AAC (003)

ACCELERATED ACCESS COLLABORATIVE

THE AAC APPROACH TO ADDRESSING HEALTH INEQUALITIES

Executive summary:

- The disparities in health outcomes we have seen during, and as a consequence of, the Covid-19 pandemic has bought in to sharp focus the need to address health inequalities including within our research and innovation work.
- The CORE20Plus5 model set out by NHSE to address health inequalities aligns closely with the grand healthcare challenges set out in the Government's Life Sciences Vision and represents a clear opportunity for AAC partners to work together.
- This paper sets out some proposed changes to AAC programmes to better address the ambition set out in the CORE20Plus5 work.
- The paper also sets out the huge amount of activity already ongoing amongst AAC partners to reduce opportunities under a number of key themes and offers the opportunity to discuss whether there is more we could do collaboratively across AAC partners.

Board members are asked:

- Do board members agree with the expectations and principles outlined in the paper?
- Do members agree with proposals for where could we go further, better align, or work collaboratively, using the AAC to best achieve this?
- Are there areas that have not been considered?

Background:

1. COVID-19 has shone a light on the need to address health inequalities in our health system. We have seen disproportionate deaths from COVID-19 amongst those living in the most deprived areas, and by ethnicity; People of Bangladeshi ethnicity have around twice the risk of death than people of White British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Black Caribbean and Other Black ethnicity had between 10 and 50 per cent higher risk of death when compared to White British people[1].
2. The impact on NHS capacity caused by the pandemic has also had an exacerbating effect on wider pre-existing disparities in multiple disease areas. On average waiting lists have increased by more than half (55.2 per cent) in the most deprived areas, compared to a third (36 per cent) in the least deprived areas, and a national average of 42 per cent[2].
3. In response, the NHS has committed to its Core20PLUS5[3] approach to support the reduction of health inequalities at both national and system level. The approach defines

[1] NHS public board paper on Health Inequalities, June 2021

[2] Kings Fund from NHS data

[3] https://www.england.nhs.uk/about/equality/equality-hub/core20plus5

a target population cohort – the most deprived 20% of the national population, plus other groups experiencing poor health access – and identifies '5' focus clinical areas requiring accelerated improvement including maternity services, severe mental illness, chronic respiratory disease, early cancer diagnosis and finding hypertension to reduce cardiovascular disease (CVD) and stroke.

4. The 2021/22 NHS England (NHSE) operational planning guidance also set out 5 key areas of immediate focus for systems in tackling health inequalities – specifically the need to 1. Restore NHS services inclusively, 2. Mitigate against digital exclusion, 3. Ensure datasets (specifically the collection and recording of ethnicity data) are complete and timely, 4. Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes, and 5. Strengthen leadership and accountability.
5. These strategic priorities and the 5 key clinical areas set out in the Core20PLUS5 approach closely align with the 7 grand healthcare challenges set out in the Government's Life Sciences Vision, with NHS ambitions for recovery, and with the approach to addressing health inequalities in innovation and research set out in this paper. They represent a shared purpose and clear focus for NHS, industry, and charity collaboration through the AAC over the coming period
6. COVID-19 showed us how working together on a defined mission provides a shared focus and urgent need to work with innovators and research communities to develop solution that solve our biggest issues. The rollout of the vaccine has been a great example, not just the development of the vaccines in record time but in ensuring rapid, at scale, and equal adoption. Through working with local community and faith leaders, the NHS was able to increase the rate of COVID-19 vaccination uptake amongst more hesitant groups (e.g. from 38% in January 2021 to 70% in May 2021 for people from a Black African ethnic background). The use of real time national data tools aligned with other approaches such as using places of worship and pop-up centres, sharing best practice in community engagement, and culturally competent communications enabled us to target and therefore successfully reach populations who had not previously come forward for vaccination.

