



SBRI Healthcare Programme

An NHS England funded initiative delivered by
the Eastern Academic Health Science
Network

www.sbrihealthcare.co.uk
[@sbrihealthcare](https://twitter.com/sbrihealthcare)



Agenda

25th June, London

- 10.30** Welcome from Chair - David Parry, CEO, South East Health Technologies Alliance (SEHTA)
- 10.45** Clinical Presentations - Dr Adrian Hopper, Geriatric Physician and Professor Mike Hurley focusing on:
- Introducing the Older People with Multiple Morbidities challenge
 - Functional Difficulties
 - Falls
 - Faecal and Urinary Incontinence
- 11.20** Clinical Q&A
- 11.45** Overview of the SBRI Healthcare Programme – Cynthia Ugochukwu, SBRI Healthcare lead, Innovate UK and Karen Livingstone, National Director, SBRI Healthcare
- 12.00** The application & assessment process – Nick Offer, SBRI Healthcare Project Manager, Health Enterprise East
- 12.10** Q&A session (All speakers)
- 12.30** Lunch and networking (until 14.00)





SBRI Healthcare Briefing Seminar: Older people with multiple morbidities

Thursday 25 June

Outline

- Clinical Context of Older People with Multiple Morbidities
- Competition Briefs
 - Addressing functional needs in the elderly
 - Minimising the impact of falling
 - Faecal and urinary incontinence in frail elderly people
 - Q & A

Older people with multiple morbidities

- Multiple morbidities - suffering two or more chronic conditions
- Affects patients all ages but prevalence increases markedly with age
- Poor patient outcomes/experience and significant drain on system resources
- Frailty: Key challenge that has been shown often to overlap with multi-morbidity

Challenges

- AHSNs have engaged with their networks to identify key clinical challenges

Frailty

- Reduction in physiological reserve
- Multiple systems are close to or past the threshold of clinical failure

So that

- Minor external stresses lead to increased disability or death

Clinical Frailty Scale*



1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.



2 Well – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.



3 Managing Well – People whose **medical problems are well controlled**, but are **not regularly active** beyond routine walking.



4 Vulnerable – While **not dependent** on others for daily help, often **symptoms limit activities**. A common complaint is being “slowed up”, and/or being tired during the day.



5 Mildly Frail – These people often have **more evident slowing**, and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.



6 Moderately Frail – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.



7 Severely Frail – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).



8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.



9. Terminally Ill - Approaching the end of life. This category applies to people with a **life expectancy <6 months**, who are **not otherwise evidently frail**.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.

2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

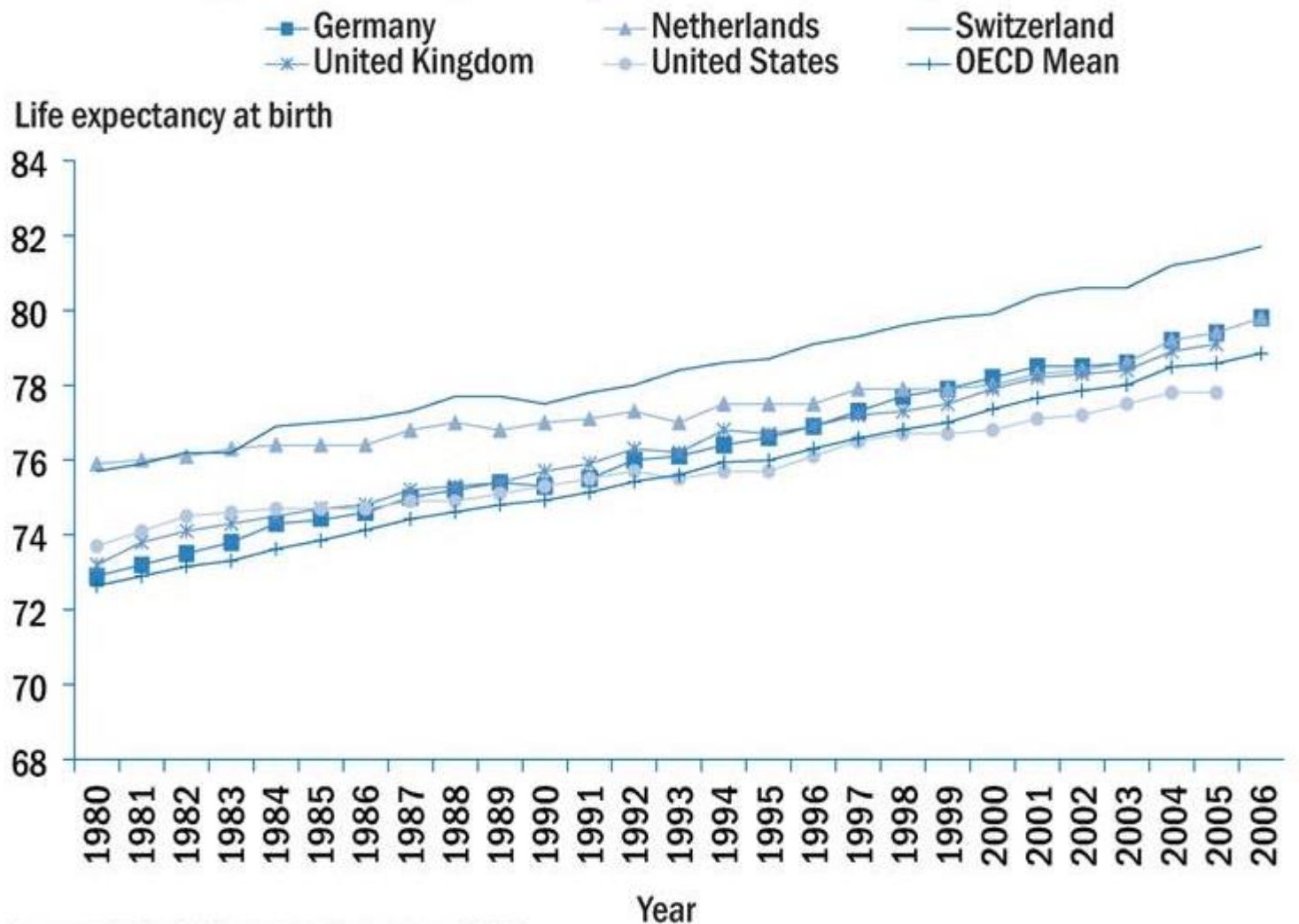
© 2007-2009. Version 1.2. All rights reserved. Geriatric Medicine Research, Dalhousie University, Halifax, Canada. Permission granted to copy for research and educational purposes only.



Common Clinical Scenarios in Frailty

- Immobility
- Instability (falls)
- Incontinence
- Intellectual frailty (dementia/delirium)

Figure 6. Life Expectancy at Birth over Time, 1980-2006



Source: OECD 2008 Health Data (June 2008).

