Experiences of spread & adoption across the AHSN Network during COVID-19

This short report draws upon the experience of 26 staff from 14 Academic Health Science Networks (AHSNs) and their spread activities from March to June 2020 during the COVID-19 pandemic.

Three identical online focus groups (FG 1-3) were conducted, each driven by the questions:

What has been the experience of spread and adoption by AHSNs (approaches taken and changes in the environments they are conducting spread work within), and what impacts have been seen during the COVID-19 pandemic?

A range of projects were discussed by participants, involving accelerated and reactive work. Projects discussed included existing AHSN network projects such as TCAM, RESTORE2, Atrial Fibrillation, IPT ITT and RUP products, Electronic Repeat Dispensing and PINCER. There was also discussion of a range of bespoke COVID-19 work to meet local health system needs, such as virtual clinics, telemedicine and digital access to care homes, ITU patient transfers, total triage models, GP informatics dashboards, cardiac rehabilitation and outpatient pathways.

This synthesis of learning is written with the aim of informing the work of AHSNs in supporting local systems going forward. The report forms part of the AHSN Network and NHS England funded study *Review of spread and adoption approaches across the AHSN Network*.

Key findings

1. AHSNs have applied an ethos of speed and flexibility in their support for local health and care systems. They have been simultaneously proactive in their offers of support (e.g. introducing innovations) and reactive to the needs of health systems rapidly changing their own ways of working.

2. AHSNs identified different strategic responses to meeting the needs of their systems:
    a. Responding through the acceleration of existing programme or innovations
    b. Rapid roll-out of new ways of working
    c. Identification of approaches and innovations to meet pressing need.

3. A combination of accelerated spread of existing solutions and reactive work has led to enhanced relationships with local system partners. It was reported that health services felt listened to and were ‘worked with’, rather than ‘done to’, during these unprecedented times.

4. Shifts within the national context had a substantial impact on the ways in which the AHSNs could work. AHSNs reported increased systems for engagement and partnership through which to work (e.g. the cells), more rapid decision-making processes, and a shared purpose which gave impetus to

the need to change and adopt new ideas and approaches.

5. Despite the need for rapid roll-out, AHSNs recognised the need to still be collecting and using evidence to consider both outcomes and process. This was seen as being important to both the safety of patients and service users, as well as to create sustainable adoption, meeting the information needs of commissioners.

6. Further evidence is being collected on outcomes and impacts, but the evidence of change made so far is very much in relation to process, with a strong emphasis on the positive impacts on relationships both between AHSNs as well as between AHSNs and the systems within which they work.

System factors affecting spread activity during COVID-19

It is particularly important to start by recognising that COVID-19 produced an 'unfreezing effect', seeing **important shifts in organisational structures, processes and cultures that influenced the work of the AHSNs**. Whilst some of these were negative, the vast majority were positive, and whilst it is recognised that the shift away from a pandemic setting may also result in a shift away from these positive working environments, it is useful to understand what changed, what this meant for AHSNs and what can be learnt from how AHSNs adapted to a new context. This is especially relevant, as the longer the changed response to a crisis, the more likely it is to become a more permanent, cultural shift.

There were clearly positive actions taken on the part of AHSNs which reflected well within the system and enabled rapid spread and change. AHSNs were largely able to respond proactively to the challenges faced in their areas. As health systems rapidly reorganised and acknowledged the need for change, **the role of the AHSNs appeared to become particularly relevant** and recognised as such by the system. This is important to build on going forward and is proving to be a springboard to next phase working for many AHSNs.

Systems which had been difficult for AHSNs to work with in terms of enabling change, opened up to new ideas and put in place **systems which allowed for rapid decisions to be made**. These conversations were often quick and easy to put in place, and allowed for further work to be done around systems to enable them to be open for future innovation.

