Accelerated Access Review

Themes in feedback following the Interim Report

Independent analysis by The Evidence Centre

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Themes in feedback following the Interim Report

Prepared by The Evidence Centre, an independent organisation

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Executive summary

In October 2015, the Accelerated Access Review published an Interim Report outlining key propositions to guide future planning. The Review asked people and organisations to share their views about these propositions for speeding up access to new medicines and health technologies. This document summarises the main trends in feedback following publication of the Interim Report.

Background

The Accelerated Access Review is considering how to speed up access to innovative drugs, devices and diagnostics for people using NHS services. Following engagement between July and September 2015, the Review published an Interim Report setting out five propositions for the future:

- **Proposition One: Putting the patient centre stage** - Patients should be given a stronger voice at every stage of the innovation pathway.
- **Proposition Two: Getting ahead of the curve** - A radically new approach is required to accelerate and manage entry into our health system for the emerging products that promise the most significant, potentially transformative impact in terms of patient benefit and overall value.
- **Proposition Three: Supporting all innovators** - In addition to accelerating access to a select number of the most promising new products, our end-to-end innovation pathway can, and should, also be more responsive to the wider, irrepressible surge of innovation presented at all levels of the system, particularly where its introduction will contribute to better outcomes for patients and more productive and efficient ways of delivering care.
- **Proposition Four: Galvanising the NHS** - The NHS must be an active partner in promoting innovation, and must be incentivised to adopt new products and systems quickly and effectively.
- **Proposition Five: Delivering change** - Building on existing health system structures, a new system architecture is required at local and national level to accelerate access to the best new products and related models of care on a sustainable basis, within a framework of collective agreement to ambitions and goals.

Between October 2015 and early January 2016, the Review team took part in meetings and invited feedback via a website and by email / post. Seventeen questions were posed and respondents also provided general feedback about the propositions. This document provides an independent analysis of key themes in the feedback received following publication of the Interim Report.

Responses

Individuals and organisations provided a total of 79 comments via the website and 50 responses by email / post or as part of notes from meetings. Some people and organisations provided more than one response so these were grouped together, making a total of 64 responses from unique respondents. About one fifth of these responses (22%) were submitted through a dedicated website, three quarters were submitted via email, post or meetings (73%) and 5% combined online and other submissions.

Although people were not asked to specify whether they were representing an organisation or responding as an individual, it appears that most feedback came from organisations. Less than 10% of responses appeared to be from individuals. Most responses from organisations were from the pharmaceutical industry, voluntary sector and academic / research / think tank groups.

Key messages

Responses stated that they supported the work of the Review and the five propositions. They reported that the principles guiding next steps were sound and that further detail about how these principles would be put into practice would be welcomed.

Table 1 lists the questions posed following publication of the Interim Report and the main trends in feedback. Some responses provided general comments about the five propositions or other broad comments. However, these were generally related to the questions posed by the Review so all of the responses have been compiled and analysed according the topic areas in the questions posed.

It is important to remember that each response could represent many different people. For example, some responses were from meetings with many participants and other responses were from large organisations.

Table 1: Summary of key trends in feedback to Phase 2 of the Accelerated Access Review

Question	Responses	Key themes
Proposition One: Putting the patient centre stage		
How could patient-led outcome measures inform the evaluation of new products and the decisions made by regulators and other key bodies in the system?	17	• There was support for using patient-led outcome measures to support the evaluation of new products, though some responses questioned the practicalities of this. • It was suggested that tools such as the EQ-5D and QALYs did not fully account for the range of outcomes that are important to patients. • There was a call to involve patients earlier and throughout the process, including in developing appropriate outcome measures and being part of NICE assessment panels.
What are the key concerns for patients across the whole pathway of an innovation product?	15	It was perceived that key concerns for patients included: • Information and transparency • Involvement in innovation • Speedy access to products • Safety • Choice • Funding of products of choice • Equity in access to products
How can we make sure our proposed system architecture includes sufficient opportunity for patient interaction?	32	• Responses emphasised the need to provide information in an accessible format to support patient participation. • It was suggested that the NHS Constitution could be used to enhance involvement. • It was felt to be important to monitor the extent of patient involvement and set up processes to deal with insufficient involvement. • There were suggestions about how to expand patient involvement within NICE processes. • There was thought to be much scope for joint working between patient groups, industry and statutory services. • However some responses stated that many other factors may override the patient voice in decision-making and that it was important to be realistic about what could be achieved.

Question	Responses	Key themes
Proposition Two: Getting ahead of the curve		
How could the acceleration of the most transformative products apply in particular therapy or disease areas?	18	• Responses suggested that it was important not to prioritise transformative products at the expense of others. • It was felt that having a separate funding mechanism for transformative products while they are under 'conditional' status would be worthwhile. • It was thought to be important to differentiate processes for different types of products, such as those for rare diseases.
How could each component of the accelerated pathway for medicines, devices, diagnostics and digital health products work?	27	• Responses wanted a clear definition and criteria for transformative products. There was a concern that only a limited number of products would be covered. • It was suggested that policies and definitions could be closely aligned with the US FDA and the European Medicines Agency. • Early discussions with MHRA and NICE during the assessment process were thought to be helpful. • Responses from the pharmaceutical industry expressed concerns about suggestions in a separate consultation about the Cancer Drugs Fund. • There was a desire for more robust and less fragmented data systems within the NHS, including better use of real world data and patient registries. • Responses were keen to ensure the pathway gave thought to improving uptake after approval.
What are the pros and cons of different ways of reimbursing innovative products?	20	• Feedback was provided about risk share schemes, flexible reimbursement schemes, pay as you use models, fast track reimbursement, proxy insurer models, capped price per patient, PASLU, price volume agreements, partial or mixed repayments, sponsoring small and medium enterprises and Part IX of the Drug Tariff
What could be the role of key national bodies in delivering the accelerated pathway and how can these bodies ensure patients are embedded in all decision-making processes?	23	• Some responses suggested that all medicines should be reviewed under the auspices of NICE to standardise the approach to value assessment. • Monitor and CQC could monitor variation in uptake at a local level. • Patient groups should be involved in dialogue. • It was suggested that the transparency of decision-making could be improved at NHS England and NICE.

Question	Responses	Key themes
Proposition Three: Supporting all innovators		

How useful do you find our proposals for a new system of guidance and support?	18	• Responses were generally supportive of the proposals for a new system of guidance and support, though some did not feel the Review went far enough in recommending system transformation.
		• Suggestions included:
		  ○ Clarifying the support available to various parties
		  ○ Clarifying the responsibilities of national and local commissioners and regulators
		  ○ Having consistency across countries and product types
		  ○ Ensuring patients, industry and statutory services have a mechanism for early proactive and ongoing communication
		  ○ Ensuring clear plans for implementation and accountability

How can we ensure that the proposed new system for supporting innovators complements and streamlines current systems and avoids duplication?	15	• Enhancing collaboration between organisations • Strengthening the mandate and resourcing of NICE • Operating a single national value assessment system
Are there any quick wins or significant barriers to innovation that our proposals for a new system support do not address?	20	• Quick wins might include developing a single central value assessment process for all medicines and supporting the NHS to systematically decommission products. • Suggested gaps that the Review could further explore included covering a wider range of medicines and products, tackling widespread delayed usage of new medicines and evolving NICE beyond cost-per-QALY approaches.

Question	Responses	Key themes
Proposition Four: Galvanising the NHS		

How can the NHS be incentivised and supported to introduce innovative technologies?	18	• Proposed methods to incentivise and support the NHS to increase the uptake of innovative technologies included:
		  ○ Workforce development, including innovation champions and training
		  ○ Co-ordination and collaboration between organisations
		  ○ Setting targets and using data to monitor uptake
		  ○ Financial incentives
		• Interestingly, financial incentives were not overly emphasised. Responses recognised that the NHS is a complex system and that incentives are needed on many levels.

How could a fund to support system re-design operate and how could it be funded?	9	• Responses suggested setting up a Transformation Fund using finances from some of the PPRS rebate or using funding directly from the Department of Health. • Responses did not want to see existing funds already used for increasing access to innovative treatments, such as the Cancer Drugs Fund, repurposed into a Transformation Fund. One response stated this about this question, but others mentioned this in other parts of their feedback.
How could this proposed new system architecture be developed in a way that galvanises the NHS to promote innovation?	26	• It was suggested that there should be channels where patient organisations, industry and the NHS regularly met. • Adoption methods could be linked to new models of care and accountable care organisations. • Engaging with frontline and NHS management staff may be key. This could include building skills in change management, freeing staff time to learn about innovations and take part in research and having local change champions. • In addition to financial incentives, accelerated pathways could describe decommissioning opportunities and the financial benefits. • The desire for a clear implementation plan and ways to monitor progress was stressed. • The Innovation Scorecard was mentioned as a mechanism for strengthening transparency.

Question	Responses	Key themes
What are the costs and benefits of this new approach, which positions the NHS as an active partner in promoting innovation?	10	• Perceived benefits included early access to technologies for patients, greater investment in the UK from industry and the potential for cost savings. • Potential costs included short-term funding to set up new infrastructure, adding an extra layer of bureaucracy and increasing risk as regulatory frameworks are redesigned.
Proposition Five: Delivering change		

How should we define the remit and priorities of the Innovation Exchange function and the Innovation Partnership?	20	• There was mixed support for the notion of Innovation Exchanges and the Innovation Partnership. About half of the responses were supportive and half challenged this idea. A key concern was about the appropriateness of AHSNs leading the process.
		• Suggested priorities included:
		  ○ Delivery of access and uptake
		  ○ Uptake measurement
		  ○ Identifying promising areas which need additional support and funding
		  ○ Building on the work of the NICE Implementation Collaborative

Should the proposed Innovation Partnership and Concordat be held to account by a supporting co-ordinating committee?	9	• There was no clear pattern in comments about this question. Some responses supported a committee. Others questioned the value of such a committee and others suggested that charities, patients and other organisations should be part of the process.
What are the costs and benefits of the proposed new system architecture to accelerate the development of, and access to, the best new products	12	• The most frequently mentioned perceived benefit was the potential for long-term cost savings. • The most frequently mentioned costs or limitations included concerns over the feasibility of AHSNs leading processes and the potential lack of involvement of other organisations.

Responses to the Review

Background

The Accelerated Access Review aims to speed up access to innovative drugs, devices and diagnostics for people using NHS services. In 2016 the independent Review will make recommendations about pathways for the development, assessment and adoption of innovative medicines and medical products within the NHS. The Review is focusing on medicines, medical technologies and digital health (hereafter jointly referred to as 'products' or 'innovations').

The Review is progressing in phases. Between July and September 2015, the Review team asked for feedback related to collaboration, regulation, reimbursement, adoption and the involvement of people using services. In September 2015, the Review team paused to reflect on feedback. An Interim Report was released outlining five key propositions for future policy and planning, which incorporated suggestions received in the first phase.

The five propositions outlined in the Interim Report are:

- **Proposition One: Putting the patient centre stage** - Patients should be given a stronger voice at every stage of the innovation pathway.
- **Proposition Two: Getting ahead of the curve** - A radically new approach is required to accelerate and manage entry into our health system for the emerging products that promise the most significant, potentially transformative impact in terms of patient benefit and overall value.
- **Proposition Three: Supporting all innovators** - In addition to accelerating access to a select number of the most promising new products, our end-to-end innovation pathway can, and should, also be more responsive to the wider, irrepressible surge of innovation presented at all levels of the system, particularly where its introduction will contribute to better outcomes for patients and more productive and efficient ways of delivering care.
- **Proposition Four: Galvanising the NHS** - The NHS must be an active partner in promoting innovation, and must be incentivised to adopt new products and systems quickly and effectively.
- **Proposition Five: Delivering change** - Building on existing health system structures, a new system architecture is required at local and national level to accelerate access to the best new products and related models of care on a sustainable basis, within a framework of collective agreement to ambitions and goals.

This document summarises key themes from feedback following the release of the Interim Report, based on analysis by an independent team.

This section describes how trends from the responses were analysed and provides an overview of the number and type of responses received. The following sections describe feedback about each of the questions posed by the Review team, grouped into five sections corresponding to the propositions above.

Compiling responses

Receiving responses

The Accelerated Access Review team disseminated information to organisations and stakeholder groups, took part in discussions and publicised the Review using a dedicated website and social media and blogs. Following publication of the Interim Report, the Review team posed 17 key questions of interest.

Individuals and organisations were invited to submit comments via a website or by email, post or by taking part in meetings.

Identifying trends

An independent organisation, The Evidence Centre, drew together the main themes from all of the responses, focusing on practical suggestions for change. The analysis team was not involved in any other aspect of the Review and had no vested interest in the outcome.

The purpose of the analysis was to provide a summary of key themes in feedback. The analysis was not designed to substitute for reading each response to the Review or to provide a great deal of detail.

The Accelerated Access Review team received all responses and provided copies to the independent analysis team. The analysis team read every response and collated the feedback about each question into in an electronic spreadsheet, along with background details about the respondent, where available.

Where responses did not explicitly answer questions posed by the Review, material relevant to the topic areas of the questions was extracted. Around 20% of responses provided general feedback about the propositions rather than addressing specific questions, but due to the broad nature of the questions and feedback it was possible to categorise these responses in terms of the topics covered in questions. Any additional content outside the scope of the questions was also examined, but very few comments were not related to a topic covered by the questions.

All of the verbatim feedback for each question was categorised to identify trends. The analysis team drew out recurring feedback and examined any trends based on the sector from which responses came.

