ABHI Response to 10 Year Health Plan
December 2024

Q1. What does your organisation want to see included in the 10-Year Health Plan and why?

The Plan should make specific reference to how best utilise technology to deliver the three shifts. HealthTech offers enormous potential to help the NHS in its journey, but the NHS is still regarded as being poor at the adoption and spread of technology. A clear mandate to actively pull technology into the system, including the policy ideas listed in this response would be enormously helpful in allowing staff the freedom they need to make better use of technology, both new and existing.

Q2. What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

Funding -funding flows need to be designed to encourage providers to deliver care in new settings, with incentives to encourage the switch. During the pandemic, the NHS worked hard to deliver a very high proportion of its Outpatient appointments virtual. Subsequently targets to maintain levels have fallen away and should be reintroduced.

For example, remote monitoring in cardiovascular disease also addresses many of the priorities in Lord Darzi's report and all the three NHS shifts. It has benefits in overcoming inequality of access, by ensuring those in remote locations or with limited mobility can still be treated, and reducing the environmental impact of the healthcare delivery, through lessening the emissions produced when visiting a hospital.

The roll out of Virtual Wards has demonstrated what might be possible, but to overcome the concerns of clinicians over safety, more sophisticated technology needs to be invested in. Currently the default option is to keep patients in hospital to carry out very basic observations. Technology enabled step down facilities could ease the pressure on hospitals, facilitating earlier discharge.

Hospitals do offer economies of scale, allowing, for example, staff to cover absences more easily that might be possible in community settings. Hospitals should be incentivised to deploy their own staff into community settings to improve capability and capacity in that setting

Q3. What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

Barries to the adoption of technology are very well rehearsed, ranging from lack of funding, lack of time to for staff to spend on introducing new technology, "not invented here" syndrome, and the need for one part of the system to invest when the benefit is realised elsewhere with no financial links between the two.

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Transformational technologies are the only ones that are seen as being valuable. This leads to the continued use of older versions of technologies and improved outcomes being withheld from the system and patients.

CDEL rules are preventing investment in HealthTech capital solutions even when there is money available.

Procurement in the NHS is overly focussed on acquisition cost rather than value. As a result technologies that demonstrably improve prevention, earlier intervention, productivity and efficiencies are lost to the NHS. Initiatives such as NICE's Late Stage Assessment programme have reinforced the belief that the overwhelming priority of the NHS is procurement based almost exclusively on achieving the lowest possible price

Funding for R&D is significantly higher than funding for adoption and spread and is protected. This leads to slow and sometimes even reversed access to innovation.

Innovation is considered to be everyone's job, and in doing so, it becomes nobody's job. This means that resource and support is not available to deliver changes that lead to improved outcomes. Innovation roles are also among the first to be cut when financial pressures bite.

Real world evidence (RWE) is often overlooked in favour of randomised clinical trial (RCT) evidence. This leads to a reliance on controlled clinical trial data at the detriment of analysis of good RWE.

HealthTech products are highly regulated, and post-Brexit the potential to develop a sovereign regulatory system to support growth offers a once in a generation opportunity to position the UK as a global leader in HealthTech. However, the UK's regulatory environment currently acts as a barrier. Regulatory uncertainty, alongside increasing costs and lengthy timelines, has had a detrimental impact on investment into the UK. As our 2024 industry survey indicates, over half of companies are now delaying bringing innovation as a consequence.

Delivering a framework of the recognition of approvals from other, trusted jurisdictions is the clear enabling priority for the sector, with four times as many indicating it as 'likely to considerably improve attractiveness' as compared to any other initiative. However, at the time of writing, the MHRA is currently consulting on this and its proposals are a matter of serious concern for the industry. The first is a recognition model, allowing CE-marked devices from the EU to enter the GB market without additional reviews. This is the situation that has existed since Brexit and will continue indefinitely for the majority of other sectors where goods have required a CE Mark. However, this is proposed to be limited to 2028/2030, after which (apart from low-risk devices) the model would cease.