We have a real opportunity to systematically address health inequalities through our existing work programmes and we should start now by:

7. **Working with Academic Health Science Networks (AHSNs) to support Integrated Care Systems (ICS) to identify evidence-based solutions for each of the Core20Plus5 clinical areas and best practice ways in which systems can implement these by:**

    a. Refocusing and reframing the AHSN national innovation programmes which support spread to align with this approach. This includes our work on Rapid Uptake Products (RUP), where we have made the decision to pause the previous so we can support innovations that better align with Core20PLUS5 and the Life Sciences Vision. We will work with AHSNs and ICS's to:
        i. Undertake local engagement to understand local pathways for Core20PLUS5 areas and to provide support on the evidence based medicines, medical devices, diagnostics and digital products available to address these;
        ii. Understand and prepare for the next generation or innovations coming through; and
        iii. Identify research and evaluation gaps and feed this into the relevant prioritisation processes so that we can better identify how we can answer the questions of tomorrow

2. **Developing our national capacity and capability to support systems by:**

a. Bolstering our national demand signalling and horizon scanning capability and resource. Developing the relevant research questions so that we can get the answers for our future health inequality needs and signal to industry where we cannot identify any available solutions to meet our needs. Identifying the key innovations in the pipeline and linking these to national transformational deals, embedding clinical decision making in commercial processes, and ensuring we continue to focus our programmes on these areas through NHS Insights Prioritisation Programme (NIPP).
b. Strengthening the link between AHSCs and AHSNs and national commercial deals through the innovation pipeline and embedding health inequalities considerations across all processes.
c. Supporting a stronger link between NHS needs and the work of NIHR, MHRA and NICE using health inequalities as a focus.
d. Working with NHSE strategy unit to ensure our knowledge of the pipeline is baked into a 5-year forward view that helps systems plan and target development longer term.
e. Refocussing our product development funding streams to support health inequalities – providing dedicated challenge funding in areas of health inequality focus. SBRI will shortly be running a new £15m open call for early cancer diagnostics and future calls throughout 22/23 will be focussed on other key health inequality areas or seek products explicitly through a Core20PLUS5 lens.
f. Work closely with the NIHR, DHSC, the research community and the Centre for Data Collaboration, to increase diversity in trial participants as we focus on increasing pace, and scale of research (as we have supported in the Galleri trial) so we can generate the evidence we will need to solve our key health challenges in a way that most closely reflects our whole population's health needs (including those who may not have the agency to readily advocate for themselves), our health system and infrastructure
g. Commissioning our programmes with a data architecture that ensures we are recording who we are helping, so we can proactively surface any inequalities and consistently re-focus on programmes to address health inequalities where these occur. This includes leveraging the role of the NHS as anchor institution in tackling health inequalities by reviewing where investment is placed in different local systems from Life Sciences sector and the NHS so we can ensure more consistent economic investment in disadvantaged communities through all our nationally supported programmes[4]

3. **Developing our national capacity and capability to support the NHS workforce by:**
   a. Embedding the importance, and methods, of working with diverse communities in our innovation education programmes including clinical entrepreneurs programme (CEP) and National Innovation Accelerator (NIA). This includes supporting innovators to use the Health Inequalities Improvement Matrix and equality impact assessments in their initial development phase to understand how best to target their products and include this in design (i.e. ensuring we design digital products for diverse populations and then adapt to affluent communities, rather than the other way round) and embedding health inequalities in the selection process for innovators to support with these schemes

Initial conversations with AAC partners have shown an incredible appetite for addressing health inequalities and for working together

8. We asked all AAC partners to tell us about ongoing work to tackle health inequalities in their organisations. The response showed that there is a huge amount already being

