Medicines & Healthcare products Regulatory Agency

AGENDA FOR BOARD MEETING HELD IN PUBLIC

10:00 am – 12:30 pm on Tuesday 16 January 2024

Chair: Professor Graham Cooke

	AGENDA ITEM	**PURPOSE**	**PRESENTER**
10:00	INTRODUCTION		
	1. What is the purpose of this meeting, who are the Board Directors and are there any absences?	Information	Chair
	2. Are there any new Declarations of Interest?	Information	All
	3. What were the minutes and actions from the last meeting?	Approval	Chair
	AGENCY PERFORMANCE		
10:15	4. What are the most important current activities and priorities from the CEO's point of view?	Context	June Raine
10:35	5. What was the financial and people performance of the MHRA for this year up to 30 November 2023?	Assurance	Rose Braithwaite
10:55	6. How effectively is the MHRA maintaining its performance on clinical trials and how are plans for the new regulatory system progressing?	Assurance	Marc Bailey
	HEALTHCARE ACCESS		
11:20	7. How is the system of international recognition enabling access medicines for UK patients?	Assurance	Julian Beach
	ASSURANCE		
11:40	8. What assurance can be provided by the Patient Safety and Engagement Committee?	Assurance	Mercy Jeyasingham
11:50	9. What assurance can be provided by the Audit and Risk Assurance Committee?	Assurance	Michael Whitehouse
12:00	10. What assurance can be provided by the Organisational Development and Remuneration Committee?	Assurance	Amanda Calvert

	EXTERNAL PERSPECTIVE		
12:10	11. What questions do members of the public have about the items on this Board Meeting Agenda?		Chair
12:30	CLOSE OF MEETING		

MHRA Board Declarations of Interest – January 2024

The MHRA Board is responsible for advising and agreeing the strategic direction of the Agency, endorsing the Agency's recommendations to Ministers on key financial and performance targets, and advising on and monitoring plans to ensure those targets are met.

The Board supports the Chief Executive Officer in the effective delivery of services and overall performance by providing leadership, developing strategy, advising on the delivery of policies, maintaining high standards of corporate governance, scrutinising performance and ensuring that controls are in place to manage risk.

The Board and its Non-Executive Directors have no involvement in any regulatory decisions affecting medicines, medical devices or any other products or services delivered by the Agency. These decisions are the responsibility of the Chief Executive Officer, supported by the Executive Committee.

Name and MHRA Role	Name of Other Company or Organisation	Nature of interest	Paid	Current
Professor Graham Cooke Non-Executive Director & Interim Co-Chair	Imperial College NHS Trust and Chelsea & Westminster NHS Foundation Trust	Honorary NHS Consultant	Yes	Yes
	NERVTAG	DHSC NERVTAG committee member	No	Yes
	NIHR	NIHR Research Professor	Yes	Yes
	NIHR	Influenza platform trial in the UK	Yes	Yes
	NIHR	Chair DSMB (PROTECT-V trial)	No	Yes
	Pfizer	Pneumonia study with Imperial College Healthcare Partners	Yes	Yes
	30 Technology Ltd	Consultant/Advisor	Yes	Yes
	DNAnudge Ltd	Consultant/Advisor	No	Yes
	Seventh Sense Biosystems	Consultant/Advisor	Yes	Yes
	Sanofi CoV	Chair of End Point Review Committee for vaccine trial	Yes	Yes
	WHO	Chair of Committee for Selection and Use of Essential Medicines	No	Yes
Dame June Raine Chief Executive	World Health Organisation (WHO) Committee on Safety of Medicinal Products	Member	No	Yes
Dr Marc Bailey Chief Scientific Officer	Nokia Corporation	Ex-employee shareholder	No	Yes
Dr Junaid Bajwa Non-Executive Director	Microsoft	Employed (Chief Medical Scientist at Microsoft Research), Shareholder	Yes	Yes

Name and MHRA Role	Name of Other Company or Organisation	Nature of interest	Paid	Current
	Merck Sharp and Dohme	Ex-employee shareholder	No	Yes
	Ondine biomedical	Non-Executive Director	Yes	Yes
	Novartis Industry Council	Advisory to UK Pharma Exec	Yes	Yes
	UCLH	Non-Executive Director	Yes	Yes
	Whittington NHS Trust	Associate Non-Executive Director	Yes	Yes
	NHS	GP, Physician (Sessional)	Yes	Yes
	Nuffield Health	Governor (NED)	Yes	Yes
	Nahdi Medical Corporation	Non-Executive Director	Yes	Yes
	DIA Global	Board Member	No	Yes
Julian Beach Interim Lead, Healthcare Quality & Access	None	N/A	N/A	N/A
Liz Booth Chief People Officer	None	N/A	N/A	N/A
Rose Braithwaite Chief Finance Officer	Mental Health Foundation	Treasurer	No	No
Amanda Calvert Non-Executive Director & Interim Co-Chair	Astrazeneca	Ex-employee shareholder Immediate family member	No	Yes
	Quince Consultancy Ltd	Provides consultancy services including companies in the healthcare sector.	Yes	Yes
	Athenex Pharma	Quince Consultancy providing strategic consultancy on oral oncology chemotherapy platform. ILAP applicant and Marketing Authorisation applicant.	No	No
	Cambridge Judge Business School	Member of Advisory Board	No	Yes
	Duke Street Bio	Advisory / Consultant	Yes	Yes
	Fennix Pharmaceuticals	Founder of start-up company planning to develop oral chemotherapy product into Phase 2 trial. Not yet trading.	No	No
	High Value Manufacturing Catapult	Non-Executive Director	Yes	Yes
Dr Alison Cave Chief Safety Officer	None	N/A	N/A	N/A
Dr Paul Goldsmith Non-Executive Director	Closed Loop Medicine Ltd	Shareholder, director & employee; MA submission	Yes	Yes
	Summit Inc	Shareholder	No	Yes
	Ieso Digital Health	Shareholder	No	Yes
	Institute of Global Health Innovation (IGHI), Imperial College, London	Visiting Professor	No	Yes
	MDU Ltd	Director	Yes	No

Name and MHRA Role	Name of Other Company or Organisation	Nature of interest	Paid	Current
	MDU Investments Ltd	Director	Yes	No
	NHS	Consultant Neurologist	Yes	Yes
	NHS	Clinical Senate Member	No	Yes
	Radix Big Tent Foundation	Trustee	No	Yes
	Sleepstation	Co-founder of original programme, 2012-2014	No	No
Claire Harrison Chief Digital & Technology Officer	None	N/A	N/A	N/A
Haider Husain Non-Executive Director	Healthinnova Limited	Chief Operating Officer	Yes	Yes
	Milton Keynes University Hospital NHS Foundation Trust	Non-Executive Director	Yes	Yes
	British Standards Institute	Panel Chair BS30440 – Use of AI within Healthcare	No	Yes
	Dementia Carers Count	Trustee	No	Yes
	World Wars Muslim Memorial Trust	Trustee	No	Yes
	Microsoft Corp	Ex-employee shareholder	No	No
	BBC	Family Member	No	Yes
	NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board	Associate Non-Executive Director	Yes	Yes
Mercy Jeyasingham MBE Non-Executive Director	NHS South West London Integrated Care Board	Non-Executive Member	Yes	Yes
Raj Long Non-Executive Director	Gates Foundation	Employee – Deputy Director	Yes	Yes
	Bristol-Myers Squibb	Ex-Employee Shareholder	Yes	Yes
	RESOLVE (Sustainable solutions to critical social, health, and environmental challenges)	Scientific Advisory	No	Yes
	Novartis	Ex-Employee Shareholder	Yes	Yes
	EC IMI NEURONET EC Innovative Medicines Initiative (IMI) Non-Product	Scientist Advisory Board	No	Yes
	Gates Venture – EC Innovative Medicines Initiative (IMI) Non-Product – IMI European platform for Neurodegenerative Disorders	Advisory	Yes	Yes
	HUYA Bio	Access Advisory	Yes	No
	PAVIA – PV Africa Board (EC Funded)	Advisory Board	No	Yes
	WHO – Sustainable COVAX Manufacturing Strategy for Regional Health Security	Advisory Expert	No	Yes
	UK Health Security Agency	Associate Non-Executive Board Member	Yes	Yes
	EU Innovative Health Initiatives (IHI)	Advisory Expert for this EU public-private partnership	Yes	Yes

Name and MHRA Role	Name of Other Company or Organisation	Nature of interest	Paid	Current
		funding health research and innovation funded by European Commission		
Laura Squire OBE Chief Healthcare Quality & Access Officer	None	N/A	N/A	N/A
Michael Whitehouse OBE Non-Executive Director & Interim Co-Chair	South East Coast Ambulance Services NHS Foundation Trust	Deputy Chair & Senior Independent Non-Executive Director Chair of Audit Committee Chair of Charities Committee	Yes	Yes
	Cruse Bereavement Charity	Trustee Chair of Finance and Audit Committee	No	No
	Republic of Ireland Audit Office	Member of Audit Committee	No	No
	National Audit Office	Board Member and Chief Operating Officer until 17 April 2017	No	No
Glenn Wells Chief Partnerships Officer	None	N/A	N/A	N/A

Medicines and Healthcare products Regulatory Agency

Minutes of the Board Meeting Held in Public on 21 November 2023

(09:30am – 12:00pm)

NIBSC, Blanche Lane, South Mimms, Potters Bar EN6 3QG

Present:

The Board

Professor Graham Cooke	Non-Executive Director & Interim Co-Chair
Dr June Raine DBE	Chief Executive (remotely via Zoom)
Dr Marc Bailey	Chief Science, Research & Innovation Officer
Dr Junaid Bajwa	Non-Executive Director
Julian Beach	Interim Executive Director, Healthcare Quality & Access
Liz Booth	Chief People Officer
Rose Braithwaite	Chief Finance Officer
Dr Alison Cave	Chief Safety Officer
Amanda Calvert	Non-Executive Director & Interim Co-Chair
Dr Paul Goldsmith	Non-Executive Director
Claire Harrison	Chief Digital & Technology Officer
Haider Husain	Non-Executive Director
Raj Long	Non-Executive Director
Dr Glenn Wells	Chief Partnerships Officer
Michael Whitehouse OBE	Non-Executive Director

Others in attendance

Rachel Bosworth	Director of Communications and Engagement, MHRA
Carly McGurry	Director of Governance, MHRA
Natalie Richards	Head of the Executive Office, MHRA
Marie Donatantonio	Deputy Director, Health & Safety and Quality Assurance (for item 8)
James Pound	Deputy Director, Standards & Compliance, MHRA (for item 6) (remotely via Zoom) (for item 6)
Kathryn Glover	Deputy Director, Medicines Regulation and Prescribing, DHSC

INTRODUCTION

Item 1: What is the purpose of this meeting and who are the Board Directors?

1.1 Professor Graham Cooke opened the meeting. Professor Cooke welcomed Liz Booth who has joined the MHRA as Chief People Officer and a member of the Board.

1.2 The Chair set out his expectations and priorities for this Board meeting held in public which was being live streamed to the registered audience and recorded. The Chair welcomed everyone to the meeting, including a broad range of observers including patients and members of the public, representatives of patient groups, healthcare professionals, government officials, industry, media and MHRA staff.

Item 2: Are there any Apologies or Declarations of Interest?

2.1 Apologies were received from Alison Strath, Chief Pharmaceutical Officer for Scotland; Greig Chalmers, Head of Chief Medical Officer's Policy Division in the Scottish Government; and Cathy Harrison, Chief Pharmaceutical Officer for Northern Ireland.

2.2 The Board reviewed the Declarations of Interest (DOIs) for all MHRA Board members. There were no new declarations this month. The Chair reviewed the DOIs and was satisfied that there were no conflicts of interest preventing any Board Member from participating in the full agenda of this meeting.

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

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

AGENCY PERFORMANCE

Item 4: What are the most important current activities and priorities from the CEO's point of view?

4.1 Dr June Raine presented the Chief Executive's monthly report, which covered the following:

(i) Science, Research and Innovation – including latest updates on the Clinical Trials notification scheme; the UK Stem Cell Bank's 20th anniversary; the Innovative Devices Access Pathway; NHS Diagnostics; a novel vaccines platform; Chikungunya vaccine development; antimicrobial resistance; biological product safety; polio vaccine quality control; influenza vaccines; the WHO Expert Committee on Biological Standardisation; pandemic preparedness; stability of biologics; quality assurance; and a grant award from DHSC and the Engineering and Physical Sciences Research Council;

(ii) Healthcare Access – including updates on national new drug applications for tirzepatide, epcoritamab, tirlecitinib and dostarlimab; gene therapy for sickle cell disease; the reliance route to market access; COVID-19 vaccines; national applications performance; software as a medical device change programme; the artificial intelligence airlock; electronic patient information; and the international recognition team;

(iii) Patient safety – including updates on new isotretinoin prescribing advice; valproate dispensing in original packs; Operation Pangea; CPRD's patient engagement event; and an education series for medical students;

(iv) Digital & Technology – including updates SafetyConnect; Intellicase replacement; the International Recognition Procedure; the Regulatory Management System; and the service desk maturity project; and

(v) Dynamic organisation – including an update on the Civil Service People Survey.

4.2 The Board thanked Dr Raine for her report and provided comments relating to the diversity of attendance at the CPRD patient engagement event; international recognition and ensuring the Board is assured this work is progressing to time; the Agency's approach to information sharing across the healthcare system; an action was agreed to provide the Board with an update on how information sharing is managed across the system.

Action 105: Provide the Board with an update on how information sharing is managed across the healthcare system and how this aids international recognition processes. Glenn Wells & Julian Beach

4.3 The Board provided further comments relating to clinical trials; the work of Operation Pangea; the work on the electronic Patient Information Leaflet and how this should be discussed at PSEC within 6 months; the CPRD Trusted Research Environment; it was agreed that an update should be provided to the Board on the Trusted Research Environment. The Board noted that it will be vital for the Board to review the progress on implementation of the international recognition procedure to ensure the Agency is meeting its commitment to delivering innovation by facilitated an access. An action was taken to provide the Board with an update of the work of the Criminal Enforcement Unit. The Board noted Dr Raine's report with thanks.

Action 106: Provide the Board with an update on the work of the Criminal Enforcement Unit. ***Alison Cave***

Action 107: The Patient Safety and Engagement Committee should review the progress on the electronic Patient Information Leaflet.
Mercy Jeyasingham

Item 5: How well have the business plan targets been met and what is planned in each of the operational areas?

5.1 The Board considered a report describing how well the Agency's Business Plan targets have been met, and what is planned in each of the operational areas. The Board noted that overall the Agency is on track to deliver its Business Plan objectives for 2023/24 with areas that are at risk of slippage having sound mitigations in place to bring them back on track. The Key Performance Indicators (KPIs) have been expanded to show new areas of operational delivery and will continue to be developed over the remainder

of the year. They show a number of areas of successful delivery but do flag areas where the Agency needs to continue to work to improve its performance.

5.2 The Board noted the report and provided comments relating to health inequalities and women's health; delays on ILAP approvals – noting that the reason for the backlog in ILAP approvals was not related to the clinical trials backlog, and is presently being reviewed and actions taken to address this issue; the need for clear and prompt communications to stakeholders; patient engagement training for staff and monitoring staff training records; staff recruitment; ensuring clear metrics for clinical trials; and the successful debt recovery activities. The Board noted the report with thanks.

Item 6: How effectively is the MHRA maintaining its performance on clinical trials and how are plans for the new regulatory system progressing?

