

ACCELERATED ACCESS COLLABORATIVE (AAC) BOARD

Meeting date: 20 March 2024

Paper Title: Health Tech Adoption and Acceleration Fund (HTAAF) Lessons Learned

Agenda item: 4

Report author(s): Vin Diwakar, National Director for Transformation (interim), Transformation Directorate, NHS England
Lily Tang, Deputy Director, MedTech Innovation Team, IRLSS

Paper type: For discussion

AAC Priority Area:

Research	<input type="checkbox"/>	Building innovation capacity	<input type="checkbox"/>
Demand signalling and horizon scanning	<input type="checkbox"/>	Innovator support	<input type="checkbox"/>
Uptake of proven innovation	<input checked="" type="checkbox"/>	Cross-cutting (Health Inequalities,	<input type="checkbox"/>
Other (statutory, governance)	<input type="checkbox"/>	Net Zero, Life Sciences Vision)	

Ask of the AAC Board:

- Note the lessons learned from the Health Tech Adoption and Acceleration Fund (HTAAF) programme to date.
- Discuss additional ways the lessons learned could be applied to a similar programme.

Executive summary:

In August 2023 NHS England was asked by the Department of Health and Social Care (DHSC) to deliver a £30m Health Tech Adoption and Acceleration Fund (HTAAF) through Integrated Care Systems (ICSs), by 31st March 2024. The aim of the programme was to expedite the adoption of technologies that would map to local priorities.

ICSs were invited to submit applications to implement technologies covering the following categories: virtual wards, at home management, elective recovery, clinical productivity, self-management, early cancer diagnosis and others.

This paper provides a summary of the lessons learned from delivery of the HTAAF programme which will enable the Innovation, Research and Life Sciences (IRLS) team to better deliver similar funds in the future.

Background

1. In August 2023 the then Secretary of State for Health and Social Care asked NHS England (NHSE) and the Department of Health and Social Care (DHSC) to award a non-recurrent revenue fund of up to £30m (the Health Tech Adoption and Acceleration Fund (HTAAF)) to Integrated Care Systems (ICSs)

to expedite the adoption of technologies which map to local priorities. See Annex 1 for an overview of the timeline.

2. ICSs were invited to submit applications up to £700K to implement technologies covering the following categories:
 - Virtual wards
 - Elective recovery
 - At home management – diagnostics and treatment
 - Clinical productivity
 - Self-management
 - Early cancer diagnosis
 - Other
3. All 42 ICSs submitted applications, some for multiple projects. All applications met a essential criteria which were developed with DHSC and local systems:
 - Addresses a national priority
 - Accelerates the adoption of technologies that address a local unmet need
 - Has tangible benefits for patients and/or improves staff productivity
 - Recurrent funding from April 2024 will be met by the ICS
4. Some of the technologies identified in the applications met the following desirable criteria:
 - NICE recommended
 - Late-stage so it can be easily incorporated into pathways to facilitate adoption at pace
 - Cost-saving
 - Digital Technology Assessment Criteria (DTAC) compliant where appropriate
 - Reduction in health inequalities and contribution to our net zero ambitions
5. Applications were initially screened, and then reviewed by a senior programme panel, which included:
 - Verena Stocker, IRLSS Interim Director and Senior Reporting Officer for HTAAF
 - Erika Denton, NHSE Transformation Directorate Interim Medical Director
 - David Lawson, DHSC Director of MedTech
6. All ICSs received a funding allocation of up to £700k. The funds requested were allocated for the following technology categories:
 - Virtual Wards/Clinics £10m e.g. Brave AI and Docobo.
 - Elective Recovery £6m e.g. Digital consent, waitlist management tools and tools to support recovery.
 - At home management – diagnostics and treatment £4.5m e.g. MinuteKidney.

- Clinical productivity, £3.8m e.g. Better Platform, Omnicell and Patienteer.
 - Self-management, £3m e.g. GetUBetter.
 - Early cancer diagnosis, £600k e.g. EndoSign Sponge test.
 - Other, £400k Genedrive.
7. The fund's initial aim was to help relieve winter pressures. However, systems did not receive their share of the funding until December. This means they had limited time to plan to maximise the use of the funding. Funds were transferred to ICBs on the 5 December. The focus for the remainder of this financial year is to support the system in spending the fund by 31 March 2024.
 8. Work is underway to develop work with the ICBs to evaluate the overall impact of HTAAF, but with minimal reporting burden on the sector. See Annex 2 for detailed metrics by technology category that have been explored in engagement meetings with the sector and can be extracted from data already collected.

Lessons Learned

9. As part of the evaluation of HTAAF, NHSE, DHSC and the Commissioning Supporting Unit (CSU) teams held a lessons learned session on 27 February 2024. This included discussions covering the successes and challenges of the development, application process and evaluation of HTAAF, drawing together perspectives from across organisations and distilling key recommendations for the potential development and execution of any similar future programme. The distilled learning is presented in the tables below (see Table 1, 2 and 3).
10. Delivering the HTAAF programme has also highlighted and reinforced positives with good engagement established early on and productive working relationships across key partner organisations in particular NHSE, DHSC, ICSs, Regional Medical Directors (RMD), Regional Director of Digital Transformation (RDDTs) and the Health Innovation organisations to deliver the programme at pace.
11. The ability to quickly operationalise and deliver a fund, including the seamless transfer of finances to ICS within challenging timelines was a success. The learning from this programme and the relationships we built, better position the system to deliver similar funds in the future.