"Suddenly with COVID they're like, I'm going to need a fundamentally new capability. I need to be able to manage all my outpatients remotely, or I need to be able to monitor long-term conditions remotely. What can you do? Right, we've got Attend Anywhere, accuRx, myCOPD, all of these other things that we've tried out before on national programmes. Suddenly, [health systems] are listening and looking at getting them in and you're having more nitty-gritty conversations about where the IT infrastructure might not be right." — **(FG3)**

A **sense of permission to make decisions** within the system was felt by AHSNs, as has been reflected in much of the evidence around shifts within NHS organisations. Leadership was empowering people to make decisions and putting people in positions that matched their skills to make those decisions. There were fewer committees to get decisions through and therefore **implementation was quicker and easier**. Decisions were also sped up by the **'give it a go' attitude**, with systems being less likely to query evidence from a different setting.

"We're trying something, there isn't the evidence base, and the lack of evidence base is sometimes causing us a bit of a problem but it feels like it's the right thing to do and I think what's happened with COVID-19 is, organisations are more willing to accept and try things that are different." — **(FG1)**

In the same way, the more permissive system, in which **a shared purpose** and sense of urgency for solutions was evident, also appeared to be **more open to experimentation**.

"I think the pandemic, if nothing else, has created that sort of urgency within the system and a bit more risk-taking and less risk-aversion, which I think as long as

we're rigorous and diligent with governance, is great." — **(FG2)**

Another important factor in enabling rapid change was a **top-down mandate**, which may seem to work against the notion of permissiveness within the system but which did allow for decisions to be made to speed up change where previously there had been local barriers.

"But the fact that the mandate is very clear, that you have got to move your appointments and triage into digital responses, has really given way to the shift." — **(FG2)**

These positive shifts which saw an opening up of the system, and AHSNs responding reactively to this change in terms of being able to support and implement rapidly are clearly a context of the pandemic. However, the ways in which the AHSNs responded, which we will see more of in the next section, but which included building on previously built relationships, offering support, being available to offer solutions and to problem-solve have brought to light behaviours and approaches which are of value going forward.

In terms of negative contextual features, some AHSNs experienced **blockages around competing priorities** within a system overloaded with the crisis as well as with national level information and guidance. Particularly in the early stages of COVID-19, it was difficult to see how to help. However, most felt that over time, and with positive engagement, the **role of AHSNs became clearer and more valuable to the system.**

"My sense from our [AHSN] is that lots of the projects that we've started during COVID-19 have come from the system. I feel like you used to spend a lot of time trying to convince people to do stuff and now they come to the AHSN, in a way that perhaps they didn't before." — **(FG2)**

Case study #1:
Adapt and connect for rapid spread of existing national programmes

Whilst COVID-19 saw the rapid spread of new ideas and approaches, the AHSN Network also focused on the adaptation of approaches to accelerate the spread of existing national programmes – most notably, RESTORE2™. The value of this system for monitoring deterioration in care homes was recognized during COVID-19, and AHSNs across the country worked with local systems to undertake rapid spread of the approach.

The existing barriers to working with care homes still existed, however AHSNs found that by building on existing contacts, working with willing and existing networks, and linking clearly to local priorities through the new cell structure, adaptation and spread was possible.

AHSNs reported the importance of being very clear on the offer, given the opportunity for care home staff to discuss and share their concerns and linking them up with clinical advice and support. National guidance helped, however there was a need to make this relevant and useful.

Clear communication was key, as was the use of virtual training and bespoke discussion sessions. The network talked of the importance of maintaining patient focus and above all, being agile and flexible. They worked regionally in some cases, joining with other AHSNs and mobilizing staff in a way that reflected their skillsets and experience.

"Communication is obviously vital, and relationships are really important, particularly when you're trying to implement something quickly. You need to identify the right resource. Don't ignore the culture and the local politics because they're really important. Align your incentives." — **(FG1)**

AHSNs' experience of spread activity during COVID-19

When considering the experiences of different AHSN staff at project level, as noted above, there were clearly different types of activities undertaken to respond to the new context of the pandemic. In particular, three types of AHSN spread activity were apparent: **adapting and connecting, rapid roll-out and accelerating existing opportunities**. These are described in the case studies highlighted in this report. Furthermore, several key mechanisms were identified which contributed to generating creative speed of spread.

