Compass Carter Osborne

HealthInvestor Awards 2024 WINNER
Executive Search Firm of the Year

HealthTech Round Table

Discussion Chair, Penny Dash

A discussion around the challenges and opportunities within HealthTech domestically and globally

Attendees

Penny Dash
Portfolio Chair and Advisor

Discussion Chair

Kalle Conneryd Lundgren
COO, Kry

Molly Gilmartin
Investment Director, Albion

Peter Hames
Co-Founder, Sleepio

Ben Horner
MD & Partner, BCG

Dominic King
Senior Vice President, Optum

Jocelyn Ormond
Partner, Ashfords

Luke Osborne
Senior Partner, Compass Carter Osborne

Joe Stringer
Portfolio Chair

Susan Thomas
Clinical Director, Google Health

Katherine Tryon
Director of Health Strategy, Vitality

Introduction

Health Tech funding in Europe reached £650 million in Q1 2024 (up 22% on the previous quarter) and Wes Streeting called for a tech and data-driven reform of the NHS, citing "grim" results from the Darzi report.

This discussion will analyse the challenge and opportunity within HealthTech innovation at a time when investment and transformation is crucial to UK health system reform.

Luke Osborne
Senior Partner,
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Key Areas of Discussion

- Where can technology improve health care? What are the tangible examples of tech improving systems and experience? What are the blocks and the barriers?
- What is the role of the NHS – what should it be doing / not doing in the journey of innovation?
- How should innovation be funded? NHS, start-ups, insurers, retailers? How can we set up appropriate partnership arrangements between financiers, payers, providers and patients while increasing return on investment (ROI)?
- How do we ensure effective transformation – can we engage Drs to create a user-led co-designed experience that will provide personal touch with the benefits of tech innovation?
- What can we do to set an orchestrated direction of travel for AI with consistency of motivation and goals?
- What is the direction of travel for EU and UK regulation of AI, particularly in healthcare, and how may this impact differently on digital health start-ups and big tech?

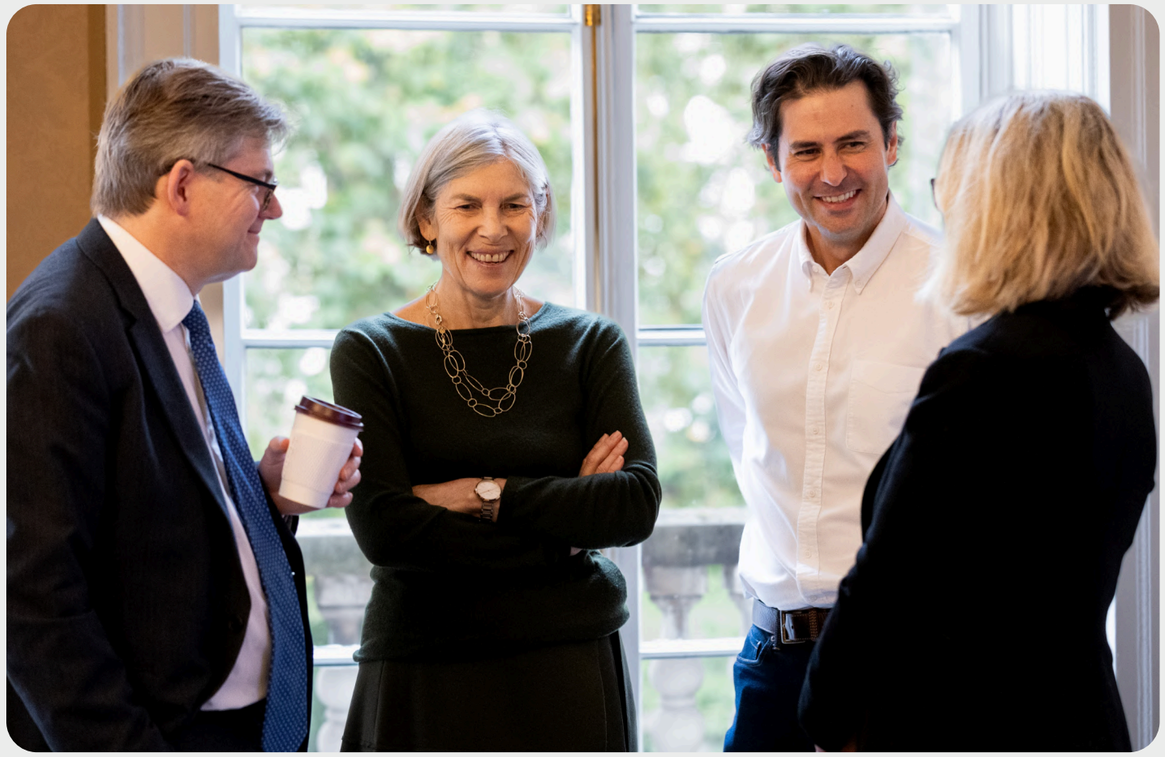
Commissioners, technology providers, investors and other key stakeholders from across the healthcare spectrum were brought together by Compass Carter Osborne at a recent round table event to discuss how new technological innovations can be integrated into healthcare to truly transform UK and global services.

