Accelerated Access Collaborative Board Meeting: **Public Minutes**

4 March 2020 3-5pm

Room 136B 1st Floor, Skipton House, 80 London Road
London SE1 6LH

Chair:

Professor Lord Darzi of Denham OM KBE PC FRS (Director of the Institute of Global Health Innovation, Imperial College London)

Attendees:

Haseeb Ahmad (President, Association of the British Pharmaceutical Industry)

Tamsin Berry (Director, Office for Life Sciences)

Aisling Burnand MBE (Chief Executive Officer, Association of Medical Research Charities)

Sir Andrew Dillon (Chief Executive Officer, NICE)

Richard Hames (Executive Board Member, British In Vitro Diagnostics Association)

Professor Gillian Leng (Deputy Chief Executive and Director for Health and Social Care NICE)

Hugh McCaughey (National Director of Improvement, NHS England & NHS Improvement)

Ruth McKernan (Chair, BioIndustry Association Board)

Hilary Newiss (Chair, National Voices)

June Raine (Interim Chief Executive, MHRA)

Piers Ricketts (Chair, Academic Health Science Network)

Dr Sam Roberts (Chief Executive Officer, Accelerated Access Collaborative and Director of Innovation, NHS England & NHS Improvement)

Sir Simon Stevens (Chief Executive Officer, NHS England & NHS Improvement)

John Stewart (National Director of Specialised Commissioning, NHS England & NHS Improvement)

Dr Louise Wood (Director: Science, Research & Evidence, Department of Health and Social Care)

Other attendees:

Richard Booth (Policy and Strategy Senior Manager, Accelerated Access Collaborative, NHS England & NHS Improvement)

Anna Dijkstra (Deputy Director, Accelerated Access Collaborative, NHS England & NHS Improvement)

Julia Dudley (Deputy Director, NHS Innovation, Office for Life Sciences) Will Field (Head of Access Policy and Implementation, NHS Innovation, Office for Life Sciences) Emma Hutchison (Manager, Accelerated Access Collaborative, NHS England & NHS Improvement) Fay McCracken (Associate Director, NICE) Kristen McLeod (Director, Office for Life Sciences)
Apologies: Matthew Gould (Chief Executive, NHSX) Neil Mesher (Board Member, Association of British Healthcare Industries ABHI) Chris Whitty (Chief Medical Officer, DHSC)

Summary of actions

#	Action	Owner	Due Date
1	Interested AAC organisations and Public Health England to explore what can be done to support near patient testing and therapeutics for COVID-19.	AAC board members and delivery team	March 20
2	AAC scorecard information on adoption of AAC supported innovations to be presented to Royal Colleges and professional leadership groups to build further support for these products.	AAC Delivery team	Update at next Board meeting
3	AAC teams working with providers on adoption strategy to meet with those working in regional improvement hubs to ensure alignment.	Hugh McCaughey and AAC Delivery Team	Next Board meeting

Note: These minutes are a summary record of the main points discussed at the meeting and the decisions made. They are not intended to provide a verbatim record of the Board's discussion.

1 Welcome and introductions

1.1 Lord Darzi welcomed board members to the meeting and noted that it is Andrew Dillon's last meeting. He welcomed Gillian Leng as an observer who will now represent NICE at the Board until Andrew's replacement is appointed.

2 Review of minutes and actions from the previous meeting

2.1 The Board agreed the content of the previous minutes.

2.2 Sam Roberts provided an update on meeting with the devolved nations. The team have spoken with Scotland, Wales and Northern Ireland administrations and work is progressing to agree areas of alignment with a number of meetings taking place shortly.

2.3 John Stewart gave an update on roll-out and staging of histopathology independent genomic testing. There are three stages to meet the priorities for patients:

- First phase is for identifying patients with very rare tumours and NTRK mutations, which affects approximately one hundred patients.
- Then the next roll-out is for patients where standard therapies have not been successful, and they are fit for further treatment. This is expected to lead to 30,000 tests.
- Finally, there is a cohort of approximately 100,000 patients where we aim to identify the mutations and treat earlier in the pathway.

3 Programme Update

3.1 Sam Roberts informed board members that the AAC's work programme is progressing well and on track to deliver 90% of its work commitments in year one:

1) The specification for the build of the Innovation Portal has been agreed and the AAC team are working with partners including the AHSNs and NICE;
2) Demand Signalling is in its analytical phase for the first tranche of topics;
3) Horizon Scanning work for early stage products is ongoing and the infrastructure is not just focused on medicines;
4) The AI Award closed today [4th March], and the next stage will deliver testing of AI technologies starting in October;
5) Stronger adoption and spread has been achieved across the AAC supported products which we will see in the AAC scorecard; and
6) We will discuss later the spending review as part of the work to deliver on an agreed funding strategy.

