Medicines & Healthcare products Regulatory Agency

AGENDA FOR BOARD MEETING HELD IN PUBLIC

10:00 – 12:00 on 16th March 2021

Chair: Stephen Lightfoot

	AGENDA ITEM	PURPOSE	PRESENTER
10:00	INTRODUCTION 1. What are the priorities for this meeting and how will the meeting run?	Information	Chair
	2. Are there any Apologies or Declarations of Interest?	Information	All
	3. What were the minutes and actions from the last meeting?	Approval	Chair
10:10	CURRENT CONTEXT 4. What are the current key issues from the CEO's point of view?	Discussion	June Raine
10:30	HEALTHCARE ACCESS 5. How is the agency going to build on its scientific expertise and laboratory research to help achieve the vision of protecting and improving patient health?	Approval	Christian Schneider & David Webb
10:50	6. What has been the impact of EU Transition on regulatory approvals and the work of the agency in the first two months after leaving the EMA network?	Discussion	Sam Atkinson
11:05	PATIENT SAFETY 7. What are the proposed outcomes from the new Patient and Public Involvement Strategy and how are they going to be achieved?	Approval	Mercy Jeyasingham & Rachel Bosworth
11:25	DYNAMIC ORGANISATION 8. What are the key requirements in the new Unitary Board Conflicts of Interest Policy?	Approval	Chair
11:35	EXTERNAL PERSPECTIVE 9. What questions do members of the public have for the MHRA Board?	Discussion	Chair
12:00	CLOSE OF MEETING	-	Chair

Medicines and Healthcare products Regulatory Agency

Minutes of the Board Meeting Held in Public of 16th February 2021

(10:00 – 12:30)

By Zoom Webinar

Present:

The Board

Stephen Lightfoot	Chair
Professor David Webb CBE	Deputy Chair
Dr June Raine CBE	Chief Executive
Dr Samantha Atkinson	Interim Chief Quality and Access Officer
Dr Barbara Bannister MBE	Non-Executive Director
Amanda Calvert	Non-Executive Director
Anne-Toni Rodgers	Non-Executive Director
Professor Bruce Campbell	Non-Executive Director
Jon Fundrey	Chief Operating Officer
Mercy Jeyasingham MBE	Non-Executive Director
John Quinn	Interim Chief Technology Officer
Dr Christian Schneider	Interim Chief Science Officer
Professor Liam Smeeth	Non-Executive Director
Michael Whitehouse OBE	Non-Executive Director

Others in attendance

Rachel Bosworth	Director of Communications
[redacted]	Secretary to the Board and Head of Directorate Executive Assistant to the Chair

Government Legal Department (GLD)

Fleur Ruda	Deputy Director, MHRA, Medicines & Pharmacy, GLD

Department of Health and Social Care (DHSC)

Ronan McDonald	Head of Medicine Regulation, DHSC

Devolved Administrations

Kerry Chalmers	Medical Devices and Legislation Head of Unit, Scottish Government
Professor Alison Strath	Interim Chief Pharmaceutical Officer, Scottish Government
Cathy Harrison	Chief Pharmaceutical Officer, Department of Health Northern Ireland

Item 1: Introduction

What are the priorities for this meeting and how will the meeting run?

1.1 The Chair set out his expectations and priorities for this public Board meeting which was being live streamed to the registered audience and recorded.

1.2 The Chair welcomed all to the meeting, including a broad range of observers representing a broad range of patient groups, other health bodies and staff.

1.3 The Chair and the Board congratulated Professor Liam Smeeth on his appointment as Director of the London School of Hygiene and Tropical Medicine, however noted that due to this new appointment unfortunately Professor Smeeth has asked to step down from the Board due to the pressures on his time and this will be the last meeting of the Board that he will be able to attend.

Item 2: Are there any Apologies or Declarations of Interest

2.1 There were no apologies this month.

2.2 Amanda Calvert made a declaration of interest. A client of Ms Calvert, who she works for on a consultancy basis, is considering using the ILAP process. The Chair noted the declaration.

2.3 Bruce Campbell made a declaration of interest. Professor Campbell has been asked to advise a company on a product called an aerosol shield (which is not a medical device) which is designed to give protection to healthcare professionals treating patients. The Chair noted the declaration.

Item 3: What were the minutes and actions from the last meeting?

3.1 The Board reviewed the minutes and actions from the last meeting and updates were provided on the outstanding actions.

CURRENT CONTEXT

Item 4: What are the current issues from the CEO point of view?

4.1 Dr June Raine presented the Chief Executive's monthly report, which covered topics within the four strategic priorities: (i) healthcare access – including updates on Covid-19 vaccines, therapeutics, and tests, reagent panel for detecting SARS-CoV-2, an AI roundtable with NHS X, the Innovative Licensing and Access Pathway, and publications; (ii) patient safety – including updates on Covdi-19 vaccine safety, investigating Covid-19 risk factors and outcomes, the isotretinoin public consultation, the Medicines and Medical Devices Bill, an international workshop on medicines in pregnancy and breastfeeding, and a number of product safety issues; (iii) dynamic organisation – including updates on the international work of the Agency, and the Agency Change Programme; and (iv) financial sustainability – including an update on the Delivery Plan 2021/22.

4.2 Dr Raine in particular noted that the Agency has achieved a number of big milestones and there has been a lot of intensive work on access. Safety is a theme which runs through the whole of the Agency's work; a dynamic organisation with opportunities for the future will be delivered with the effort and commitment from all of the Agency's staff.

4.3 The Board thanked Dr Raine for her report and provided comments relating to the opportunities CPRD will provide and the vital role CPRD has been playing in relation to Covid-19 research; opportunities to expand the coverage of CPRD and utilising CPRD in trial recruitment; partnership working with the National Institute for Health and Care Excellence (NICE), the Scottish Medicines Consortium (SMC) and with colleagues in Wales and Northern Ireland; the proportion of reports to the Yellow Card Scheme from patients; clinical trials in paediatrics and pregnant women and how to address gaps in data; and ensuring continued supply of products to Northern Ireland.

4.4 The Board discussed issues of bioequivalence between different generic medicines and noted that patient reports are vital for highlighting any issues in this area. This work is vital as generic products are a critical part of the NHS provision of medicines.

HEALTHCARE ACCESS

Item 5: How does the Innovative Licensing and Access Pathway fit into the future regulatory offer of the Agency?

5.1The Board considered a paper describing how the Innovative Licensing and Access Pathway (ILAP) will fit into the future regulatory offer of the Agency. The Board noted that the ILAP fulfils the ambition for enhanced collaboration between stakeholders such as NICE, the SMC, and patients. ILAP also provides for alignment of data requirements where possible, and provides a platform for bespoke and timely advice to developers across the whole of the medicines regulatory pathway in support of earlier patient and market access.

5.2 The Board noted that one of the tools utilised by ILAP is clinical trial recruitment through CPRD; there are many opportunities CPRD could bring to this pathway. A vital component of ILAP is opportunities throughout the entire pathway for patients to input. The Board reviewed the proposed initial list of measures for monitoring progress with ILAP.

5.2 The Board noted the report and were pleased that 10 Innovation Passport applications have been received since the ILAP was launched 6 weeks ago, a very positive start. The Board provided comments relating to the work of the SMC and NICE; opportunities for patient engagement and involvement in ILAP which can be reviewed by the Patient Safety and Engagement Committee (PSEC); time and cost incentives for applicants to use the ILAP process; ensuring the process is sustainable and costs are covered; the definition used for an innovative product which includes unmet need as well as other categories; and success measures including time in to clinical use.

5.3 The Board noted the vital aspect of patient engagement in this work. Further comments covered ensuring conflicts of interest and confidentiality are managed; ensuring adequate training of staff involved in the process; and the importance of partnership working. The Board agreed two key actions.

Action 23: Review the operations, financial model, strategic outcomes and stakeholder feedback on ILAP.

Action 24: PSEC to review opportunities for patient engagement and involvement in ILAP

PATIENT SAFETY

Item 6: What assurance can be provided by the Patient Safety & Engagement Committee?

6.1 The Board considered a paper which provided an overview of the first Patient Safety and Engagement Committee (PSEC) meeting. The Board noted that discussion of the Patient and Public Engagement and Involvement Strategy raised a number of issues that need to be clarified and explored; an action was agreed to present this strategy to the Board at the next meeting. The PSEC is scheduling meetings every two months in advance of meetings of the Board, until the end of the calendar year, and has started to prioritise its work programme. Ensuring equity of access to the Yellow Card Scheme (YCS) across the entire patient population was discussed – the PSEC should review the opportunities to develop the YCS. The Board noted the vital work of the PSEC and was assured that the PSEC is taking this forward.

Action 25: Present the Patient and Public Engagement and Involvement Strategy to the Board.

Action 26: The PSEC to review the opportunities for developing the Yellow Card Scheme and ensuring equity of access across entire patient population.

DYNAMIC ORGANISATION

Item 7: What assurance can be provided by the Organisational Development & Remuneration Committee?

7.1 The Board considered a paper which provided an overview of the first Organisational Development and Remuneration Committee (ODRC) meeting. The Board noted that the ODRC reviewed the following topics: (i) the People Survey; (ii) talent; (iii) organisational development; (iv) people strategy; and (v) future topics for consideration. The ODRC reported that despite the challenges of the pandemic and the majority of staff working from home, the Agency's staff have remained focused, have taken pride in their work and delivered for patients.

7.2 The Board noted the assurance on the understanding of staff views from the People Survey, the plans for cross-agency communication and the focus on staff health and wellbeing, particularly in a year of significant organisational change. The Board agreed that staff wellbeing and the ability to attract and retain talent as part of a new and comprehensive People Strategy is vital. An action was taken for the ODRC to review Diversity and Inclusion to provide assurance to the Board.

Action 27: The ODRC to review Diversity and Inclusion to provide assurance to the Board.

FINANCIAL SUSTAINABILITY

Item 8: What is the current financial performance of the MHRA against its 2020/21 Business Plan?

8.1 The Board considered a summary of the current financial performance of the Agency based on the first nine months of the year. The Board noted that the Agency is currently forecasting a £7.5 million operational loss in this financial year.

It was noted that the Agency is expecting to receive £12.8 million transition funding from DHSC to partly offset the loss of income from the EU following EU Exit; and the cost of providing employer contributions for staff pensions has increased by £2.2 million this year. The Agency has cash reserves which it must utilise to fund investments in new technology and the future operating model. The Agency's cost base must be carefully reviewed and aligned to the demand in a post-transition world.

8.2 The Board expressed concern about the current financial performance of the Agency and noted that there may be a lag in reporting of change costs and technology costs. The Agency is undertaking rapid design work to transform the organisation and its technology infrastructure over the next two years.

Item 9: What assurance can be provided by the Audit & Risk Assurance Committee?

9.1 The Board considered a paper following a previous action for the Audit and Risk Assurance Committee (ARAC) to review the financial scenarios and risks around the Future Operating Model. The Board agreed with the ARAC that at present the Agency is not financially resilient and will not be financially sustainable in the long term unless the change programme is implemented. There is also a need for greater focus on benefit realisation risks and how this is reported to the Board.

9.2 The Board reviewed the other issues covered by the ARAC, in particular the framework which the Agency had put in place to ensure the successful implementation of the recommendations of the Independent Medicines and Medical Devices Safety Review by Baroness Cumberlege. The Board agreed that the ARAC should undertake a further review to provide assurance that actions have been taken on the Medical Devices internal audit report which only provided limited assurance.

Action 28: ARAC to confirm that actions have been taken on the limited assurance internal audit report on medical devices.

EXTERNAL PERSPECTIVE

Item 10: What questions do members of the public have for the MHRA Board?

10.1 The Board answered a range of questions from members of the public.

CLOSE OF MEETING

SUMMARY OF ACTIONS FROM MHRA BOARD MEETING – 16 February 2021

Action Number	Action	Owner	Date	Status
Carried Forward from previous meetings				
7	Provide an update to the Board on the Memorandum of Understanding with NICE	June Raine	~~23/11/20~~ 16/03/21	Chair & CEO Meeting in March
13	Conduct review of CPRD. Further action 19/01/21: Include how to expand data sources for CPRD's role in safety surveillance.	Jon Fundrey	~~16/03/21~~ 20/04/21	Delayed to April
15	Review Agency Fee structure to ensure closer alignment with costs of delivery	Jon Fundrey	15/06/21	
16	Produce a single 2-year Agency Delivery Plan to replace existing Corporate and Business Plans.	Jon Fundrey	20/04/21	
20	Present update on the Trade & Cooperation Agreement with the EU to the Board	Sam Atkinson	16/03/21	On Agenda
21	ARAC to review governance and risks of the new medical devices regulatory framework	ARAC	18/05/21	
22	Present an update to the Board on how the short, medium and long-term deliverables from IMMDSR are being measured over time.	June Raine	20/07/21	
New actions				
23	Review the operations, financial model, strategic outcomes and stakeholder feedback on ILAP	Sam Atkinson	18/05/21	
24	PSEC to review opportunities for patient engagement and involvement in ILAP	PSEC	20/04/21	
25	Present Patient and Public Involvement Strategy to Board	June Raine	16/03/21	On Agenda
26	PSEC to review the opportunities for developing the Yellow Card Scheme and ensuring an equity of access across entire patient population	PSEC	20/04/21	
27	ODRC to review Diversity and Inclusion to provide assurance to the Board	ODRC	20/04/21	
28	ARAC to confirm that actions have been taken on the limited assurance internal audit report on medical devices	ARAC	18/05/21	

Medicines & Healthcare products Regulatory Agency

BOARD MEETING HELD IN PUBLIC

16th March 2021

Title	What are the current key issues from the CEO's point of view?
Board Sponsor	June Raine
Purpose of Paper	Discussion

Medicines & Healthcare products Regulatory Agency

Chief Executive's Report to the Board
16th March 2021

This report gives a brief overview of the current issues from the CEO's point of view. The Board is asked to consider and agree the priorities.