6.1 The Board considered a paper describing current clinical trial assessment performance and the work programme for the future sustainability of clinical trial assessment including the new clinical trial regulations. The Board noted that all clinical trials applications received since 1st September 2023 have been assessed within statutory timeframes. All applications received prior to the 1st September 2023 have been assessed and there is no backlog of clinical trial applications.

6.2 The Board considered the report and provided comments relating to the impact on public health; implementing mechanisms to ensure a sustained process; performance monitoring measures; developing an integrated clinical trial tracking system; consideration of when to redeploying staff back to their original roles; recruiting and training new staff; implementing a transferable training system to increase the pool of trained staff; working with NIHR clinicians; the new cost and fees model and how to develop this through engagement with stakeholders; the wider impact on the rest of the Agency; it was agreed that a review should be undertaken on any backlogs in any other areas of the Agency's work.

6.3 The Board provided further comments relating to consideration of sharing digital infrastructure with other organisations as recommended in the O'Shaughnessy review such as HRA noting that the Board will be provided with regular progress updates on the O'Shaughnessy review recommendations; and avoiding unnecessary duplication. The Board were assured by the progress, and agreed that a further update should be presented to the January Board relating to the new ways of working.

Addition to action 101: Provide the Board with an update on the new proposed Clinical Trials process. Undertake a review of any other backlogs in the Agency.
Marc Bailey

DYNAMIC ORGANISATION

Item 7: How is the People Strategy helping the agency become a great place to work?

7.1 The Board considered a paper describing the Agency's People Strategy 2023-2026, "Enabling people to flourish", which was published in July 2023. The strategy sits

alongside the agency's 3-year Corporate Plan and Business Plan for 2023/24 as the extent and quality of the delivery of agency outcomes and performance goals is dependent on what all those who work at the agency do and how they do it as well as a supportive working environment and access to required information, learning and tools. The Board noted that the People Strategy relies on a partnership approach between colleagues and the agency/HR with an expectation that all will take an active role to enable successful outcomes.

7.2 The Board considered the paper and provided comments relating to refreshed work planning; the need for cultural change; how turnover in the Agency is now returning to a more normal rate following the transformation; ensuring leaders walk the talk; learning from other organisations; equality, diversity and inclusion; creating a culturally competent workforce; utilising pulse surveys to capture real time feedback with rapid turnaround; attracting and retaining talent; graduate schemes; enabling great performance and swift delivery; developing the Agency's talent acquisition strategy; fully utilising in-year awards; and ensuring the Board reviews the results of the People Survey as soon as possible.

Action 109: Provide an update on the People Survey results to the Board.

Liz Booth

Item 8: What are the key priorities for the MHRA's Health & Safety Strategy?

8.1 The Board considered a paper describing the key priorities for the MHRA's Health & Safety Strategy. The current MHRA Health, Safety and Wellbeing Strategy (HSW) runs from 2019 – 2024. The Board considered the details of the strategy, along with an example of the annual action plan that sits underneath the strategy to monitor its delivery. Due to the significant changes since the HSW was written in 2019, there are plans now for developing a new, more holistic, HSW strategy to take us forward for the next 5 years. The Board noted that the new strategy will run from early 2024, addressing gaps in the current strategy. The style will also be updated to provide a clearer narrative for the reader and will include the action plan that demonstrates the delivery over the 5 years to cover all the strategic objectives.

8.2 The Board noted that the new strategy will be for all the activities of the Agency covering a broad range of health and safety requirements including safety of staff working in the office, at home, and in high-risk activities both on site at South Mimms laboratories and in off-site locations.

8.3 The Board considered the key priorities to be addressed by the new strategy and provided comments relating to sharing best practice; embedding a positive health and safety culture throughout the Agency; ensuring clear lines of accountability and embedding health and safety targets in individuals targets; ensuring sufficient resource and expertise to sustain the Agency's statutory responsibilities; mental health; resilience; establishing an early warning system with regular reporting; coverage of safety champions cross-Agency; and keeping the Board updated as the HSW is developed.

Action: Provide a further update on the progress of the Health, Safety & Wellbeing Strategy to the Board. ***Marc Bailey***

ASSURANCE

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

9.1 The Board considered an assurance report from the Audit and Risk Assurance Committee (ARAC). The ARAC met on Tuesday 12 September and reviewed progress in implementing the recommendations of the Health and Safety Executive; the Agency's current financial position and the likely end year performance; assurance on how the Agency will implement lessons learned from the 2022-23 external audit; considered three reports from Internal Audit exploring in more detail the Agency's cyber security resilience; considered the Agency's risk register including new and emerging risks; and considered a report on the Agency's performance in responding to complaints. The Board provided comments relating to capital spend; cyber risks; the annual risk horizon scanning meeting; and the finance report. The Board noted the report for assurance.

Item 10: What assurance can be provided by the Organisational Development and Remuneration Committee?

10.1 The Board considered an assurance report from the Organisational Development and Remuneration Committee (ODRC). The ODRC met on 25th September 2023 and reviewed the progress made in improving processes for the delivery of priority services; reviewed how the recruitment, talent management and succession planning strategies and processes support the delivery of the corporate plan objectives; undertook an annual review of diversity, equality, and wellbeing; and reviewed plans to improve business performance management reporting for the 2023/2024 business plan. The Board provided comments relating to clinical trials; implementing performance targets; health and safety and early reporting systems; and governance and decision making. The Board noted the report for assurance.

EXTERNAL PERSPECTIVE

Item 11: What questions do members of the public have for the MHRA Board?

11.1 The Board answered a range of questions which had been submitted by members of the public before and during the meeting. These questions concerned ILAP; workforce planning and future proofing; clinical trials; and health and safety.

ANY OTHER BUSINESS

12.1 No items of other business were raised and the Chair closed the meeting.

ACTIONS FROM MHRA BOARD MEETING IN PUBLIC – 21 November 2023

The actions highlighted in red are due this month

Action Number	Action	Owner	Date	Status
Carried Forward from previous meetings				
29	16/03/21: Present an Agency Science Strategy to the Board. 15/11/22: Revise the Science Strategy to include clear prioritisation; and greater inclusion of in-house expertise on behavioural science with a complementary expert group. Include vaccines work as a specific area of expertise, alongside biologics and the UK Stem Cell Bank, to create a distinctive offering to make the UK an internationally recognised centre of excellence in this field. A review of scientific committees should also be undertaken. Present a further update to the Board in March 2023. 21/03/2023: Science Strategy to be presented to the Board in July. 11/07/23: Present an update to the Board on progress against each of the themes in the Science Strategy at the end of 2023.	Marc Bailey	~~21/09/21~~ ~~16/11/21~~ ~~17/05/22~~ ~~15/11/22~~ ~~21/03/23~~ ~~11/07/23~~ 12/12/23	
70	18/01/22: Develop and present a Data Strategy to the Board.	Alison Cave & Claire Harrison	~~17/05/22~~ ~~18/10/22~~ ~~15/11/22~~ ~~18/04/23~~ ~~12/12/23~~ 19/03/24	
73	15/02/22: Develop a Sustainability Strategy.	Glenn Wells	~~17/01/23~~ ~~16/01/24~~ 19/03/24	
99	11/07/23: Patient involvement in internal audit should be reviewed by the Patient Safety and Engagement Committee. 21/11/23: This is being built into the audit process.	Carly McGurry	21/11/23	Completed
101	11/07/23: Action: Present an update to the Board on the performance and proactive	Marc Bailey	~~21/11/23~~ 16/01/24	On agenda

	communications and engagement activities related to clinical trials which will maintain trust in the Agency from industry and research customers. 19/09/23: Provide an update to the Board in November 2023 on the progress of the new clinical trial process pilot. Prepare a plan for training and upskilling of staff to increase resilience across the Agency. 21/11/23: Provide the Board with an update on the new proposed Clinical Trials process. Undertake a review of any other backlogs in the Agency.			
102	11/07/23: Invite the Patient Safety Commissioner to a future Board meeting.	Alison Cave	21/11/23	Completed
103	19/09/23: Provide the Board with a breakdown of PQs received in the last quarter.	Glenn Wells	21/11/23	Completed
104	19/09/23: Develop a reputation strategy for the Agency with reputation index measures.	Rachel Bosworth	~~21/11/23~~ 19/03/24	
New Actions				
105	21/11/23: Provide the Board with an update on how information sharing is managed across the healthcare system and how this aids international recognition processes.	Glenn Wells & Julian Beach	19/03/24	
106	21/11/23: Provide the Board with an update on the work of the Criminal Enforcement Unit.	Alison Cave	21/05/24	
107	21/11/23: PSEC to review the electronic Patient Information Leaflet	Mercy Jeyasingham / Alison Cave	19/03/24	
108	21/11/23: Provide the Board with an update on the Trusted Research Environment	Alison Cave	19/03/24	
109	21/11/23: Provide an update on the People Survey results to the Board	Liz Booth	19/03/24	
110	21/11/23: Provide a further update on the progress of the Health, Safety & Wellbeing Strategy to the Board	Marc Bailey	21/05/24	

Medicines & Healthcare products Regulatory Agency

BOARD MEETING HELD IN PUBLIC

16 January 2024

Title	**What are the most important current activities and priorities from the CEO's point of view?**
Board Sponsor	June Raine
Purpose of Paper	Context

What are the most important current activities and priorities from the CEO's point of view?

'TOP 10' HEADLINES

- The MHRA is now consistently approving clinical trials applications within statutory timeframes and working with stakeholders on implementing a new regulatory framework
- The International Recognition Procedure was launched on 1 January, speeding up access for patients while maintaining our focus on national applications for innovative products
- The Agency's licensing performance for established medicines remains a top priority following recruitment delays and process redesign is under way via a cross-Agency group
- Two new Approved Bodies for medical devices have been granted, supporting manufacturers and enabling timely patient access to safe and effective MedTech products
- Eight innovative MedTech products are being selected for the Innovative Devices Access Pathway pilot and experience will inform an aligned pathway for all innovative products
- We are working with Innovate UK to establish Centres of Excellence in Regulatory Science and a webinar for applicants will be held this month on priority areas for research
- We communicated to healthcare organisations the need to prepare for new measures to reduce the prescribing of the antiepileptic Valproate unless no other medicine is effective
- Following Yellow Card reports of addictive behaviour with the antipsychotic medicine aripiprazole we reminded healthcare professionals to discuss this with patients and carers
- The genetically stable polio vaccine nOPV2 developed by MHRA scientists has earned WHO Prequalification, the first Emergency Use Listing vaccine to achieve prequalification
- We have taken enforcement action leading to the conviction and prosecution for supply of controlled drugs, supply of prescription-only medicines, and money laundering.

SCIENCE, RESEARCH, AND INNOVATION

Clinical trials

1.1 Last year, the clinical trials unit had a significant challenge, culminating in a backlog of applications. In Autumn 2023, we cleared the backlog by introducing a risk-proportionate approach for assessing clinical trials, redeploying staff across the Agency to the clinical trial unit and using external contractors. Since 1 September 2023, all clinical trial submissions, both initial and amendments have been assessed within the statutory timelines. We are now working on a new clinical trial operating model to inform the new clinical trial regulations. The clinical investigations and trials operations team is working to introduce a better and faster reporting and data analysis system. The clinical investigations team is reviewing submissions for medical device investigations according to the statutory timelines and there is no backlog.

Innovative Devices Access Pathway

1.2 Following the publication of the Mclean Report in May 2023, and the launch of the Innovative Devices Access Pathway (IDAP) pilot, a wide field of around 80 applications has been received of which a number are software as a medical device. Patient experts have completed their shortlisting of these applications according to the agreed criteria focusing on unmet clinical need. These will be presented to the final selection panel meetings in January when the final 8 for the IDAP pilot will be selected. The experience gained in the pilot will be very useful alongside the refresh of the Innovative Licensing and Access Pathway (ILAP).

Patient and Public Involvement for lab-based researchers' workshops

1.3 We have organised two externally facilitated workshops on 'Patient and Public Involvement for lab-based researchers' to support the National Institute for Health and Care Research (NIHR) Regulatory Science Research Unit with its objectives. The two events will be held in January at South Mimms.

Patient engagement – Group B Streptococcus

1.4 On 11th of December, SRI R&D Vaccines hosted an inspiring event with the Group B Strep Support (GBBS) charity, which is dedicated to aiding families impacted by Group B Streptococcus (GBS) and supporting vital research to combat this infectious agent's effects on newborns. The meeting served a dual purpose; in the first instance, it allowed us to introduce our team's initiatives in addressing GBS disease, particularly in expediting the development of a much-needed vaccine to safeguard newborns. Secondly, the meeting also provided MHRA staff invaluable insight into the commendable work undertaken by GBSS to support affected families and facilitate crucial research.

Polio vaccine nOPV2

1.5 The global eradication of polio is a significant public health goal. The journey to eradicating polio faces hurdles not encountered with other notable disease eradication programmes. The traditional oral poliovirus vaccine is used in many parts of the world, but it comes with a risk of vaccine derived poliovirus, which have the potential to cause significant morbidity including paralysis. The development of a novel oral polio vaccine type 2 (nOPV2) makes available an innovative tool to address this risk. The Global Polio Eradication Initiative (GPEI) partners, with various countries, have deployed this vaccine which was originally designed by our scientists at South Mimms: they have been heavily involved in proving the utility of this vaccine in clinical and field studies. In 2021 the WHO granted the vaccine Emergency Use Listing. Now, in December 2023, nOPV2 earned full licensure from the Indonesian regulatory authority as well as WHO Prequalification. nOPV2 is the first EUL-approved vaccine to achieve prequalification. This is a significant milestone and makes it easier for more countries to access and use the vaccine for outbreak response.

Zika virus

1.6 Scientists from SRI R&D Vaccines contributed to the consultation on the WHO R&D Zika Roadmap and Integrated Arbovirus Strategy, held in London. The meeting was organised by the WHO, the Center for Infectious Disease Research and Policy (CIDRAP), and the Wellcome Trust. The meeting focussed on the consultation to review the Zika virus R&D roadmap, which serves as a comprehensive strategy to prioritise research and activities to accelerate availability of effective medical countermeasures, i.e., vaccines, diagnostics, and therapeutics, to reduce risk of Zika virus infection and its associated complications. Also, the meeting expanded on research priorities to other arboviruses. Outcomes of the consultation will be considered by the Zika virus Task Force and incorporated in the final document.

Pandemic preparedness

1.7 The MHRA and the Coalition for Epidemic Preparedness Innovations (CEPI) have signed a new framework agreement to extend the participation of our South Mimms laboratories in the CEPI Centralised Laboratory Network (CLN) for COVID-19 to other priority pathogens of public health concern. Since 2020 our South Mimms laboratories were one of the original 8 laboratories which were part of the CEPI CLN for COVID-19. The CLN was created to harmonise the assessment of COVID-19 vaccine candidates by sharing the same methodology and critical reagents. In 2021, CEPI launched a call to expand the geographical areas for COVID-19 laboratories part of the network and to extend the testing to new viral diseases including CEPI priority pathogens. We have been successful in our application to join the new extended network and the work for the measurement of immune responses elicited by vaccine candidates against viruses of public health concern.