3.2 The two main risks for AAC are:

- Communications – This has improved with the team launching the new website, hosting the first innovator surgery and scheduling a number of Webex meetings. However, there is still limited capacity which may compromise our ability to report on commitments.
- Recruitment – There continue to be delays in recruitment, and roles are being advertised internally and externally. We have agreed to use existing resources to cover urgent/high impact responsibilities, but some other areas of work may be delayed by up to three months, such as the new rapid uptake products.

3.3 Andrew Dillon flagged that NICE is moving forward with work to increase the number and speed of appraisals, but to achieve this aim they need the cooperation and support of industry and all system partners. A critical issue is increasing the number of appraisals that have only one committee meeting. For this to happen, stakeholders need to work with NICE on the process and on improving technical engagement. There also needs to be close collaboration with the NHS England and NHS Improvement commercial team, and NICE need to ensure there is appropriate staffing and efficient use of resources to deliver the increased volume and speed required.

3.4 Simon Stevens highlighted that there are four areas of priority categories for the Covid-19 response:

1) Digital therapies to reduce face-to-face encounters
2) Near patient testing
3) Therapeutics
4) Vaccines

3.5 Simon asked the Board to consider how partners may be able to help accelerate technologies for Covid-19 to help reduce the burden, particularly in relation to near patient testing and therapeutics. This was welcomed by the board with numerous offers to help and details on how partners were already supporting the response to Covid-19.

Action: AAC Delivery Team and interested Board members

3.6 Sam Roberts gave a live demonstration of the AAC dashboard which is an interactive web-based platform designed to monitor and report the impact of the AAC. It includes a range of measures that can be substantially and directly affected by AAC programmes. A soft launch of the dashboard will be taking place on 5 March and the dashboard will be available to Board members, on NHS Futures, at the end of March.

3.7 Sam showed the current quarter 3 access data for the RUPs and other products. Hilary Newiss congratulated the team on the progress and asked about plans to ensure this adoption became a sustainable change. Sam spoke about the work of the AHSNs to address this specific area and about the policy options being explored to ensure adoption became business as usual. For example, for PCSK9 inhibitors we are putting in place relevant QOF indicators, and for Heartflow and placental growth factor-based testing this is being included in the standard contract as per the funding mandate. Additionally, the AAC will also follow the first cohort of RUPs for two years to monitor their adoption.

3.8 Lord Darzi asked about professional leadership engagement and requested we go and show the Royal Colleges this data to show that these innovations aren't pilots but should be widely adopted.

Action: AAC Delivery Team

3.9 Sam outlined the team's previous engagement with the Royal Colleges and then described recent work from the team which have carried out deep dives at eight acute Trusts to find out why they are successful at adoption. The details were then presented back and discussed with Carrie MacEwen (Chair of the Academy of Medical Royal Colleges), ICS leads and NHS Trust Chief Executives to understand how to support adoption. The findings will be incorporated into a joint paper with CQC to help create an innovation measure for CQC to implement.

3.10 Piers Ricketts flagged that the adoption of medicines and medical devices requiring pathway transformations are different. Medicines are easier to adopt and then to change away from because the decision can be driven by a clinician, whereas the required pathway transformation and number of people required for adoption of medical technologies means they are harder to adopt, but then also harder to change away from them.

3.11 Hugh McCaughey said the Improvement directorate is also working on similar areas and is keen for the adoption strategy work to be aligned with work his team are carrying out with the Improvement Hubs.

Action: Hugh McCaughey and AAC Delivery Team

3.12 The Board congratulated the AAC Delivery Team on the positive achievements on adoption and all their collaborative work areas to date, especially now that we can demonstrate the impact of the AAC on innovators, patients, system savings and economic growth within the Dashboard.

4 Funding Mandate Update

4.1 Sam Roberts presented the paper. The Funding Mandate was one of the eight commitments of the AAC, it aims to address the imbalance of devices, diagnostics and digital products, relative to medicines, with regards to mandated availability based on NICE guidance. To ensure implementation is manageable in the first year (from April 2020) the policy proposed supporting a limited number of products that met the criteria. The products to be supported are:

- Placental Growth Factor-based testing (PlGF)
- SecurAcath
- Heartflow

4.2 After the first year we may want to consider the criteria and look for opportunities to be a little more ambitious in the number of products supported. Gillian Leng agreed with this approach as evaluation is key. Evaluation of the first year will be from a number of sources: national data sets for Heartflow, bespoke economic evaluation for PlGF and possibly a combination of both for SecurAcath.

4.3 The Board were happy with the approach taken and the proposed next steps.

5 Close

5.1 No other business was raised.