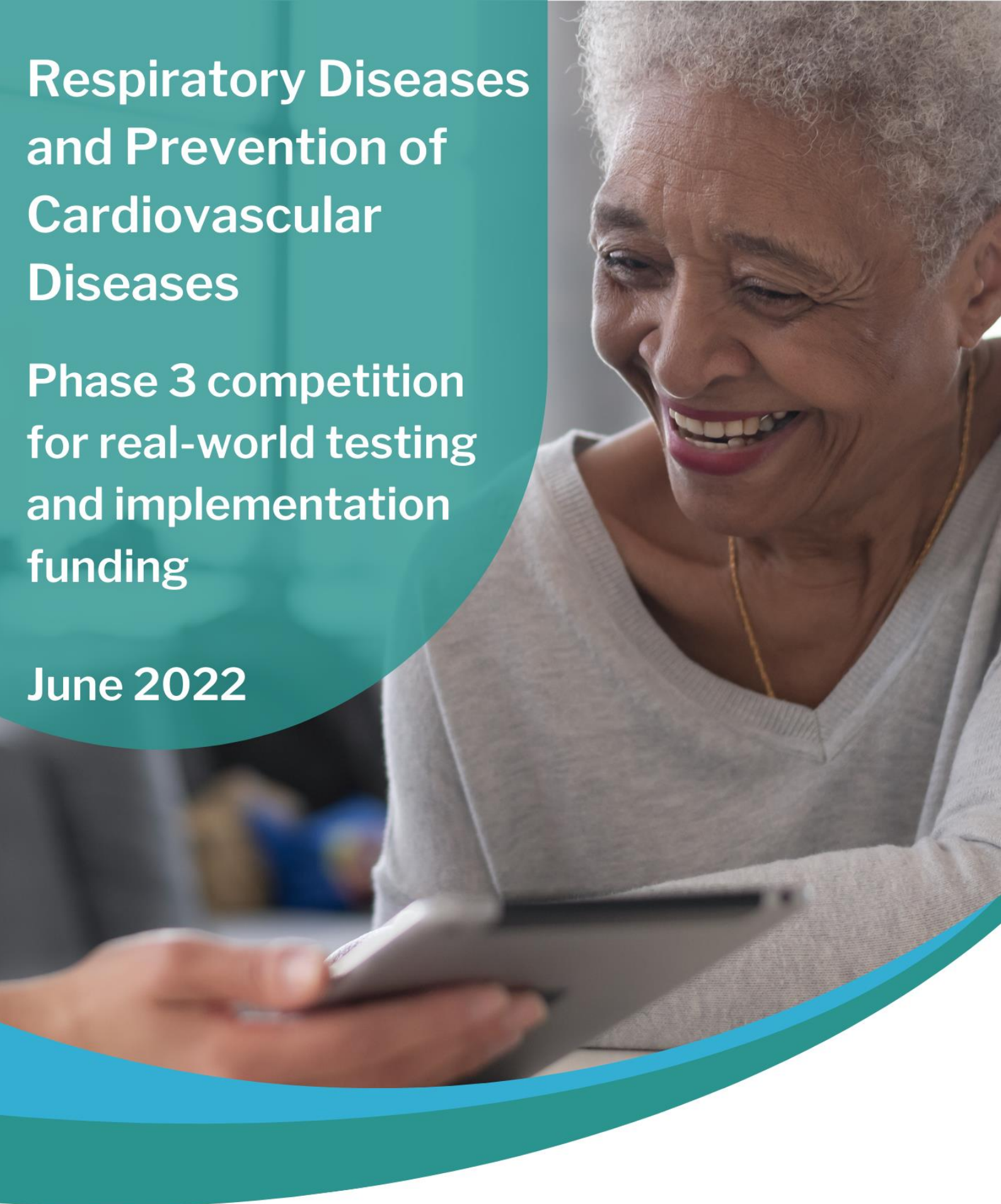


Respiratory Diseases and Prevention of Cardiovascular Diseases

Phase 3 competition
for real-world testing
and implementation
funding

June 2022



Contents

1 Executive Summary

2 SBRI: Phase 3 funding competition

- Themes and categories
- Accelerated Access Collaborative's ambitions
- Workforce pressure