Reporting on trends

This report lists the number of responses that commented about a particular topic, the main trends in feedback about each topic and the main sectors from which feedback came. The feedback is arranged according to the five key propositions outlined in the Interim Report, as listed previously. Responses could provide multiple comments about each proposition or question.

There were overlaps in the topics covered in some of the questions. For instance, more than one question mentioned national bodies and more than one question asked about funding systems. This means that when reporting the comments, there is duplication in some of the feedback across the questions.

Feedback from responses is reported without assessing the feasibility of the suggestions made, or weighing the relative pros and cons of various suggestions. The purpose of the document is to provide an overview of the feedback received. The Accelerated Access Review team is responsible for considering all of the trends and for reading each of the responses in detail to decide how to use the feedback.

Quotes are used throughout the report to illustrate key points made. These quotes were chosen to provide a flavour of what responses said and to show the variety of different types of respondents.

It is important to recognise that one response does not equate to one person. Some responses were from organisations or groups representing many hundreds or thousands of people or comprised notes from discussion events with many participants. For this reason, the number of responses that made a certain point should not be used to judge the scale of agreement.

Characteristics of responses

Number of responses

Seventeen individuals and organisations provided 79 comments via the Review website. Fifty responses were received by email, post or as part of notes from meetings. Some of the emailed responses contained multiple documents.

Some people and organisations provided more than one response containing different points. Responses from the same person or organisation were grouped together to avoid double counting, bringing the total number of unique responses analysed to 64.

In addition, the Accelerated Access Review team also received feedback as part of iterative discussions. This developmental feedback was not provided to the independent team for analysis. The themes summary is based on formal responses to the Review.

Types of responses

About one fifth of the 64 responses (22%) were submitted through a dedicated website, three quarters were submitted via email, post or meetings (73%) and 5% combined online and other submissions.

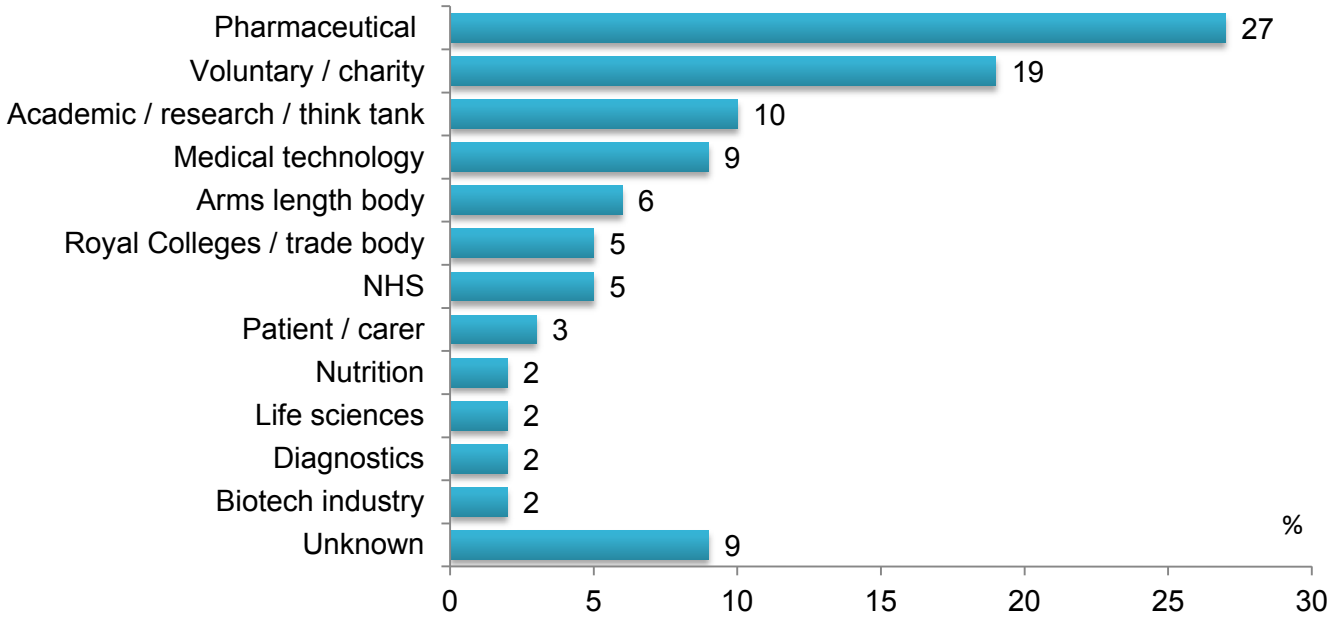
Types of respondents

Figure 1 shows the sectors from which responses came. This includes responses from organisations and from individuals responding from a specific sector. The most common sectors were the pharmaceutical industry, the voluntary sector and academic / research / think tank organisations.

Although people were not asked to state whether they were representing an organisation or responding as an individual, it appears that less than 10% of responses were from individuals.

Demographic details such as age, gender and geographic location were not collected as part of the Review.

Figure 1: Sectors represented in responses to Phase 2 of the Accelerated Access Review



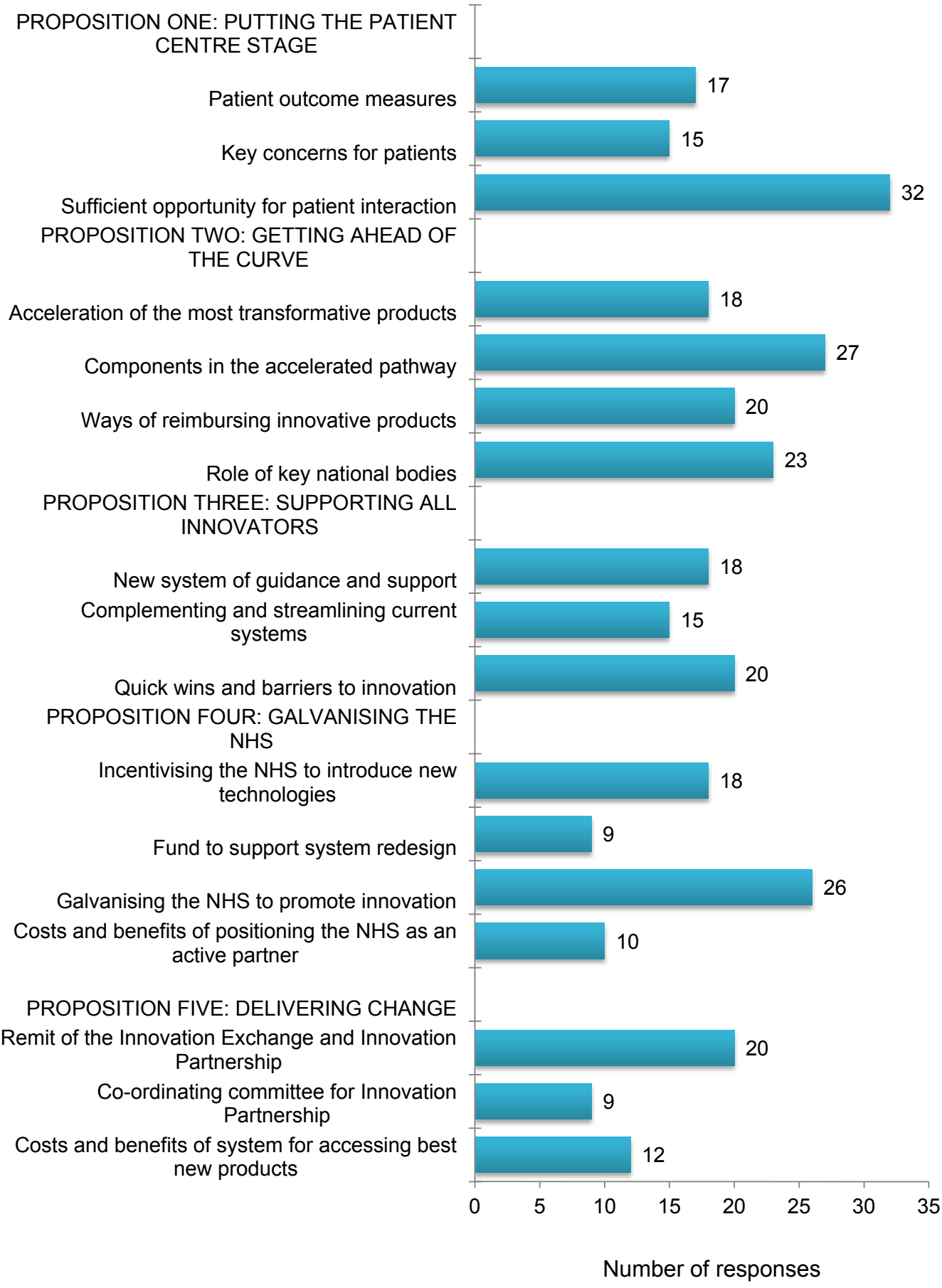
Note: Percentages are based on all 64 responses

Questions addressed

Figure 2 shows how many responses addressed each of the seventeen Review questions or contained material about the topics covered in the questions. The exact wording of the questions is provided in Table 1 (in the Executive Summary) and referred to throughout the document. The purpose of this figure is to show ‘at a glance’ which topics were most commonly commented about.

This section has outlined how themes from responses were compiled and the characteristics of the responses. The rest of this document explores what responses said about each of the five propositions and the Review questions in turn.

Figure 2: Number of responses providing feedback about each of the Phase 2 Review questions



Proposition One: Putting the patient centre stage

This section summarises feedback relating to **Proposition One: Putting the patient centre stage - Patients should be given a stronger voice at every stage of the innovation pathway.**

The Review questions related to this proposition were:

- How could patient-led outcome measures inform the evaluation of new products and the decisions made by regulators and other key bodies in the system?
- What are the key concerns for patients across the whole pathway of an innovation product? This might include issues around inequalities, safety, efficacy, transparency and more
- How can we make sure our proposed system architecture includes sufficient opportunity for patient interaction?

Feedback about each question is listed in turn. Responses could provide multiple comments about each question. In some instances, responses provided feedback about this proposition as a whole, rather than answering specific questions. This feedback has been incorporated with the responses to questions as all covered the same broad topics.

Overall, responses were positive about giving patients a stronger voice throughout the innovation pathway. Responses from charities were particularly favourable about this proposition.

How could patient-led outcome measures inform the evaluation of new products and the decisions made by regulators and other key bodies in the system?

In total, 17 responses provided feedback about this topic. These responses came from the pharmaceutical sector (4 responses), charities (4 responses), academic / research organisations (2 responses), arms length bodies (1 response), the NHS (1 response) and trade bodies (1 response). Four responses did not provide sufficient detail to ascertain their sector.

The key points in feedback included:

- **support for using patient-led outcome measures** to inform the evaluation of new products
- queries about how using broader outcome measures would be **implemented** in practice
- suggestions that tools such as the EQ-5D and QALYs did not fully account for the **range of outcomes** that are important to patients.
- suggestions for **involving patients throughout**, including the development of measures and as part of NICE assessment panels

Responses supported the need to pay more attention to assessing outcomes and determining value from a patient perspective. (12 responses)

> ***"No new products should even start the design phase without the end user being in the process. It would not happen in any other industry so why in healthcare. From the beginning companies should be told that they must have an end user as part of their team."***
>
> **(Response from an individual)**

It was suggested that patients should be involved in co-producing outcomes and that patient-reported outcome measures should be developed early in the innovation pathway. (4 responses)

Outcomes of interest

Responses suggested that it was important to move away from emphasising only the cost per Quality Adjusted Life Year gained (QALY) to focus on other outcomes that are important to patients. This may include wider society impact, psychological issues and burden of illness, as per the Department of Health's consultation about value-based assessment of new medicines. (5 responses)

> ***"While cost per QALY measures can provide a useful indicator of an individual's anticipated health gain following a medical intervention, they do not fully capture the benefit a treatment can offer to patients and families, particularly if they are affected by a rare condition. Therefore, it is clear that the health economist's tool box needs updating so that funding bodies can make decisions that enable patients with rare conditions to access new treatments, in line with public and government opinion and the equity standards of the NHS Constitution."***
>
> **(Academic / research / think tank)**

Responses stated that some patients reportedly feel that the EQ-5D is a crude measure of health related quality of life which is not necessarily appropriate for capturing the range of symptoms and emotions experienced by people affected by rare conditions. More in-depth measurement of disease burden and treatment benefit may be more valuable in a rare disease context than a crude measure. (1 response)

Others suggested that it would be useful to broaden the definition and approaches used to assess cost-effectiveness. (2 responses)

> ***"I would like to see more recognition of the economic elements to decision making. It is worth reminding your readers that cost-effectiveness is not about measuring whether a new technology is 'worth' its price. It is about making sure that the benefits of the new technology outweigh the inevitable loss of health that will arise through giving up other resources in the NHS in order to pay for the new technology. If the losses ("opportunity costs") outweigh the benefits of the new treatment, then the health system (and its patients) will be worse off."***
>
> **(Academic / research / think tank)**

Whilst there was support for using patient-reported outcome measures (PROMs), responses stated that it could be difficult to gather this data and that PROMs are sometimes not well defined. (2 responses)

> ***"Patient-reported outcome measures (PROMs) provide feedback directly from patients about how they feel or function in relation to a health condition and its therapy, and as such could provide important insight into patient experience of new health interventions. Nonetheless, there are many different PROM instruments, and the quality of these instruments - in terms of their appropriateness, feasibility, interpretability, precision, responsiveness, reliability and validity - varies considerably. Exactly how PROMS might be utilised to inform the evaluation of new products should be carefully considered with engagement from all stakeholder groups to ensure aims will be achieved."***
>
> **(Pharmaceutical industry)**