EXECUTIVE SUMMARY 'TOP 10' HEADLINES

- Regulatory Guideline published on adapting vaccines for COVID-19 variant
- GMP inspection of Serum Institute of India conducted to facilitate additional manufacturing capacity for AstraZeneca Covid-19 Vaccine for the UK
- Ongoing partnership work with DHSC/NHS Test and Trace to ensure COVID-19 tests continue to perform as expected
- Weekly publication of suspected adverse drug reactions to COVID-19 vaccines continues with over 2,000 Yellow Card reports per day
- Ban lifted on use of UK plasma for manufacture of immunoglobulin medicines
- First Innovation Passport issued under the Innovative Licensing and Access Pathway for a medicine for the treatment for von Hippel Lindau disease
- EU Exit work continues, with focus on clarity on outstanding issues for industry
- Partnership agreement with NICE updated and renewed in order to support more collaborative working between the two Agencies, together with a refreshed workplan
- Regulatory Science Roundtable held in conjunction with the Academy of Medical Sciences to explore advances in regulatory science with a range of stakeholders
- Progress with MHRA change programme via series of staff engagement sessions setting out the high-level design of the Future Operating Model.

HEALTHCARE ACCESS

COVID-19 vaccine variants guideline

1. Work continues as a priority on the impact on vaccine efficacy of new COVID-19 strains. On 4 March we published a guideline which lays out a regulatory approach for updating authorised coronavirus vaccines, should mutations at any time make them less efficacious due to insufficient cross-reactivity. The document provides guidance for vaccine manufacturers on the quality, non-clinical and clinical studies that could support the introduction of amended vaccines designed to improve vaccine efficacy against novel coronavirus strains. This Guideline is the first to be published jointly with Australia, Canada, Singapore and Switzerland since MHRA joined the ACCESS consortium.

GMP inspection of Serum Institute India vaccine production site

2. A successful overseas Good Manufacturing Practice (GMP) inspection of the Serum Institute of India was performed on 8th-16th February 2021. The inspection involved four inspectors, of which two physically attended the manufacturing facilities in Pune India to assess the manufacturing controls associated with the manufacture of the Oxford/ AstraZeneca vaccine. A GMP certificate was issued following the inspection which will facilitate significant additional vaccine delivery capacity within the supply network.

COVID Tests update

3. To support our work on COVID-19 variants of concern, we are collaborating with international regulators, proactively engaging with manufacturers to provide regular in silico analyses for assurance on continued assay performance, requiring manufacturers to provide their sequencing data at the time of registering their devices with MHRA and reviewing our reporting arrangements to reduce barriers to laboratories reporting potential performance issues with assays in use. The Target Product Profile (TPP) on breath biomarkers was published and the TPP on Lateral Flow self-tests continues to evolve with guidance from the In Vitro Diagnostics Expert Advisory Group. Our partnership work with DHSC/NHS Test and Trace continues, with a focus on ensuring tests are used in accordance with the Exceptional Use Authorisation (EAU) and continue to perform as intended.

UK Plasma ban lifted

4. In 2020, the MHRA undertook a comprehensive scientific review of the safety of UK plasma to manufacture immunoglobulin products. The Commission on Human Medicines considered the evidence and recommended that UK-sourced plasma can be used for the manufacture of immunoglobulins subject to several risk-mitigation measures. This means that for the first time in over 20 years, since the ban was implemented in light of concerns about transmission of CJD, UK plasma can again be fractionated to increase the availability of immunoglobulin medicines for the benefit of NHS patients in the UK.

First Innovation Passport issued

5. The Innovative Licensing and Access Pathway (ILAP) supports our goal for enhanced collaboration between stakeholders (including NICE, the Scottish Medicines Consortium (SMC), and patients), alignment of data requirements where possible, and provides a platform for bespoke and timely advice to developers across the whole of the medicines regulatory pathway in support of earlier patient and market access. Since the launch of ILAP on 1st January 2021, we have received 12 Innovation Passport applications from a wide range of developers, from large companies to a spin-out from a leading UK University. We have had strong interest from companies who have welcomed our flexible approach to provide a platform for multi-stakeholder input. Product areas include oncology and rare diseases. The cross partner ILAP Steering Group meets twice monthly to coordinate the pathway and decide on Innovation Passport applications. The first Innovation Passport was issued on 26th February for Belzutifan, a treatment for von Hippel Lindau disease (a rare genetic disorder).

MHRA/NICE partnership agreement

6. A partnership agreement between MHRA and NICE was adopted in 2014 and has been renewed every two years since then. The purpose of the agreement is to define the joint working arrangements between the two organisations and to set out the priorities and programme of work for the next two years. The MHRA and NICE have been working closely to update the existing agreement to ensure it takes into account the new direction and opportunities that lie ahead. A refreshed agreement agreed at the Chairs/CEOs meeting on 4th March sets out a new framework for closer and more collaborative working. These new ways of working will capitalise on the new regulatory freedom that leaving the EU provides, as well as the opportunities to truly innovate the way the MHRA and NICE collaborates in order to most effectively support the safe use of healthcare products by UK patients and the public, ensure timely healthcare access by patients to healthcare products and to champion innovation and growth for the UK Life Sciences.

Regulatory Science Roundtable with Academy of Medical Sciences

7. In partnership with the Academy of Medical Sciences, on 3rd March we hosted a Regulatory Science Roundtable meeting, to consider the current regulatory landscape for innovative medical products and explore how advances in regulatory science can enable efficient and effective regulation of current and emerging medical products. The meeting included a range of stakeholders, including academic researchers, innovators, funders and patient representation, with the aim of discussing current regulatory frameworks for innovative medical products and defining what is meant by regulatory science. The Roundtable also identified the future priorities for regulatory science in the UK, reflecting on lessons learnt during the COVID-19 pandemic, and explored the roles of different stakeholders in working with the regulator to achieve these priorities. A report of the Roundtable is being prepared and the key points and next steps identified at the meeting are being further considered.

Ongoing EU Exit work

8. In December 2020 UK legislation came into force which forms the basis of the framework for regulating medicines and medical devices following the UK's exit from the European Union. There are certain areas where we do not have a finalised policy position and we are working closely with DHSC to resolve these areas as soon as possible. This includes areas such as falsified medicines, where we have agreed a 12-month period of regulatory flexibility, and where we have agreed to recognise EU approvals for a set period of time. In May 2021 the EU Medical Devices Regulations will come into force in Northern Ireland. We are working with colleagues in Northern Ireland Executive to ensure that industry is prepared for the change as this will result in differences in the legislative framework between Northern Ireland and Great Britain. Meanwhile we continue to receive large volumes of correspondence from industry and we are engaging through industry fora and with the trade associations.

International collaboration

9. To strengthen international collaboration we have participated in three events:

    - UK-Japan Life Sciences R&D Roundtable – this provided senior representatives from the Japanese life sciences industry insight into the world-leading science and research that is taking place in the UK, and highlighted the contribution which innovative regulation can make to this ecosystem, particularly in the UK's new, innovation-friendly regulatory system

    - India's International Conference on Pharmaceutical Industry – this provided the opportunity to demonstrate, alongside other global regulators, our commitment to collaboration with India and other global partners. We will be working with India's Central Drugs Standard Control Organisation (CDSCO) in the coming weeks to develop a regulatory cooperation work plan to reflect the commitments made in the MoU with CDSCO, which we recently signed.

    - Workshop with the National Medical Products Administration (NMPA, the Chinese regulator) - this was the first of 15 planned workshops funded through the Foreign, Commonwealth & Development Office Prosperity Fund and focussed on novel clinical trial design. The workshop was well received with high levels of interaction, and MHRA experts will continue with the delivery of the remaining workshops throughout the year. We look forward to enhancing our relationship with our counterparts at NMPA, and to improving patient access to safe, effective and high-quality medicines in line with international standards.

PATIENT SAFETY

COVID-19 vaccines surveillance

10. On 5 February 2021 we published our surveillance strategy for monitoring the safety of all UK-approved COVID-19 vaccines. To coincide with this, we also published the first of what are now regular weekly COVID-19 vaccine safety reports. These provide details on the suspected side-effects to the vaccines reported through our safety monitoring system, the Yellow Card scheme. The data have shown that the vast majority of reported side effects are mild and in line with most types of vaccine, including the seasonal flu vaccine. We have participated in a large number of online events (co-ordinated by Cabinet Office) with BAME communities and others to address concerns from these groups and encourage vaccine take-up.

Use of Real-World data

11. To support the Agency carrying out statutory COVID-19 vaccine surveillance, the Clinical Practice Research Datalink (CPRD) is receiving near real-time vaccination and hospital data and linking these datasets to daily updated CPRD primary care data. CPRD receives the full vaccination dataset and adverse reactions dataset, minus patient identifiers, from NHS E, via NHS Digital every 24 hours. There is about a 24-48-hour lag between a vaccine being administered in any setting and CPRD receiving the data. CPRD also receives hospital secondary care user data from NHS Digital every 24 hours. These anonymised data, which are not available through any other route, provide the Agency with up-to-date information to evaluate the safety of the COVID-19 vaccines deployed in the UK population.

Drug safety issues

12. In February. the Drug Safety Update bulletin carried articles on the following:

- Esmya and risk of liver injury Because of a rare risk of serious liver injury, use of Esmya (ulipristal acetate 5mg) has been restricted to only intermittent treatment of moderate to severe symptoms of uterine fibroids in pre-menopausal women in whom surgical procedures are not suitable or have failed. Esmya should not be used in patients with an underlying liver disorder and liver function should continue to be checked before, during, and after treatment. The product information and risk materials for medicines containing ulipristal acetate 5mg are being updated and a letter has been sent to relevant healthcare professionals to inform them of the latest safety advice.

- Switching from tablets to hydrocortisone granules A case of adrenal crisis was reported in an infant with adrenal insufficiency in UK who was switched from treatment with hydrocortisone soluble tablets to Alkindi granules. The product information for Alkindi is being updated with appropriate advice for parents/carers about recognising the signs and symptoms of adrenal insufficiency and a letter has been sent to healthcare professionals.

- Pregabalin and risk of severe respiratory depression Pregabalin is indicated in adults for the treatment of neuropathic pain, as adjunctive therapy in people with epilepsy, and for generalised anxiety disorder. A recent European review reported cases of severe respiratory depression associated with the use of pregabalin alone in some patients. Use of pregabalin with opioid medicines or other central nervous system (CNS) depressant medicines has previously been known to be associated with reports of respiratory failure, coma, and death.

CE mark suspended for B-lite breast implant

13. There has been a temporary suspension of the CE Mark for B-lite breast implants because of a manufacturing issue. The devices team have reviewed the technical and biological data associated with this case and have concluded that it is a quality management issue and that there are no identifiable additional safety risks. This will be kept under review.

Valproate Registry

14. The MHRA has been working on the Valproate Registry with NHS Digital, to monitor the use of valproate in girls and women in the UK and compliance with the current regulatory position, and to identify and monitor any children born to women on valproate. The first phase of development of that registry, comprising linkage of routinely collected England-wide data sets on community prescribing collected by the NHS Business Services Authority and pregnancies collated by NHS Digital via the Maternity Services Dataset and Hospital Episode Statistics, has been completed. Work is now ongoing to extend the registry to include women UK-wide and to ensure data can be captured on compliance with the Pregnancy Prevention Programme for all women of childbearing potential, including those receiving private prescriptions. The registry will also be extended to include all women prescribed any anti-epileptic, as recommended by the Independent Medicines and Medical Devices Safety Review.

Patient safety and prescribing quality improvement

15. The Clinical Practice Research Datalink (CPRD) has issued the most recent patient safety and prescribing quality improvement (QI) reports, in partnership with the Royal College of GPs, to over 1700 GP practices who share their anonymised data with CPRD. These bespoke GP practice level reports are focused on long term prescribing of antipsychotics or antidepressants in individuals with learning difficulties. The reports enable case finding of individual patients who may benefit from a drug prescribing review. Benchmarking data is also provided comparing prescribing by the GP practice against other practices in CPRD's GP Network. Indicators used in the CPRD QI reports are based on Public Health England's Stopping Over-Medication of People with a Learning Disability, Autism or Both (STOMP) project, which aims to improve the quality of life of people with a learning disability, autism or both by reducing the potential harm of inappropriate psychotropic drugs. In addition CPRD is providing data and expert scientific advice to assist NICE in developing Quality and Outcomes Framework (QOF) indictors focussed on antidepressant prescribing by GPs.