3 Respiratory Diseases

- Background and Introduction
- Strategic priorities
- Categories

4 Prevention of Cardiovascular Diseases

- Background and Introduction
- Strategic priorities
- Categories

5 Useful Information for Applicants

- Eligibility
- Phase 3: Entry criteria
- Allowable costs and duration
- Desirable exit points
- Technologies excluded from this competition
- Additional considerations
- The SBRI Healthcare Programme
- Application process
- Key dates

Executive Summary

Evidence-based and cost-effective interventions often fail to be implemented into routine health and social care practices, a challenge which could be addressed by real-world validation of innovations in their intended setting by accelerating their uptake and facilitate adoption and spread.

The SBRI (Small Business Research Initiative) Healthcare Programme is committed to supporting the NHS in delivering the objectives of the NHS Long Term Plan (LTP), and the Phase 3 funding will support implementation studies that generate the evidence in real-world settings necessary to progress towards future uptake and provide potential adopting organisations with an understanding of the implementation pathway and assurance of benefit delivery.

In 2022/23, the SBRI Healthcare Phase 3 Programme seeks to address challenges in two key focus areas and aims to identify innovative solutions which can be adopted by the NHS:

1. Respiratory Diseases
2. Prevention of Cardiovascular Diseases

Applicants are asked to consider the impact of their innovation on the whole system and to be aware of the competitive environment, even considering working together with other companies and organisations to bring forward solutions that can make a real difference. Health inequality is a core component of this competition, and equity of access and experience should therefore be a central pillar of any successful innovation.

SBRI: Phase 3 funding competition

The SBRI Healthcare Phase 3 funding competition invites innovations at an advanced stage of development to accelerate their uptake into relevant health or social care settings. The aim of the call is to facilitate the collection of evidence in real-world settings and build on the value proposition required by commissioners and regulators to make purchasing or other recommendations and decisions.

There is no shortage of innovation in the NHS or the health sector more widely. However, innovation has not diffused as quickly, or had the impact seen in other industries, particularly in reshaping how clinical services are delivered. This is despite the NHS having natural advantages over many other health systems including universal coverage of a diverse population, national standards, and relatively rich healthcare data.

[Real-world validation](#) of an innovation can accelerate its uptake and bring benefits to both industry, and health and social care by facilitating the adoption and spread of innovation. This may be achieved by providing potential adopting organisations with an understanding of the implementation pathway and assurance of benefit delivery. Alongside this, real world validation can support industry to generate investment and enhance a product's sales story to enable growth and job creation.

The [Accelerated Access Collaborative](#) (AAC) funds the SBRI Healthcare Programme which brings together industry, government, regulators, patients and the NHS. It removes barriers and accelerates the introduction of ground-breaking innovations which will transform care. It supports the NHS to more quickly adopt clinically- and cost-effective innovations, to ensure patients get access to the best new treatments and technologies. Innovations include medicines, diagnostics, devices and digital products. It ensures that research and innovation meet the needs of the public, patients and the NHS.

Within the AAC is the Academic Health Science Networks' ([AHSNs](#)). [Their experience of adoption and spread](#) suggests the need of a collective process underpinned by knowledge exchange methods (both formal and tactic) across systems to build consensus and understanding about needs, viable solutions (or innovations) and their implementation. The spread of innovation is also about understanding local variation, as contextual factors are difficult to influence, given they are dynamic and driven by the interactions and relationships between the components of the system.

Although this makes it difficult to have a universal 'blueprint' for our work, the AAC has launched, with the support of the AHSNs who work closely with their local ICSs, initiatives such as the [MedTech Funding Mandate \(MTFM\)](#). The policy supports devices, diagnostics, or digital products to reach NHS patients more quickly and has three key objectives:

- Ensuring equity in healthcare provision is achieved by monitoring patient access to the supported technologies across the NHS in England.
- Directing the NHS to the medical technology innovations that are most effective and likely to give savings on investment.
- Supporting the NHS to develop a sustainable approach to overcoming the financial barriers to adopting medical devices, diagnostics, and digital products.