There was a call to involve patients, clinicians and methodologists in the development of appropriate patient outcome measures. For example, closely aligning health economics / health technology assessment (HTA) methodologists with developing PROMs ideas may help to ensure that patient-led outcomes measures are used and valued in HTA assessments. (4 responses)

> ***"Patient Reported Outcome Measures (PROMs) are useful in providing solid evidence of differences in patient outcomes and experiences between products. For conditions such as urinary incontinence, patients are best placed to identify and report changes in outcomes as they are experts in self-management and understand the small differences in usage between products. For PROMs or quality of life surveys to be useful, they must be consistent for each condition and clinically validated. Existing PROMs can be used, but should Innovation Exchanges or the Innovation Partnership produce one, they should do so in coordination with clinicians and specialist patient groups."***
>
> **(Charity sector)**

> ***"Although, PROMS have traditionally been used during clinical trials to establish the comparative effectiveness of different treatments, they are driven by the objectives of the innovator instead of the patient. PROMS need to be designed and developed before commencement of a clinical trial through discussions with patients, caregivers and patient organisations. This would ensure the production of an appropriately patient-focused PROM that could then accurately inform the design and development of a new product."***
>
> **(Charity sector)**

Some suggested that it was not always possible to measure outcomes of importance to patients within short randomised trials and that therefore trial data should not be the only or main source used when making decisions. (1 response)

Disease specific outcomes

Some suggested that the regulation process and pipeline is too long, particularly for medications for people with terminal diagnoses or rare disease. Responses stated that terminal patients should have more access to innovative approaches if they wish, and the outcomes of these approaches should be effectively recorded. (3 responses)

There was a call to use disease specific PROMs to inform the evaluation of new products as well as more general outcome indicators. (1 response)

Role of NICE

It was suggested that NICE should be provided with a clear mandate and additional resources to enable more effective patient input. This may include appointing NICE Patient Sponsors. (3 responses)

> ***"NICE needs to revise and strengthen its processes for seeking, paying heed to and making effective use of patient input into HTA decision-making. Patient input needs to be embedded throughout the process, with a strengthened Public Involvement Programme team and utilisation of a clinician and patient panel at Appraisal Committee meetings."***
>
> **(Pharmaceutical industry)**

> ***"NICE has made an effort to include 'patient experiences' when evaluating new products, however, this appears to be a small component of their decision-making processes. We believe the patient voice is undervalued in the presence of the many other expert voices i.e. economists, statisticians, mathematicians and clinicians. NICE must be transparent about how it uses patient submissions/input and provide clearer guidance on the evidence it needs from patients/patient groups. Parity must be achieved between the difference evidence sources used to make decisions. If manufacturers included validated PROMs in their clinical trial data, NICE could use these to give stronger weighting to the patient submissions."***
>
> **(Charity sector)**

A response suggested that models of patient input from Scotland and Wales could be drawn upon. (1 response)

Role of innovators

Some suggested that all innovators should be asked to carry out qualitative research to assess outcomes. (1 response)

It was proposed that the government could provide financial support for smaller companies to conduct this type of research, given the costs involved. (1 response)

The importance of investing in an IT infrastructure to provide real world data was emphasised. Industry responses suggested that such infrastructure should be publicly funded. (2 responses)

The number of responses providing feedback about this topic was too small to make robust comparisons between sectors. However in broad terms, all sectors stated that they supported greater use of patient-led outcomes measures. Responses from the pharmaceutical industry were more likely to highlight practical issues that may need to be worked through. Responses from the charity sector were more likely to call for the involvement of patients in co-producing outcome measures.

What are the key concerns for patients across the whole pathway of an innovation product? This might include issues around inequalities, safety, efficacy, transparency and more.

In total, 15 responses provided feedback about this topic. These responses came from charities (4 responses), the pharmaceutical sector (3 responses), academic / research organisations (2 responses), the NHS (1 response) and trade bodies (1 response). Four responses did not provide sufficient detail to ascertain their sector.

According to responses, key concerns for patients across the whole pathway of an innovation product include:

Information and transparency

- Access to **independent information** about available and upcoming products (7 response)
- **Transparency** around evidence and decision-making processes (4 responses)
- Providing information in an **accessible** format (2 responses)

Involvement

- **Influencing** new product innovation (4 responses)
- Ability to take part in **clinical studies** (4 responses)
- Ensuring the **voice of patients** is heard (3 responses)
- Engagement with **harder to reach groups** and those that are less vocal (1 response)
- Prioritising **outcomes that matter to patients** (1 response)

Speed

- **Quicker access** to innovative products. It was suggested that research and regulatory processes do not reflect patients' benefit/risk perspectives, particularly where patients have limited alternative treatment options (8 responses)
- Speed in hearing **NICE decisions** (1 response)
- Quicker **rollout** of products once they have been approved (3 responses)
- **Accountability** within the system for making products available quickly once approved (1 response)

Safety

- Robust **processes** for checking the safety and effectiveness of innovations (6 responses)
- Clear **information** about the safety of products (2 responses)

Choice

- Being able to make an **informed choice** about a product (2 responses)

Funding

- Having the products of choice **funded** (2 responses)

Equity

- Confidence that patients will be prescribed the best treatment for their particular health condition, **no matter where they live** in the country (6 responses)
- Improved ability to get a medicine that, in theory, should be available, but where there are variations due to **local differences** in access/formulary decisions (1 response)

> ***"Equity of access to innovations is an important national issue and one that requires urgent consideration from a patient perspective. At present patients who are able to access individual areas of clinical excellence and expertise have much more opportunity to benefit from innovations than patients in the rest of the country."***
>
> **(Academic / research / think tank)**

> ***"While a focus on streamlining regulation is to be welcomed, patient safety cannot be compromised by cutting corners – no matter how well intentioned. The current regulatory system provides important protections for patients and it is critical that nothing undermines the regulatory and legal framework."***
>
> **(Pharmaceutical industry)**

> ***"Patient groups express concern that the benefits sought in new medicines research is frequently targeted on improvements in what researchers believe are easily measureable rather than what matters to patients. Consulting patients earlier in the research process may lead to research prioritising other areas of benefit such as relating to quality of life, potentially leading to different technologies being followed up."***
>
> **(Charity sector)**

These key factors were just as likely to be suggested by responses from all of the sectors that provided comments about this topic. Responses suggested that prioritised factors should be validated with patients rather than relying on feedback from organisations.

How can we make sure our proposed system architecture includes sufficient opportunity for patient interaction?

In total, 32 responses provided feedback about this topic. This includes responses that provided general comments about Proposition One, rather than answering specific questions. Responses about this topic came from the pharmaceutical sector (12 responses), charities (10 responses), the medical technology sector (2 responses), academic / research organisations (1 response), the nutrition sector (1 response) and the NHS (1 response). Five responses did not provide sufficient detail to ascertain their sector.

Recurring suggestions for strengthening systems for patient interaction included:

- Providing **information** in an accessible format to support participation
- Highlighting relevant features of the **NHS Constitution** to enhance involvement
- Measuring **outcomes** that are important to patients
- **Monitoring** the extent of patient involvement and setting up processes and bodies to deal with insufficient involvement
- Expanding patient involvement within **NICE** processes
- Involving **patient groups** in planning and engagement
- **Joint working** between patient groups, industry and statutory services
- Recognising that many **other factors** may override the patient voice in decision-making and taking steps to address this

Patient information

Responses stated that it is important for the Review to define what is meant by 'meaningful patient interaction' to avoid a 'tick box exercise'. This may involve mapping out the stages of patient participation within the proposed system architecture. It was argued that simply publishing information does not equate to meaningful patient interaction. Having patients involved from the outset was deemed to be important. (3 responses)

> ***"To truly embed patient centricity you have to start with the patient in the room at the very beginning. There is no point in commenting on a system once it is built. Let patients help build it."***
>
> **(Response from an individual)**

Responses said that information should be provided in an accessible manner, including alternative formats. This may include plain language summaries of technical documents (2 responses)

Adding information about what treatments should be available for specific conditions to a portal such as NHS Choices was proposed as a way to increase access to information, as was revising Innovation Scorecards to be more patient friendly. (3 responses)

Some said that clinicians should play a key role in informing patients about clinical trials and encouraging them to take part. (1 response)

> ***"A survey of 392 health professionals found that a fifth do not use tailored information resources available to them to talk to their patients about research and around a third of nurses (31%) and GPs (34%) reported not feeling confident to discuss research with their patients."***
>
> **(Charity sector)**

It was suggested that an online database could list trials that are recruiting so that patients and clinicians could search for relevant ongoing research. It was felt that the Clinical Trials Gateway could be improved to increase recruitment for studies. It may be possible to merge the data from the NIHR portfolio into ClinicalTrials.Gov to avoid duplication and increase the extent to which innovators publicise their trials. (9 responses)

Others said that Local Innovation Exchanges and the national Innovation Partnership should publically advertise opportunities for patients to get involved along the innovation pathway. (1 response)

Role of the NHS Constitution

Some suggested that the content of the NHS Constitution should be highlighted in the innovation pathway. Patients may be unaware of their legal right to approved treatments and the NHS pledge to inform patients of research studies in which they may be eligible to participate. (6 responses)

> ***"NHS England should promote much greater awareness of the patient rights and responsibilities in the NHS Constitution, including the key rights on medicines. The Constitution was first published almost seven years ago and awareness among patients remains low."***
>
> **(Pharmaceutical industry)**

Measuring outcomes

Some responses emphasised the importance of prioritising patient-led outcomes and feedback. These comments replicated those provided in response to a specific question about patient-led outcomes, so are not repeated here. (3 responses)

Monitoring involvement

Responses suggested that it was important to have mechanisms in place to monitor the extent to which AHSNs, the Innovation Partnership and industry were involving patients at necessary stages and a body to report to if this was not occurring. (7 responses)

> ***"NICE approved medicines are intended to be available on the NHS within 90 days for the use of patients following discussion with their doctor about their suitability. We know this is often not the case, and indeed the potential of the NHS Constitution as a tool for change has not been fully realised. With this in mind we support the idea of a patient platform that would allow individuals or representative bodies to challenge access to and availability of innovations in the NHS. This has considerable potential to improve access, and to provide patients with a clear and simple route through which to seek redress if they are denied access."***
>
> **(Pharmaceutical industry)**

> ***"(We) called for NICE to host a new Office for Patient Outcomes (OPO), an NHS equivalent of the Office for Budget Responsibility (OBR). The OBR has been viewed as a successful independent body producing forecasts for the economy and judging Government performance against stated financial measures and targets. The proposed Office for Patient Outcomes would focus on how the NHS is achieving improved outcomes through monitoring of all existing outcomes and quality measures and indicators, incorporating international comparisons."***
>
> **(Pharmaceutical industry)**

Some felt that an independent, senior patient representative should be appointed to the National Innovation Partnership. (1 response)

An annual survey about the extent of patient involvement at various stages of the pathway was also suggested. (1 response)

Role of NICE and NHS England

Responses suggested that NICE should be provided with a clear mandate and additional resources to support increased use of patient perspectives and evidence. (5 responses)

Some suggested strengthening the NICE Public Involvement Programme (PIP) team and ensuring better integration across all aspects of the appraisal process, with the appointment of a NICE Board sponsor to champion this work. (7 responses)

NICE could enhance methods to gather patient evidence, including revising submission templates so that they are better aligned to the scope of appraisals and more user friendly and using a clinician and patient expert panel at Appraisal Committee meetings. (3 responses)

Improvements were suggested to ensure that patients are supported to be active participants in Clinical Reference Groups. (3 responses)

Role of patient groups

Responses, particularly those from the voluntary / charity sector, noted that patient organisations should have a role within the proposed system architecture, including being part of the Innovation Partnership and co-producing materials. (6 responses)

> ***"We note with interest the National Innovation Partnership references the MHRA, NICE and NHS England but makes no mention of patient representatives or industry. Both are an omission that we feel needs to be reconsidered."***
>
> **(Charity sector)**

> ***"Third party, independent organisations could be encouraged (and appropriately financially supported) to build wide-scale public awareness of rights and entitlements and how they can access and interface with the appropriate systems, something which for many individuals is a daunting prospect."***
>
> **(Pharmaceutical industry)**

Responses suggested working with patient organisations to collect patient outcomes and disseminate information about innovations. (3 responses)

Some suggested that the Review could outline how industry could contribute to more rapid patient access to treatment through making appropriate contact with relevant patient organisations at the earliest stages of product development. This would need to be managed transparently in line with industry standards. (1 response)

Linking with industry

It was suggested that NHS England and the Department of Health should work directly with industry and academia to encourage global businesses to place trials in the UK. (1 response)

Responses thought that there should be a forum whereby patient groups, the NHS and industry could meet and plan together. (3 responses)

> ***"Improve patient awareness and understanding of clinical trials – establish greater collaboration between NIHR, industry and patient groups to ensure that patients receive information, advice and support concerning accessing clinical research. The AAR team should consider establishing a forum for all relevant parties to discuss these issues on a quarterly basis."***
>
> **(Pharmaceutical industry)**

Practicalities

A number of responses suggested that whilst strengthening the patient voice was an ideal to strive towards, there may be difficulties doing this in practice. Inertia, internal budgeting silos, local cost containment and a lack of aligned policies and incentives were suggested as outweighing the patients' voice in getting access to innovative products. It was suggested that the patient voice should be incorporated into the procurement process. (4 responses)

> ***"It is important that the patient perspective is incorporated into procurement processes from the early design stage onwards. In some cases patient groups can act as a conduit for patient perspectives, representing the views of many patients affected by a particular condition. Asking patients early on what is missing from the current standard of care can help to quantify the innovation requirements to inform the framework of a tender."***
>
> **(Medical technology sector)**

Other responses, particularly from industry, suggested that it was important to be realistic about what patient involvement can achieve. (3 responses)

> ***"The proposals for giving more weight to user requirements are welcomed, but there is a place for technology push as well as demand pull. It is unrealistic to expect patients to be aware of the clinical potential of new scientific and engineering advances, and opportunities need to be provided for innovators to show patients radically new ideas, and hear their reaction. The danger of the patient-driven proposals as currently drafted is that attention will be focused too much on improving present products, and will exclude the opportunity to envisage disruptive new technologies."***
>
> **(Medical technology sector)**

Some said that it was important to get a balance of feedback from different patient groups, including those that may be less vocal. (2 responses)

> ***"It is important to acknowledge that there are groups of patients who are less vocal and potentially more vulnerable than others. Ensuring the voice of these patients is heard is critical. Efforts must be made to ensure engagement with the hard-to-reach groups. Otherwise the risk is that the most vocal will dominate."***
>
> **(Pharmaceutical industry)**

There was a call to use similar processes across the four countries of the UK.

