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Building a better working world

NHS Insights Prioritisation Programme Evaluation

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Navigation key

	Finding/ recommendation
	Example of best practice
	Hypotheses/ evidence

EY Legal Disclaimer

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This report was concluded in May 2023. Material events which have occurred since the report was concluded will not be reflected in this evaluation.

1. Executive summary

1.1 Context and background

The NHS Insights Prioritisation Programme (NIPP) was set up in 2021 in response to the COVID-19 pandemic. The programme aimed to accelerate the evaluation and implementation of promising innovations that support post-pandemic ways of working, build service resilience, and deliver ongoing benefits to patients. Through providing funding and a framework for approaching service evaluation activities, NIPP facilitated the evaluation of 14 innovation and intervention projects across England. NIPP evaluations were initiated in November 2021 during the recovery phase of COVID-19, which had an impact on the delivery of evaluation activities.

The AHSN network appointed a team comprised of subject matter resources from Ernst and Young LLP to undertake an 11 week (February 2023-May 2023) independent evaluation of NIPP. This retrospective evaluation sought to capture key learnings from programme delivery and offer recommendations to inform opportunities for post-NIPP activities and future innovation programmes within the NHS.

1.2 Results

This evaluation draws on a mixed-methods, Magenta-book aligned approach and utilises both qualitative and quantitative methods combined with secondary research. It provides a detailed report of NIPP, based on insights collected through primary research activities with programme stakeholders. Methodology of this evaluation has been co-designed with key stakeholders identified by the NIPP delivery team.

Overall, projects shared positive sentiment towards their participation in the NIPP programme, in relation to both collaboration between ARCs and AHSNs and new skills gained. The programme was considered a *'fantastic opportunity for ARCs and AHSNs to work together,' 'a good way to channel funding to what to focus on'* and *'a brilliant opportunity'* amongst project teams.

From our analysis of intended design of NIPP versus its delivery, we can conclude that NIPP was successful in:

- Facilitating a more structured approach for the funding and acceleration of innovations and interventions, particularly in comparison to previous initiatives, such as the Beneficial Changes Network (BCN)[1].
- Having a clearly structured application process that enabled 14 out of 15 applicant projects in securing funding.
- Almost all projects managed to meet NIPP deadlines, despite many redesigning their evaluation methodologies to deliver on time.
- Learning and knowledge sharing events that took place as part of NIPP were generally recognised as helpful and enabled network thinking among ARCs and AHSNs across regions.

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[1] Beneficial Changes Network official page, available from: https://www.england.nhs.uk/beneficial-changes-network/workstreams/

- Delivering an appropriate level of communication, particularly in relation to expressing the ambitions and expectations of NIPP.
- Introducing project extensions, in response to projects struggling to meet programme timelines.
- Acting as an accelerator for ARC and AHSN collaboration, for those with existing relationships established prior to NIPP. Those who had little to no existing ARC-AHSN relationship felt enabled to build them while working on NIPP, despite this causing some delays to evaluation.

All 29 findings that have emerged from our evaluation have been sectioned into three themes: programme design, collaboration, data governance & patient and public involvement and engagement (PPIE). They describe positive, negative as well as neutral experiences and observations across the themes identified. Whilst the experience of NIPP was generally positive, our evaluation has identified several areas of development that should be considered in the design of future innovations programmes and post-NIPP activities. The more actionable findings include:

Programme design
Finding 2: Insufficient timelines for bid submission and a lack of mobilisation period were barriers for co-production of proposals and timely recruitment of project team members. Finding 9: Despite early communication from the programme team, communication throughout the duration of the programme was considered inconsistent. An absence of a Project Support Officer (PSO) for the full duration of NIPP, as well as a transition in Programme Lead, might have impacted the provision of consistent support and guidance. Finding 11: Learning and knowledge sharing events were generally recognised as helpful and enabled network thinking; more frequent learning and networking opportunities would have been beneficial. Finding 13: Clarity regarding the role of regional leads in NIPP, varies between NHSE regions, both amongst project teams and regional stakeholders. This led to disparity amongst projects in successful engagement with their regional leads. Finding 14: Feedback on quarterly reports appeared inconsistent, with project teams citing little to no feedback following the submission of reports. As a result, they perceived quarterly reporting as a 'box ticking' exercise. Finding 15: Project teams considered KPIs in quarterly reports as process-driven, rather than outcome-oriented. As a result, it was felt that KPIs were not designed to measure the impact of innovations and interventions on patient outcomes. Finding 16: The format of quarterly reports did not enable projects with multiple funding sources, to reflect additional funding streams. Finding 17: Equal distribution of funding between NIPP projects was aimed to facilitate collaboration rather than competition, however, did not reflect regional inequalities. Finding 18: Upon receiving programme funding, projects were responsible for distributing their funds as appropriate.

Collaboration

Finding 22: Contrasting approaches to evaluation between ARCs and AHSNs, appeared a common barrier to successful collaboration.

Data governance & PPIE

Finding 23: Project teams cited R&D approvals as a significant barrier for conducting primary research activities with staff and patients, due to extensive approval timelines.
Finding 24: Despite NIPP being designed to avoid the requirement for ethics approvals, due to timeline constraints, this approach did not align with traditional ARC ways of working. As a result, many projects built in evaluation activities that required ethics approvals and were required to lean on ARC expertise to overcome this barrier.
Finding 27: Where data governance influenced evaluation design, some projects cited decreased confidence in quality and depth of their evaluation.
Finding 29: For projects that had no established PPIE connections, access to participants appeared more of a challenge and in some cases, resulted in requirements for evaluation extensions or avoiding qualitative research altogether.

In addition to the above findings, a number of good practices and methods for overcoming barriers have been identified throughout this evaluation and are covered in Chapters 7 and 10.

1.3 Conclusions

NIPP was successful in accelerating the evaluation of 14 promising innovations and interventions across NHSE. By providing funding and a dedicated framework, NIPP facilitated service evaluation activities and collaboration across projects as well as across ARCs and AHSNs, building capacity and expertise for future evaluation activities.

Due to limited evidence available, there is difficulty concluding whether NIPP succeeded in contributing to the wider NHS Reset and Recovery initiative, as well as ICS and regional needs. At the time of this independent evaluation, each of the 14 projects lack sufficient evidence and time in field, to demonstrate whether NIPP was successful in accelerating implementation of these innovations. Conclusions are described further in Chapter 9.

We summarise our findings with respect to the evaluation hypotheses and research questions below:

H1: Programme timelines impacted the design of evaluations

Programme timelines did impact the design of evaluations for some projects, who felt the need to redesign planned activities to meet evaluation deadlines. The timeline provided for NIPP project application and delivery, was cited amongst the top two barriers to successful programme delivery. Amongst these projects, it became apparent that timelines were insufficient to incorporate all planned activities such as effectively

mobilising a team, getting approvals, and conducting primary research and/or collecting existing data. This led to some projects re-designing their evaluation approach mid-programme, after realising their original plans were too ambitious to meet deadlines.

H2: Having previous collaborative experience between AHSNs and ARCs played an acceleratory role on project delivery

The programme increased collaboration between 14 out of 15 ARCs and AHSNs, regardless of whether projects had previous experience of working together. Timelines for evaluation varied somewhat from those intended, with less mature projects reporting a period of 12-14 months to conduct evaluation activities, versus an intended 18 months. Projects that again, due to mobilisation requirements, requested an extension, faced a further impact on the time remaining for planned evaluation activities.

H3: Governance around data access and ethics/R&D approvals had a negative impact on project outcomes

For some projects, governance had a negative influence on evaluations, impacting both the ability to overcome ethics and R&D approvals in a timely manner, as well as overcome requests to access existing data. As a result, some projects had to reduce the scope of their approach to complete evaluation activities on time.

As a result of changes in scope, individuals from these projects cited less confidence in the quality and value of their evaluation outputs, compared to their planned approaches.

It is challenging to draw conclusions on the impact of data governance on patient outcomes, as at the time of this evaluation, the programme is ongoing, with two projects still finalising their rapid insights reports. However, we can rely on project team members' evaluation of their own outputs.

1.4 Recommendations

In response to the results of the evaluation, a set of key recommendations have been identified that should be considered for the design of future innovations programmes within the NHS, as well as post-NIPP activities and wider evaluation activities beyond NIPP. Recommendations centre around programme design and collaboration between ARCs and AHSNs and include the following:

Programme design and collaboration

Recommendation 1: Provide NIPP projects and key stakeholders with clarity on their roles, programme objectives, key milestones, and desired outcomes, during the onboarding process, whilst considering differences in maturity of innovations/interventions selected for NIPP and maturity of ARC-AHSN relationships.

Recommendation 2: As a part of the NIPP application process, projects should be required to explore and report on the expected governance approvals involved in their evaluation activities and experience in managing them.

Recommendation 3: Create a dedicated mobilisation period to reduce the impact of restricted programme timelines and enable better planning, timely distribution of roles, internal administration, and preparation of sites for data access.

Recommendation 4: Generate specific, measurable and time-bound (SMART) KPIs in

project reporting, to ensure they are relevant and meaningful to projects. Provide guiding principles for project specific KPIs to maintain consistency and direction.
Recommendation 5: Design a structured, consistent approach for providing projects with feedback on quarterly reports and facilitate two-way communication between programme management and individual projects.
Recommendation 6: Facilitate more frequent opportunities for collaboration and knowledge sharing between projects, to enable network-level thinking.
Recommendation 7: Recognise and communicate best practices for effective collaboration between ARCs and AHSNs.

1.5 List of abbreviations

AAC – Accelerated Access Collaborative
AHSN – Academic Health Science Network
ARC – Applied Research Collaboration
BCN – Beneficial Changes Network
ICS – Integrated Care System
NHSE – NHS England
NIHR – National Institute for Health and Care Research
NIPP – NHS Insights Prioritisation Programme
PPIE – Patient and Public Involvement and Engagement
PSO – Project Support Officer
IRLS – Innovation, Research and Life Sciences
RWE - Real World Evaluation

2. Introduction

The NHS Insights Prioritisation Programme (NIPP) was set up in 2021 by NHS England and the NHS Accelerated Access Collaborative (AAC) to accelerate the evaluation and implementation of promising innovations that support post-pandemic ways of working, build service resilience, and deliver ongoing benefits to patients.

To build on the collaboration between the BCN and AAC, NIPP provided competitive funding to enable and improve collaboration between 15 Academic Health Science Networks (AHSNs) and 15 Applied Research Collaborations (ARCs).

ARC-AHSN collaborations were invited to bid for a share of a £4.2m investment, to test and evaluate promising innovations within their Integrated Care Systems (ICS). Each of the successful projects, has since conducted evaluation activities including demonstrating the impact of their innovations on health inequalities, across one of four priority areas: remote consultation, remote monitoring, new approaches to service delivery and health and social care workforce innovation. The programme was designed to run for 18 months with selection process taking place in September-October 2021 and evaluation activities starting from November 2021 until March 2023.

3. Evaluation scope and hypotheses

3.1 Evaluation scope

Our evaluation has been conducted at a programme level and does not assess performance of the individual projects enrolled onto NIPP. This scope reflects two major constraints:

1. Timing of this evaluation has coincided with the final delivery phase of the programme, with in-project activities taking place until 23 May 2023, such as impact reports of the two projects that received an extension, which is beyond the timeframe for this evaluation.

2. Maturity of the innovations that were selected to participate in NIPP was varied. Inconsistency in project maturity has made it challenging to conduct a robust evaluation of the impact of innovations on patient outcomes, particularly when drawing comparisons.

The scope of our evaluation has been limited to engagement with key programme stakeholders, representing NHSE, NIHR, AHSNs and ARCs. Engagement is dependent on stakeholders' active participation in research activities including workshops, interviews, and a survey. Evaluation activities have taken place over an 11-week period, facilitating evaluation of intended design and its delivery, data collection and analysis (both qualitative and quantitative) and report write up.

Data collection has been designed around three key areas of evaluation. These areas were identified through co-design activities with NIPP stakeholders, and are:

- Programme design
- Collaboration
- Data governance & PPIE

Analysis of project cost allocation, innovation themes and intended scope remit has been undertaken. It is not possible to conduct an in-depth cost-benefit analysis of the projects due to limited reporting of the value delivered by individual projects, as well as the scope of each project (e.g. participant reach).

3.2 Evaluation hypotheses

Co-design workshops and exploratory conversations with the programme delivery team members, have led to the development of three key hypotheses. Based on these hypotheses, the evaluation has sought to answer the following research questions:

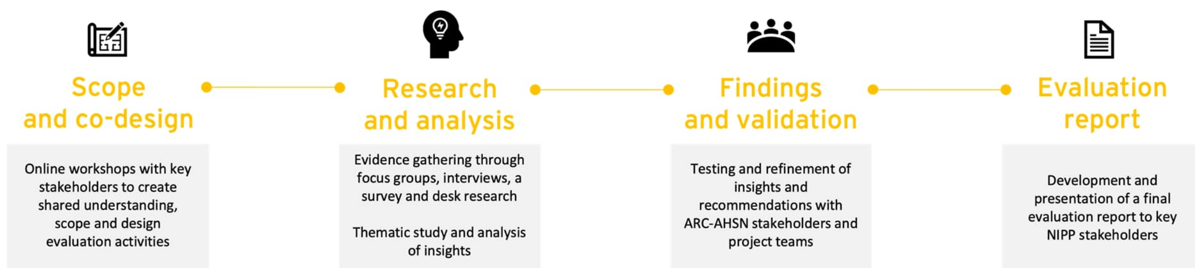
Table 1: Research hypotheses and questions

Hypotheses	Questions		
1. **Programme design:** NIPP timelines impacted the design of evaluations	What were the key barriers and enablers of...	Programme design?	How did the delivery of the programme compare with what was planned and what were the main factors affecting the differences?
2. **Collaboration:** Having previous collaborative experience between AHSNs and ARCs played an acceleratory role on project		ARC-AHSN collaboration?	What measurable indicators were there to enable an evaluation of the programme meeting its objectives?
3. **Data governance & PPIE:** Governance around data access and ethics/R&D approvals had a negative impact on project outcomes		Data governance & PPIE?	What are recommendations and considerations that might be beneficial for any future rapid real-world evaluation and implementation of innovations?

4. Methodology

To establish both the intended and actual design of the programme, our evaluation has used a mixed methods approach, combining qualitative (workshops, focus groups, in-depth interviews) and quantitative (survey) methods as well as a review of secondary resources, including shared files via the NHS Futures collaboration platform.

The intended design chapter has been shaped using information from the NHS Futures collaboration platform, publicly available information as well as through in-depth exploratory conversations with key stakeholders from the central coordination team.



4.1 Workshops

Initial workshops were used to co-develop a methodology for the programme evaluation, whilst later, post-evaluation workshops were conducted to test the feasibility of recommendations suggested by this evaluation.

The aim of the co-design workshop was to create an evaluation methodology and identify the key areas of focus for the evaluation of NIPP.

The approach for the methodology co-design workshop was delivered in several stages:

1. Pre-workshop preparation: the evaluation team identified workshop participants by relying on guidance from the central coordination team. The group consisted of central coordination team members, ARC/AHSN steering group members and national stakeholders. Seven stakeholders participated in the workshop and a second session was later conducted, to accommodate two stakeholders who had previously been unavailable. The central coordination team managed invitations and correspondence for the online sessions, including communicating an introduction to the evaluation, its objectives, and goals and expectations of the workshop.
2. Workshop: The workshop was conducted remotely, with the use of Mural, a digital collaboration tool. The purpose of the workshop was to create a shared understanding of the NIPP evaluation project; co-design research questions and hypotheses; agree on the objectives and analysis approach for both primary and secondary research; identify the key barriers and facilitators to programme success and agree on an ideal evaluation report format. The discussion was facilitated by the evaluation researchers and participants shared their ideas verbally, whilst researchers documented these insights using the Mural board.

3. Analysis: The research team used workshop outputs to develop hypotheses, identify key research questions and inform the content of the focus groups, interviews and survey.

Following data collection, post-evaluation workshops were designed to sense-check findings and test the feasibility of emerging recommendations and considerations. The methodology for these workshops followed the same structure as the early co-design workshops and were segmented into three stages:

1. Pre-workshop preparation: After sending invitations to the identified stakeholders, the NIPP evaluation team developed a Mural to guide the discussions.
2. Workshops: 16 stakeholders, representing each of the 14 NIPP projects, participated across two workshops to discuss emerging recommendations that were considered within the remit of the NIPP central coordination team. A third workshop later took place, consisting of steering group members as well as key national stakeholders, to provide a more strategic view on the system and comment on considerations for wider stakeholder groups, such as universities, NHSE and NIHR.
3. Analysis: All insights from workshops have been anonymised and incorporated into Chapter 10 that reports on recommendations and considerations.

4.2 Focus groups

Focus groups were used to identify common barriers, facilitators, and opportunities, across three key areas of the programme: programme design, ARC-AHSN collaboration and data governance & PPIE.

1. Participants: Participants were split into three groups and included a combination of NIPP project leads and supports from ARCs and AHSNs across each of the 14 projects, as well as a representative from the 15th project that did not pass the application process.
2. Focus group preparation: Following the co-design workshop, a Mural board was developed to facilitate discussion and enhance collaborative participation during focus groups.
3. Focus groups: A member of our research team led the discussion and a notetaker captured key points on sticky notes. Focus groups were recorded and automatically transcribed.
4. Analysis: All key quotes were clustered by pre-defined themes and subthemes in a data extraction file, as co-designed during the methodology workshop. Insights were then identified using thematic analysis. All supporting quotes are anonymised and incorporated into the evaluation report, to evidence each insight.