Themes and Categories

Under this Phase 3 Funding Competition, two themes have been identified via consultation with clinicians and other stakeholders working in healthcare provision.

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

- 1. Respiratory Diseases**
- 2. Prevention of Cardiovascular Diseases**

Proposals that support NHS England and NHS Improvement's ambitions in reducing health inequalities and carbon emissions, whilst alleviating the pressure on workforce, are particularly welcome if they meet the challenges described in the current document.

Accelerated Access Collaborative's ambitions

NHS England and NHS Improvement launched the [Core20PLUS5](#) initiative, in 2021, to reduce health inequalities at both the national and system level. The approach defines a target population cohort, the 'Core20' and identifies 5 focus clinical areas requiring accelerated improvement. The Core20 are the most deprived 20% of the national population as identified by the national index of multiple deprivation while PLUS are population groups experiencing poorer than average health access, experience or outcomes which are not captured in the Core20 alone.

The five clinical focus areas are outlined below:

- 1. Maternity:** ensuring continuity of care for 75% of women from Black, Asian and minority ethnic communities and from the most deprived groups.
- 2. Severe mental illness (SMI):** ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in learning disabilities).
- 3. Chronic respiratory disease:** a clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.
- 4. Early cancer diagnosis:** 75% of cases diagnosed at stage 1 or 2 by 2028.

5. Hypertension case-finding: to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

The NHS strategy also includes ambitions to become the world's first net zero national health service. The "[Delivering a Net Zero Health Service](#)" report sets out the ambition and two evidence-based targets, which include:

- To reduce direct emissions (NHS Carbon Footprint) and reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032.
- To reduce influenced emissions (NHS Carbon Footprint Plus) and reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

As outlined in the LTP, sustainability commitments range from reducing single-use plastics and water consumption, through to improving air quality. The Greener NHS National Programme was formed to drive this transformation, while delivering against broader environmental health priorities.

Workforce pressure

There is a drive in the LTP and in the UK Government's Life Sciences Vision to reduce pressure on NHS services, for instance, through driving improvements in care pathway management through technology.

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](#).

The [NHS People Plan](#) recognises that the NHS workforce has been under strenuous pressure since the response to COVID-19 began, and there will be further challenges ahead. Workload remains a pressing concern calling for new ways of working and delivering care.

Respiratory Diseases

Background and introduction

The term 'respiratory diseases' encompasses a wide range of conditions affecting the airways and lungs. Some are chronic conditions (e.g. asthma and chronic obstructive pulmonary disease [COPD]), others are associated with infections (e.g. pneumonia, tuberculosis), cancer (e.g. lung cancer, mesothelioma), or genetic predisposition (e.g. cystic fibrosis and primary cellular dyskinesia). It is estimated that [1 in 5 people](#) in the UK have been diagnosed with a respiratory disease. Patients are commonly diagnosed when a respiratory disease has progressed, leading to poor prognoses and patient outcomes. Asthma affects 8 million people in the UK, and [two-thirds of patients](#) are still not receiving optimal care to manage their condition. Information last updated by NICE in 2016 says an estimated [3 million people have COPD](#) in the UK, "of whom 2 million are undiagnosed". Improved diagnostic capacity, and early referrals into the most appropriate care pathway may ensure patients [get the right care at the right time](#).

The LTP reports that hospital admissions for lung disease have risen over the past seven years at [three times the rate](#) of all admissions generally. [Respiratory diseases](#) are a major factor in winter pressures faced by the NHS; and pneumonia continues to put pressure on the NHS, with community acquired infection a leading cause of hospital admission.

