specifically regarding the priority list that emerged from the AHSN voting, it is understandable that the AHSNs would have revisited this initial list (as stated in para 2.6). In doing so, it was also logical that SIM would have been reconsidered and then brought back into the short list of candidates. There are three reasons why this would be so - 1) SIM had already made the long list of the initial nominations and received some, albeit insufficient, support from AHSNs to

progress at that stage 2) it had a background of support from and active connection to national programmes and 3) many AHSNs were unaware of the small number of cases on which the schemes evaluation was based,

- It is my view that had there been complete awareness of the low level of cases in the evidence base then it is very probable that AHSNs would not have agreed to this being part of the national roll out programme and may have chosen another route for the innovation to progress (including further evaluation or more gradual uptake and concept testing).

- It cannot be completely ruled out however that AHSNs who had, or were aware, of *similar* schemes to the specific SIM approach, may *still* have supported it in their prioritisation - in the belief that, if selected, the innovation programme would be flexible, allowing a number of similar variations of the Isle of Wight SIM approach to be included in the national roll out. In other words, knowledge of similar schemes in their own localities may have given assurance to those AHSNs *even if* they had been aware of the low level of individuals who had actually experienced the specific Isle of Wight SIM scheme

The Development of the Initial Proposals into Hard Business Cases

2.8 An agreement to move the national programme forward with SIM however was reached and this then meant that it faced further scrutiny, for which a more detailed business case was needed. This business case required processing SIM through a number of criteria which required extrapolation from the limited base of evidence available due to the small scale of its use to date. As would be the case therefore, the business case that was developed and synthesised for SIM was always likely to be a more speculative case with a higher possibility of exaggerated outcomes as a consequence. But it was *this* case that went into the papers for the later stages of selection, and so the estimate of money to be saved and ROI were always likely to have greater scope for inaccuracy. These caveats were not made as clear as would be desirable when the paperwork and business case moved forward through to the next stages of selection and sign off.

The Impact of Extra Resources for the Programme

2.9 The ultimate decision to allocate a greater level of resources to the programme by NHS England allowed a greater range of innovations to be included than had originally been thought and so some programmes with lower levels of support from all the AHSNs were able to qualify and be added to the programme overall. This confirmed SIM as one of the national programme innovations when it may not otherwise have been included, if the money available had been at the lower levels initially anticipated.

3. Findings Related to the Implementation of the SIM Scheme Once Selected

Predictability of a Difficult Roll Out and Implementation

3.1 From the outset it was likely that AHSNs would face a less straightforward roll out of SIM than with a number of the other initiatives they supported, for the following reasons

- the speculative nature of the business case was converted into outcome and output expectations which were likely to be over ambitious given the base upon which the extrapolated figures were made

- the requirement to roll out the specific Isle of Wight SIM approach meant that agreements needed to be reached for inclusion of any local schemes with similar characteristics but not matching completely the specific approach. One of the questions needing to be answered at that time for example was how the SIM approach differed from Court liaison and street triage schemes. (SIM was defined however to be a more proactive approach for supporting individuals rather than a crisis response),

- academic input from UCL established greater clarity on the definition of the SIM approach by creating equivalence criteria and an equivalence protocol to help the AHSNs assess different approaches. This was applied by a number of AHSNs with at least one scheme's submission for assessment being deemed not to be equivalent, whilst at least two others were deemed suitable to be included and counted as part of the SIM roll out.

- the definition of the scheme itself and schemes 'deemed equivalent' mattered in regards to the level set for the original estimated impact-able population for the service model and therefore the level of ambition for adoption over the two years of AHSN support as part of the national roll out. The initial level placed pressure on both AHSNs and the originator of the model (at the same time as the originator was endeavouring to build a sustainable business model) to achieve what was a very ambitious figure for national coverage. However, this was addressed in year 2 of AHSN support, when all agencies agreed a resolution, on the basis of the greater definitional clarity of SIM, to reduce the estimated population that could be supported by the model and this led to an easing of the adoption trajectories.