Table 1: Lessons learned – Programme development

Issue	Impact	Improvements and lessons	Lesson owner
(a) Complying with Digital Innovation Spend Committee (DISC) and Her Majesty's Treasury (HMT) conditions was challenging	An 'in year' fund meant that the sector had to have business cases on hand for projects they could implement within 6 months. Challenging local procurement processes meant that some projects had to be changed.	Encourage greater collaboration between HIN and local systems by sharing examples of how this happened for HTAAF to enable the system to be more agile to respond to ministerial announcements.	DHSC/NHSE
(b) More could have been done to ensure ICS projects align with national priorities e.g. Early Value Assessments (EVAs)	Due to the timelines, an opportunity to engage ICSs in exploration of new potentially efficacious technologies was missed; pre-existing plans or familiar technologies were prioritised to deliver in time.	Discuss the alignment of EVAs to national and local priorities with NICE. NICE and NHSE engage with ICSs and socialise EVA supported technologies. Provide a communication forum on Future NHS so ICSs can see exemplar use cases.	NHSE/NICE
(c) Clinical/service level engagement was challenging in the timescales.	ICSs did not always have time to identify clinical champions for projects. Clinical buy in and leadership facilitates more efficient implementation. Clinicians that didn't have close ICB relationships missed the application deadline.	IRLS and DHSC should continue to build on relationships made with national and local clinical leaders through HTAAF to encourage healthcare systems to prepare for future funding opportunities.	DHSC/NHSE
(d) Funding was divided equally between all 42 ICBs to simplify the application process.	HTAAF allocations are unrepresentative of ICS population size, demographics, deprivation level, digital maturity, or capacity to utilise funding.	Future funding programmes should test the optimal level at which the allocation is made to account for system maturity. Then also consider a different division of available funding, to better account for differing population needs.	NHSE

Issue	Impact	Improvements and lessons	Lesson owner
(e) ICSs were unable to incorporate HTAAF funding into their financial planning processes.	Greater ability to plan could have facilitated more effective utilisation of funds, and better communication of fund utilisation in applications.	Early engagement with systems will enable NHSE national and regional teams, and the HIN more time to support systems before they apply. ICSs should have a minimum 2-4 weeks to complete their applications.	DHSC/HMT
(f) The programme did not nationally commission the HIN or CSUs to help with applications, implementation, or evaluation.	The HIN were happy to be involved outside of the NHSE commission, and some were included in applications as project managers, and evaluation partners. Other potential organisations (e.g. universities) can also support ICSs as experts in implementation and evaluation.	Demonstrate the benefit of involving HINS and other partners in ICS bids	NHSE/DHSC
(g) The programme started with a call to industry but was delivered via an ICS-led approach.	All teams involved, including DHSC, NHSE, ICSs, ICBs and HINs, experienced strong lobbying from industry to be included in applications.	Clearer communication on programme design to both the system and industry. How do we strike the correct balance the involvement of industry?	NHSE/DHSC
(h) Multiple projects per application were permitted and received	ICSs did not have a limit on the number of projects they could submit for the £700K therefore, making the review process resource intensive, and potentially diluting the impact of the fund.	For future programmes, we should consider limiting the number of projects per ICS to an agreed maximum. Consider tightening application 'guardrails' to specific programmes with estimated impact e.g. EVA products.	NHSE/DHSC
(i) Due to challenging timescales, retrospective, rather than proactive due diligence on technologies in applications.	Due diligence on digital technologies carried out retrospectively via ICSs contacting the NHSE Transformation, Strategy, and Enterprise Architecture (TSEA) team could mean that technology is at risk.	Collaboration between ICS and the TSEA team would enable more time for due diligence for digital technologies. Ensure sector understand the role of the NHSE TSEA team. Ensure TSEA representation on application review panel	NHSE

Table 2: Lessons learned – Application process

Issue	Impact	Improvements and lessons	Lesson owner
(j) Timescales meant that 42 applications had to be rapidly screened, most containing up to 10 projects. It was essential to ensure HTAAF did not duplicate other NHSE/DHSC financial support.	The application review process was burdensome, with timescales which did not allow for clarification requests, and did not utilise learning from previous AAC fund programmes (e.g. InHIPP). Patient and Public Involvement and Net Zero consideration were not comprehensively appraised.	Design a more transparent and robust initial review and panel review process with appropriate timescales. Automating the extraction of application data could accelerate application screening, reduce burden on teams and give panels more time to review content. Consider more functional application submission routes e.g. The Innovation Service	NHSE

