

NHS Reset and Recovery and New Ways of Working

Competition for
development funding

NHS England
NHS Improvement
SBRI Healthcare

August 2021



*The***AHSN***Network*



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Executive Summary

The National Health Services, across all UK Nations, have faced a deep crisis since the start of the COVID-19 pandemic, with staff working tirelessly to support patients, and all non-urgent planned surgeries postponed or cancelled to adjust to the demand of the pandemic.

The system is now facing a challenge to recover on all care areas with a mounting backlog of health issues that the service will have to address in the pandemic's wake. Restoring non-COVID care will take time and resources. In addition to increased demand on the NHS, staff in emergency departments are now having to work differently from how they did pre-pandemic, with extra time needed for applying personal protective equipment and performing rapid COVID-19 tests on patients.

Social distancing rules and enhanced infection prevention control measures have also meant fewer beds and less clinical space. However, figures have shown a positive trend for routine operations, cancer and mental health care now rebounding sharply.

Recognising the need to support the NHS services, to reset and recover from the pandemic, we seek to address this immediate challenge with a funding competition that will facilitate the implementation of developed innovations in the relevant healthcare settings.

The competition seeks to address the critical need of supporting the NHS resetting and recovering from the pandemic, and finding new adapted ways of working to support the system finding appropriate ways of working, through taking services outside hospitals and closer to patients or supporting the workforce delivering care effectively.

The ambition is to find mature innovative solutions, with demonstrated evidence of efficacy and accuracy that address one or both of the following areas:

- 1. Reducing the NHS workforce pressure**
- 2. Increasing NHS effectiveness**

Applicants are asked to consider their innovation on the whole system and their impact on care pathways and services delivery. Innovators should also demonstrate they are aware of the competitive environment, even considering working together with other companies to bring forward solutions that can make a real difference.

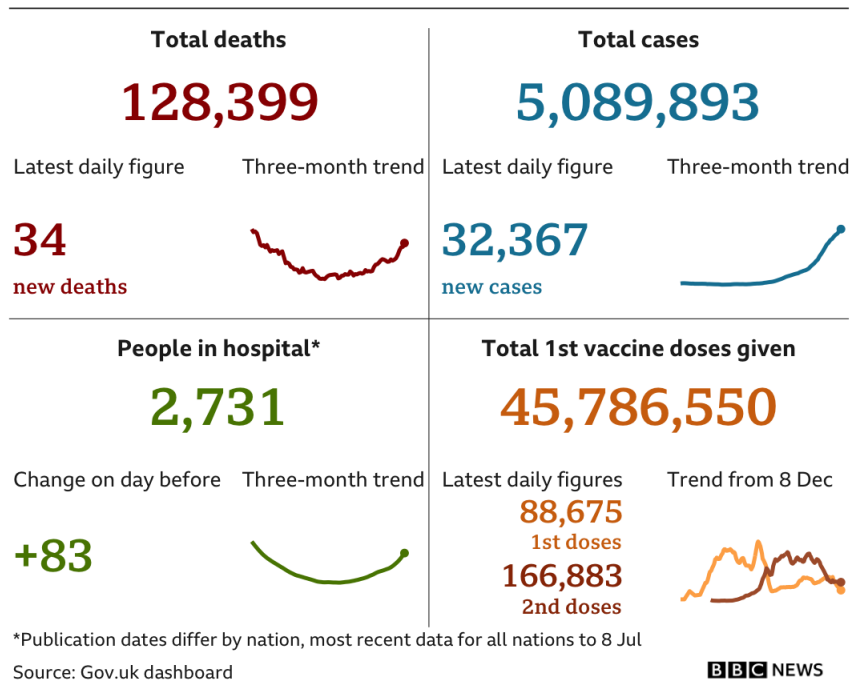
Applicants should take into account the baseline they need to innovate from, having taken into consideration the forced changes brought by the COVID-19 pandemic. This competition is open to supporting the implementation of technologies and solutions in a real-world environment, in order to generate real-work evidence to support future adoption.