Biosimilars

1.8 Work on WHO International Standards (IS) for tumour necrosis factor (TNF) antagonists has continued in the R&D Biosimilar team. The patent on the originator golimumab product, a fully human monoclonal antibody approved for e.g., active rheumatoid arthritis, psoriatic arthritis, ulcerative colitis, and polyarticular juvenile idiopathic arthritis expires this year in both USA and EU. Consequently, a WHO IS has been developed jointly with the European Directorate for Quality of Medicines in support of a golimumab monograph in the European Pharmacopoeia. A report on the 1st WHO IS for golimumab demonstrating its suitability as an anchor for potency assessment based on results from an international multi-centre study has been submitted to the WHO Expert Committee on Biological Standardisation. Since golimumab can induce formation of anti-drug antibodies resulting in loss of efficacy, the applicability of the IS for better and standardised tests for clinical patient monitoring has also been shown. The IS will facilitate global harmonization of potency of different products as well as golimumab monitoring tests supporting clinical decision-making and better outcomes.

Cell and gene therapies

1.9 Advances in cell and gene-based therapeutics as well as other regenerative medicine products have increased the need for high quality, robust, and validated measurements for cell characterization, which are heavily based on flow cytometry. The R&D Biotherapeutics team is collaborating with the National Institute of Standards and Technology (NIST) Flow Cytometry Standards Consortium to develop measurement solutions and standards to improve confidence, establish measurement traceability, and enable comparability in flow cytometry measurements, with more emphasis on the cell and gene therapy application field. We were invited to present the “UK perspective on flow cytometry standards” at the "NIST-FDA Workshops on Measurements and Standards for Advanced Therapy”. This highlighted the involvement of a team across R&D and Standards and Compliance in promoting manufacturing innovation, and in supporting characterization and testing to facilitate regulatory approval.

Funding success

1.10 SRI R&D was successful in a joint grant application from the Research Technology Organisation/Catapult Scheme, funded by Innovate UK. The grant is with Oxford SimCell (a Vaccine SME) and we have been awarded funds to test a novel Pseudomonas aeruginosa derived candidate vaccine vector in the MHRA-developed monocyte activation test. The work will start this month.

HEALTHCARE ACCESS

Performance on established medicines

2.1 New assessment approaches are being introduced to tackle the backlog of applications for established medicines which has accumulated following the Covid pandemic and the Agency's transformation changes, which resulted in loss of experienced staff and delays in recruitment and training. These new approaches include implementation of a new risk-based assessment procedure, recruitment of more assessors and encouraging companies to convert their national applications to a reliance procedure. There is a potential for conversion of 30% of applications to reliance. Close monitoring is in place and longer-term solutions for sustainability are being worked up.

New product for advanced melanoma

2.2 A new combination product Opdualag (nivolumab-relatlimab) was authorised via FDA's Project Orbis for the treatment of advanced melanoma. This combination of monoclonal antibodies enhances T cell activity against tumour cells and is more effective at slowing disease progression compared to nivolumab alone.

International Recognition

2.3 The MHRA launched the new International Recognition Procedure (IRP) from 1 January 2024. This offers a new application procedure that allows the Agency to access the expertise of trusted regulatory partners who have already authorised products. While the Agency retains the ultimate authority to accept or reject applications submitted under IRP, the shared global expertise inherent in the IRP Process is designed to result in a more rapid, efficient, and cost-effective process for applicants. The IRP adds to the existing processes that will help to bring life-saving medicines to UK patients without unnecessary delay. We have already received some pre-submission eligibility checker forms, especially those that are for New Active Substances.

Windsor framework

2.4 The Agency has released new guidance on labelling and packaging of medicinal products for human use following agreement of the Windsor Framework. This guidance is designed to provide information on the implementation of labelling and packaging requirements for medicinal products for human use under the Windsor Framework. The Windsor Framework sets out the long-term arrangements for the supply of medicines into Northern Ireland. It will ensure that medicines can be approved and licensed on a UK-wide basis by the MHRA, with medicines using the same packaging and labelling across the UK, and provides for the disapplication of European Union (EU) Falsified Medicines Directive (FMD) requirements for medicines marketed and supplied in Northern Ireland.

British Pharmacopoeia

2.5 Following successful publication of BP2024 in August 2023 (which became effective on 1st January 2024), a new British Pharmacopoeia (BP) Website was launched in December 2023. We listened to prior consultation responses from our users and have made it easier to navigate to desired content, track updates and place orders for our standards. The new website also improves the experience for our own editorial staff, whilst additional analytics capabilities allow our marketing team to better understand our user's browsing habits. A pipeline of additional content and increased functionality is under way. A BP delegation attended the 14th International Meeting of World Pharmacopoeias (IMWP), and the BP will lead in developing a new Charter for the IMWP in 2024. BP is also a main contributor for a Sustainability Principles declaration at the next meeting.

MedTech Roadmap

2.6 On 9th January we published the RoadMap for future regulation of medical technologies, which will cover healthcare AI, software and diagnostics as well as implantable devices, helping to detect and prevent diseases but requiring a new regulatory framework to ensure patient safety. The planned regulations will also be designed to deliver greater international harmonisation, with more patient centred, proportionate requirements for medical devices that are responsive to technological advances. The roadmap sets out a route to deliver the regulation through a series of new statutory instruments. Priority measures will be put in place this year and core elements of the new framework will be implemented next year.

Approved Body increase

2.7 In December 2023, following a detailed assessment process to ensure that their ability to undertake impartial and objective conformity assessments, we granted two Approved Bodies and extension to the scope of their designation. TÜV SÜD are now designated to undertake conformity assessment of active implantable medical devices, and UL International UK Ltd are now designated to undertake conformity assessment of general medical devices. This continues the expansion of capacity in Approved Bodies for the certification of medical devices (including IVDs) in GB. This supports manufacturers to bring their products to the UK and supports patients to access safe and effective products in a timely way. All designated Approved Bodies, and the detailed scope of their designation, are published on our website.

PATIENT SAFETY

Valproate

3.1 A National Patient Safety Alert was issued on 28 November 2023 to Integrated Care Boards in England and their equivalents in the devolved nations with supporting communications to relevant stakeholders, requesting organisations put a plan in place by 31 January 2024 to implement the new regulatory measures for valproate (sodium valproate, valproic acid and valproate semisodium). This followed a comprehensive review of safety data, advice from the Commission on Human Medicines and an expert group, and liaison with clinicians and organisations. These new measures aim to ensure valproate is only prescribed if other treatments are ineffective or not tolerated, and that any use of valproate in women of childbearing potential who cannot be treated with other medicines is in accordance with the Pregnancy Prevention Programme. To support organisations with the development of their action and improvement plan, the Public Assessment Report of the valproate review was published.

Aripiprazole and impulse control disorders

3.2 We have received concerns from stakeholders about a lack of awareness of the association between the antipsychotic medicine aripiprazole and the development or worsening of addictive gambling behaviours. Since 2023, there has been an increased number of Yellow Card reports for aripiprazole which include gambling, gambling disorder or obsessive-compulsive disorder. A review of the available evidence was considered by the Neurology, Pain and Psychiatry expert advisory group (NPPEAG) of the Commission on Human Medicines (CHM). The NPPEAG noted that the Summary of Product Characteristics (SmPC) and the Patient Information Leaflet (PIL) for aripiprazole contain information regarding pathological gambling and other impulse control disorders, that these may result in harm to the patient and others if not recognised and advising consideration of dose reduction or

stopping the medication if a patient develops increased urges while taking aripiprazole. The NPPEAG recommended that reminding healthcare professionals and patients of these risks.

Criminal Enforcement Unit

3.3 Two members of the CEU's SMT attended the December meeting of the Working Group of Enforcement Officers (a working group of the Heads of Medicines Agencies) in Madrid. Among the key presentations and discussions during the event were sessions on tackling the online medicrime threat and the illegal sale of falsified or unlicensed GLP-1 receptor agonists. Separately, in CEU Operation Pyarr, sentencing took place in December, resulting in one defendant receiving 3 years' imprisonment, and two other defendants receiving 12 months imprisonment for the supply of Class B and C controlled drugs, the supply of prescription-only medicines, and money laundering.

Vitamin B12 and cobalt allergy

3.4 Hydroxocobalamin and cyanocobalamin are oral and injectable forms of vitamin B12 that are used to treat vitamin B12 deficiency, and these medicines contain cobalt. We received 3 Yellow Card reports of a suspected reaction associated with vitamin B12 treatment and cobalt allergy. There is literature evidence of cobalt sensitivity reactions following administration of vitamin B12. Following our review, we have requested relevant Marketing Authorisation Holders (MAHs) to update the SmPC and the PIL to advise patients that cobalt is contained within vitamin B12 and that they should talk to a healthcare professional if they have a known cobalt allergy.

Long COVID

3.5 In 2023 CPRD completed its support of recruitment into 'The Long COVID study' run by University of Birmingham for which CPRD supplied real world data. Subsequent to a paper looking at symptoms and risk factors for long COVID in non-hospitalized adults, a further publication from this study has been published in BMC Primary Care journal. This paper: "The cost of primary care consultations associated with long COVID in non-hospitalised adults: a retrospective cohort study using UK primary care data" explores the costs of primary care consultations associated with long COVID and the relationship between risk factors and costs. The study found that the annual incremental cost of primary care consultations associated with long COVID was over £23M at the national level in comparison with unexposed individuals. Among patients with COVID-19, a long COVID diagnosis and reporting of longer-term symptoms were associated with a 43% and 44% increase in primary care consultation costs respectively, compared to patients without long COVID symptoms.

Carbomer eye gels

3.6 We issued precautionary safety advice regarding possible contamination of specific batches of carbomer-containing lubricating eye gels branded Aacarb, Aacomer and Puroptics with the bacterium *Burkholderia cenocepacia.* These products are used to relieve symptoms of dry eye. This communication advised patients and users to stop using the affected products immediately and to return it to the place of purchase. The safety advice also contained recommendations for individuals with cystic fibrosis and patients with certain risk factors who are at higher risk of adverse effects from *Burkholderia cenocepacia*. Advice of the Interim Devices Working Group was obtained. Investigations are ongoing to determine if there is a link between cases of clinical infections and use of these products. We are working very closely with UKHSA who have issued a National Patient Safety Alert on this issue.

DIGITAL AND TECHNOLOGY

RegulatoryConnect

4.1 The outline programme business case was submitted to DHSC on 20/12/23 and is currently going through keyholder review with comments due to be responded to on 19 January. The final version of the case, addressing any keyholder comments will then go to the Investment Committee on 5 February. Release 1 deliverables are all on track for this quarter. The first deliverable of Legacy Archive Search went live on time as a private beta with HQ&A assessors on 21 December. Release 2 activities continue in parallel with the planned go-live for PL, PCL and Inspections on track for November 2024. The main risk to the programme remains capital expenditure funding for 2024/25.

SafetyConnect

4.2 Work is ongoing to go-live with the new SafetyConnect adverse events system by end of Q4. User Acceptance Testing (UAT) is underway. A risk was identified regarding the use of PowerBI for reporting necessitating a comparison of alternative tools. A decision has been made to move forward with MicroStrategy as a replacement for PowerBI. This final phase of the project will deliver new functionality for the case management of adverse events for medicines, vaccines, blood and e-cigarettes, allowing the Agency to switch-off Sentinel and Lotus Notes vigilance systems.

International recognition enhancements

4.3 Enhancements to Sentinel and Appian went live 1–3 December. One minor issue was identified immediately after post go-live user validation testing on 4 December and was quickly resolved. Post go-live support with our third-party supplier completed successfully on 8 December with handover of service into business as usual. These technical enhancements supported business readiness for 1 January 2024 when the International Recognition regulations came into effect.

Freedom of Information case management

4.4 Functional and non-functional requirements were agreed at the end of last month and incorporated into the tender pack for the FOI case management tool, which was issued to a shortlist of suppliers on the G-Cloud framework this week. Bids are due early January 2024, with contract award planned for mid-January. The project is on track to meet planned delivery this financial year.

PARTNERSHIPS

Access Consortium Promise Pathway

5.1 The Access Consortium working group for new active substances has established an aligned process for priority review, which includes the decision on priority status. In order to facilitate the process for applicants, common timelines for the priority review request have been established, and the request is evaluated in a collaborative way, seeking a consensus decision. In creating the Promise Pilot Pathway, the Access partners sought commonality in their respective criteria for priority review. Applications for new active substances fulfilling the following criteria are eligible for the Promise Pilot Pathway: diagnoses, treats or prevents a condition that is serious, life-threatening or severely debilitating; and for which no other treatment is currently registered and marketed in participating jurisdictions for the proposed indication. The scope of the Promise Pathway will be further reviewed after the pilot.

Centres of Excellence in Regulatory Science and Innovation

5.2 We have been working with Innovate UK (part of UK Research and Innovation) and the Office for Life Sciences (OLS) to create Centres of Excellence in Regulatory Science and Innovation (CERSIs). The first stage of this is to support the funding call that will support creation of networks and partnerships that will form the CERSI. This call for Regulatory Science Innovation Networks went live on 13 December 2023. The call will close on 31 January and Partnerships will be organising a webinar on 24 January to inform applicants of Agency needs from the CERSI. Following the close of the call, we will remain in close collaboration with Innovate UK and OLS to select applicants and manage the call for full funding.

Information sharing

5.3 Following approval from ExCo, Partnerships have circulated a Memorandum of Understanding for signature from our UK wide health partners to facilitate operational and technical information sharing. This coincides with the inclusion of a consent step at the point of application to the Agency. In addition, Partnerships have secured consent for the first time from two companies for sharing of technical information. With both operational and technical information being shared across the UK, it will be possible to accelerate closer collaboration and coordination of all steps in the approval, health technology assessment and access pathway.

DYNAMIC ORGANISATION

Leadership event

6.1 On 30th November we held our first all-leaders event to reflect on our role in delivering for our stakeholders, on building a culture that drives improved customer service, and taking collective and individual ownership in achieving this. Over 100 leaders attended from across the Agency and heard from two inspiring external speakers illustrating their own journeys, through proactivity, taking personal responsibility and handling adversity in unique ways. Breakout sessions enabled exploration questions on a range of issues from service delivery and operational performance improvement to culture change. It was agreed that further all-leaders events should build on the success of this first one.

Civil Service Staff Survey results

6.2 Our One Agency Leadership Group comprising all L1-3 managers met in December to consider the recent Civil Service Staff Survey results and develop an Action Plan. The Agency's engagement score has increased from 49 to 58 which indicates positive change in people's intentions to 'Stay', 'Say' (speak positively about the Agency) and 'Strive'. The draft Action Plan was discussed and is due for publication in the week commencing 15th January 2024. We have selected three areas of focus to continue to build on the progress we have made in Staff Engagement this year. These are:

- Raising concerns and protecting wellbeing
- Optimising process, productivity and workloads
- Improving confidence in and transparency of leadership decision making

The survey results showed some variation between teams. Directors and Chief Officers will consider local actions in addition the corporate priorities.

Innovation award

6.3 On 29th November at the annual awards event of the Organisation for Professionals in Regulatory Affairs the NHS Covid-19 App Regulatory Team received the TOPRA Innovation award. Collaboration with NHS Digital enabled the regulatory compliant launch of second most downloaded app of 2020. This was estimated to have prevented around I million cases of Covid-19, 44,000 hospitalisations and 9,600 deaths in its first year. The award was received on behalf of the collaboration by Mark Grumbridge, MHRA Deputy Director of Clinical Investigations.