As with spread and adoption during non-pandemic times, **relationships have been key to ensuring spread during the COVID-19 pandemic**, with a particular emphasis on building on established relationships to identify need and offer support. These relationships also enabled AHSNs to quickly **understand the new organisational structures and decision-making groups**, which became central to enabling action, identifying new gatekeepers and understanding the context. **Understanding need** became central to the work being done. Finding new ways of engaging, using **virtual communication**, enabled rapid communication and helped with decision-making.

"One of the great things was that we already had quite a lot of established relationships with our CCGs, and GP practices in many cases. That was a great complement to the regional team and meant that we were able to get conversations going with our GP practices very, very quickly, to say, 'Look, we're here to help you onboard these online consultation tools and video consultations and we're your sounding board." — **(FG3)**

Another important area of relationships to build on was those with innovators, with AHSNs reporting that having **easy access to a range of innovators allowed them to provide a rapid range of solutions to meet need.**

Existing relationships also meant that once programmes or innovations were identified as being particularly important or useful in the face of COVID-19, AHSNs could **identify early adopters** from whom to gather stories and information about what had worked well and how. This then helped with spread amongst other organisations or partners.

"I think, importantly, we utilised our existing contacts and started to work with the willing because we needed to turn this around quickly. We already had a network that we worked with on a regular basis, so we used that network." — **(FG1)**

Case study #2:

Rapid roll-out of national priorities

Although the use of digital and video consultation across primary care was in the pipeline, COVID-19 resulted in the need for uptake to happen more swiftly than some may have wanted.

The AHSN Network worked closely with NHSX, NHS England and NHS Improvement to help this to happen, in many cases working regionally across AHSNs. First steps were to understand what was needed and what the situation was on the ground, with uptake of digital consultation approaches being very mixed across primary care networks (PCNs). Local stories from early digital adopter champions proved extremely important in helping spread, with such champions outlining how they had made it work for them and what their experiences had been. Sharing learning across PCNs through webinars and virtual discussion groups was helpful.

At the same time, AHSNs were aware of the need to bolster the evidence base, and work started on the development of quality improvement tools and capabilities as well as more in-depth evaluations. As well as the practical approaches to spread, the teams reported how an emphasis on benefit to patients and staff really helped.

"Thinking about not just roll-out but getting what works best for those in question is really important. We all worked together, and we were all in it with the same aim, which was the best experience for the patient. Understanding the benefits of these tools and being able to articulate those really well is so key." — **(FG2)**

These relationships also evolved alongside the new structures and needs of the system, with many **AHSNs being asked to work alongside and within local and national bodies** such as NHSX, and NHS England and NHS Improvement, as well as local system cell structures. Being asked to be part of these structures opened up new ways of working very closely alongside stakeholders, allowing for contributions to decision-making about potential solutions.

"We've been asked to sit on a newly-formed planned care alliance, so as an AHSN, we are bringing value by feeding into exactly what solutions we have in each of those digital areas." — **(FG3)**

Very importantly, **AHSNs also talked of the value of working with neighbouring AHSNs**, working together to speed up impact and provide the support needed for national organisations.

In order to work within these new methods, AHSNs described the **need for agile methods of engagement.**

"We've been able to adapt our methodology, take an agile approach where needed, so not being too prescriptive about the approach that we take with the system and what will work for each of them to mobilise." — **(FG1)**

This **agility was also recognised in the ways in which AHSN workforce were used**, with staff sometimes being deployed to work directly within member organisations, **working with other AHSN staff and sometimes taking on more operational tasks than was usual,** as well as working outside job roles related to existing skill sets.

Case study #3:

Accelerating the opportunities to meet local need

COVID-19 saw a shift in the approach taken by many AHSNs, with a stronger emphasis on understanding the needs of local systems and how to serve those needs. In some cases, this resulted in approaches and innovations where spread has stalled, being rapidly taken up (in some cases nationally) as they were seen to be highly relevant to a new context.