DYNAMIC ORGANISATION

Staff engagement sessions on Future Operating Model

16. Following approval by the Board of the Agency's Future Operating Model based on the product lifecycle for medicines and medical devices and aligned to the Agency's four main strategic priorities of patent safety, healthcare access, dynamic organisation and financial sustainability, we are now moving forward to finalise the detailed design and implementation of the future organisation. A series of engagement sessions has been held with MHRA staff setting out the high-level design of the Future Operating Model. At the beginning of this new phase we have been working to define how we will best utilise staff's expertise and input to inform the detailed decisions we need to take, as well as to identify a limited number of areas for early implementation on a 'no regrets' basis, building the momentum for and evidence of real change.

FINANCIAL SUSTAINABILITY

Progress with Delivery Plan 2021/22

17. The development of the Agency's Delivery Plan for 2021/22 is nearing completion, with a focus on those objectives which will drive the change programme over the next year. Key objectives relate to innovative healthcare products including diagnostics and software as a medical device, strengthened patent safety systems, and increased use of automation, together with a focus on corporate cost reduction. A series of constructive 'Challenge' meetings have been held to debate the priorities accorded to ongoing activities and ensure that the design principles agreed by the Board for the future operating model are adhered to, in particular those relating to patient and public involvement and the Agency's culture change.

June Raine
Chief Executive
March 2021

Medicines & Healthcare products Regulatory Agency

BOARD MEETING HELD IN PUBLIC

16 March 2021

Title	**How is the agency going to build on its scientific expertise and laboratory research to help achieve the vision of protecting and improving patient health?**
Board Sponsor	Christian K Schneider
Purpose of Paper	Approval

Medicines & Healthcare products Regulatory Agency

How is the agency going to build on its scientific expertise and laboratory research to help achieve the vision of protecting and improving patient health?

1. Executive Summary

1.1. This paper sets out how we will adapt our laboratory science (including the inter-linked functions of research, standards development and batch release) to ensure we exploit our unique capabilities, act as an enabler to the Agency's innovation agenda and maximise our impact on patient safety and healthcare access. The laboratory research activities perform the vital function of keeping the other scientific services at the forefront of life science technology developments and fit-for-purpose. The proposals set out in this paper also underpin our continued and important role supporting UK government's ambitions for the life sciences sector.

1.2. This paper requests Board approval to develop and deliver an Agency Laboratory Strategy that will increase the impact of the Agency's research and scientific delivery. This Agency Laboratory Strategy would form part of the Regulatory Science Strategy and will define the scientific functions that the Accommodation Strategy will need to support. If the Strategy is approved, then the paper requests the advice of the Board on the development and implementation of the Strategy.

1.3. An important part of the vision is to ensure that the work of the laboratories is better communicated both to patients and patient bodies but also to clinicians and expert users so that the scientific results generated are better utilized. This paper will ask for support from the Board to review the current approaches to communications and engagement and incorporate improved measures into the Laboratory Strategy so that the communications can be better coordinated with the scientific progress.

2. Introduction

2.1. **The Agency Laboratories**

The Agency supports two laboratories – the larger facility at South Mimms that houses NIBSC and the MHRA/British Pharmacopoeia (MHRA/BP) laboratories that are currently hosted by LGC Group (formerly the Laboratory of the Government Chemist) at Teddington. The MHRA/BP labs have been the subject of significant review by ExCo and CET. A procurement exercise for the continued outsourced provision of the MHRA/BP laboratory is in progress and outsourcing is expected to continue until 2027. A similar review has not been held for the laboratories at South Mimms as the site is owned by the DHSC; instead the future facility and operational requirement for NIBSC is being delivered by the Accommodation Strategy.

This paper will remind the Board of the laboratory capabilities at NIBSC and suggest ways forward including how the Laboratory Strategy will cover both NIBSC and MHRA/BP laboratories.

2.2. What regulatory activities do the laboratories in the MHRA support?

2.2.1. NIBSC has three statutory requirements:

i. to perform independent quality testing of biological medicines released onto the GB and NI markets, (Independent Batch Release, IBR), with a view to independently confirm the medicine's quality (and thus safety and efficacy) and increase public confidence;

ii. to develop, manufacture and distribute Biological Reference Materials both nationally and internationally, with a view to define the International Unit of biological medicines that enables safe and efficacious administration to patients; enable the reliability of analytical tests for diagnosis and treatment of diseases (both major and rare);

iii. to perform the necessary Regulatory Research to ensure that these two activities are supported by state-of-the-art skills and knowledge, and with a view to generate further standards in areas of unmet need; to refine control testing methodology (e.g., to reduce animal testing; to make testing more reliable; to make testing more sustainable etc); and with a view to understand the course of diseases in a better way, in order to generate smart and relevant approaches to their prevention, diagnosis or treatment.

2.2.2. A non-statutory requirement has emerged over many years that NIBSC performs activities to support the government response to public health emergencies. The exact details of this response cannot be predicted as the nature of the emergency is often unknown. The most recent example is the ongoing COVID-19 pandemic.

2.2.3. NIBSC delivers these requirements with over 150 biological scientists, many of whom are leading international experts who use their expertise to support the breadth of different biological medicines now routinely used preventively and therapeutically. The majority of these scientists deliver through scientific work based in the laboratory.

2.2.4. The MHRA/BP Laboratory provides physicochemical testing capabilities and serves two functions:

i. To support the regulatory activity of the Agency. For example, pre-approval testing of medicines, testing of samples obtained by Inspectors and the Enforcement Group as part of investigations and in response to public health incidents.

ii. To support the work of the British Pharmacopoeia through the development of monographs (quality standards for medicines) and establishment and maintenance of chemical reference standards (BPCRS) that are a component of these quality standards.

2.3. How does this laboratory science deliver the vision of protecting and improving patient health?

2.3.1. NIBSC carries out very technical work that does not usually require direct engagement with the patient. Consequently, the patient benefits are indirect, but still significant, as the NIBSC outputs improve the ability of the healthcare community to improve the health outcome of the patient or improve the effectiveness of preventative health measures.

2.3.2. The Independent quality testing is a precaution to ensure that no error has occurred in any manufacturing batch or no counterfeit ingredients have entered the supply chain that would introduce a change to the drug product that could harm the patient once administered. The utility to patient safety is recognised by multiple international regulators and the NIBSC scientists both perform contract testing for, and advise other regulators on, the quality and safety of biological medicines being deployed in their countries as part of the UK's international agenda. The value of independent batch release has recently been recognised more widely by government and the public in the Covid-19 pandemic where NIBSC batch release was able to confirm Covid-19 vaccine batch quality and provide reassurance to the public in the UK.

2.3.3. The Reference Materials are used to provide a known measure of the biological activity of a given biological medicine so enabling independent verification of the potency, a measure of clinical efficacy, and so the effectiveness of any treatment. There is no one measure for biological activity and this requires NIBSC to maintain a highly diverse set of biological laboratory techniques in order to support virtually all categories of biological medicine. This unique capability has led to partnership with the World Health Organisation (WHO) as the leading provider of international biological reference materials and ensuring international comparability for biological activity measurements and so global patient support.

2.3.4. Biological Medicines are an area of considerable scientific and technical innovation and the science required to measure their biological activity is continuously evolving. The Regulatory Science Strategy steers the Agency response to this scientific innovation, and areas of impact have recently been presented to the Board (paper MHRA 09-OB-2020, 23 November 2020). The capability to perform laboratory research both enables NIBSC scientists to trouble-shoot and improve the methods used to measure biological medicines and, vitally, significantly motivates the scientific experts, enabling NIBSC to retain the best staff. The research activities build and maintain the credibility of the Agency as a provider of expert scientific advice and foster scientific links with industry, academia and regulatory bodies. This exchange of advice accelerates biological innovation and enables the Agency to influence the international development of biological medicines. It is a cornerstone of the Agency's ability to provide early technical advice to developers as part of the Innovative Licensing and Access Pathway (ILAP) and support Scientific Innovation.

2.3.5. The work of the MHRA/BP Laboratory has an important impact on the Agency's work to ensure patient safety and enable healthcare access.

- The physicochemical capabilities provided by the laboratory are critical as an enabler for appropriate regulatory decision making in the interest of patient safety. For example, the MHRA/BP Laboratory has played an important role in our management of nitrosamines in medicinal products through testing of medicines and development of test procedures. The data generated by this testing has enabled regulatory decision making as to the safety of marketed products and the decision to initiate medicines recalls where appropriate.

- The quality standards of the BP are a key component in the medicines regulatory system alongside assessment and GXP (Good Practice in the laboratory, manufacturing, etc.) activities and are used in over 100 countries worldwide. They provide assurance throughout the supply chain that patients receive medicines of acceptable quality, supporting both their safety and efficacy. Standards also act to enable market access by establishing public and authoritative requirements for medicines, helping to facilitate the assessment of generic medicines. Innovation is also supported by standards through the diffusion of knowledge and technology transfer and the establishment of commonly accepted quality considerations e.g. for a new analytical technology, and we have several initiatives in progress to bring our standards to bear on supporting innovation. One example is the partnership formed with the Cell and Gene Therapy Catapult and our work to develop standards to support the highly innovative field of ATMPs (Advanced Therapy Medicinal Products) working with colleagues at NIBSC. We have undertaken public consultations and published strategies in the fields of biological medicines (monoclonal antibodies and ATMPs) and analytical innovation (Quality by Design) and the success of this work will be seen in the coming year with the publication and establishment of a range of new standards in these areas.

2.4. What are the Agency laboratories' unique scientific capabilities?

2.4.1. NIBSC laboratory facilities support the end-to-end process of developing a laboratory standard from working with patient samples using biological containment facilities, studying biological medicines and pathogens in animal models, in vitro cell-based and biochemical assays for biological activity to high end analytical techniques for detailed molecular analysis of biological molecules. Rapid and focused application of this work is enabled by the Standards Production Division's facility that undertakes research to develop production techniques that retain biological activity for years (and even decades), scales up these formulations and runs a production facility for packaging and distributing biological standards. These facilities are supported by multi-purpose laboratories to maintain a flexible facility that can rapidly be repurposed to work with bacterial and viral pathogens, validate medical diagnostic assays, study ATMPs based on human stem cells and so on.

2.4.2. A significant unique feature is the co-location of all of the above, including multiple levels of biological containment and the ability to rapidly reassign facilities to

address new biological challenges. This co-location enables the scientists to collaborate closely on the end-to-end development of a new standard or assay for IBR and this collaboration is often categorised by NIBSC as research. This has been most recently demonstrated for the support of COVID-19 diagnostics, vaccines and increasingly therapeutics while continuing to deliver other independent batch release activities, developing new WHO reference materials, delivering grant-funded research, performing contract-funded fills for other customers and maintaining the sales and distribution of existing standards.

2.4.3. The NIBSC laboratories represent the “swiss army knife” of biological science. This contrasts with the industrial approach to build dedicated laboratories focused on high throughput /production line approaches to a small number of different biological experiments. This fits the capital investment resources of industry, when they need a scientific facility they generate the investment to build it from scratch. As a government laboratory NIBSC seldom has access to this “build from the ground up” approach and so has evolved to make the optimal use of what is available. There is also no equivalent in academia; academic laboratories may house multiple different scientific research functions in single buildings but they seldom have to coordinate their facilities to generate products and lack the quality system investment required to perform tests and develop products that can be used in industry and healthcare.

2.4.4. NIBSC allows the Agency to deliver patient benefit through its unique capability is to take crude biological preparations and produce quality system-controlled products of the highest level delivered by staff who can switch comfortably from research to quality controlled rigorous testing. There are few equivalent scientific establishments globally.

2.4.5. The physicochemical capabilities provided through the MHRA/BP Laboratory are similar to those that exist in Quality Control and Analytical Development Laboratories in the pharmaceutical industry. Whilst the capabilities themselves are universal it is the unique fusion of the BP staff within MHRA and the laboratory, as well as the knowledge of our regulatory work and standards setting programme, that are critical to ensuring we deliver these important areas of our work. The current outsourced model provides flexibility and delivers financial sustainability. The biological testing capabilities of NIBSC and partnership working with peer organisations support our regulatory and BP standards setting work in these areas.

2.5. Examples of recent scientific achievements driven by the laboratory capability

2.5.1. The following examples show how NIBSC and MHRA/BP laboratory science has supported the Agency response to infectious diseases:

2.5.2. NIBSC scientists are part of a UK Biotech Consortium led project that has resulted in the identification of Novel COVID-19 Antibody Therapy Candidates that might protect against or treat SARS-CoV-2 infections. Two antibodies will be taken

forward for further development as both potential monotherapies and an antibody "cocktail".