Publication: R. E. Leu, F. F. H. Rutten, W. Brouwer et al., The Swiss and Dutch Health Insurance Systems: Universal Coverage and Regulated Competitive Insurance Markets, The Commonwealth Fund, January 2009





Addressing functional needs in the elderly

Prof. Mike Hurley

UK demographics of the ageing population

Age Group	2012	2032	% change
0-14	11.2m	12.2m	9↑
15-59	38m	38.8m	2↑
60-74	9.4m	12.3m	31↑
75+	5m	8.5m	70↑

Source: ONS: National Population Projections 2012-based Statistical Bulletin¹

There are now **more** people in the UK aged **60 and above** than there are **under 18**²

Nearly **one in five** people currently in the UK will live to see their **100th birthday**³

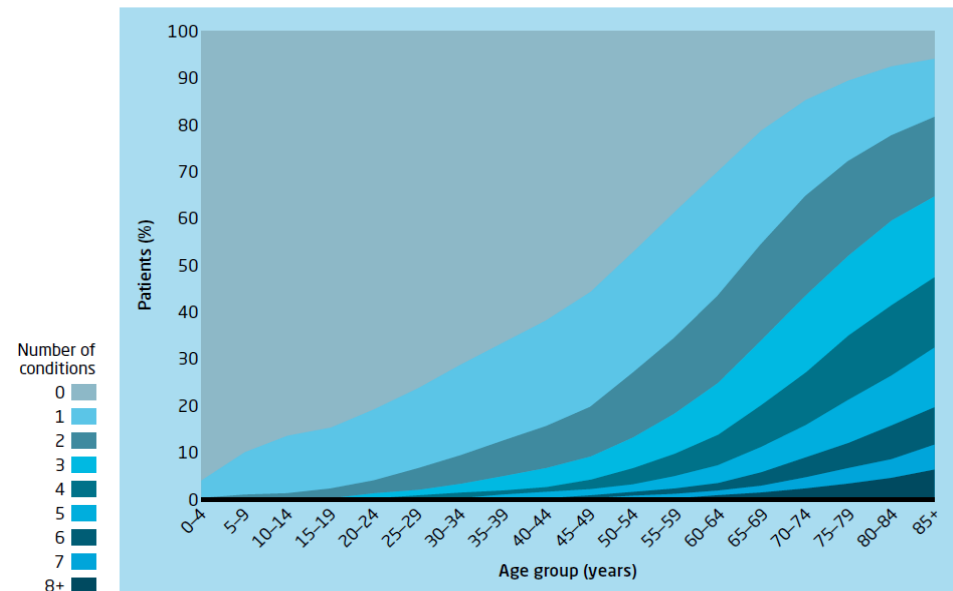
The ageing population and long term conditions (LTCs)

Increasing age associated with LTCs - diabetes, CVD, respiratory, MSK, depression, dementia

Many more people living many years with physical and psychosocial impairment, disability and dependency

- Over **15 million** people in UK have one or more LTC
- Rule of thumb: **One LTC per decade lived**
- Due to the ageing population, number of people with LTC will **increase 23%** over the next 25 yrs

Morbidity (number of chronic conditions) by age group



Source: Barnett *et al* 2012
Reprinted from *The Lancet*, vol 380, pp 37-43

The burden of LTCs

LTCs account for;

- **50%** GP appointments
- **64%** outpatient appointments
- **70%** inpatient bed days
- **75%** of total health & social care budget (£7.50 of every £10 spent)

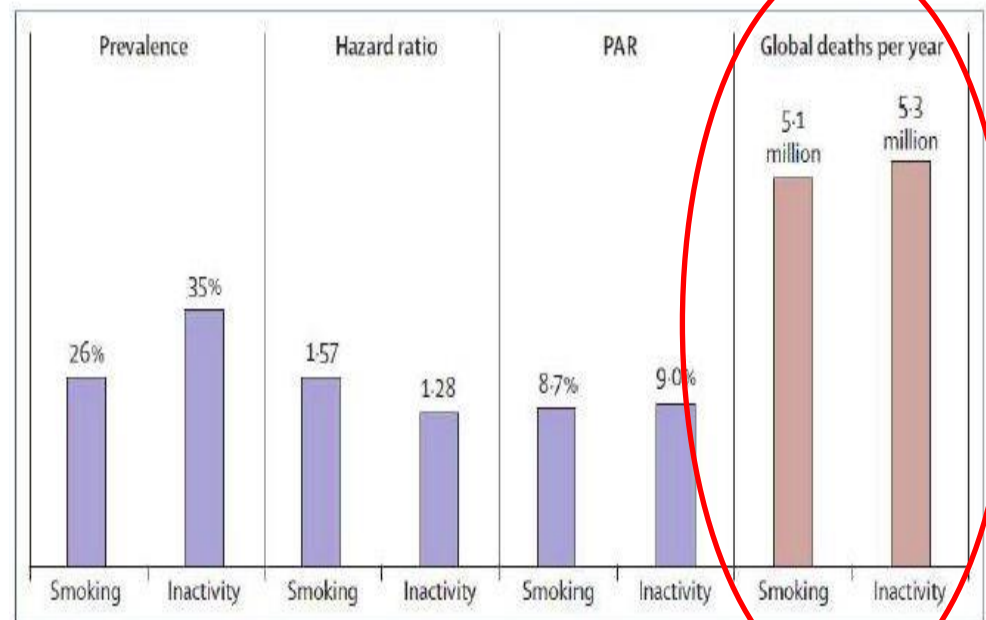
Problem of physical inactivity

**Inactivity =
ill-health, disability and
mortality**

Inactivity - “independent risk factor” for disability – causes disability in the absence of chronic pathology.

UK, direct and indirect costs of inactivity estimated at >£8billion/yr (excludes £7billion/yr related to obesity strongly linked to reduced activity).

Global burden of physical inactivity



Benefits of physical activity

Activity = health, ability, life

Even moderate physical activity

- ameliorate the risks and effects of inactivity, on multimorbidity
- equivalent to 10-20 years “rejuvenation”
- increase longevity

Live longer

- 30% **reduction** in all cause **mortality** (most compared to least active)

Live better – reduce ill-health and disability

- 20-35% **lower** risk of **cardiovascular** disease, stroke, CHD
- 30-40% **lower** risk of **metabolic syndrome** – high blood pressure, abdominal obesity, low HDL/high LDL cholesterol, type 2 diabetes
- 30% **lower** risk of colon **Ca**, 20% lower risk of breast Ca
- 36-68% **lower** risk of **hip fractures** for highly active people
- Better **mental health** - 20-60% reduction risk of depression, dementia, increased self-esteem, confidence,
- self-determination, independence

Its never too late.

Even in elderly people increasing level of physical activity increases the likelihood of living longer and staying functionally independent.