The Importance of Quantitative and Qualitative Measurement

3.2 The performance metrics for SIM roll out, and the success of the programme focused on the numbers of people engaged in the programme and just as with the selection process, did not include any public/patient involvement through the use for example of PROMs or PREMS. The consequence of this again was to deny the AHSNs a richer understanding of the success or otherwise of their implementation. (It should be acknowledged however that the AHSN Network later supported a feasibility study into an evaluation of SIM by North Thames CLARC which included a qualitative element, and two subsequent research bids In 2019 to NIHR for studies that included qualitative elements. It is disappointing that these research bids were unsuccessful).

3.3 Use of PROMs and PREMS at that stage, as part of the selection process, may well have provided earlier insights into any particular issues arising from the SIM approach at an earlier stage. They may also have enabled the AHSNs to have a greater clarity and deeper understanding of how to define SIM and any equivalence.

3.4 Concerns around the implementation of the SIM approach were initially raised when the expected number of individuals engaged was lower than that aspired to, and the evidence that the approach had significantly less consistent application in all parts of the country than was originally intended by making it part of the national programme. This was felt in some cases to be due to lack of focus but in some other cases the local partnerships with the Police Constabularies did not prioritise the SIM type programme or did not prioritise the specific SIM approach over their local variation.

The Emergence of a Pragmatic Approach

3.5 As referenced in para 3.1 a pragmatic and shared agreement was reached to clarify the definition of the SIM implementation, to allow for the inclusion of agreed equivalent local variations of the approach. As a consequence the overall numbers were adjusted and the geographic consistency of its application also improved. This pragmatic approach was welcomed but the concerns over SIM numbers at that stage could also have triggered a more fundamental assessment of the benefits of the SIM approach, including gathering more qualitative information from individuals engaged in the programme and the staff delivering it.

3.6 The change in measurement did not trigger a deeper review, even though by that stage the numbers of people engaged in the scheme would have allowed for a stronger evaluation of the scheme than was a originally undertaken for the purposes of putting it forward for roll out beyond the Isle of Wight

4. Conclusions relating to the selection and implementation process of the national programme at its inception

There is much to learn from the analysis of the process by which SIM was selected and then implemented as part of the 'national innovations' programme. Most have been referenced above in the findings but in summary, the following are the most significant conclusions

4.1 The development and adoption at pace and scale of an innovation is a process that has many stages in its iteration. Two such stages are the initial phase to demonstrate proof of concept and then the further stage of its 'spread'. The lack of precision in the early stages of the new selection procedure as to which stage in their development an innovation would be deemed suitable for the national scheme created ambiguity and caused problems for AHSNs selecting and ultimately implementing appropriate innovations

4.2 The process of alignment of the programme with national priorities is legitimate and sensible. When any such priority happens to be in an area of little previous investment, research or evidence base for change, then adjustments in the selection criteria would need to be explicitly clear. In this case, unsurprisingly as it was the very first year of the approach, the adjustments were not clear or transparent and this caused problems for the AHSNs throughout the process of selection

4.3 The initial evidence base for SIM being based on a small number of individuals should have raised more questions as part of the selection process. This may have led to SIM not being part of the programme at that stage but possibly diverted into other streams of support from AHSNs, or a slower, more iterative, step wise approach to roll out and spread.

4.4 A clear stated option within the national programme for a more gradual roll out of some innovations could have helped to test out the proof of concept but this would have sat awkwardly with the intention of the national programme to roll out across the country on a speedier more comprehensive basis

4.5 There was a dominance of quantitative measurement over qualitative measurement throughout the programme overall (eg an absence of PROMs, PREMs and public/patient input). This meant that the selection process failed to provide AHSNs with the optimal basis for their consideration. It also impacted on the development of the business case and the targets set for implementation. (At the time this was noted as an issue by the AHSNs but didn't lead to changes). Even when the process

for measuring SIM was changed, the lack of qualitative information meant AHSNs had only a partial picture of the scheme's success.