2.5.3. A novel oral polio type 2 (nOPV2) vaccine was developed and given WHO Emergency Use Listing approval for new Countries in WHO's Western Pacific and South-East Asia regions that are affected by these outbreaks. NIBSC has been involved in this work for many years and the emergency use listing is the first of its kind for a vaccine and has helped pave the way for potential listing of COVID-19 vaccines in the same way for emergency use.

2.5.4. NIBSC has produced a series of reference materials to support the NHS in their implementation and continual monitoring of molecular assays detecting winter respiratory viruses, Influenza, Respiratory Syncytial Virus and SARS CoV2. The materials, in the form of single dilutional series of each virus and a blended combination of all three, will allow diagnostic laboratories to understand assay sensitivity across different platforms and ensure optimal day to day performance of assays. This work highlights the important links between NIBSC and NHS to help bring in new assays at pace.

2.5.5. Scientists in the NIBSC Polio team have been able to detect SARS-CoV-2 viral RNA in five wastewater samples from London between February and June 2020. This showed that early detection of low levels of SARS-CoV-2 RNA was possible and that the SARS-CoV-2 viral RNA concentration estimated in wastewater samples was proportional to the number of cases reported at the time of sample collection. Results showed a large reduction in viral RNA concentration in sewage between April and May 2020, most likely due to the lockdown measures introduced in the country. Nucleotide sequencing analysis revealed sequence similarities between sewage SARS-CoV-2 strains and virus isolates from clinical cases in England. This environmental surveillance testing of sewage is a process already carried out in monitoring levels of polio and NIBSC has shown that this could be used for early detection of peaks in other virus transmission.

2.5.6. The MHRA/BP Laboratories supported the Agency response to COVID-19 through its support for the medicines supply chain. This included testing of imported medicines, increasing access and availability of standards with a focus on those for medicines used to treat COVID-19 patients and participation in international collaboration to develop standards for new therapeutics.

2.6. What needs to be done to further develop a pro-active communications plan to increase the profile and public health value of our laboratory research

2.6.1. The good news stories listed above and regularly posted on the website show that the laboratory work has the potential to significantly impact public health and the Agency has worked hard to improve its communications with significant progress to date.

2.6.2. The NIBSC Communications Management Group (NCMG) is a standing committee responsible to NIBSC's Senior Management for overseeing the proposal, delivery and monitoring of NIBSC's annual communications plan. It aims to provide an interface between the Agency's corporate Communications Division to create an integrated strategic planning approach to produce the best outputs, ensure feasibility and alignment with overall corporate strategy, and ensure that there is maximal buy-in to the specific objectives that flow from these strategies.

2.6.3. The NCMG has divided its efforts across four focus areas with scientific representatives across each pillar: the NIBSC Website, Events, Publishing and Media and Thought Leadership. The KPIs for each pillar are presented quarterly to NIBSC Senior Managers. There has been significant progress in all four areas: the number of website users has increased by 90% to 18,884 (Dec 2020 vs 2019), on average 81% of attendees rated the NIBSC webinars as good/excellent, over 20 scientific and expert publications have been promoted and a considerable social media presence with 116 posts on Twitter and LinkedIn and 48 positive media features generated in the current year to date.

2.6.4. The work by the NCMG establishes a good foundation for communicating information and increasing the awareness of the NIBSC. However, there are opportunities to further monitor the impact of such communications to specific stakeholders such as patients and public. This requires more focused measures to be applied in addition to the NCMG work. This paper requests suggestions from Board members and will incorporate them into the communications plan for the Agency Laboratory Science Strategy as appropriate.

2.6.5. The BP has an annually developed marketing plan, developed with our publisher and MHRA Communications, to promote the work of the BP from a commercial perspective and collect insight to measure our impact. For key strategic initiatives (e.g. biologicals strategy) full communication plans have been implemented to maximise public engagement and impact. Collaborative working with our international partners in areas of strategic interest has also been used to amplify our brand and credibility in key global regions.

3. Proposal

3.1. Option analysis

3.1.1. The Board are asked to consider the usefulness of an Agency Laboratory Strategy to address the renewal of the laboratory facilities, the scope of the experimental science including the current remits for biology and chemistry with consideration whether it should be extended to support medical devices and other areas of the Agency, and what changes need to be made to the current communications plan to further improve the impact and value of the Agency's experimental science. Options include:

3.1.2. ***Do nothing***

Some of the components of the laboratory strategy can be found in the Regulatory Science Strategy, the NIBSC Science Strategy, the Accommodation Strategy, the current NIBSC and MHRA/BP communications plans and various Business Plan targets. If this situation continues then these may be delivered piecemeal, but the lack of coordination will diminish the impact and return on investment of these components. The Agency Laboratory Strategy will enable success to be defined and establish measures against which progress can be judged.

3.1.3. ***Support some outsourcing and partnership activities***

The South Mimms site has a finite number of scientific facilities and this can create constraints in certain laboratory science areas. The staff think creatively to avoid such constraints and various projects have been initiated to create informal collaborations to try and access facilities. These “bottom-up” approaches have merit, and some may be the best solution to a particular experimental scientific need, but the lack of coordination means that these do not scale up to give wider benefits. Communications continue to be delivered with current resources and activities with most of the activity supporting science dissemination but the patient and public engagement and involvement elements less well-resourced and monitored.

3.1.4. Support the establishment of an Agency Laboratory Strategy aligning this Strategy with the delivery of the Size and Shape Change Programme

This will set out the aims of maintaining and investing in experimental science capability by the Agency and embed the communications work more closely with the scientific deliverables, in particular looking at the additional communications work required to improve the benefits to the patient.

4. Recommendation

4.1. This paper requests Board support for the establishment of an Agency Laboratory Strategy that will align with the Agency Regulatory Science Strategy, incorporate adaptions to the existing communications plans and be delivered as part of the Delivery Plan.

4.2. It further requests Board input on the scope and application of this Strategy so that it ensures that experimental science delivered by the Agency ensures Patient Safety and Healthcare Access.

Christian K Schneider
10 March 2021

Medicines & Healthcare products Regulatory Agency

BOARD MEETING HELD IN PUBLIC

16 March 2021

Title	What has been the impact of EU Transition on regulatory approvals and the work of the agency in the first two months after leaving the EMA network?
Board Sponsor	Sam Atkinson
Purpose of Paper	Discussion

Medicines & Healthcare products Regulatory Agency

What has been the impact of EU Transition on regulatory approvals and the work of the agency in the first two months after leaving the EMA network?

1. Executive Summary

1.1 It is now just over two months since the end of the transition period (EOTP) on 31st December 2020. A Partnership Agreement was reached between the United Kingdom (UK) and the European Union (EU) on 24th December 2020 which, although detailed in most areas, left several areas still to be negotiated or finalised with the EU through 2021. Some changes to regulatory process were deferred until 31st December 2021 (i.e. Falsified Medicines Directive (FMD)) and other areas entered a period of standstill (two years for medicines (December 2022) and two and half years for medical devices (June 2023)). The regulatory landscape for medicines and medical devices in UK changed on 1st January 2021 with new routes for submission and product registration including those for application to GB only. For Northern Ireland (NI) the Northern Ireland Protocol (NIP) came into force which has created regulatory challenges for industry and the Agency. The Partnership Agreement with the EU included important elements of the UK's negotiating asks in respect of medicines such as an agreement to recognise Good Manufacturing Practices (GMP) inspections and provisions that facilitate the sharing of information on GMP inspections. The agreement also established a medical product working group which is empowered to exchange regulatory information which will continue to ensure the safety of patients.

1.2 MHRA has introduced new routes to market including the Innovative Licensing and Access Pathway (ILAP) which aims to reduce the time to market for innovative medicines. It harnesses expertise at the right time across the agency and from the MHRA's healthcare partners to develop a roadmap to facilitate timely product development.

1.3 The MHRA is no longer part of the European Medicines Agency (EMA) or it's working groups or the EU network for medical devices. As a result, we are no longer able to share or receive information from the EMA or with the European Commission, EU competent authorities or notified bodies. This has resulted in changes in working practices for the agency and for industry.

2. Introduction

Impact Assessment

2.1 Annex A provides a summary of business volumes for key work types for the first 2 months of this year compared with the same period in 2020 and 2019. As expected, medicines

applications using the new routes are starting to come in and the new national responsibilities are also reflected. The balance of work is expected to continue to evolve over the next few months. The snapshot for that period does not reflect the ongoing work on vaccines.

2.2 For devices we are still in the early stages as requirements to register products come in over the course of 2021, with the largest volume of products likely to be registered in the latter part of the year. It is not possible to directly compare statistics from previous years because the requirements have materially changed, as has the registration system itself. Nonetheless, nearly 40,000 registrations of devices to date gives an early indication of the significant volumes that will be coming through over the course of the year. The total number to be registered is unknown but from other jurisdictions it is anticipated to be somewhere between 600,000 and 2,500,000 devices registered at Unique Device Identifier (UDI-DI) level. From 1st January 2021 manufacturers based outside the UK needed to appoint a UK Responsible Person (UKRP) to take responsibility for the product in GB and register the manufacturers devices with MHRA.

2.3 Relevant device details from the new register will be required by the Medical Device Information System for implantable medical devices being developed by NHS Digital. This helps support the Independent Medicines and Medical Devices Safety Review recommendations delivery. It is encouraging that during the first month over 95% of registrations of implantable devices included the UDI-DI details

2.4 The new regulations will require new interoperable medical device IT systems linked via device registrations.

Innovation

2.5 The demand for scientific advice and innovation office regulatory advice remains high and has significantly increased compared with the same months in previous years. The ILAP has generated considerable interest with 12 passport applications received in the first two months; the first “Innovative Passport” was issued in late February publicised by a press release and article in the Financial Times.

2.6 The UK as a destination to conduct clinical trials remains strong with first-in-human clinical trials increasing year on year over the past 3 years (82 in FY19/20; 102 in FY20/21 and 108 in this financial year to date).

2.7 MHRA support for novel trial designs has seen their use increase over the past 3 years. That facilitated success of the UK response to COVID-19, via platform trials such as PRINCIPLE and RECOVERY. Eleven of the 29 trials with a novel design approved in 2020 were for COVID-19 indications.

2.8 Support for innovative trial conduct such as remote monitoring and building-in virtual/decentralised elements where appropriate builds resilience and establishes a more patient-centric approach that will help to ‘bring the trial to the patient’ and reach underrepresented groups.

Access

2.9 The early applications from companies using the new routes to market have been received and as anticipated companies are continuing to seek advice in relation to the most appropriate options for specific products.

2.10 On the EC Reliance route, business areas are working together to resolve any procedural practicalities on a case by case basis to enable the applications to progress in a timely way. All but one application is for a new active substance.

2.11 The international collaborations of Orbis and ACCESS have generated a very good level of interest with 5 applications submitted through Orbis (all new active substances) and 1 planned for ACCESS.

2.12 Application volumes in the first 2 months of this year for the previously available national and European routes are lower than the 2020 monthly average but this is likely to be compensation for submissions in December at double the monthly average. We anticipate a significant increase in regulatory activity following resolution of issues contingent on outstanding policy and legal matters under negotiation with the EC.

2.13 For medical devices the registration system has worked well with manufacturers comfortably getting to grips with the new system and appreciating the supportive training videos.

2.14 The regulations require that by the 1st January 2021 all medical device on Great Britain market be registered at UDI-DI level. The main concern is making sure that the requirement to register is fully recognised as the first deadline for higher risk products nears at the end of April. For details of volumes during the first two months see Submissions for Devices at Annex A.

Safety

2.15 National deployment of COVID vaccines has been the main focus for pharmacovigilance in the first two months of 2021. Evaluation of adverse event reports and signal assessment for these vaccines is not impacted directly by EU Transition.

2.16 Meeting agendas for the European Pharmacovigilance Risk Assessment Committee (PRAC) and its recommendations are being scrutinised for impact on UK licences. UK expert advice is being sought where appropriate.

2.17 There will be challenges in maintaining consistent product information across the UK but we will aim to ensure that the information for patients and prescribers and safety messages are consistent for NI and GB.

Pharmacovigilance requirements for Northern Ireland are causing additional complexity and uncertainty for industry, in particular, with respect to reporting to EU databases. This is an issue which remains to be resolved with the EU. The volume of enquiries from industry remains high as a consequence.

2.18 With respect to Medical Devices there have been challenges in reduced frequency and speed of information sharing. Outside of the EU system we have less data to act on and have to take direct responsibility for more safety investigations rather than being able to work share with other EU competent authorities. Whilst we have tried to maintain open communications on a post market basis, this has been less smooth than before. Information sharing agreements are required to reset the expectations of the relevant parties. The UK is no longer able to influence the actions of other Competent Authorities especially with regard to Notified Bodies, this has led to slow or absent responses to questions raised by MHRA. These issues have led to increased time spent on post market issues where there is an EU component.