[4] This links to the Levelling Up Plan Mission

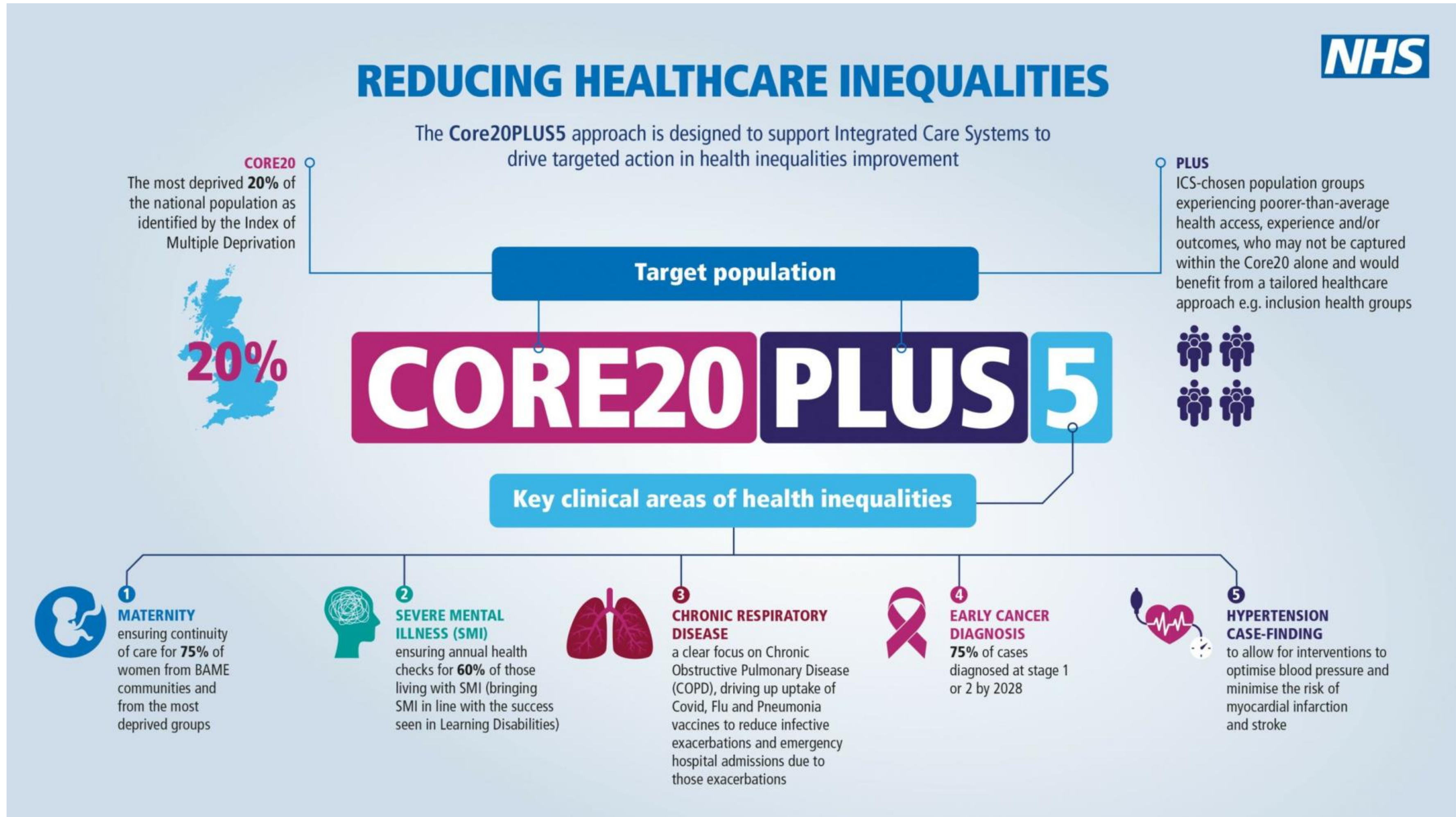
done and an encouraging consistency in the actions that partners are taking to address health inequalities, but there may be opportunities to better co-ordinate or align our work in order to maximise its impact.