Each year in the UK there are [approximately 700,000 admissions](#) to hospital due to lung disease, leading to more than [6.1 million hospital bed days](#). COPD is the second largest cause of emergency hospital admission in the UK, with a third of people with a first admission for an exacerbation not yet diagnosed. Lung disease exerts a heavy economic pressure on society, and is estimated to cost the NHS in the region of [£11bn per year](#). [90% of NHS spend](#) on asthma goes on medicines, but incorrect use of medication can also contribute to poorer health outcomes and increased risk of exacerbations, or hospital admission.

Breathlessness is a very common symptom that is shared by cardiac and lung conditions, as well as psychological and mental health conditions, and is compounded by physical de-conditioning. [Pulmonary rehabilitation](#) offers a structured exercise and education programme designed for those with lung disease or breathlessness. 90% of patients who complete the programme experience improved exercise capacity or increased quality of life. However, it is currently only offered to [13% of eligible COPD patients](#). By expanding [pulmonary rehabilitation](#) services over 10 years, 500,000 exacerbations can be prevented, and 80,000 admissions avoided. Ensuring [appropriate referral pathways](#) for specialist programmes, such as pulmonary rehabilitation or smoking cessation services and equitable access to these remain. Long COVID syndrome showed the pivotal role of primary care providers as well as relevant specialist rehab professionals, social care workers, psychosocial workers, mental health professionals in providing appropriate care to patients, empowering them to take part in the management of their disease, improving adherence to treatment, and long-term outcomes.

Mortality considered preventable from respiratory disease in the under 75s (2017 to 2019) [was 2.9 times higher](#) in the most socioeconomically deprived areas in England compared to the least deprived. Respiratory disease is, therefore, a major contributor to the overall life expectancy gap between the rich and the poor, a gap that is widening. Other factors such as greater exposure to risk factors (such as smoking, air pollution, poor housing, and occupational hazards) as well as variation in healthcare quality and access, a growing geriatric population, and the Covid-19 pandemic are driving a continued demand for innovation. Specific groups are at significantly higher risk of respiratory illness, such as people with severe mental illness, people with learning disabilities, and the homeless.

Strategic Priorities

The [LTP identified respiratory disease](#) as a key clinical area, and includes the following priority areas around improving treatment and support for people with respiratory disease and do more to:

- Detect and diagnose respiratory problems earlier.
- Support those with respiratory disease to receive and use the right medication.
- Improve the response to pneumonia to relieve pressure on hospital admissions.
- Enable more people with heart and lung disease to complete a programme of education and exercise-based rehabilitation will result in improved exercise capacity and quality of life in up to 90% of patients.

[The Taskforce for Lung Health](#), is a collaboration of influential voices in UK lung health, has created a [five year plan](#) which overlaps and supports some of the ambitions outlined in the [LTP](#). The plan aims to prevent more people from developing lung disease and to transform the care of people living with lung disease.

The [Life Sciences Vision](#) describes ‘reducing the mortality and morbidity of respiratory disease, in the UK and globally’, as core to the vision. There is a real opportunity to advance the science in this area, and through that significantly reduce the number of attacks, hospitalizations and deaths over the next decade. Therefore, Government, Industry and NHS England will explore options to:

- Create more effective treatment options for asthma, particularly for children and young adults.
- Drive innovation in the understanding and treatment of COPD.
- Improve care pathways through improving diagnostic capacity and technology.

Categories

Category 1: Early Diagnosis

Innovative technologies, both for adults and paediatrics use, are sought to improve early diagnostic capacity and triage of high-risk patients to the most appropriate care pathway.

Potential solutions include (but are not limited to):


- Diagnostic tools that can be delivered in different point of care settings (e.g., pharmacies, GPs, community care) to identify early signs of respiratory conditions, thereby enabling early administration of treatments to delay or halt the onset of more serious disease.
- Tools to train and upskill primary and community care staff and/or allow specialists to review patients with primary care practitioners efficiently and without the need to travel to interpret results and accelerate referral.
- Innovations which more precisely diagnose the cause of breathlessness and triage to specific treatment pathways.
- Digital solutions for effective triage of high-risk patients to direct them to the most appropriate care pathway and/or for enhancing the quality of data collated from home testing.
- Molecular diagnostics to identify / detect respiratory infections to inform the correct use of treatment/antibiotics in a timely manner.
- Improved delivery/use of at-home spirometry tests and/or alternative technologies (e.g. sound and acoustics, sonar, breath analyses, etc.) that may not be reliant on an hardware interface and that can overcome the current limitations of potential inaccuracy and sustained forced exhalation.
- Innovations that allow detecting conditions other than lung cancer as part of lung health checks.