NHS Reset and Recovery and New Ways of Working

The COVID-19 pandemic in the UK

The COVID-19 pandemic is the greatest disruptive force so far, of the 21st century. There have been more than 5 million confirmed cases of coronavirus in the UK and more than 128,000 people have died, [government figures](#) show. However, these figures include only people who have died within 28 days of testing positive for coronavirus. At the time of writing, the NHS has delivered more than 46 million COVID-19 vaccinations to people across England. Data shows that the vaccination programme is having a significant impact on transmission rates, and, coupled with the public's adherence to social restrictions, this means that hospitalisation rates have been drastically falling across all regions and local areas.

Coronavirus in the UK



The pandemic though continues to present us with ever-changing challenges. As vaccines developed in short timescales never previously thought possible are being approved and used in the UK, new variants of the virus with greater transmissibility continue to emerge. The COVID-19 pandemic will undoubtedly remain a challenge for some time to come.

Impact of COVID-19 in the NHS

COVID-19 has changed the NHS and social care, precipitating rapid transformation at a time of immense pressure and personal and professional challenge.

Over the last 12-18 months the NHS has worked tirelessly to support the country in response to the COVID-19 pandemic. While the NHS has never been a COVID-19-only service, the pandemic has impacted on all aspects of its care and delivery, with elective and diagnostic activities among those services that have been disrupted. This has led to a considerable backlog of people waiting for NHS treatment.

While the reconfiguration of NHS services and suspension of all non-emergency elective procedures were critical to meet the surge in demand for COVID-19 patients in 2020, there were wider and more significant consequences for the health and care system, including the requirement for social distancing that has reduced capacity of wards / units / diagnostic services. The latest available statistics indicate that postponing all non-urgent acute care, in combination with the substantial changes in patient behaviour meant that the NHS is currently facing a large backlog of non-COVID-19 care.

By the end of February 2021, there were 4.7 million patients waiting for treatment, of which 387,885 were waiting in excess of 52 weeks for elective surgery and routine procedures. This was a significant increase from December 2020, where 224,205 patients were reported to have waited beyond 52 weeks. Prior to the pandemic, in order to meet the 18-week standard, the NHS would have required to treat a further 500,000 patients annually for a consecutive 4 years. Nevertheless, although the pandemic's full impact on access to urgent and routine care in England is still emerging, recent NHS England figures ([May 2021](#)) report that the total consultant-led referral to treatment NHS waiting times have reached a record high of 5.3 million. Early planning data on current trajectories project that resolving the backlog could potentially span over a period of up to 5 years (~2026), an outcome which NHS Trust leaders recognise as being suboptimal.

The cost of recovery will be substantial, and, on average, it is estimated to require an additional £1.9 Bn/annum. Arguably, to clear the backlog by 2023/2024, while managing the normal increase in new referrals to treatments would translate into an increase of NHS activity by 11% (4,000 extra consultants and 17,000 extra nurses/annum) which is not realistic due to staff constraints and current staff shortage.

The lack of clarity around the extent of impact of COVID-19 on NHS productivity levels and the effectiveness of a roadmap for services to resume its ability to function remotely and at scale, further highlights the need for disruptive technologies that can offset the growing pressure on the NHS. While digital transformation in healthcare has accelerated over the course of the pandemic, this still remains an underexploited area for development. The pandemic has highlighted the need for effective, efficient and intelligent care, enabled by innovative digital technologies, where a bold and transformative approach is required to tackle the growing, and increasingly unsustainable, pressures faced by the system.

Snapshot: NHS waiting times and workforce

It is internationally recognised that the NHS has responded well to COVID-19. In spite of having to adapt and develop to an extraordinary degree, the service not only managed a huge wave of COVID-19 patients but also continued to treat millions not infected with the virus. The sustained impact of the pandemic will leave a backlog of care in excess of anything seen over the last 12 years. Although urgent and emergency procedures have largely been maintained, much of the growth in waiting lists and waiting times comes from low complexity, high-volume procedures for conditions ranging from painful bone and joint conditions, to ear, nose and throat and ophthalmology ([Building back elective care](#)), affecting hundreds of thousands of patients.

In 2016, the number of patients waiting for treatment for more than 18 weeks was 269,589 while the waiting list was an estimated at 3.5 million patients. This figure increased three fold by January 2020 to 730,267 with a waiting list in excess of 4.42 million patients, reflecting the lack of capacity of NHS activity to meet the demand.