4.3 Interviews

The NIPP programme evaluation team conducted 25 out of 27 in-depth semi-structured interviews. Two stakeholders could not participate due to lack of availability during the evaluation period. Interviews each lasted 45 minutes and were conducted via Teams and phone.

1. Interviewees: Semi-structured interviews took place with two groups of stakeholders; programme level and project level.

2. Interview preparation: Two different interview guides were developed for each interview type – one for programme level stakeholders and another for project level stakeholders. The objectives of the programme level interviews were to build an understanding of the overall NIPP strategy; understand barriers and facilitators to successful delivery of NIPP across the key areas: programme design, ARC-AHSN collaboration and data governance & PPIE, and understand key insights and experiences of the operational aspects of NIPP. The objectives of the project level interviews were to build an understanding of project level experiences of NIPP; understand barriers and facilitators to successful delivery of NIPP projects, across programme design, ARC-AHSN collaboration and data governance & PPIE, and understand experiences and ability to address NIPP programme goals and KPIs throughout NIPP.
3. Interviews: Researchers followed the discussion guide, to cover each of the three topic areas, however, the discussion was designed to be semi-structured and did pivot based on individual attitudes and experiences. All interviews were recorded and automatically transcribed, whilst researchers took notes during interviews.
4. Analysis: All key quotes were clustered by pre-defined themes and subthemes in a data extraction file, as co-designed during the methodology workshop. Insights were then defined using thematic analysis. All supporting quotes were anonymised and incorporated into the evaluation report, to evidence each insight.

4.4 Survey

Quantitative data was collected to support descriptive data on common barriers and facilitators to the delivery of NIPP and assess the impact of these barriers on project delivery. The survey was in field for approximately three weeks from 27 March 2022 – 17 April 2022 and was built using a third-party survey solution, Qualtrics.

1. Target audience: Survey responses represented project leads and support team members from AHSNs (63% of respondents) and ARCs (37% of respondents). The final sample size was 37 responses, with some respondents not completing the entire survey, resulting in a minimum of 34 responses for a subset of questions. Originally, the survey was piloted to a target audience of 65 participants, identified by the central coordination team, including project team members (project leads from ARCs and AHSNs and project support team members) as well as regional and national stakeholders. The survey was distributed to the identified audience through the official programme email with a series of reminders shared both by the NIPP programme lead as well as the NIPP programme evaluation team. Due to low survey response rates, as a result of Easter and bank holidays, as well as time constraints for the overall evaluation, it was decided to limit the survey sample to project team members only. This enabled the evaluation team to close the survey after 3 weeks in-field, with an 81% participation rate, which amounted to 37 out of 46 responses. Another reason for downsizing the sample was an uneven distribution of responses from project teams (n=38) versus national (n=10) and regional stakeholders (n=2), which would have resulted in responses being skewed towards project perspectives, had all stakeholder groups been reported.
2. Analysis: Due to the small sample size, only a basic descriptive analysis was considered feasible by the evaluation team.

4.5 Cost-benefit analysis

Stage 1 and 2 applications, quarterly reports and rapid insights reports were reviewed to identify proposed and actual benefits. Where possible, analysis has been undertaken to quantify the costs of these benefits.

Planned and actual funding was analysed to understand spend on staffing – ARC/AHSN and non-staff costs.

The proposed innovation themes, health and social care setting, and intended scope were mapped to understand the intended spread and scale of the projects.

4.6 Limitations

Regional engagement: The majority of regional leads, from within NHS England (NHSE) regional teams, have not responded to requests to participate in the evaluation research. This was most likely driven by a lack of engagement in the programme itself and, therefore, a limited understanding of the benefits of participating in the evaluation. As a result, the evaluation will include only high-level reporting of the role and impact of regional leads. Their perspective on the overall NIPP experience will also be limited, due to lack of representation.

Cost-benefit analysis: It is not possible to conduct an in-depth cost-benefit analysis of the projects due to limited reporting of value and scope measures. For the majority of projects, the metrics identified in project proposals and reported in quarterly reports are not sufficiently detailed to allow for this analysis.

Survey response rate: Due to a low survey response rate in the first two weeks, and the resulting decision to downsize the final survey sample to project team members only, our evaluation will include representative quantitative responses from project team members and not national and regional respondents.

Interviews: Some project-level interviews were conducted with two interviewees, representing both the project ARC and AHSN. This approach was conducted in order to increase engagement with representatives efficiently, to meet evaluation timelines. Having representatives from both organisations in one interview might have led to project team members expressing some bias in reporting on their experiences, particularly whilst discussing experiences of collaboration.

5. Intended programme design

5.1 Background of NIPP

In late December 2019, China reported an emergence of a novel coronavirus (COVID-19) that spread across the globe at unprecedented speed[2]. This led to a global pandemic that became one the greatest challenges to global health in modern history. To respond to the challenges of the pandemic, the NHS pivoted to explore the delivery of patient care in a new environment. This setting saw patients discouraged from travelling to hospital unless essential, and traditional ways of delivering services putting staff, patients and public at risk of contracting COVID-19[3].

Healthcare has an ongoing need to deliver innovations that improve patient outcomes. The pandemic proved itself as a chief disruptor and accelerator of these innovation activities. By demonstrating resilience and the ability to rapidly develop and scale promising innovations into health and care services, the NHS began to learn from the pandemic and attempt to future-proof its services.

NHS England (NHS England and NHS Improvement at the time) set up the Beneficial Changes Network (BCN). The BCN was a collaborative network of health and social care stakeholders and people with lived experience, that aimed to harness, capture and evaluate the benefits of changes that took place over the pandemic[4]. The BCN collected over 3,000 submissions of innovations that were either accelerated or created under pressures of the pandemic. The results of these submissions were clustered into four priority areas: remote consultation, remote monitoring, new approaches to service delivery, and health and social care workforce innovation. This information fed into an NHS Futures Collaboration Platform and was intended to share good practice and celebrate achievements across the NHS and its innovation landscape.

The BCN initiative identified innovations that showed signs of positive patient outcomes, to be scaled across the wider health and care system. However, it was recognised that there was a lack of robust evidence to validate these innovations in real-world settings. As a result, the AAC and NIHR set up NIPP to create an evidence base that would support the adoption and spread of proven innovations across England.

The aim of NIPP was *'to accelerate the evaluation and implementation of promising innovations that supports post-pandemic ways of working, builds service resilience and delivers benefits to patients'*.

NIPP builds on the collaborations between the BCN and the ACC by providing funding for regional collaboration between 15 AHSNs and 15 ARCs. Some of these ARCs and AHSNs have worked together in the past.

In 2013, NHS England established 15 AHSNs across England to spread innovation at pace

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[2] World Health Organization, News, available from: https://www.who.int/news/item/27-04-2020-who-timeline---covid-19

[3] NHS England and NHS Improvement letter from 17 March 2020, available from: https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/urgent-next-steps-on-nhs-response-to-covid-19-letter-simon-stevens.pdf

[4] Beneficial Changes Network official page, available from: https://www.england.nhs.uk/beneficial-changes-network/workstreams/

and scale[5]. In 2019, the NIHR funded 15 ARCs to support applied health and care research that responded to and met the needs of local populations and local health and care systems[6]. Creating an environment for purposeful collaboration between these two types of organisations was agreed as a major KPI of NIPP, creating an evidence base that would support the adoption and spread of proven innovations across England.

5.2 Key objectives of NIPP

- To facilitate ARC/AHSN contribution to NHS Reset and Recovery by generating rapid insights in relation to promising innovations.
- To identify interventions that will contribute to ICS and regional needs, aligned to the four BCN themes (remote consultation; remote monitoring; new approaches to service delivery; and Health and Social Care workforce).
- To build local capacity and expertise for evaluation and implementation.

5.3 Funding

The commissioners (AAC, NIHR and NHSEI) provided NHSE sourced funding of £4.2 million in approximately equal shares to each project (maximum £275,000 per project) led by Applied Research Collaborations (ARCs) and Academic Health Science Networks (AHSNs). This set up was aimed to facilitate collaboration between ARCs and AHSNs and enable them to test promising innovations that serve regional needs and address the aims and objectives of the programme. Projects that passed the selection process, were to be granted funding from 1 November 2021 until 31 March 2023.

5.4 Application process

A pre-selection process was designed to review and shortlist applications from across regions.

Projects eligible for submission to the NIPP programme were required to meet the following criteria:

- Promising innovations that could be tested at pace to generate quick insights within 18 months
- Have ICS support and be supported by NHS Regional teams
- Be aligned with at least one of the four innovation themes identified through the Beneficial Changes Network (remote consultation; remote monitoring; new approaches to service delivery; and Health and Social Care workforce).

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5 Accelerated Access Collaborative, Academic Health Science Networks page, available from: https://www.england.nhs.uk/aac/what-we-do/innovation-for-healthcare-inequalities-programme/academic-health-science-networks/

6 National Institute for Health and Care Research, available form: https://www.nihr.ac.uk/explore-nihr/support/collaborating-in-applied-health-research.htm

The following criteria was encouraged:

- Promising innovations that could be tested at pace to generate quick insights to support NHS service delivery
- Ongoing ARC-AHSN projects that supported further testing/evaluation across a wider geographical footprint
- Projects that built on existing collaborative ARC-AHSN projects
- Initiatives that were part of national ARC priority programme but were not funded due to financial constraints
- Initiatives amongst the BCN 'Top 10' Evidence Reviews.

The pre-selection process was delivered in two stages.

Stage 1:

During stage 1, each ARC-AHSN collaborative was required to submit an outline of their proposals by 23 September 2021, giving them four weeks to prepare, starting from 13 August 2021. Each ARC-AHSN could submit up to three proposals, from which only one would be prioritised for full application during stage 2.

Stage 1 submission required every project team to submit the following: a project summary outlining AHSN and ARC leads, a brief description of proposed projects in plain English, reporting of early conversations/planned engagements with ICS/Regional partners and reporting of the top three risks to delivery.

Assessment of stage 1 applications took place in the form of a sharing event, in which the 15 projects met to peer review each others' applications. These sessions were facilitated by the programme team and aimed to enable collaboration, offering peer support amongst projects to strengthen applications, narrow down each list of up to three ideas to a single idea and avoid duplication of projects within each of the four themes.

Stage 2:

The stage 2 application deadline of 15 October 2021 required each ARC-AHSN collaborative to submit one full proposal that had been prioritised following stage 1 application and the peer review assessment. Stage 2 submissions included an application form, project delivery plan, costing and summary presentation.

The stage 2 assessment of final applications was subject to two processes. The first process was conducted by a Due Diligence Panel that assessed every project against the following criteria:

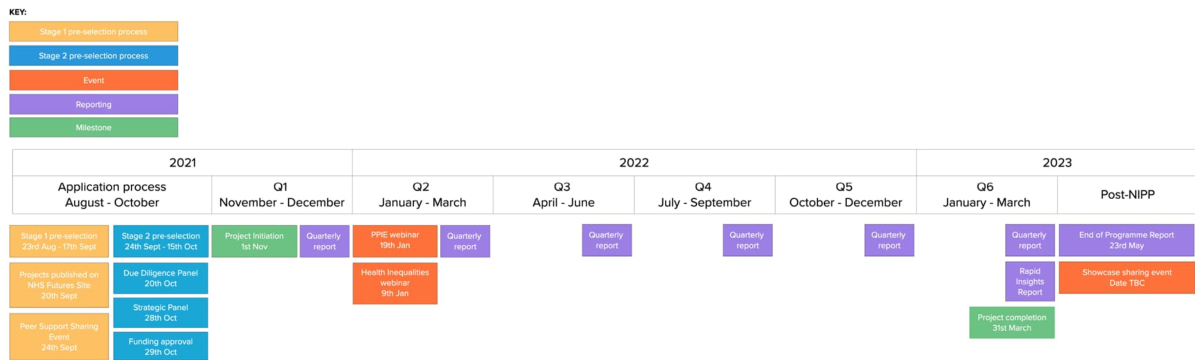
- Ability of the project to meet its predefined project criteria
- An appropriate outcomes framework in place to measure impact
- Feasibility of the innovation
- Likely value of knowledge generated through the evaluation

As a result of this assessment, the Due Diligence Panel determined whether a given project could proceed to review by the Strategic Panel. The panel also had to make a recommendation to either support or not support funding application to the Strategic Panel. The Strategic Panel then considered applications for strategic fit and relevance to NHS Reset and Recovery in late October, before providing funding confirmation and feedback on successful and unsuccessful applications.

5.5 Timeline

Stage 1 selection took place on 17 September 2021, with a sharing event taking place the following week, on 24 September. The stage 2 submission deadline was 15 October 2021, giving ARC-AHSN collaboratives two weeks to take onboard feedback from the sharing event and finalise their single proposal for final submission. The Due Diligence panel took place on 20 October and a Strategic Panel review took place on 28 October, with the final decision shared with each ARC-AHSN team within one week. Following this, all successful project teams were expected to start work on their projects from November 2021 onwards. Figure 1 below demonstrates the timeline of NIPP, as intended.

Figure 1: NIPP timeline of events



Source: EY Seren Analysis

5.6 Reporting

Assurance reporting and KPIs

Through the course of the NIPP programme, each project team was expected to report quarterly to the Innovation, Research and Life Sciences team (IRLS) as part of AHSN reporting and NIHR, as part of ARC reporting, via established reporting routes. The process involved completing a standardised reporting template, following each quarter of the NIPP lifespan. This assurance reporting template captured the following KPIs:

- Delivery against project plan
- Rapid insights
- Updates on ARC-AHSN collaboration
- Risks and issues in such spheres as: patient outcomes and PPI; health inequalities, dissemination of NIPP outputs and outcomes; systems engagement
- Resource utilization.

Each KPI had to be self-evaluated with a RAG status, with space provided to capture detail on risks, impact and mitigation actions.

Financial reporting

Upon initial NIPP application, projects had completed a costing template of planned staff and non-staff costs. In subsequent quarters of the programme, each project was required to report quarterly on actual spend, in order to track actual versus planned spend.

End of programme reporting

On 23 May 2023, all project teams were expected to submit their end-of-programme report, which should include:

- 2021-22 - Quarter 4 Report at project end
- Rapid Insights Guide
- Contribution to NIPP Programme Summary Report
- Contribution to a showcase/sharing event to share the outputs of each project and programme level reflections.
- Finance update including underspend - to be submitted using NIPP Costing Template.

5.7 Programme governance

The programme governance structure included:

1. Programme delivery group – comprised of ARC and AHSN representatives from each NHS region. Responsibilities included assisting in shaping the programme, supporting two-way communication between regions and the programme leads and facilitating cross-regional communication.
2. ARC-AHSN steering group – comprised of representatives of local ARCs and AHSNs. Responsibilities included providing an oversight of the local NIPP projects and identifying and developing collaborative working between organisations for the benefit of patients, health and care staff and local health systems.
3. Financial oversight – was delivered by HIN Manchester AHSN. Responsibilities included providing an AHSN lead role, undertaking financial oversight and reporting for pay-out of award funds to successful applicants.

5.8 Communication

The plan for communicating the programme to relevant audiences included:

- Communications support provided to local projects (ARC and AHSN)
- Knowledge sharing sessions and workshops
- NIPP website[7]
- Future NHS Collaboration Platform (for internal file sharing)
- Quarterly Reports – stakeholder map; system engagement update; capture of outputs and national communications opportunities
- Sharing emerging themes with ARC/AHSN Steering Group and using this reporting as a route to escalate challenges and risks
- Programme 'check-ins' to capture emerging themes and outputs
- Collaborative blogs and case studies, published on AHSN Network website
- Input to NHSEI National Teams/learning events e.g. Health Inequalities Improvement

[7] NIPP website, available from: https://www.ahsnnetwork.com/about-us/supported-initiatives/nhs-insights-prioritisation-programme-nipp/

- Learning events for each of the priority areas: remote consultations, remote monitoring, new approaches to service delivery, and health and social care workforce innovation and health inequalities)
- AHSN Quarterly Report; Network annual impact report
- National events
- Publications.

6. Operational insights

Operational insights have been reported to identify the delivery of the intended design of NIPP. These observations are derived from the study of programme materials as well as primary research with programme level stakeholders.
Operational insights are not intended to reflect the experiences of project and programme stakeholders, but in many cases, can be evidenced by these experiences, documented in Chapter 9.

Programme resource

- The first programme lead was in role until June 2022 (Q3 of NIPP timeline), while the second programme lead joined in August 2022 (Q4 of NIPP timeline). The AHSN Network Strategy Director covered the resource gap between the two programme leads, whilst also undertaking the role of interim coordination director from January 2023.
- A Project Support Officer (PSO) was identified as a required resource to support with programme administration, documentation, communication, and engagement activities. As a result of the AHSN network failing to recruit for this role, NIPP lacked a dedicated PSO for the full programme duration. Instead, PSO responsibilities were supported by a communications manager from January to April 2023 as well as by the programme lead.
- These gaps in resource impacted consistency in programme communication, support following quarterly reports, and facilitation of events and networking.

Funding

- Distribution of NIPP funding across projects was considered independent of project features, such as the size, complexity, or region.
- Funds received ranged from £205,400 to £274,999, with the exception of one project that received £357,352.36. This misaligns with initial programme guidelines that stated a maximum funding of £275,000 per project (see appendix, section 11.2).
- Projects that reported underspending in the funding they received passed back any underspend to the programme commissioner.
- As demonstrated in finding 16, some projects received funds from other sources, however, this was not highlighted in quarterly reporting. These additional funding sources may explain the discrepancy in funds received across projects.