4.6 On the continuing nature of a 'national programme' of innovations, the emerging role of ICSs adds a new dimension to the selection of innovations and is material to the pace and scale of innovation roll out. There is now a greater opportunity to align innovative solutions to problems identifiable on an ICS footprint, and this should usefully help to inform any selection to a national programme. Statutory ICSs will enable a process for iterative spread rather than simply operating on either an ad hoc individual Trust basis or a country wide comprehensive basis through the national programme.

5. Action taken or in train since the initial establish of the programme that relate to the conclusions drawn

	Action Undertaken	Notes
Refreshed purpose of the programme with greater clarity of objectives	This has occurred and the AHSNs have been clearer about the programme and purpose. The Network now has a clear strategy and associated business plan developed that addresses the need for a curated pipeline of innovation.	There is a need with the recent pandemic, new legislation and turnover of leaders to ensure that the managerial and political leadership of the programme remains aligned on the place and purpose of a national programme for rolling out innovations. This includes a systematic evidence based selection process.
Earlier stage differentiation of types of candidate schemes	This has occurred on the back of greater scrutiny of the evidence base for selection being part of the process. The pipeline that the Network has established enables a full assessment and staging of innovations	Whilst this programme is clearer on this issue, the wider landscape of routes for innovations to pursue remains confusing and joint work between the AHSN Network, NICE and MHRA is focused on addressing this challenge
Selection to be based on qualitative as well as quantitative data with patient/public engagement	There have been some examples of good practice but not yet adopted on a systematic basis or comprehensive scale. However all potential programmes now have a full evidence assessment undertaken and the AHSN Network now has full patient and public engagement in the design and selection of national programmes and this is described in the Network's 2021 PPI strategy	One of the most important and positive outcomes to emerge from the SIM experience/review would be to use it reinforce the need for bringing the public/patient voices and experience into the process It is recognised that the AHSN did support two research bids in 2019 that were unsuccessful but which did include qualitative elements in the bid.
Earlier ongoing evaluation of selected schemes	This has largely been built through the redesign of AHSN programme delivery	

New alignment with ICS priorities	As ICSs are early in their development this will need further thought and actions. AHSNs have recognised the importance of supporting ICS priorities and have begun to act as the 'innovation arm' for their local ICSs.	Some early work with STPs and informal ICSs offers some good practice that could be adopted universally and help to shape the local and national programmes
Earlier indication of priorities for innovation to suppliers and innovators	This is being addressed through the redesigned approach to AHSN programme delivery however the signalling of need by the NHS to innovators remains an NHS challenge. The AHSN Network has established an Innovation Exchange programme to communicate these needs to innovators in a more structured approach designed to accelerate innovation where greatest need exists. The AHSNs led a research and innovation needs joint survey between NHSE and NIHR to address this challenge.	
Ongoing learning and review of the programme overall	AHSNs may wish to consider this more proactively as they respond to this review	

6. Ongoing recommendations to AHSNs going forwards based on the learning review overall

The following recommendations emerge from my assessment of the initial selection process and management of the programme (that included SIM), and changes made to the programme and its processes by AHSNs since. They reflect that many of the initial problems have been addressed fully or in part, and so, these recommendations cast forward to ensure there is a process of continuous learning built in, as NHS and care structures change as the new system of Integrated Care emerges.

Clarity of Purpose of the 'National Innovations' Programme

5.1 The AHSN network, on behalf of the AHSNs, should regularly refresh the purpose of their 'national innovations' programme and establish clearly the nature of innovations that are suitable for the programme.