In April 2021, the median waiting times had decreased significantly to 11 weeks, yet the number of referrals to treatment pathways over 18 weeks increased to 1.81 million. Contrastingly, the number of referrals to treatment pathways over 52 weeks decreased from 436,127 recorded in March 2021 to 385,490 in April 2021. While these figures are reflecting a positive trend, they are 35-fold the numbers recorded in April 2020 and 368-fold in April 2019, an inevitable consequence of de-prioritising care following the pandemic.

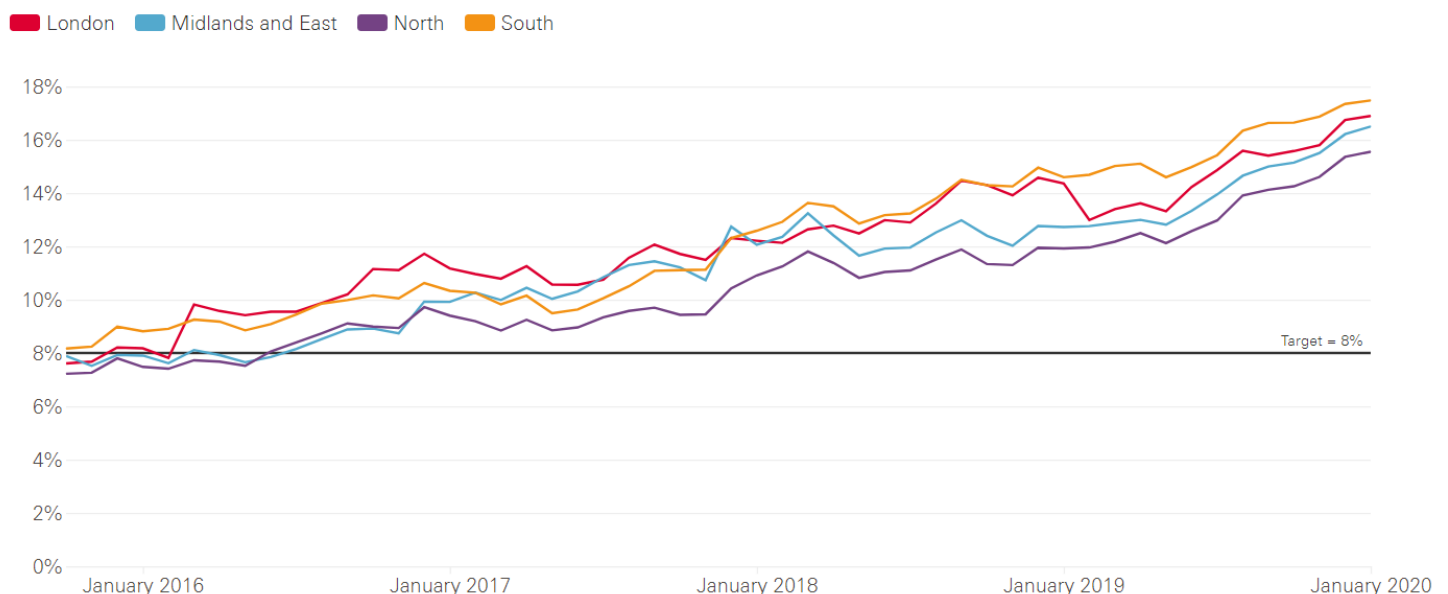


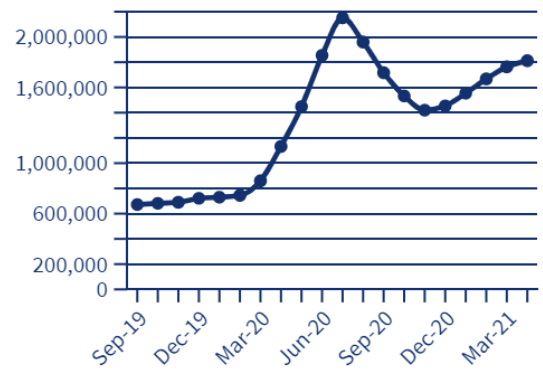
Figure 1: Health Foundation analysis of NHS England: Referral to Treatment (RTT): 18 Weeks RTT waiting times data compared to the 8% (100%–92%) target.