A second pathway, a reliance model, leverages approvals from trusted regulators, such as the EU and USA, but requires additional GB-specific conformity checks carried out by third-party Approved Bodies. These proposals introduce several challenges. Key concerns include the high costs and extended timescales associated with the reliance model, as the requirement for conformity assessments by Approved Bodies could make it prohibitively expensive, particularly for complex and higher-risk devices. Experience in the EU suggests that these assessments can take an average of 18 months, significantly increasing costs and delaying

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market access. As a result, such processes may discourage manufacturers from prioritising the GB market, potentially affecting the availability of HealthTech for patients.

In addition to these costs, the proposed MHRA registration fees are estimated to total £16.5 million annually across the industry, with further compliance costs potentially adding up to £30 million per year industry-wide. These financial pressures could impact business sustainability and risk limiting NHS access to innovative and established HealthTech solutions.

Q4. What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

Key to enabling this shift, will be coordinated and holistic strategy for diagnostics. We offer some suggestions in our response to Q5.

Q5. Please use this box to share specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivered in, for example:

• **Quick to do, that is in the next year or so**
• **In the middle, that is in the next 2 to 5 years**
• **Long term change, that will take more than 5 years**

'Quick to do'

1. Given the diverse nature of the sector and some of the peculiar barriers to the adoption of innovation, ABHI recommends appointing a HealthTech Champion who would be able to address challenges and policy anomalies that, on the one hand seek to improve the uptake of technology, but on the other make the NHS an unattractive customer for its suppliers. The individual should be supported by government officials and feed into the cross-government health and growth missions. A suitably experienced individual, and one with a good appreciation of the machinery of government, could do much to join up policy and help the NHS make better use of technology.

2. Professionalise the adoption of innovation through a range of initiatives, including;

   > Ensuring there is a framework for the adoption of innovation by the NHS in partnership with the HealthTech Sector.

   > Protect time for innovation within clinical timetables while enabling joint posts to allow NHS clinicians to work in industry.

   > Appoint Board level Chief Innovation Officers in all NHS organisations and provide the resource and mechanisms to ensure innovation is managed and measured, in part through the CQC Well-led framework.

   > Centralising activities for a once only "passport" approach to allow technologies utilised in one part of the NHS to be rapidly adopted elsewhere.

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> Bring NHS savings targets in line with wider HMG productivity initiatives i.e. moving from a one-year time horizon to five years.

> Amend Innovation Adoption Initiatives to encourage innovations that improve NHS productivity as well as focussing on discrete clinical areas.

'In the Middle'

1. Leverage NHS data to drive innovation, improve patient outcomes, and boost economic growth. Establishing a national resource through a network of federated Subnational Secure Data Environments (SNSDEs) would enable HealthTech researchers and companies to access vital healthcare data securely and ethically, fostering advancements in HealthTech solutions. The network should integrate NHS data systems across different departments, regions, and care providers to create a seamless, unified, multi-modal data landscape.

2. There are a series of measures Government can use to improve the regulatory environment for HealthTech and allow NHS better access to technology. They include:

   > Accepting certain non-UK approvals of HealthTech products including the US and EU.

   > Developing a process for handling innovations, such as that outlined in the MHRA's Software as a Medical Device (SaMD) Roadmap, and determining the merits of the Innovative Devices Access Pathway (IDAP).

   > Shifting the focus of UK regulatory resource towards post-market surveillance to support innovation.

   > Developing innovative approaches to regulation, such as Outcomes Based Cooperative Regulation (OBCR).

3. **Cardiovascular Disease**

CVD affects roughly seven million people in the UK and is a significant cause of disability and death, with 175,000 deaths from heart and circulatory diseases in the UK each year. Proportionate support both for and from the health system is necessary. Yet, as outlined in Lord Darzi's Report, the outcomes for cardiovascular conditions in the UK are going in the wrong direction – the mortality rate for people under the age of 75 began to increase during the COVID-19 crisis, and rapid access to treatment has deteriorated.

ABHI is calling for a National Cardiovascular Strategy, as recommended in the ABHI Cardiovascular Health Check Report Within this strategy, particular focus should be placed on highlighting the inequality of access and care for cardiovascular disease, an increased emphasis on early diagnosis, and increasing the use of remote monitoring. This strategy would also support the asks in the British Heart Foundation's 'Hearts Need More' campaign.