> ***"(We) noted the potential benefits of emulating patient involvement processes used in appraisals conducted by the Scottish Medicines Consortium and All Wales Medicines Strategy Group. Harmonisation across the UK would itself be helpful for companies, and there are helpful lessons which can be drawn from initiatives such as PACE and applied within NICE or elsewhere."***
>
> **(Pharmaceutical industry)**

Overall, there were few discernible differences in the responses from different sectors. All expressed support for embedding patients more fully in innovation pathways, but industry responses were more likely than others to state that this may be challenging to achieve.

Proposition Two – Getting ahead of the curve

This section summarises feedback relating to **Proposition Two: Getting ahead of the curve - A radically new approach is required to accelerate and manage entry into our health system for the emerging products that promise the most significant, potentially transformative impact in terms of patient benefit and overall value.**

The Review questions related to this proposition were:

- How could the acceleration of the most transformative products apply in particular therapy or disease areas?
- How could each component of the accelerated pathway for medicines, devices, diagnostics and digital health products work? We are most interested in your comments relating to: How the most promising and transformative products are identified; How a new 'managed access' pathway would build on existing schemes (such as the Early Access to Medicines Scheme, the Adaptive Pathways Pilot and the Cancer Drugs Fund) and the work of the National Institute for Health and Care Excellence (NICE); How accelerating access would impact the way that products are priced and reimbursed in the NHS.
- What are the pros and cons of different ways of reimbursing innovative products? Some examples might include: price-volume agreements; multi-year agreements conditional on the achievement of certain outcomes; patient cost caps, or other mechanisms.
- What could be the role of key national bodies in delivering the accelerated pathway and how can these bodies ensure patients are embedded in all decision-making processes? Examples of key national bodies include but are not limited to NHS England; The National Institute for Health and Care Excellence (NICE); Medicines and Healthcare products Regulatory Agency (MHRA).

Feedback about each question is listed in turn. Responses could provide multiple comments about each question.In some instances, responses provided feedback about this proposition as a whole, rather than answering specific questions. This feedback has been incorporated within the responses to questions as all covered the same broad topics.

How could the acceleration of the most transformative products apply in particular therapy or disease areas?

In total, 18 responses provided feedback about this topic. These responses came from charities (7 responses), the pharmaceutical sector (4 responses), the NHS (2 responses), academic / research organisations (1 response), the nutrition sector (1 response) and trade bodies (1 response). Two responses did not provide sufficient detail to ascertain their sector.

Responses gave examples and case studies in areas such as antibiotics, cancer, continence, cystic fibrosis, gene therapy, medical nutrition, MS, muscular dystrophy, Parkinson's disease, patient safety, rare diseases, statins, self-management, transplants and urology amongst others.

The Review team read the examples in detail so the substantive content is not included here. However, key themes spanning these responses included:

- The importance of clearly **defining transformative products**. It was proposed that 'entry criteria' should be relatively permissive for products that have the potential to make a difference and should align with FDA Breakthrough criteria. (1 response)

- Ensuring that **patient perspectives** help to define transformative products. (3 responses)

"It is vital that patient perspectives be taken into account in determining which products are transformative and should be accelerated. Patients are the best judges of what constitutes an unmet medical need, and their views should be at the centre of this scheme."

(Charity sector)

- The potential to use existing **disease registries** to collect data for use in research, annual reporting, quality improvement, cost analysis and to create early access programmes for novel products. (2 responses)

- Using **adaptive clinical trials** evaluate patients' reactions to a drug early in a trial and then modifying / adapting according to the findings. (1 response)

- Ensuring that **clinical staff** are allocated time to take part in trials and counting work on trials towards specialist training for doctors, physiotherapists and nurses. (1 response)

- Using evidence generated from the **real world** use of medicines to inform the appraisal process and subsequent reimbursement decisions. (1 response)

- Using a **hub and spoke model** so centres can work together to undertake clinical trials. (2 responses)

- Having a **separate funding mechanism** for transformative products while they are under 'conditional' status. This may involve risk sharing schemes and may be particularly useful in supporting small and medium sized enterprises. (5 responses)

- Having ways to **differentiate** between varying types of innovations, with ongoing reviews for products related to rare diseases and assessment of a wider range of outcomes. (5 responses)

"For innovative medicines in the field of rare diseases that regulatory bodies need to stop viewing health technology assessment as a single yes/no decision. Rather, for innovative treatments with less evidence available, decision-making should be more like the model used for screening programmes, with decisions reviewed regularly and mechanisms for encouraging further research into the technology between cycles"

(Charity sector)

- Undertaking scenario simulation or **using case studies** to test the core proposals of the Review to see how applicable models are to different therapy areas. (1 response)

- Finding solutions to access **off-patent drugs** for new indications. (1 response)

- Considering ways the NHS England and NICE could address **barriers in uptake** and rollout due to not being able to show immediate cost savings to budget holders. (2 responses)

- Ensuring that accelerating transformative products does not happen at the expense of other 'mainstream' products. (5 responses).

"In relation to prioritising disease specific areas we appreciate that it is not appropriate to treat all categories of medicines the same (for example, primary care medicines compared to specialised medicines) and that there needs to be flexibility within the system to allow for this. However, we believe that there should be as much standardisation and consistency across disease areas as possible to avoid increasing complexity, unduly prejudicing some diseases or introducing practical implementation challenges."

(Pharmaceutical industry)

"In cases where manufacturers of devices need access to funding to develop evidence, they can be at a disadvantage in competitive bids if their devices address Quality of Life (QoL) issues primarily such as 'continence management' where they might be competing for funding against a novel diagnostic for example for cancer."

(NHS)

"The Review's focus on 'transformative treatments' strikes us as limiting. Should it be taken to mean that work arising from the Review will not encompass treatments for low prevalence diseases, however great their impact on those who develop them? … Historically, the voluntary sector has been left to make much of the running in respect of rare diseases."

(Charity sector)

There were no differences discernible in the feedback provided about this topic by various sectors.

How could each component of the accelerated pathway for medicines, devices, diagnostics and digital health products work?

In total, 27 responses provided feedback about this topic. These responses came from the pharmaceutical sector (14 responses), charities (5 responses), academic / research organisations (2 responses), medical technology companies (2 responses), an arms length body, a life sciences consultancy and a trade body. One response did not provide sufficient detail to ascertain their sector.

Overall there was support for implementing pathways for identifying and assessing new products more rapidly. Responses suggested that robust processes would need to be in place for identifying promising technologies, building on existing regulatory processes and rolling out after approval.

> ***"This proposition has the potential to dramatically benefit NHS patients by enabling them to more rapidly access clinically promising treatments at an earlier stage, in areas of high unmet medical need… Identifying these medicines, their potential for treatment and their impact to health services, can be effectively achieved through earlier, more robust horizon scanning, utilising databases such as UK Pharmascan as well as earlier signals from company pipeline disclosures and clinical research."***
>
> **(Pharmaceutical industry)**

Identifying promising and transformative products

Responses said that thought was needed regarding the criteria used to decide what was defined as a transformative product and when to undertake a rapid assessment. (4 responses)

> ***"It is challenging to make that assessment early in the development pathway of a medicine, so we must recognise from the outset that this will be a preliminary decision and it should be based on clear and transparent criteria. Moreover, any terminology and criteria related to these medicines must be understood within the global context in which they will be assessed."***
>
> **(Pharmaceutical industry)**

One response suggested the definition: 'a product that demonstrates the potential to deliver significant measurable improvement in health outcomes, or patient led outcomes and in some instances system outcomes or financial outcomes, compared to available alternatives.' (1 response)

There was concern that the pathway described in the Interim Report might be considered for only a very limited number of selected products. This concern was most consistently expressed by the pharmaceutical industry. (15 responses)

> ***"The identification of a few medicines as 'most significant, potentially transformative' will perhaps encourage negative perceptions of other medicines approved to benefit patients… It would be in no one's interest to create a tiering in the system that potentially devalues a significant cohort of innovations."***
>
> **(Pharmaceutical industry)**

> ***"We support the aim of Proposition Two to accelerate and manage entry into the NHS for 'breakthrough' products and we see the potential to dramatically benefit some NHS patients. Whilst we recognise the need for prioritisation, it is important that we move towards a coherent system for all products. The Review should lead the way towards a framework in the UK that not only spots and accelerates access to breakthroughs early, but also ensures a route to patients for the other medicines within a system that ensures value for money for the NHS."***
>
> **(Pharmaceutical industry)**

Some thought that regulators needed stronger industrial input. This could be provided through a Technical Advisory Board who could help regulators to continually scan for emerging technologies and ensure the regulation keeps up to pace with technical progress. (3 responses)

> ***"It is important that collaboration between public and private sector bodies is encouraged to promote new technology and to help identify those technologies with the most potential for cost-savings in the long, as well as, short-term. Producer-distributor forums and a robust practice review procedure to monitor the potential cost-saving effects of new technologies are two potential means of achieving this."***
>
> **(Trade body)**

An independent topic selection panel was proposed. (2 responses)

There was a focus on using horizon scanning to plan for budgets and possible service design changes. Understanding major new classes of technology rather than focusing on individual products was suggested. (5 responses)

> ***"We strongly support the idea of enhanced horizon scanning to spot the potential of new medicines for treatment and, critically, their impact to health services as far in advance as feasible. The UK has relatively strong processes for horizon scanning, by international standards, but even here we do not fully explore the extent to which new technologies offer the potential for redesign of delivery of care in a more efficient way."***
>
> **(Pharmaceutical industry)**

In digital health, it was stated that the current regulatory path is passive because the company has to approach the regulator. It was suggested that a more proactive process for identifying promising innovations was needed. (1 response)

Some wanted to ensure that the initial innovators were recognised rather than the 'fast followers' (1 response)

Building a managed access pathway

Responses said that when NICE should consider both the value proposition and the risk attached when determining the assessment route. (1 response)

Others thought that all products should go through the same route and be assessed by the same type of committee. (4 responses)

> ***"We believe that all medicines should only undergo one single clinical and cost effectiveness assessment, ideally under the auspices of NICE, in order to standardise the approach to value assessment."***
>
> **(Pharmaceutical industry)**

There was concern over sending medical technologies down two separate routes, with a lack of clear rationale. (1 response)

Some said that timing may be problematic with any medical technology scans due to the relatively short timescales attached to marketing authorisation for medical technology and IP issues meaning that products are developed in secret. (2 responses)

Responses were favourable about adaptive medicines pathways, including Conditional Marketing Authorisation, the Adaptive Pathways Pilot and the PRIME scheme. (5 responses)

It was suggested that more clarity was needed around existing accelerated pathways permitted by the European Medicines Agency (EMA). This might be addressed by developing a 'how to' guide. It was thought that any changes to the UK system should link closely with the EMA. (2 responses)

Commissioning through evaluation could be of benefit for the adoption of new treatments and interventional devices/procedures as well as medical technology and digital products that do not often fulfil 'mainstream' product processes. (4 responses)

A number of responses suggested that it would be worthwhile to align UK policies and definitions with the US Food and Drug Administration (FDA) approaches. The importance of alignment with Europe and throughout the four countries of the UK was also mentioned (5 responses)

Some felt that eligibility for the fast track process should be subject to patient demand and demand for product uptake. If there is no demand for that product then it should not be eligible. A number of responses cross referenced to comments reported earlier about patient-led outcome measures. (3 responses)

Responses said that there were elements of the Early Access to Medicines Scheme (EAMS) and the Cancer Drugs Fund that have benefited patients and should be maintained. In particular, early discussions with the Medicines and Healthcare Products Regulatory Agency (MHRA) and NICE were thought to be helpful. However it was noted that the uptake of products within the EAMS scheme has generally been slow. (5 responses)

Responses said that it was important to maintain the provision for a 30-day implementation of NICE positive technology appraisal guidance for EAMS medicines, rather than the standard 90 days post NICE recommendation. (2 responses)

Some responses stated that there were concerns across industry about how the Cancer Drugs Fund would be implemented and that current proposals being consulted about separately were not fit for purpose. (5 responses)