9. We have set out eight thematic areas as cross cutting strands for AAC partner action going forward. A full list of actions being undertaken by the AAC partners and in wider programmes in NHS E/I. in each theme is set out in annex B, and includes some suggestions on the additional contribution the AAC can bring by enabling collaboration, and/or identifying where we might seek to go further. The themes are:
    i. AAC Partners will act as system wide advocates for the centrality of tackling health inequalities through innovation and research, agreeing a shared approach as the AAC, and articulating its importance as a thread amongst all that we do.
    ii. AAC will support a co-ordinated focus on areas where we can have the biggest impact on addressing health inequalities initially focussing on the priorities set out in the NHS Core20PLUS5 approach – particularly the specific 5 disease areas identified.
    iii. Ensure the impact of health inequalities is explicitly considered in the assessment and funding requirements of our programmes.
    iv. Provide staff within our organisations with tools to understand and tackle HI in day to day work – and utilise the AAC as a forum to share best practice with other partners.
    v. Enable the involvement of those with lived experience in our innovation and research work and ensuring diverse participants in our programmes.
    vi. Ensure all programmes have plan to collect and analyse data on HI, within the bounds of what is currently possible, and working with national and local data teams to improve the collection of health inequalities data for innovation over time.
    vii. Explore how we can best use national levers, knowledge, and capacity to support local systems to address health inequalities in innovation and research programmes.
    viii. To enable the AAC as forum to regularly update, track, and share best practice in each of these areas.

Board members are asked to:

- Discuss and support the approach, ambition and themes outlined in the paper
- Identify any areas that have not been considered
- Identify any areas for further collaboration

Annex 1: The Core20PLUS5 approach



Annex B: Summary of activity by AAC partners against thematic areas of work

Thematic area	Actions	Where we could go further
AAC Partners will act as system wide advocates for the centrality of tackling health inequalities through innovation and research, agreeing a shared approach as the AAC, and articulating its importance as a thread amongst all that we do.	○ DHSC have established the Office for Health Improvement and Disparities (OHID) and announced that there will be Health Disparities White Paper later this year. They have indicated they are keen to include potential for innovation and research with this and will be engaging with AAC as work on white paper develops. ○ NHSE have announced a new focus on Health inequalities including the publication of its 5 strategic priorities for tackling health inequalities and the Core20PLUS5 approach to help local systems identify areas where biggest difference can be made. ○ NICE are developing a vision of its approach to health inequalities and will be communicating to staff and stakeholders. ○ The Care Quality Commission (CQC) have reviewed and published their five year strategy which includes a renewed focus on tackling health inequalities. ○ In addition to the core work of AHSNs in delivering programmes of work which support/focus upon tackling inequalities, AHSNs continue to support ICSs to develop their own responses and strategic plans to address health inequalities and ensure alignment to Core20PLUS5, demonstrating the role of innovation in this. ○ Tackling health inequalities and ensuring alignment to Core20PLUS5 is increasingly becoming core to everything the AHSNs do and the work they do to support local systems, see below for further examples of this e.g. outcomes framework, equality impact framework, diversity group and pledges. ○ NIHR published Best Research for Best Health – the next chapter- which clarified the principles which guide their work. There is a renewed focus on HI, with confirmation of action to address inequalities in the type of research they fund and the importance of addressing imbalances and inequalities associated with socio economic status.	Developing a shared action plan on areas of joint work, and publicly set this out - potentially as part of, or alongside, the white paper on health disparities. Develop a shared charter or consensus statement that all partners can sign up to setting out a joint approach to tackling health inequalities in health innovation and research. A commitment to collaboration on shared communications plans around HI bringing together a stronger joint government, NHS, industry and charity message on key issues and announcements.