In a joint British Cardiovascular Societies consensus document, it is noted that whilst cardiovascular disease is still the leading cause of death for women globally, they are underdiagnosed, undertreated and under-represented in clinical trials. A report from the British

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Heart Foundation found that, in England, those living in the most deprived areas have the highest prevalence of smoking, physical inactivity and obesity, a lower likelihood of starting cardiac rehab, lower hospital admission rates for cardiovascular elective care but higher rates for emergency care, all of which lead to poorer health outcomes. It is further reported by the Kings Fund that rates of cardiovascular disease are higher among Black and South Asian groups than white groups, but despite this there is still under-representation of ethnic minority patients in trials. Inequalities in cardiovascular disease are multifaceted and as such need to be addressed urgently.

The longer a patient waits to be treated, the higher their risk is of becoming disabled or dying prematurely. Early diagnosis should be prioritised to ensure patients can have the best possible outcomes. For example, as outlined in the report Break free from CVD, a solution would be to proactively detect heart valve disease in community pharmacies. In addition, raising awareness can increase detection rates. For example, The FAST campaign, pioneered by The Stroke Association and NHS England, was transformative in its awareness raising for the general public to recognise the most common signs of a stroke, saving many lives. Similar support from the government should be given to the SLOW campaign (Shortness of breath, Lightheadedness on exertion, Older than your years, or Weary). Heart valve disease is a serious yet treatable condition, affecting more than 1.5 million people in the UK alone. Despite this, awareness of the symptoms in the general public is incredibly low.

4. Diabetes

Diabetes is a pressing health challenge, impacting an ever-increasing number of people and significant socio-economic impacts. By 2030, diabetes is projected to cost the UK's National Health Service (NHS) over £16 billion annually. However, through national leadership and policy co-ordination, the benefits of HealthTech can help to shift the focus of activity towards prevention, early intervention, and innovative care models. In doing so, the UK can not only improve health outcomes but also position itself as a world leader in diabetes management.

The UK has an opportunity to lead the global fight against diabetes by utilising more technology, redesigning care services, and promoting a unified national approach.

ABHI recommends that the UK Government should continue the focus by NHS England in creating a National Diabetes Strategy joining up prevention initiatives, technology-based diabetes management, and research into curative treatments. This strategy should include specific targets for reducing the incidence of diabetes, improving care outcomes, and ensuring equitable access to treatment and technology. By focusing on prevention and the use of technologies that mitigate these risks, the UK can dramatically reduce the financial burden on healthcare systems and society more widely.

5. Diagnostics

The centrality of diagnostics to the NHS' ability to deliver patient services is beyond doubt - NHS England delivers approximately 26 million diagnostic tests at a cost of £6billion each year with diagnostics playing a key part of more than 85 per cent of clinical pathways. Patients view diagnostics as a fundamental part of the NHS and the need for investment to modernise services and boost access is universal in their feedback. To maximise the value diagnostics

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offer and enable the three health shifts, the speed at which they are integrated and embedded into clinical pathways must be addressed.

Early diagnosis offers the opportunity to treat diseases successfully rather than be detected at a late stage when treatment options are limited. No one test can achieve this, and workforce shortages, outdated processes, and inefficiencies are impacting the delivery of an integrated approach to how diseases are prevented, diagnosed, and treatment progression monitored.

The UK does not fund diagnostic technologies on comparable levels to other advanced economies. It is well below the OECD average for the number of CT, MRI and PET scanners available in hospitals. Industry analysis highlights that a third of endoscopy equipment is over 7 years old and that the UK, as compared to EU15 nations, sits at the bottom, on a per capita basis, of the in-vitro diagnostic market.

The Times Health Commission noted that the NHS typically invests 1.5% of its budget in technology and data, as compared to 4 to 5 per cent in the US and 8 to 10 per cent by organisations undergoing major technology-based transformations. Further, the Commission highlighted that Trusts could achieve a return of £3 – £4 for every £1 of investment in technology.

The gains in capacity provided by Community Diagnostics Centres (CDCs) are welcome but many are not fulfilling their original purpose of providing community-based services.

Innovate UK Contracts for Innovation (formerly known as the Small Business Research Initiative or SBRI) offers a mechanism to solve complex challenges by running competitive funding opportunities, to develop and adopt new solutions and technologies. They provide an opportunity to sustain economic growth.