CPRD and Global AI Cardio-health challenge

6.4 An MHRA collaboration with FDA and the US Department of Veterans' Affairs (V-CHAMPS) has been announced the winner of the global AI cardio-health challenge, bringing together cutting-edge health data and AI expertise from both sides of the Atlantic, and helping to drive forward our combined understanding of AI applications to improve public health. This challenge has not only shown how advances in AI methodology can help improve healthcare, by providing forecasts of certain health outcomes in specific patient populations like veterans, it has also demonstrated the potential of synthetic data for initial training and testing of AI algorithms. Details of the challenge and names of the winning teams can be found at **https://lnkd.in/exDFQ76M**

AGENCY PRIORITIES

8. In summary, the current priorities for the Agency are to:

I. Maintain the Agency's focus on delivering its core business functions, meeting assessment targets for all key services and eliminating any backlogs

II. Deliver an innovative access pathway for devices which allows the Agency to streamline products that will benefit patient and public health

III. Operationalise the new international recognition framework which allows the Agency to streamline approvals for safe and effective medicines, and progress plans for international recognition for medical devices

IV. Refocus the Regulatory Management System programme replacing legacy IT systems, taking account of Agency priorities and the need to integrate transformed business processes

V. Create centres of excellence in regulatory science and innovation which further improves the UK's research infrastructure.

Dr June Raine, CEO
January 2024

Medicines & Healthcare products Regulatory Agency

BOARD MEETING HELD IN PUBLIC

16th January 2024

Title	What was the Finance and HR performance of the MHRA for the 8 months of the financial year up to 30th November 2023?
Board Sponsor	Rose Braithwaite
Purpose of Paper	Assurance

What was the operational performance of the MHRA for the first 8 months of the financial year up to 30 November 2023?

1. Executive Summary

1.1 Financial performance at the end of November shows a Year to Date (YTD) Resource underspend of £10.7m compared to budget and a Capital underspend of £4.9m compared to budget. Our latest forecast shows that by the end of the year we are expecting a Resource surplus of £7.9m, a reduction of £1.5m compared to the last finance report, whereas the Capital position is much closer to budget with a forecast underspend of only £0.5m.

1.2 As an Arm's Length Body (ALB) within the accounting boundary of the Department for Health and Social Care (DHSC), the Agency is not able to utilise any retained surpluses for future years. In contrast to the financial arrangements of the Agency when it was a Trading Fund, our new reporting requirements mean the Agency must manage all expenditure and income within the financial year and does not allow the Agency access to any previous year reserves.

1.3 The forecast underspend has reduced due to the inclusion of most the extra spend bids approved by ExCo. However, lower staff costs and higher income means that the forecast surplus has not reduced as much as anticipated. Hence, there is still financial headroom for additional Resource spending as well as the agreed return of unused funding to DHSC.

2. Financial Performance

AGENCY PERFORMANCE – RESOURCE (RDEL)

The Resource position of the Agency is a large YTD underspend of £10.7m compared to budget. Without DHSC funding, the Agency's Resource net position would be a £3.3m deficit compared to a budgeted deficit of £14m. We forecast a full year result of £7.9m RDEL surplus with DHSC funding. Once risks and opportunities are taken into account (see table 2 below), that surplus can be reduced to £4.44m.

Table 1 - Agency Financial performance to the end of November 2023

November 2023 Resource	Period Actual £M	Period Budget £M	*Variance vs Budget* *% / £M*	YTD Actual £M	YTD Budget £M	*Variance vs Budget* *% / £M*	Full Year Forecast £M	Full Year Budget £M	*Variance vs Budget* *% / £M*
Trading Income	12.8	11.3	13%	95.6	92.8	3%	143.2	140.7	2%
Staff Costs	7.8	8.0	3%	60.2	62.8	4%	92.4	94.9	3%
Operating Costs	5.9	4.7	(25%)	35.9	38.8	7%	60.5	59.4	(2%)
Operating Net Position	**(0.9)**	**(1.4)**	**0.5**	**(0.5)**	**(8.8)**	**8.3**	**(9.7)**	**(13.6)**	**3.9**
CPRD Reserves Funding	0.0	0.0	0%	0.4	0.4	0%	0.6	0.6	0%
Staff Costs	0.1	0.1	48%	0.5	1.9	75%	1.7	0.0	0%
Change Costs	0.5	0.5	(20%)	2.7	3.7	27%	6.7	8.6	22%
Projects Net Position	**(0.6)**	**(0.5)**	**(0.0)**	**(2.8)**	**(5.2)**	**2.4**	**(7.8)**	**(8.0)**	**0.3**
Agency Resource Net Position	**(1.5)**	**(1.9)**	**0.4**	**(3.3)**	**(14.0)**	**10.7**	**(17.5)**	**(21.7)**	**4.2**
DH RDEL Operational Funding	1.7	1.7	2%	13.8	13.7	0%	25.3	20.6	23%
DH RDEL Project Funding	0.0	0.0	0%	0.0	0.0	0%	0.0	0.0	0%
Total RDEL	**0.2**	**(0.2)**	**0.5**	**10.5**	**(0.3)**	**10.7**	**7.9**	**(1.1)**	**8.9**

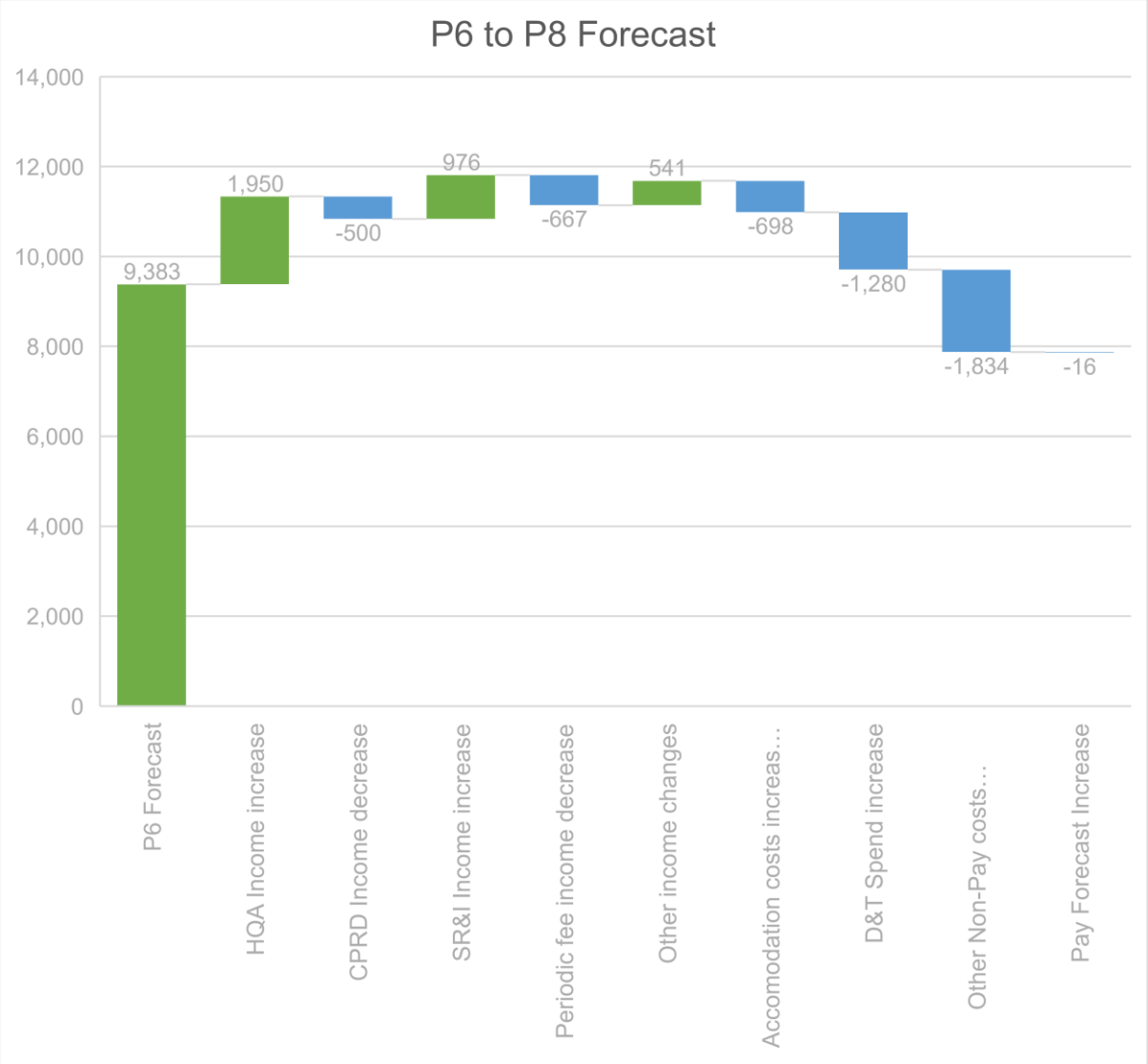
November 2023 Capital	Period Actual £M	Period Budget £M	*Variance vs Budget* *% / £M*	YTD Actual £M	YTD Budget £M	*Variance vs Budget* *% / £M*	Full Year Forecast £M	Full Year Budget £M	*Variance vs Budget* *% / £M*
Change Costs	1.7	1.6	(7%)	11.4	16.3	30%	25.0	25.5	2%
Agency Capital Net Position	**(1.7)**	**(1.6)**	**(0.1)**	**(11.4)**	**(16.3)**	**4.9**	**(25.0)**	**(25.5)**	**0.5**
DH Capital Funding	2.1	2.1	0%	17.0	17.0	0%	25.5	25.5	0%
Total CDEL	**0.4**	**0.5**	**(0.1)**	**5.6**	**0.7**	**4.9**	**0.5**	**(0.0)**	**0.5**

Table 2 - Identified RDEL Risks and opportunities

P8 Forecast	**7,855**
RDEL Risks + Opps	
Reprofiling of the Chancellors innovation funding between years	-1,000
Return of unspent Covid Grant money	-1,000
Recognition of RSRU SR&I Grant Income	900
Q2 Bids Approved but not in the forecast	-400
Accounting for the interest recovery from last year	-1,314
Other risks	-600
Revised Forecast	**4,441**

Table 3 - FORECAST CHANGES – since P6

	RDEL Forecast Changes	
	P6 Forecast	**9,383**
Income	HQA Income increase	1,950
	CPRD Income decrease	-500
	SR&I Income increase	976
	Periodic fee income decrease	-667
	Other income changes	541
Non-Pay	Accommodation costs increase inc Q2 bids	-698
	D&T Spend increase	-1,280
	Other Non-Pay costs Increases inc Q2 Bids	-1,834
Pay	Pay Forecast Increase	-16
	P8 Forecast	**7,855**



Income

2.1 The Agency receives most of its funding from trading income realised in the performance of its Regulatory obligations, supplemented by direct funding from its sponsor department, the Department for Health and Social Care (DHSC).

2.2 Trading income in November was £12.8m, which was £1.5m above budget. This is a very strong result led by licensing activities in HQA and periodic fee income.

2.3 Trading income Year-to-Date (YTD) at the end of November was £95.6m, 3% above the YTD budget. The full year forecast is for income performance to continue at current levels to finish at £143.2m, 2% over budget. This is an increase of £2.3m on the last finance report, which is mostly down to better-than-expected HQA income as the impact of the move of medical assessors to SR&I to support clinical trials has not been as significant as previously expected.

Staff Costs

2.4 Staff costs in November were £0.2m (3%), below budget, and very similar to last month's actual. The variance is now much closer to budget than in previous months because of the general pay increase. Looking forwards, we forecast pay costs to increase slightly from a YTD 4% underspend to a final 3% underspend because of recruitment into roles within the Agency's agreed structure and the new temporary roles including those funded through the HMT Innovation funding. However, the pay forecast did reduce slightly from the last report because the recruitment into the HMT Innovation roles has been slower than expected.

Non-Pay Costs

2.5 Spend on other operating costs in the month of November was £5.9m, 25% over budget. This was in line with the forecast which sees the YTD 7% underspend turn into a 2% overspend by the end of March. We should expect overspends in future months as spend increases, mostly on Contracted Out Services and IT spend, and the Q2 approved extra spend bids.

2.6 The FY forecast increase in non-pay costs is due to the additional spend approved by ExCo after the Q2 forecast and an increase in D&T spend.

Resource Change Expenditure

2.7 At the end of November, resource change costs were £2.4m behind the YTD budget. Most of the underspend relates to Safety and Surveillance projects, such as Intellicase, which were approved late, and hence started spending late. Budgets were also set in view of scopes that have now changed or reduced.

2.8 The FY forecast underspend is expected to be much smaller at £0.27m because of a forecast £1.6m overspend in RegulatoryConnect. RegulatoryConnect have spent £0.8m YTD and are forecasting an additional £1.7m of spend over the next 4 months as they finalise the reporting elements of the system.

£'000s	RDEL Period			RDEL Year to Date			RDEL Full Year		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Platforms									
Regulatory Management System (RMS) Core (R1.0)	338	82	(256)	796	629	(167)	2,513	935	(1,578)
Technology Maintenance Uplift	0	41	41	742	329	(412)	1,000	1,000	0
	338	**122**	**(215)**	**1,538**	**959**	**(579)**	**3,513**	**1,935**	**(1,578)**
Safety & Surveillance									
SafteyConnect (formerly CIVS)	55	5	(50)	194	68	(126)	114	114	0
COVID-19 Inquiry project	29	60	32	321	987	666	701	1,517	816
Yellow Card Biobank project	30	117	87	130	1,024	895	1,030	1,500	470
IntelliCase Replacement	48	208	160	131	1,667	1,536	869	2,500	1,631
	162	**390**	**228**	**775**	**3,746**	**2,971**	**2,714**	**5,631**	**2,917**
CPRD									
CPRD Trusted Research Environment (CPRD TRE)	78	59	(19)	442	390	(52)	606	584	(22)
IRSP Scalability	8	0	(8)	84	0	(84)	85	0	(85)
CPRD Website Enhancement	0	0	0	(18)	0	18	(18)	0	18
CPRD Online Learning Platform	0	0	0	0	0	0	0	0	0
CPRD Customer Portal	0	0	0	0	0	0	0	0	0
	86	**59**	**(27)**	**508**	**390**	**(118)**	**673**	**584**	**(89)**
Healthcare Quality and Access									
Innovative Devices Access Pathway (IDAP)	22	0	(22)	238	0	(238)	766	0	(766)
	22	**0**	**(22)**	**238**	**0**	**(238)**	**766**	**0**	**(766)**
Scientific Research & Innovation									
South Mimms Capital Programme 23/24	0	0	0	0	0	0	0	0	0
	0	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Enablement									
Redundancy Costs 23/24	0	0	0	155	484	329	732	484	(248)
	0	**0**	**0**	**155**	**484**	**329**	**732**	**484**	**(248)**
Closed projects still incurring costs									
Applications Outsourcing Contract Transition	0	0	0	24	0	(24)	18	0	(18)
Chart of Accounts	0	0	0	(50)	0	50	(50)	0	50
	0	**0**	**0**	**(26)**	**0**	**26**	**(32)**	**0**	**32**
Grand Total	**607**	**571**	**(35)**	**3,186**	**5,579**	**2,393**	**8,367**	**8,634**	**266**

AGENCY PERFORMANCE – CAPITAL

£'000s	CDEL Period			CDEL Year to Date			CDEL Full Year		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Platforms									
Regulatory Management System (RMS) Core (R1.0)	1,598	1,054	(545)	7,916	12,058	4,141	14,327	13,924	(403)
Technology Maintenance Uplift	0	0	0	340	664	324	1,198	1,660	462
	1,598	**1,054**	**(545)**	**8,257**	**12,722**	**4,465**	**15,525**	**15,584**	**60**
Safety & Surveillance									
SafteyConnect (formerly CIVS)	51	90	39	422	839	417	1,096	1,096	0
COVID-19 Inquiry project	0	0	0	0	0	0	0	0	0
Yellow Card Biobank project	0	0	0	0	0	0	0	0	0
IntelliCase Replacement	0	0	0	0	0	0	0	0	0
	51	**90**	**39**	**422**	**839**	**417**	**1,096**	**1,096**	**0**
CPRD									
CPRD Trusted Research Environment (CPRD TRE)	201	115	(85)	633	996	363	1,005	1,256	251
IRSP Scalability	91	75	(16)	515	697	182	786	980	194
CPRD Website Enhancement	26	26	0	104	52	(52)	156	156	0
CPRD Online Learning Platform	20	20	0	60	40	(20)	140	120	(20)
CPRD Customer Portal	100	50	(50)	100	100	0	300	300	0
	437	**286**	**(151)**	**1,412**	**1,885**	**473**	**2,388**	**2,812**	**424**
Healthcare Quality and Access									
Innovative Devices Access Pathway (IDAP)	0	0	0	0	0	0	0	0	0
	0	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Scientific Research & Innovation									
South Mimms Capital Programme 23/24	(365)	172	537	1,310	890	(420)	6,000	6,000	0
	(365)	**172**	**537**	**1,310**	**890**	**(420)**	**6,000**	**6,000**	**0**
Enablement									
Redundancy Costs 23/24	0	0	0	0	0	0	0	0	0
	0	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Closed projects still incurring costs									
Applications Outsourcing Contract Transition	0	0	0	0	0	0	0	0	0
Chart of Accounts	0	0	0	0	0	0	0	0	0
	0	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Grand Total	**1,722**	**1,602**	**(120)**	**11,401**	**16,336**	**4,935**	**25,008**	**25,492**	**484**

2.9 All of the capital budget has to be provided either by DHSC or from other Government Departments via the Commissioner Pays model which allows for the transfer of capital budget between departments.