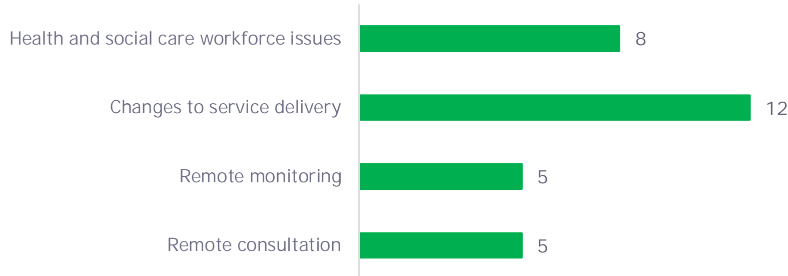
Participation

- Following the application process, one ARC-AHSN collaboration out of all 15 applicants did not pass application stage 2. As a result, this project team did not secure funding and participate in NIPP.

Project innovation theme, health and social care setting, and reach

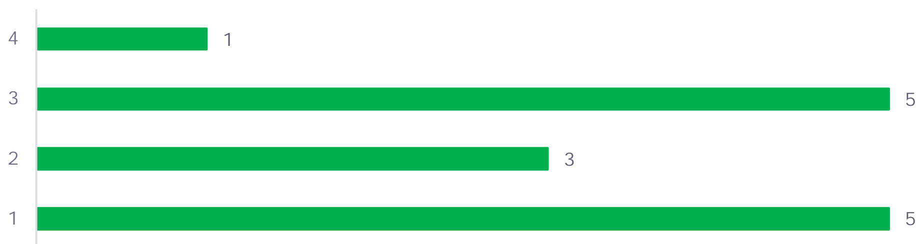
Stage 2 project applications identified the relevant innovation theme(s), health and social care setting(s) focus and project reach. These categorisations give an indication of the remit of each project, there is not a section that requires the project to identify the volume of patients involved in the project.

Figure 2. Addressing changes to service delivery appeared the most common theme across projects



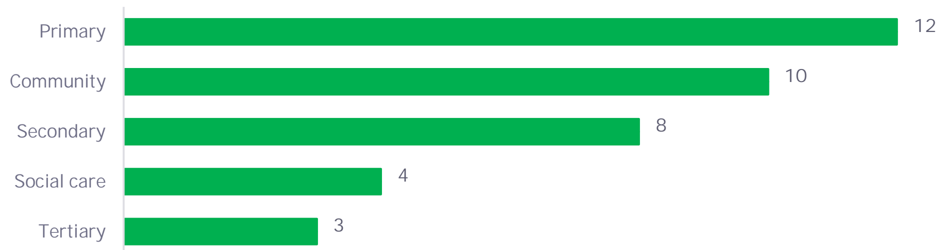
Source: EY Seren Analysis

Figure 3. Addressing 1 to 3 innovation themes count appeared the most common count across projects



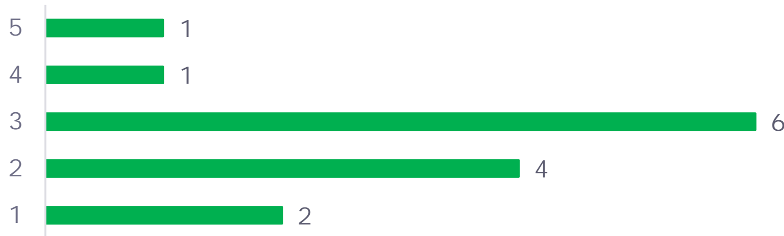
Source: EY Seren Analysis

Figure 4. Primary care appeared the most common across project health and social care settings



Source: EY Seren Analysis

Figure 5. The most common reach of social care settings appeared to be 3 settings (count)

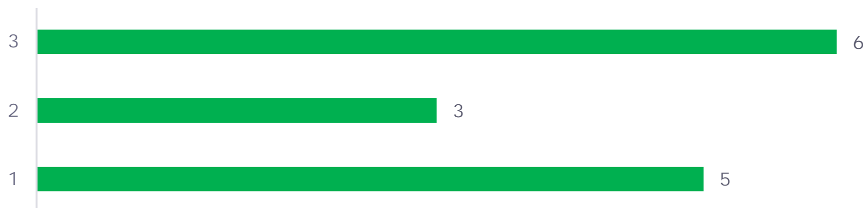


Source: EY Seren Analysis

Figure 6. Regional reach appeared the most common reach across projects (count)

Source: EY Seren Analysis

Figure 7. Reach count per project varies between 1 and 3 reach areas



Source: EY Seren Analysis

Regional leadership and support

- AHSNs were requested by the programme team, to share project proposals with their respective regional leads and to report project progress and escalations to these leads via established AHSN quarterly assurance mechanisms. NIPP programme leadership considered these meetings the responsibility of NHSE to facilitate, however, they did not appear to have taken place.

National engagement

- An objective of NIPP included the contribution of ARC-AHSNs to NHS Reset & Recovery, by generating rapid insights in relation to promising innovations. Despite this, the programme did not engage the NHS Reset & Recovery board at any point during delivery.

Quarterly reporting

- Projects were provided with a reporting template to complete and submit each quarter. Templates included both programme-wide and project-specific KPIs, for which projects were expected to provide a RAG status and verbatim update. As reports were specific to projects, to review overall programme performance or draw comparisons between projects, reports from across projects must be compared.
- Assurance reporting was delivered quarterly to IRLS (AHSN reporting) and NIHR (ARC reporting). These reports were delivered to the ARC-AHSN steering group, who were expected to help overcome challenges flagged by project teams.
- The level of detail provided by projects within each report varies both between projects and quarters. In some cases, reports feature only a RAG status with no verbatim update. This lack of consistency makes it difficult to draw comparisons over time or between projects.
- Quarterly reports feature both programme-wide KPIs, as well as project-specific KPIs that projects were requested to create during the early stages of NIPP. When studying quarterly reports, project-specific KPIs also appear to overlap with programme-wide KPIs, in some cases. Some of the KPIs chosen by projects, for example, those connected to recruitment of PPIE or access to data, were based on assumptions, since plans had not yet been developed. Project teams mentioned that there was no guidance around the form and shape of these KPIs, which led to discrepancy between projects. Upon studying quarterly reports, it is evident that projects took various approaches to generating specific KPIs. Some projects shape KPIs around innovation setup and piloting, whereas others focus on data collection activities. An approach for overcoming these issues is introduced in Section 10.1, recommendation 4.

Financial reporting

- In addition to quarterly reporting of KPIs, the programme also required projects to complete and submit a quarterly a financial report template, on a detailed line-by-line basis. Financial reporting was designed to detail planned versus actual costs. In addition to this, the quarterly reporting template also featured a standard 'Financial Process' KPI.

End of programme reporting

- Following programme completion, projects were expected to submit a 'Rapid Insights Report' aimed to outline key findings following the evaluation and provide recommendations for future research and scale up. These reports may also be considered as case studies, to be incorporated into the AHSN Network case study library.

- The Rapid Insights Report template allows project teams to document their project background, approach, outcomes and next steps, however, doesn't capture project impact or benefits in the form of metrics or KPIs. Reports, therefore, provide context of the project however lack demonstration of the benefits that could be associated with the innovation and encourage future research or scaling.

Extension applications

- The programme was designed to run over 18 months, with the selection process taking place between September and October 2021, and evaluation activities from November 2021 until March 2023.
- For two projects, the final report deadline was amended from March to May 2023, as a result of these projects requesting an extension to initial timelines, in order to overcome delays to evaluation activities.
- There was no formal process defined for requesting project extensions at the start, but an informal process was developed later, resulting in a lack of visibility of what the process entails and the criteria upon which the programme team would approve or deny extensions.
- As a result of extension requests, the intended 18-month programme timeline has not been met for 2 of the 14 NIPP projects.

7. Results

Our evaluation found that general sentiment towards NIPP from both project and programme level stakeholders was positive, with those involved considering it a valuable experience to have participated in. Project teams *'loved being part of the project…the whole concept of NIPP has been a really good idea'* and cited that they would feel encouraged to participate in similar programmes in the future.

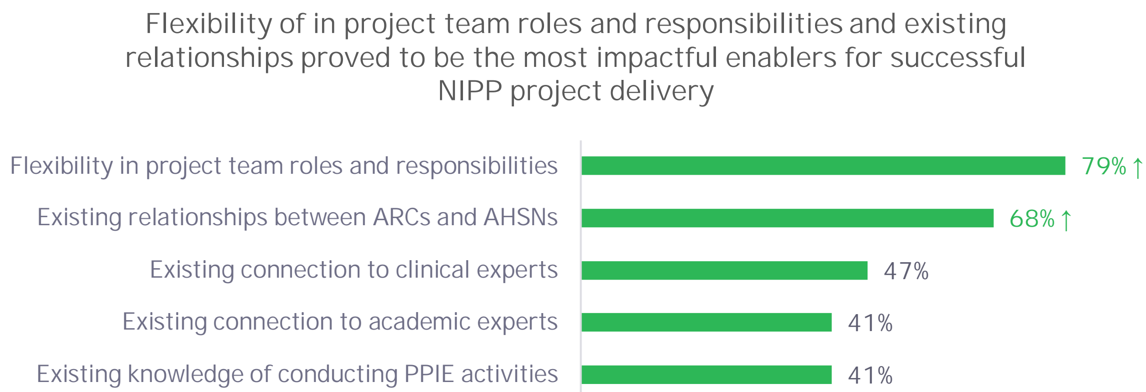
- NIPP was considered a particular enabler for collaboration and knowledge sharing between ARCs, AHSNs. One project lead explained that they *'wanted to continue collaboration between ARCs and AHSNs but were struggling to find funding to keep this running. NIPP came at the right time to secure further funding to continue our partnerships.'* This is further explored in Section 7.2 of this chapter.

- NIPP also facilitated a more structured approach for the funding and acceleration of innovations and interventions with one programme stakeholder citing it as a '*good way to channel funding towards what we should be focusing on…a brilliant opportunity and I really enjoyed it.'*

Figures 8 and 9 below, demonstrate the most common barriers and enablers to successful project delivery, as reported by project teams, in our survey.

When asked about the most impactful enablers, 79% of respondents chose flexibility in project team roles and responsibilities as the top enabler, followed by 68% of respondents relying on existing relationships between ARCs and AHSNs (Figure 8).

Figure 8: Top enablers for successful project delivery

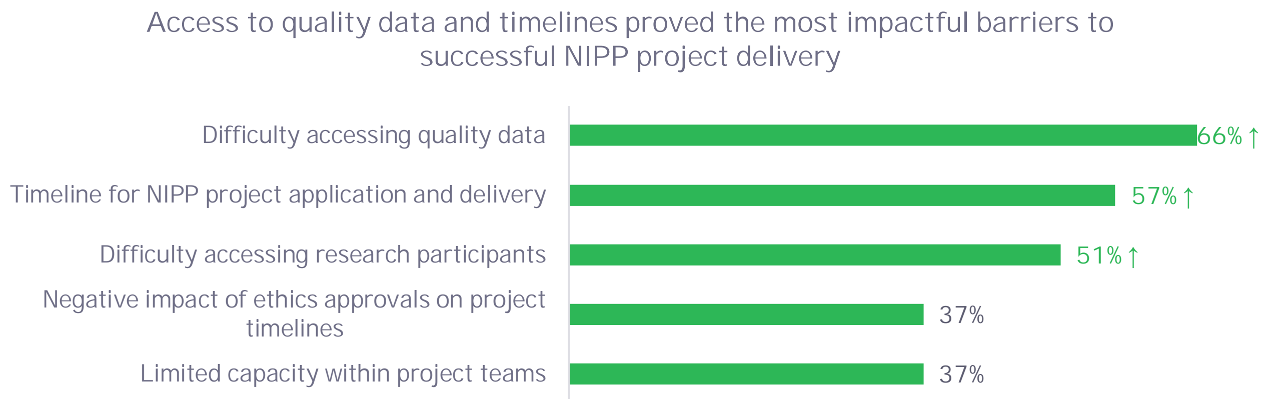


Source: EY Seren Analysis | n=34
Note: Top two enablers are significantly different from the average (p=0.05)
Q: The following list includes enablers that may have supported NIPP teams in delivering a project successfully. Take your time to look at the potential enablers to success in delivering projects within the NIPP programme. Please select up to five enablers that you felt had the most positive impact. [Chart represents top five enablers]

While the programme has been well-received by participants, there are clear themes that

have been identified, for how NIPP could be improved in the future.
66% of survey respondents cited difficulty accessing quality data, as the most impactful barrier, followed by timelines for NIPP project application and delivery (57% of respondents) and difficulty accessing research participants (51% of respondents) (Figure 9). The influence of data access on project delivery is further explored in Section 7.3 of this chapter.

Figure 9: Top barriers to successful NIPP project delivery



Source: EY Seren Analysis | n=34
Note: Top three barriers are significantly different from the average (p=0.05)
Q: The following list includes barriers that may have restricted NIPP teams in delivering a project successfully. Take your time to look at the potential barriers to success in delivering projects within the NIPP programme. Please select up to five barriers that you felt had the most negative impact. [Chart represents top five barriers]

The below Sections 7.1-7.3 in this chapter, provide a detailed evaluation of programme performance, based on insights collected through primary research activities with NIPP stakeholders. Insights have been sectioned into three key themes upon which data collection was organised: programme design, ARC-AHSN collaboration and data governance & PPIE. These sections demonstrate further value generated by NIPP, as well as areas of development that should be considered in the design of future innovations programmes and post-NIPP activities. The quotes from stakeholder engagement are shown in *italics* and anonymized, however, programme versus project engagement is highlighted.

7.1 Programme design

This section provides an overview of findings related to the design of NIPP, including programme structure and timelines, programme communication and reporting, support and guidance provided to projects, programme funding and regional and national stakeholder engagement.

Timelines and mobilisation

Finding 1
The NIPP application process was clearly structured and supported 14 out of 15 applicant projects in securing funding.

Finding 2

Insufficient timelines for bid submission and a lack of mobilisation period were barriers for co-production of proposals and timely recruitment of project team members.

Finding 3

Differences in maturity of innovations/interventions selected for NIPP, as well as maturity of ARC-AHSN relationships, created inconsistencies in programme experience, between projects.

- Overall, the two stage NIPP application process was easily understood by project teams, who were aware of what was requested of them and what the process would involve. The application process was clearly communicated to applicants during programme initiation, through onboarding materials and communication with the programme lead.

  > *"Ambitions of the NIPP programme were clear and the exam question was relatively easy to answer during application.* Project stakeholder
  > *Strong communication with [programme lead] of what was expected of us."* Project stakeholder

- Despite this, application timelines were considered insufficient and the deadline for submission did not enable teams to effectively collaborate on and co-produce their proposal. According to our survey, 57% of respondents found timelines for NIPP project application and delivery to be one of the most impactful barriers to successful delivery of their project (Figure 9, page 28). This was true, in particular, for project teams where ARC and AHSN staff had little to no previous experience of working together. Such project teams felt that there was insufficient time to build collaborative relationships, while others mentioned that they *'could not do much detailed groundwork and piloting to inform evaluation due to strict deadlines'* and '*lacked time to design a thoughtful approach*'. Others felt that even though they managed to deliver within timelines, they dedicated a significant amount of time during the submission process, to set direction.

  > *"To make it impactful, you need to interview, understand the impact, methods had to evolve.* Project stakeholder
  > *More time to plan and deliver, otherwise principles were good."* Project stakeholder

  - Innovations/interventions approved for NIPP, varied in level of maturity, which negatively impacted programme experiences for less mature ideas. Due to the absence of a dedicated mobilisation period, it was generally felt that innovations/interventions should be either in progress or ready to 'hit the ground running' in advance of applying to NIPP. Projects that considered themselves less mature, shared more challenges mobilising in early stages of the programme.

    > *"You couldn't do this unless you already had a pretty good idea of what you wanted to do."* Project team member

  - A team member of the project that was unsuccessful during the application process, also felt that NIPP timelines impacted their choice of project, explaining that *'NIPP meant we had to shoehorn our projects into their timeline'* and *'everyone had to find something that would suit the outcomes of the NIPP programme, rather than the NIPP programme saying how can we help you'*. Moreover, their reflection on the programme was that 'the *project would need to either already be underway or be close to being underway'*.

- Instead of local priorities dictating national strategy, a top-down approach was developed. As a result, timelines between receiving funding and delivering a full evaluation were considered short and some felt that longer timelines might have allowed scope for a broader nature of projects.
- Creating and submitting applications within the given timeframe was further impacted by encouragement from the programme team for each region to submit between one and three ideas. For projects who chose to submit multiple ideas, submissions were considered 'rushed' and insufficient time was provided to allow for detailed, considered applications.

  "Applying for three projects meant that we could only really shape each idea at a high level rather than an in-depth application of one idea – the last idea was thrown in last minute." Project team member

- The decision for projects to submit multiple applications, appeared to be a result of guidance from the central coordination team that multiple applications would *'increase the likelihood of successful submission.'* It was agreed by the programme team that multiple submissions would encourage pooling of the best possible innovations/ interventions per project, for entry into a stage 1 peer review. The best option per project, was then submitted to a stage 2 due diligence panel. The submission of multiple ideas per project was also encouraged to identify potential areas for future collaboration within or across regions.