Table 3: Lessons learned – Programme evaluation

Issue	Impact	Improvements and lessons	Lesson owner
(k) Although local evaluation was a condition of funding, programme evaluation was not planned until certainty of delivery.	ICSs were unclear of national reporting expectations. Ability to generate generalisable evaluation findings was missed.	Incorporate programme evaluation into programme design from the outset. Ensure applications require detailed evaluation plans. Provide more central support for ICSs during the application process.	DHSC / NHSE
(l) Communities of practice or for sharing learning between ICSs are only developing slowly.	Peer learning groups for sharing implementation lessons and prior experience have been slow to develop	Establish peer learning and support expectations from the outset as conditions of funding	NHSE

Next steps

Developing a more agile response to funding opportunities

12. Over 120 projects were rolled out with HTAAF funding and the fund was well received by systems. However feedback on timelines has been a recurring theme. NHSE engagement has been key to successfully generating initial support with the RMDs, RDTs, RDDTs and the HINs for the fund. ICS and trust leaders supported applicants.
13. To meet the conditions of the fund, projects that were 'in train' were encouraged. This has surfaced an increasing need for the system to be prepared for future funding opportunities, by having high quality business cases readily prepared. This is something NHSE can continue to encourage and support, through our interactions with regional and local teams and the HIN.
14. The burden of the application process was also a strong theme. NHSE operationalised this fund at significant pace, by working across teams that have experience in building the processes and tools required. NHSE should continue to strengthen, automate, and streamline processes so future programmes can be executed in a more streamlined way.
15. Engagement will continue between IRLSS, DHSC and the ICSs to evaluate the impact of this fund. HTAAF funded technology implementations promise useful learning which can be leveraged locally, regionally, and nationally, to further transform NHS services and strengthen national support for innovative MedTech.

Board members are asked to:

1. Note the lessons learned from the Health Tech Adoption and Acceleration Fund (HTAAF) programme to date.
2. Discuss additional ways the lessons learned could be applied to a similar programme.

Annex 1 – Health Tech Adoption and Acceleration Fund (HTAAF) Timeline

Date (2023)	Action
Between Mid August and 4th October	Produce a business case for HMT Design the tech categories Hold engagement sessions Design the application forms Press release for HTAAF launch inviting applications into a dedicated inbox with a three-week application window
4 th October	NHSE programme team email RMDs the assessment criteria and process packs
4 th to 27 th October	RMDs, NHSE programme team support ICSs through application process
27th October	Deadline for applications
27 th October to 2nd November	Applications are reviewed, with sign-off going through Verena Stocker (NHSE SRO), David Lawson (DHSC MedTech Director) and Erika Denton (Interim National Medical Director for Transformation)
6 th to 13 th November	Secretary of State for Health and Social Care submission for approval
W/c 13 th November	Regions and ICSs notified by letter of application results
13 th November	NHSE to provide DHSC Investment Appraisal with a complete list of successful ICS bids outlining which Trusts have implemented which priority technology following the issue of application outcomes (DISC condition)
By 15 th November	NHSE put written agreement in place with NHS finance for the transfer of funds. NHSE complete internal processes for payment to ICSs
By 17th November	DHSC confirms reimbursement of all panel approved applications and technology use cases, a total of up to £30m to NHSE , following HTAAF panel agreement of successful applications and technology use cases.
W/c 4th December	Funding is transferred by NHSE to successful ICSs
November – March 2024	Ongoing governance and data sharing between NHSE and ICSs to track progress against available KPIs. For 1st December: NHSE to provide an update to DHSC Investment Appraisal on progression of the DISC funding approval conditions (DISC condition) For 15th December 2023 and 15th March 2024: DHSC to update HMT on the: Funding administered and expected outturn; Selected technologies; ICS' partaking; Numbers of technologies forecasted and actually rolled out (HMT condition)

Annex 2 – Detailed metrics by technology category Timeline

Technology category	Metric
Virtual Wards	Change in no. of GP appointments or home visits
	Change in no. of A&E attendances
	Change in admissions/ readmissions
	Change in length of stay for inpatients
	Change in no. of bed days
	Cost savings / return on investment
At home management - diagnostics and treatment	Change in no. of admissions or readmissions
	Change in length of stay for inpatients
	Change in no. of bed days
	Change in no. of hospital referrals
	Change in average waiting time
	Change in medicines spend
	Change in medications wastage
	Cost savings / return on investment
Elective recovery	Change in no. of delayed and cancelled surgeries / procedures
	Change in no. of did not attend (DNA) appointments
	Change in waiting list length
	Change in patient throughput (Increased or decreased number of patients seen / treated / operated on)
	Change length of stay for inpatients
	Cost savings / return on investment
Clinical productivity	Change in medication wastage
	Change in medication errors
	Change in patient throughput (Increased or decreased number of patients seen / treated / operated on)
	Change in patient waiting times
	Change in no. of admissions or readmissions
Self-management	Change in no. of GP appointments or home visits
	Change in no. of A&E attendances
	Change in no. of bed days
	Change in patient throughput (Increased or decreased number of patients seen / treated / operated on)
	Change in no. of admissions or readmissions
Early cancer diagnosis	Change in cancer diagnosis rate
	Change in accuracy of cancer detection
	Change in waiting list for cancer diagnostics
Other	Change in ambulance journey times
	Change in no. of delayed and cancelled surgeries / procedures