Effecting behavioural change

- *Knowledge* – why, what, how
- *Form intention*
- *Motivational interviewing* - explore people's motivations, aspirations and expectations about the consequences of engaging in a behaviour
- *Action plans*
- *Coping plans*
- *Self-efficacy*

Addressing functional needs in the elderly

Challenge 1: Detecting frailty and monitoring deterioration

The need: For those involved in research and clinical care of frailty to have simple, valid, accurate and reliable methods to detect frailty

What if we could easily monitor frailty and the deterioration of frailty?

What if GPs could remotely monitor whether or not patients were coping (e.g. through wearables)?

What if data could be available to all stakeholders?

What if we could detect changes in daily living patterns e.g. routines, outings, hygiene, hydration etc?

What if we could detect indicators such as respiratory rate?

What if information on current state of frailty could be available to e.g. carers, emergency staff etc?

Addressing functional needs in the elderly

Challenge 2: Activities of daily living

Activities of daily living include:

- Dressing above and below the waist
- Grooming
- Bathing/showering
- Light housework
- Preparing meals

Difficulties performing activities of daily living may be exacerbated and, equally, exacerbate conditions, triggering the need for additional and escalating levels of care.

EG. the decline in ability to cope with daily activities is associated with increased frailty, a diminished quality of life, increased service utilisation and higher healthcare costs

Addressing functional needs in the elderly

Challenge 2: Activities of daily living

What if there were technologies available to assist frail, elderly, multi-morbid patients cope with activities of daily living?

What if there were technologies to remind and assist people with essential activities?

What if there technologies to help people remain independent within their home environment?

What if there were technologies to enable people to maintain a healthy fluid balance?

What if there were technologies to ensure good nutrition?

What if there were technologies to help people remain mobile?

What if there were technologies to assist with personal care?

Addressing functional needs in the elderly

Challenge 3: Treatment burden

- Individuals suffering from a collection of chronic illnesses are more likely to be receiving concurrent medications→polypharmacy
- Polypharmacy, means patients experience consequent difficulties with treatment adherence further impacting the successful management of conditions
- The associated lifestyle changes required to both understand and manage multiple conditions puts a burden on the patient and can exacerbate physical and psychological difficulties and increasing use of healthcare services

The need:

- Technologies and solutions that can assist patients with the burden of treatment, including:
 - Adhering to disease management plans and lifestyle changes
 - Drug concordance, adherence and compliance

Addressing functional needs in the elderly

Challenge 3: Treatment burden

What if there were technologies to help frail, elderly multi-morbid patients manage their conditions?

What if there were technologies to help relieve the burden of managing multiple conditions in the elderly?

What if there were technologies to improve treatment compliance and adherence in the multi-morbid elderly?

What if there were technologies to help frail patients understand how best to manage their particular combination of conditions?

What if there were technologies designed inclusively to assist in the delivery of a medication or treatment?



Minimising the impact of falling

Dr. Adrian Hopper

Minimising the impact of falling

Financial costs

- Falls are estimated to cost the NHS £2.3billion each year.
- 1 in 3 people over 65 fall each year, rising to 1 in 2 for adults over 80.
- Injuries caused by falls are common in older people particularly fractures in those with osteoporosis
- Recurrent falls are associated with increased mortality, increased hospitalisation and higher rates of long-term care.

Minimising the impact of falling

Falls:

Causes are multifactorial

- May be setting specific and linked to acute illness
- Older people are particularly vulnerable due to:
 - Frailty causing problems with strength, balance and mobility
 - Delirium/Dementia
 - Cardiovascular issues – hypotension/syncope
 - Visual impairment,
 - Poly-pharmacy
- Interventions to prevent falling can have significant positive impact.
- Most falls are unreported
- This is a population challenge

Minimising the impact of falling

Physical consequences:

- Bone fractures, head injuries, soft tissue injuries or tears to the skin (lacerations) and often require hospital treatment.
- Hip fractures are the most serious fall-related injury in older people
- Around 15% of people suffering hip fractures die in hospital and a third do not survive beyond one year

Minimising the impact of falling

Current approach : secondary prevention (reduce falls by 30%)

- Fall prevention services provide multifactorial risk assessment and diagnosis for patients who have fallen
- Early gait disturbance recognised by simple walking test
- Strength & balance training – but only if sustained adherence
- Optimising environment for safety
- Vision assessments
- Medicines review
- Diagnosis of syncope, hypotension, vertigo
- Bone health (FRAX – <https://www.shef.ac.uk/FRAX>)

Minimising the impact of falling

The challenge:

What if we could better minimise harm from falls?

What if we were better able to prevent people from falling?

What if we had a way of preventing injuries from falls?

What if recovery from falling could be faster?

What if fear of falling could be overcome?

What if we could accurately predict risk of falling?

What if we could target interventions?

What if we could reduce the likelihood of falling?

What if we had better ways of detecting osteoporosis?

What if fractures could heal quicker?

What if other injuries could heal quicker?

What if confidence and independence could be improved?