  "Had a peer review session with other projects within their category to foster feedback, identify opportunities for collaboration and narrow down their three ideas to a single idea." Programme stakeholder

  "Stage 1 assessment also provided the occasion to signpost projects to potential opportunities for synergy or alignment with relevant/existing workstreams." Programme stakeholder

- Project teams had to coordinate their application across multiple stakeholders: ARCs, AHSNs and clinicians, which was described as *'a lot of activity over a short period of time '.* A proportion of the application process was spent initiating communication and securing shared buy-in between groups, leaving little time to dedicate to shaping the proposal.
- Completing the NIPP application process and signing AHSN contracts were also cited as time consuming early on in the project, impacting the time remaining for evaluation activities. Timing for ICS approvals was considered tight and acted as a barrier to kicking off project work, in line with programme timelines.
- For some projects, recruiting staff from the ARC community was a challenge. This, in some part, appeared to be a result of lack of knowledge of NIPP amongst ARCs, meaning time and effort was required to secure buy-in and involvement.
- A lack of capacity amongst ARC teams and a limited academic budget, created little flexibility to fill required roles within a short period of time.

  "ARCs already had programmes of work that they had already committed to. This created delays for projects in building new teams. Margins were so tight due to university budgets." Project team member

- Institutional barriers for setting up the operational activities required to start work were particularly challenging for ARCs. ARCs are used to operating at a different speed to AHSNs, with regard to the approvals needed for particular activities. One ARC representative mentioned that collaboration agreements, financing and invoicing were still going through university processes during the final months of the project, as their

systems and research infrastructure had not been designed to respond to short timelines.

- One project team reported that timelines for bidding were not unusual as both ARCs and AHSNs are *'used to crazy timelines in bidding for funding'*.
- For one project team, having a dedicated resource to own and shape the application helped to achieve a successful submission in line with application deadlines.
- Despite application timelines being considered insufficient amongst most project teams, applicants proved their ability to overcome this challenge, with 14 of 15 projects succeeding in securing programme approval and funding.

Evaluation timelines and study design

Finding 4

Insufficient programme timelines impacted evaluation activities, with multiple projects redesigning their intended evaluation approach. As a result, projects cited low confidence in their evaluations and three projects reported that timelines have meant evaluations will not reflect the true impact of their interventions.

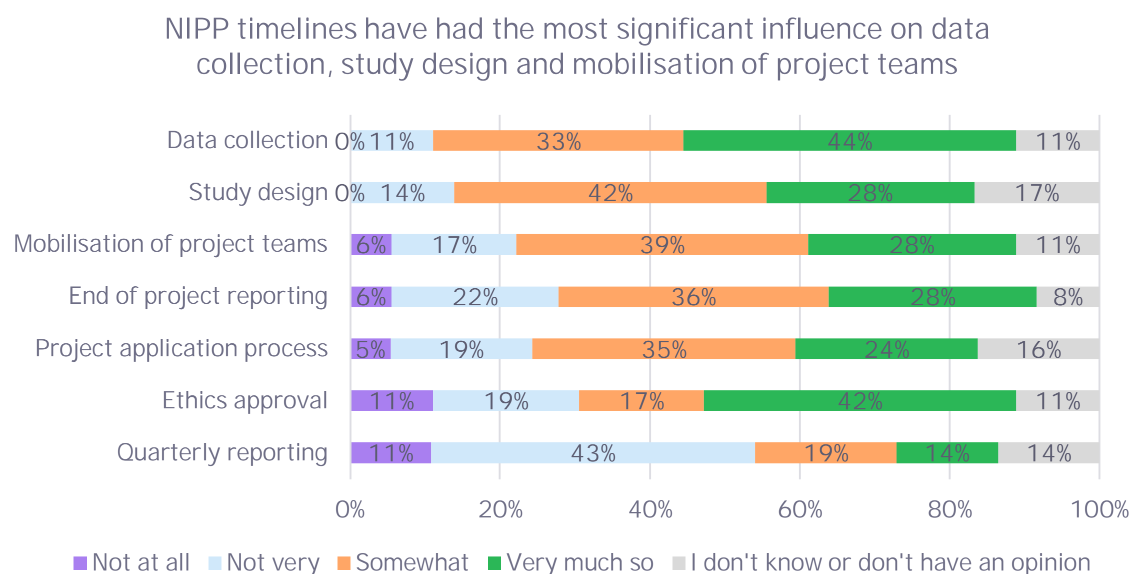
Finding 5

A changing landscape around data governance in a post-COVID-19 world, as well as funding uncertainty around AHSNs, had the largest impact on the delivery timelines.

Finding 6

Almost all projects managed to meet NIPP deadlines, despite many redesigning their evaluation methodologies to deliver on time.

Figure 10: Impact of NIPP programme timelines on the design of evaluation activities



Source: EY Seren analysis | n=36

Q: To what extent do you feel that NIPP programme timelines have influenced the design of your evaluation activities, such as method used? Please provide a response for each of the following stages of the NIPP programme listed.

- Our survey demonstrated that 73% of respondents felt NIPP timelines will have impacted the quality of their project evaluation outputs (Q: To what extent do you feel that project timelines will have impacted the quality of your evaluation outputs? n=34; note: this statement combines respondents who selected either 'somewhat' or 'very much so'). Data collection and study design were considered the areas most impacted by timelines, with 78% of respondents agreeing that timelines have 'somewhat' or 'very much' affected data collection and 70% of respondents agreeing that timelines have impacted their study design (Figure 10; page 31).
- As a result of insufficient timelines for evaluation, multiple projects reported that their intended evaluation approach had to be reconsidered due to timelines not allowing for detailed activities. Project redesign typically involved removing primary data collection such as staff and patient interviews, to mitigate the negative impact of recruitment on timelines. These projects instead relied on existing data upon which to base their evaluations.
- For other projects relying on quantitative data collection, redesign included collecting aggregate rather than patient level data and use of NHSE collected routine data to speed up data access approvals and analysis activities. Some projects felt this impacted the quality of their real-world evaluations, removing the ability to address the influence of innovations/interventions on individual patients. Many felt that a more comprehensive programme would be required to conduct detailed qualitative research projects to measure patient health inequalities.
- Despite guidance from programme stakeholders to avoid the need for data collection in evaluation design, most project teams appeared to build primary research activities into their approach, resulting in governance that might have otherwise been avoided.

  > *"We wanted off the shelf projects that were already being implemented…we said clearly to forget anything that needed full ethics approval."* National stakeholder
  >
  > *"NIPP should communicate the type of activities that research projects should be adopting; better clarity on the evaluation approaches that should be adopted, appropriate analytic capability to analyse real world, existing data."* National stakeholder

- Amongst project teams who did not redesign activities to reflect timelines, some felt they had overpromised on the activities and objectives outlined in their initial application. In two cases, this resulted in a request for extensions beyond the original NIPP submission deadline.

  > *"Typical of all research activity…when you pitch for funding you overpromise what you can deliver…we were slightly worried about some of the projects at the start…they looked ambitious and sure enough it turned out they had overpromised on the key elements they could achieve in the timeline."* National stakeholder

- Planning and implementation activities that took place during COVID-19 made it harder to predict and consider how various processes might look during a post-COVID-19 recovery period. External influences also resulted in evaluation redesign, where new data governance had been introduced or changed since initial application.

  > *"Lots of the red tape had gone once we moved into the recovery phase. In some of our community of practice events when people spoke about implementation, it became clear that the landscape has changed, and the experience was not transferrable since red tape was gone [during*

implementation in COVID-19 times] unlike now when some of it is back." Project team member

- Despite most project teams overcoming rigid timelines through redesigning and rescoping their evaluation activities, 3 projects reported that the timelines have meant evaluations will not reflect the true impact of their interventions. This appears to be especially true for less mature projects. These project teams felt that NIPP timelines have resulted in interventions experiencing an insufficient period upon which to be evaluated. For some, the impact of both COVID-19 and winter pressures on the NHS have impacted the period of 'normality' upon which to measure interventions. This view was also shared by some national stakeholders, who felt that 18 months was insufficient to evaluate the impact of interventions and didn't allow time to embed the intervention properly.

  "Too compressed overall... they [the interventions] haven't had time to bed in properly." National stakeholder

  "Intervention designed to work 24/7 and not currently in a position to do this, so data collection doesn't reflect this setup. We would need to apply for another NIPP project to test on a larger scale." Project team member

- Despite timelines being considered insufficient amongst many, only 2 projects requested an extension from the programme team, with the remaining 12 projects able to deliver their evaluation activities within the 18-month window.
- For projects more heavily weighted towards implementation than evaluation, timelines were considered suitable. Project representatives explained that this allowed them to *'keep momentum going as, if it's too long, it can feel like it's dragging'*.
- Positive sentiment towards programme timelines also stemmed from programme level stakeholders, who felt the timeline was appropriate and driven by external factors. Programme leads and national stakeholders explained that timelines were influenced by an *'instability of NHS regarding funding and commissioning'* as well as an uncertain future of AHSNs, following the expiration of their five-year Master licence in April 2023, with a one-year extension for 2023/24.

Hypothesis 1

The evidence above supports our hypothesis 1: Programme timelines impacted the design of evaluations. This was a result of insufficient time to conduct planned evaluation activities and no consideration for data and ethics requirements in the pre-selection process. This led to some projects needing to re-design their evaluations mid-programme, after realising they had overcommitted to the activities they could deliver. Strict timelines were influenced by commissioning and funding uncertainty of NHS.

Guidance and setting expectations

Finding 7

Projects considered NIPP well-structured and organised, particularly in comparison to previous initiatives, such as the BCN.

Finding 8

Projects felt the level of communication received from the programme team was appropriate, particularly in relation to the ambitions and expectations of NIPP.

Finding 9

Despite early communication from the programme team, communication throughout the duration of the programme was considered inconsistent. An absence of a Project Support Officer (PSO) for the full duration of NIPP, as well as a transition in Programme Lead impacted the provision of consistent support and guidance.

- Communication enabled individuals to feel well informed and most project teams felt the '*ambitions of NIPP were clear and relatively easy to answer during application… strong communication from the leadership of what NIPP involved, timelines and what is expected from us at the start*'.
- Many appreciated their relationship with the programme lead, including their open-door policy and the opportunity to receive informal feedback. Having direct engagement with this resource was considered valuable and both instances of programme lead were considered *'brilliant'*, *'fantastic'* and *'particularly supportive'*.

  "NIPP leadership was brilliant, very approachable. What was great was the trust that developed. … So much stuff was going on, so it was good it [NIPP] wasn't heavy in terms of …management. Project team member

  Brilliant in pushing us along to get stuff done. Project team member
- The frequency and volume of communication delivered to projects was also considered appropriate.

  "Happy to be left to get on with it. We were happy with the level of interaction, it's hard to have one-fits-all approach." Project team member
- Many considered NIPP well-structured and organised, particularly in comparison to their previous experiences of BCN.

  "Appears to be better than some of the previous models used." Programme stakeholder
- One project team mentioned that the digital platform set up for NIPP was effective, accessible for all and enabled collaboration between organisations.
- A common topic that projects would have valued more communication and guidance on, was how to distribute ARC and AHSN roles. Instead, teams felt they dedicated a large proportion of time to identifying and fulfilling individual roles and responsibilities themselves.

  "Expectations of ARCs and AHSNs aren't always clear…it should be more prescriptive." Project team member
- A change of programme leads in June 2022, created a gap in during the transition of resource. A number of teams found this challenging to navigate, due to difficulties in maintaining continuity of programme governance and relationship building.
- Further resourcing challenges included the absence of a consistent PSO. This negatively impacted the ability of the programme team to deliver frequent and consistent guidance and communication for the full duration of NIPP, as well as implementation of some planned collaboration activities.

Size and scale of NIPP projects

Finding 10

Smaller, regional NHS projects struggled to secure stakeholder buy-in and prioritisation, in comparison to large-scale, national projects.

- Several project teams appeared skeptical about the feasibility of scaling NIPP innovations and interventions. These individuals felt that many small projects within the NHS are currently struggling with implementation and scaling, due to their size.
- Individuals instead suggested funding fewer, larger scale projects in order to avoid challenges such as securing buy-in, becoming a priority for sites, and achieving significant impact and sustainability.
- Another suggested approach was to support the most promising projects, regardless of region, instead of focusing on a quota of approving one project per region.
- Despite this, it was acknowledged that NIPP had been designed to reflect traditional NHS architecture; to address local population priorities and health inequalities. Should small, locally developed projects continue to be identified and recruited, the programme should ensure they are supported with challenges around securing buy-in, accessing quality data and effectively utilising resources.

Knowledge sharing and network facilitation

Finding 11

Learning and knowledge sharing events were generally recognised as helpful and enabled network thinking; more frequent learning and networking opportunities would have been beneficial.

- Organised learning events, such as programme webinars, were considered highly beneficial, providing individuals with valuable guidance and the opportunity to meet and collaborate with other projects.
- Despite this, some individuals felt these events took place too late in the programme and would have been more valuable early on, enabling teams to implement their learnings sooner.
- Others found these events *'quite specific in their topic area (PPIE and health inequalities)'*, which did not allow for wider discussion of experiences. Projects felt that earlier connections with other teams would have enabled them to better share their programme experiences and provide peer support in sharing common challenges and solutions.
- Some individuals recognised the value of NIPP in connecting with other NIPP projects from across regions, based on shared goals and experiences, and would have valued better facilitation of this from the programme team.

  > *"NIPP gave us focus and the opportunity to share skills and experiences. It would have been nice to have a NIPP lead to own this and facilitate networks across projects."* Project team member

- Some project teams would also have welcomed the facilitation of networks within each of the 4 programme themes. Where projects experienced barriers, some felt isolated and would have sought comfort in knowing they weren't alone in their experiences. One project representative explained that they had tried to facilitate their own network for innovations involving elderly patients, however the network lacked value as it was created late on in the programme. Had connections been made earlier and facilitated by the programme team, they felt this network would have been more valuable.

  > *"Opportunities to connect with other NIPP project teams and the NIPP programme team were limited."* Project team member

> *"Don't have visibility of other project reports so don't know how they are doing or how we are doing in comparison to them – shared learning aspect is lacking."* Project team member

- Other projects expressed a desire to have engaged with other projects in their region. Despite a lack of formal opportunities for regional engagement, some demonstrated initiative in organising collaborative sessions with other projects within their region, helping them to align and avoid duplication.

> *"We set up a community of practice with the region, used this learning forum to learn cross-sites and get insights from the group."* Project team member
>
> *"Our regional projects have monthly catchups, it helps with peer support, learning about each other's projects."* Project team member

- Others were happy with the level of engagement with other project teams as they recognised the differences amongst projects and challenges, acknowledging that '*it's hard to have a one-fits-all approach*'.
- The infrequency of collaborative opportunities between projects, may again have been a result of the lack of a dedicated PSO for the full duration of NIPP.

Prioritisation of NIPP amongst national NHS stakeholders

Finding 12

Engagement and buy-in from national NHS stakeholders appeared to vary amongst projects. Having an engaged NIPP national leads proved valuable in supporting with access to stakeholders and prioritisation of activities, however successful engagement appeared to be dependent on existing stakeholder connections and awareness of NIPP.

- Engagement with national stakeholders was perceived as valuable, particularly where project teams would need to explore key considerations for scaling effectively.

> *"National engagement is a good thing...this is usually dependent on leads within the projects having a pre-existing network of people working in that area at a national level. This should ideally be happening across the programme."* National stakeholder

- An ability to engage with national stakeholders however, appeared dependent on projects' existing connections within the NHS. As a result of varying existing networks across projects, the support experienced from national stakeholders varied.

> *"Lack of presence from wider stakeholder groups [NHSE and ICS] in reviews and project playbacks."* Project team member

- National engagement of NHS stakeholders also appeared dependent on awareness of NIPP, with teams feeling that a general lack of introduction to NIPP amongst these groups, resulted in limited buy-in. Projects had expected NIPP to have been more widely communicated to wider NHS colleagues in advance of launch. For some projects, this lack of awareness proved a barrier to engagement regarding commissioning, planning and conducting research activities and identifying opportunities to scale. It was unclear to projects, who was deemed responsible for facilitating this initial stakeholder engagement and knowledge building.

> *"Commissioning board lacked understanding of NIPP – didn't feel like they had read the brief so were regularly having to explain what we were there for."* Project team member

"We had throughout this period been using existing networks to try and connect with the national virtual ward team and were eventually successful in achieving this at the very end of Q2 2022/23. However, this was done with no help from the national NIPP team." Project team member

- Some teams cited that constantly changing and evolving NHS stakeholder groups created difficulty in securing and maintaining support. The fluidity of NHS staff between roles created the need for continuous engagement with new stakeholders, slowing down evaluation activities in some cases.

"Changes to staff meant the team went through a large transition of key stakeholders. Our current main regional contact doesn't know what NIPP is and so we have to educate stakeholders on the background of our project and how we have come to operate today." Project team member
"Staff changes slowed down evaluation activities." Project team member

- Most project teams reported successful collaboration activities at a local level, but little experience of engagement outside of their region. Only two projects recognised the value of being connected to a national stakeholder, such as a national lead.
- For these projects, engagement with a national lead proved valuable in accelerating evaluation activities, by providing access to their existing networks for participant recruitment. National leads were also able to prioritise requests for data access and R&D approvals in some cases, reducing the impact of governance processes.

"National lead helped to identify sites and helped to minimise governance. Asked sites to share the existing data, which was already anonymised." Project team member
"Project leads were not working with the regional lead; it was the national lead who helped with the study design and used his connections." Project team member

- One project team reported that having an established working relationship with their ICS also proved itself as an enabler, when building their NIPP application and designing their evaluation.