Industry Feedback

2.19 The Agency has experienced a surge in enquiries since September 2020 which has not reduced since the EOTP. Due to the practical implications for industry including decisions they need to make on how to manage their regulatory strategies for placing products on the UK market, their current focus is on those areas impacted by EU guidance. These include handling of Mutual Recognition and Decentralised products (MR/DCP) and batch testing. Submissions for conversion of centrally authorised products to GB MAs have also generated a number of technical enquiries.

2.20 Since 1st January there have been 1,452 enquiries submitted though the Customer Services Centre (CSC) with more than 1000 further enquiries to Divisional and subject specific mailboxes as well as e-mails to individuals and collated questions submitted through Trade Associations. Repeat enquiries and follow ups have added to the demand, with approximately 2,650 ‘follow-up’ and repeat enquiries having been received by the CSC. In relation to medicines, many of these relate to the outstanding policy areas currently under negotiation with the European Commission. Many enquiries are complex requiring input from across the agency.

3. Proposal

Opportunities

3.1 The Government has presented an ambitious vision for the country to become a leading global hub for life sciences and an internationally competitive trading partner with the EU and the rest of the world. The UK has a unique opportunity to strengthen its reputation as a leader in life sciences by building a smart regulatory environment, putting patient protection at the centre, whilst supporting innovation.

3.2 The Agency continues actively to define new regulatory approaches for the UK post transition and post-standstill. These new regulatory frameworks will enable the UK to develop innovative pathways for medicines, develop a competitive regulatory framework for clinical trials, and implement future devices regulations.

3.3 The ambition of one of these, the ILAP, is to reduce the time to market for innovative medicines. By harnessing expertise at the right time from across the agency and the MHRA’s partners, the National Institute for Health and Care Excellence (NICE) and the Scottish Medicines Consortium (SMC), the ILAP allows for enhanced coordination and monitoring of important product development activities. Innovating existing regulatory

processes will enable the Agency to reduce time to approval thereby allowing quicker access to medicines and associated medical devices for the UK.

3.4 Rolling reviews of vaccines for COVID-19 have shown how the UK can lead the way, securing access to vaccines and other treatments and move rapidly to ensure public health and patient safety. Rolling review is now one of the access pathways that is offered for all new chemical and biological medicines.

3.5 The MHRA is now in a much better position to pursue international agreements for the UK without the hinderance of European Union rules and regulations that have previously limited the UKs ability to act independently. This, and the ability to engage in international collaboration will ensure the UK is at the forefront of future developments in healthcare and will enable the UK to secure global supply chains. MHRA is now a member of the ACCESS consortium, a full participating member of the FDA lead Orbis programme for Oncology products and will be an observer to the Medical Device Single Audit Programme (MDSAP) soon.

Challenges

3.6 There remain several challenges due to ongoing negotiations with the EU that were not resolved at the EOTP and these are a cause for concern as they could put at risk the supply of some medicines to Northern Ireland. The Agency is committing significant resource to identify solutions and working closely with the Department of Health and Social Care (DHSC) and Cabinet Office towards resolution of these matters and meets regularly with Trade Associations to manage ongoing uncertainties.

3.7 Live negotiations with the EU are covering Northern Ireland regulatory activities that fall within the NIP including, but not limited to

- Recognition of GB based regulatory activity for Northern Ireland which primarily affects applications in EU Mutual Recognition and Decentralised procedures
- Qualified Person Responsible for Pharmacovigilance (QPPV), Pharmacovigilance System Master File (PSMF) and Northern Ireland packaging
- Batch Testing, where there is a requirement to clarify the position for industry as soon as possible on current and post standstill provisions for Batch Testing

4. Recommendation

4.1 Given the significant changes to the regulatory landscape for both Great Britain and Northern Ireland it is too early to see how companies will adapt their regulatory strategies to take advantage of the opportunities and manage the challenges. The following recommendations are proposed:

- As a priority, bring to a conclusion the areas of uncertainty in relation to EU discussions

- Continue to advocate new routes to market in the UK to facilitate early patient access to medicines

- Continue regular interaction with industry through the Trade Associations to identify issues in this early phase and help them to navigate solutions

- Continue to closely monitor the volume and pattern of work coming to the agency together with resource requirements to enable demand to be supported in an agile way.

Sam Atkinson
09 March 2021

ANNEX A

Submissions for Medicines

	Jan & Feb 2021	Jan & Feb 2020	Jan & Feb 2019
PIPS	16	n/a	n/a
Product Licensing New Applications			
National Total	95[1]	116	69
Including			
EU Reliance	*18*	n/a	n/a
Orbis	*5*	n/a	n/a
MHRA as RMS	0	29	6
MHRA as CMS	13	0	46
Product Licensing Variations			
Notifications	3,016	2,655	2,426
Minor Changes	1,907	1,909	1,628
Complex Changes	414	410	522
Early Access to Medicines			
EAMS Promising Innovative Medicine	3	2	2
EAMS Scientific Opinion	1	0	2
Clinical Trials			
Total	142	149	150
First in Human	17	14	8
ILAP Passport	12	n/a	n/a

[1] 139 national initial applications were received in December 2020, this compares to the average of 71 applications received per month in 2020.

- Of the national applications, 20 applications cover 11 new chemical or biological entities:
- 5 oncology products submitted as part of the Orbis collaboration
- 1 product for treatment and prevention of Covid-19
- products submitted using the EC reliance route
- 1 product submitted under the MR/DC reliance route

Also of note 15 abridged applications which are extensions of centrally authorised products have been submitted directly to MHRA.

Scientific Advice

Advice to Companies [2]	Jan & Feb 2021	Jan & Feb 2020	Jan & Feb 2019
Innovation Office	51	47	30
Scientific Advice Meetings	37	21	23

[2] Only includes formal scientific advice requests not routine regulatory advice.

Conversion of Marketing Authorisations

Since the EOTP a huge exercise within Information Processing Unit (IPU) to *Convert Centrally Authorised Products (CAPs) to UK Authorisations (MA's)*, generally referred to as CAP Grandfathering, has begun to convert all existing CAP MAs into UK MAs. Licensing Division has previously issued GB MA numbers effective from 1st January 2021 and together with IPU continues to support companies with technical and regulatory advice in relation to the submissions for their portfolio. To date the Agency has received 520 CAP Grandfathering submissions out of a total of 2,600 expected during the 12 month period permitted for these submissions.

Consumer E-cigarettes

	Jan & Feb 2021	Jan & Feb 2020	Jan & Feb 2019
Consumer E-cigarettes	446	2,997	n/a

Submissions for Devices

Registrations	Jan & Feb 2021	Jan & Feb 2020	Jan & Feb 2019
Total No. of Device Registrations at UDI-DI level	39,388		
Class III	6,970	n/a	n/a
Class IIb	3,527	n/a	n/a
Class IIa	3,112	n/a	n/a
Class I	21,859	28*	110*
Custom-made	1,342	30*	112*
All IVDs	1,499	-	273*
No. of different GMDN Device types Registered	3,287	n/a	n/a
Total Appian accounts approved	528	160	158
UKRP accounts	468	n/a	n/a
- No. of Manufacturers represented by the UKRPs	492	n/a	n/a
Manufacturers who have added or updated devices	447	514	173
New Importer	48	n/a	n/a

* Note these figures are from device registrations in 2019 and 2020 on Lotus Notes. They cannot be compared to 2021 as there was no requirement to register at the more granular level of GMDN code/term, or the even further granular UDI-DI product level, which is now required.

Medicines & Healthcare products Regulatory Agency

BOARD MEETING HELD IN PUBLIC

16 March 2021

Title	What are the proposed outcomes from the new Patient and Public Involvement Strategy and how are they going to be achieved?
Board Sponsor	June Raine (delegated to Rachel Bosworth) and Mercy Jeyasingham
Purpose of Paper	Approval

Medicines & Healthcare products Regulatory Agency

What are the proposed outcomes from the new Patient and Public Involvement Strategy and how are they going to be achieved?

1. Executive Summary

1.1 The first draft of the Patient and Public Involvement (PPI) strategy was approved by the Executive Committee (EXCO) in November 2020 and reviewed by the Patient Safety & Engagement Committee (PSEC) on 3 February 2021. The strategy was updated following helpful feedback from the PSEC and was reviewed by the EXCO on 2 March 2021. The PPI strategy sets out a high-level strategic approach for the agency, recognising that there is much work to be done once approved, in building a granular delivery plan. We have used "involvement" in our title for brevity, as we consider "engagement" a precursor to involvement.

1.2 A robust outcome evaluation framework that enabled greater consideration to be given to individual patient needs was developed in response to the feedback from PSEC, and this together with other small refinements was approved by EXCO on 2 March 2021.

1.3 The Board are asked to consider this paper and the strategy for approval, in advance of final public consultation (subject to ministerial approval), and publication of the strategy in late spring of 2021.

2. Introduction

2.1 In summer 2019, the agency embarked on an extensive UK wide public consultation on how to improve its engagement and involvement of public and patients in its work. The consultation received over 800 responses from organisations and individuals, from across the UK, and the analysis identified four key areas to be addressed.

- There was limited knowledge of the MHRA and its relevance to them. This was driven by low levels of awareness of the organisation, as well as depth of awareness or understanding of its role or purpose within health. This was also highlighted through the Independent Medicines and Medical Devices Safety (IMMDS) Review led by Baroness Cumberlege, which stated: *If they have concerns patients need to know what the MHRA does and how to contact it. The MHRA must work both for patients and with them.*

- A lack of transparency in the agency's decision making. For those that understood a little of the organisation, they found it difficult to understand how decisions were made and whether they had any opportunity to influence them. Again, this was reflected in the IMMDS Review which stated: *There should be a requirement on the MHRA to demonstrate how patient views have been taken into account and influenced the regulatory decision*.
- There was limited response to those that contacted the agency, with issues or questions raised and the patient often not knowing how their engagement with the organisation had been dealt with.
- Partnerships could be utilised far more than they were and at key points in our processes. There were many offers to help and support the agency in its work, by providing access through charities to specific patient groups or hard to reach audiences.

2.2 The findings from our own consultation were more broadly reinforced and central to recommendation 6 of the IMMDS Review published on 8 July 2020 which stated: *It (the agency) needs to ensure that it engages more with patients and their outcomes. It needs to raise awareness of its public protection roles and to ensure that patients have an integral role in its work.*

2.3 The agency's clear commitment to improving patient and public engagement was set out in the Corporate Plan 2018-23 and was also reflected in the Business Plan 2020-21 as a key part of our strategic goals and ambition.

2.4 The first draft of the Patient and Public Involvement Strategy was informed and developed in 2020, and has now received input from EXCO, the Patient Safety & Engagement Committee as well as feedback from individuals and organisations on our Patient Group Consultative Forum.

2.5 It's important to note that we have not stood still since our consultation was carried out in 2019. Over the last eighteen months there has been significant progress and delivery across many areas covered by the strategy to improve our approach including the involvement of users in the design and delivery of digital products and services. Some examples include;

- Ensuring that patient engagement is built into critical points in the Innovative Licensing & Access Pathway (ILAP).
- Engaging with patients on the Safety Connect programme, asking for feedback in terms of transparency and feedback mechanisms they would like to see.
- Developing e-learning and training packages on what patient focus, and good patient engagement looks like for all MHRA staff.
- Significant increase in the use of our Patient Group Consultative Forum across the organisation, with patient participation in workshops to inform and provide insight on key issues. This recently involved an extended PGCF session focused on devices that discussed the future rules for medical devices in the UK, and a session led by NHS Digital on the Medical Devices Information System.
- Improving online access to Patient Information Leaflets (PILs) and Summaries of Product Characteristics (SPCs).

2.6 In developing our PPI strategy, we looked at what we can learn from health organisations both nationally and internationally and considered how the development of stronger partnership arrangements can help us make significant progress, faster. Here are some examples that we particularly admire from other health partners;

- Our Patient Group Consultative Forum (PGCF) already provides us with a valuable patient perspective on different aspects of our work, but we need to increase its size and reach, ensuring it is sufficiently diverse and representative of the patient population. We are not alone in our need to recruit a large patient pool to support our decision-making. The Care Quality Commission (CQC) has built a large patient engagement base with their Citizen Participation Platform prominently featured on their website homepage and with over 6,500 individuals registered to help and work with them. This size and scale is important to ensure that the broadest patient spectrum is considered, but not everyone has the same capability when it comes to engaging online and we need to ensure that we hear the voice of all audiences. (An ONS report in 2019 found that whilst 91% of adults in the UK were recent internet users, this fell to 47% for the 75+ age group).

  In contrast to the large patient pool built by CQC, the National Institute for Health and Care Excellence (NICE) has adopted an approach of recruitment to address a specific need rather than building a large base. This is supplemented by guidance and handy toolkits for staff to consider when running sessions or providing help and support to patient members attending. It covers everything from sharing and explaining documentation in advance of the session, to how to follow up afterwards.