5.2 As part of any refresh the AHSNs should be clear of the process for assessing earlier stage innovations where there may be less initial evidence but where a national approach (eg for establishing further proof of concept) is legitimate. There should also be clarity on the process by

which innovations that might need to be deliberately rolled out on a more iterative basis can be included or excluded from the national programme

Evidence Base for Selection and Evaluation

5.3 The selection and evaluation process for the programme going forward should encompass both quantitative and qualitative measures such as PROMs and PREMS, and also include greater input from patient/public perspectives in the whole process.

5.4 Maintaining a rigorous process of assessment of schemes put forward for the national programme is essential to ensure the correct balance of legitimate national priority setting with the scientific evidence base of effectiveness underpinning candidate schemes. This process should be appropriately funded and recognised in the allocated resources from NHS England to AHSNs

5.5 There should be earlier and ongoing evaluation built into the process of implementation to allow for any early warnings that the innovations selected were not delivering as expected. This is especially important for those innovations selected into the national programme with a smaller evidence base at an earlier stage in their development

The Emergence of the ICSs and their relationship with this Programme

5.6 The AHSN Network should consider how the new relationship between ICS and ANSNs might interface with this national programme to recognise the importance of adoption of innovations on a larger scale footprint than individual Trusts or places, which might not as yet be considered for a national roll out

Signalling of priorities and the link with innovators

5.7 Early indication of priority areas for both the service in general and the national programme specifically, should be set out for suppliers and innovators on a 3-5 year horizon to allow them to understand the health and care system problems in good time for them to develop solutions. This will require good communication between the AHSN network and DHSC/NHS England, recognising that there will always be shorter term expedient priority areas signalled with much less notice.

7. Final Word

In looking at the conclusions I draw from the review of the process leading to the selection and implementation of SIM as part of a national programme of rolling out innovations, I believe that actions taken since by the AHSNs largely address the issues I have identified. Equally they provide assurance that learning has occurred and the operation now of the programme is a stronger one. There is still however more work to do (as set out in my recommendations) to ensure that the national programme fulfils its potential and has a major role in delivering improvements within the NHS and Care system going forward.

Mike Farrar CBE, FRCGP, FRCP

November 2021

Appendix A - Terms of Reference for the Review

To review the AHSN Network and AHSNs' support for SIM and report to a joint committee of the Chairs and Chief Officers of the 15 AHSNs. The review should report by the end of October 2021.

The review should consider the following areas as within scope:

1. To review and summarise the policy context within which the SIM model emerged and gained interest with a particular focus on how this informed the response to SIM of health and care systems, police forces and national bodies.
2. To review
    a. early AHSN involvement with SIM from its inception as a pilot in 2013/14 on the Isle of Wight.
    b. the process for selecting the SIM innovator as a fellow on the National Innovation Accelerator in 2016 and the subsequent support provided to the innovator by the NIA programme.
    c. AHSN support for the model and interactions with health care systems, police forces and NHS England between 2016 and before the commencement of support by the AHSN Network as a national programme in April 2018.
    d. The process whereby the AHSN Network identified and then selected SIM as one of the cohort of programmes put forward for consideration by NHS England for national adoption under the 2018/10 Master Services Licence Agreement with each of the 15 AHSNs.
    e. The AHSN Network's running of the national programme from April 2018 to March 2020 including, where relevant, experience at a local AHSN level.

1. To report findings and any recommendations arising from the review to the joint committee of the Chairs and Chief Officers of the 15 AHSNs.
2. The report will be shared with AHSNs' national commissioner – NHS England, and published on the AHSN Network website.

Review Process

A suggested approach may cover:

A review of all relevant documentation including reports, emails and meeting minutes from the key periods of support programme selection, development and delivery.

Interviews with all relevant current and former AHSN personnel and relevant external partners.

Planned Deliverables / Outcomes

An independently produced report that provides insight into:

- the context within which decisions were taken in relation to the support programme
- the effectiveness of AHSN Network processes and ways of working in identifying, selecting and supporting the programme.
- key learning points to improve future operation of the AHSN Network and its selection and support of national spread programmes.

Timescales

The review should report by the end of October 2021.