The COVID-19 pandemic drove a ‘culture of innovation’ across the health and care system, which should be nurtured and maintained as we reset. Staff are now more willing to share knowledge, experience, and stories in relation to culture and leadership, and recognise their role in enabling and sustaining change normal ([Reflecting on the COVID-19 pandemic to inform the health and care system of the future](#)), however the pandemic left the NHS with an exhausted workforce. The intensity of the pandemic response has had a marked impact on NHS staff and left the healthcare workforce in a strained and fragile state. In many areas, the same group of staff who have worked tirelessly through the pandemic, and who are delivering the vaccination programme, will be asked to step up, once again, to recover the backlogs ([Building back elective care](#)) and continue to support patients’ care.

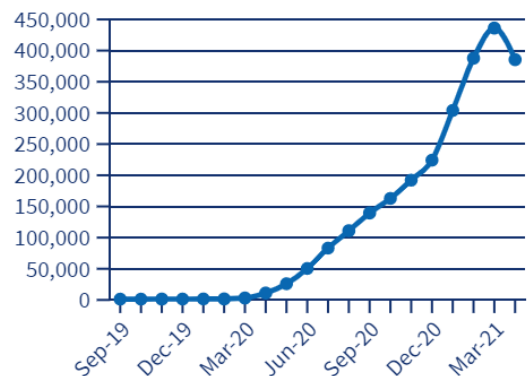
The NHS is the largest employer in England, with nearly [1.2 million full-time equivalent \(FTE\) staff](#) working in hospital and community services, and is facing a workforce crisis. NHS hospitals, mental health services and community providers are now reporting [a shortage of nearly 84,000 FTE staff](#), severely affecting key groups such as nurses, midwives and health visitors. General practice is also under strain with a shortage of 2,500 FTE GPs; projections suggest [this gap could increase to 7,000 within five years](#) if current trends continue. Shortages of GPs and other staff working in primary care and community services are putting ambitions to deliver more care out of hospitals at risk. Unfilled vacancies increase the pressure on staff, leading to high levels of stress, absenteeism and turnover. This has been compounded by the Covid-19 pandemic which has exacerbated long-term issues such as chronic excessive workload, burnout and inequalities [experienced by ethnic minority staff](#). Another possible related issue is the [early retirement](#) from GPs and hospital doctors in England and Wales that has soared in 13 years from 401 GPs and hospital doctors that took early retirement in 2007/08, to 1,358 in 2020/21 – an increase of 239%.

In July 2020, NHS England and NHS Improvement published the [NHS People Promise](#) and a [2020/21 People Plan](#), setting out how to address workforce pressures through greater recruitment and a renewed focus on a compassionate and inclusive culture. The pandemic has underlined how [staff often work under enormous strain](#) as a result of workforce shortages.

Patients waiting over 18 weeks



Patients waiting over 52 weeks



Total waiting (millions)

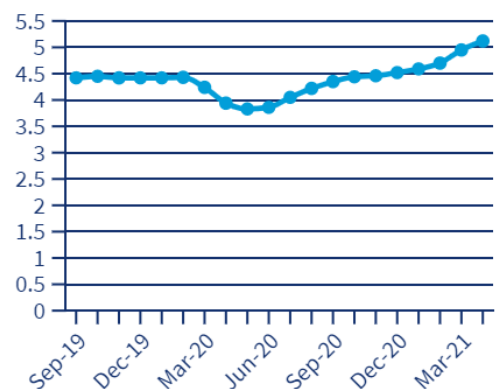


Figure 2: NHS Digital analysis of consultant-led referral to treatment waiting list.

The [NHS Long Term Plan](#) recognised the need to address this but was not supported by a detailed workforce plan. To add to the problem, the replacement and recruitment of staff can take a long time therefore leading to qualified staff shortages that may take years to recover.

COVID-19 and Health Inequalities

The COVID-19 pandemic highlighted the prevalence and impact of health inequalities, with higher COVID-19 risk evident among particular communities.