It was highlighted that there is no single data repository in the NHS. Fragmentation creates issues with for data governance and interoperability. Better use of patient registries, collection of failure data, use of real world data and speeding site selection and processes for clinical trials were suggested. (10 responses)

There were also calls for use of more flexible cost-effectiveness assessment, such as flexing QALY ratios up or down across a portfolio of products. (1 response)

It was stated that a simple route map for how manufacturers engage with the Accelerated Pathway process will be needed. (1 response)

Some responses, particularly from charities, were concerned about proposals to speed up clinical trial processes as they were concerned that this may result in lower quality evidence and risks to patient safety. (2 responses)

> ***"As currently proposed, we do not feel able to support the idea of commercial access agreements to introduce experimental treatments to wider use at an earlier stage. Treatments that are still in development should be deployed in an experimental context, although we would support effective measures to reduce costs and delays associated with this process."*** **(Charity sector)**

Responses stated that uptake after assessment was a major barrier. Some pointed to a post-evaluation planning committee used in Scotland which has a remit and resources to consider how products will be adopted. (6 responses)

> ***"Speeding up and measuring appropriate uptake has the potential to support alternative pricing and reimbursement models, due to increased opportunity for certainty on returns for all parties."***
>
> **(Pharmaceutical industry)**

Impact on pricing and reimbursement

Responses suggested that pricing and reimbursement of medicines, whether accelerated or not, should continue to be done efficiently and transparently, according to the value they deliver to patients. This needs to take into consideration existing approaches such as the Pharmaceutical Price Regulation Scheme (PPRS). (1 response)

Suggestions for funding approaches included seed funding and uplift / changes in tariffs. However, it was considered that tariff reference costs are slow to adapt to the market. (4 responses)

A pricing panel type approach was thought to be feasible, but responses wanted one body to be ultimately accountable. (1 response)

Responses thought that in order to set national prices for devices some kind of national procurement function would be needed. For this reason, it was thought that there may be more scope for new approaches with specialised services, due to being fewer commissioners nationally. (1 response)

The potential for risk sharing between the NHS and industry was discussed. (2 responses)

> ***"It may be that industry and the NHS can collaborate and share the risks of future evaluation through commissioning schemes. Equally, there might be other areas in which joint funding approaches can help generate evidence to support a decision on the future adoption or rejection of an innovative product."***
>
> **(Pharmaceutical industry)**

Blended discounts could be considered to allow flexible pricing for multiple indications. (1 response)

There could be two levels of pricing for repurposed products that are imposed at the point of prescription and reimbursement. (1 response)

There were few differences in the themes emphasised by different sectors, though responses from the pharmaceutical industry were more likely to question how transformation products would be defined and identified.

What are the pros and cons of different ways of reimbursing innovative products?

In total, 20 responses provided feedback about this topic. These responses came from the pharmaceutical sector (9 responses), charities (3 responses), academic / research organisations (1 response), trade bodies (1 response), the nutrition sector (1 response), biotechnology (1 response) and diagnostics (1 response). Three responses did not provide sufficient detail to ascertain their sector.

Responses noted that a menu of reimbursement strategies may be needed rather than a single approach for all.

> ***"Pros and cons vary from product to product and a 'one size fits all' model is not appropriate. A framework is needed which is flexible enough to accommodate a range of commercial and managed entry schemes. An innovative reimbursement model should be able to take a holistic perspective around the whole system value by integrating data across the different sectors of the NHS."***
>
> **(Pharmaceutical industry)**

> ***"Several of the proposed schemes could be suitable within the UK but their attractiveness would depend on many things including, but not exclusively, the context in which these schemes are being considered and critically the relationship with the PPRS; the category of medicines/disease area the scheme is applied to, and whether this would be purely for a transformative medicines pathway or more broad implementation; the accompanying regulatory and governance framework; he organisation the suggested negotiation would be undertaken with, and at what level (national, regional or local) the negotiation would take place… proposed alignment into the mainstream regulatory, NICE, NHSE and CCG systems and processes; the ability to engage in dialogue between Industry and the providers, commissioners and negotiating body."***
>
> **(Pharmaceutical industry)**

Table 2 lists the pros and cons reported about various reimbursement mechanisms mentioned in responses.

Table 2: Suggested pros and cons of various reimbursement strategies

Approach	Pros	Cons
Risk share schemes	• Of benefit to facility management innovations (1 response)	• Transfer of risk from the NHS to the company (1 response) • Query value for money (1 response)
Flexible reimbursement schemes	• Able to be continually reviewed to ensure funding models match evolving technologies (4 responses) • Required for the vast capital investment needed to achieve NHS savings (1 response) • Allows prices to be adjusted up and down on the basis of specific and agreed to evidence demonstration (1 response) • Useful for vaccines and diet (1 response) • Allows for more personalised medicine (1 response) • Permitted under the Pharmaceutical Price Regulation Scheme (PPRS) (2 responses)	
Pay as you use models	• Could be considered (1 response)	
Fast track reimbursement	• Speeds uptake if funding is granted immediately for technologies (especially under conditional license) (2 responses)	• Most applications to fast track schemes in places like Germany are rejected with no indication why (1 response)
Proxy insurer models	• Used in the US (1 response)	
Consumerable models	• Attractive to SMEs and hospitals that have no budget for capital expenditure. (1 response)	
Sponsor small and medium enterprises to provide a service	• Novel funding approach (1 response)	
Capped price per patient	• Supports uptake (1 response)	
Partial or mixed repayment	• Allows correction of price at technology level, not industry level (1 response)	
Price volume agreements	• Can be centrally negotiated so they can be adopted at scale (2 responses)	
PASLU – this is a patient access scheme but was commented on in the context of reimbursement	• Can be built upon to improve the system (2 responses)	• Accepts simple discount schemes only (2 responses)
Part IX of the Drug Tariff	• Provides a clear route to get new products approved and agree a price (1 response)	

What could be the role of key national bodies in delivering the accelerated pathway and how can these bodies ensure patients are embedded in all decision-making processes?

In total, 23 responses provided feedback about this topic. These responses came from the pharmaceutical sector (8 responses), charities (3 responses), arms length bodies (2 responses), trade bodies (2 responses), the NHS (2 responses), an academic / research organisation (1 response), medical technology company (1 response) and nutrition organisation (1 response). Three responses did not provide sufficient detail to ascertain their sector.

Responses outlined potential roles for NHS England, NICE, Medicines and Healthcare products Regulatory Agency, AHSNs and other bodies.

NHS England

- Ensure the Five Year Forward View commitment for 'meaningful local flexibility' for payment rules and regulatory requirements does not create a postcode lottery in access to innovative treatments. (1 response)
- Pilot new innovations with trusts or via drug tariff and in doing so bypass regulatory for a beta test phase. (1 response)
- Ensure that local commissioners are supporting charity funders of research. (1 response)
- Increase transparency in decision-making. (1 response)
- Cover the cost of treatments whilst evidence remains uncertain. (1 response)

National Institute for Health and Care Excellence (NICE)

- All medicines should be reviewed under the auspices of NICE, with a new mandate, to standardise the approach to value assessment. (7 responses)
- Have more transparent clinical guideline processes. (2 responses)
- Have more transparent decision-making processes. (3 responses)
- Include non-QALY benefits when carrying out appraisals. (2 responses)
- Have greater dialogue with patient organisations and commissioners. (3 responses)
- Increase NICE resource / capacity to account for more evaluation of devices, diagnostics and digital products. (2 responses)
- Adapt the Office for Market Access for non-industry partners such as charities and academics. (1 response)
- Implement a process for accelerating the adoption of NICE recommendations. (3 responses)
- Expand the Medical Technologies Evaluation Programme. (1 response)

- Retain the NICE Implementation Collaborative (NIC) Board, with NICE as NIC's Sponsor organisation. It was stated that NIC is the only cross sector group actively working together to find solutions around the implementation of evidence-based and cost-effective NICE guidance. (1 response)
- National-level horizon scanning could be developed to address the needs of the population and the system, with an assessment of the budget impact being done at this level. (1 response)
- Work with companies to make it more likely that they will have an evidence-based value proposition at an earlier stage in the product lifecycle, with advice from NICE targeted on system priorities that are likely to have the most impact in terms of clinical and population need. (1 response)
- Near-parallel regulatory and HTA reviews. (1 response)

"(We) call for a new mandate for NICE to improve patient outcomes and contribute to economic growth via dissemination of innovation. Further, a single, national value assessment for all medicines, supported by a revised decision making framework needs to be developed in order to make best use of available resources and expertise, and removing inconsistencies and duplication across the NHS."

(Pharmaceutical industry)

Medicines and Healthcare Products Regulatory Agency (MHRA)

- Establish a working group to discuss with patient organisations, academics, NICE and others, what could be done to make the licensing process more accessible to organisations or individuals other than pharmaceutical companies. (1 response)
- Have representatives within the MHRA for patient organisations, academics and others to approach for advice and to highlight new evidence. (1 response)

NIHR

- Ensure that the NHS supports the most innovative research, working with patient representative bodies to set research priorities. The NIHR Horizon Scanning Centre (NIHR HSC) and Clinical Reference Networks could help to identify innovative research. (1 response)

Academic Health Science Networks (AHSNs)

- Identify early stage innovative research and off-label treatments which are showing promising results. (1 response)

Other bodies

- Create Regional Medicines Bodies to manage the medicines budget; support the appropriate use of generic medicines and ensure savings are reinvested in newer, branded medicines; purchase medicines approved by NICE and undertake flexible negotiations with manufacturers which incentivise and drive uptake; measure and support uptake via a medicines implementation plan. (1 response)
- The British Standards Institution has a role to play in ensuring the UK is properly represented when creating standards. (1 response)
- Monitor and CQC should monitor variation of adoption at a local level. (3 responses)
- Have a national mechanism to support and incentivise adoption. (2 responses)
- Clinical Commissioning Groups should to be notified of early promising trials. (2 responses)
- Local Drugs and Therapeutic Committees should focus on adopting products with a positive NICE Technology Appraisal. (1 response)
- Consider the role of NIHR Healthcare Technology Co-operatives (HTCs) in contributing to the successful delivery of the innovation pathway for medical technology. Their role helps to identify and prioritise unmet clinical needs nationally and to accelerate solutions by bringing the right teams and skills together. (1 response)
- Introducing functionality via MyNHS to enable people to look at local uptake of key technologies in their area. (1 response)
- Helping patient groups to form and adequately supporting them throughout the engagement process. (2 responses)
- Draw on charities to support patient involvement. (1 response)

There were no substantial differences in the responses about this topic from various sectors.

Proposition Three – Supporting all innovators

This chapter summarises feedback relating to **Proposition Three: Supporting all innovators - In addition to accelerating access to a select number of the most promising new products, our end-to-end innovation pathway can, and should, also be more responsive to the wider, irrepressible surge of innovation presented at all levels of the system, particularly where its introduction will contribute to better outcomes for patients and more productive and efficient ways of delivering care.**

The Review questions related to this proposition were:

- How useful do you find our proposals for a new system of guidance and support?
- How can we ensure that the proposed new system for supporting innovators complements and streamlines current systems and avoids duplication?
- Are there any quick wins or significant barriers to innovation that our proposals for a new system support do not address?

Feedback about each question is listed in turn. Responses could provide multiple comments about each question. In some instances, responses provided feedback about this proposition as a whole, rather than answering specific questions. This feedback has been incorporated within the responses to questions as all covered the same broad topics.

How useful do you find our proposals for a new system of guidance and support?

In total, 18 responses provided feedback about this topic. These responses came from the pharmaceutical sector (9 responses), charities (3 responses), trade body (1 response), an academic / research organisation (1 response), medical technology sector (1 response), diagnostics sector (1 response) and nutrition sector (1 response). One response did not provide sufficient detail to ascertain their sector.

Responses were generally supportive of the proposals for a new system of guidance and support. They made suggestions about how the proposals could be developed further and implemented in practice. Key suggestions included:

- Clarifying the **support available** to various parties
- Clarifying the **responsibilities** of national and local commissioners and regulators
- Having **consistency** across countries and product types
- Ensuring patients, industry and statutory services have a mechanism for early proactive and **ongoing communication**
- Ensuring clear plans for **implementation** and accountability

In addition to proposing areas to strengthen, some responses went further, saying that the system requires broader reform in order to tackle current issues and inequalities. It was suggested that whilst better information is always helpful to innovators, the impact of current proposals may be limited for innovative medicines without systemic change and meaningful commitment. Feedback about Proposition Three was thus perhaps the most likely of all the propositions not to be generally favourable. Responses tended to support Proposition Three but feel that it did not go far enough. Most responses about this proposition were from industry of various sorts and all industry sectors provided similar feedback.