Thematic area	Actions	Where we could go further
	○ ABHI's Board of Directors is driving a heightened focus on Equality, Diversity, and Inclusion amongst its members to ensure the sector is truly representative of the patient populations it serves. ○ AMRC have been convening its members to discuss their shared priorities around health inequalities. They are scoping and mapping the related activity across our charities.	
AAC will support a co-ordinated focus on areas where we can have the biggest impact on addressing health inequalities initially focussing on the priorities set out in the NHS Core20PLUS5 approach – particularly the specific 5 disease areas identified.	○ The AAC's innovation programmes are being re-orientated to focus on the 5 key clinical areas set out in the Core20PLUS5 document including launching NHS funded challenges in the SBRI programme for each of the Core20PLUS5 areas along with a specific call around broader products that can support HI, delivering specific demand signalling and horizon scans in each of the 5 areas, and prioritising Core20PLUS5 in our adoption support programmes at a national level. ○ OLS and the NHS are developing "missions" in several areas that align with Core20PLUS5 areas including early cancer diagnosis, mental health, and obesity. Dedicated funding has been provided by government through the SR and will support joint industry NHS work to develop innovative solutions from basic research through to NHS adoption. ○ NICE have collated guidance and quality standards against each of the clinical priorities and are sharing practical tools and guidance in each of these areas with the NHS. ○ AMRC are planning to bring together different disease area charities to identify shared opportunities and barriers where it might be useful to work together ○ AHSNs are working with ICS systems to develop local AHSN programmes focused on addressing specific HI issues and delivering national programmes with a focus on Core20PLUS areas. ○ AHSNs are also delivering national programmes with a focus on Core20PLUS areas (e.g. NIPP programme). As part of this, equality impact assessments are being used to inform planning around ongoing	There is the potential to reach a shared understanding of the unmet needs in research and innovation in each of the priority areas. The AAC is expanding its demand signalling and horizon scanning capability and there will be an increased focus on these clinical areas. The outputs from this demand signalling and horizon scanning can be developed and disseminated in partnership with AAC partners to establish a shared understanding of where our programmes should be focussing. We also then need to continue to develop our programmes to ensure they are fit for purpose in promoting research in priorities areas where it is lacking and accelerating the adoption and spread of the technologies identified and developed following signals of need. The board is considering a paper on the

Thematic area	Actions	Where we could go further
	community engagement work which targets specific population groups aligned to Cire20PLUS5. ○ Where possible, AHSNs are also leveraging existing local and national programmes to maximise health equity gains and ensure alignment to Core20PLUS5. ○ NIHR are funding 15 Policy Research Units which each have tackling health inequality as a core part of their remits and a establishing policy research programme health inequalities initiative to fund research to identify actions that will address inequality (beyond simply describing it).	MedTech pipeline that will be central to this.
Ensure the impact of HI is explicitly considered in the assessment and funding requirements of our programmes.	○ All AAC programmes include an assessment of the impact on health inequalities, with a EHIA undertaken for each. ○ All partners are feeding into Professor Dame Margaret Whitehead's review into potential ethnic bias in the design and use of medical devices ○ NICE are developing a systematic process for consistent and transparent consideration of health inequalities in guidance production at all stages ○ NIHR are undertaking a series of evaluations of practical interventions led by the NIHR Public Health Research programme, put forward by Directors of Public Health, designed to reduce inequalities.	Bring relevant partners together to support alignment and share best practice on definitions, criteria, panel diversity and decision making, and how assessing impact on health inequality in our innovation and research funding programmes Agree how we can best share information about the assessment of HI impact of products coming out of programmes to support evaluation, adoption and spread work for those products. Promote and raise awareness of the role of industry across the Life Sciences Sector in tackling health inequalities
Provide staff within our organisations with tools to understand and tackle HI in day to day work	○ NICE are developing a set of definitions and conceptual framework for health inequalities and these will then translate into operational definitions and socialising these across the organisation	Doing more to share our approaches, tools, and training provision, developing a community of best practice in this space,

Thematic area	Actions	Where we could go further
– and utilise the AAC as a forum to share best practice with other partners.	○ The AAC team have developed a Health Inequalities toolkit setting out practical guidance and key principles all staff should address in establishing a programme of work including ○ AHSNs conduct equality impact assessments of national and local programmes and assess AHSN Network activity against an outcomes framework. This maximises the impact of our work, ensuring alignment to the health inequalities agenda and Core20PLUS5. ○ AHSNs support, guide, and advise the innovators they support to ensure their innovations are relevant to the Core20PLUS population and consider diversity and health inequalities. For example, supporting innovators to clearly articulate how their innovations can support the system to reduce health inequalities and result in specific health equity gains.	bringing together nominated leads to understand what good looks like. Share approaches with the wider system supporting systems and frontline staff to utilise innovation and research in work to tackle health inequalities and proactively communicate the value of this.
Enable the involvement of those with lived experience in our innovation and research work and ensuring diverse participants in our programmes.	○ The AAC team are developing toolkits to help those undertaking research and evaluation activities to adapt their approaches, enabling more effective engagement with named underserved communities that their research is intended to benefit, ○ NIHR are seeking to broaden recruitment into NIHR studies to improve equity of access to research opportunities for people across the country, including by providing a Research Targeting Tool which helps teams identify geographical areas with greatest prevalence of disease and plan their recruitment accordingly, to support the NIHR's focus on responding to predictable demographic and disease trends and some under-served areas, ○ Through the AHSN's are using local connections to work closely with seldom heard communities and community groups with lived experience to understand their needs.	Map our collective PPI to better enable true co-production in innovation pathways so that we can start from what already exists and build on PPI work already happening across the partnership. Share knowledge, both in terms of patient insights, but also in new ways of working, engagement methods, toolkits and resources and best practice guidance. Establish an involvement advisory group. Develop bespoke PPI activity, including co-production approaches for each of our work programmes.