Numbers are striking. People living in the most deprived fifth of areas of England were two to three times more likely to die than people of the same age living in the least deprived areas. This inequality is also seen in numbers of deaths, which are 35% higher in the poorest areas than in the wealthiest. This is despite the fact that more deprived areas tend to have younger populations, so would be expected to have fewer deaths. Looking at the years of life lost, we see that, on average, those dying from COVID-19 in the poorest fifth of areas lost 11 years of life, compared with 10 years lost in the wealthiest areas. This difference is because those dying in the poorest areas were younger. Putting this together with the higher number of deaths in the poorest areas, we estimate that the poorest areas have lost 45% more life years than the wealthiest. In the poorest areas of England there were 35% more deaths and 45% more years of life lost than in the richest areas ([Unequal pandemic, fairer recovery, Health Foundation](#)).

The immediate risks to people's health go beyond the direct harm caused by the virus. Reprioritisation of healthcare services to manage COVID-19-related demand has led to increased unmet need for care. Health Foundation analysis shows that 6 million 'missing patients' did not seek treatment in 2020, which could mean many living with poor health for longer. While the NHS is resetting, challenges and opportunities to build a more inclusive service must be considered.

NHS priorities and commitment to deploy new ways of working

In March 2021 the [2021/22 priorities and operational planning guidance](#) was published in which the NHS set out its priorities:

- A. Supporting the health and wellbeing of staff and taking action on recruitment and retention
- B. Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19
- C. Building on what we have learned during the pandemic, to transform the delivery of services, accelerate the restoration of elective and cancer care, and manage the increasing demand on mental health services
- D. Expanding primary care capacity to improve access, local health outcomes and address health inequalities
- E. Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay
- F. Working collaboratively across systems to deliver on these priorities.

The Government has agreed an overall financial settlement for the NHS for the first half of the year which provides an additional £6.6bn + £1.5bn for COVID-19 costs above the original mandate. In addition, £1.5bn funding has been allocated for elective recovery, mental health and workforce development.

Embedding new ways of working is critical for the future delivery of care. During the pandemic, NHS and social care staff adopted innovative ways of working to make best use of their skills and experience to benefit patients. These workforce transformations must be embedded in the “new normal” to support recovery and longer-term changes:

- Providers should maximise the use of and potential benefits of e-rostering, giving staff better control and visibility of their working patterns, supporting service improvements and the most effective deployment of staff.
- Local systems are also encouraged to make use of interventions to facilitate flexibility and staff movement across systems, including remote working plans, technology enhanced learning and the option of staff digital passports.

The [Life Sciences vision](#), recently published, also focuses on the importance of building on the new ways of working triggered by COVID-19 to tackle future disease missions, and states that the UK was able to have a leading Life Sciences response to COVID-19 through combining a set of existing strengths with new ways of working:

- An at-risk mindset – accelerating and investing in projects with a clear understanding that the outcome was uncertain.
- Integration of procurement – R&D investments and risks were linked to procurement from the start, providing the incentive and structure for business to seriously engage, and included a concerted effort to ensure Small and Medium Enterprises (SMEs) could act as key partners.
- Clear and measurable objectives and metrics were set.
- Private sector engagement – Engagement was fundamental and underpinned by deep regulatory engagement, cooperation on infrastructure to support trials and manufacturing, and the appropriate sharing of risk.
- Clear accountability and leadership – with the senior sponsorship and industrial experience required to deliver, and all unnecessary bureaucracy removed to support delivery.
- Long term legacy planning was central from the start – it made investments more impactful and provided stability and certainty to companies when co-investing with Government.

The Categories

Under the overall theme of “NHS Reset and Recovery and New Ways of Working”, two categories have been identified *via* consultation with clinicians and other stakeholders working in provision of care across the spectrum.

Applicants are expected to respond to one of the following categories:

- 1) **Reducing the NHS workforce pressure**
- 2) **Increase NHS effectiveness**

Those submitting applications are also asked to consider:

- How will the proposed solution impact on the care system, and how will the system need to be changed (including people, processes and culture) in order to deliver system-wide benefits?
- How will you ensure that the innovation will be acceptable to patients (and their families and wider support network) and to health and social care workers? How could these groups be involved in the design of a solution and its development?
- How will you ensure that the innovation is affordable to the NHS and wider system, such as Integrated Care Systems (ICSs), both immediately and throughout the life of the product? What evidence, both health economics and delivery of true impact will the NHS and wider system require before the technology can be adopted?
- How will you ensure that the innovation enhances equity of access (e.g. takes account of underserved ethnic or economic groups) and helps the NHS towards it’s target to reach net zero carbon.