Clarifying roles

As in feedback to other questions posed by the Review, a key area of interest was how NICE can evolve to deliver a more flexible and streamlined system, covering a wider range of products alongside a new tiered HTA model. It was suggested that NICE should cover all medicines to promote consistency and reduce duplication. (7 responses)

> ***"If NICE is able to take a proportional approach to its appraisals based on the quality of the evidence available to support evaluation of a product, NICE's processes could become more efficient and patient access could be accelerated. A further efficiency might be found in the deployment of NICE's evidence summaries.These provide a good, rapid indication of a product's benefits and could be put to use in the context of accelerating access, rather than simply for informational purposes. This would also help harmonise methodologies across the UK, for example emulating the Form A process in Wales."***
>
> **(Pharmaceutical industry)**

> ***"Non-NICE reviewed medicines are subject to multiple clinical or cost effectiveness reviews at a regional and local level, each using different criteria and timeframes, and often resulting in long delays and varying levels of access for patients within localities for the same medicines. This process is duplicative, lacks transparency, consumes unnecessarily high levels of resource and fails to adequately engage industry. Greater standardisation and national oversight should lead to considerable efficiency savings for the NHS, better equity of access for patients and improved predictability for industry."***
>
> **(Pharmaceutical industry)**

It was suggested that local formulary committees and medicines management teams should be refocused away from duplicative medicines appraisal and generating protocols, to concentrate on implementing medicines optimisation. (1 response)

Some outlined how AHSNs may benefit from focusing on their original mandate to reduce variation and accelerate the adoption of innovation at pace and scale. (1 response)

Responses stated that it would be useful to have more clarification about the type and intensity of support available, including support for not-for-profit funders of research. (1 response)

Responses also suggested that it would be helpful to clarify the roles of national-level and local commissioners in providing support, especially as commissioners are under greater pressure to make efficiency savings. (2 responses)

Responses stated that partners should work together but have clear roles and accountability. Some responses mentioned that the proposed national Innovation Partnership was a good idea to facilitate this and that this should include links to patient organisations and other end users. (6 responses)

> ***"Input from industry and users alike is required. This is particularly the case when considering how new technology may affect formularies and the range of products available to users. A formal mechanism for engagement between patients, the NHS and industry would be welcomed as an indication of commitment to innovation in tandem with, rather than at the expense of patient choice."***
>
> **(Trade body)**

Consistency

It was proposed that different assessment processes needed to be aligned to provide clarity on entry to the market. Setting out the interchange between NICE technology appraisals, assessments by NHS England's specialised commissioning team and any local initiatives was recommended. (2 responses)

It was also suggested that all products should undergo a single national value assessment with transparent, standardised processes and competency standards. This could be implemented via the four UK NHS regions 'under licence from' NICE. (2 responses)

Some pointed to possible discrepancies between medicines versus diagnostics, technologies and nutrition. (3 responses)

> ***"Efforts to encourage innovation at all levels of the health system are welcome but care should be taken to ensure that these initiatives do not widen the gap between pharmaceuticals and medical technologies. The funding directive behind NICE pharmaceutical technology appraisals already sets medical technologies on a less sure footing where a positive recommendation from NICE does not signal automatic NHS reimbursement. Introducing a similar funding mandate for medical devices and diagnostic products would help to address this inequality."***
>
> **(Medical technology sector)**

Types of support

There was a desire for more support for innovators on entry to the system, including for smaller companies. (1 response)

Responses also suggested that it would be helpful to have support and guidance about the innovative use of existing medicines for new indications. (1 response)

Implementation

There was a call for improved accountability for innovation uptake, including a commitment to measure improvement. (2 responses)

Responses said they would like to know how the recommendations from the Review will be taken forward and how implementation will be monitored. There were concerns that investment was decreasing so proposals may not be realistic. (2 responses)

Some suggested that they would like to see more prompt timelines built into implementation plans. It was stated that the NHS may take quite a bit of time to adopt initiatives. (1 response)

'How to' guides were thought to be useful, but perhaps limited in what they could achieve. It was recommended that these should be written in in clear language so they are accessible for every day product users as well as industry experts. (2 responses)

One response suggested that more proactive dialogue was needed and that innovators needed to be encouraged to engage early with regulators. (1 response)

> ***"A key challenge is how to encourage developers to communicate with regulators such as the MHRA or EMA earlier and more often than is common practice. It is not sufficient for the advice and support to be available, its availability needs to be promoted widely. Any new system will need to proactively engage with developers and encourage them to consider their interactions with regulatory bodies as a conversation rather than a single hurdle to be overcome."***
>
> **(Charity sector)**

How can we ensure that the proposed new system for supporting innovators complements and streamlines current systems and avoids duplication?

In total, 15 responses provided feedback about this topic. These responses came from the pharmaceutical sector (8 responses), charities (3 responses), academic / research organisations (1 response), the NHS (1 response), a trade body (1 response) and the diagnostics sector (1 response).

There was acknowledgement of current duplications in the system and support for streamlining processes.

> ***"There are currently eight routes through which licensed medicines for rare conditions can be evaluated and/or commissioned to enable patient access on the NHS. These routes are managed either by the National Institute for Health and Care Excellence (NICE) or NHS England, however currently it is not clear how or why one medicine evaluation approach or access pathway is selected over another. A lack of system coherence also means that time and money is wasted because two publicly-funded bodies, NICE and NHS England, have evaluated the same medicine simultaneously a number of times. Moreover, with such a multiplicity of approaches and pathways, the risk of making inconsistent decisions that result in inequitable access to medicines for patients with rare conditions is increased. As a result, some life-changing medicines are not being made available to the patients who need them even though less effective medicines are being funded. There is a need to rationalise and streamline all medicine evaluation pathways, with a defined role and decision making framework at each stage."***
>
> **(Charity sector)**

Responses emphasised the need for:

- A focus on the pathway-specific and system-wide changes needed to **embed innovations** proven to work effectively and affordably. (3 responses)
- **Collaborative working** between key national bodies. (3 responses)
- Strengthened mandate and streamlined processes for **NICE**. (7 responses)
- Increased **resourcing** for NICE. (3 responses)
- Operate a **single national value assessment** in England. (3 responses)
- A system that allows innovators to develop and test their products in controlled conditions that can **replicate mainstream systems**, but removes some of the challenges associated with cost and resources. (2 responses)
- Greater **flexibility on pricing approaches** / patient access schemes (PAS) to include outcomes based approaches. (1 response)
- Increasing the range of products reviewed through **Commissioning through Evaluation**. (1 response)
- Including **NIHR Healthcare Technology Co-operatives** (HTCs) in the Innovation Partnership. (1 response)
- Ensuring that once that technology has become embedded in best practice, it seamlessly transfers to the **tariff system**. (1 response)
- Persuading commissioners and trusts to **invest** and take a long term view. (1 response)
- Building the recommendations of the Review into work being undertaken by **Vanguard sites**. (2 responses)
- **Educating staff** in new skills and practices. (1 response)
- Wider inclusion of expert and **patient opinion**. (2 responses)
- **Monitoring innovation uptake**, including through the Innovation Scorecard. (1 response)
- Consideration about whether **Academic Health Science Networks** are or are not well suited to lead on NHS-wide adoption and diffusion of innovations. (2 responses)
- Some responses were not convinced that **pathways** suggested by the Review would help to reduce duplication. (3 responses)

"We are concerned that the proposals outlined in the interim report simply add additional pathways and bodies to the already overcomplicated system, without removing any or clarifying entry requirements. Instead it might be more effective to better exploit existing flexibilities, and rationalise and streamline all the pathways to commissioning."

(Charity sector)

Are there any quick wins or significant barriers to innovation that our proposals for a new system support do not address?

In total, 20 responses provided feedback about this topic. These responses came from the pharmaceutical sector (10 responses), charities (5 responses), academic / research organisations (2 responses) and the NHS (1 response). Two responses did not provide sufficient detail to ascertain their sector. Some of these responses outlined perceived gaps in the Review as a whole, rather than focusing on proposed new support systems.

Potential quick wins

Suggestions about issues to prioritise in order to secure prompt gains included:

- Provide **dedicated resources** and develop the necessary infrastructure to support national implementation. (1 response)
- **Enhancing alignment** between NICE, NHS England, local commissioners, providers, vanguards, innovation test beds, Academic Health Science Networks, clinical leaders and patients. (1 response)
- Develop a **single central, or sub national, HTA** / value assessment process for all medicines, with local formulary and medicines committees re-directed to focus on medicines optimisation. (4 responses)
- Enable and encourage the NHS to systematically identify and endorse opportunities to review and **disinvest** in medicines or procedures where appropriate. (3 responses)
- Extend **conditional approval** to innovative medical devices. (1 response)
- Opportunity to attract EU public-private partnership **funding** from the Innovative Medicines Initiative (IMI) to progress outcomes measurement. (1 response)
- Ensure implementation of the Ministerial Industry Strategy Group Short Life Working Group (MISG SLWG) discussions about **non-NICE medicines**. (1 response)
- Review relative product uptake rates at Ministerial level using the Competitiveness Indicators and the **Innovation Scorecard**. (1 response)

Perceived gaps in proposals

Suggestions about potential areas that the Review could usefully consider included:

- Covering a **wider range of products**, rather than 'transformative' products. This may include biosimilars and branded generics. (8 responses)
- **Repurposing** medicines. (2 responses)
- Giving equal weight to **technologies and diagnostics** as to pharmaceuticals. (2 responses)
- Evolving NICE beyond using **cost-per-QALY** approaches. (4 responses)
- Reviewing **commercial models**, patient access schemes and flexible pricing as provided for in the PPRS. (3 responses)
- Setting up a **consistent approach** for commercial and managed access schemes, taking account of NHS England's consultation on the Cancer Drugs Fund. (2 responses)
- **Tackling widespread delayed usage** of new products by promoting an end to end pathway. (8 responses)
- Considering **multi-year financial flexibility**. (2 responses)
- Considering how to liberate funding from existing programme or system budgets using the **RightCare** approach. (1 response)
- Exploring how to change **commissioning culture**. (1 response)
- Addressing barriers to conducting and taking part in **clinical trials**. (2 responses)
- Fully recognise the role charitable and **patient representative organisations** in driving change in the NHS. (1 response)
- **Monitoring adoption** through tools such as the Innovation Scorecard and clear accountability for implementation. (2 responses)
- Revising the National Intellectual Policy guidelines to give **ownership** and control to innovators who need to drive for their innovation for many years. (1 response)
- Attracting EU **funding** to drive forward use of big data in outcomes measurement. (1 response)

"Three years after launch the UK only manages to achieve 50% of the average usage for new medicines compared to a basket of developed countries. This means that for the average new medicine half of patients in the UK who could reasonably be expected to benefit from it are missing out three years after it has been made available. If we are to be true to our desire to put patients at the heart of the Review, we cannot ignore these vast numbers of patients lacking access to new medicines."

(Charity sector)

Proposition Four – Galvanising the NHS

This chapter summarises feedback relating to **Proposition Four: Galvanising the NHS -The NHS must be an active partner in promoting innovation, and must be incentivised to adopt new products and systems quickly and effectively.**

The Review questions related to this proposition were:

- How can the NHS be incentivised and supported to introduce innovative technologies?
- How could a fund to support system re-design operate and how could it be funded?
- How could this proposed new system architecture be developed in a way that galvanises the NHS to promote innovation?
- What are the costs and benefits of this new approach, which positions the NHS as an active partner in promoting innovation?

Feedback about each question is listed in turn. Responses could provide multiple comments about each question. In some instances, responses provided feedback about this proposition as a whole, rather than answering specific questions. This feedback has been incorporated with the responses to questions as all covered the same broad topics.

How can the NHS be incentivised and supported to introduce innovative technologies?

In total, 18 responses provided feedback about this topic. These responses came from the pharmaceutical sector (7 responses), charities (3 responses), academic / research organisations (3 responses), the medical technology sector (2 responses), the NHS (1 response) and a trade body (1 response). One response did not provide sufficient detail to ascertain their sector.

Proposed methods to incentivise and support the NHS to increase the uptake of innovative technologies included:

- **Workforce development**, including innovation champions and training
- Co-ordination and **collaboration** between organisations
- **Setting targets** and using data to monitor uptake
- **Financial incentives**

Interestingly, financial incentives were not overly emphasised. Responses recognised that the NHS is a complex system and that incentives are needed on many levels.

Workforce

Some said that there was a need to empower doctors to take up new technologies. Examples were cited of the US and Germany where doctors have individual budgets to use innovations. (3 responses)

> ***"To incentivise the process of developing system-wide changes to care pathways and procedures, clinical engagement is crucial. The best way to achieve this is to find a means of giving individual clinicians the time and incentives not only to participate in developing and evaluating innovations that could improve patient care, but also in sharing their learning with local and national colleagues, and in national consensus building and policy development for appropriate amendments to care pathways, clinical guidance and commissioning to support widespread adoption of beneficial innovations."***
>
> **(Academic / research / think tank)**

Having an 'adoption champion' or professional leadership at NHS organisations may help. (3 responses)

Some suggested that incentivising teaching hospitals to champion innovation would mirror the process of developing centres of excellence. Trusts could be encouraged to require a certain amount of clinical expert time be allocated to innovation. (2 responses)

Continuing professional development and promotion by Royal Colleges may increase excitement amongst clinicians about getting involved in innovation. (3 responses)

Patients could also be a lever for support, putting pressure on the NHS to increase uptake. (3 responses)

Co-ordination and collaboration

Having a platform on which clinicians can share and promote technologies could help overcome having to speak to each commissioner and trust separately. (3 responses)

It was proposed that NHS Innovator Trusts and Vanguard sites could be encouraged to partner with small and medium sized enterprises, perhaps by having networking events. (3 responses)

Some said that AHSNs could help to organise engagement between hospital trusts and patient groups / organisations. They could also promote new innovations and peer to peer comparison. (1 response)

It may be important to ensure that trusts are not at a financial disadvantage if they choose to test and adopt innovative products and approaches. One approach might be for lead providers to be identified to test innovation on behalf of a network of others. This would have the added benefit of reducing duplication. (1 response)

Targets and data

Responses suggested setting national predicted uptake figures for all new medicines and using the Innovation Scorecard or other tools to measure uptake against these figures. CCGs that deviate from the national target by a certain percentage would be held to account. (2 responses)

Another idea was trusts and commissioners sharing prescribing rates and other indicators as a way of pushing each other forward. It was suggested that websites such as Open Prescribing (https://openprescribing.net) could have an impact if the scope of the tool is widened to include specialised treatments used by prescribers and commissioners at the local level. The Innovation Scorecard was also mentioned. (3 responses)

A NICE mark of approval could be developed, analogous to the BSI kitemark, which can be applied to products that NICE has recognised as efficacious and cost-effective.