Category 2: Monitoring and management: accessing the right care at the right time

Innovative solutions are sought to ensure an integrated approach that reduce admissions, or re-admissions, and that provide access to personalised care, while empowering patients to be part of the decision making and management of their disease.

Potential solutions include (but are not limited to):

- Innovations that improve adherence, e.g., through devices that simultaneously measure both function and administered medicines, including educational tools, particularly children and young adults.
- Tools that enable acquisition of continuous real-world data e.g., through remote monitoring, that include the collection of associated psychological and



environmental factors, to predict and prevent exacerbations and assess the progress of disease in real time.

- Early access to rehabilitation programmes that allow professionals to remotely monitor and advise patients while they perform their exercises or take their medications to reduce social isolation and pressure for service delivery.
- Tools that take into consideration the management of behavioural aspects to breathlessness and address anxieties in respiratory dysfunctions.
- Innovations that improve rehabilitation adherence through gamification of treatment plans.
- Solutions that take into consideration the need of specific population groups such as those with learning disabilities, mental illnesses, or communication impediment and those hard to reach.
- Development of “hospital at home” solutions specific to the broad range of respiratory patients and their needs.

Prevention of Cardiovascular Diseases

Background and introduction

There are 7.6 million people living with CVD in the UK, and this is a leading cause of premature disability, mortality, health inequalities, and is responsible for one in four deaths each year ([British Heart Foundation UK Factsheet](#)). The [UKHSA estimated](#) the annual healthcare costs in England relating to CVD are around £7.4 billion, with an annual cost of the wider economy of £15.8 billion.

There are several risk factors that increase the likelihood of CVD, which can be modifiable or non-modifiable. Based on [recent research](#), approximately 70% of CVD cases and deaths can be attributed to a relatively small number of modifiable risk factors, such as tobacco use, alcohol, diet, diabetes, and education. Similarly, the [Global Disease Burden study](#) highlights that metabolic factors such as high blood pressure, high cholesterol, and high blood sugar are the predominant causes of preventable CVD.

However, certain risk factors are not modifiable. In addition to age and the male gender, familial hypercholesterolaemia (FH), and people of South Asian or African Caribbean origin are associated with an increased risk of CVD ([NICE](#)).

Strategic Priorities

The [LTP](#) recognises CVD as the single most significant area in which the NHS can save lives, and has an ambition to prevent 150,000 strokes and heart attacks over the next ten years. The prevention priorities are:

- Early detection and treatment of atrial fibrillation, high blood pressure, and high cholesterol as the leading preventable causes of CVD.
- Improve the effectiveness of primary and community care health checks to provide rapid treatment for those with high-risk conditions.
- Timely preventative treatments for high-risk individuals.
- Improved access and uptake of cardiac rehabilitation to improve long term recovery and reduce the risk and impact of another cardiac event.

Those from low-income communities across the UK are disproportionately affected by CVD. People living in the most deprived areas are almost four times more likely to die prematurely from CVD compared with the most affluent ([Office for Health Improvement & Disparities](#)). Thus, hypertension and case-finding were flagged as a key clinical area to be addressed through NHS England and NHS Improvement's Core20PLUS5 initiative.

The [Life Sciences Vision](#) also identified the need for early detection of those at risk of developing severe CVD in primary and community care in order to provide timely interventions. In particular, it was suggested that technology combinations could be supported for a national rollout if the efficacy to address the health needs is demonstrated and maintained.