Category 1: Reducing the NHS workforce pressure

Background

The NHS workforce was already carrying over 90,000 vacancies prior to COVID-19, with a further 120,000 vacancies in social care ([NHS Reset: A new Direction for Health and Care](#)). Services are still delivered at reduced capacity. As the NHS rises to the challenge of restoring services, meeting the new care demands, and reducing the care backlogs that are a direct consequence of the pandemic, supporting staff recovery, their health and wellbeing, and improving workforce supply is key to ensure that the NHS can restore services in a sustainable way.

The COVID-19 pandemic has been a watershed moment for technology and digital transformation. Technology was an enabler in reducing the care burden, increasing speed and agility, better managing and coping with the effects of COVID-19, and identifying the approaches that should be sustained for the longer term in the ‘new normal’ ([Reflecting on the COVID-19 pandemic to inform the health and care system of the future](#)).

Challenges

Innovative solutions are sought to reconfigure patient pathways to release pressure on a stretched NHS workforce and include but are not limited to:

1. Diagnostic and screening tools which can be operated by non-medically trained staff and care workers away from hospital to assist with outpatient backlogs and capacity / demand mismatch and prevent unnecessary visits to the hospital.
2. Tools that enable care workers in care homes to perform an increased number of clinical assessments and collect information through integrated IT systems that can be a point to point connection involving care homes, GPs, secondary care and ambulances (and social care) to enable appropriate sharing of data and information.
3. Access to community diagnostic testing and/or remote consultations, for example
 - Through the development of mobile and/or community diagnostic hubs providing “one stop shop” diagnostics for patients presenting with long-term conditions (e.g., audiology services, diabetic patients, FIT testing, long-term respiratory disorders, shortness of breath, blood analysis, ultrasound, confusion, etc) and long-COVID.
 - Mobile diagnostic services that support pattern recognition, leveraging the power of artificial intelligence, to empower the more junior NHS workforce to accurately and safely perform a range of tests, and make faster clinical decisions.
4. Educational and training programmes, tools or technology that enhance learning through:
 - Remote and/or virtual training tools for temporary staff / agency worker / community workers to enable the safe delivery of services within robust governance frameworks, and provide the best support within a short timeframe.
 - Remote and/or virtual real-time orientation of the existing workforce (including nurses and resources deployed in the wider community) to enhance training in NHS settings which experience acute pressure.

Solutions should take into consideration the implementation of a set of online guidelines for clinical staff to ensure patients in all parts of the country had the same standard of up-to-date treatment. Governance in primary care and communities should also be considered and developed carefully.

Innovators should take into account:

- The redesign of healthcare delivery models, including the integration and specialisation of services.
- An approach for an agile, fluid and multidisciplinary workforce, affecting staffing, training, and leadership requirements.

Category 2: Increasing NHS effectiveness

Background

Patient safety is a central concern in restarting services, however, there is also a delicate balance to be managed between minimising immediate risks to patient safety during a pandemic and mitigating against the longer-term risks associated with delayed treatment. It is paramount to ensure support to patients to “wait well” and manage their condition as they wait for treatment. The impact of long waiting lists will be felt within primary care ([Building back elective care](#)) which will need to be supported to deliver a quality service.

Prolonged delays in accessing some types of elective care are expected to have a negative impact on patient outcomes. For example, increased numbers of people who experience sight loss and reduced cancer survival due to late diagnosis – prior to the pandemic, far more cancers were diagnosed following a routine referral than via screening. Longer waits for other types of care may not affect outcomes, but may leave people waiting longer in severe pain or discomfort – some of whom need treatment, such as hip or knee surgery, which will allow them to return to work or restore their independence ([Elective care in England](#)).