  NHS England (NHSE) has built something similar with a dedicated resource for patients to find out more about participation – how to do it and how to get involved. This year they are also preparing to launch their Patient & Public Voice Partnership creating an interactive network for Patient and Public Voice (PPV) partners working with the organisation. This would include e-bulletins, online discussion forums, a range of learning, development and peer support opportunities, as well as virtual and face-to-face events.

  These are just a few examples that demonstrate that we are not alone in our need to gather information and insight from a truly representative patient pool. We already engage charities/groups through our Patient Group Consultative Forum, as well as devolved nations (e.g. we work and collaborate with the Scottish Medicines Consortium) but we need to be more ambitious and build our partnership network further still. This could include the Royal Colleges, the National Institute of Health Research (NIHR), as well as adding more charities to our network. This access to a far wider pool where we need it, taking into account data and privacy compliance, would reduce the cost to the agency whilst delivering the best insight and information on different topics or issues.

  We are in active discussion with partners to identify opportunities for greater partnership working in this area, exploring the possibility of reciprocal access across these different patient engagement mechanisms. We plan to run a pilot in the coming months.
- Further afield, we have also been impressed with the Patient Listening Sessions run by the FDA in the US, where open conversation is encouraged between patients around a

particular topic or theme, with the regulator listening in. Whilst questions can be posed to this forum, its strength lies in the open discussion that can be listened into, providing a far broader and deeper understanding of patient concern and sentiment.

- There is much to observe and learn from other health organisations, and we will return to consider this later in this paper.

3. Proposal

3.1 The IMMDS Review highlighted the key areas where the health sector and the MHRA needed to do better in engaging with and involving patients and the public. When the IMMDS report was published in July 2020, the development of the MHRA patient engagement and involvement strategy was already well advanced, and our own consultation findings were reinforced by those of the Review. Today, MHRA is an organisation embracing significant transition and change on its journey to become a truly patient-focused regulator.

3.2 We recognise that this is a journey where we need to make great strides quickly, building on the progress in this area we have made already, whilst acknowledging that the scale of transition required will be delivered over a longer timeframe, embedding and ingraining new ways of working to achieve our vision. **Patient engagement and involvement is critical to our ability to deliver better health outcomes for patients.**

3.3 This significant transformation embedded in the PPI strategy has three broad pillars to enable it;

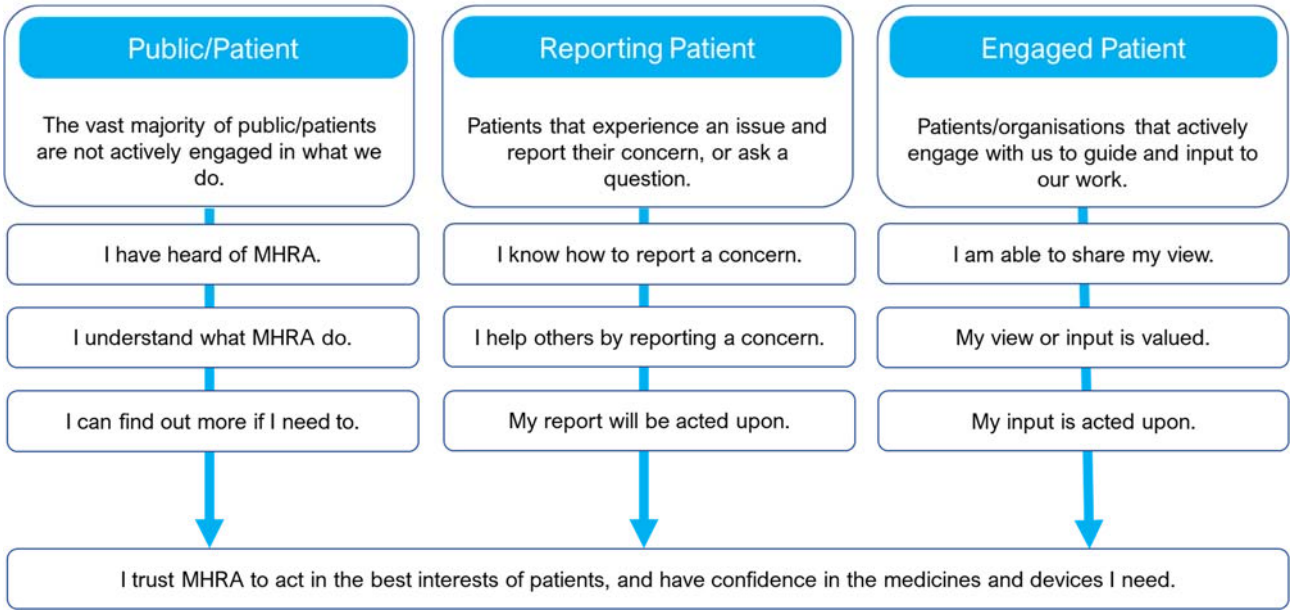
- Our ability to truly INVOLVE patients
- Our ability to RESPOND to patients
- Our ability to transform our CULTURE to put patients at the heart of all that we do.

However, engagement and involvement are the start and not the end point. We will be measured on what we do with everything that we glean from the engagement and involvement – the difference that we make for patients as a result. This means we need a clear framework of patient outcomes to guide us.

3.4 We have to consider and measure patient engagement in its broadest sense. This means thinking beyond those that choose to work with us, respond to a call for evidence, notify us of an adverse drug/device reaction (ADR), use our digital products and services or who contact the Customer Service Centre. There does not appear to be any agreed methodology on the measurement of patient engagement, so we have built an approach which provides most value to the agency and which considers the total patient population. The visual below identifies three groups to help frame patient outcomes. These are; Public/Patients, Reporting Patients and Engaged Patients.

The majority of the patient and public audience are found in the first group, **Public/Patients.** This group are not actively engaged in what we do. Those that contact us to notify of an ADR through Yellow Card, use our digital services or products, respond to a call for evidence, or, for example, simply ask a question of us around an issue via the Customer Service Centre are **Reporting Patients**. Finally, patients who actively engage with our

work through, for example the PGCF, workshops or ILAP engagement can be thought of as **Engaged Patients**.



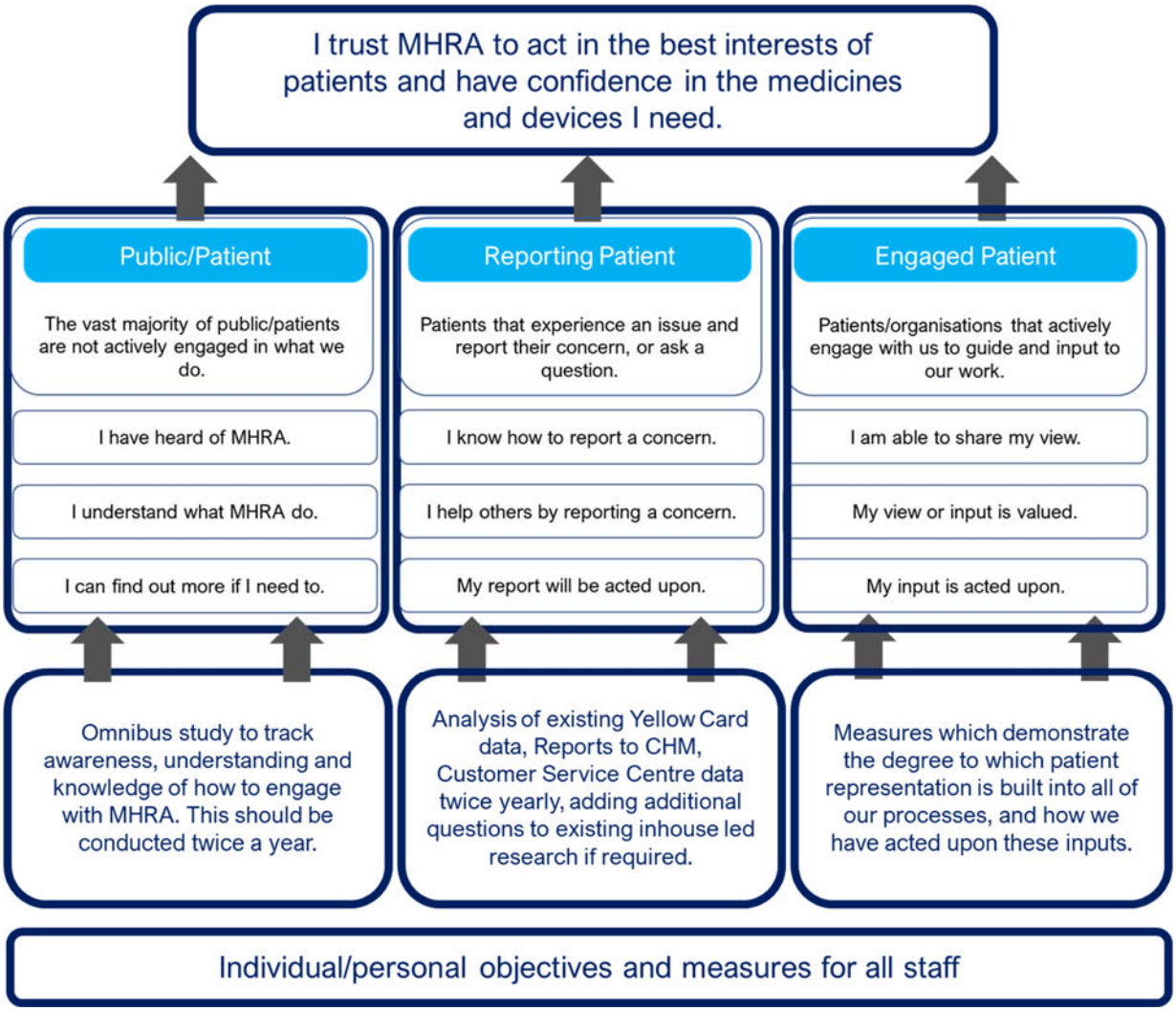
To have a clear indication of our progress we need to have outcome measurement across all three groups as they all significantly impact upon our broader reputational measure of trust and confidence in medicines and medical devices, and in the MHRA. This evaluation approach builds upon a standard model used by Cabinet Office and across government to consider outputs, outtakes and outcomes.

Three outcomes have been created for each of the patient groups, under which our objectives and activity can be aligned as well helping us to identify any gaps. This approach is focused upon patient engagement but could easily be adapted to consider patient experience as well. For the Public/Patient group this would be the anticipated experience of engaging with us. We can build in more stringent measures for the Reporting and Engaged groups considering the speed of our response to a question or ADR, the churn rate of our patient group, or the extent to which they recommend engagement with MHRA to their friends. All of these provide insight into their experience.

3.5 We propose creating a **patient engagement index** for each group so that we can monitor our progress twice a year. We will explore the creation of an overall patient engagement index although this would require us to place a weighting on each group and reach agreement on how any weighting might be calculated. This might be challenging, and not add significant extra value.

3.6 The diagram below sets out how our measurement of activity at a more granular level can be aligned to each of the groups, and how that in turn impacts upon public confidence and reputation. The next stage in building the framework involves the addition of measures that we currently have or monitor, and introducing new measures where there are gaps. We will measure and ensure that patient involvement is built into our processes. This could include the introduction of clear go/no go decisions where further development cannot continue

unless there is evidence of patient engagement at key points. Another example could be providing clear evidence that every product decision going to the Commission on Human Medicines (CHM) has received patient input, what that input said and what we have done (or not done) as a result. It is in our ability to influence and improve on these inputs that will determine how we will deliver on the proposed outcomes. It is what we do as a consequence of the engagement, and less about the engagement itself.



The design and delivery of all future digital products and services will include the user – via focus groups, user research, customer journeys, feedback surveys such as system usability scores and the performance of these products and services will be tracked and used to prioritise improvements and enhancements. This builds on existing governance and scrutiny provided by bodies such as the Digital, Data and Technology Assurance Group that includes Cabinet Office, NHS-X and the Department of Health and Social Care (DHSC) as well as representatives from across the agency to ensure digital standards are being met. Our approach does however need to ensure that we do not lose voices in the process by excluding those unable to engage digitally, or through disability. Partnerships can also

have a significant role to play here, providing access to important groups through organisations who already have trusted connections with these audiences.

3.7 Our strategy has significant ambition, and we recognise the considerable challenge that this presents us in realising our goal. We will only be successful if we ensure that ownership is driven deep into the organisation – something which we all think about, embrace and do, rather than it being performed by a single central team. Whilst it is difficult to draw direct comparisons with other health partners, we have looked at the level of resource which others commit to patient engagement.

The Health Research Agency (HRA) has a team of 4, supplemented with additional patient engagement leads assigned to key programmes/projects. At the other end of the spectrum NICE has a team of 18 in their Public Involvement Programme, with strategic guidance provided by a separate System Engagement Team, as well as additional support from Communications.

