ACCELERATED ACCESS COLLABORATIVE (AAC) BOARD

Meeting date: 29 November 2023

Paper Title: Lessons learnt from national innovation adoption and spread

Agenda item: 5

Report author(s): Vin Diwakar, National Director of Transformation, NHS England

Paper type: For discussion

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:

- Note the common themes from lessons learnt and evaluations of a 'basket' of AAC programmes.

- Consider the implications of these for existing programme and, more importantly, future areas where the collective power of AAC partners could be deployed to support the adoption and spread of innovation.

Executive summary:

The AAC, and constituent partners, have delivered several major programmes that sought to accelerate the adoption of innovations, often on a national scale. These often sought to exploit economies of scale and ensure that the widest clinically appropriate population had access to novel treatments and models of care as possible.

This paper presents an aggregation of themes associated with lessons learnt from across AAC programmes that have sought to promote adoption and spread of innovative products. This represents a rapid analysis as opposed to full evaluation of any single programme, with the aim of identifying commonalities. Identified themes should be taken into consideration when specifying any new programmes or considering refinements to existing work packages.

Background

1. The Accelerated Access Collaborative (AAC) has an agreed objective to "support the uptake of proven medicines, medical devices, diagnostics and digital products." To do this the AAC Board has considered the obstacles to innovation adoption and the routes to overcome these barriers for a range of products across a number of programmes. But our approach needs to be informed by the learnings from ongoing and legacy programmes. The intention of this paper is to capture learnings from work completed as part of the AAC's

remit. It does not cover broader reflections on innovation adoption taken from broader partner experience. Much of this is being captured in the work of the Innovation Ecosystem Programme, covered in agenda Item 4.

Considerations

2. The AAC, and constituent partners, have delivered several major programmes that sought to accelerate the adoption of innovations, often on a national scale. These often sought to exploit economies of scale and ensure that the widest clinically appropriate population had access to novel treatments and models of care as possible.

3. Examples of major national programmes in the recent past include: the Rapid Uptake Products (RUPs) programme, the roll-out of inclisiran and lipid management pathways, the Galleri® GRAIL trial, and the MedTech Funding Mandate (MTFM).

4. In March 2022 a paper was discussed at the AAC Board that confirmed a change in approach from supporting individual products in favour of pathway interventions. This aligned with a focus on innovation to address health inequalities. Note that individual products or categories may still be subject to adoption and spread support where there is a population health benefit, or when place in the context of transforming a broader pathway.

5. AAC programmes have metrics and evaluation designed and planned at their outset. This enables tracking of impact. This data is included in the Chief Executive reports that the AAC Board receives. In turn, these also allow for the identification of areas where lessons can be learnt.

Recommendation

6. Lessons learnt exercises, formal and informal evaluations have been carried out for programmes delivered by the AAC and partners. These have informed refinements to existing programmes (i.e. the different iterations for RUPs or MTFM), as well as newer and ongoing programmes (i.e. Innovation to address Health Inequalities Programme (InHIP)).

7. There are several themes that emerge from the aggregation of lessons learnt across programmes (including the Early-Stage Programme). Note that some or all apply to different programmes:

    a. **Clinical leadership and clinical networks are essential** - Perhaps the most consistent factor in success or failure of a programme has been the presence of clinical leadership. A strong clinical champion has been associated with the success of many programmes, providing authority and credibility on the subject matter and ‘speaking the right language’ to the clinical community. The success of the Galleri® GRAIL trial was associated with strong clinical leadership from the relevant National Clinical Director from the outset. Conversely, it was clear that there would be only limited clinical support for some products proposed for RUPs support, severely

impairing the effectiveness of adoption support. This clinical leadership needs broad support – working with national clinical networks, professional bodies, and trade unions – including regional and local networks consistent with the principle of subsidiarity. This requires early and broad engagement with a particular focus on a shared agreement on the evidence base (or the evidence base required to support adoption into a pathway).

To support this, NHS England is:

i. Undertaking greater and earlier engagement with clinical policy teams to direct focus and providing support to clinical teams to undertake demand signalling in key areas.
ii. Placing adoption programmes within broader pathways that align with clinical programmes – e.g. the lipid lowering pathway.
iii. Reviewing and making changes to senior clinical leadership posts in NHS to ensure they reflect innovation and research priorities.

b. **Ensure capacity for pathway redesign - guidance and toolkits:** Generally, the implementation of innovative treatments and approaches will require clinical pathways to be redesigned or refreshed. This requires:

i. capacity and resource to redesign and evidence new pathways;
ii. clinical leadership and networks to support systems at all levels to transform pathways;
iii. co-production with users by experience;
iv. a structured approach to large scale system change;
v. clear guidance and toolkits to support the move to new pathway;
vi. incentives and levers and a systematic approach to minimising disincentives;
vii. access to evaluation, data and analytics to create real world evidence;

This is also critical to ensuring that adoption moves from initial support into business as usual. In some instances, for example with roll out of inclisiran, the focus was on building new tools and the product specific guidance rather than placing the transformation within existing broader clinical pathway transformation work around lipid lowering. Ultimately this approach impacted on the speed and depth of adoption.