Categories

All CVD including, but not limited to, heart diseases, vascular dementia, stroke, and peripheral artery disease are considered for this competition. Applications are invited to address one of the categories below.

Category 1 - Early detection of high-risk individuals

Innovative solutions are sought to promote early detection of high-risk individuals who would benefit from early interventions, including pre-symptomatic individuals and those that are likely to develop additional conditions.

Potential solutions include (but are not limited to):

- Use of digital solutions on primary, secondary care, or genomic data to identify those that are particularly at risk of developing CVD and associated conditions.
- Tests that can predict those at risk of developing CVD in asymptomatic individuals in the short or long term, especially those that can be deployed in GP surgeries, community pharmacies, or care homes.
- Improved identification of those who would benefit from existing tests, e.g., BNP and atrial fibrillation, to predict the onset of CVD.
- Addressing workforce and/or equipment pressure associated with early detection of CVD (e.g., portable ECG in primary care, reduce duplication of tests, etc).
- Joined up database to share patient information, facilitating referrals across primary, secondary, and tertiary care, and allowing patients to access and add to their personal health records.
- Early deterioration detection of patients with known CVD in the community to prevent secondary care attendance.

Category 2 - Improving prevention strategies

Preventative therapies could be more effective if targeted, provided at a certain point prior to the onset of symptoms, or made more accessible or engaging.

Potential solutions include (but are not limited to):

- Use of digital solutions (e.g., explainable AI) to recommend personalised interventions to assist healthcare professionals.
- Use of genomics data to tailor the appropriate CVD prevention therapy and dosage for patients.
- Improving the uptake and long-term adherence to preventative interventions, including preventative medications and cardiac rehabilitation.

Category 3 - Patient empowerment and self-management

Access to information, patient activation, support for behavioural modifications and pathways that encourage uptake of testing and interventions that can assist with early prediction/detection of risk and presentation of symptoms.

Potential solutions include (but are not limited to):

- Innovations that can support tailored and evidence-based lifestyle changes, using defined parameters (e.g., age, sex, ethnicity, physiological parameters, etc), to reduce the risk of developing of CVD.
- Systems to alert people when one or a combination of longitudinal, clinically accepted physiological parameters are outside of the reference range.
- Tools to empower and encourage individuals to report relevant symptoms (e.g., breathlessness, leg swelling, fatigue, xanthelasma, etc), and attend screening and review appointments.
- Targeted engagement, activation and for high-risk individuals or communities (e.g., low income, isolated, busy lifestyle, etc) to encourage lifestyle changes, self-monitoring (e.g., self-measurement wearables for blood pressure and cholesterol), screening attendance, and reporting early signs of CVD.

Useful Information for Applicants

Eligibility

The competition is open to any innovation (e.g., medical device, in-vitro diagnostic, digital health solutions and AI solutions, behavioural interventions, and service improvements) that meets the entry criteria and the challenges described below.

Single organisations (contracts are executed with individual legal entities) based in the UK or EU from the private, public and third sectors, including companies (large corporates and small and medium enterprises), charities, universities, and NHS Foundation Trusts, given a strong commercial strategy is provided, are eligible to apply. Organisations based outside the UK or EU with innovations in remit for this call can apply as subcontractors of a lead UK/EU based organisation or via a UK or EU subsidiary.

Collaborations are encouraged in the form of subcontracted services as appropriate.

Phase 3: Entry criteria

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

To be eligible for the SBRI Healthcare Phase 3 Funding Competition, proposed technologies must meet the following:

- UKCA marked or CE-marked with a clear timeline to achieve UKCA mark by 01 January 2023. If regulatory approval is not obtained, evidence should be provided to demonstrate that the technology is close to obtaining approval and/or in use in at least one NHS Hospital Trust.
- Clinical efficacy and safety demonstrated through an appropriate and relevant clinical evaluation.
- For digital solutions, evidence that the technology has passed or close to passing the necessary information governance and cyber security requirements where relevant. Evidence that the NHS England and NHS Improvement [Digital Technology Assessment Criteria \(DTAC\)](#) has been considered should be demonstrated in your proposal.
- Clear implementation partnerships established with relevant service(s) / partner clinical site(s) and relevant clinical team(s).