We currently have a team of 4 supported by 1 apprentice, but it is clear that we need to grow this by 2 or 3 specialists to make the progress we seek. The Public, Patient and Stakeholder Engagement team will be the central co-ordinating hub for all patient engagement across the agency, with awareness, input and co-ordination/approval across all aspects, and using its expertise to deliver the best results for patients. The additional resource will act as key strategic drivers/leaders who can work to guide, nurture and embed our patient focus deep into the organisation. This core team are already supported by a small network of patient engagement champions and we'd like to also expand this further to ensure we have champions in all key teams. The need to grow our team and network is becoming increasingly urgent but for a good reason. Our internal transformation campaign "One Agency. Delivering For Patients" together with a new patient focus value for all staff, is working well and we have seen a significant rise in requests to the team for support in involving patients in their work. It's essential that we are able to meet these new requests, encouraging and fulfilling them rather than pausing this interest and ambition.

3.8 The increase in requests has put pressure upon our Patient Group Consultative Forum and highlighted the important role of partnerships. Our group consists of over 120 organisations and individuals that we contact to provide a patient voice and valuable input on a wide range of issues.

We urgently need to address this to ensure their voice remains fresh and representative of the wider patient population. The approach of other organisations was highlighted earlier, and whilst we will look to build and ensure our own group is more representative, we are also working to build partnerships with other health organisations and put in place reciprocal arrangements. Longer term we would like to explore the possibility of building even stronger partnerships to create a much larger shared patient pool, and both NICE and HRA have said they would be interested in discussing this further.

We can also make better use of the patient insight and knowledge gleaned across the agency from the many different workshops and forums we conduct, making it more easily available and accessible to inform other projects or workstreams. This was highlighted in the IMMDS Review as '*Collect once, use often'*. We know that we often engage with similar

patient groups on similar issues to those of other health partners, and therefore we will explore the creation of an insight exchange with other health partners, and a co-ordinated shared patient pool would help make this possible.

3.9 Our ability to make the best use of technology will also have an impact on our speed of progress. Building a larger Patient Group Consultative Forum will need us to move from spreadsheets to an online system that is both easier for patients to join and find out about, and easier for us to manage and identify patients who fit the criteria for a particular engagement initiative. We need to recognise that not everyone will want to engage in this way, and we will build in checks into our selection process for patient involvement to be sure that we are obtaining a representative sample and failing that adopt a different approach.

4. Recommendation

4.1 The Board endorse the high-level strategic objectives as set out in this document.

4.2 The Board provides approval to seek ministerial sign off to proceed to final public consultation, and then publication of the strategy in late Spring 2021.

Mercy Jeyasingham/Rachel Bosworth
March 2021

ANNEX: Proposed Patient and Public Involvement Strategic Objectives 2020-25

1. Patient and public involvement

Objective:
We will develop and introduce clear processes for engagement and involvement, to ensure teams have a systematic means of engaging and involving patients and the public in their work and that we publish how we do that.

We intend to deliver and have these processes embedded across the agency **by June 2022.**

Supporting objectives:
We will define and measure the type of outcomes that might be expected from that engagement and involvement.
With health inequalities in mind, we will identify stakeholders who are not active members of patient groups and create opportunities for them, as well as under-represented groups and diverse communities, to interact with us (e.g. minorities, older people, those with learning disabilities, those who do not have English as their first language).
We will explore collaborations with other health regulators to provide a collective training/resources offer to patient groups.
We will look for ways to reflect the views of children and young people in our work, who may have different perceptions to their medical issue and how it is treated.
We will learn from the National Standards for Public Involvement and other examples and models of good practice that we might seek to adopt for the Agency.

Examples of how we will achieve this:
- Identify ways to ensure that patients and the public can be better informed about the specific products used in their healthcare to enable them to make more informed decisions
- Commission research on post-COVID-19 public understanding of risk (vis-a-vis medicines, devices and vaccines), how risk is best communicated
- Develop a process to more systematically involve patients and the public in our regulatory decision-making processes, committees and governance. To include:
  - Through our Innovative Licensing and Access Pathway, incorporating patient and public views on the benefits and risks of medical products and the overall development programme, ensuring that medicines and devices are developed in a way that considers their needs
  - Piloting new approaches to ‘design-in’ patient and public engagement and involvement to our processes, including patient and public input in the regular review of patient safety ‘signals’ and new sections in assessment report templates that act as a prompt to check that patient and public engagement has been considered
  - Developing the use of Patient-Reported Outcomes so that it is built into all of our licensing decisions
  - Formalising the work of our Patient Group Consultative Forum, including regular attendance from the Agency’s Executive Committee, so that it becomes truly representative of the whole healthcare landscape and the central route through which the ‘patient and public voice’ is communicated to the Agency

- Build transparency into our regulatory systems, decision-making processes, committees and governance, and we will report on what impact the involvement of patients and the public has had. This will include:
  - The Board's new assurance committee on Patient Safety and Engagement will provide oversight of and challenge to the Agency on how well we are achieving these aims

- Increased involvement of patients and the public in drafting of public-facing information material including on GOV.UK. e.g.
  - When producing guidance for patients, public or healthcare professionals on medicines or medical devices that will be published on GOV.UK, wherever possible we will share the draft guidance with the target audience for comment before publication and seek to incorporate that feedback in the final version where possible/practicable/appropriate.
  - Seek patient and public views on concepts and material for communications at the appropriate time in the decision-making process to ensure as far as possible that they are shaped around patient need/preferences

- To supplement a new programme of Board meetings in public, introduce a schedule of regular (e.g. twice yearly) public meetings where we will explain our work and ask patients and the public proactively for their views on medicines, medical devices and other issues being considered by the Agency or which patients and the public wish to raise with us, as well as seeking their help in deciding our priorities:
  - We will seek initial views from our Patient Group Consultative Forum on potential topics

- We will explore ways to provide greater opportunities for patient and public involvement in the development of patient safety information and more general materials to help explain the benefit and risk approach to the regulation of medicines and medical devices.

2. Responsiveness

Objective:
In designing and delivering our services, we will embed the 'patient and public voice' to ensure that those services meet the needs of the patients and other members of the public who use them. We will implement a process allowing for more agile and regular review of high-risk issues, with a system that flags when more in-depth involvement of patient groups is needed.

We intend to deliver this **by December 2022.**

Examples of how we will achieve this:

- As we design our new operating model, we will introduce systems and standards of service delivery that focus on the importance of regularly updating those who have raised a concern and informing them about any other relevant issues and ongoing work, in order to build confidence and trust
  - Develop a cross-Agency protocol on responding to patients when they raise concerns, including thresholds to ensure urgent response when appropriate
  - Improving user experience of Yellow Card scheme
  - Develop and continue to build the Customer Service Centre as the single point of contact for patients and public.

3. Internal culture

Objective:
We will introduce new systems, processes and training to support a change in our culture, so that every member of staff considers the patient and public perspective in their decisions, and that all staff are well supported and involved in delivering that change.

We aim to deliver this **by June 2022.**

Examples of how we will achieve this:

- Introduce new ways of working as outlined in sections 1 and 2 above, with patients and the public central to how we develop our new operating model for the Agency
- Regular patient speaker programme, with patient advocates giving presentations to staff about how we can engage patients and the public and involve them in our work
- Introduce a programme of training for our staff to support them in engaging more effectively with patients and the public
- Incorporate into the work/thinking/behaviours of all staff by ensuring 'Patients and Public' is a common thread within our emerging Delivery Plan 2021/23. '*Our core focus will be on patients and public, placing them at the heart of our thinking*'
- Develop and share examples from across the agency of staff bringing to life our value '*We focus outwards on patients and the public'*, highlighting indicative behaviours to help staff know if they are performing well in this area or if they need to change
- Build patient and public engagement into the corporate induction for all new starters, including patients and others talking about the importance of the Agency engaging with patients and the public
- Embed a focus on patients/customers within the Agency's new performance development scheme so it is reflected in goal plans for staff

4. Measuring outcomes

Objective:
We will develop, build and embed a clear patient outcome evaluation framework that ensures we consider all patients and which enables us to demonstrate our progress in delivering our vision of being a patient focused regulator.

We intend to deliver this **by December 2021.**

In measuring patient engagement outcomes, it is important that we consider patient engagement in its broadest sense, and beyond the scope of many of the actions contained in the strategy. Our model comprises three patient groups that we engage with to considerably varying degrees. Successfully delivery of this approach will rely on our ability to align all activity and measures of patient engagement and involvement with our high level framework of outcomes.

Our engagement outcomes are an important driver of our overall reputational measure of trust in the MHRA brand and in public confidence in medicines and medical devices. We will create a patient engagement index for each group, and we will explore the validity and appropriateness of creating an overall patient engagement index.

Outcome Framework

The outcome framework will provide us with a robust understanding of patient engagement and experience across the three main groups, but we also require far greater depth in our approach to evaluation and this would include:

- Evidence of increased speed with which we involve patients in signal management (i.e. the process by which data or information that may suggest a new causal association, or may contribute new information about a known association, between a medicine and a side-effect with a medicine or a problem with a medical device, that justifies further investigation)
- Evidence of increased number of clinical trial protocols that the Agency recommended that patient-reported outcome measures should be built into their design
- Tangible and an increasing volume of evidence that the Agency is demonstrating that it is taking into account what patients and the public have told the Agency and that it is acting on that input
- Immediate feedback from patients and the public – set of standard questions for the interactions a patient has with the Agency (e.g. based on 1-5 star rating and the reason for giving that rating), with a procedure in place to proactively act on feedback received
- Commission independent provider to conduct focus groups or interviews with patients and the public who have been involved in activities to identify strengths and areas for improvement as we continue to develop in this area. To include representation from under-represented groups/communities
- Six-monthly survey, targeted at those who have engaged with the Agency (where known) and published on GOV.UK, to gather feedback from patients, the public and other stakeholders on overall progress against our objectives/actions towards achievement of our outcomes – to include both quantitative and qualitative feedback
- We will use the Government Service Standard to guide the development of our new Digital Services, and assess our performance against those standards
- Quarterly pulse check (asking the question: 'how are we doing?') with patient groups via the Patient Group Consultative Forum
- Annual YouGov or Ipsos MORI poll on broader public understanding of risk to help us amend how we deliver
- Benchmark against other regulators including in other sectors and outside the UK

Internal Culture Change Measures

- Patient and public engagement-specific question/s in annual Civil Service People Survey
- Surveys of staff pre/post-training
- Develop and monitor an employee index as part of the existing quarterly pulse survey of staff, and linked to the One Agency change programme.
- Analysis of other metrics including number of staff attending monthly patient speaker presentations, number of staff undertaking patient and public engagement and involvement training as part of induction or continuing professional development, number of patient/public partners involved in activities and diversity of those participants

5. Partnerships

Objective:

We will develop a cross sector partnership plan that builds and delivers collaborations with partners across the health sector to improve the effectiveness of engagement and share patient insight.

We intend to deliver this **by March 2022.**

Our partners across the health sector have an important role to play and we will continue to build ever closer relationships that enable us all to deliver the best outcomes for public and patients.

There are two core areas where this can add significant value and where we will focus our effort;

Insight Exchange
Our increasing patient engagement through consultations, workshops and forums provides us with a rich source of research and data which needs to be consolidated into one point. This could provide us with a rich source of patient insight that could be shared across the agency to inform new projects and maximise the return on investment. We can be sure that other health partners also manage similar insight resources and we need to explore whether it is possible to build a more co-ordinated approach, removing duplication, and making better use of the information we hold to the benefit of patients.

Patient Engagement Mechanisms
We intend to overhaul our Patient Group Consultative Forum to make it far more representative of the patient population and improve its diversity. Again, we know that other health partners have built similar pools and we would be keen to look at whether a syndicated collaboration is possible.

In the absence of this, or until we can realise that ambition, we will also engage health partners to access existing patient population pools held by others, and where it makes no sense for us to duplicate an already effective approach.

Medicines & Healthcare products Regulatory Agency

BOARD MEETING HELD IN PUBLIC

16 March 2021

Title	What are the key requirements in the new Unitary Board Conflicts of Interest Policy?
Board Sponsor	Stephen Lightfoot
Purpose of Paper	Approval

Medicines & Healthcare products Regulatory Agency

What are the key requirements in the new Unitary Board Conflicts of Interest Policy?

1. Executive Summary

1.1 This paper presents a draft Unitary Board Conflicts of Interest (COI) policy which has been updated since the establishment of the Unitary Board. The policy states the rules to be followed by Board members holding and declaring interests in the pharmaceutical and medical devices industry, provides guidance on holding and declaring other relevant interests, and on how interests that have been declared will be managed. The Board are asked to review the policy for approval and immediate implementation.

2. Introduction

2.1 In September 2020 the composition of the MHRA's Board changed with a shift to a truly Unitary Board, comprised of both Non-Executive and Executive Directors. The attached Conflicts of Interest Policy has been updated for all Directors, Executive and Non-Executive, on the new MHRA Unitary Board.

2.2 Previously, the rules concerning interests of Executive Directors were laid out in the "Dealing with Staff Conflicts of Interest" policy which applies to all MHRA staff as civil servants. This policy still applies to Executive Directors and sits alongside the Policy on Declaring and Managing Interests for Members of the MHRA Unitary Board.