The UK has a strong global advantage in genomics research and clinical application of genetic testing. The preventative health agenda requires a level of insight on disease development and progression which genomics is uniquely positioned to offer. Understanding the genetic drivers of disease and key risk factors allows for early behavioural actions and targeted medical interventions. We have outlined the opportunities in our paper.

ABHI makes the following recommendations to make the best use of diagnostic technologies.

> Each Integrated Care System should develop a comprehensive diagnostics strategy to integrate services from separate diagnostic modalities and complement national effort. A foundation of this must be standardisation of protocols, workflows and systems as a critical first step in ensuring that diagnostic technologies can be effectively scaled across healthcare systems.

> Funding of diagnostic technologies needs to rise and should be focused on a modernising imperative to ensure the latest generation of equipment, software, digital and data tools future-proof the delivery diagnostic services, streamline activity and improve efficiency.

> Health systems that lead the way as technology pioneers, should be supported to develop as "centres of excellence" for trials and rollouts of advances in AI and digital-

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based diagnostic technologies. This provides for organisations to not only showcase to peers the potential of technology transformation but also attract industry investment in research and development.

> To reduce pressures on hospital and GP services, the next phase of the CDC programme must have more ambitious targets for i. increasing the number of centres based truly in the community, ii. providing a greater range of tests, iii. Partnering with private providers to build new facilities and provide capital investment.

> CDCs which are "ready now" should move to procure innovative diagnostic tests which not only enable the provision of more elective diagnostic activity but also help to triage, assess and treat patients to ease pressures on other health services, such as A&E and general practice

> A coordinated and cohesive series of Innovate UK Contracts for Innovation should be scoped and executed to:
>   o Utilise the Pharmacy First programme and/or the PCN scheme to build more evidence to support scale-up of point-of-care testing based in these primary care facilities.
>   o Model the wider health, societal and economic costs of antimicrobial resistance so that an updated baseline is published from which AMR advancement initiatives can be benchmarked. Far too often, the use of diagnostic tests in infectious disease pathways is rejected on the grounds of not meeting cost-effectiveness due to the narrow comparison with the prescribing of relatively inexpensive antimicrobials. This is at the expense of the wider health and societal determinants of antimicrobial stewardship.

> Expand and simplify patient eligibility via the National Genomic Test Directory to ensure equitable and appropriate access to genetic testing and to aim in mainstreaming more genomic testing and to cover a broader range of diseases beyond cancer and rare genetic diseases.

> Develop and monitor key performance indicators on equity of access to genomic testing, and linkages between data holdings to allow for research on the impact of genomics including healthcare resource utilisation and patient outcomes (e.g., for whole genome sequencing).

> Incorporate genomics education into training curricula and provide ongoing professional development for current clinicians.

> Develop patient-facing tools that explain the significance of genetic testing in plain English, enabling individuals to make informed choices about their health.

> Invest in digital health platforms to provide personalised risk assessments and lifestyle recommendations based on a combination of genetic profiles, healthcare records, and up to date wearables data, fostering a culture of prevention.

> Develop a framework for industry collaboration to allow for the Genomics Education Programme to strengthen its impact, and co-develop materials with industry partners.

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> Fund translational research that bridges the gap between genomic discoveries and clinical applications, with a focus on preventive therapies.

> Support the development of advanced technologies such as polygenic risk scoring, and multi-omics research to provide a more comprehensive understanding of disease risk and development.

> Support pharmacogenomic trials across primary and secondary care settings to establish how best to integrate Pharmacogenomics into routine healthcare.

> Support the development of decision support tools to provide real-time genomic insights at the point of prescribing.

> Increase workforce education to support the application of pharmacogenomic data in clinical decision-making.

> Support and expand rollout of the Generation Study to benefit more families and make data available for further research.

> Integrate genomic data into electronic health records, ensuring insights are available throughout a patient's life.

6. Digital Health

Digital Health presents substantial untapped opportunities for healthcare improvement. Collaboration between the NHS, industry, and government help to prevent complications and reduce hospital admissions.

As such, ABHI recommends a national programme for the development and deployment of Digital Health, a proposal of which can be found here. The programme should involve several key elements. Enhancing digital infrastructure is essential, and includes investing in high-speed connectivity, robust health data platforms, and secure cloud computing systems. These investments will enable better access, sharing, and analysis of health data across the NHS, supporting the development of innovative digital tools and services. Secondly, maximising the value of NHS data is equally crucial. By improving data integration, governance, and access through initiatives like the Secure Data Environment (SDE) network, the NHS can leverage its vast data resources for research and development, driving innovation in areas like AI and predictive analytics.