Responding to this learning, NHS England is:

viii. Seeking to base programmes around whole pathway transformation rather than on individual products, with a planned approach to determining “what needs to be true” to transition to routine practice.
ix. Using access pathways, such as Innovative Licensing and Access Pathway (ILAP) and Innovative Devices Access Pathway (IDAP) as they mature, to enable early implementation planning and to understand implications for implementation or guidance production.

c. **Careful about the intended and unintended consequence of funding and incentives**: It is important that there are the right payment and financial

incentives built into any deployment. Our programmes have shown that central funding has been more effective at driving change but not sustaining it. Earlier AAC programmes like the Innovation and Technology Payment (ITP) showed that central purchasing drove uptake, but this was not sustained once central funding was removed – particularly for products where there is a competitive market of products. Instead MTFM has utilised short term pathway transformation funding and clear guidance to the system to support availability of innovative products without central procurement, but this approach has struggled where transformation funding is not available. Implementing an indicator in the Quality Outcomes Framework (QOF) for inclisiran was associated with an increase in uptake. But hard levers such as MTFM or QOF have justifiably high levels of evidence required to be introduced. Linked to funding is the need to consider appropriate procurement and commercial mechanisms. This is the subject of a separate agenda item.

Responding to this learning, NHS England is:

i. Developing frameworks in MedTech and digital health to have a more consistent approach to who pays for what and when – a rules-based pathway.
ii. Move away from incentivising individual products and develop a commercial approach informed by horizon scanning and market intelligence.

d. **The role of national versus local:** Historically programmes sought to pursue a national approach to adoption and spread (for example, RUPs, AI Award, MTFM). This was to ensure the widest population benefits from innovation, especially in rare condition areas. The reality of commissioning in England is more complex, with 42 Integrated Care Systems (ICSs), with different local priorities, decision-making processes and risk appetites. Local systems have different requirements ahead of adopting innovative products. This may include different evidence thresholds, and these may vary by setting (i.e. primary or secondary care). There may also be different incentive and reimbursement approaches required for different settings. Health Innovation Networks (HINs) are also well placed to adapt national aims to more local approaches, and collectively have successfully delivered ‘National Programmes’ using locally adapted approaches. Programmes that have supported national aims but allowed for local variation, such as InHIP and the current Health Tech Acceleration and Adoption Fund (HTAAF), seek to take this blended approach.

Responding to this learning:

i. Develop and strengthen national approaches to evidence development, data and analytics, curation, and standardisation, especially in light of the national commissioning of specialist services.
ii. Programmes should ensure activity happens ‘at the right level’; National outcomes, strategy, guidance and tools should de designed to support local flexibility and autonomy in adoption.

e. **Definitions of the stage of adoption vary:** We do not currently have a fully shared understanding of stages of innovation, the implications for support/action required at each stage, or how this differs across technologies. This lack of consistency can cause differing expectations from stakeholders on what can realistically be achieved. For example, although inclisiran had a well-developed clinical evidence base, and had received positive NICE guidance, its rollout in a primary care setting was novel, in a way that would not have been the case in a secondary or specialised setting. Conversely, because it was focussed on specialised treatments, the Early-Stage Products Programme which supported the adoption of Advanced Therapeutic Medicinal Products (ATMPs) and Histology Independent Treatment (HITs), was being supported by teams with knowledge, experience and capacity to adopt complex interventions and therefore the additional support we could provide was limited. A better framework is required which sets out which products require what support and at which stage, particularly in emerging fields such as digital health or innovative MedTech.

   Responding to this learning:

   i. Work is ongoing under the remit of the MedTech strategy in DHSC to develop a common innovation taxonomy to define stages of MedTech innovation and the specialised commissioning team in NHSE are leading a piece of work to establish a "rules-based pathway" for medicines.
   ii. The Digital Health team is developing policy and guidance on how digital products should be defined.
   iii. Through use of the NHS Innovation Service there is an opportunity to create consistent 'stages' of innovations across AAC partners. This would align with the steps identified in the HealthTech innovation pathway mapping project, presented to the AAC Board in March 2023.

Next steps

8. The areas identified above as lessons learnt represent an aggregation of themes from across AAC programmes that have sought to promote adoption and spread of innovative products. This represents a rapid analysis as opposed to full evaluation of any single programme, with the aim of identifying commonalities.

9. These themes should be taken into consideration when specifying any new programmes or considering refinements to existing work packages. They should also be considered alongside the findings of Workstream 1 in the Innovation Ecosystem Programme (IEP, a separate agenda item).

Board members are asked to:

1. Note the common themes from lessons learnt and evaluations of a ‘basket’ of AAC programmes.

2. Consider the implications of these for existing programme and, more importantly, future areas where the collective power of AAC partners could be deployed to support the adoption and spread of innovation.