Accelerated Access Collaborative

ACCELERATED ACCESS COLLABORATIVE (AAC) BOARD

Meeting date: 22 March 2023

Paper Title: **NHS as an innovation partner:** Supporting an innovative access system and mobilising the NHS life sciences ecosystem.

Agenda item: 3

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Paper type: Discussion and Approval

AAC Priority Area:

Research	☐	Building innovation capacity	☒
Demand signalling and horizon scanning	☒	Innovator support	☒
Uptake of proven innovation	☒	Cross-cutting (Health Inequalities, Net Zero, Life Sciences Vision)	☐
Other (statutory, governance)	☐		

Ask of the AAC Board:

The Board is asked to:

- Note the progress on delivering the improvements to the access system discussed at the AAC board in November, and the planned next steps.
- Discuss and comment on the planned piece of work to mobilise the UK's health research and innovation ecosystem behind the NHS and Governments key clinical priority areas.

Executive summary:

This paper builds on the discussion at the November AAC board of how to realise the potential of a coordinated access system between NHSE, NICE and the MHRA, and a focus on a set of key clinical priorities. It updates on progress on delivery of the actions set out in that paper and planned next steps.

It goes further and sets out a proposal for a piece of work to help align the work of the NHS innovation ecosystem, to best support the research, development, and implementation of innovative technologies identified through this approach.

Background

1. In November, the AAC board discussed the unique global offer the UK could provide through a co-ordinated approach between the regulator, HTA body and the NHS as single purchaser health system to accelerate the development and deployment of technologies, if focussed on a set of priority areas which aligned the priorities of the NHS, government, and the life sciences industry.

2. Good progress has been made against the actions set out in that paper and we are beginning to deliver in several key areas.

3. However, we are aware that this good progress is set within the context of a challenging picture more broadly for the NHS and life sciences sector. Ongoing pressures for the NHS stemming from recovery, the resulting limits on capacity for the system to engage in research and innovation, and broader inflationary pressures are impacting on life sciences activity. In particular, clinical trials recruitment has become an increasing challenge, as has innovation adoption in some areas (although counteracted by massive innovation in areas of recovery including use of digital tools and virtual wards). We recognise that an improved access system relies on thriving research and adoption systems to perform.

4. This paper, updates on the progress made so far to deliver on the actions agreed at the meeting in November, and sets out an approach for mobilising the wider NHS life sciences ecosystem as an innovation partner to academia, industry, and the government. In doing so, we recognise the need to align the proposals set out here with the outcome of the VPAS negotiations, but the contents of which are out of scope for this paper. We also recognise that this remains a very crowded environment with multiple initiatives and organisations, and any proposed actions will need by prioritised, phased, and have clarity on who is responsible for leading the change.

Update on progress

5. The previous board paper (available here) set out three phases of work:
    a. **Step 1: a set of actions to improve the programmes being delivered by AAC partners** in the respective stages of the pathway including the development of the MHRA's innovation passport, increasing the use of proportionate approach to appraisals by NICE, and a move by NHSE to earlier engagement and implementation planning for new innovations.
    b. **Step 2: improve ways of working between NICE, MHRA and NHSE** including data and information sharing and co-ordinated demand signalling and horizon scanning.
    c. **Step 3: Focus the above on clear priorities** – agreed to be early cancer diagnosis, neurodegeneration, mental health, and cardiovascular disease.

6. On step 1:
    a. NICE has already delivered an increasing number of reviews of medtech and digital products – publishing Early Value Assessments (EVA) and eight conditional recommendations for digital mental health products.
    b. NHSE has:
        i. Completed a review of the pathway for medicines archetypes and have agreed a set of recommendations and shared steps with partners. Emerging findings from this work are presented at Annex A.

ii. Finalised the pathway mapping for medtech products (*see separate papers AAC006a and AAC006b HealthTech Innovation Pathway Mapping*) and is considering how we can support the implementation of the wider work developed in the government's medtech strategy (*which is subject to consideration and further discussion at Item 4 on the agenda*).
iii. Furthered work across NHSE on roles and responsibilities towards implementation planning. This will build on the best practice approach currently taken by specialised commissioning (for medicines and high-cost device) to initiate implementation planning on a 2–3-year horizon. Expanding to cover all forms of technologies, bringing in all partners from across NHSE (and at regional and local level), and focussing on the clinical areas agreed at the last meeting.
iv. Initiated the review of our funding and award programmes. To be completed by end June 23.

7. We are now beginning work on the priorities in **step 2** including more detailed work on data sharing, developing a support offer around real-world evidence generation for products in the EVA process, agreed detailed scoping for the first co-ordinated horizon scanning and demand signalling work around neurodegeneration.