Faecal and urinary incontinence in frail elderly people

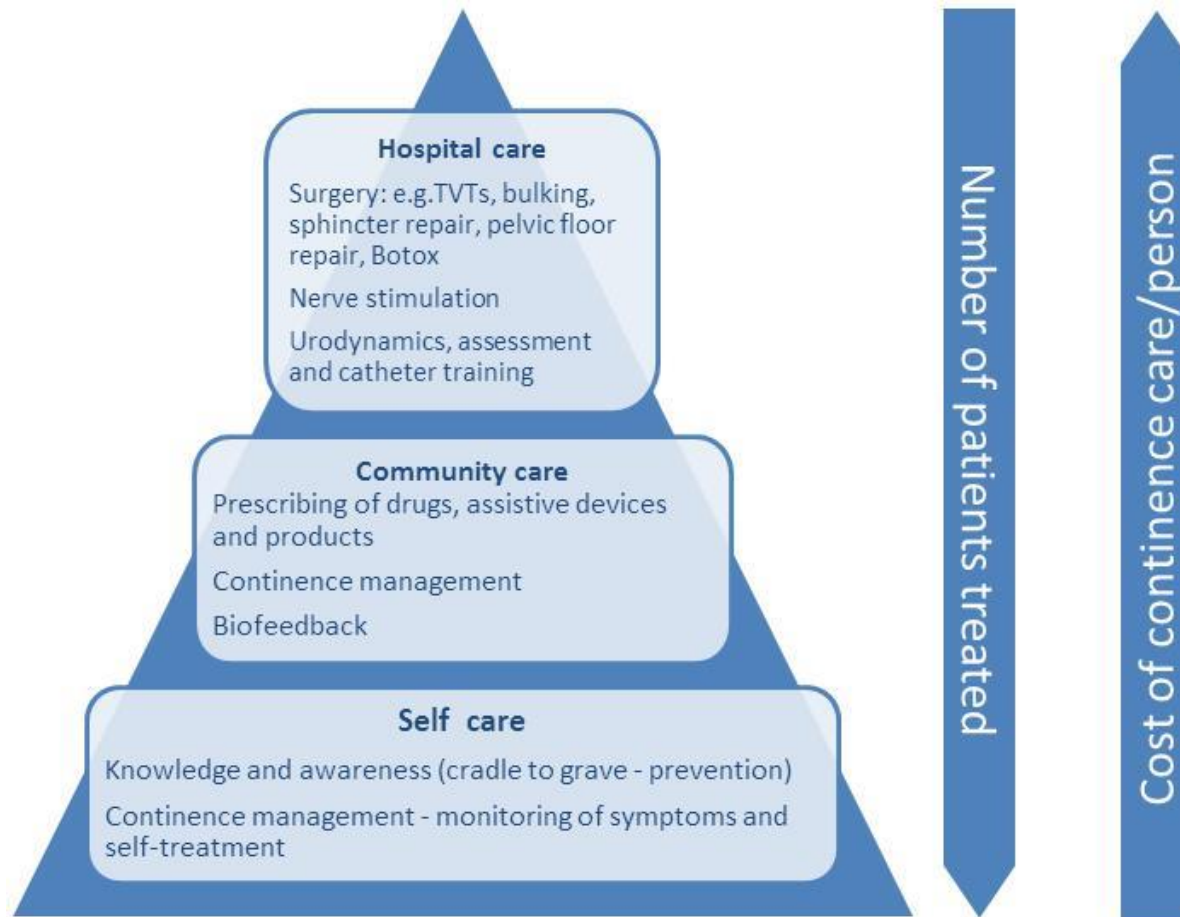
Dr. Adrian Hopper

Faecal & Urinary Incontinence in Frail, Elderly People

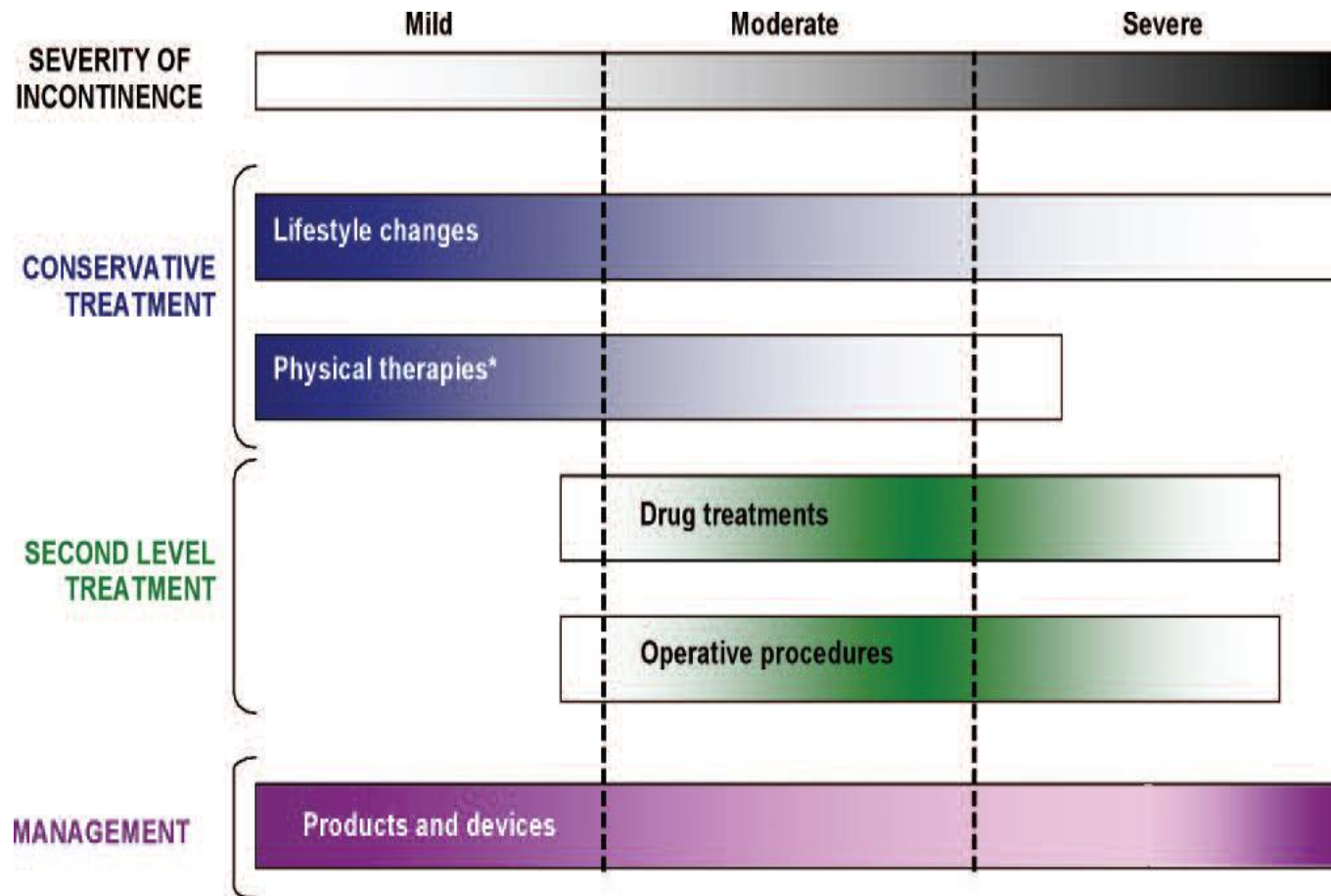
Clinical Context

- A set of symptoms not a disease and there is often an underlying cause that can be treated
- In some cases early treatment can prevent incontinence later in life or reduce symptoms
- Very common, and more common in older people, but need not be a consequence of ageing
- At least 1 in 3 older people in nursing homes have incontinence
- Often present with other conditions, especially in the elderly
- Treatments for other co-morbidities can result in incontinence
- Many older people have cognitive impairment
- Continence management is what we offer frail elderly people – usually pads or indwelling catheters
- Balance between independence and care by others

Faecal & Urinary Incontinence in Frail, Elderly People



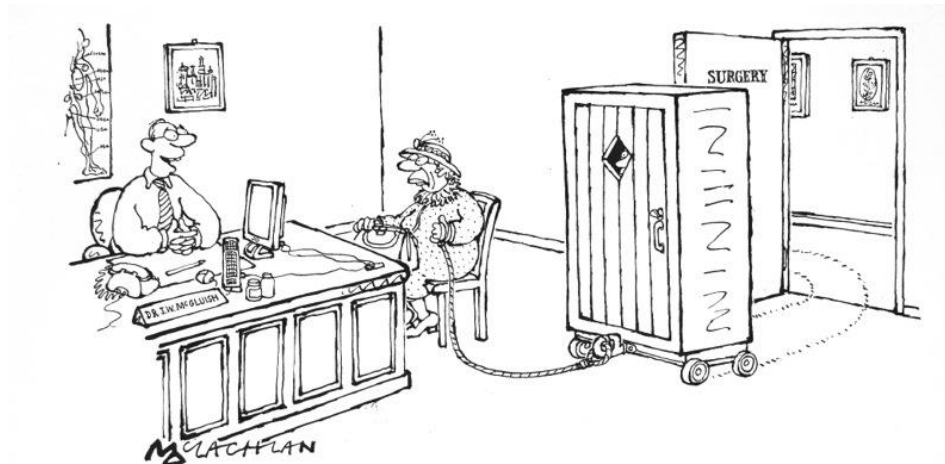
Faecal & Urinary Incontinence in Frail, Elderly People



Faecal & Urinary Incontinence in Frail, Elderly People

Aims:

- Give older people a sense of dignity and control and enhance quality of life
- To reduce incontinence in our elderly population



"And of course, your husband's uncontrollable incontinence must make life very difficult for you, Mrs Bixby."