Finances

Responses suggested that the 12-month clinical budget cycle does not necessarily fit the timescale of technology returns. It was proposed that a three-year cycle may be more appropriate. (4 responses)

Some emphasised the need to move away from a strategy based on cost containment towards thinking about how earlier access to medicines can play a role in reducing overall system expenditure. (4 responses)

> ***"It is very important to make financial savings from better care arising from innovation, given the need to make £22 billion of efficiency savings by 2020, to address the £30 billion resource gap identified in the Five Year Forward View. The emphasis of savings should be long-term rather than short-term."***
>
> **(Trade body)**

Others said that financial incentives through the tariff system would accelerate adoption (2 responses), though some responses believed that the tariff system would need to be revised to incentivise change. (2 responses)

Funding investment in innovation at demonstrator NHS trust sites was another proposal. (1 response)

A 'fast track' or framework approach could be developed to support smaller enterprises, including as part of procurement processes. (1 response)

Commercial partnerships with industry were suggested as a way to share costs. (2 responses)

Responses recognised that the NHS was a complex system and that simplistic ‘carrot’ or ‘stick’ approaches were unlikely to work in isolation. Multiple strategies at various levels will likely be needed. (3 responses)

> ***“Trying to deliver top down solutions is likely to 'fail'. It may be better to think in terms of an ecosystem that is nurtured through macro level policy, investment and measures at the top, and allowed to grow bottom up, through micro level local initiatives that are then rapidly adopted, together with a few 'key stone' initiatives at a meso level to create momentum. Thinking about how you would nudge a biological ecosystem might offer clues to the approach.”***
>
> **(Academic / research / think tank)**

> ***"There is much more that could and should be done to address the barriers that currently inhibit the adoption and integration of research and innovation into the NHS. This includes ensuring that all NHS staff training includes developing the knowledge and skills required for innovative thinking; greater value is attributed to successful innovation at all levels and that it is officially recognised and rewarded; research regulation and permissions are streamlined; collaboration between the NHS and research communities is actively encouraged; suitable incentives and funding initiatives are put in place; and that registries are created to enable the collection and exploitation of real world patient data, and promote the sharing of research findings and best practice.”***
>
> **(Charity sector)**

How could a fund to support system re-design operate and how could it be funded?

In total, 9 responses provided feedback about this topic. Six of these responses were from the pharmaceutical sector, two from the charity sector and one from an academic / research organisation.

With regards to how a transformation fund could be financed, suggestions included:

- Using finances from some of the PPRS rebate to set up a fund, as with the New Medicines Fund in Scotland. (4 responses)
- Funding directly via the Department of Health. (1 response)
- Not repurposing existing funds used for increasing access to innovative treatments, such as the Cancer Drugs Fund. (1 response)

Other comments relating to setting up and operating a specific fund included:

- Support for setting up a Transformation Fund. (4 responses)
- Support for the 'Specialised Services Commissioning Innovation Fund' (now suspended). (1 response)
- Providing funding to medical charities. (1 response)

"We welcome the proposal for a transformation fund and believe this has real potential to help NHS organisations prepare positively for the introduction of new medicines. This should be closely tied to the quality agenda in the NHS and aligned with the delivery of the Five Year Forward View. It will be important to consider organisational capacity and capability alongside funding provision if this is to be successful."

(Pharmaceutical industry)

How could this proposed new system architecture be developed in a way that galvanises the NHS to promote innovation?

In total, 26 responses provided feedback about this topic. This included comments about Proposition Three in general. These responses came from the pharmaceutical sector (13 responses), charities (3 responses), arms length bodies (2 responses), academic / research organisations (1 response), the medical technology sector (1 response), the nutrition sector (1 response), the NHS (1 response) and a trade body (1 response). Three responses did not provide sufficient detail to ascertain their sector.

The feedback to this question repeated many of the key themes described in other sections. Some of the comments focused on identifying barriers to innovation in the NHS, rather than potential solutions. Key suggested issues to address included:

- Organisational roles and collaboration
- Workforce development and liaison
- Finance
- Implementation

Organisational roles

Responses stated that linking various parts of the eco-system is key, rather than reinventing the same activities. (2 response)

NHS England and Public Health England can support NHS system change by identifying which potentially transformative innovations are likely to require large scale health system changes and to agree a clear plan for how stakeholders will work together to ensure that health services are ready. (2 responses)

Areas of high patient and NHS need may not always be evident to industry, so the NHS needs to communicate what it needs from industry. Having channels where industry, the NHS and patient groups regularly meet may promote learning and action. (4 responses)

In order to ensure a joined up system architecture, responses believed that it would be useful to have clarity about the relationships between new regional bodies and key related stakeholders, including NICE, AHSNs and the NICE Implementation Collaborative and related groups. Partnership agreements may be needed between some of these organisations. (3 responses)

Responses recognised that it will be important to link mechanisms into new models of care / Vanguard sites and new accountable care organisation systems. (5 responses)

Responses suggested that AHSNs should have focused roles to energise NHS teams. Some said that AHSNs are often focused on small and medium enterprises in their regions, which overlooks companies outside their region and larger companies who may have good technologies for the NHS. (2 responses)

Some suggested that there has been ongoing conflict between reducing the number of suppliers into the NHS (which favours large corporates) and the need to support small and medium sized enterprises and drive economic growth. This could be overcome by introducing some form of quota for small and medium sized enterprises suppliers, as is the case in the USA. (1 response)

Workforce

It was reported that a potential barrier to innovation is NHS staff's ability to engage with research. A solution could be increased promotion and support of research in the NHS, including ensuring protected time for staff to get involved. (4 responses)

> ***"By involving commissioners and healthcare professionals in early discussions, it is possible to develop innovations that meet a specific need which should, in turn, support swifter roll out of innovative products in a system that is ready for them."***
>
> **(Medical technology sector)**

Some responses suggested that the structure and function of the health service does not empower clinicians to innovate. Instead it may stifle innovation by not providing the resources, training and time needed for professionals to deliver changes in their practice safely and effectively. (1 response)

It was felt that increased clinical leadership for innovation is needed. This could be supported through Royal Colleges and a network of clinical champions. (2 responses)

> ***"There is a strong view amongst companies that the innovation infrastructure needs to be decluttered / redesigned. Clinical leadership is vitally important and their formal engagement in the innovation process is key. Clinicians tend to have a greater tenure in a hospital as compared to CEOs who tend to move on more regularly. Can the Royal Colleges or the Royal Society of Medicine be a vehicle for engaging with specialist groups of clinicians?"***
>
> **(Charity sector)**

Responses emphasised the importance of accountability for delivering innovation at a local level. This may include identifying a responsible person, or champion, in each locality to oversee uptake of innovation in their region. (4 responses)

It may be helpful to engage in training to strengthen change management and project management skills in the NHS to enable change at pace and scale. (5 responses)

> ***"Investment in more expertise in change management is needed to help bring about the necessary change in culture. Change management practitioners and networks of Change Advocates at grass roots levels within the NHS are needed. This will also require solid development of information networks and sharing of data."***
>
> **(Pharmaceutical industry)**

Finances

Some felt that funds to promote innovation should be allocated of substantial size and made up of new funds, not repurposed NHS funds. (1 response)

Responses suggested that support and funding was needed for collaborative work to develop or adapt care pathways, professional standards and policies to facilitate optimal implementation of innovations. (3 responses)

Multi-year commissioning and funding flexibilities may encourage adoption. (2 responses)

Responses stated that as long as there is no funding direction for NICE-approved devices and diagnostics, companies have little incentive to invest in clinical trials to generate appropriate evidence. (1 response)

There was a call to help the NHS prioritise health economic measures and give due consideration to their implications. (1 response)

Commissioning through Evaluation in collaboration with local commissioners may be a powerful vehicle for change. (1 response)

The potential role of the drug tariff in supporting consistent uptake was stressed, with responses saying that this should be more widely promoted to CCGs. (2 responses)

Accelerated pathways could describe decommissioning opportunities alongside the cost of adding new treatments to help support the business case for reprioritisation of innovation. There is potential to use a fund for service redesign to enable smooth transitions. (4 responses)

Implementation

Responses said that NICE-recommended medicines should be adopted on formularies without further restrictions or modifications within 30 days. (2 responses)

A national innovative technology list, of 20 to 30 technologies, could be given to providers and a CQUIN or similar awarded if they can demonstrate having adopted and embedded their choice of five of these. (1 response)

Responses emphasised that there need to be clear objectives and measurement of progress of adoption, linked to incentives. (3 responses)

Using more targeted Innovation Scorecards could increase transparency around the uptake of innovation. (6 responses)

> ***"The Innovation Scorecard is a good start and has already played a key role in identifying variation in utility across the NHS. The Scorecard was originally meant to be stretching and challenging and retains promise to do so, it therefore needs to evolve, to enable it to be a really useful tool which allows good practice to be identified and exemplified. Ownership of the Scorecard should be given to an independent group – perhaps a patient or an academic group or a combination of these, with a strong interest in uptake of innovation – to ensure the Scorecard remains vital."***
>
> **(Pharmaceutical industry)**

Variation in adoption could be made a priority within the regulatory framework spanning Monitor, CQC and NHS England's Assurance Framework. Non-compliance with adoption targets could be made a factor that could lead to 'special measures.' (1 response)

Some suggested that the adoption of medical technologies should be a high priority because this can be a relatively inexpensive way to improve patient care. NHS processes need to incentivise commissioners to adopt medical technologies. (1 response)

Some responses drew attention to findings from Innovation Health and Wealth. The strategy reportedly offers learning and proposals for supporting the adoption and diffusion of innovation within the NHS. (2 responses)

Others said that the Review could usefully outline the steps that should be taken to develop a commissioning mindset through training, policies and processes that could be replicated locally. (2 responses)

There was a call to ensure that recommendations from the Review itself are rated according to the extent to which they can be easily implemented. Responses said they would like to see a detailed implementation plan. (2 responses)

What are the costs and benefits of this new approach, which positions the NHS as an active partner in promoting innovation?

In total, 10 responses provided feedback about this topic. These responses came from the pharmaceutical sector (5 responses), charities (2 responses), academic / research organisations (1 response), the NHS (1 response) and a trade body (1 response).

Suggested benefits

Suggested benefits of the proposed new system architecture included:

- Patients could benefit from earlier and more **widespread access** to technologies that improve their health, regardless of their geographic location. (3 responses)
- The UK could be seen as a more attractive place for **investment** by pharmaceutical companies. (3 responses)
- Potential to **collect data** in a way that few healthcare systems can. (2 responses)
- **Duplication may be reduced** across the NHS, especially by refocusing local Medicines Management Committees onto medicines optimisation. (1 response)
- Commitment to uptake may increase the potential for **flexible price agreements** that could result in cost savings for the NHS. (1 response)
- The short-term costs of establishing bodies such as Innovation Exchanges will be offset in the long-term as improvements in access to innovation lead to more **cost-effective** use of resources. (1 response)

Suggested costs

Potential costs from the proposed new system architecture were:

- The expanded role for NICE and AHSNs is likely to require some **funding**. (1 response)
- Short-term investment in **technology** may be needed to improve efficiency and save costs. (2 responses)
- Local and regional committees could add another **layer**. (1 response)
- Accelerated implementation of innovations will involve some degree of **risk** which will vary between different innovations. (1 response)
- Regulatory frameworks help to ensure patient safety and efficacy of the intervention. There is a risk that redesigning requirements will introduce **risk for patients**. (1 response)
- Commissioning is focusing on contracting, rather than driving innovation and its adoption. Additional NHS **commissioning capacity** is needed to undertake the clinical engagement, strategy development, service specifications and delivery of innovative technologies. (1 response)
- The barriers to uptake of new innovations can be many and varied within the NHS. The concept of '**system impact**' needs to be understood rather than simply the cost of a new intervention. (1 response)

Proposition Five – Delivering change

This chapter summarises feedback relating to **Proposition Five: Delivering change - Building on existing health system structures, a new system architecture is required at local and national level to accelerate access to the best new products and related models of care on a sustainable basis, within a framework of collective agreement to ambitions and goals.**

The Review questions related to this proposition were:

- How should we define the remit and priorities of the Innovation Exchange function and the Innovation Partnership?
- Should the proposed Innovation Partnership and Concordat be held to account by a supporting co-ordinating committee? Should the proposed Innovation Partnership and Concordat be supported by a light-touch coordinating committee, perhaps independently chaired, to ensure that the key participants hold themselves individually and collectively to account for their leadership and management of the innovation pathway?
- What are the costs and benefits of the proposed new system architecture to accelerate the development of, and access to, the best new products?

Feedback about each question is listed in turn. Responses could provide multiple comments about each question. In some instances, responses provided feedback about this proposition as a whole, rather than answering specific questions. This feedback has been incorporated with the responses to questions as all covered the same broad topics.

Many responses stated that Proposition Five was key as it underpinned all other components of the Review.

How should we define the remit and priorities of the Innovation Exchange function and the Innovation Partnership?

In total, 20 responses provided feedback about this topic. These responses came from the pharmaceutical sector (11 responses), charities (3 responses), academic / research organisations (2 responses), the NHS (1 response), medical technology sector (1 response) and a trade body (1 response). One response did not provide sufficient detail to ascertain their sector.