"We literally just hit the black book, who can we call? Who can we literally pick up the phone to and say, 'Business as usual has paused, clearly you have different needs right now; what are they?" — **(FG1)**

One of the key elements here was an acceleration in decision-making, with AHSNs noting how decisions could be made extremely quickly in the new system and previously insurmountable barriers could be overcome. There was also a sense that things just had to happen, and that decisions could be made to try things out without them being perfect. New national guidance and push from national organisations occurred, as did the shared purpose of people whose priorities shifted and aligned. There was also the need to adapt existing ideas to fit the new circumstances. What was important was ensuring that the new approach was not just temporary, but that suitable strategic and operational consideration was given to ensure sustainability.

This agility also fit with the way in which the system was operating, meaning that AHSNs felt the need to work quickly and in a way that allowed for rapid testing, using **quality improvement methodologies** where known and appropriate, and sometimes with **an attitude of 'give it a go'.**

"We agreed as a group that we would stand the service up nationally. Now, that was really scary but sometimes you just have to take control of a situation. I just had to make a decision that said, you know what? Blow it! It won't be perfect but let's go with it." — **(FG2)**

This way of working was recognised as being important at the time to enable rapid acceleration of adoption.

However, the AHSNs also reported that they felt the **need to continue to collect and use evidence** about outcomes, both to ensure safety, as well as to ensure sustainable change. Putting in place evidence collecting measures at the start **helped to reassure commissioners** that the approach would be validated.

"As AHSNs, it's really important that when something has happened really quickly, we make sure that we're doing what we can with the system to extract learning at every possible moment, then helping the system to optimise the changes that have been made sustainably afterwards - some of which will be good and some of which won't be." — **(FG1)**

Rapid adaptation and creativity was also needed to adapt existing innovations and approaches to meet the needs experienced during COVID-19, with one AHSN carrying out a 78-hour hackathon to develop an existing innovation to meet shifting need. AHSN staff were prepared to be flexible and put this effort in, with many reporting the impetus of a shared aim within the system and the need to always consider working towards patient benefit.

"What was at the front of our mind was; how will this help and support the carers who were asking to use it, because I believe often when we put digital innovation in people's hands, we forget the very people that we're asking to use it." — **(FG1)**

Possible implications for AHSNs

Whilst recognising that the learnings in this report will have different implications for different AHSNs, there are some key areas of response which have been particularly valuable and which will be of relevance going forward, as AHSNs continue to support their local systems in response to COVID-19.

1. There has been increased flexibility in how AHSNs have reacted to the needs of their local systems, and this could be built upon. Rapid and timely gathering of understanding about systems, stakeholders and need, coupled with a good understanding of solutions, allowed the response during the crisis period of the pandemic to be relevant and useful.

2. Relationships were reported as critical to successful spread both pre- and during COVID-19. AHSNs could consider what makes these relationships successful and continue to invest the time and effort needed to create solid networks with stakeholders.

3. COVID-19 has encouraged AHSNs and health systems to engage with digital communication methods and these have been highly successful in terms of increasing engagement and efficiency. AHSNs could review their practices in relation to system engagement to consider novel solutions, but recognise that face-to-face communication may still be required to build new relationships.

4. COVID-19 has presented opportunities for AHSNs to work more closely with regional and national organisations such as NHSX and local NHS regional teams. Working within regional cells set up to respond to COVID-19 has enabled closer connection between AHSNs and cross-system partners. These relationships could be capitalised on.

5. The need to work flexibly to meet changing health system needs has seen AHSNs shifting the ways in which workforce are structured. Going forward, AHSNs should organise staffing resources to maintain flex-teams that work to strengths rather than job roles and can respond reactively to system requests for support.

6. AHSNs have played an important role in facilitating conversations across systems that have been more open to sharing and learning from each other from March to June 2020. The value of this could be recognised and built upon in AHSN work going forward.

7. Consideration could be made as to how to collect evidence about not only the outcomes of rapidly implemented change, but the mechanisms that enabled those changes to be put in place so rapidly and what this means for sustainability. There is value both in terms of understanding the safety of new approaches and also in helping systems to adopt change sustainably.

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