2.10 The Agency has a FY Capital budget of £25.5m, of which we forecast to spend £25m. £13.9m is set aside for RegulatoryConnect, which at the YTD position, is underspending significantly with £4.1m behind YTD budget. Spend in November was £0.55m over budget and we expect the increase in costs to continue in coming months as the project catches up with the forecast. RegulatoryConnect and SafetyConnect are both flagging pressure within their budgets to the end of the year and so the underspend currently forecast is likely to be used.

2.11 Other projects with significant capital funding are the South Mimms Capital Programme (£6m), SafetyConnect (£1.1m) and CPRD projects (£2.8m).

2.12 The FY forecast is for the underspend to reduce considerably as all capital projects accelerate spend. However, the risk with a spend profile heavily weighted to the second half of the year is that spend will continue to move to the right beyond March 24 and hence the Agency would lose the budget.

2.13 In December D&T were successful in winning an additional £0.85m of capital to support work this year on cyber security. This has not yet been included in the capital figures for the year.

Customer Debt Levels

2.14 The Agency performance against agreed cash management KPI's is advised below, both targets have been achieved in November:

KPI's	November	Target	Comments
	£m	£m	
Total Debt	8.5	<11.6	Less than one month budget trading income should remain outstanding
> 6 Month Old Debt	776k	<2.3	Less than 20% of target total debt should be in excess of 6 months

3. People Performance

3.1 We had 1,244.46 people in post at the end of November 2023 (FTE, permanent, fixed term and Phd students covering established posts).

3.2 There has been a further reduction in our turnover of staff to 8.7% bringing turnover under the levels considered 'healthy' by the CIPD (10-15%) but reflective of Agency turnover pre pandemic and pre transformation. Although this turnover rate is below the 'healthy' range, given the turbulence of turnover through the pandemic and during/post transformation, this would be considered a healthy rate for the Agency at this time.

3.3 Despite a challenging employment market for all sectors, we continue to see an increase in the number of joiners versus leavers, reflected in our steadily decreasing turnover. We welcomed 13 new starters to the Agency in October versus 11 voluntary leavers.

3.4 Chief Officers and hiring managers prioritise their recruitment based on their business needs. In November, there were 50 campaigns live and 28 new roles

advertised in that month. Recruitment remains at peak levels and whilst there is some additional resource in the HR team to help manage this, it is a tricky balance to manage the reactive pipeline and pressure to get adverts out and new staff in. Recruitment as we know is a resource intensive activity, and it also remains a challenge for Groups to manage shortlisting and interviewing.

Group	Live Campaigns*	Vacant posts advertised**
Corporate	4	3
D&T	4	3
Enablement	8	3
HQ&A	11	9
Partnerships	3	1
S&S	11	3
SR&I	19	7
Total	**50**	**28**

* adverts were open during the month of November ** adverts opened in November

3.5 In respect of our 141 'vacancies' these are split by Group as follows:

Group	Vacancies	% vacancies FTE
Corporate	13	12%
D&T	15	14.1%
Enablement	10	10.1%
HQ&A	33	9.2%
Partnerships	1	3.8%
S&S	35	12.3%
SR&I	34	12.8%
Total	**141**	**11.3%**

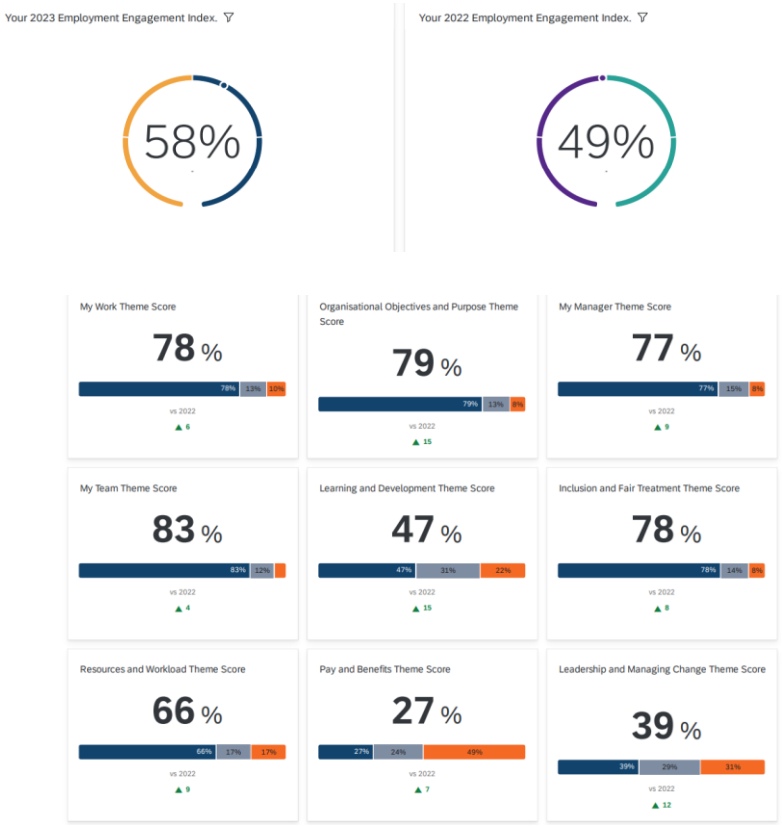
3.6 Sickness absence has decreased at 4.7 days per FTE (annualised October 2022 – November 2023) and by Group is as below:

Group	Average days by FTE
Corporate	7.4
D&T	2.4
Enablement	3.5
HQ&A	4.4
Partnerships	7
S&S	4.1
SR&I	5.6
Total	**4.7**

3.7 The long and short term split by Group is not given as it could inadvertently identify colleagues, particularly in the smaller Groups or where absence is attributable to one person. Particularly in the smaller Groups and in Functions, the long-term absence of one person can skew the absence rates significantly. We continue to support staff

who experience ill health through a range of interventions, including Occupational Health, our Employee Assistance Programme and our internal Wellbeing Ambassadors.

3.8 In related performance news, People Survey scores for 2023 were released on 5th December and are promising, with increases in scores across all the themes, and a 9% increase in our engagement index. Whilst we acknowledge that the starting point was from a relatively low point, it is reassuring to see the upward trajectory which will underpin the ambition to move our engagement score into the late 60% next year:



3.9 The results as a whole will be analysed – Agency wide and by Group/function - and key messages shared with ExCo and the Board in the new year.

4. Group Performance

4.1 Chief Officers of the three fee-earning operational groups have been set budget for income and expenditure.

4.2 The tables presented below include only those operational budgets over which Chief Officers have control. They don't include DHSC funding and allocated income from the Periodic Fee which the Agency receives to fund non-income generating activity.

Scientific, Research and Innovation

£'000s	Period			YTD			Full Year		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Trading Income	2,079	2,000	79	18,233	17,989	244	29,690	28,134	1,556
Staff Costs	1,637	1,532	(105)	12,803	12,040	(763)	19,289	18,200	(1,088)
Non-Staff Costs	871	557	(313)	4,074	4,052	(22)	5,664	5,871	208
Operating Position	**(430)**	**(90)**	**(340)**	**1,356**	**1,896**	**(541)**	**4,737**	**4,062**	**675**

4.3 SR&I is in an overall good position. The YTDs operating position at the end of November shows a slight negative variance to budget, driven by a staff overspend. However, this is within the vacancy rate assumption and in part due to extra roles approved for SR&I so not a concern. Although we forecast the pay overspend to grow, strong trading income towards the end of the year means a positive full year forecast.

4.4 At the end of November, YTD income was £0.24m above budget. Income has improved significantly over the last few months and is expected to keep on accelerating towards the end of the financial year. This is because the team has made important progress to clear the backlogs in the Sale of Goods and Services. Although very positive, we expect performance in this category to dip towards budget once the backlog has been fully cleared. We also expect income from grants to increase once all grants are properly accounted for in the Full Year result.

Healthcare Quality and Access

£'000s	Period			YTD			Full Year		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Trading Income	4,575	3,509	1,066	31,459	28,682	2,777	45,864	42,784	3,080
Staff Costs	2,259	2,283	24	17,797	17,939	143	27,657	27,118	(539)
Non-Staff Costs	520	467	(53)	3,439	3,736	297	5,269	5,585	315
Operating Position	**1,795**	**759**	**1,036**	**10,223**	**7,007**	**3,216**	**12,938**	**10,081**	**2,856**

4.5 HQA is in a very strong YTD financial position, finishing November with positive trading income, and lower staff and non-pay costs compared to budget.

4.6 Trading income in November was considerably better than budget, leading to YTD performance of 10% above budget. The YTD income position is driven by strong results in Licensing activity in Population Health and Innovative Medicines, such as National Applications and Variations. Other income lines in Authorisation Lifecyle such as Labels and Leaflets, Devices Registrations and Tobacco Products Directive are performing well above target.

4.7 The only area performing behind budget are some Inspection lines such as GCP and GDP because of capacity constraints in those teams.

4.8 The Full Year trading forecast income increased significantly since the P6 forecast in view of recent income results. In previous months, we had forecasted £1m drop in HQA income because of the move of Medical Assessors to clinical trials work in SR&I. However, we are still not seeing any impact on income actuals in likely affected areas, which continue to perform well. We have reduced the provision for the impact of the move in the most recent forecast.

4.9 In term of staff costs, spend is slightly below budget because of the number of vacancies across teams. However, we expect staff costs to increase in the next months as fixed term roles approved out of the underspend or the Chancellor's Innovation funding are onboarded.

4.10 Non-Pay spend is also below budget mainly because of lower T&S costs in the Inspections teams.

Safety and Surveillance

£'000s	Period			YTD			Full Year		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Trading Income	1,889	1,878	11	14,287	14,810	(523)	21,452	22,842	(1,390)
Staff Costs	1,650	1,952	302	13,411	15,336	1,925	20,261	23,183	2,922
Non-Staff Costs	1,224	739	(484)	5,339	5,875	537	7,817	8,881	1,064
Operating Position	**(985)**	**(812)**	**(172)**	**(4,462)**	**(6,401)**	**1,939**	**(6,626)**	**(9,221)**	**2,595**

4.1 Safety and Surveillance is partly funded through income generated within the group which is in the Trading Income line above, and by income from the Periodic fee which is not included as it is not direct income in the group's control.

4.2 The overall YTD financial position is positive because of a very significant staff costs underspend against budget. This is due to a budgeting error rather than the S&S vacancy position.

4.3 Income at the end of November was £0.52m below budget and is expected to continue performing below budget till the end of the year. Although CPRD is performing better than last year in cash terms, it is falling slightly behind its ambitious income budget for this financial year.

4.4 In terms of non-pay costs, the YTD position is also significantly under budget because of lower IT spend. The FY forecast is for the IT underspend to increase further. This is because of lower CPRD spend as more than expected VAT is recoverable. Overall, this means that CPRD will finish the year with a balanced budget.

Corporate recharges & non-fee earning groups

4.11 We have a number of non-fee earning groups which directly support our three fee-earning areas. These include Partnerships, Digital & Technology, Corporate and Enablement Groups. These form the basis of Agency corporate charges that, as in each year, will be shared across Agency operational areas to recognise where costs should be borne.

		Period			YTD			Full Year		
Corporate Overhead groups	**Nov-23**	**Actual**	**Budget**	**Variance**	**Actual**	**Budget**	**Variance**	**Forecast**	**Budget**	**Variance**
Enablement	Trading Income	14	0	14	37	0	37	37	0	37
	Spend	1,012	958	(54)	7,062	7,854	793	11,710	11,778	68
	Operating Position	**(998)**	**(958)**	**(40)**	**(7,024)**	**(7,854)**	**830**	**(11,672)**	**(11,778)**	**105**
Partnerships	Trading Income			0			0			0
	Spend	183	220	37	1,273	1,726	453	2,440	2,609	169
	Operating Position	**(183)**	**(220)**	**37**	**(1,273)**	**(1,726)**	**453**	**(2,440)**	**(2,609)**	**169**
Corporate	Trading Income	4,085	3,818	267	30,589	30,548	41	44,508	45,822	(1,314)
	Spend	1,841	1,620	(221)	13,305	13,054	(251)	21,803	19,658	(2,144)
	Operating Position	**2,244**	**2,198**	**46**	**17,284**	**17,494**	**(210)**	**22,706**	**26,164**	**(3,458)**
D&T	Trading Income	135	92	43	1,015	736	278	1,612	1,104	507
	Spend	2,518	2,387	(130)	17,628	19,960	2,331	30,931	31,418	488
	Operating Position	**(2,382)**	**(2,295)**	**(87)**	**(16,614)**	**(19,223)**	**2,610**	**(29,319)**	**(30,314)**	**995**

4.12 Financial performance for each of the non-fee earning group has been outlined above.

4.13 Enablement is operating under budget because of lower than budget staff costs and non-pay costs, such as Legal spend, Seminar and Committee costs. We forecast spend to increase significantly in the last months of the year due to recent approvals for additional spending, but the group will still finish slightly below budget.

4.14 Partnerships has no Trading income stream of its own. Spend is behind budget at YTD because of lower than budgeted staff costs, although this is due to the pay budget being too high rather than the number of vacancies. We expect spend to increase in the coming months on the basis of non-pay projects funded through the Chancellor's innovation funding.

4.15 YTD Corporate income is at budget, as higher than expected periodic fee income makes up for the loss of interest income after a HMT direction that as an Agency we are not entitled to receive interest on our bank balances. However, we expect periodic fee income to reduce in the last months of the year leading to a small overall FY income negative variance. In terms of costs, YTD corporate spend is close to budget.

We forecast that non-pay spend will increase significantly over the next months due to extra spend approvals.

4.16 Digital and Technology has a small income stream from the RAMAXL platform which is performing well. In terms of pay spend, this is below budget because of the number of vacancies. In terms of non-pay, at the end of November, D&T is overall 13% below budget because of lower IT costs. We expect spend to increase in future months towards budget.