The programme should also emphasise workforce development, focusing on training healthcare professionals in digital skills and creating new specialist roles to support digital transformation. Additionally, policy support is critical to streamline regulatory processes and incentivise the adoption of Digital Health innovations within the NHS. Cybersecurity measures will be required to safeguard patient data and maintain operational stability, particularly as the use of connected HealthTech expands.

7. Orthopaedics

Orthopaedics is an area that has seen significant increases in waiting times in recent years. Demographic pressures mean that the burden is only set to increase, and accordingly things must be done differently to ensure effective care can be delivered within the resources available. Joint working between industry and the NHS can help address the elective backlog and ease the pressure on the NHS workforce.

ABHI recommends further investment in specialist orthopaedic centres and surgical hubs to engage with industry in joint working to harness the benefits of innovative medical devices. Industry solutions for pathway management, preoperative planning, robotics assisted surgery, operating theatre efficiencies and regenerative medicine approaches for joint healing offer huge benefits to patients and clinicians Joint working with industry can ensure the benefits of these innovations are utilised right across the NHS.

8. Robotic-assisted surgery (RAS)

RAS has made significant advances in the UK since its introduction in the late 1990s. Despite the global uptake, including over 1.8 million procedures in 2022, RAS adoption in the UK has been inconsistent. Whilst over 100 UK hospitals have integrated RAS systems, its implementation often depends on local availability rather than patient need, in part due to high acquisition costs and a lack of a unified national strategy, unlike in Wales and Scotland. This inconsistent adoption limits the full potential of RAS, which offers notable benefits like reduced recovery time, minimised physical strain on surgeons, and increased access to minimally invasive procedures.

The potential of RAS is substantial. It has shown significant growth, particularly in urology, colorectal, and gynaecological surgeries. The technology underpinning RAS integrates advanced robotics, AI-driven decision-making, high-definition imaging, sensors for real-time feedback, and augmented reality for enhanced surgical precision. These technologies require strong R&D capabilities, robust clinical support, and extensive workforce training to be effectively implemented.

To maximise the benefits of RAS across the UK, ABHI recommends a national programme focusing on four core areas: real-world evidence, equitable access, education and training, and sustainable financing. More detail on the proposed programme can be found here. Collecting standardised real-world evidence is crucial to validating the clinical and economic value of RAS, facilitating its broader integration into NHS services. These data will help identify areas of high demand and guide system deployment to optimise capacity. Ensuring equitable access to RAS is essential; access should not be influenced by geography, socioeconomic status, or gender. National incentives and benchmarks can help standardise access and support the utilisation of surgical hubs, particularly in high-demand specialties like orthopaedics.

Education and training are critical for successful RAS implementation. A standardised curriculum for surgical staff at all levels, including non-surgical support roles, is recommended to build a skilled workforce capable of handling the complexities of RAS. Additionally, patient pathways must be adapted to accommodate RAS, enhancing efficiency and reducing hospital stays.

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Sustainable financing is needed to overcome the costs associated with RAS. Flexible funding models, including value-based procurement and central financing, can support strategic investments in RAS technology, allowing healthcare providers to realise long-term benefits. Continued collaboration between the NHS and industry partners is essential to provide the necessary training, technical support, and infrastructure for effective RAS deployment.

9. Stroke

As noted by the Stroke Association, stroke is a leading cause of disability and the fourth biggest killer in the UK. It is forecasted that over the next 10 years the number of stroke survivors will increase by 60%, potentially adding a cost to the NHS of £75 billion. Whilst there are technologies that provide cost effective diagnosis and treatment for stroke, speed of access remains unequal across the UK. It is critical that patients get seen imminently to prevent life-altering changes.

Evidence shows that to maximise patient outcomes following an ischemic stroke, accessing thrombectomy services quickly is essential. However, point-of-care diagnosis, timely referral, and access to 24/7 specialist stroke centres providing such treatment remains a challenge across the UK. Only 3.3% of patients receive this routine treatment, leaving the UK lagging lag behind many other countries, with treatment rates varying hugely between London and regions like the East and North East. As outlined in the Lord Darzi report, there is vast disparity in the number of patients with a suspected stroke who have the necessary imaging within an hour of being in hospital, with some hospitals being as low as 40%.