2.3 Non-Executive Directors previously relied on what is set out in their letter of appointment about Conflicts of Interest.

2.4 The Seven Principles of Public Life outline the ethical standards expected of public office holders and comprise of selflessness, integrity, objectivity, accountability, openness, honesty and leadership. Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs. The new COI policy ensures Board members are held to account to these principles.

3. Proposal

3.1 The policy sets out the rules to be followed by Board members holding and declaring interests in the pharmaceutical and medical devices industry. The policy also provides guidance on holding and declaring other relevant interests, and on how interests that have been declared will be managed.

3.2 The COI policy supports a culture in which the Agency is transparent about the interests of Board members so that the effect of interests is known, understood and managed. The draft Unitary Board Conflicts of Interest Policy is attached for consideration.

4. Recommendation

4.1 The Board is asked to consider and comment on the Unitary Board Conflicts of Interest Policy and approve it for immediate implementation. This will assure members of the public of the Agency's commitment to being open and transparent.

Stephen Lightfoot
March 2021

Policy on Declaring and Managing Interests for Members of the MHRA Unitary Board

Responsible Officer: Stephen Lightfoot
Author: [redacted]
Date effective from: XX March 2021
Next review date: January 2024

1. INTRODUCTION / PURPOSE

1.1 This policy sets out the rules to be followed by the members of the MHRA Unitary Board (herein known as the Board) holding and declaring interests in the pharmaceutical and medical devices industry. The policy also provides guidance on holding and declaring other relevant interests, and on how interests that have been declared will be managed.

1.2 This policy supports a culture in which we are transparent about the interests of Board members, so that the effect of interests is known, understood and managed.

2. SCOPE

2.1 This policy applies to all members of the Board: both Non-Executive Directors and Executive Directors, in the latter case, in the context of the Board meetings.

2.2 Separate policies apply to Executive Directors and other members of staff, as well as members of expert advisory committees.

2.3 The Chair is responsible for taking the final decision on how declared interests should be handled. Where the interest is declared by the Chair, the responsibility lies with the Deputy Chair in consultation with the Board Secretary as appropriate. If it is necessary, legal advice may be sought from DHSC Legal advisers on any interest.

3. INTERESTS WHICH NEED TO BE DECLARED

3.1 It is the responsibility of each individual to identify and to declare all relevant interests. The following types of interest must be declared by the Chair and members of the Board:

- Their own financial interests in or payments from the pharmaceutical and medical devices industry or other relevant industries (financial interests are either personal or non-personal, and either specific to a product being discussed, or non-specific);
- Financial interests in the pharmaceutical and medical devices industry held by members of their immediate family;
- Any business interests or positions of authority outside of their role in the MHRA regardless of whether they are linked to the health sector or not
- Any other matter that could affect their impartiality, or that could reasonably be perceived as affecting their impartiality.

3.2 At a meeting, personal interests must be declared as specific (that is, payment relates to a particular product under consideration), or as non-specific (that is, not related to the particular product under discussion).

Definitions

3.3 "Medical Device Industry" and "Pharmaceutical Industry" are defined as:

- Companies, partnerships or individuals who are involved in the manufacturing, supply, selling, offering to supply, storage, importing, or exporting of medical products (encompassing medical devices and medicinal products), active substances, excipients, parts, materials and accessories.
- Trade associations representing companies involved with such products.
- Companies, partnerships or individuals who are directly concerned with research, development or marketing of a medical product and medical devices which is being considered by the Agency.

3.4 "Immediate family" is defined as a spouse or partner and members of the family living in the same household.

4. DECLARATION OF INTEREST

4.1 The Chair and Board members are required to make a full declaration of interests on appointment and annually. They must also inform the Board Secretary promptly of any changes or updates to the terms of their declaration during the year. If an individual is uncertain as to whether or not an interest should be declared, he or she must seek guidance from the Board Secretary.

4.2 The Chair and members are also required to make further declarations of relevant interests at meetings, where they will be advised as to the procedure that will apply.

4.3 The declaration of interest form is available in **Annex A.**

4.4 The process for declaring interests is as follows:

Declaration of interest submitted prior to the MHRA Board
Reviewed by the MHRA Chair and interests added to the register of interests on appointment

⬇

Declared interests available to Board members at the meeting
At the start of the meeting, attendees asked to declare any changes to the declared interests and any potential conflicts of interest in relation to the items to be discussed.

⬇

Interests are recorded in the minutes
Details of the interests are recorded in the Board meeting minutes including whether the member who took part in the proceedings. Register of interests is updated.

⬇

Annual renewal of declarations
All Board members to complete their annual renewal or make a nil return and the register will be updated as appropriate

Annual declaration

4.5 Each year every Board member must make an annual declaration. This must cover:

- all the financial (personal and non-personal) interests in the medical devices and/or pharmaceutical industry of the Chair and members currently held or held in the last 12 months;
- financial interests in the medical device and/or pharmaceutical industry that they know of that are held by their immediate family.
- any business interests or positions of authority outside of their role in the MHRA regardless of whether they are linked to the health sector or not

4.6 Board members and the Chair are also required to include in the annual declaration details of any other matter which could reasonably be regarded as affecting their impartiality.

4.7 A member must declare a personal specific interest if an individual has worked on a product under consideration and is receiving or has received payment for that work.

Declarations at meetings

4.8 At any time in the year, if the Chair or members become aware of a matter on which any discussion at Board meetings could be regarded as affecting their impartiality, they must alert the Board Secretary. This will ensure that the Board Secretary can withhold any papers on such matters from that member.

4.9 On receipt of papers, if the Chair or members realise that there is a matter for discussion which could call into question their impartiality, they must immediately alert the Board Secretary who will note that this member will leave the meeting for this part of the agenda.

4.10 At the beginning of each Board meeting, the Chair and members are required to declare relevant interests, whether or not those interests have previously been declared to the Agency.

4.11 If an issue arises for discussion during the meeting on which the individual believes could call into question their impartiality, they should immediately speak up, excuse themselves from the discussion and leave the meeting.

4.12 The Chair is responsible for taking the decision on how declared interests should be handled (where the interest is declared by the Chair, the responsibility lies with the Deputy Chair in consultation with the Board Secretary as appropriate).

5. PARTICIPATION IN DISCUSSIONS WHEN AN INTEREST HAS BEEN DECLARED

5.1 The following paragraphs describe, for each category of interests declared, the actions to be taken.

Personal Interests

5.2 The Chair and Board members' declaration of their own interests will identify them with the interests declared, but the interests declared do not need to be quantified.

- Involvement in the development of a product will usually debar an individual from ever participating in discussion on that product. A less significant involvement, or less specific work with or on a product, may not permanently debar an individual, but such decisions will need to be taken on a case by case basis, taking account of the nature of the involvement, its specificity and when the work was undertaken.

- If an individual has declared a personal non-specific interest the individual must take no part in discussions on that agenda item, except at the Chair's discretion to answer questions from other members.

- If the individual has declared a personal interest in relation to a member of his or her immediate family, he or she should similarly take no part in discussions except at the Chair's discretion to answer questions from other members. Such interests may range from a family member's major role in the development of a product under consideration to a family member's shareholdings.

- A member must declare a non-personal specific interest if the organisation for which the individual is responsible is currently receiving payment in respect of work done on the device and/or product. The individual will generally not be able to take part in proceedings where an organisation for which they have responsibility, has carried out specific work on the product under discussion.

- A member must declare a non-personal, non-specific interest if their organisation is currently receiving payment which does not relate to the product under discussion. Such an interest will not normally debar an individual from taking part in discussions, unless exceptional circumstances arise in which it is not appropriate for them to do so.

- If an individual declares non-personal interests of an immediate family member, this will not generally prevent him or her from taking part in discussions.

Non-Personal Interests

5.3 When the annual declaration includes matters relating to other persons, names are not required, nor do the interests declared need to be quantified. For example, in declaring shareholdings only the company name is required, not the numbers or values of shares held. Family members should be referred to simply as: "immediate family member" and closely connected persons as "other person". In nearly all circumstances this will protect the anonymity of those whose interests must be declared by the serving committee member, although we recognise that in very exceptional circumstances it may be possible for that individual to be identified.

Interests of the Chair

5.4 For the purposes of paragraph 6.1 to 6.3, if the interest in question has been declared by the Chair, the discretions referred to in those paragraphs should be exercised by the Deputy Chair in place of the Chair in consultation with the Board Secretary as appropriate. Where the Chair has declared an interest, he should step down as Chair for the agenda item to which the declared interest relates.

6. RECORDS AND PUBLICATION

6.1 All declared interests that are relevant or could be perceived to be relevant to MHRA's work will be entered onto the register of interests.

6.2 The annual declaration made by the Chair and members of the Board will be published each year in the MHRA Annual Report.

6.3 The register of current interests for Board members will also be published on the MHRA page on GOV.UK.

7. REVIEW

7.1 This policy will be reviewed every 3 years unless an earlier review is required.

Board COI Policy – Annex A: Declarations of interest form

MHRA Unitary Board member – Register of interest form

Name				
Name of company / organisation	**Nature of interest / role**	**Personal (ie remunerated) or Non-Personal**	**Specific (ie individual product) or Non-Specific**	**Current Interest Now or in Last 12 Months**

Signed Date

Board COI Policy – Annex B: Examples of interests to be declared

1. Personal interests

1.1 A personal interest in the context of this policy, involves the payment, in any form, to an individual personally, by a pharmaceutical or medical devices company whose business may be directly affected by decision of the Board.

1.2 At a meeting, personal interests must be declared as ***specific*** (that is, payment relates to a particular product under consideration), or as ***non-specific*** (that is, not related to the particular product under discussion).

1.3 The following main examples of interests to be declared should not be regarded as a definitive list, and the Board Secretary will advise (with legal advice if necessary) if the Chair or any Board member is in any doubt.

- ***Consultancies:*** any consultancy, directorship, position in or work for the pharmaceutical or medical devices industry which attracts regular or occasional payments in cash or kind;
- ***Fee-paid work:*** any work commissioned by the pharmaceutical and medical devices industry for which the individual is paid in cash or kind;
- ***Shareholdings:*** any shareholding in or other beneficial interest in the pharmaceutical and medical devices industry. This does not include shareholdings through unit trusts or similar arrangements where the individual has no influence on financial management;
- ***Expenses/hospitality provided by a pharmaceutical or medical device company:*** special rules apply to attendance at conferences or similar events. These are covered in the last section of this annex.
- ***Unit trusts and similar:*** Assets over which the Chair and members and/or their immediate family have no financial control (such as holdings in a wide share portfolio - Unit Trust or similar - where the Fund Manager has full discretion over the composition of the portfolio) do not need to be declared. However, funds held in a portfolio in which Chair and Board members and/or their immediate family have the ability to instruct the Fund Manager as to the composition of the fund, must be declared.

- ***Pension entitlement*** Accrued pension rights from earlier employment in the pharmaceutical or medical devices industry do not need to be declared.

2. Non-personal interests

2.1 A non-personal interest in the context of this Policy, involves payment that benefits a department for which an individual is responsible, but is not received by the member personally. As with personal interests, non-personal interests at a meeting must be declared as specific or non-specific. The main examples that follow should not be regarded as a definitive list, and the advice of the Board Secretary should be sought if the Chair or any Board member is in any doubt.

- ***Fellowships:*** the holding of a fellowship endowed by the pharmaceutical industry or medical device industry;

- ***Support by the pharmaceutical industry or medical device industry:*** any payment, other support or sponsorship by the pharmaceutical or medical device industry that does not convey any pecuniary or material benefit to the individual personally but that benefits his/her position or department;

- ***Grants from a company:*** for example, for the running of a unit or department for which an individual is responsible;

- ***Grants or fellowships to sponsor a post or staff member in the unit for which the individual is responsible:*** this does not include financial assistance given to individual students;

- ***Commissioning of research or other work or advice from staff who work in a unit for which the individual is responsible;***

- ***Conference, scientific meeting or other meeting attendance funded by the pharmaceutical or medical device industry.***

3. Other relevant interests

3.1 It is not only financial interests in the medical device and/or pharmaceutical industry that are relevant. A wide range of other matters may also be considered to be relevant, depending on the circumstances and matters under consideration by the Board, and could include any business interests and positions of authority outside of your role in the MHRA.

3.2 There are no hard and fast rules concerning “other” interests that need to be declared. The legal rule against bias in the decisions and proceedings of public bodies can be stated as follows: if a fair-minded and informed observer would conclude, in all the circumstances, that there is a real possibility of bias, the Board member should not take part in proceedings. It is therefore not relevant that the Board member themselves believes that they are unbiased, impartial or has an open mind.

3.3 In considering whether an interest is relevant and should be declared, the guiding principle must be whether the matter might reasonably be perceived as possibly affecting a Board member’s impartiality. Members of the Board should always seek advice from the Board Secretary if they are in any doubt about whether or not a matter is relevant. The Board Secretary will seek legal advice if necessary.