5. Recommendation

4.17 The Board should note the resource surplus shown by the forecast at the end of November. This is not a confirmed figure and various risks and opportunities exist that could change the central estimate.

4.18 The Board is asked to discuss whether the Agency has made best efforts to utilise its budget in particular prioritising spend on reducing work backlogs as far as possible in this financial year.

Rose Braithwaite
January 2023

Medicines & Healthcare products Regulatory Agency

BOARD MEETING HELD IN PUBLIC

16th January 2024

Title	How effectively is the MHRA maintaining its performance on clinical trials and how are plans for the new regulatory system progressing?
Board Sponsor	Marc Bailey
Purpose of Paper	Assurance

How effectively is the MHRA maintaining its performance on clinical trials and how are plans for the new regulatory system progressing?

1. Executive Summary

1.1 This paper sets out a new operating model for regulation of clinical trials. It includes the regulatory strategy, capacity/capability considerations, legislative, cost/fee, communications and digital infrastructure elements. The proposals also address how we will meet the objectives of the UK Government Life Sciences Vision, the outcomes of the Lord O'Shaughnessy review and act as an enabler to UK life sciences.

1.2 The proposal builds on the Government response to consultation on legislative proposals for clinical trials and the lessons learned during the last 6 months as we have eliminated the clinical trials applications backlog and returned to acceptable operational performance.

1.3 All clinical trials applications (initials and amendments) received since 1st September 2023 have been assessed within statutory timeframes and there is no backlog of clinical trial applications.

2. Background

2.1 Clinical Trials regulation under the Medicines for Human Use (Clinical Trials) Regulations 2004 is one of 14 functions of the Medicines and Healthcare products Regulatory Agency (MHRA) as set out in the Framework Agreement between the MHRA and DHSC. It is delivered by the Science, Research and Innovation group (SRI) as a key component of the 'lifecycle' model of our "One Agency" strategy. It integrates medical research on medicines' efficacy with innovation in treatment, supporting access and patient safety.

2.2 The clinical trials team receives an average of 17 initial applications and 108 amendments for approved CTAs each week. Statutory timeframes for the assessment of clinical trials are 30 calendar days (initial application) and 35 calendar days (substantial amendments).

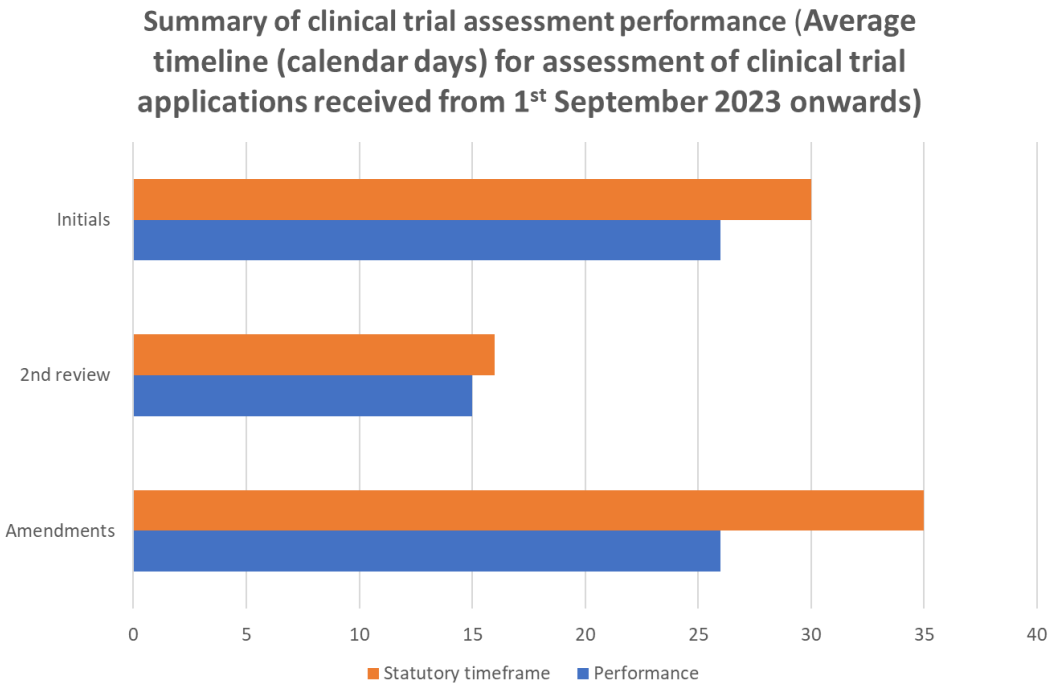
2.3 The clinical trial unit at the MHRA faced a significant challenge last year, culminating in a backlog of 966 applications in July 2023. The backlog was cleared thanks to several measures adopted by the Agency: introducing a risk proportionate approach for assessing clinical trials, redeployment of staff from across the Agency to the clinical trial unit and using external contractors.

2.4 The sustainability of the assessment performance of the clinical trial unit has a major impact on the national and international clinical trial ecosystem; therefore, a new strategy and operating model are required to ensure ongoing performance.

3. Update on performance

3.1 All applications received from 1 September for initials and amendments have been assessed within statutory timeframes, and robust reporting processes are in place to monitor performance. The most recent data for clinical trial assessment performance are summarised in Figure 1 below.

Figure 1 Summary of clinical trial assessment performance (Average timeline (calendar days) for assessment of clinical trial applications received from 1st September 2023 onwards)



4. Performance management

4.1 Interim measures put in place to resolve the backlog will be retained in the early part of 2024 with a phased reduction to March 24, to ensure continued performance. These include the retention of a small residual number of redeployed assessment staff from within MHRA whilst we onboard newly recruited assessors, as well as the use of NIHR's clinical network and external contractors to support clinical trials.

5. Vision for clinical trials

5.1 The Agency's vision for clinical trials is one that:

- ensures patients and their safety are at the focus of all clinical trials assessments
- ensures risk-proportionate regulatory oversight as trials progress through the phases

- aligns with key partners within the UK healthcare system and internationally making the UK the best location to conduct clinical trials.
- world leading in facilitating the use of innovative trial design and technology, including for our own processes.
- brings the benefits of clinical trials to everyone, taking in to account the impact of health inequalities.

6. New clinical trials operating model

6.1 The focus of MHRA assessment is to ensure the safety of participants in clinical trials and this varies depending on the type of trial and its phase. Therefore, this requires a flexible and risk-proportionate approach to assessment/notification compared to the historical assessment model that applied multidisciplinary assessment in a more uniform manner. The following section sets out changes to the regulatory model for the approval of clinical trial initial applications and amendments. These proposals build on the consultation response and the new risk-proportionate assessment processes and innovations developed as part of the response to the backlog in clinical trials during 2023, this includes the launch of a new notification scheme for the approval of low-risk clinical trials in October 2023.A high level plan is included in annex 1.

Clinical trial initial applications

6.2 A retrospective analysis of 4616 clinical trial initials submitted between February 2019 and October 2023 to the MHRA informed the risk-stratified approach endorsed by the Commission on Human Medicines and adopted during 2023. This risk stratification categorised trials as high, medium and low risk based on a range of criteria. This stratification also formed the basis of the criteria used for the new notification scheme.

6.3 Feedback from the workshops conducted with stakeholders between November and December 2023 and a retrospective analysis of our existing notification scheme criteria has confirmed that (i) the existing notification scheme criteria are too limited and that only a small proportion of trials would meet the criteria and (ii) that a wider scope and set of criteria can be safely applied to the notification of initial applications.

6.4 Therefore, our intention is to maximise the safe use of notifications for relevant clinical trials and focus our multidisciplinary assessment resources on higher risk and more complex trials, which will predominantly be in earlier phases including First in Human. The existing notification scheme criteria will be reviewed in January 2024 and expanded within the existing regulations. This will maximise the safe benefit for clinical trials and patients in the UK.

6.5 A workshop is to be held with a sub-group of our stakeholder group in January 2024 to further validate proposals for the criteria for notification of initial clinical trial applications across all phases of trials and this to inform the new regulations.

Our initial estimate is that potentially up to 40% of all initial clinical trial applications would be able to be processed as notifications.

Clinical trial amendment applications

6.6 Clinical trials are conducted in compliance with the approved protocols. Nevertheless, changes are often required to the trial protocols or documents after they receive regulatory approval. These amendments can be substantial or non-substantial, depending on the type of necessary change, with only substantial amendments requiring submission to MHRA for approval. Assessment of clinical trial amendments is stratified according to risk (including complexity) and divided into significant, moderate and limited categories.

6.7 Feedback from the workshops conducted with stakeholders in November and December 2023 identified that the use of notifications could also safely be applied to amendments across all phases of clinical trial based on risk (including complexity). Therefore, our intention is that we maximise the safe use of notification for relevant amendments and focus our multidisciplinary assessment resources on higher risk amendments.

6.8 We will explore if the existing notification scheme criteria can be reviewed and expanded to include amendments in Q1 2024. This would maximise the safe benefit for clinical trials and patients in the UK. A workshop is to be held with a sub-group of our stakeholder group in January 2024 to further validate proposals for the criteria for notification of initial clinical trial amendments across all phases of trials and this to inform the new regulations. Our initial estimate is that potentially up to 80% of all clinical trial amendments will be able to be processed as notifications.

New approach - clinical trial 'lifecycle' package

6.9 To further enhance our support across all phases of clinical trials we will develop the clinical trial life cycle package (CTLP) that will be designed to provide enhanced support across the life cycle of clinical trials from phases 1 to 3 and 4. Under this new approach the sponsor would submit the complete application adopting the combined phase approach, including their plan for phase 1 (e.g. FIH), 2, 3 and 4 to be conducted in the UK as their main centre.

6.10 The sponsor would then receive a full scientific advice meeting (SAM) during Phase 1 (e.g., FIH), as required scientific advice in Phase 2 and abbreviated scientific in Phase 3. The primary submission, including all phases, may require amendments following the results of each phase, and this would require the submission of an amendment for each phase. The sponsor would be able to discuss their amendments during their development plan, and the MHRA assessment team would provide their input before submission.

6.11 As this concept is novel and untested, a workshop is to be held with a sub-group of our stakeholder group in January 2024 to further validate these proposals including likely volumes/demand.

Upstream scientific advice

6.12 Maximising the safe use of notification approvals and the risk proportionate assessment process developed during 2023, will allow assessment resources to be re-focussed on the higher risk trials such as phase 1, 2 and complex phase 3 studies designs (including novel trial designs such as adaptive trials, decentralised and trials using novel technology) These are the most demanding, knowledge and labour-intensive clinical trial submissions, requiring significant expertise and in-depth knowledge of the topic and the regulations.

6.13 The new clinical trial operating model will enhance scientific advice meetings (SAM), which are essential for phases 1, 2, and trials with complex/ novel trial design and FIH trials and will be provided before the clinical trial submission to the MHRA. By doing this, the clinical trial submission will be strengthened and will require less time for assessment because most of the work will be conducted upstream and not downstream, accelerating the review process, and reducing the time taken for the review including avoidance of GNAs. This approach will greatly impact on the sponsors, patients, and clinical trial ecosystem, streamlining the clinical trial journey from conceptualisation to delivery.

How does the new operating model meet the needs of the Life Sciences Vision and Lord O'Shaughnessy review?

6.14 The new operating model will reduce the time taken to approve trials and delays in set-up, including the goal of reaching a 60-day turnaround time for all approvals. It will accelerate, and provision of SAM upstream will enable, rapid approval with focused resources for complex trials and work to reduce grounds for non-acceptance (GNA).

6.15 The new operating model will support the ambitions for clinical research and its ability to transform the nation's health as set out in the life sciences vision by ensuring a reformed regulatory environment that will accelerate approvals and minimise regulatory burden whilst boosting our upstream innovation enabling support on prioritised therapeutic areas, This includes upskilling our staff in the relevant clinical and scientific specialities and system alignment with key partners including NIHR and HRA.

Good Clinical Practice (GCP)

6.16 It is essential that the future operating model ensures international interoperability for clinical data in support of marketing authorisations (MA) and avoidance of dual

regulatory standards within clinical trials. To that end we will align with the ICH E6 GCP principles in the new regulations as previously described within the public consultation conducted in January 2022. This approach supports standardisation of processes for MA applicants, reducing regulatory burden of navigating differing national frameworks.

6.17 We will generate appropriate guidance alongside stakeholders, partners (and where appropriate patients) to support the implementation of the new regulation. In particular, further development of guidance for risk adaptive approaches for the conduct of clinical trials, which further supports a pragmatic approach to the implementation of the regulation for trials not intended to support a MA application.

6.18 The introduction of the new regulation and development of guidance provides an opportunity to ensure the approach for inspection activities associated with clinical trials is pragmatic, risk-based and allows proportionate mechanisms for compliance oversight, in line with the inspection compliance strategy. For example, compliance monitoring via the risk based GCP inspection programme, to protect participants and provide confidence in regulatory decisions. Principles of Outcome Based Cooperative Regulation can be explored, taking into account system wide adaptations within the regulatory infrastructure.

International collaboration

6.19 We will prioritise international collaboration to maximise patient benefit, enable accelerated approval for multinational trials, cooperation during public health emergencies and the opportunities for mutual reliance on clinical trial approvals. This includes collaboration multilaterally through ICMRA, ICH and ACCESS. For example, exploring opportunities for collaboration on assessment and potential work sharing mechanisms with ACCESS partners.

Capacity and Capability to deliver the new operating model

6.20 A full assessment has been undertaken of the capacity (FTE) requirements across assessment and support functions that will be required to deliver the new operating model. This has been informed by modelling of scenarios for the impact of expanded notification approvals and accurate productivity data for assessment. The increased assessment, compliance and support function capacity required will inform budget proposals for FY 24/25 and onwards for CIT and once confirmed recruitment campaigns will be initiated at pace.

6.21 The following areas have been identified as priorities for skills and capability development.

- Therapeutic areas and technologies identified in the Life Sciences Vision and Agency Science Strategy
- Equality, diversity, inclusion (EDI)
- Use of data

- Drugs in pregnancy and lactation
- In silico trials
- Synthetic control arms (SCAs)
- Digital twins for clinical trials

Update on progress with new legislation

6.22 Timelines for the new legislation are subject to confirmation for later in 2024. This timeline will then inform plans for the implementation of the new legislation. We are working to ensure that lessons learned from the crisis response are reflected in the new legislation. We held a well-attended external workshop on 3 November, with a range of relevant stakeholders, where there was clear support, and broad consensus across the group, for our policy approaches. We are now preparing further instructions to lawyers, in particular on the details of a notification scheme covering both initial applications and amendments.

Plan for stakeholder engagement and development of guidance

6.23 We intend to utilise the engagement of key stakeholders from the November workshop, and the phase 1 workshop held on 20 December 2023, and bring in further technical or operational expertise where required. We are planning to update key stakeholders in January and establish the membership for smaller, targeted groups. Sub-groups will be formed to address specific technical criteria such as: the criteria (all phases) for the notification of initial CTAs; the criteria (all phases) for the notification of substantial amendments to CTAs; and to further develop the lifecycle procedure for CTAs. These and additional sub-groups of stakeholders, including patient representation, will enable the co-creation of guidance to support the new regulations aligned with the implementation timelines once confirmed.

Fees and cost model

6.24 The current Clinical Trials fees are not appropriately priced for the future operating model. As per guidelines of HM Treasury's Managing Public Money handbook, the fees we charge must be fully cost recovering.