Challenges

Innovative solutions are sought to increase NHS effectiveness and include but are not limited to:

1. Risk stratifications tools to stratify and prioritise patients to ensure all patients can access care at the right time and at the right place.
2. Tools that enable the NHS to model and manage waiting lists in order to:
 - Identify and monitor low complexity, high volume patients that can be managed in the community before they enter the waiting list.
 - Manage patients on the waiting list in order to (i) ensure their symptoms do not escalate thus requiring interventions and (ii) prevent further attendance to primary care and community diagnostics
 - Ensure all pre-surgery tests/investigations are efficiently booked in and performed ahead of hospital visits.
3. Transform services through robotic process automation to reduce burden on NHS staff and on administrative tasks.
4. Develop integrated systems that allow a point-to-point connection of patients records everywhere at any time, and that can communicate the information in real time in various diverse settings. The systems need to enable access to all test results to prevent duplication of diagnostic efforts and enhance effectiveness of care.
5. Technologies that can be used in primary or community care settings to shift downstream the diagnostic, rule-in or rule-out of patients presenting with symptoms and avoid the use of expensive, time-consuming procedures in secondary care.

Useful Information for Applicants



Innovations on the radar

Given the importance and long term nature of this challenge, there are many products already in the market or in later development. It is important that potential applications for this competition carefully consider the competitive landscape.

It may even be appropriate to consider partnering with another solution provider to generate something even more compelling that addresses the challenge systematically.

The list below illustrates some examples of innovations that have been funded by National programmes with the potential for addressing emergency care issues (it is not intended to be an exhaustive):

[Skin Analytics](#) that provides AI-supported dermatology support the recognition of the most common malignant, pre-malignant, and benign skin lesions, including melanoma the Deep Ensemble for the Recognition of Malignancy (DERM).

[TympaHealth](#) has also developed the Tympa system that enables the delivery of a safe, and cost-effective, digital ear inspection, and is currently developing an algorithm screening tool using machine learning to identify anomalies in the ear which could be prioritised for review and early detection.

[Cytosponge](#) was also developed as a new innovative test to identify Barrett's oesophagus, a condition that can increase a person's risk of developing oesophageal (food pipe) cancer. Cytosponge is a soluble capsule that contains a small sponge attached to a thread. When the sponge is retrieved from the gastrointestinal tract, it collects small samples of cells that can then be sent to pathology for analysis. It's a simple test that can be done in a GP surgery or hospital setting outside of the traditional endoscopy suite and enables to prevent unnecessary visit to endoscopy.

Location-based technology is one of the simplest and most effective ways to ensure that hospital staff are not moving from one zone to another. To address this need, Navenio's infrastructure-free indoor location solution has accelerated the creation of crowdsourced maps through users' movements, automating feature extraction and the processing of floorplans, which will enable a 10-fold improvement in deployment speed. By way of example, Navenio's trained AI can ensure that a patient moves from a 'red' to a 'green' zone needs approval by an infection control specialist before being carried out. Therefore, patients could be rerouted to preserve a ward's integrity.

There have been [other initiatives](#), supported by NHS England and NHS Improvement funding to recover elective services:

- Lancashire and South Cumbria ICS is also using AI to prioritise and identify the right level of care and support needed for patients on the waiting list.
- Devon ICS is repurposing the Exeter Nightingale to perform diagnostic tests, and patients in the south west will also benefit from the extension of virtual wards so patients can receive medical support from home.

Technologies excluded from this competition

There are a number of technologies, or types of solution, which are already available, sometimes from multiple suppliers, these are listed below. Any technologies that negatively impact staff workloads will also be excluded.

- Early cancer detection and efficient diagnosis technologies and solutions are excluded as they are covered in the SBRI Healthcare Cancer Competition.
- Systems and solutions that do not consider full integration and end-to-end implementation for a chosen pathway.
- Technologies that may increase burden on the workforce, that are not fully inclusive and diverse and that may contribute to creating health inequalities (including digital exclusion or data inequalities).

Additional Considerations

- Given the rural nature of many places, an over-reliance on home and community interventions needing to be permanently online should be considered (Wi-Fi and phone signals in rural locations may be weak or unreliable).
- Innovators are asked to consider the cost of data use, which would negatively impact on accessibility by some low income or marginalised communities.
- For any digital intervention, the [NICE Digital Health Technology Framework](#) should be consulted and your application should evidence your plan to meet the appropriate evidence guidelines. This comprises both clinical effectiveness and economic evaluation.
- Evidence that the [NHSX Digital Technology Assessment Criteria](#) (DTAC) has been considered should be demonstrated in your proposal.