Extent of support

The proposed 'Innovation Partnership' is a partnership of key bodies in the innovation pathway, which includes NICE, NIHR, MHRA, NHSE and NHS Improvement. This partnership would work together to manage the innovation pathway at a national level, including functions such as horizon scanning, shared objectives, coordination, cross pathway planning for uptake and implementation of 'promising products'.

Within the 20 responses that commented on this, about half were supportive of this model of regional Innovation Exchanges and the national Innovation Partnership and half were not supportive or questioned specific implementation issues.

> ***"We do not believe there is value in the Innovation Exchange concept at a regional level as it would add a further unnecessary layer of bureaucracy to the system. This is the role that AHSNs were intended to perform four years ago when IHW was launched. In our experience, AHSNs as a whole have not yet proven their ability to deliver systematically improved uptake of innovation or major patient improvement projects."***
>
> **(Pharmaceutical industry)**

Some responses said that they welcomed the Innovation Exchange and Innovation Partnership but that the descriptions in the Interim Report were at too high a level to allow them to understand how these would be operationalised. (3 responses)

On the other hand, a number of responses challenged the value of the Innovation Exchange function and the Innovation Partnership. Comments in this regard focused on the role and perceived limitations of Academic Health Science Networks.

Some responses said that AHSNs were well meaning but have limited resources. In this view AHSNs were seen to be useful for making introductions to individual clinicians but little more. (5 responses)

Others said that AHSNs are too local. In this view they did not have scope to provide national or international support. Therefore the Partnership body would need to go beyond the current AHSN remit. (4 responses)

"We are not convinced that AHSNs currently have the necessary 'teeth' to deliver the change in practice and culture needed. We do not believe that all AHSNs currently and consistently fulfil the role of providing an exchange for information and catalyst for innovation at the local level, which is disappointing. The AHSNs were established to 'spread innovation at pace and scale.' Three years down the line … there is limited evidence that this has been achieved – certainly in relation to medicines uptake… While some AHSNs are further developed than others, our observation is that, in aggregate, AHSNs have done little to change the culture and practice of the NHS regarding adoption of innovative medicines."

(Pharmaceutical industry)

"Responsibility for delivering access and uptake needs to be better hard-wired into mainstream NHS systems covering NHSE, CCGs and providers. This must be in addition to any enhanced role for the AHSNs if we are to deliver the ambition of the Review."

(Pharmaceutical industry)

Some responses believed that AHSNs had a role to play in the new architecture, but that they needed to focus on spreading best practice and avoid duplication. (3 responses)

Others said clarity was needed about how the mandate for AHSNs will evolve and how they will be placed alongside other NHS accountable bodies. (1 response)

Some suggested that rationalisation of AHSNs would be of value, with a maximum of eight to ten AHSNs to secure efficiencies (1 response).

Priorities

Responses suggested that the remit and priorities of the Innovation Exchange function and the Innovation Partnership should include:

- Improved access and uptake. (6 responses)
- Uptake measurement (4 responses)
- Pathway design support. (2 responses)
- Identifying areas of promising research which need to be better supported and focused on. (2 responses)
- Providing guidance about standardisation of evidence requirements for medical devices and diagnostic products. (1 response)
- Considering funding arrangements to address delays in devices being incorporated into relevant tariffs. (1 response)
- Ensuring that there is a mechanism to allow flexible pricing and reimbursement discussions to take place for valuable products that are not nationally commissioned and/or categorised as transformative. (1 response)
- Building on the work of the NICE Implementation Collaborative. (4 responses)

Practicalities

Responses also commented on the practicalities of implementing this architecture. It was suggested that:

- A clear mandate and governance is needed, with oversight and scrutiny. Accountability needs to be built in. (5 responses)
- More detail is needed on the role of NHS England and other existing infrastructure. (6 responses)
- The Care Quality Commission could also be given a formal role in assessing trust uptake. (1 response)
- It is important to define the bodies as simply and specifically as possible to ensure clarity of scope and to avoid the kind of ‘mission creep’ demonstrated by the AHSNs. (2 responses)
- The Concordat agreement should be complemented by firm requirements within role specifications of key individuals to ensure innovation is adopted within NHS institutions. (1 response)
- Clear criteria would be needed to determine which medicines or other technologies are introduced to the NHS through the innovation pathway and whether this will only apply to ‘transformative medicines’ (1 response)
- It will be important to ensure the Concordat is clear in its language about the duty of organisations to promote innovation, so that it does not become a tool to reduce the use of new medicines that represent incremental innovation or are innovative for small patient groups. (1 response)

- The operating framework for each Innovation Exchange should be uniform to avoid significant geographical variation. (1 response)
- Decisions should be able to be appealed. (1 response)
- Industry should play a role in helping shape the innovation pathway. (4 responses)

"The success of the network of local Innovation Exchanges, supported by a national Innovation Partnership, will be judged on whether this infrastructure succeeds in accelerating access to innovation… The introduction of innovation should be supported by all parts of the health system at every level in partnership. To ensure that this happens, we believe that industry should have a formal role as part of the national Innovation Partnership. This could take the form of a sub group that reports to the proposed coordinating committee."

(Pharmaceutical industry)

There were no discernible differences in the comments made by various sectors.

Should the proposed Innovation Partnership and Concordat be held to account by a supporting co-ordinating committee?

In total, nine responses provided feedback about this topic. These responses came from the pharmaceutical sector (4 responses), charities (2 responses), an academic / research organisation and a trade body. One response did not provide sufficient detail to ascertain their sector.

Three responses believed that the proposed Innovation Partnership and Concordat should be held to account be a co-ordinating committee with appropriate transparency. Clear accountability and requirements for the Innovation Exchanges were also stated to be desirable.

Three responses said that charities, patients and others should be involved in the Partnership and any coordinating committee.

Another response said that whilst a good idea in principle, the committee would need to have enough power to make a difference.

One response thought that creating another committee would be duplicative and unnecessary. This response suggested that accountability should reside with MISG which includes representation from all relevant parties.

One response said that regardless of whether or not a committee is put in place, key parameters should be measured, with minimum requirements set and incentives put in place.

Due to the small number of comments about this topic, it was not possible to differentiate whether some sectors were more likely to support a co-ordinating committee than others.

What are the costs and benefits of the proposed new system architecture to accelerate the development of, and access to, the best new products?

In total, 12 responses provided feedback about this topic. These responses came from the pharmaceutical sector (6 responses), an academic / research organisation, a medical technology organisation, a nutrition organisation and a Royal College. Two responses did not provide sufficient detail to ascertain their sector.

Benefits

Perceived potential benefits included:

- Scope to harness and enhance the remit of **existing structures**. (2 responses)
- Potential for long-term **cost savings**. (4 responses)

Costs and challenges

Potential perceived costs or limitations were:

- Potential for **duplication** of functions with AHSNs. (2 responses)
- **AHSNs** do not have the necessary 'teeth' to deliver the change in practice and culture needed. (3 responses)
- Focuses on a **small number** of organisations. (3 responses)
- Not having **industry representation** on the Innovation Partnership. (1 response)
- Does not provide a clear, streamlined pathway for **less high profile technology** that can provide both improved system efficiency and improved outcomes. (1 response)
- Horizon scanning needs to recognise the **differences between sectors**. (2 responses)
- Resources to support and implement **change management** are needed. (1 response)
- Steps towards **national formularies** create the risk of cost considerations superseding local expertise and patient outcomes. (1 response)
- Does not describe how to improve alignment of **payment systems**. (1 response)
- Needs to say how **small companies** should engage. (1 response)
- Needs to include **metrics** to ensure measurement of delivery. (1 response)

Summary

Key messages

The key messages from feedback to the Review following publication of the Interim Report are summarised here.

Overall, responses were positive about the five propositions set out in the Interim Report and the broad direction of travel of the Review. Responses often said they felt that their feedback during the first phase of the Review had been listened to and incorporated. Responses congratulated the Review team on the work to date and said they welcomed the opportunity to be involved in an ongoing manner.

Proposition One: Putting the patient centre stage

About half of the responses received provided feedback about one or more topics related to Proposition One, putting patients at centre stage.

There was a call from responses to involve patients earlier and throughout the innovation process. Responses emphasised the need to provide information in an accessible format to support patient participation. It was suggested that the NHS Constitution could be used to enhance involvement.

It was felt to be important to monitor the extent of patient involvement and set up processes to deal with insufficient involvement.

There was thought to be much scope for joint working between patient groups, industry and statutory services.

There were suggestions about how to expand patient involvement within NICE processes.

There was support for using patient-led outcome measures to better support the evaluation of new products, though some responses questioned the practicalities of this.

It was suggested that tools such as the EQ-5D and QALYs did not fully account for the range of outcomes that are important to patients.

Responses felt that all organisations needed to be willing to listen to and engage with patients on more than a superficial level.

> ***"We agree that patients (and carers, both formal and informal) together with other healthcare professionals should be given a stronger voice. However, a voice alone will not influence unless the right organisations are willing and tasked to listen and are expected to justify why decisions may differ from patient opinion. Patients need the tools to influence financial and procurement decisions."***
>
> **(NHS)**

Key concerns for patients across the whole innovation pathway were reported to be information and transparency, adequate involvement, prompt access to products, safety, choice, funding to allow access to products of choice and equity of access to products.

Proposition Two: Getting ahead of the curve

About two fifths of the responses provided feedback about one or more topics related to Proposition Two.

Responses suggested that it was important not to prioritise transformative products at the expense of others. Responses wanted a clear definition and criteria for transformative products. There was a concern that only a limited number of products would be covered. It was suggested that policies and definitions could be closely aligned with the US FDA and the European Medicines Agency.

It was proposed that having a separate funding mechanism for transformative products while they are under 'conditional' status would be worthwhile.

It was thought to be important to differentiate processes for different types of products, such as those for rare diseases.

Some responses suggested that all medicines should be reviewed under the auspices of NICE to standardise the approach to value assessment.

Responses said that patient groups should be involved in dialogue and could help to increase patient involvement.

There was a desire for more robust and less fragmented data systems within the NHS, including better use of real world data and patient registries.

Responses were keen to ensure the pathway gave thought to improving uptake after approval. Monitor and CQC could monitor variation in uptake at a local level.

Proposition Three: Supporting all innovators

Around one third of the responses provided feedback about one or more topics related to Proposition Three.

Responses were generally supportive of the proposals for a new system of guidance and support, though some did not feel the Review went far enough in recommending system transformation.

Suggestions included:

- Clarifying the support available to various parties
- Clarifying the responsibilities of national and local commissioners and regulators
- Having consistency across countries and product types
- Ensuring patients, industry and statutory services have a mechanism for early proactive and ongoing communication
- Ensuring clear plans for implementation and accountability
- Enhancing collaboration between organisations
- Strengthening the mandate and resourcing of NICE
- Operating a single national value assessment system

Quick wins might include developing a single central value assessment process for all medicines and supporting the NHS to systematically deinvest or decommission products.

Suggested gaps that the Review could further explore included covering a wider range of products, tackling widespread delayed usage of new products and evolving NICE beyond cost-per-QALY approaches.

Proposition Four: Galvanising the NHS

Around two fifths of the responses provided feedback about one or more topics related to Proposition Four.

Proposed methods to incentivise and support the NHS to increase the uptake of innovative technologies included:

- Workforce development, including innovation champions and training
- Co-ordination and collaboration between organisations
- Setting targets and using data to monitor uptake
- Financial incentives

Responses suggested setting up a Transformation Fund using finances from some of the PPRS rebate or using funding directly from the Department of Health. Importantly, responses did not want to see existing funds already used for increasing access to innovative treatments, such as the Cancer Drugs Fund, repurposed into a Transformation Fund.

In addition to financial incentives, accelerated pathways could describe decommissioning opportunities and the financial benefits.

It was suggested that there should be channels where patient organisations, industry and the NHS regularly met.

It was felt that engaging with frontline and NHS management staff may be key. This could include building skills in change management, freeing staff time to learn about innovations and take part in research and having local change champions.

The desire for a clear implementation plan and ways to monitor progress was stressed.

The Innovation Scorecard was mentioned as a mechanism for strengthening transparency.

Proposition Five: Delivering change

Around one third of the responses provided feedback about one or more topics related to Proposition Five.

There was mixed support for the notion of Innovation Exchanges and the Innovation Partnership. About half of responses were supportive and half challenged this idea. A key concern was about the appropriateness of AHSNs leading the process.

Suggested priorities for the Innovation Partnership included:

- Increasing access to and uptake of innovative technologies
- Measuring uptake
- Identifying promising areas which need additional support and funding

Some responses supported having a co-ordinating committee to oversee the Innovation Partnership. Others questioned the value of such a committee and some responses suggested that charities, patients and other organisations should be part of the process.

Other comments

In addition to providing feedback about the Propositions, a small number of responses made other comments about the Review. The most common of these included:

- Congratulating the Review team for the work done to date
- Suggesting that the Review was on the right path and supporting the general principles
- Requesting more details in the final Review report, including an implementation plan and metrics
- Suggesting that the challenges faced require more radical change than ‘tweaking’ the current system
- Suggesting that the focus of the review is on too narrow a range of products rather than ‘mainstream’ products
- Continuing to reflect on the rich feedback compiled for the Review, including taking account of areas prioritised by many responses
- Including solutions for devolved nations and consistency across regions

The Accelerated Access Review team will consider all of the feedback received when further developing practical solutions and next steps.