Faecal and urinary incontinence in frail elderly people

Challenge 1: Prevention

What if we could break down the taboo surrounding incontinence by informing and educating people of all ages into the causes and how to prevent incontinence?

What if we can identify and monitor individuals who are at risk from incontinence?

Would identification and long-term monitoring of women at risk of incontinence after childbirth reduce complications later in life?

Would self-monitoring tools empower individuals to prevent pelvic floor decline?

Can we demystify and remove the stigma associated with incontinence and its treatments?

What if we had integrated, patient-centred systems that addressed pelvic floor function and health in the context of an individual's life-span?

What if technology could help individuals of all ages and abilities be motivated to undertake pelvic floor exercises on a frequent basis?

Faecal and urinary incontinence in frail elderly people

Challenge 2: Diagnosis

What if we could accurately diagnose and treat all individuals with faecal or urinary incontinence?

What if we had non-invasive, low cost, point of care diagnostics that could be used by non-clinicians in residential care homes or individuals in their own homes?

What if diagnostic accuracy could be improved leading to more appropriate treatment outcomes?

What if we could diagnose those individuals who are most at risk of complications of continence treatment or management, such as urinary tract infection?

What if devices can be incorporated into continence management products for more accurate monitoring of incontinence and associated problems, e.g. infection or hydration

Faecal and urinary incontinence in frail elderly people

Challenge 3: Treatment

What if we could have cost-effective, reliable, long-lasting, easy to use, minimally invasive, biocompatible and safe treatments suitable for older people?

What if we had an effective non-surgical solution to stress UI symptoms, which is more effective than pelvic floor exercises, and more widely usable than surgery?

What if the physiological function of the sphincter muscle could be restored?

What if patients own cells could be used to restore sphincter

What if degenerating sphincter muscle could be re-conditioned or regenerated?

What if we had a non- or minimally-invasive treatments that could be delivered in outpatient or residential care

What if we had an implantable device that would function for extended periods without further intervention?

Could electrical stimulation for continence symptoms be made more comfortable, reliable, cheaper and easy to use?

Can the effect of Onabotulinum toxin A treatment be more predictable?

Could more 'sensitive' surgical instruments reduce risk of incontinence post radical prostatectomy?

Could improved methods of stoma formation improve surgical outcomes?

Faecal and urinary incontinence in frail elderly people

Challenge 4: Management

What if we can offer personalised continence management that offers patient dignity and minimises the effects of social stigma?

What if absorbent products included built-in smart sensors?

What if we had an intermittent catheter that does not need lubrication and can be reused?

Can indwelling catheters be designed to resist or repel urease-producing bacteria?

What if we had a genuinely leak-free, comfortable, easy to use and aesthetically acceptable urinal for women who may be confined to a wheelchair or a bed?

What if we had urine collection bags that are discreet, safe and aesthetically acceptable?

What if we had fashionable clothing designed to make using continence aids discreet and functional?

Would accurate early patient detection of urine infection reduce need for antibiotic treatment?

What if we had novel continence management aids for symptom relief that offered patients complete confidence?

How can we improve bladder training and use of continence devices for vulnerable individuals and those with cognitive impairment?

Introducing the SBRI Programme

Cynthia Ugochukwu

SBRI Healthcare lead

Innovate UK



SBRI is a pan-government, structured process enabling the Public Sector to engage with innovative suppliers:

- ✓ Helping the Public Sector address challenges
 - Using innovation to achieve a step change
- ✓ Accelerating technology commercialisation
 - Providing a route to market
- ✓ Support and the development of Innovative companies
 - Providing a lead customer/R&D partner
 - Providing funding and credibility for fund raising



SBRI Key features

- ✓ 100% funded R&D
- ✓ Operate under procurement rules rather than state aid rules
- ✓ UK implementation of EU Pre-Commercial Procurement
- ✓ Deliverable based rather than hours worked or costs incurred
- Contract with Prime Supplier
 - ✓ Who may choose to sub contract but remains accountable
- IP rests with Supplier
 - ✓ Certain usage rights with Public Sector – Companies encouraged to exploit IP
- Light touch Reporting & payments quarterly & up front



Things to Note

- Any size of business is eligible
- Other organisations are eligible as long as the route to market is demonstrated
- All contract values quoted **INCLUDE** VAT
- Applications assessed on Fair Market Value
- Contract terms are non-negotiable
- Single applicant (partners shown as sub contractors)
- Applicants must fully complete the application form



Eligible costs (all to include VAT)

- Labour costs broken down by individual
- Material Costs (inc consumables specific to the project)
- Capital Equipment Costs
- Sub-contract costs
- Travel and subsistence
- Other costs specifically attributed to the project
- Indirect Costs:
 - General office and basic laboratory consumables
 - Library services/learning resources
 - Typing/secretarial
 - Finance, personnel, public relations and departmental services
 - Central and distributed computing
 - Cost of capital employed
 - Overheads