Engagement with regional leads

Finding 13
Clarity regarding the role of regional leads in NIPP, varies between NHSE regions, both amongst project teams and regional stakeholders. This led to disparity amongst projects in successful engagement with their regional leads. Most teams are not connected to a regional lead and as a result, rely on the existing networks of AHSNs or ARCs to connect with stakeholders for recruitment activities.

- In general, most projects appeared disconnected from their dedicated regional lead. Where this was the case, there appeared to be no upfront connection or introduction, in some cases leaving projects unaware of who the stakeholder was or what their role in NIPP should involve. Some were not sure if their regional leads were familiar with research or evaluation activities, whilst others reported that regions were not engaged in NIPP and were unaware of the value they could bring. Assurance activities that were due to take place between projects and regional leads, did not always occur.

"It's hard to see what regional teams could have done that would have helped the projects once running." National stakeholder

> *"Our main regional contact doesn't know what NIPP is and so we have to educate stakeholders on the background of our project and how we have come to operate today."* Project team member

- NIPP was a nationally directed programme, therefore, quarterly reporting was aimed to inform NHSE IRLS team on progress. There was an expectation from the NIPP central coordination team that NHSE IRLS team would report back to regions about NIPP. Due to limited engagement of regional leads, our evaluation was not able to test this assumption.
- Regional leads were considered a valuable connector to existing local networks, well-placed due to their understanding of regional needs and their role in supporting AHSNs by providing strategic direction and project mobilisation. In practise however, their limited capacity appeared a barrier to supporting their region with NIPP. Project teams mentioned '*priorities of COVID-19*' as a bigger focus area for regional leads, as well as the small scale of NIPP projects and '*similarity with other things in the landscape*' as reasons why NIPP was not considered a priority.

> *"In practise they are not best placed as they have very limited capacity…worsening picture…1/3 of their staff are being cut…useful allies but its whether they can actually deliver on it."* National stakeholder

- Many project teams appeared to instead, lean on their existing networks to identify and secure access to necessary groups of staff and patients to recruit for qualitative evaluation of their innovations/interventions. In most cases, the ability to facilitate these connections was recognised as an attribute of AHSNs.
- One region proved an exception and within this region, the lead was considered highly engaged and a valuable source of support. Their activities included supporting projects in unblocking challenges and helping to identify stakeholder panels for to enable research activities and ensure patient representation. This approach aligned with NIPP's objective of delivering 'promising innovations with impact' to their respective regional/ICS priorities by being generated 'ground-up' not 'top-down.'

> *"Regional teams requested project in the first place – this "pull" approach was effective and meant we didn't have to pitch or push for our idea to be accepted…Strong connection with regional team which is valuable as we rely on them for delivery."* Project team member

- While only two regional leads were involved in this study and able to comment, there seems to be a general lack of oversight of NIPP activities amongst regional leads.

Value of quarterly reporting

Finding 14
The central coordination team considered quarterly reports a helpful mechanism for keeping track of project challenges. Despite this, feedback on quarterly reports appeared inconsistent, with project teams citing little to no feedback following the submission of reports. As a result, they perceived quarterly reporting as a 'box ticking' exercise.
Finding 15
Project teams considered KPIs in quarterly reports as process-driven, rather than outcome-oriented. As a result, it was felt that KPIs were not designed to measure the impact of innovations and interventions on patient outcomes.

- The central coordination team expressed positive sentiment towards quarterly reports and valued having visibility of project status and performance.

  "Having a dedicated quarterly review is helpful, it means teams can evidence issues…at least we have a track record of risks. Programme stakeholder
  Reporting was able to pick up on poor ability to address PPIE and health inequalities." Programme stakeholder
  "NIPP programme requests monthly highlight reports as a 'light touch' approach to monitoring each project." Programme stakeholder

- Despite this, some projects mentioned a lack of clarity around the purpose of quarterly reporting and were unclear on how this information was used. This appeared to be a result of receiving little to no feedback following the submission of reports. Project teams would have valued visibility of whether the NIPP team considered their project 'on track' and where issues were raised, had expected the programme team to respond and provide support.

  "Haven't received feedback on our reports so we don't know how we are getting on." Project team member
  "Put information in and we get little out…doesn't have two-way dialogue." Project team member
  "We were not sure what would trigger conversations [with the NIPP leadership team]." Project team member

- Where projects had used quarterly reporting to raise an amber or red RAG status and request support from the programme team, the support received varied. Whilst most projects benefitted from the ability to informally discuss their status report and challenges with NIPP leadership, one team explained that they received no response after raising an amber RAG status. The project team used their quarterly report to request support from the programme team, in connecting with stakeholders for research recruitment, but cited no response.

  "We had no feedback when we flagged things as red…we asked for support with recruitment issues and didn't hear back…the NIPP team could have helped us to unblock delays or negotiated an extension." Project team member

- Teams that received feedback found it valuable as it provided reassurance.

  " Received regular feedback from NIPP team on quality of information being recorded in reports, individual project progress and progress in comparison to other projects." Project team member

- 24% of respondents felt that the NIPP reporting approach did not enable them to effectively demonstrate the value of their project (Q: To what extent do you feel the NIPP reporting approach (i.e. frequency and templates provided), has enabled you to demonstrate your project successfully?; n=34; note: this statement combines responses from 'not at all' and 'not very much' categories). Some national stakeholders and project team members found KPIs were not specific enough and instead appeared to only *'process-driven'*, *'capture learnings'* and *'felt like objectives rather than KPIs'*. The most cited example of an '*unhelpful*' KPI that was considered hard to report on, was the KPI for collaboration between ARCs and AHSNs, with difficulty sourcing robust evidence or metrics to demonstrate successful collaboration.

  "Collaboration isn't enough to demonstrate that we can have an impact with the funding…what are the outcomes and impact of the funding – need better governance around this…what is the patient outcome?" Project team member

- One national stakeholder also found the number of KPIs too large and 'would never put this amount of KPIs' into a reporting framework.
- Several project teams mentioned that a RAG rating approach was not sufficient in measuring success and raised a need for more outcome-driven measures.

  "KPIs could be more outcome-driven or focused on achievements." Project team member
- The NIPP team and national stakeholders recognised that KPIs did not align equally to the factors involved in NIPP (e.g., PPIE, health inequalities and collaboration) and instead were more aligned to NHSE priorities. This happened since NHSE had a more active role in supporting with project management during the set up and initial development period. The programme, therefore, lacked KPIs that resonated with project teams. 80% of survey respondents felt that programme KPIs were not fit for purpose or relevant to their individual project (Q: How confident do you feel that the NIPP programme KPIs were fit for purpose and relevant to your project?; n=35; note: this statement combines responses from 'somewhat' and 'very much so' categories).

Format and frequency of quarterly KPI reporting

Finding 16

The format of quarterly reports did not enable projects with multiple funding sources, to reflect additional funding streams.

- Some project teams found quarterly reporting of finances '*too intense*' and '*cumbersome and dissimilar to other programmes.*
- Where projects received funding from additional, local sources and NIPP represented only a share, the programme team did not explicitly request projects to report additional funding streams or dedicate an area of reports to document this. Some teams felt this created additional work and 'fudging of numbers'.
- No formal process for documenting multiple funding sources, also resulted in inconsistent data capture amongst teams. It appears that the programme team was therefore not always aware of projects being funded by multiple sources.

Funding distribution between NIPP projects

Finding 17

Equal distribution of funding between NIPP projects was aimed to facilitate collaboration rather than competition, however, did not reflect regional inequalities.

- Distribution of NIPP funding across projects was independent of project size and complexity and saw each project receive a 'fairly equal' grant of no more than £275,000, with the exception of one project. This decision was guided by a desire to encourage collaboration between projects, rather than introducing an element of competing for funding. Upon speaking with project teams, no project cited experiences of competitiveness or a 'battle' to secure funding.

  "We did not want some projects to gain large funding while others gained nothing. Therefore, we took the decision to set criteria that projects would have

to meet, in order to distribute money fairly equally between the projects." Programme stakeholder

- This funding approach did however, mean that regional inequalities, such as cost of labour, were not considered, creating some disparity between projects in what they could achieve with the funding provided. Despite this, financial reporting does not demonstrate incidences of insufficient funding, making it difficult to identify the impact of regional costs on projects' ability to fund activities.

  "Funding approach has not taken into consideration the different financial needs of each project e.g., project size, different costs per region etc." Programme stakeholder

- This approach to distribution also appeared to overlook the evaluation activities and resulting costs, of individual projects. Projects conducting primary research with more nuanced or hard to reach participants, were likely to incur higher recruitment costs than those relying on existing data or recruiting only internal NHS staff.

  "Some projects may look small, but it doesn't mean their costs are low: projects working with more vulnerable, or niche members of the community can be expensive. Things can look disproportionately expensive that might not be." National stakeholder

Funding distribution between ARCs and AHSNs

Finding 18

Upon receiving programme funding, projects were responsible for distributing their funds as appropriate.

- Project teams appeared to differ in their approaches to distribution of funding between ARC and AHSN, providing the opportunity for projects to distribute funding in a way that best suited their team structure and planned activities. This variation in approach was demonstrated through projects' financial reports.
- A small proportion of projects distributed funding equally between ARC and AHSN

  "We split the funding 50:50...worked together quite well together." Project team member

- Other projects acknowledged the likely evaluation-heavy nature of activities and weighted funding towards ARCs in order to reflect the volume of their activities.

  "Not equally split between AHSN (35%) and ARC (65%) – this was our decision so wasn't inappropriate or unfair but did influence who did what." Project team member

- For some projects, funding approaches involved a higher proportion being delivered to AHSN teams. This caused dissatisfaction amongst ARCs, particularly with ARC teams perceived as conducting the majority of 'heavy lifting' evaluation activities whilst AHSN took on the role of project manager.

  "AHSNs got most of the money but ARCs have done most of the work." National stakeholder

Programme extension

Finding 19

Initial programme design did not consider a need for extensions; however, this was later introduced in response to projects struggling to meet programme timelines.

- Two project teams cited requesting an extension from the programme team, due to insufficient time available to complete evaluations. The need to request extensions had not been considered during the programme design, however the central coordination team appeared responsive in facilitating extensions, as requests arose.
- As a result of the reactive nature towards project extensions, one team explained that the extension application process lacked structure and clarity. There appeared to be no formal process to follow, resulting in little visibility of how the decision to approve or reject their application would be made.

  "Extension approval lacked structure and clarity of how the decision would be made...it needs consistency." Project team member
- Other projects were deterred from applying for extensions, due to a nervousness around damage to their reputation. A lack of understanding of the extension process and whether applications were encouraged, appeared to influence this fear.

  "Another project had been unsuccessful in applying for an extension, so we didn't apply." Project team member

7.2 Collaboration

The following findings relate to experiences of collaboration between ARC and AHSN colleagues within and between NIPP projects. Insights include the influence of existing ARC-AHSN relationships, conflicting ways of working and different organisational cultures, and the ability of NIPP to better facilitate collaboration.

Existing relationships between ARCs and AHSNs

Finding 20

NIPP acted as an accelerator for ARC and AHSN collaboration, for those with existing relationships established prior to NIPP. Those who had little to no existing ARC-AHSN collaboration, felt enabled to build this relationship while working on NIPP, despite this causing some delays to evaluation.

- Most ARCs and AHSNs that had an established relationship were reassured through NIPP that these two organisations offered a 'natural fit' for each other and recognised the complementary value brought by each group. According to our survey (Figure 8, page 27), 68% of respondents reported existing relationships to be the most impactful enabler for successful NIPP project delivery.

  "One of our advantages was that as ARC/AHSN had really good working relationship before the NIPP. Usually, it takes ages to get to know each other. We worked with the AHSN lead a year before. Flagged this idea before and when NIPP came up, it became a good vehicle to activate. If we had to work from scratch, it would have been a lot slower." Project team member
- Projects who had collaborated in advance of NIPP also expressed an existing mutual trust, reducing overall conflict and facilitating more efficient evaluation activities – ARC teams were trusted to conduct evaluation activities, whilst AHSNs took on the role of project manager.
- Existing relationships also ensured individuals had a better understanding of the differences between ARC and AHSN ways of working, both cultural and organisational.

This reduced the risk of conflict when agreeing on evaluation methodologies, compared to those new to each other's approaches and ways of working.

- Having strong relationships at organisational level and being hosted at the same location geographically, also acted as an enabler to project delivery from an organisational viewpoint. Such ARCs and AHSNs were integrated at an IT system level, used the same language and had similar organisational challenges. Other organisations that were not hosted at the same location but had strong personal relationships, recognised the value of each other and reported organisational integration as one of the key benefits of NIPP.
- Communication was also better enabled between ARCs and AHSNs with previous experiences of collaborating. These projects were able to harness their existing forums and meetings to discuss their progress and collaborate closely.
- For projects with little to no existing relationship between ARC and AHSN, it was cited that more time had to be dedicated to mobilisation and relationship building activities, early in the programme. Ensuring individuals had clarity on preferred approaches, roles and responsibilities and division of tasks was considered time consuming but acted as an enabler for successful collaboration.

  "Identifying which skills each party owned was a big enabler...we focused on what needed delivering and who was best to deliver each as a result." Project team member

  "...play on natural strengths...AHSNs did project management and ARCs owned research." Project team member

- For groups who struggled to mobilise quickly and required these upfront activities, the 18-month timeline allocated to evaluation was cut short, resulting in between 12-14 months to complete evaluation activities. The remaining 4-6 months was spent preparing team resource and designing activities.

Hypothesis 2

The above evidence supports hypotheses 2: Previous collaborative experience between ARCs and AHSNs acted as an accelerator for project delivery. Existing relationships between ARC and AHSN team members, meant that individuals were aware of the skillsets of each organisation, enabling easier assignment of roles and responsibilities. Project teams that lacked this knowledge and experience, struggled to assign roles easily, with some expressing examples of duplication of work within projects. Participation in NIPP has improved both ARC-AHSN relationships and collaboration, both of which can be leveraged post-NIPP in the wider evaluation space.

ARC and AHSN collaboration and networks

Finding 21

Despite early challenges amongst some teams, NIPP has been perceived as an enabler for better collaboration between ARCs and AHSNs. Some projects felt the benefits of these relationships will extend beyond NIPP.

- BCN acted as a catalyst in building working relationships between teams that embarked on the NIPP journey, which later introduced the opportunity for ARCs and AHSNs to continue to collaborate and bid for funding. NIPP provided a common purpose to work towards, an enabler for collaboration between ARCs and AHSNs.

  "NIPP has accelerated something that probably wouldn't have happened otherwise. We had previously been connected and in communication, but

NIPP provided the opportunity for a shared project and something to work on together." Project team member

- Our survey showed that the share of respondents who would consider ARCs and AHSNs teams as collaborative, improved from 70% to 97% as a result of NIPP. The share of respondents who felt that their teams were not collaborative at all dropped from 24% to 3% (Figure 11, page 45, note: the first statement combines respondents who selected either 'somewhat' or 'very much so').
- Individuals expressed a positive sentiment to their achievements during NIPP, in relation to their collaboration and new skills gained. Flexibility in project team roles and responsibilities was cited as the most impactful enabler for successful project delivery, demonstrating that where projects were effective in collaborating, this proved an enabler for evaluation activities (Figure 8, page 27).

  "Fantastic opportunity to force ARCs and AHSNs to work together, achieved what it was meant to do. It's a good way to channel funding to what to focus on. Yes, I'm doing a pitch to NIPP2. Brilliant opportunity and I really enjoyed it." Project team member

  "It gave us a lot of transferrable skills." Project team member
- ARCs and AHSNs have utilised extensive colleague networks, to better facilitate evaluation activities. This has been cited as particularly valuable during recruitment, where ARCs would otherwise have had little connection to NHS staff and patients.

  "AHSN programme manager was able to link us with access to stakeholders – provided useful high-level contacts that we didn't have at the start of the project." Project team member

  "ARC has connected AHSN team to links that we wouldn't otherwise have had – has added value and sped up activities." Project team member
- AHSNs have developed their knowledge of conducting evaluation activities, through utilising the skillsets of ARCs in research design and methodology, as well as facilitation of ethics approvals.

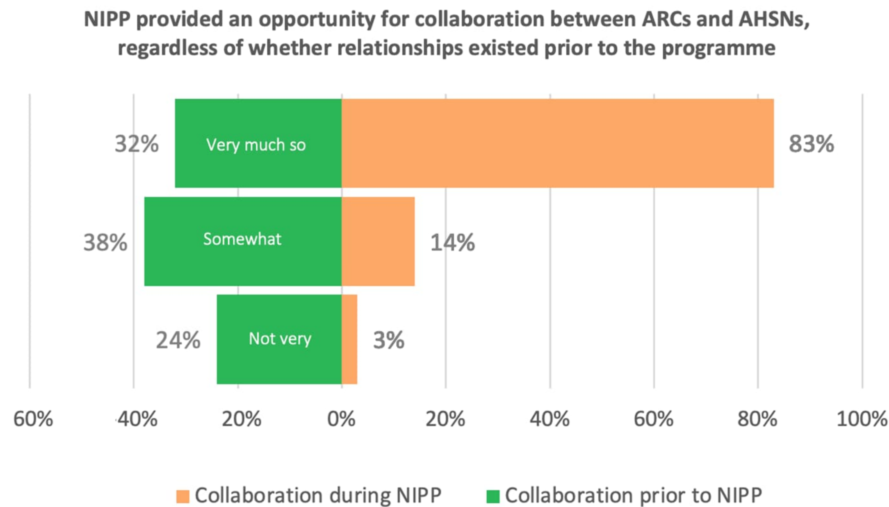
  "This level of detailed research is new to AHSNs: understanding trade-offs between rapid versus robust research was a huge learning curve." Project team member

  "ARC have all the research technical expertise and can bring that value." Project team member
- Having an individual with a joint role across AHSNs and ARCs, embedded within a project team, enhanced integration and collaboration among a number of projects. Projects that included the integrator role were able to gain a more rapid and impartial understanding of the world of both ARC and AHSN, whilst more easily adjusting to each other's ways of working.
- In one region, ARC and AHSN collaboration was perceived as ineffective by the regional lead, who explained that ARCs were not utilised for their evaluation expertise. This echoes with the challenge of finding the right balance between academic rigour and rapid evaluation, while being challenged by varying maturity of ARC-AHSN relationships.