Thematic area	Actions	Where we could go further
Ensure all programmes have plan to collect and analyse data on HI, within the bounds of what is currently possible, and working with national and local data teams to improve the collection of HI data for innovation over time.	○ NHSE have developed the Health Inequalities Improvement Dashboard are in the process of developing a health inequalities dashboard enabling local areas, and national teams, to understand health inequalities data for their areas. ○ The AAC team are looking to understand how we can begin to track HI data for all of our products receiving national support – and utilising tools to better target excluded communities in our adoption and uptake plans (as has been done for lipid management including inclisiran) ○ NICE are piloting approaches using real world data, and supporting cross ALB work to establish how to incorporate RWE into HI assessment ○ NIHR are evolving systems to support more complete representation of the population in research including: ▪ Monitoring the diversity of NIHR clinical research participants. ▪ A requirement for researchers to demonstrate how they consider the characteristics and circumstances of research participants. ▪ The NIHR INCLUDE initiative, which delivers a framework guide to funders, researchers, and delivery teams as they design and assess clinical research proposals. ▪ The Race and Equality Public Action Group (REPAG), which is working to understand and tackle barriers to participation and involvement in research. ○ AHSNs - As part of the Patient Safety Collaborative (PSC) commission, all PSCs are required to undertake a scoping exercise, triangulating data from several sources to better understand the ethnicity and demographics and social deprivation factors that are present across the system	We all need to do these things more consistently, and consistently across programmes. All partners commit to collecting HI data for their programmes where possible, sharing with partners both the outcome and learning from programmes, but also successful approaches to data collection. Support national attempts to improve data collection on HI and the collation and analysis of that data to support the adoption of innovation

Thematic area	Actions	Where we could go further
Explore how we can best use national levers, knowledge, and capacity to support local systems to address HI in innovation and research programmes.	○ ABHI are working with the national network of Academic Health Science Networks to identify exemplar areas where industry can help address the structural determinants of health ○ AHSNs working directly with ICSs to develop local AHSN programmes on specific HI issues, national programmes on Core20PLUS communities ○ NIHR are working through the 15 Applied Research Collaborations with local communities to tackle local health and care priorities and reduce health inequalities. ○ NIHR are working with Local Authorities to create Health Determinants Research Collaborations enabling LAs to work with academics to undertake research and evaluation to address health inequalities. The NIHR School for Public Health Research (SPHR), which works to increase the evidence base for cost-effective public health practice and supports local public health practitioners and policymakers to engage with research, includes a dedicated health inequalities research programme.	Ensure health inequalities is consistently and explicitly embedded in all system resources on research and innovation, including guidance, implementation tools, training and materials for local systems Align any direct support being provided by a regional and locally based teams, including understanding how industry can provide best support to local system in targeting and deploying innovations so as to mitigate HI.
To enable the AAC as forum to regularly update, track, and share best practice in each of these areas.	○ Sharing of current activities to feed into this paper on AAC partner activities	All partners to work with AAC HI lead to produce an annual report outlining the impact AAC partners work have had on health inequalities within innovation and research and setting priorities for the following year. Establish a dedicated AAC partner HI leads group, to provide joint oversight of areas of collaboration and to ensure continuing alignment on the areas set out in this paper. We propose that this would be headed up and resourced by the AAC delivery team in IRLS.