www.innovateuk.org/sbri

website contains details of all SBRI competitions



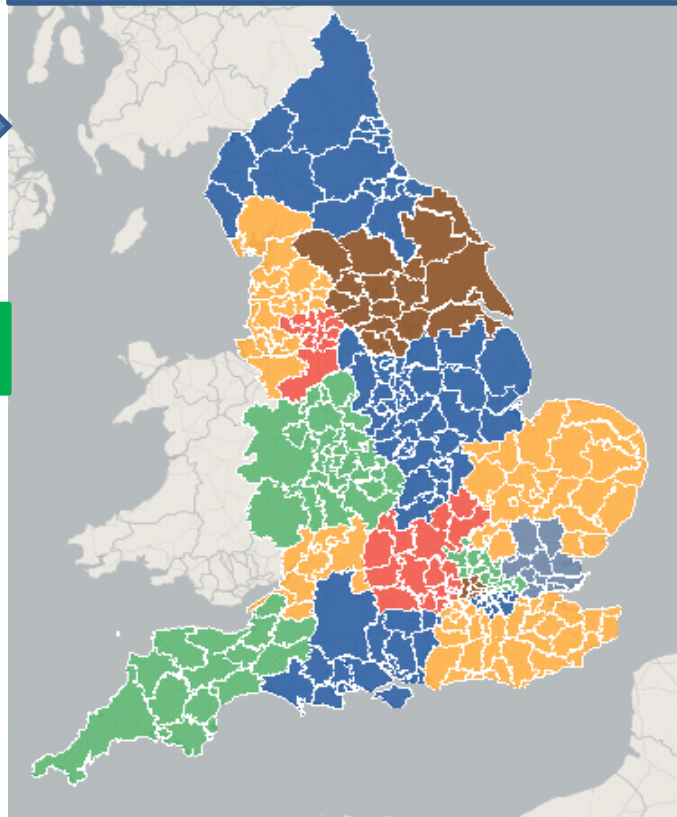
The NHS Innovation Agenda



Created
AHSNs

Lead SBRI

15 Academic Health Science
Networks



We will double our investment in the Small Business Research Initiative to develop innovative solutions to healthcare challenges, encourage greater competition in procurement of services, and drive growth in the UK SME sector



SBRI Process

AHSN led - typically undertaken by clinicians – service driven

AHSN led - Workshops with industry to support understanding

PHASE 1: Typically 6 months – max of £100k

PHASE 2: Typically 12 months – milestones agreed & monitored

PHASE 3: Typically 12 months – milestones agreed & monitored

Problem Identification

Open call to Industry

Feasibility Testing

Prototype development
Pathway testing &
Proof of Value

Assessment

Assessment

Open Procurement

Due diligence & contracts



New Competition Spring 2015



Minimising the impact of falling

SBRI Healthcare NHS England competition for development contracts
June 2015

Minimising impact of falls



Addressing functional needs in the elderly

SBRI Healthcare NHS England competition for development contracts
June 2015

Functional needs



Faecal and urinary incontinence in frail elderly people

SBRI Healthcare NHS England competition for development contracts
June 2015

Urinary & faecal Continence



Competition launch: 15 June 2015

Closing Date: Noon 11th August 2015

Industry workshops: 18th June, Birmingham; 25th June, London

Contracts awarded: November 2015



Case study:

POLYPHOTONIX

The PolyPhotonix bio-photonic research and development company has developed a light therapy sleep mask costs £250 for 12 weeks' treatment.

- Diabetes is the most common cause of preventable adult blindness in the developed world. Treating it costs the NHS about £1bn a year. Currently treatment costs of as much as £10,000 per patient for each eye.
- Trials have shown that eye disease can be reversed with significant results after as little as six months. Approximately 30 clinics around the country are trialling the product including Moorfields eye hospital. It is anticipated that Noctura 400 will receive NICE approval by the end of 2015.

£1,458,158 awarded

Estimated savings at £1 billion per annum

Product available now

60 employees directly created as a result of SBRI funding.

Approximately £2 million of additional investment has also been secured by the company.



"There is no contest that I would choose the mask over the laser treatment. It is easy to use and removes any traumatic experience that occurred when having my eyes lasered."



Case Study:

Fuel 3D Technologies

Oxford University Spin out Company, Fuel 3D Technologies has devised a novel 3D camera which allows for improved monitoring and clinical intervention of chronic wounds in clinics, hospitals and in patient homes.

- The Eykona Wound Measurement System, which was launched in the UK in December 2011 and is already being used in 20 NHS hospitals and primary care settings, allows community nurses to monitor the wounds while having the back-up of hospital-based experts.
- Images can be evaluated without the need for patients to visit outpatients – increasing effectiveness and reducing costs. The technology allows wounds to be assessed by volume giving a more accurate picture of wound healing.

£1,215,663 awarded
£millions estimated savings
16 jobs created currently & £7m
investment secured
Product available: from 2012



“Our success in securing SBRI Healthcare support increased market awareness and helped to validate the Eykona Wound Measurement System. The SBRI funding also carried significant weight with the wider investment community and was instrumental in helping us achieve our funding objectives,”

Stuart Mead, Chief Executive, Fuel3D



Case study:

Advanced Digital Institute

Pathways through Chronic Pain is being developed as a cost-effective Cognitive Behavioural Therapy (CBT)-based pain management programme without the need for direct involvement by a therapist or clinician.

- An estimated 5.3 million people suffer from chronic pain in England which has a major impact on sufferers' lives, with 24% reporting a diagnosis of depression and 26% reporting an impact on employment.
- Self-help digital products to support people with chronic pain. The technology will enable both patient and practitioner to have a balanced step-wise process to self-assess, self-manage, and self-monitor changes in pain.



advanced
digital
institute



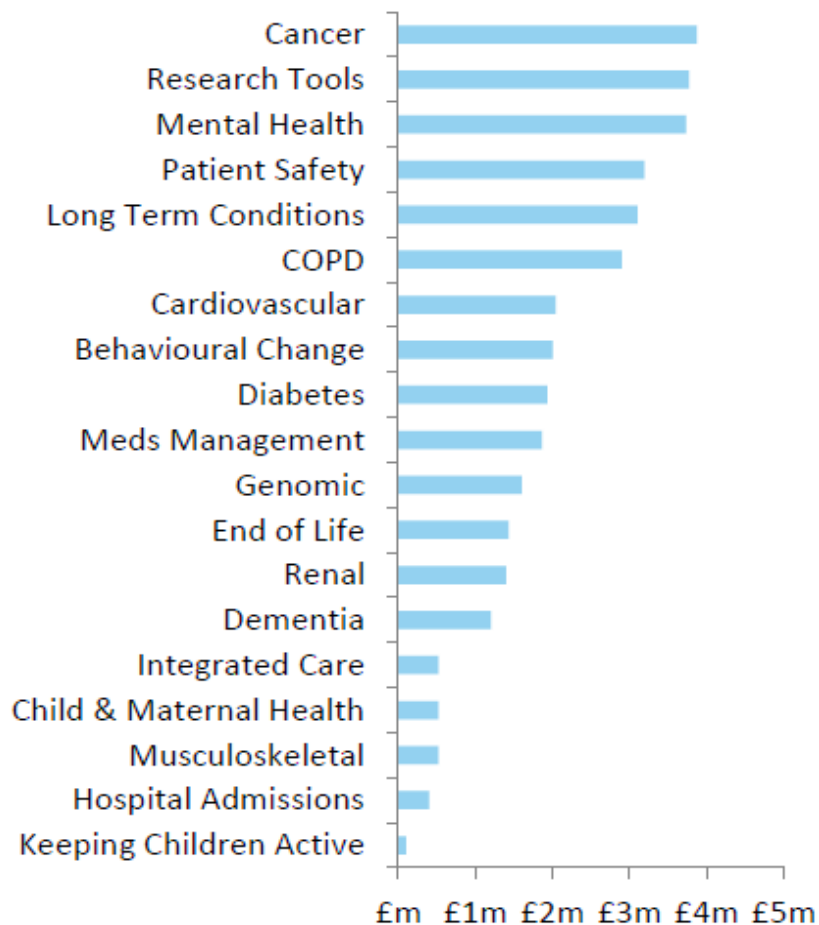
"One of things I really loved about it was that I got quite poorly for a few days and I started struggling with my activity goals, and kept recording 'I struggled, I struggled'. After a couple of times the app flashed up and said 'are you sure this goal isn't too high for you – do you want to adjust your goal'. I thought this is brilliant and so I changed it and started meeting it again and that was so much better than keeping failing."