6.25 Therefore, the proposed, new future fees will be based on cost modelling volumes forecast, staff required and recording activity data for initials, assessments, scientific advice, and notifications.

6.26 The Fees and Charges review, and the activity recording exercise led by Finance function commencing January to March 2024 will allow us to price our fees required to deliver the new operating model for Clinical Trials and ensure we are fully recovering our costs. We already have the staff costs and volumes to feed

into the activity recording exercise. We will be able to indicate the new fees and percentage increase in our fees for the new operating model by early April 2024.

6.27 We are working closely with Finance colleagues to develop and scrutinise our cost model and future fees alongside consideration of impact of competition on fees level in accordance with HM Treasury's Managing Public Money handbook. The new fees will go live as part of the agency wide fee uplift in April 2025.

Digital Infrastructure

6.28 D&T are exploring both short term improvements to existing technology and processes for Clinical Trials as well as medium-long term substantial improvements to our processes and technology. This will be undertaken in collaboration with whom we operate the Combined Ways of Working.

Communications strategy

6.29 We have evolved from the agency's immediate clinical trials crisis response which involved increased, transparent communications and an enhanced, proactive customer service response; and have now built a programme of communications, stakeholder, and customer engagement activity, underpinned by a strategy to rebuild our reputation and support delivery of the UK's ambition to be a global life sciences destination. Consistent reassuring messaging and increased visibility of the MHRA's activities to all segmented audiences are the cornerstones of our strategy; with customers at the heart of any service-level changes.

7. Recommendation

The Board is asked to consider the information provided and advise:

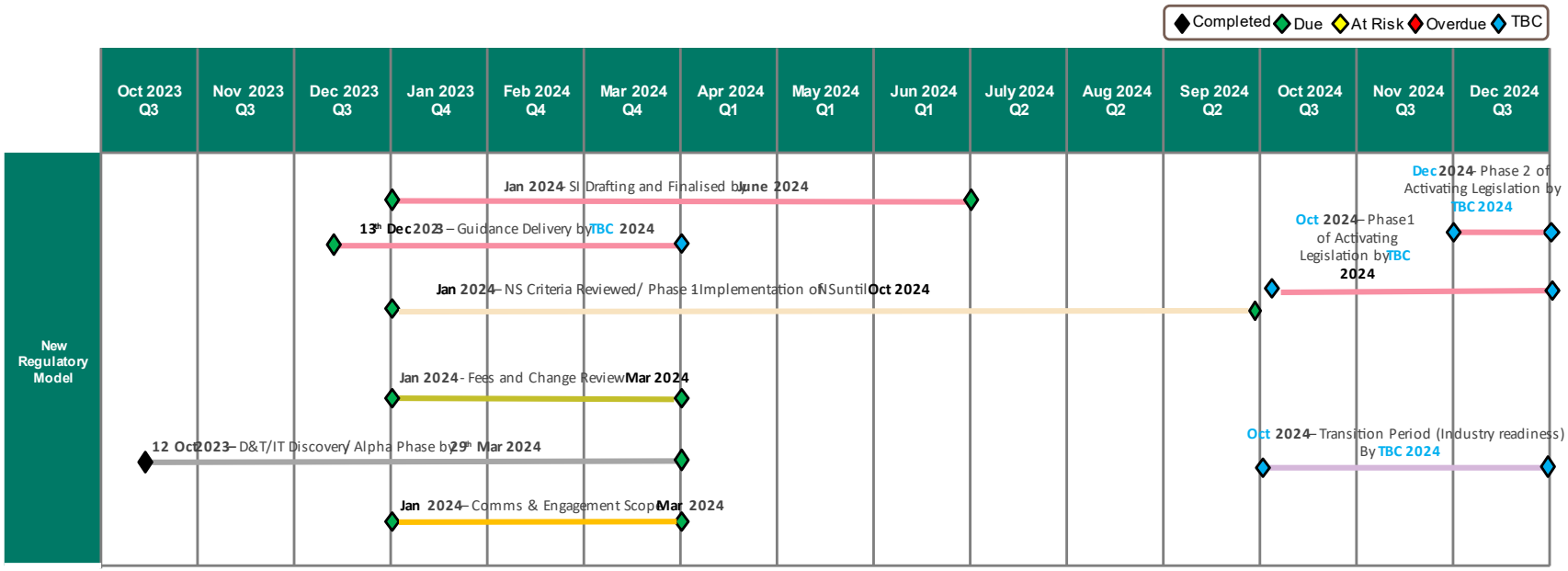
7.1 Is the approach adopted for maintaining ongoing sustainability of clinical trials assessment performance adequate and effective?

7.2 Do the high-level plans for the new operating model give an acceptable level of assurance that the MHRA will meet the needs of patients, the ambitions of the life sciences vision, the Lord O'Shaughnessy review and ensure the UK is an attractive destination for clinical research?

Marc Bailey
January 2024

ANNEX 1 HIGH LEVEL PROVISIONAL PLAN

Clinical Trials New Regulatory Model Timeline of Delivery



NB: This is the current proposed timelines, however collaborative discussions and agreements with HRA need to take place, the timelines may move accordingly

NB: CT will be operating on old fees regs till the new fees uplift go live in April 2025

Medicines & Healthcare products Regulatory Agency

BOARD MEETING HELD IN PUBLIC

16th January 2024

Title	How effectively is the system of international recognition enabling access to medicines for UK patients?
Board Sponsor	Julian Beach
Purpose of Paper	Assurance

How effectively is the system of international recognition enabling access medicines for UK patients?

1. Executive Summary

1.1 From 1st January 2024, the new International Recognition Procedure (IRP) was launched. The IRP Framework provides an approach which allows the MHRA to take into account the decision-making of trusted regulatory partners thereby creating another pathway for streamlined access to medicines for the benefit of UK patients.

1.2 The IRP operates with applications approved by our trusted partners, the FDA, Health Canada, TGA (Australia), PMDA (Japan), HSA (Singapore) and Swiss Medic as well as our existing acceptance of EU and EEA applications. The recognition of other decisions provides the added benefit of allowing all regulators to follow routes of national approval and collaboration ensuring a coherent global medicines landscape, with common understanding of standards of patient safety.

1.3 This route complements our national regulatory route, as well as the existing collaborative routes of Project Orbis and the Access Consortium work-sharing routes thereby offering the flexibility of several routes for companies to obtain a Marketing Authorisation (MA) from the MHRA. In addition, the framework allows for handling the product lifecycle covering certain types of application. All benefit UK patients through the possibility of earlier access to medicines.

1.4 The Board is asked to note the processes put in place to ensure appropriate throughput of applications within the published timeframes and to note the challenges that this route may bring which will be monitored.

2. Introduction

2.1 From 1 January 2024, the MHRA launched the new International Recognition Procedure (IRP) for medicines utilising pre-existing approvals from 7 Reference Regulators (RRs): Australia, Canada, the European Economic Area (EEA and national approvals from Member States), Japan, Switzerland, Singapore and the United States.

2.2 The Agency has had existing reliance routes in place since UK left the EU. These routes were the EC Decision Reliance Procedure (ECDRP) that allowed the Agency to rely on European Commission decisions without further assessment, (now replaced by IRP) and the Mutual Recognition/Decentralised Reliance Procedure (MRDCRP), allowing the agency to take into account authorisations granted through MR/DC procedures in its decision making (now incorporated under the umbrella of IRP).

2.3 For initial applications in IRP there are two recognition pathways and timetables that apply. These determine the level of review that will need to be undertaken by the assessment teams. These are:

2.3.1 Recognition A: 60-day timetable

To be eligible for Recognition A, the RR approval must have been granted within the previous 2 years. A CHMP positive opinion or an MRDC positive end of procedure outcome is an RR approval for the purposes of IRP

2.3.2 Recognition B: 110-day timetable

To be eligible for Recognition B, the RR approval should have been granted within the previous 10 years. A CHMP positive opinion or an MRDC positive end of procedure outcome is an RR approval for the purposes of IRP, with conditions where particular conditions will drive review, for example:

- Designation of Orphan status
- Advanced therapy medicinal product (ATMP) as classified by the HMRs 2012
- At least one manufacturing site is not yet GMP certified.
- The Environmental Risk Assessment (ERA) has not been assessed by the RR.
- The Risk Management Plan (RMP) has not been assessed by the RR.

For recognition B applications applicants can include certain changes to their submission that were not submitted and approved by the RR. They therefore require a focussed assessment using the relevant experts for the type of change made.

2.4 The IRP can be used for line extensions, variations (Type 1B, Type II) and renewal applications (including annual renewal of conditional MAs and annual reassessment of exceptional circumstance MAs). Variation timetables will follow our existing timeframes.

3. Key activities of MHRA

3.1. The MHRA has invested considerable time preparing for the introduction of IRP. This started with Partnerships Group evaluating existing recognition procedures operated by other international regulators and considered how the principles could be incorporated into the Agency's approach. Having decided on the regulatory approach, from September onwards the focus was ensuring appropriate preparations were in place within MHRA ready for handling these applications from the 1Jan 2024 and preparing industry for the new routes.

3.2. A series of workshops were run to build the process and identify the best way to handle the various application types, optimising use of resource against complexity of applications. A final challenge session was run over two weeks to ensure that the changes had been optimised as far as possible.

3.3. This culminated in several progressive familiarisation sessions and a training day for assessment teams in both Healthcare Quality and Access (HQA) and Safety & Surveillance (S&S). The Authorisation Lifecycle (AL) team held a similar programme of change with two sessions being run. A final training session on IR Product Lifecycle applications with Assessors will take place early in the new year.

3.4. HQA Group is recruiting 7 additional staff with some roles appointed and other exercises in progress, to supplement the existing experienced staff. A new role, Head of International Recognition, has overall accountability for all procedures submitted through IRP, including coordination of resources and adherence to timetables. On-boarding of the successful candidate is projected to occur by the end of January. In the interim the procedures are managed by other HQA Senior Management Team members, Deputy Director (DD) of Innovative Medicines, DD of Established Medicines and DD of Authorisation Lifecycle.

3.5. Change management for companies started with early engagement with Industry trusted partners. Subsequently two webinars were run for Industry covering the rationale for international recognition, the principles of the framework and how to apply through IRP. The second webinar covered how to apply in detail. Several Industry representatives were also involved in helping to test the Beta Version of the digital Eligibility Form which is used by applicants to identify whether their initial MAs will follow route A or route B timeframes. These supplemented the full guidance which is published on the international recognition website pages.

3.6. As with all new framework processes there will be a bedding in time, and we will keep risks and challenges under review. The group will also be ensuring that processes are further optimised, as needed, to meet the Key Performance Indicators that are needed internally and those published externally.

4. Challenges identified so far

4.1. Industry may wish to move applications from existing national processes and timetables to use international recognition, or the company may choose to withdraw a national application and resubmit through IRP. Both may have a financial impact. We will monitor this situation; our intention is that for any applications submitted prior to 1 January 2024 where assessment has started then companies can update their dossiers and submit any RR assessment reports. These will facilitate assessment, but these cannot be processed or charged as IRP applications since they were submitted before introduction of the scheme. If assessment has concluded, then we will not allow additional information to be

submitted. We will refund for work that has not been undertaken on the national application in line with the fees regulations.

4.2. We have set the fees for IRP based on current reliance fee options. When the Agency undertakes a future review of the fees experience may show that these will need to change to reflect the true input of resource that is required for different types of application. This does means that we could be undercharging for the current work. A review of timelines will be performed over the first 3 months of operations, to tie in with the fees review and then subsequently depending on the amount of available information.

4.3. It is anticipated that the requirements for international recognition will evolve over time as more experience is gained by both Industry and the MHRA, with different types of authorisations granted by international regulators. As this happens, we will update guidance to ensure we are optimising our approach whilst maintaining safety of UK patients. Changes are being made to improve throughput of applications to reduce backlogs. These changes will start to show improvements and we will be monitoring carefully to balance both current backlogs and new receipts.

4.4. The main challenge overall will be achieving the right balance between reliance work and de novo assessments in particular of innovative products and first-off-patent generics.

5. Next steps

5.1. Next steps are to carefully monitor the process and performance of IRP and reflect on any changes required allowing a bedding-in time of at least 3 months. Key metrics of numbers of applications received and duration of processing will be actively monitored and provided to stakeholders both internal and external. While detailed guidance for IRP has been published, this will be reviewed as required and updates to existing guidance on the MHRA website will be made to reflect our experience of the IRP process, questions from industry and any changes over the coming months.

6. Recommendation

6.1 The Board is asked to note the progress made in implementing the IRP process, and that close monitoring is in place to ensure appropriate progress in all areas of the new IRP.

6.2 The Board is asked to comment on any aspects where IRP can be strengthened while not detracting from MHRA’s role as an enabling regulator for innovation.

Julian Beach
January 2024

Medicines & Healthcare products Regulatory Agency

BOARD MEETING HELD IN PUBLIC

16 January 2024

Title	What assurance can be provided by the Patient Safety and Engagement Committee (PSEC)?
Board Sponsor	Mercy Jeyasingham
Purpose of Paper	Assurance

What assurance can be provided by the Patient Safety and Engagement Committee (PSEC)?

1. Executive Summary

1.1 PSEC discussed two substantive items which were: the Patient Involvement Strategy and CPRD's Research data governance process. It also discussed future topics for the committee.

1.1.1 The Committee reviewed the progress made in implementing the Patient Involvement Strategy over the last year, and the plans for 2024-25. The Committee noted good progress but were particularly keen on increasing consistency of reward to lay members and their diversity.

1.1.2 The Committee discussed the key findings from the post-implementation review of CPRD's new Research Data Governance (RDG) process. The Committee were supportive of CPRD reviewing and streamlining criteria and process for triaging applications but noted that both internal and external processes delivered decisions well within a two-week target.

1.1.3 The Forward plan for the Committee scheduled some new areas of development for the agency as well as regular feedback on items already reviewed.

2. Introduction

2.1 The twelfth meeting of the Patient Safety and Engagement Committee was held on the 7th November 2023.

3. PSEC discussed each of the following items at the meeting on the 7th November 2023;

3.1 **What progress has been made in implementing the Patient Involvement Strategy over the last year, and what are the plans for 2024-25?**

The Patient Involvement Strategy has been a key priority for the Committee since its launch. A particular area of emphasis has been how to evaluate the strategy, determining and monitoring deliverables against progress. Over the past two years, the strategy had certainly had some successes however the Committee advised that specific examples in a case-study format could be the most powerful indicator of some of the strategy's successes. The recruitment of lay members was also discussed as a key point. There are multiple projects across the Agency which have separate policies for the payment of lay members. Bringing this together in one policy to give clarity to MHRA bodies that benefit from lay member contributions was also identified as a priority, with the policy to come back to the Committee once it has been agreed. Inclusivity should be a key pillar within this policy, not excluding those busy with work or caring responsibilities. The Committee also recommended reviewing approaches such as the EU's approach to patient involvement where involvement is treated as a requirement for licensing decisions, meaning that involvement happened in a more systematic way. Trying to ensure that involvement

includes not just those with the loudest voices, but also those who may have contrasting views or experiences to give a balanced, well-rounded view was also highlighted as a challenge that the Agency could tackle. Overall, the Committee was assured that good progress had been made, however there were two areas for further assurance that the Committee requested items on for a future meeting: the lay member incentive/pay policy and evaluation of the Patient Involvement Strategy to ensure that good examples were being effectively highlighted. An evaluation methodology had been agreed at the last committee meeting which would provide a further evidence base on progress.