Allowable costs and duration

The project will be 100% funded up to the value of £500,000 (NET costs, excl. VAT) for a maximum of 12 months.

Project costs can include:

- Labour
- Materials
- Capital equipment
- Subcontractors
- Travel & subsistence
- Indirect costs

Please ensure the proposed project deliverables could be reasonably achieved within the proposed contract duration, and all requested costs are justified and represent fair market value.

Please note that SBRI is a pre-commercial procurement process, and the resulting contract is subject to VAT. VAT is the responsibility of the invoicing business.

Desirable exit points

The aim of the funding is to generate real-world evidence to support rapid local or regional roll out of the innovation. Awarded proposals are expected to demonstrate some of the following exit points upon project completion:

- Implementation effectiveness demonstrated
- Partnership developed for implementation in multiple sites
- Registration to [HealthTech Connect](#) / NHS Innovation Service
- Evidence of health and financial impact: health economics analysis (i.e., cost benefit analysis, budget impact model)
- NHS Business case
- Demonstrated impact (clinical/transformation/clinical pathway)
- Climate sustainability assessment
- Equality and Health Inequalities impact assessment
- Other relevant evidence to ensure local adoption following project completion, facilitating adoption further afield (e.g. scaling-up plan and strategic plan towards adoption and spread, marketing tools development).

Technologies excluded from this competition

All proposals should also be aware that the following will also be excluded:

- Basic research and innovations in the creation phase.
- Systems and solutions that will not easily integrate or communicate with NHS/community setting systems. Some evidence of interoperability and/or work to assess this will be required.
- Technologies that do not comply with GDPR policies.
- Technologies that may increase burden on the workforce.
- Technologies that will increase health inequalities (including digital exclusion or data inequalities) and inequity of access to care e.g., digital technologies that are inaccessible to certain communities that experience digital poverty.
- Innovations that are not co-designed with patients and end users.

With reference to the individual challenges, the following technologies will be considered out of remit:

Respiratory Disease

- Innovations focussed on lung cancer, particularly on early diagnosis.
- Apps that provide general wellbeing and lifestyle change recommendations without clinical evidence to support their benefits.
- Wearables or monitoring apps (e.g. measuring physiological signs using combined technologies) that do not have a clinicians' interface and input.

Prevention of Cardiovascular Disease

- Apps that provide general wellbeing and lifestyle change recommendations without clinical evidence to support their benefits.
- Apps that provide cardiac rehab training without clear considerations into user engagement or long-term adherence.

Additional Considerations

Those submitting applications are also asked to consider:

- 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).
- 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. Please consult the NHS England and NHS Improvement guidelines for “Designing and building products and services” for the latest links to relevant standards, guidelines, and consultations.

- Evidence that the [Digital Technology Assessment Criteria](#) (DTAC) has been considered should be demonstrated in your proposal.
- How will the proposed solution impact 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 services are re-designed to consider the needs and accessibility of vulnerable or hard-to-reach groups?
- How will you support the NHS in reaching its net zero targets by reducing carbon emissions and consider the impact of innovation on the care pathway?
- 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.
- Furthermore, consideration should be taken towards the scalability of the technology and the necessary adaptations for different service user groups.

SBRI Healthcare Programme

The SBRI Healthcare Funding Competition is launched by the AAC 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 Phase 3 Funding 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 12 months and up to £500,000 (**NET**) 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 **14 June 2022**. The deadline for applications is **13:00 BST on 26 July 2022**.

SBRI application process

This competition is part of the 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 the AAC 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 **20 June 2022**. 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 **13:00 BST on 26 July 2022**.

Key dates

Competition launch	14 June 2022
Briefing event	20 June 2022
Deadline for applications	26 July 2022 (13:00 BST)
Interview Panels	October 2022
Contracts awarded	December 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>



ACCELERATED
ACCESS
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TheAHSNNetwork