£885,970.00 awarded
Estimated savings to NHS at £20 million per annum
4 jobs created currently
Product available: summer 2015

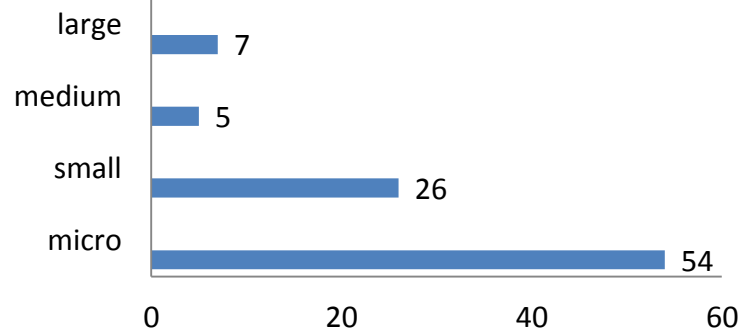


The emerging picture?

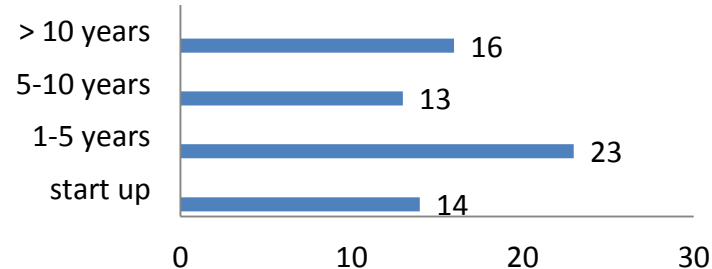
SBRI spend to date by theme



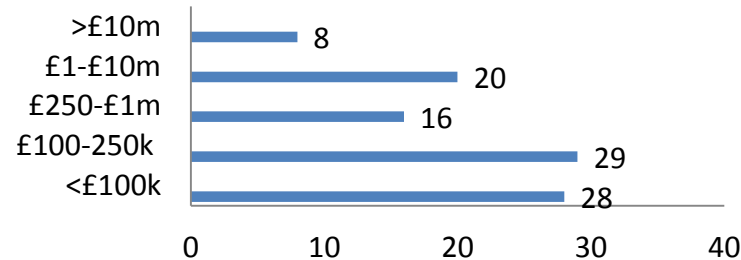
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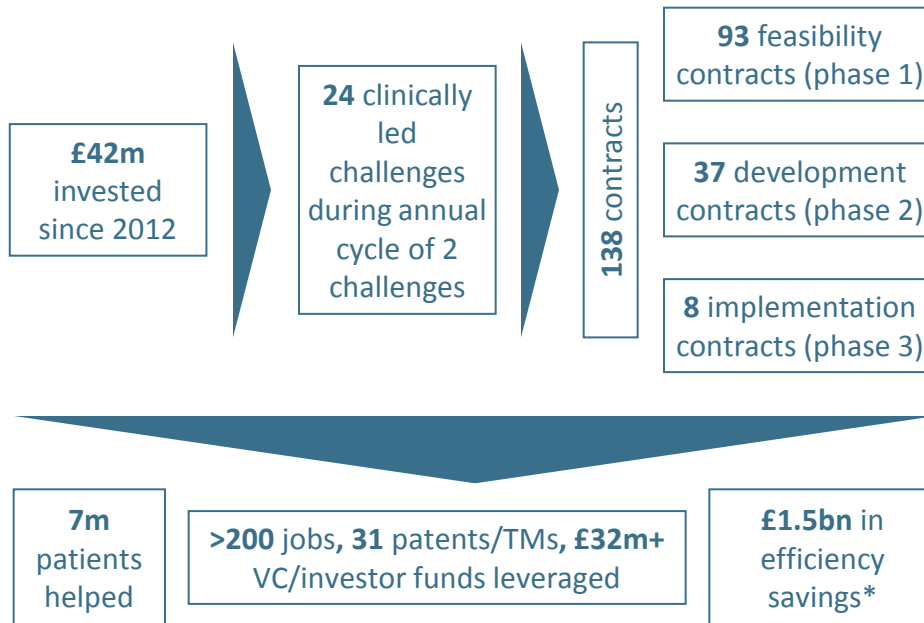


Turnover



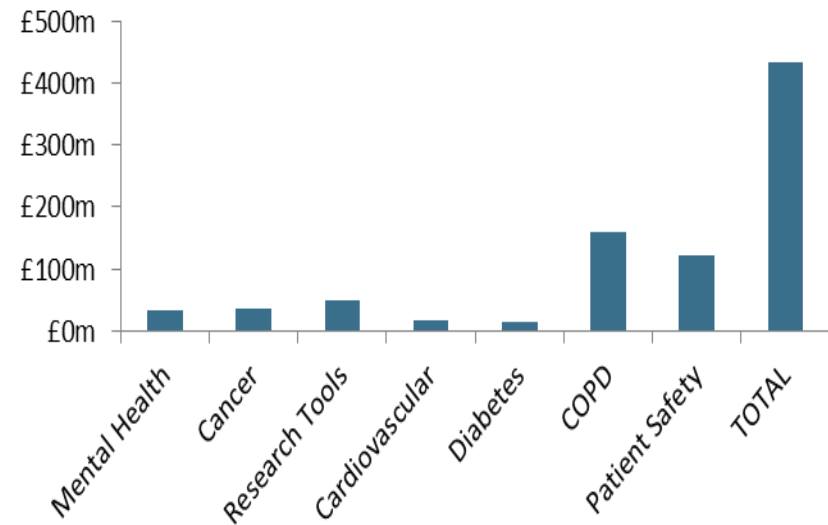
Outcomes

NHS funded, AHSN led programme, with national clinical and industry engagement and the potential to deliver substantial NHS efficiency saving and health benefits



* Min. est. over 10 years, for the pipeline as at Summer 2014. Max £9bn.