  "AHSNs aren't resourced to provide academic grade evaluations but they aren't involving ARCs enough to fill this gap. Project team member

  AHSN led project with ARCs sitting 'behind the scenes' which doesn't feel appropriate – could make better use of ARC skills." Project team member

Figure 11: Extent to which NIPP acted as an enabler for ARC-AHSN collaboration



Source: EY Seren Analysis | n=37
Q: To what extent would you consider the ARC and AHSN teams within your project, as collaborative?
Q: To what extent were the ARC and AHSN teams in your project connected in advance of enrolling onto the NIPP programme? (Response options included: Not at all (excluded due to 0 responses)| Not very | Somewhat | Very much so)

Differences of ARC and AHSN evaluation approaches and role distribution

Finding 22
Contrasting approaches to evaluation between ARCs and AHSNs, appeared a common barrier to successful collaboration.

- Contrasting approaches to evaluation appeared to cause conflict within some projects, with ARC and AHSN team members failing to agree on an appropriate approach. This was considered responsible for slowing down evaluation design. The most common example of such disagreements appeared between the ARCs' more traditional, detailed and robust evaluation approach, in comparison to the faster paced approach of AHSNs, relying on lower levels of evidence.

  "There was a clash between approaches to innovation and research approaches: neither are better, they are just different. This has caused operational issues. There were inherent tensions that research is more focused on detail, whereas innovation cannot work like this and moves faster, relying on lower levels of evidence." Project team member
  "Inherent tensions that research is more focused on detail, whereas innovation cannot work like this and moves faster." Project team member
- Amongst some AHSNs that felt pressured by NIPP timelines, there was a perception that ARCs would 'slow down' evaluation activities due to their more traditional approaches. Others felt that delivery would be slowed a result of passing information between two organisations. This highlights the fact that some project teams' collaboration did not help to overcome their perceptions about each other, which

resulted in an 'us' versus 'them' sentiment that stood in the way of effective collaboration.

7.3 Data governance & PPIE

The following findings relate to data governance and the influence of this on project evaluation activities. Insights include the influence of ethics and R&D approvals, data access, and patient and public involvement (PPIE). This section also reports on examples of best practices applied by projects to overcome the cited barriers.

R&D approvals for conducting primary research

Finding 23

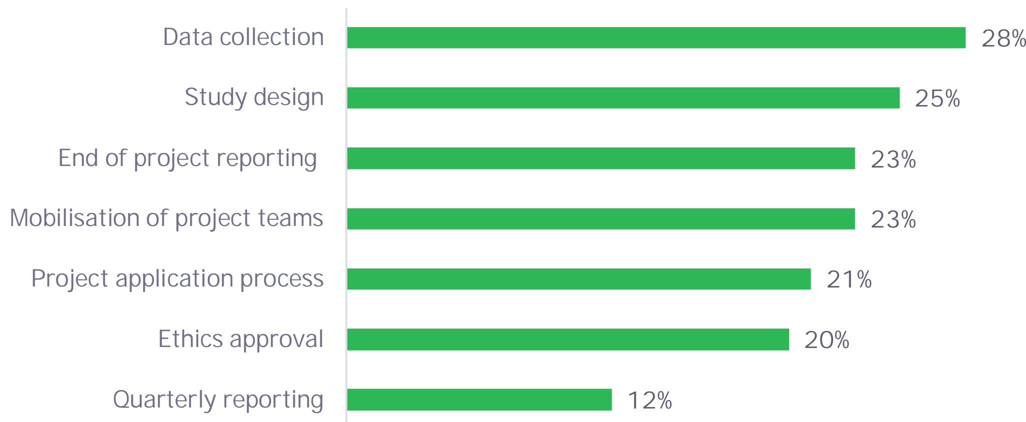
Project teams cited R&D approvals as a significant barrier for conducting primary research activities with staff and patients, due to extensive approval timelines.

- To conduct qualitative studies, many projects had to secure R&D approvals. R&D approvals appeared the biggest barrier amongst approval processes, due to limited capacity and lengthy backlogs amongst NHS trusts. The priority of NIPP within these backlogs also appeared to be an impacting factor, with large scale studies being prioritised over smaller, regionally driven requests.

  > *"R&D approval has been a bigger issue…the priority of this varies depending on their capacity and what else they are working on. This can take longer than ethics approvals. R&D departments are challenged so this is understandable, they are still recovering from pandemic backlogs."* Project team member

- Projects that involved several NHS sites had the biggest issues in securing R&D approvals, as this required approaching each NHS site separately and completing paperwork for each individually.
- Our survey demonstrated that data collection was the area of evaluation design most negatively impacted by NIPP timelines (Figure 12; page 47). Restrictive programme timelines, coupled with lengthy governance timelines, further impacted teams' ability to collect primary data within the allocated period for evaluation.

Figure 12: Areas of evaluation most impacted by NIPP timelines



Source: EY Seren Analysis | n=36

Q1: To what extent do you feel that NIPP programme timelines have influenced the design of your evaluation activities, such as method used? Please provide a response for each of the following stages of the NIPP programme, listed.

Ethics approvals for conducting primary research

Finding 24

Despite NIPP being designed to avoid the requirement for ethics approvals, due to timeline constraints, this approach did not align with traditional ARC ways of working. As a result, many projects built in evaluation activities that required ethics approvals and were required to lean on ARC expertise to overcome this barrier.

- Alongside R&D approvals, project teams cited ethics approvals as a barrier for conducting primary research activities with staff and patients. Ethics approvals were, however, considered less impactful than R&D approvals as a result of allocated timelines built into HREC, in order to review and approve ethics requests. Local NHS R&D projects do not however, have the same allocations for requests that are not considered portfolio studies.
- The central coordination team expressed that NIPP was designed to avoid the requirement to address detailed research questions, to fulfil an aim to move at pace. As a result, evaluations were priority over research projects. Despite this, there appeared to be a gap in understanding and this message was not effectively cascaded to all project team members. This, coupled with a preference amongst academics to conduct detailed research, due to their culture and traditional approaches to evaluation, meant some projects incorporated detailed research into their evaluation approach and thus faced ethics and R&D approvals.
- Some projects recognised that NHS ethics represents a lengthy process that doesn't align with NIPP, resulting in several project teams changing their evaluation design and following ethics approvals of their adjacent universities instead.

> *"Had to go through university ethics no matter how long the project is, collecting anonymised routinely collected data and interviews, no need for NHS ethics application (can take months). Unis do it quick. Was done in the*

first 2-3 months. Still took a bit more time than we wanted, and it put us on the backfoot at the start, which impacted RAG. It wasn't a difficult process." Project team member

- Delays with ethics approvals appeared to be in part, due to the back-and-forth nature of submission. Upon receiving feedback from research sponsors, project teams were required to make relevant iterations and resubmit their approval requests.

  "Inevitable that somebody will come back with something…it's a pretty sensitive situation…expecting them to spend time talking with people about their challenges." Project team member

- Some AHSNs reported a lack of awareness of governance approvals, resulting in them not having factored these delays into project timelines. Amongst these projects, ARCs were cited as enablers for overcoming governance challenges, due to existing experiences in navigating research approvals and data access.

  "We [AHSN] aren't from a research background and lacked awareness of the timelines…it was an evaluation project - we misunderstood that there would be a need for approvals. ARCs ran with the ethics and AHSNs didn't get involved." Project team member

  "We didn't compromise on scope of projects; the ARCs saw a problem and went away and resolved it." Project team member

  "Both lead researchers were very experienced, and they work in this geography, and they knew how to overcome barriers. They adapted and it came from experience." Project team member

Hypothesis 3

The above evidence confirms hypothesis 3, demonstrating that governance around conducting data collection activities had a negative impact on project outcomes and thus influenced the ability and/or time taken for projects to collect primary data.

Best practice: ethics approvals
Finding 25

Some projects were able to overcome the prospect of lengthy R&D and ethics approvals, by redesigning evaluation activities and drawing on existing literature.

- Following programme guidance and previous experience of governance, some projects designed their evaluation activities to exclude primary data collection, in order to eliminate the need for approvals. Examples of approaches included:
- Two projects collected aggregate rather than patient-level data, in order to reduce complexity of ethics approvals and increase the likelihood of obtaining approvals more rapidly.

  Looked at data on GP practice level, focus groups – one of the main strengths of this work, obtaining ethics for GP practice easier than at patient level. That was a tradeoff in order to feasibly achieve what was planned and yet have something robust. Project team member

- Other projects collected existing or routinely collected NHS data to remove the need for primary data collection entirely, despite a desire to conduct primary research, had timelines been less restrictive.

> *We wanted to conduct interviews with patients about their experiences of the service and what it would look like in an ideal world – however, we were told the ethics approval for this could take 12 months, so we didn't achieve it.* Project team member

- Two projects also conducted 'informal' research such as unrecorded staff interviews. This enabled teams to build an understanding of the value of interventions, whilst awaiting governance approvals, reducing the impact of governance delays.

> *...researchers have found a workaround by having conversations with staff unrecorded and not named as interviews, so we can start research before approvals complete.* Project team member
>
> *Conducted informal patient research that didn't require ethics approval; didn't necessarily use this data in evaluation but was very useful in understanding value of the implementation and the specific benefits to patients.* Project team member

- One project reported overcoming the barrier of lengthy ethics approval by drawing on existing literature review and previous studies to fill gaps in their research.

- Two projects also conducted 'informal' research such as unrecorded staff interviews. This enabled teams to build an understanding of the value of interventions, whilst awaiting governance approvals, reducing the impact of governance delays.

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- One project reported overcoming the barrier of lengthy ethics approval by drawing on existing literature review and previous studies to fill gaps in their research.

Data access

Finding 26
Projects relying on existing data, experienced challenges in securing access to data systems, due to poor maturity of data governance and system integrations.
Finding 27
Where data governance influenced evaluation design, some projects cited decreased confidence in quality and depth of their evaluation.

- Some projects that decided to use routinely collected data instead of primary data collection, still experienced a negative impact of approval delays. Securing access to existing data systems has proven at times slow, delaying their ability to pursue evaluation activities at pace.

> *"At the moment it's a painful process to access data for research, even though it's always in the interests of better care."* Project team member

- Some project teams reported that they faced inconsistent processes around data access, across different sites. This meant they had to introduce their own approaches to overcoming data access issues. One project achieved this by sharing best practice approaches and information protocols followed by sites with more mature data

governance. This enabled learning between sites and facilitated a speedy resolution of data challenges.

> *"There is no standard data set for urgent care services across NHS – every service has its own way of collecting data."* Project team member

- A lack of political will was cited as one of the reasons for poor data access for evaluation purposes. Some interventions that aimed to transform certain elements of care, faced resistance from staff members.

> *"[Anonymised] services have been very difficult to work with and haven't been happy to share live data about activity in their areas. Some of this is driven by economic fear because of how they are currently contracted."* Project team member

- Another reason for slow data access appeared to be a result of a lack of standardised process for requesting and securing access to existing data. Approaches to submitting access requests differed across sites, as well as who to submit these requests to. This resulted in projects needing to educate themselves on data governance processes, each time they approached a new site.

> *"There is no shared access to data systems creating difficulties in accessing data."* Project team member

- As a result of challenges related to data governance, some projects pivoted their evaluation design from primary data collection to the use of existing data.
- In some cases, the quality and depth of existing data was considered poor or insufficient, resulting in challenges conducting robust evaluations. A common example of this included the collection of data at an aggregate rather than patient level.

> *"Frequency of data available as well as its granularity makes it hard to conduct real-world evaluations and makes it challenging to demonstrate impact at aggregate level instead of patient level, which is more important."* Project team member
>
> *"Lack of data granularity available changed the depth of the study ... data is national/generic rather than granular data we need per area, which makes it harder to draw conclusions at a system level."* Project team member

Hypothesis 3

We are unable to conclude whether this had a direct impact on projects' abilities to achieve their intended evaluation outcomes, as the programme is still ongoing, with two projects still finalising their rapid insights reports. However, we are able to draw upon project team members' own confidence in their evaluation outputs.
The evidence demonstrates that the redesign of evaluations to avoid primary data collection, resulted in more limited data collection amongst projects and a reliance on secondary data. This had a negative impact on the robustness of evaluations, due to reduced confidence in the quality of existing data, supporting hypothesis 3.

PPIE networks

Finding 28

Existing connections to PPIE networks proved an enabler for recruiting research participants.

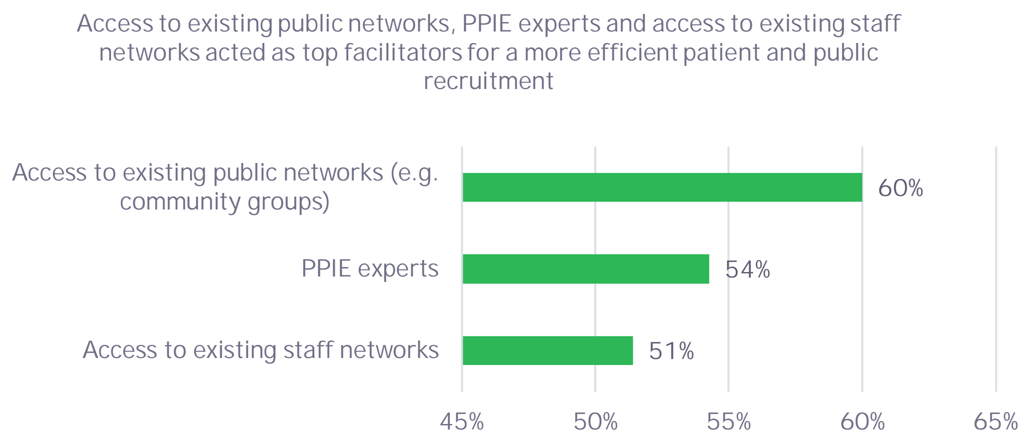
- Where evaluation approaches involved primary research with patients and service users, some projects felt NHS staff created a bottleneck in access to participants. NHS staff were relied upon to provide connections to these individuals, however, poor capacity, as a result of limited resource and COVID-19 and winter pressures, meant they often couldn't dedicate time to support with recruitment. This resulted in delays to recruitment and in some cases, an inability to recruit altogether.

  "Had to recruit lived experience participants through the service provider at [anonymised] hospital. Reliant on them asking patients whether they would like to take part in an interview...obviously a really busy hospital service...we didn't have any control over how or if they had actually spoken to people." Project team member

  "Main barriers were trying to talk to people about COVID-19 during pandemic – staff were very busy with winter pressures…trying to do evaluation under a system with huge pressures was challenging." Project team member

  "...engagement with NHS staff for research was challenging due to the crunch they were experiencing." Project team member

Figure 13: Top facilitators for more efficient patient and public recruitment



Source: EY Seren analysis | n=35

Q: Which, if any, of the following resources, facilitated a more efficient patient and public recruitment for the study? Please select your top 3 facilitators.

- Our survey showed that access to existing public and staff networks, as well as PPIE experts, were considered the most effective facilitators for efficient patient and public recruitment, by more than half of respondents (Figure 13; page 51). Projects with existing engagement with PPIE networks found that these networks could support with guidance on recruitment approaches and provide direct engagement with participants.

  "They [PPIE network] provided us with guidance on how to engage with research participants, dos and don'ts. This supported us in preparing for PPIE activities ahead of engaging with participants." Project team member

- Projects with no existing PPIE connections struggled to secure connections to patients and public when recruiting for evaluations.

"Those that didn't have a pipeline of research [participants] ready for use, have had issues with recruitment so we had to reappraise and give them extra time." Project team member

"NHS had other priorities…had issues with recruiting patients so gave up on it." Project team member

Best practice: PPIE activities
Finding 29

Dedicating a proportion of project funding to data collection and PPIE activities, enabled teams to speed up evaluation activities.

- Some project teams decided to use social media to advertise opportunities for participation and avoid a dependence on NHS staff for recruitment. One team reported that adopting this approach, coupled with accessible language and terminology, facilitated their recruitment.
- Several ARCs and AHSNs reported that they tapped into existing PPIE groups and leads. For projects addressing health inequalities, however, a requirement for a more diverse panel, was not always easily accessible through these existing panels.
- A number of project teams succeeded in overcoming issues with participant recruitment and data access, by assigning funding to accelerate these activities. Dedicating funding to participant incentivisation reduced challenges in recruiting patients for primary research. For teams with no funds available to incentivise, participation was a common challenge.

  We set aside funding to incentivise participants which reduced barriers of access. Project team member
- Paying for an established PPIE organisation to support with recruitment activities, supported teams experiencing challenges in sourcing appropriate patient segments.