3.2 **What are the key findings from the post-implementation review of CPRD's new Research Data Governance (RDG) process?**

The item on the CPRD's RDG process came from an early conversation when the process was being established, with PSEC wanting post-implementation assurance. The agreed process was to make more internal decisions so that more complex decisions could be escalated to external experts. Oversight of decisions is made by the Scientific Advisory Committee. The balance between using an internal process and external expert review committees was discussed. Although the desired 70/30 split was not being met, this was largely around triage of public interest which led to more expert reviews. The Committee also discussed any feedback received by applicants, however the most important aspect for applicants was that the two-week target had been met rather than how it was assessed (e.g., internal versus external review). The Committee gained assurance from the team that the relevant skills required for review were contained within the CPRD to interpret and clarify the data requests being made. The Committee endorsed the recommendations to change the triage process (specifically to pilot the application of protocol triage based on a single CPRD team member rating, supported by regular calibration exercises to ensure consistency in the application of the criteria) as well as clarify triage criteria to try to rebalance the proportion of protocols requiring ERC review in line with the initial modelling projections. It also recommended that CPRD explore how to streamline the review process further to align with the national direction of travel on risk proportionate reviews, taking lessons learnt from the Agency's notification scheme for low-risk clinical trials.

3.3 **PSEC's Forward Plan**

There was a short discussion on the forward plan, and the agendas for the next two meetings have started to be populated. As well as items added as a result of the conversation around the Patient Involvement Strategy, other items were added on a discussion around a forthcoming report on medical devices when it is released, and a review of relevant risks that fall within the remit of PSEC.

3.4 **Any other business**

The one item of any other business was the recruitment of a replacement lay member of PSEC after the resignation of one of the two lay members of the committee.

4.0 Conclusion

4.1 The Committee made recommendations on each of the papers but was assured that the Agency was heading in the right direction on the two substantive items. An issue was raised around the resignation of one of the lay members, and a preference was agreed for a recruitment process to attempt to be open to both current lay members for the Agency and a wider field. Governance colleagues will be working with the Patient Engagement team a consultant on the lay member recruitment programme, to recruit the second lay member for the Committee.

Mercy Jeyasingham
Chair Patient Safety and Engagement Committee
Non-Executive Director MHRA
November 2023

Medicines & Healthcare products Regulatory Agency

BOARD MEETING HELD IN PUBLIC

16 January 2024

Title	What assurance can be provided by the Audit and Risk Assurance Committee (ARAC)?
Board Sponsor	Michael Whitehouse
Purpose of Paper	Assurance

What Assurance can be provided by the Audit Risk and Assurance Committee (ARAC)?

1. Executive Summary

1.1. ARAC met on 1 December. The Committee sought assurance on progress in addressing issues identified by the Health and Safety Executive (HSE). We received an update on the Agency's financial position. We considered five reports from Internal Audit. Finally we assessed the completeness of the Agency's risk register together with a number of reports supporting the MHRA's governance.

2. Health and Safety

2.1. The Agency has made good progress in addressing issues raised by the HSE during its last inspection. A formal partnership agreement is being finalised to ensure that the MHRA has access to the necessary Specified Animals Pathogens capability. As agreed by the Board at its last meeting work is now under way to develop a new Health and Safety strategy. We applaud the enhanced priority which the Agency is giving to Health and Safety. More is still needed so that maintaining health and safety is reflected in personal objectives. Given the amount of work under way we asked that the lead Chief Officer provide additional assurance at the January board meeting that the health and safety team has sufficient resources to facilitate the improvement programme to meet agreed timescales.

3. Financial Performance

3.1. We were assured that the Agency's financial performance is being well managed. We challenged whether the projected spend for the remaining months of the current financial year is achievable. A high proportion of spend is already committed with contracts agreed and the risk of not spending as planned should be minimal. Nevertheless, the Agency has already committed to return to the Department a portion of its 2023/24 budget. While the Committee recognise the challenges of spending money effectively in the last 3 months of the financial year we encouraged the Executive to reconsider whether there are opportunities to use unspent monies given the numerous priorities which the Agency faces.

3.2. This is the first year that the Agency has not been a Trading Fund and it cannot retain any unspent monies. This means that planning expenditure effectively over a twelve month period supported by strong cash flow management is essential. These are important skills which all budget holders need to demonstrate. The Committee will continue to seek evidence that this capability is embedded across the Agency.

3.3. The MHRA's role continues to evolve and we recommend that the Agency keeps under review whether non Trading Fund status remains justified by the Office of National Statistics criteria.

3.4. We endorsed the Agency's proposal to enhance its environmental reporting in its next Annual Report. We asked to receive an early draft of the environmental section at ARAC's

April meeting. We also encouraged the Agency to draw on good practice elsewhere for example recent entries to the Public Trust Awards which include an environmental category.

4. Internal Audit

4.1. Internal Audit working effectively with the Agency presented 5 reports. These are:

- Medical Devices Incident Reporting — Substantial Assurance
- International Recognition procedures — Moderate Assurance
- RMS Reset — Limited Assurance
- Cyber Security — Limited Assurance
- Strategic and Business planning — Advisory

4.2. The Committee applaud the work of MHRA colleagues in strengthening incident reporting and in the preparations to introduce from January 2024 International Recognition for the regulatory approval of some medicines and medical devices. The latter will require ongoing monitoring by the Board but the moderate endorsement by Internal Audit gives assurance that preparations including engagement with industry are being implemented effectively.

4.3. There have been on going issues with the implementation of the Regulatory Management System (RMS), now renamed as 'RegulatoryConnect'. The focus of this programme has now been reset so that it is better aligned to support the MHRA's business objectives and to enhance its longer-term resilience. Internal Audit's limited assurance reflects the programme's governance. We welcome the assurances that all of the recommendations have or are being implemented. Further assurance should be provided shortly by the external review commissioned at the request of the Board.

4.4. More generally ARAC recommend that the transparency of the way progress with the programme is reported to the Board is strengthened to include key metrics such as percentage of process redesign completed; level of user testing completed; and progress in realising intended benefits or the resilience of the trajectory for achieving them.

4.5. The Board will shortly be asked to endorse a new business case underpinning the reset of the RegulatoryConnect programme. It will be important that the Executive sets out clearly how the governance has been strengthened and will operate. ARAC will seek further assurance at its February meeting.

4.6. We were pleased to note the progress in implementing Internal Audit recommendations. We also considered the route to removing the limited controls assurance awarded by Internal Audit for 2022-23. Achieving this for 2023-24 is ambitious but ARAC are encouraged by all work being done to strengthen. This includes a new controls assurance framework which the Committee considered in draft. A final version will be presented to ARAC in April.

5. Cyber security

5.1. In response to Internal Audit's limited assurance assessment of the Agency's cyber security the Chief Digital Officer helpfully presented the Agency's cyber resilience strategy and set out how Internal Audit's recommendations were being implemented. The Committee recognise the professionalism and the hard work which the Agency's digital and cyber specialists do to protect the MHRA's information. This is made more difficult by the legacy systems still operational which the Agency's digital programme is intended to remedy (paragraph 4.3 above). Nevertheless to obtain the level of assurance which we require for such a critical line of defence we asked to see at our February meeting the implementation plan setting out in detail, and the associated timeline, the types of controls and testing applied. We particularly want to be assured that the Agency's approach is comparable with best industry practice.

6. External Audit

6.1 We were assured that the preparation of the external audit plan for 2023-24 is on schedule and will be presented to ARAC in February. We discussed the relevance of any change in accounting or reporting standards to the MHRA's 23-24 Annual Report. None are applicable. Last year the Agency did well in presenting its Annual Report to the Board in accordance with the agreed timetable. We are assured that all is being put in place to replicate this success for 23-24.

7. Risk Management

7.1. In November ARAC participated in two horizon-scanning meetings so as to be confident that the Agency was identifying all critical risks that needed to managed to ensure that the MHRA remained an effective Regulator.

7.2. The first meeting involved the MHRA's key system partners – NICE, the Health Security Agency and the Department of Health; the second was internal including all of the Executive. ARAC was assured that the Agency is alert to identifying early enough emerging risks.

7.3. Two areas of external and internal focus were highlighted. The first is the MHRA's role as part of the wider health system and that regulatory decisions often needed to be support by complementary actions by other Agencies or the wider NHS to deliver sustainable health benefits for the public. The Agency has dedicated focus on partnership working but how effectively the wider health system works together remains a risk which is not unique to the MHRA but shared more widely.

7.4. The second is internal and the Executive agreed that the Agency needed to remain focused on the delivery of all of its statutory functions to avoid similar performance issues that arose with clinical trials.

7.5. ARAC were assured that the risk register was sufficiently comprehensive. The Committee emphasised the importance of managing reputation risk through concentrated effort on

resolving performance issues in a sustainable way as well as managing expectations through effective stakeholder engagement.

7.6. ARAC applauds the progress which the Agency has achieved in enhancing its approach to risk management. The next stage of this is defining risk appetite which is in progress.

8. Governance

8.1. The Committee received two reports – the Quarterly Fraud, Error and Concerns Report and the report on Complaints Data. Neither raised issues needing to be reported to the Board. ARAC is impressed by the way in which complaints data is now analysed to help improve performance. This is important in helping the Agency to become a Regulator that is more customer focused.

8.2. No incidents of whistleblowing were brought to ARAC's attention.

9. AOB

9.1. ARAC will next meet on Thursday 1 February 2024.

Michael Whitehouse
Chair, Audit and Risk Assurance Committee
December 2023

Medicines & Healthcare products Regulatory Agency

BOARD MEETING HELD IN PUBLIC

16 January 2023

Title	**What assurance can be provided following the meeting of ODRC on 18th December 2023?**
Board Sponsor	Amanda Calvert
Purpose of Paper	Assurance

What assurance can be provided from the meeting of ODRC?

1. Introduction

The Organisation Development and Remuneration Committee (ODRC) met on 18th December 2023 with the following objectives.

- To review the progress made in delivery of the Agency's improved service processes, and what progress has been made in delivery of RegulatoryConnect
- To review feedback from the agency Leadership Event held on 30th November 2023.

2. Progress towards improving processes for delivery of services.

In September it was noted that there had been limited progress in establishing improved service delivery processes across the Agency as key resources had been redeployed to the crisis management team that had been set up to clear the clinical trials backlog.

Whilst it was good to hear that the clinical trials backlog had been cleared and new applications were being assessed within statutory timeines, it was disappointing that change seemed to require a crisis management approach rather than a progressive and sustained approach to service improvement.

The committee reviewed the progress for changes to service delivery.

- **Strategic Change Management & Delivery Team** – The committee noted that the strategic change management and delivery team led by Mick Foy is now in place and actively supporting the operational groups to deliver improvement programmes for service delivery.
- **Risk Based Decision Making** – This approach to delivering decisions to applications for licences and clinical trial applications is fundamental to the successful operation of the Agency as an independent sovereign regulator. The transition to this way of working requires changes in "What" people are expected to do during reviews of applications; the processes for assessing applications, safety signals, clinical trials, compliance reviews; "How" they undertake reviews and how decisions are taken; the data and governance processes that support different assessment routes for lower risk and higher risk applications. There is still some way to go to embed these processes, establish the supporting governance processes and train staff at all levels. This is major focus for the Change Management & Delivery Team.
- **Clinical Trials Backlog –** The crisis management team put in place was successful in clearing the backlog. To sustain performance with resourcing sized for steady state, there have been improvements made with the establishment of an end-to-end process for assessing applications and the introduction of a notification system.
- **Established Licence Backlog -** The backlog has grown over the past year and further in the 6 months whilst resources were reallocated to work in the clinical trials crisis team. The establishment of differentiated approaches e.g. for low-risk applications such as those suitable for the international recognition route have been slow to implement. The committee recognised the progress that has been made in understanding the types of applications in the backlog and sought assurance that the successful approaches used in clinical trials such as modelling would be used in established medicines. The committee supported the setting up of a task force to address the crisis but wanted to make sure this approach would be used as an opportunity to learn and embed changes to existing practices.

3. RegulatoryConnect Progress

The committee were encouraged to see the release planning for the delivery of Regulatory Connect and were assured that Release 1 would be delivered in March 2023.

- **External User Benefits from Release 1** – The committee were encouraged that the Self-Service Portal will be included in Release 1. The ability for external users to be able to see the progress of their applications will be a major step forward. The team were encouraged to communicate extensively with industry and innovators to ensure that the benefits are delivered to them as quickly as possible.
- **Internal User Benefits and Service Process Benefits from Release 1** - Basic capabilities of reduced time to download documents, search and reductions in manual processing will be delivered for electronic Common Technical Documents (eCTD - Regulatory Submissions) Search and reporting capabilities will be improved for the data stored in the Legacy Archive. Improvements in the management of data for Regulatory Inspections will be delivered. The committee asked for assurance that these improvements were being incorporated into new ways of working and that there would be tangible measurable improvements in the assessment times for licence and clinical trials applications.
- **Release 2** – This is due to be delivered by end November 2024. This release will improve internal case management for licences and clinical trials applications and for inspections. It was agreed that Regulatory Connect is a vehicle to change legacy processes and ways of working and can be used to embed the new approval routes such as international recognition and to provide data to support the risk-based approach to regulation.
- **Training and development** – The committee stressed the importance of getting staff to quickly see the benefits of the new tools and ways of working. Communications, training and change management along with clear articulation of the benefits will be essential for a successful roll-out.
- **Technology** – The committee were pleased to note that the majority of the technology being deployed is standard technology platforms that are in common use across other regulators. The team were encouraged to learn from the FDA's experience from rolling out new technology.
- **Measuring Success** – The Agency has clear statutory commitments that must be met. RegulatoryConnect is providing tools to achieve these minimum standards and provide the data to support risk-based decision making and transparency of governance and decision-making processes. The success of the project should be measured by the achieving the performance metrics within the business plan.

4. Leadership

- **Leadership Conference** - The committee commended the team on delivering an excellent event for over 100 leaders within the Agency. It was noted that this is the first time that many of the leaders had met each other face to face and it stressed the importance of spending time face to face to build and develop leaders and teams.
- **People Survey –** The team will review the results of the People Survey in the March 2024 meeting.

5. Concluding Remarks

- The Agency has suffered major reputational setbacks during 2023 with the major backlogs arising in assessment of clinical trials applications and assessment of established medicines licence applications.
- The clinical trials crisis team have done an excellent job in clearing the backlog and improving the throughput of new applications. New ways of working and process improvements are now being embedded into "business as usual". It is disappointing that it has taken a crisis to makes these changes, but the greater resilience now established is building a firm foundation for the future.
- It has taken time to understand the appropriate number of people and the skills and experience required to cope with the demands for medicines and devices for the UK and it is recognised some teams were initially under-resourced. However there has been a reluctance to develop new ways of working and the technology and data platforms have not supported transparency and been agile enough to encourage new ways of working.
- The committee remains concerned about the rate of progress to embed improvements to deliver services but are encouraged that there are tangible signs of progress.
    - The clinical trials backlog has been resolved and new ways of working embedded.
    - The number of vacancies is reducing, and new team members are gaining experience and expertise.
    - There is a definitive plan to deliver Release 1 of RegulatoryConnect in March and the products will directly improve the assessment of applications and improve customer experience.
- Unfortunately, the backlog in established medicines has grown over the last year including as staff were deployed to work in the clinical trials crisis team. A multi-skilled task-force approach is required to address this problem, but it can build on the techniques and approach used in clinical trials.
- The committee welcomed the progress that is being made in the establishment of the Strategic Change Team and the work that is being done to develop the Agency's leaders of the future.

Amanda Calvert
Chair of Organisational Development and Remuneration Committee
January 2024