Possible Annual Savings for Autumn 2013 competition, £434m**



** This includes double-counting of some savings but excludes other significant possible gains



AHSN/SBRI companies

Scotland & N Ireland
Radisens, Edixomed,

**Grter Manchester
& NW Coast**
- Sky Med, Rapid
Rhythm, Veraz

**North East &
North Cumbria**
Polyphotonix Ltd

Yorks & Humber
Halliday James Ltd

East Midlands
Monica Healthcare Ltd,
Astrimmune Ltd

West Midlands
SensST Systems, Just
Checking Ltd

West of England
SentiProfiling, My
mHealth, HandAxe
CIC

Wessex
CreoMedical, Morgan
Automation

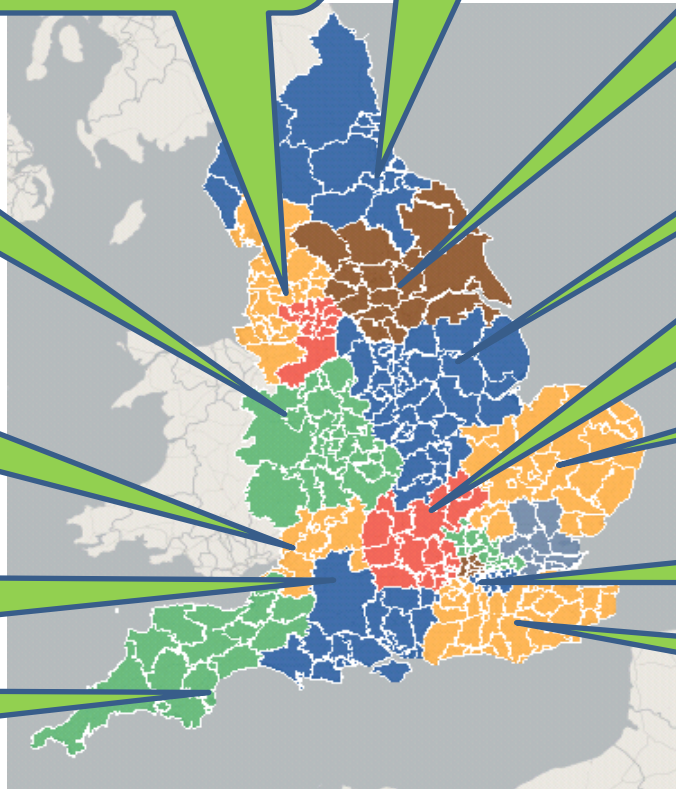
South West
Frazer Nash

Oxford -
Fuel 3D, Oxford Biosignals,
Message Dynamics

Eastern -
Aseptika,
Bespak,
TwistDX

**S.London, Imperial,
UCLP**
ABMS, Therakind,
uMotif

**Kent, Surrey &
Sussex**
Anaxsys, InMezzo



The application process

Nick Offer

SBRI Healthcare Programme Manager

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@sbrihealthcare



Application Process

www.sbrihealthcare.co.uk



bringing new technologies to the NHS



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COMPETITION OVERVIEW

Keep up to date with developments in previous and future competitions...

FUTURE COMPETITIONS

PAST COMPETITIONS

PRESENT COMPETITIONS

Addressing functional needs in the elderly

Faecal and urinary incontinence in frail elderly people

Minimising the impact of falling

Competition Now Open!

SBRI Healthcare 9 - Improve Outcomes for Older People with Multiple-Morbidities

The Small Business Research Initiative for Healthcare (SBRI Healthcare) is an NHS England initiative, championed by the newly formed Academic Health Science Networks (AHSNs), who aim to promote UK economic growth whilst addressing unmet health needs and enhancing the take up of known best practice.

SBRI FUNDING MAP

Use the map to see how the SBRI Healthcare contracts have been awarded in each AHSN area.



[Home](#) » [A-0014](#)

A-0014 (A-0014)

This submission is in stage **Active Applications** with a status of **Active**
It was last updated at: 06/16/2015 01:55:24 PM.

 [View Rankings](#)

Progress

This submission is 0.0% complete. You still need to:

- [Complete task "Download of Application Guidance"](#)
- [Complete task "Application Summary"](#)
- [Complete task "Company Details"](#)
- [Complete task "SBRI Application Form"](#)
- [Complete task "Declaration"](#)
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Active Applications

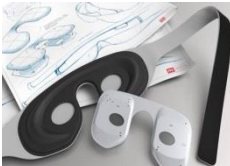
Task	Status	Actions
Download of Application Guidance	INCOMPLETE	Start
Application Summary	INCOMPLETE	Start

Members

 [Nicholas Offer](#) (Owner)

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SBRI Application Form

Required fields are noted with an *

1) Description of Proposed Idea/Technology *

Please provide a brief description of your proposed idea/technology and how this addresses the customer need, market and patient problems. Include how you plan to engage key stakeholders in Phase 1. Please consider defining the market/patient you plan to address; the implications, size, cost of the problem and market. Outline your solution and how it meets the market/patient needs, including the needs described in the competition category brief, how it could be implemented, cost of doing so and any other matters arising from its adoption. To support this description you may upload an image file by using 'Upload Proposal Document(s)' Task, which is available from the Main Application task menu. (500 word limit)

2) Technical Project Summary *

Please give a short assessment of the key technical challenges that will be overcome. List the key technical deliverables and how they will be met. In addition, please provide a short summary of the project (500 word limit).

[Application Summary](#)

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**Upload Attachment
(optional)**

PREREQUISITES NOT MET

**Upload 2nd Proposal
Document (optional)**

PREREQUISITES NOT MET

[Declaration](#)

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PREREQUISITES NOT MET



Assessment Phase Timelines

- Close competition, noon on 11th August
- Review compliance (August)
- Assessment packs assigned and issued to Technical Assessors (August)
- Each application reviewed & scored by 3 Technical Assessors (Sept)
- Assessment of long-list applications at panel meeting involving clinical leads (Sept)
- Production of rank ordered list for interview (Sept)
- Interview panels to select final winners (Oct)
- Draft and issue contracts (Nov)
- Publish contracts awarded (Dec)
- Feedback to unsuccessful applicants (Jan)



Assessment Criteria

1. What will be the effect of this proposal on the challenge addressed?
2. What is the degree of technical challenge? How innovative is the project?
3. Will the technology have a competitive advantage over existing/alternate technologies that can meet the market needs?
4. Are the milestones and project plan appropriate?
5. Is the proposed development plan a sound approach?
6. Does the proposed project have an appropriate commercialisation plan and does the size of the market justify the investment?
7. Does the company appear to have the right skills and experience to deliver the intended benefits?
8. Does the proposal look sensible financially? Is the overall budget realistic and justified in terms of the aims and methods proposed?



Key Points to Remember

- Research and define the market/patient need
- Review the direct competitor landscape and make sure you define your USP
- Consider your route to market, what is the commercialisation plan? Do you know who your customer will be, how will you distribute, how much will you charge for the product/service?
- How will the project be managed (what tools will you use, how will the team communicate etc)
- Provide a clear cost breakdown
- Make sure you answer all of the questions in sufficient detail
- Try not to use too much technical jargon, sell the project in terms the NHS will understand (outcomes, benefits to patients etc)



Contact Us

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SBRI Healthcare Programme

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