  Had to revert to paying a community organisation to support with recruitment which wasn't budgeted for originally. Project team member
- Two projects explained the use of funds to hire a dedicated team member for data extraction. Employing a resource to manage data access and extraction full time, reduced the impact of delays to evaluation.

  The team was struggling with ethics sign off, so we employed dedicated team member to gather and analyse data to avoid ethics approvals. However, this is dependent on funding available. Project team member

8. Cost-benefit analysis

The benefits of a project should be identified and baselined during its initiation stage, then regularly reported during the project and post project. Project templates for Stage 1, Stage 2 and Rapid Insights guide require details of impact - outcome and outputs, but these written descriptions are typically not quantified nor is the patient volume.

For one of the projects, it is possible to analyse the cost-benefit.

Table 2. Cost-benefit analysis

Organisation	Project	Projected impact	Cost analysis	National opportunity
South-West AHSN/ARC South West Peninsula	Evaluation of the impact of CATUs for frail patients	Avoided: 1,200 admissions 550 ED attendances redirected to CATU 1500hrs ambulance handover time	1,200 admissions at £2,359.39 = £2,831,268 550 ED admissions at £242 = £133,100 1,500hrs of ambulance handover at £133= £199,500 Total £3,163,868[8]	Potential benefit x15 = £47,458,020

Project final reports are due to be delivered at the end of May 2023, with the exception of two projects that extensions have been agreed for. It is anticipated that these reports will inform or include a cost-benefit analysis for all projects.

[8] £2,359 is average non-elective inpatient unit cost, https://www.england.nhs.uk/publication/2021-22-national-cost-collection-data-publication/, £242 is Emergency Care unit cost, ambulance hour cost of £133 https://www.bbc.co.uk/news/uk-england-nottinghamshire-63388666

9. Conclusions

NIPP has been successful in accelerating the evaluation of promising innovations, by providing an opportunity to combine academic rigour with the speed needed for innovations to succeed within the NHS. By providing funding and a framework for approaching service evaluation activities, NIPP has facilitated the evaluation of 14 out of 15 innovations and interventions across regions within NHSE. Whilst the evaluation of individual projects and their impact on patient outcomes was not in scope for this evaluation, due to limitations described in Section 4.6, some conclusions have been made based on the information available.

Overall, at the time of completing this independent evaluation, we can conclude that limited evidence exists to demonstrate the ability of NIPP to deliver against all programme objectives. Various project deliverables remain pending, including rapid insights reports, end of programme reports and a sufficient period within which innovations and interventions have been embedded into their regions.

9.1 NIPP objectives

The programme's ability to meet each of its intended objectives are outlined below:

Objective 1: To facilitate ARC/AHSN contribution to NHS Reset and Recovery by generating rapid insights in relation to promising innovations.

Of 15 applicant projects, 14 were successful in securing funding for NIPP enrolment to conduct rapid evaluations in relation to promising innovations. One ARC-AHSN was not successful in securing NIPP funding for their project, as theirs was considered less mature than other projects and not able to 'get off the ground' within NIPP timelines.

At the time of completing this evaluation, 2 of the 14 funded projects were yet to submit their rapid insights report to demonstrate retrospective evaluations of their innovations/interventions. Projects participating in NIPP varied in maturity and some reported insufficient time following NIPP evaluations, alongside an insufficient period of post-COVID-19 'normality', to demonstrate impact of their innovations on patient health outcomes at this stage.

It has also been highlighted that the outputs of NIPP have not yet been reported to the NHS Reset and Recovery board. As a result, we are not aware of board level sentiment towards the ability of programme outputs (rapid insights), to contribute to NHS Reset and Recovery.

As a result of insufficient information regarding programme outputs, our evaluation has insufficient information to draw evidence-based conclusions about whether each project has succeeded in delivering rapid insights and contributing to NHS Reset and Recovery. Following the submission of rapid insights reports to evidence project activities, it will be feasible to conclude whether each ARC-AHSN collaborative has successfully contributed to this NIPP objective.

Objective 2: To identify interventions that will contribute to ICS and regional needs,

aligned to the four Beneficial Changes Network themes: remote consultation; remote monitoring; new approaches to service delivery; and Health and Social Care workforce.

NIPP projects appeared to vary in their engagement with ICS stakeholders and regional leads, making it difficult to conclude whether projects had successfully communicated their intervention or innovation ideas to regional stakeholders and were aware of regional needs. To be considered contributory to regional needs, projects would need to have an established connection, secured visibility of regional needs and have engaged with regional leads to secure "ground-up" support for their innovations or interventions.

Our evaluation has shown that only the regional lead appeared highly engaged with the projects in their region and, therefore, demonstrated a successful "ground-up" approach that supported both regional needs and aligned to the four BCN themes. Other projects cited difficulty identifying and engaging with their regional lead.

Alignment to BCN themes of remote consultation, remote monitoring, new approaches to service delivery, and Health and Social Care workforce was reviewed through the pre-selection process, ensuring all 14 funded projects aligned to these themes. Alignment to regional needs, however, was not validated through pre-selection and would have been dependent on engagement with a regional lead.

Quarterly reporting was requested from the project teams to act as an assurance mechanism for the central coordination team to identify whether projects were on track and to inform commissioners of progress. The central coordination team had expected commissioners to facilitate engagement with regional teams, by reporting NIPP objectives to them and designing priorities around them.

Difficulties in drawing conclusion on this objective of the programme has been impacted by a lack of regional lead engagement with research activities to support this evaluation. Only two regional leads were represented in interviews and survey responses, providing a limited view of projects' engagement with their regional leads and their understanding of their role. As a result, there is a lack of evidence to rely upon, in order to assess project ability to acknowledge and contribute to regional.

Objective 3: To build local capacity and expertise for evaluation and implementation.

NIPP has demonstrated itself as an enabler for collaboration between ARCs and AHSNs. Building cohesive teams with shared knowledge and established working relationships, has meant that 14 out of 15 ARC-AHSN collaboratives are now mobilised for future success beyond NIPP.

Previously, there appeared a lack of connectivity between ARCs and AHSNs in advance of NIPP. Our survey demonstrated that respondents who considered ARCs and AHSNs teams as collaborative, improved from 70% to 97% as a result of NIPP. The share of respondents who felt that their teams were not at all collaborative, dropped from 24% to 3% (Figure 11, page 45, note: the first statement combines respondents who selected either 'somewhat' or 'very much so').

Having no centralised funding as well as cultural differences and working styles, might

have proven a barrier to effective collaboration prior to NIPP. Our evaluation showed that despite early challenges amongst some teams, NIPP has been perceived as an enabler for better collaboration between ARCs and AHSNs. NIPP has enabled project teams to grow an understanding of RWE challenges and learn how to overcome them, whilst leaning on each other's' strengths and capabilities in the spheres of evaluation and implementation.

9.2 Evaluation hypotheses

We summarise our findings with respect to the evaluation hypotheses on the three key areas of NIPP identified during the design of this evaluation (programme design, governance and collaboration) below:

Programme Design
Hypothesis 1: Programme timelines impacted the design of evaluations

Programme timelines did impact the design of evaluations for some projects, who felt the need to redesign planned activities to meet evaluation deadlines. The timeline provided for NIPP project application and delivery, was cited amongst the top two barriers to successful programme delivery (Figure 9, page 28). Amongst these projects, it became apparent that timelines were insufficient to incorporate all planned activities such as effectively mobilising a team, getting approvals, and conducting primary research and/or collecting existing data. This led to some projects re-designing their evaluation approach mid-programme, after they realised their original plans were too ambitious to meet NIPP deadlines.

Other projects were able to conduct planned evaluation activities within NIPP timelines, without the need to alter their approach and although timelines were considered challenging by many, only two projects requested an extension from the NIPP team.

Acknowledging potential challenges related to data access and ethics, NIPP showed flexibility and allowed for this extension, enabling projects to finalise their evaluations, despite extensions not being considered during intended programme design.

Collaboration
Hypothesis 2: Having previous collaborative experience between AHSNs and ARCs played an acceleratory role on project delivery

The programme increased collaboration between 14 out of 15 ARCs and AHSNs, regardless of whether projects had previous experience of working together. NIPP provided the opportunity to work together towards a shared outcome, whilst providing resources and a framework to enable collaborative activities. The programme also enabled ARCs and AHSNs to develop knowledge about each other's expertise and approaches.

Despite NIPP facilitating collaboration across projects, reaching a period of successful collaboration took longer for ARCs and AHSNs with less mature relationships. For these projects, more time was dedicated to mobilising the team, through knowledge building, co-creating an evaluation approach and assigning individual roles to facilitate collaboration.

The need for teams with less mature relationships to conduct mobilisation activities,

resulted in variance between the intended and actual evaluation timelines of NIPP. Timelines for evaluation varied somewhat from those intended, with less mature projects reporting a period of 12-14 months to conduct evaluation activities, versus an intended 18 months. Projects that again, due to mobilisation requirements, requested an extension, faced a further impact on the time remaining for planned evaluation activities.

Governance

Hypothesis 3: Governance around data access and ethics/R&D approvals had a negative impact on project outcomes

For some projects, governance had a negative influence on evaluations, impacting both the ability to overcome ethics and R&D approvals in a timely manner, as well as overcome requests to access existing data. As a result, some projects had to reduce the scope of their approach to complete evaluation activities on time. Examples of this included relying on existing data rather than collecting primary data and collecting aggregate rather than patient level data.

As a result of changes in scope, individuals from these projects cited less confidence in the quality and value of their evaluation outputs, compared to their planned approaches. 67% of survey respondents felt that the quality of their evaluation outputs had been impacted by access to existing data (Q: To what extent do you feel that challenges related to access to existing data will have impacted the quality of your evaluation outputs? n=37).

It is challenging to draw conclusions on the impact of data governance on patient outcomes, as at the time of this evaluation, the programme is ongoing, with two projects still finalising their rapid insights reports. We can however rely on project team members' evaluation of their own outputs, to some extent.

It's essential to reflect on the learnings from the pandemic and reimagine the approaches to data governance and perceptions of risk around data access. Data is a key to innovation and improvement of services and patient outcomes. With growing importance of evaluations within the NHS, efforts should be made to improve consistency of processes related to data governance across health and care systems. This will better enable evaluation activities across innovations and interventions.

10. Recommendations and considerations

Based on key learnings from our evaluation, a set of recommendations have been developed to address the barriers and facilitators identified. These recommendations should be taken into account by programme management, when designing and commissioning future programmes, as well as wider evaluation activities post-NIPP.

This evaluation recognises that NIPP operated in a political environment and, as a result, a number of recommendations have been considered out of scope for programme management or participants to address. A number of considerations have, therefore, been identified, for wider NIPP stakeholders to take into account for future evaluation activities.

Our evaluation has also identified a number of best practices that have been demonstrated by project teams. These best practices should be considered for future evaluation activities (highlighted using orange headers) as well as in the program management best practices covered in Section 10.3.

10.1 Programme design

Recommendation 1
Existing connections to PPIE networks proved an enabler for recruiting research participants. Provide NIPP projects and key stakeholders with clarity on their roles, programme objectives, key milestones, and desired outcomes, during the onboarding process, whilst considering differences in maturity of innovations/interventions selected for NIPP and maturity of ARC-AHSN relationships.

As NIPP was designed and rolled out during the early days of pandemic recovery, it is important to highlight that a changing post-COVID-19 environment may have impacted the delivery of various elements of the programme, in comparison to planned activities. Despite this, guidance around providing clarity during project onboarding, is outlined below:

- There is an opportunity to improve communication and visibility of programme expectations and objectives during programme onboarding. Onboarding is an essential period during which project teams should clarify programme objectives, plan activities, set up their necessary evaluation infrastructure and recruit all required team members. Providing projects with a consistent view of what is expected of them, will help to achieve efficiency and alignment of these activities.
- Our evaluation identified that differences in maturity of innovations/interventions selected for NIPP, as well as maturity of ARC-AHSN relationships, created inconsistencies in programme experience between projects (see Finding 3, page 29). Future programmes should consider having clearly defined innovation maturity criteria and maturity due diligence as a part of the application process. This approach could enable the programme coordination team to identify the level of support needed for each promising innovation.

- To harmonise future experiences of evaluation activities, a maturity assessment of innovations/interventions that successfully completed NIPP should take place, as a part of programme reflections. This would facilitate future spread and scale activities post-NIPP.
- Besides this, maturity assessment of collaborations between ARCs and AHSNs at an organisational level, should also consider including the ARC-AHSN project that was not selected for NIPP, to improve their chances of success in future programmes or similar evaluation activities.
- Developing governance from the outset of the programme will help project teams to navigate the stakeholder landscape and establish roles and responsibilities at each level of governance, e.g. local, regional and national. This should be reflected in a programme initiation document.
- Project teams appeared to have varying levels of understanding of the overarching goals of NIPP, as well as what was expected of individual projects. Receiving this guidance early may have better instilled confidence in the programme and ensured project teams were clear on what they needed to deliver.
- One of the key objectives of NIPP was *'to identify interventions that will contribute to ICS and regional needs, aligned to the four BCN themes (remote consultation; remote monitoring; new approaches to service delivery; and Health and Social Care workforce)'*, yet there was no established mechanism for ensuring this, due to limited involvement from regional leads. Facilitation of regional engagement during early stages of the programme could enable teams to better align their projects to regional objectives.

Recommendation 2

As a part of the NIPP application process, projects should be required to explore and report on the expected governance approvals involved in their evaluation activities and experience in managing them.

- Creating a requirement for projects to investigate and submit the specific approvals they are likely to face and indicate if they have experience of this within the team, as a part of the application process, could provide clarity on the feasibility of projects to meet NIPP timelines. This information would enable the central coordination team to flag data access risks to projects and provide them with the opportunity to redesign or rescope their planned evaluations with more feasible solutions. Valuable data should be identified in the planning phase in the form of a developed data management plan and access requirements should be well understood early on, to ensure data sharing agreements and participant identification contracts are prepared and shared in advance of evaluation.

Best practice: NHSE Sustainable Improvement Plan

The NHSE Sustainable Improvement Impact Framework aims to support large scale change programmes within NHSE, by systematically capturing the impact of these programmes of work. The guidance has been developed based on established theory and is tailored to support improvements to complex systems. It outlines a framework that evaluation teams should complete when establishing the measures, they will adopt in their evaluation activities. The framework should be completed upfront and ensures

teams identify and document the priority, rationale and limitations of each measure. Identifying potential issues or limitations of each measure in advance of completing evaluations, reduces risk of failing to collect relied upon data[9].

- Following application process, if the suggested evaluation design is deemed unfeasible for programme scope and timelines due to lengthy approvals, the following best practice should be applied:

Best practice: NIHR Framework

The NIHR have generated a framework for 'adding value in research' that consists of 10 guiding principles to support NIHR and researchers in producing high quality, transparent research. Principle 8 dictates that 'when appropriate and when it will add value to evidence users, replication, reanalysis and reuse of data from studies should be supported and facilitated'[10].

- There is currently work in progress to build a taxonomy of evaluation methodologies for spread and scale activities taking place within NHSE. This framework will aim to deliver guidance to AHSNs conducting evaluation activities, ensuring they adopt evidence-based approaches and achieving consistency in evaluation approaches across NHSE. Upon completion, this framework should be considered as a useful resource for future programmes, in order to better guide projects in their evaluation approach.
- The programme should consider conducting a learning exercise to reflect on and document potential challenges that projects might encounter during rapid evaluation, such as access to and collection of existing data as well as staff and patient recruitment. This guidance should be communicated to help future programmes to better prepare for such barriers. This should also provide clarity on the level of quantitative evidence sufficient for robust evaluations at this scale of innovation. NIPP might wish to consider inputting this knowledge into the existing real world evaluation guide and resources created by AHSNs.

Best practice: AHSN Network Guide

The AHSN network guide to conducting real world evaluations outlines the key considerations that should be addressed when developing a real-world evaluation (RWE). The guide outlines a linear set of activities that any evaluation team should conduct, in order to set expectations around the stages involved in conducting a RWE. Activities include the generation of clear outcomes at the outset of any evaluation activity[11].

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[9] Sustainable Improvement Impact Framework, NHS England, available from: https://www.england.nhs.uk/publication/sustainable-improvement-impact-framework/

[10] NIHR Adding Value in Research framework, NIHR website, available from: https://www.nihr.ac.uk/documents/nihr-adding-value-in-research-framework/20147#setting-justifiable-research-priorities

[11] Real-world evaluation to facilitate adoption at scale, The AHSN Network, available from: https://www.ahsnnetwork.com/wp-content/uploads/2022/12/R58-Real-world-evaluation-to-facilitate-adoption-at-scale.pdf

Recommendation 3

Create a dedicated mobilisation period to reduce the impact of restricted programme timelines and enable better planning, timely distribution of roles, internal administration, and preparation of sites for data access.

- Project teams impacted by short timelines for application or lack of existing collaboration between ARC and AHSN groups, expressed a desire for a mobilisation period in advance of beginning their evaluations. Even though collaboration between ARCs and AHSNs did improve for all participants of NIPP, a mobilisation period was still considered a necessary phase of any future programme to enable ARCs to recruit the right team resource and better prepare for research activities. The existing ARC infrastructure is currently not set up to enable rapid recruitment, as a result of more time-consuming bureaucratic processes than those followed by AHSNs. Some projects did not recruit a full evaluation team until six months into the programme.
- A mobilisation period would better facilitate a well-considered application, as well as an opportunity for newly formed ARC and AHSN teams to collaborate and agree project scope, roles and responsibilities. Six months has been considered a sufficient mobilisation period amongst NIPP projects, with two project leads expressing that this was the time taken to secure appropriate funding and assemble their team, reducing evaluation timelines to 12 months.
- For projects with little to no existing ARC and AHSN collaboration, a mobilisation period has also been considered an opportunity to create *'equal footing'* for programme launch, eradicating the perception that those already collaborating experienced a *'headstart'*.
- A mobilisation period could be also used to secure more funding for larger or more expensive projects and get regional teams engaged.