8. **On step 3**: We are focussing all of this in the key clinical areas as agreed by the board – early cancer diagnosis, Mental Health (with a focus on digital products), neurodegeneration, and cardiovascular disease. We have set up (or are in the process of establishing) cross NHSE clinical director led groups to understand and anticipate early-stage products to help direct this work.

Mobilising the wider ecosystem

9. Developing a co-ordinated access system is only half of the story – to realise the benefits of this access approach, we need to align the work of the NHS innovation ecosystem – our NHS research infrastructure, patients and patient groups, providers, ICSs and regions, and supporting infrastructure such as the AHSNs, to best support the research, development, and implementation of new technologies identified through this approach.

10. Amanda Pritchard has asked Roland Sinker, Chief Executive of Cambridge University Hospitals, and the Chair of the Shelford Group, to work with Matt Whitty and the team in NHSE to engage broadly with AAC and wider local partners to drive this forward.

11. For research, it will look at how best to mobilise patient involvement mechanisms and the NHS research infrastructure behind these areas – and will commence in response to the recommendations from the O'Shaughnessy review (*which is subject to consideration and further discussion at Item 5 on the agenda*).

12. Initially, therefore, it will focus on how best to mobilise real world evidence generation and adoption across the NHS, doing this through 2 lenses:

    a. **At a local and regional level** - How do we mobilise key research, clinical and operational networks to support pipeline development, to identify and mobilise key centres to support real world evaluation, and learn from programmes, such as those run by Shelford Group and the CEP InSites programme, about adopting innovation across multiple sites more efficiently and effectively. Finally, it will explore how we can best bring local decision makers and users of innovation into national prioritisation, planning and decision making.

    b. **At a national level:** How do we set up the national operating model to support this local innovation ecosystem:
        i. how can NHS decision making on innovation be best aligned – across NHSE and between national, regional, and local decision makers.
        ii. How do we best use NHS accountability, leadership, and governance to support, not inhibit, transformation,
        iii. how do we use data to understand adoption of innovation and support patient, clinician and system decision making
        iv. How should we adjust our national support and award programmes to best support activity in the system

13. The two pieces of work will proceed in parallel informing each other; and will be co-led by NHSE and other partners as we finalise the scope and workstreams. The review will focus on delivering immediate agreed actions, and developing longer term recommendations, in both of these areas in time for the life sciences council meeting in May 23. It will do this through:

    a. A national engagement exercise – a broad (yet rapid) engagement phase with national and local partners – where we would welcome the ability to engage with AAC partners and their networks.

    b. A focus on limited number of c.10 localities in first instance (to be identified) – focussing on key integrated clusters of life sciences activity and leading ICS where a focus on the priority areas can have significant impact. We would then look to expand learnings to other localities over time.

    c. Mapping of activity within these localities to understand drivers of innovation and adoption – building on work already undertaken as part of wider life sciences work.

    d. Agreeing immediate areas for action: To generate momentum, we would ask partners to help identify immediate areas for action building on those set out in the reviews of the medtech and medicines pathways, recently published broader strategies including the life sciences vision and the medtech strategy and learning from AAC activity over the last few years.

14. The work will be led by Matt Whitty and Roland Sinker with support from the IRLS policy team within NHSE but will require active participation from across the AAC partners. A time bound core working group is being established to deliver the project, with steering being provided through the AAC governance with oversight from the board itself and individual recommendations and programmes being discussed at the relevant priority co-ordination groups. We will share more details on this once established.

Board members are asked to:

15. Note the progress on delivering the improvements to the access system, and the planned next step.

16. Discuss and comment on the planned piece of work to mobilise the UK's health research and innovation ecosystem behind these clinical priority areas.

Annex

Annex A – Medicines archetypes work – emerging findings

Emerging findings

Clinical

- Critical role of **clinical leadership** and professional bodies in raising awareness of new treatment options within the clinical community
- Demand for **greater adoption support and guidance to clinicians** published in parallel with NICE guidance (clinical pathways, education materials)
- Improved **communications networks** to place information in hands of clinicians

Governance

- Perceived **unwarranted variation and duplication of processes**, decision making and service design at local level (e.g. 42 ICS, over 120 formularies)
- Improve **transparency of decision-making** and reduce regional inequity of access and variation in adoption
- Collaboration of national bodies to **identify high impact innovations earlier** and work with system leaders to ensure preparation and readiness ahead of NICE guidance

Data & finance

- **Demand for improved data** to understand uptake of new medicines
- Explore importance of **targeted financial enablers** that support the adoption of high impact innovations, balanced against the need to prioritise 'asks' of systems
- **Early modelling and planning** to understand operational and financial impacts

Policy

- Many functions with a role in medicines adoption with a desire for greater **alignment and coordination** of resources and direction
- Clearer definition on **priorities, roles and responsibilities** of the various functions
- Importance of a **shared vision** to improve patient outcomes by reducing inequalities of access to innovative medicines