ABHI recommends the increased roll out of 24-hour, 7 day-a-week specialist stroke centers, inclusive of thrombectomy capabilities, across the UK to ensure patients have the treatments to ensure the best possible outcomes. To support the centres, a programme of skills and training will need to be provided to ensure relevant resources are available to deliver, including initial education to increase understanding of all staff involved in stroke treatment, and critical resources such as additional angio suites.

10. Vascular Disease

Chronic limb-threatening ischaemia (CLTI) and the associated high rates of lower limb amputation place a significant burden on the UK health and care system, 3,068 of 11,426 procedures in the UK in 2021 were primary major lower limb amputations. In addition, currently 1 in 500 people in the UK live with a leg ulcer placing a significant burden on NHS services and over 120,000 patients are waiting to access care for their venous disease. The estimated associated healthcare costs of venous Wound Care are £3.1 billion per year.

Evidence from a recent study demonstrates that enhancing limb-salvage strategies can lead to substantial economic benefits for the NHS, with potential annual savings exceeding €9 million if amputation rates are reduced from 10% to 3%. However, the national leadership of vascular conditions remains unclear within NHSE. A National Clinical Director for Vascular, akin to that seen for heart disease and others, could oversee this initiative and others including solutions for Vascular wounds, and enable the establishment of protocols for early identification and referral of patients at risk, which is critical for resource allocation and effective intervention.

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ABHI recommends that a National Clinical Director for Vascular could lead a transformation programme that prioritises collaboration with the full ecosystem including the relevant clinical societies, clinical registries and industry partners to significantly enhance the effectiveness of vascular care. By leveraging innovations in technology and treatment methodologies, such a strategy can facilitate the adoption of evidence-based practices that promote limb salvage over amputation.

11. Wound Care

Wound Care in the UK also represents a significant healthcare burden, driven by factors such as an aging population, rising rates of diabetes, and obesity. This area of care ranks among the highest expenditures for the NHS, with estimated annual costs nearing £10 billion, 80% of which is incurred in community-based care. The bulk of these expenses are linked to the time and labour of healthcare professionals rather than the cost of Wound Care products, highlighting the need for a systemic overhaul. The sector faces additional challenges due to a shortage in the workforce, particularly among district nurses and specialist tissue viability roles. Despite recent increases in the number of community nurses, the UK remains one of the lowest-ranked countries in the OECD for non-hospital-based nursing staff, limiting the effectiveness of Wound Care management and contributing to unwarranted variations in care quality.

ABHI recommends a comprehensive national approach to enhance the Wound Care sector's role in improving healthcare efficiency and supporting economic growth, and we have developed a proposal of what this should entail. It focuses on five key areas.

Firstly, it recommends the establishment of collaborative research hubs that integrate expertise from NHS clinicians, industry leaders, and academic institutions. These hubs would drive the development of innovative Wound Care products, including advanced dressings and integrated monitoring sensors, while utilising clinical data insights to refine product designs and support evidence-based practices. Digital Health solutions form another cornerstone of the approach, emphasising the need for smart Wound Care devices that facilitate remote monitoring and patient self-management. Such technologies aim to reduce hospital admissions by allowing patients to be monitored at home, with integration into NHS frameworks through structured clinical trials ensuring adaptability and high standards of care. Policy support is another crucial aspect, advocating for clearer accountability within NHS leadership for Wound Care delivery and streamlined approval processes for new products. We propose adopting a value-based reimbursement model to enhance patient access to advanced Wound Care technologies and to encourage further investment from the industry. Workforce training and education are central to the plan's success, with a focus on expanding the roles of district nurses and specialist healthcare professionals in alignment with the NHS Workforce Plan. This would include cross-sector training programmes utilising AI and VR-enhanced tools to improve wound assessment capabilities. Finally, the strategy emphasises the importance of robust monitoring and evaluation frameworks. It proposes the establishment of performance benchmarks and long-term studies to assess the outcomes of Wound Care innovations, leveraging real-world data gathered collaboratively by NHS, academia, and industry partners.

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