Recommendation 4

Generate specific, measurable and time-bound (SMART) KPIs in project reporting, to ensure they are relevant and meaningful to projects. Provide guiding principles for project specific KPIs to maintain consistency and direction.

- Enabling tailored, SMART KPIs may better support project teams in measuring these KPIs meaningfully during activities such as quarterly reporting. Such an approach would enable better tracking of progress and comparison of projects by considering project nuances and stages. As a result of current KPIs being designed to reflect the entire programme, projects struggled to resonate with the measures and expressed a desire for them to be more project-specific or locally derived, rather than nationally mandated.
- KPIs should also be outcome-driven or focused on achievements, in order to ensure project activities, meet intended programme objectives. Project teams perceived existing KPIs as *'process-driven'* and *'more like objectives than KPIs'*, rather than focusing on patient outcomes and impact.
- Our evaluation found that alongside programme-wide KPIs, projects were tasked to choose their own project specific KPIs that fed into quarterly reports. This led to inconsistency in tracking progress across projects. Establishing some guiding principles

could help ensure better alignment and basic comparability between projects, whilst also ensuring these KPIs differentiate sufficiently from programme-wide KPIs, to be considered meaningful.

- Measurement and reporting of the impact and outcomes of projects should also extend to the rapid insight reports submitted following programme completion. As well as outlining the key findings and recommendations of evaluations, these reports should include overall impact and any benefits identified. The aim of the rapid insights reports is to provide a case study for future research and scale up. By incorporating measurable benefits, using an approach such as SMART KPIs, into these reports, benefits of innovations will be better identified, supporting the wider spread of health and care innovation across NHSE.

Best practice: Generating SMART KPIs

The GOV.UK Green Book for 'appraisal and evaluation in central government' outlines SMART objectives (or KPIs) as crucial for effective appraisal, planning, monitoring and evaluation of programmes or projects. Where these SMART objectives apply at project level, they should be considered enablers to delivery of the overall programme and remain relevant. The Green Book dictates that 'up to five or six SMART objectives should be established. More than this and a proposed scheme is likely to lack focus and is more likely to fail or significantly exceed costs and under-deliver'.

Large public sector interventions, policies or programmes often adopt the 'Theory of Change' framework to articulate programme aims and objectives, with the purpose of utilising them to measure outcome and impact. Without such a framework, it can be challenging to identify how planned activities will lead to desired outputs and outcomes. The 'Theory of Change' framework is a methodology that enables more structured planning, monitoring, and evaluation of a programme or intervention. Utilising this framework (or an equivalent) from the programme outset, with clear and measurable aims and SMART KPIs, could ensure clarity of objectives, consistency of roles and measurability of outcomes of the programme.

GOV.UK has generated a service manual for the consistent and effective delivery of public services, including a standardised framework for KPI reporting. A set of four mandatory KPIs has been generated, that apply to all GOV.UK teams responsible for the creation and running of a public service. These KPIs include: cost per transaction, user satisfaction, completion rate and digital take up. In addition to a consistent set of KPIs, teams are expected to generate their own project specific KPIs that address whether the individual service is working for users and to communicate its performance. Guidance has been published regarding how teams should approach and generate meaningful KPIs, as well as recommendations for identifying data sources and reporting KPIs.

Recommendation 5

Design a structured, consistent approach for providing projects with feedback on quarterly reports and facilitate two-way communication between programme management and individual projects.

- In addition to delivering guidance throughout the programme, a more structured approach to receiving feedback and escalating issues, would be valued by project teams. Experiences of feedback and guidance received in response to quarterly reports, appeared to vary between projects. Some project teams reported receiving consistent feedback during the first quarter of NIPP, whereas others reported no feedback on amber or red statuses raised later on in the programme.
- Roles and responsibilities should be described in a programme initiation document, where governance and responsibilities around reporting and feedback should be defined (see recommendation 1, page 58-59).
- As a result of inconsistent experiences, project teams reported a lack of clarity on the feedback approach for quarterly reports. There is an opportunity to provide better consistency around when and how teams should expect to receive feedback following reporting and how reporting information would be used.
- In order to deliver consistent, valuable feedback across all projects, programme delivery resource could be dedicated to reviewing reports and communicating dedicated feedback following each reporting period. Benefits to projects would include:
- Improved project perceptions around the value of quarterly reports
  - Currently project teams perceive little to no benefit in submitting reports, as a result of receiving no feedback on their submissions.
- Better support to teams raising issues via an amber or reg RAG status
  - Upon raising an amber or red RAG status via quarterly reports, projects had expected, and would have valued, support from the programme team in resolving issues.
- Improved understanding of project performance
  - Project teams cited a lack of awareness of whether the programme team considered their activities 'on track,' both individually and in comparison, to other teams. Providing feedback on individual performance, may better enable continuous improvement amongst projects.
- Acknowledging the level of effort required to review and provide feedback on quarterly reports across each project, an alternative mechanism for feedback might be considered in the form of quarterly board reviews. Conducting a dedicated session each quarter was a suggested solution to facilitate two-way communication between central coordination team and project teams. This would also enable project leads to report on progress and discuss escalations or requests for support. It is understood that, had a PSO been in place for the duration of NIPP, such reporting activities may have been achieved.

Recommendation 6

Facilitate more frequent opportunities for collaboration and knowledge sharing between projects, to enable network-level thinking.

- Project teams referenced the few engagements they had with other projects as valuable, however, considered them infrequent and would have valued more peer support and opportunities to collaborate. The perceived benefits of engagement with other projects included building connections to valuable stakeholder groups or contacts, sharing general evaluation experiences and learning from others' challenges and resolutions.

- Learning sessions could help project teams to address common barriers regarding ethics approvals, data access and PPIE recruitment, which were considered the top barriers to timely evaluation. Some project teams recognised the benefit of the knowledge sharing sessions that did take place but felt they were scheduled too late to have sufficient impact on evaluation activities.
- The intended programme design did feature a series of events to enhance network-thinking and develop a more collaborative community, however, only a limited number of these planned events and network-building opportunities took place.
- Specific learning and knowledge sharing sessions that would have been valuable, included sessions to discuss potential barriers that might be faced during the programme. It was cited that these sessions would be most impactful early on, in order to prepare for evaluation activities. The central coordination team should consider involving ICS and other stakeholders that could advise on unlocking some of these barriers. Additional, less focused learning sessions could be offered and facilitated on demand, during later stages of the programme. These activities should be combined as part of a communication plan, shared with programme participants at the outset of the programme delivery phase.
- NIPP should consider providing more structured, continuous guidance and support to project teams, throughout the programme. Early communication during the launch of NIPP was considered valuable and more frequent and consistent communication and guidance would continue to facilitate engagement with projects. Two-way information sharing and dialogue would have been well received and helped to maintain engagement across projects.

10.2 Collaboration

Recommendation 7

Recognise and communicate best practices for effective collaboration between ARCs and AHSNs, such as the presence of an integrator role within project teams.

- When discussing methods for effective collaboration, 4 project teams cited an *'integrated'* or *'hybrid'* team member who represented the interests of both ARC and AHSN, as a powerful enabler for collaboration.
- Benefits of an individual representing both groups included a clear line of communication between AHSN and ARC representatives within the project, visibility of roles and responsibilities within the project team and shared knowledge between team members.
- It is understood that integrator roles are not feasible across all projects, due to budget and resource constraints. NIPP should, therefore, ensure that projects teams are made aware of the opportunities associated with hybrid roles in facilitating better communication between ARCs and AHSNs, encouraging teams to identify whether having this role would be feasible within each project team. In cases where a dedicated role is not possible, teams should draw on existing resources and expertise to improve communication and collaboration between ARCs and AHSNs.

10.3 Programme management best practices

Alongside the above recommendations addressing the design and facilitation of future innovations programmes, we recommend considering a number of good practices when conducting programme management activities. The following practices have been selected based on their relevance to innovation programmes within the NHS.

Create a Project (or programme) initiation Document (PID) to support planning

- The PID should communicate all details required for successful project delivery, including the programme definition and approach, business case, roles and responsibilities, risk management and a plan for communications and project activities.
- The PID should be regularly reviewed and updated throughout the programme with clear justification and ownership, to maintain a single source of truth and reflect developments to the programme as they occur.

Appoint a dedicated programme Senior Responsible Officer (SRO)

- An SRO or Project Executive should be appointed with the responsibility of ensuring that the programme meets its objectives and delivers project benefits. The SRO should remain in place for the entirety of the programme, until programme impact has been measured or benefits realisation has taken place.

Design programme timelines to include a mobilisation period

- A dedicated mobilisation period should be built into programme timelines, in order to enable onboarding and set up of projects within the programme.
- Facilitating these activities upfront, should reduce the risk of delays to project delivery whilst also emphasizing the importance of set-up and programme readiness.

Consider building a contingency period into programme timelines

- Additional contingency time should be considered, to account for any anticipated issues that may impact the planned programme schedule.
- A contingency period should acknowledge any known, potential risks to the programme and should reflect the estimated time needed to resolve these issues.

Define escalation processes to manage and respond to risks

- Identify the potential issues that may arise during programme delivery and define processes for responding to and resolving these risks.
- This should include identification of relevant individuals and teams who will own each category of risk and who should be engaged when issues arise.

Define and communicate scoring criteria for programme applications

- Where a programme involves an application process for candidate projects, criteria upon which programme applicants are scored should be clearly defined.
- The definition of criteria ensures consistency in the application process, removing the potential for subjectivity in approved or denied applications.
- These criteria should also be clearly communicated to projects in advance of application, in order to best prepare their submissions and demonstrate the rationale behind which application decisions are made.

Adopt a framework to measure programme impact

- Several benefits frameworks exist to enable programme impact to be consistently captured and measured throughout its' timespan.

- A common example is the 'benefits realisation' framework[12]. This approach involves identifying the desired benefits of the programme, how they will be measured, who will be responsible for measuring them, and when they should be delivered by. The framework aims to improve the delivery of intended programme benefits and identifies clear accountability for achieving them.

Define a reporting structure for consistent tracking of performance

- A reporting frequency should be agreed with an ARC and AHSN representative at the programme initiation phase that reflects the level of control required, which is likely to vary during the programme.
- Exceptions in reporting process should be defined for use in the instance(s) when programme delivery deviates beyond the agreed tolerances.
- A template detailing progress from one reporting period to the next on planned work packages and products should be developed. Some reporting KPIs will be standard across the programme, the work packages and products will likely be individual to projects. The standard KPIs will include a financial metric to measure if project delivery teams are on track or has deviated from their proposed plan. The report should be used to advise on any risks or issues, and where the programme board could help.

10.4 Considerations

Consideration 1
Communicate and prioritise programmes aimed to evaluate and implement innovations/interventions amongst both NHS and university governance teams, to improve lead times for R&D, ethics and data access approvals.

National level

- The role of NHSE as an enabler for real-world evaluations, was raised by several regional and national stakeholders. While the definition of 'innovation' was inconsistent across the system, it was recognised that NHSE should provide a continuity of initiatives that couple the rigour of academic evaluations with the practicality of real-world implementation. Such initiatives should be based on NHS needs and priorities, whilst helping ARCs and AHSNs to align and plan around initiatives. This could also help to overcome cultural differences in the way that AHSNs and ARCs are currently budgeted and staffed.
- Evaluations that involved primary research and had to rely on NHS staff providing connections with patients and service users, experienced poor engagement. This was driven by limited resource and COVID-19 pressures. NHSE should ensure there is dedicated resource on sites to support NIPP projects and wider evaluation initiatives.
- Commissioners of future programmes should consider a mobilisation period to facilitate better planning and preparation for such activities.
- Following NIPP, ARCs and AHSNs should share best practices and experiences of collaboration with local Universities and Trusts, to overcome these barriers in future evaluation activities. This should also extend to building long-term relationships with

[12] Benefits realisation framework, NHS England and NHS Improvement, 2021

R&D departments to better understand their processes and help prioritise large innovation projects.

Best practice: Rapid, local level approvals

Some ARCs reported that their universities have developed rapid ethics processes to enable real-life evaluations. This proved a good practice and should be considered by other academic institutions.

Consideration 2

Regional leads should consider playing a more active role in facilitating evaluations, implementation and scaling promising innovations.

Best practice: Regional level engagement

One regional lead demonstrated the successful facilitation of evaluation activities for projects within their region by helping them to overcome barriers to evaluation. This approach aligned with NIPP's objective of delivering 'promising innovations with impact' to their respective regional/ICS priorities by being generated 'ground-up' not 'top-down'. By supporting local projects, the lead generated a network of connections to sites, as well as enabling better collaboration between projects to share experiences and learnings.
It is worth considering the above approach as an example of best practice that should be adopted by other regions, where possible.

11. Appendix

11.1 Outline of recommendations and corresponding findings

The below table outlines where findings from Chapter 7, have influenced the recommendations outlined in Chapter 10.

Table 3. Recommendations and findings

Recommendation 1: Provide NIPP projects and key stakeholders with clarity on programme objectives, key milestones and desired outcomes, during the onboarding process, whilst considering differences in maturity of innovations/interventions selected for NIPP and maturity of ARC-AHSN relationships.
Finding 3: Differences in maturity of innovations/interventions selected for NIPP, as well as maturity of ARC-AHSN relationships, created inconsistencies in programme experience, between projects.
Finding 9: Despite early communication from the programme team, communication throughout the duration of the programme was considered inconsistent. An absence of a Project Support Officer (PSO) for the full duration of NIPP, as well as a transition in Programme Lead, might have impacted the provision of consistent support and guidance.
Recommendation 2: As a part of the NIPP application process, projects should be required to explore and report on the expected governance approvals involved in their evaluation activities and experience in managing them.
Finding 23: Project teams cited R&D approvals as a significant barrier for conducting primary research activities with staff and patients, due to extensive approval timelines.
Finding 24: Despite NIPP being designed to avoid the requirement for ethics approvals, due to timeline constraints, this approach did not align with traditional ARC ways of working. As a result, many projects built in evaluation activities that required ethics approvals and were required to lean on ARC expertise to overcome this barrier.
Finding 26: Projects relying on existing data, experienced challenges in securing access to data systems, due to poor maturity of data governance and system integrations.
Finding 27: Where data governance influenced evaluation design, some projects cited decreased confidence in quality and depth of their evaluation.
Recommendation 3: Create a dedicated mobilisation period to reduce the impact of restricted programme timelines and enable better planning, timely distribution of roles, internal administration, and preparation of sites for data access.
Finding 2: Insufficient timelines for bid submission and a lack of mobilisation period were barriers for co-production of proposals and timely recruitment of project team members.
Finding 3: Differences in maturity of innovations/interventions selected for NIPP, as well as maturity of

ARC-AHSN relationships, created inconsistencies in programme experience, between projects.
Finding 4: Insufficient programme timelines impacted evaluation activities, with multiple projects redesigning their intended evaluation approach. As a result, projects cited low confidence in their evaluations and three projects reported that timelines have meant evaluations will not reflect the true impact of their interventions.
Finding 6: Almost all projects managed to meet NIPP deadlines, despite many redesigning their evaluation methodologies to deliver on time.
Recommendation 4: Generate specific, measurable and time-bound (SMART) KPIs in project reporting to ensure they are relevant and meaningful to projects. Provide guiding principles for project specific KPIs to maintain consistency and direction.
Finding 15: Project teams considered KPIs in quarterly reports as process-driven, rather than outcome-oriented. As a result, it was felt that KPIs were not designed to measure the impact of innovations and interventions on patient outcomes.
Recommendation 5: Design a structured, consistent approach for providing projects with feedback on quarterly reports and facilitate two-way communication between programme management and individual projects.
Finding 14: Feedback on quarterly reports appeared inconsistent, with project teams citing little to no feedback following the submission of reports. As a result, they perceived quarterly reporting as a 'box ticking' exercise.
Recommendation 6: Facilitate more frequent opportunities for collaboration and knowledge sharing between projects, to enable network-level thinking.
Finding 11: Learning and knowledge sharing events were generally recognised as helpful and enabled network thinking; more frequent learning and networking opportunities would have been beneficial.
Recommendation 7: Recognise and communicate best practices for effective collaboration between ARCs and AHSNs, such as the presence of an integrator role within project teams
Finding 21: Despite early challenges amongst some teams, NIPP has been perceived as an enabler for better collaboration between ARCs and AHSNs. Some projects felt the benefits of these relationships will extend beyond NIPP.

11.2 Breakdown of NIPP project funding

The below table outlines funding distribution between NIPP projects, as referenced in Chapter 6.

Table 4. Funding distribution, £

Projects (anonymised)	Funding received (£)
Project 1	233,448.33
Project 2	230,600.00
Project 3	205,400.00
Project 4	274,999.00
Project 5	357,352.36
Project 6	229,139.17
Project 7	230,743.33
Project 8	205,347.00
Project 9	274,957.00
Project 10	228,792.00
Project 11	226,041.67
Project 12	271,319.00
Project 13	265,895.00
Project 14	274,972.00

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