SBRI Healthcare Programme

The Small Business Research Initiative (SBRI) Healthcare competition is launched by NHS England and NHS Improvement in partnership with the Academic Health Science Networks (AHSNs) to identify innovative new products and services. The projects will be selected primarily on their potential value to the health service and social care system, and on the improved outcomes delivered for those in receipt of care.

The competition is open to single companies or organisations from the private, public and third sectors, including charities.

The Phase 3 competition runs in one phase only and is intended to facilitate the implementation of developed innovations. The contracts placed will be for a maximum of 9 months and up to £500,000 (inc. VAT) per project.

The implementation will be 100% funded and suppliers for each project will be selected by an open competition process and retain the intellectual property rights (IPR) generated from the project, with certain rights of use retained by the NHS.

The competition opens on **24 August 2021**. The deadline for applications is **1pm on 13 October 2021**.

Eligibility

The call is open to innovations in an advanced stage of development. The aim is to accelerate these innovations into relevant health or social settings, and to facilitate the collection of evidence in real-world settings required by commissioners and regulators to make purchasing or other recommendations/decisions.

The call is open to any innovation (e.g. medical device, in-vitro diagnostic, digital health and AI solutions and services) that meets the following requirements:

- CE mark or equivalent regulatory approval obtained for the proposed application (or evidence demonstrating the technology is close to obtaining approval) and/or Product in use in at least 1 Trust
- Clinical efficacy and safety demonstrated through clinical trial
- Clear partnership established with relevant service(s) / site(s) and relevant clinical team(s)
- For digital solutions, evidence that the technology has passed the necessary information governance and cyber security requirements

A NICE META tool evaluation is preferable, although not an entry requirement.

Desirable Exit points

The aim of the funding is to generate Real World evidence to support rapid local/regional roll out of the innovation. The funded project proposal are expected to demonstrate some of the following exit points upon project completion:

- Demonstration of implementation effectiveness
- Partnership developed for implementation in at least 1 NHS Trust
- Registration to HealthTech Connect / NHS Innovation Service
- Health economics analysis (and cost benefit analysis)
- Other relevant evidence to ensure local adoption following project completion, facilitating adoption further afield (for example budget impact model, care pathway impact model, scaling up plan and strategic plan towards adoption and spread)

Application process

This competition is part of the Small Business Research Initiative (SBRI) programme which aims to bring novel solutions to Government department issues by engaging with innovative companies that would not be reached in other ways:

- It enables Government departments and public sector agencies to procure new technologies faster and with managed risk;
- It provides vital funding for a critical stage of technology development and evidence gathering through demonstration and trial.

The SBRI scheme is particularly suited to small and medium-sized businesses, as the contracts are of relatively small value and operate on short timescales for Government departments.

It is an opportunity for new companies to engage a public sector customer pre-procurement. The intellectual property rights are retained by the company, with certain rights of use retained by the NHS and Department of Health and Social Care.

The application process is managed on behalf of NHS England and NHS Improvement by LGC Group, in partnership with the AHSNs. All applications should be made using the application portal which can be accessed through the [Research Management System](#). Applicants are invited to consult the Invitation to Tender and the Portal Guidance; a template Application Form and Frequent Asked Questions are also accessible. All documents are available on the [SBRI Healthcare website](#) to help prepare your proposal.

An online briefing event for businesses interested in finding out more about these competitions will be held on **24 August 2021**. Please check the [SBRI Healthcare website](#) for confirmation of dates for this and any further events, information on how to register and details of the challenges that will be presented at the event.

Please complete your application using the [online portal](#) and submit all relevant forms by **1pm on Wednesday 13 October 2021**.

Key dates

Competition launch	24 August 2021
Briefing events	24 August 2021
Deadline for applications	13 October 2021 (1:00pm)
Assessment	November 2021
Interview Panels	January 2022
Contracts awarded	February / March 2022

More information

For more information on this competition, visit: <https://sbrihealthcare.co.uk/>

For any enquiries e-mail: sbri@LGCGroup.com

For more information about the SBRI programme, visit:

<https://www.gov.uk/government/collections/sbri-the-small-business-research-initiative>