Despite the compelling role that technology has to play within healthcare systems such as the NHS and beyond, it was agreed that many challenges remain.

One factor is an element of dissonance from quite a lot of the medical profession in the adoption of new solutions. The round table heard that, while its members can see the potential of technology in other aspects of their lives and healthcare, the systems that enable them to use digital tools are not currently in place. This leads to people being, at times, resistant to the adoption of technology and, as a result, healthcare providers don't weave it into their processes.

Other factors are the long timescales to make investment decisions, to implement technology, and to remove redundant processes and assets.

> *"We never get anywhere because we never take out the old. We are at a juncture now that it is almost if we don't go with this, we are just going to end up with spiraling costs, poor quality care and a disillusioned workforce."*

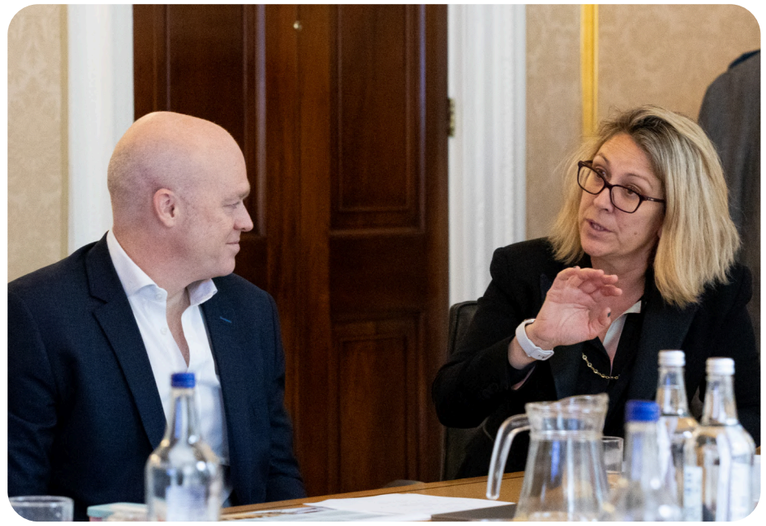


So where are the areas where technology can have an impact, how do you bring it into core healthcare services, or do you set up a parallel testing environment and see what happens?

Furthermore, what are some of the learnings from elsewhere, how can we adopt those and bring them over here? And who is responsible for this? Is this something the sector can push through existing healthcare providers, such as the NHS, but not exclusively by any means?

The panel agreed that private providers can play a role in NHS-funded services as well as their own. However, would it be better for these providers to wait and see if a more consumer driven angle develops off the side?

Ultimately the goal of adopting new technology is to enable health transformation. This could include reducing spending on services that are not currently used efficiently. Technology could also be the solution for current workforce challenges, filling in the gaps where shortage exists. Coupled with predicted demographic challenges, where a doubling of the over 85 population is forecast over the next ten years, leading to more spending on chronic diseases, transformation is needed, the panel heard.



> *"Where we are is a frog boiling in water and we are not sorting ourselves out. Technology is not the panacea for everything, but it can drive a lot."*

The importance of seeing technological innovations being implemented across the whole UK public and private healthcare ecosystem was stressed. This must be done at the highest level, with Health Secretary Wes Streeting taking the reins and producing a holistic strategy, the panel agreed.

What is needed, according to some panellists, was a health transformation vision on how technology can come together in different places to change the whole pathway as that is where we are going to see the real benefit.

In addition, there needs to be a universal understanding of the technology across all healthcare systems, as has happened in other countries. For example, in India, the government has just put in a HealthTech stack in and mandated it. However, to do something similar in the UK, would have to be smart about how you did it, the panel heard.

It was also felt that in the UK, there isn't currently an open playing field for technology and innovation to work. There should be open competition around services rather than sorting the structures, one panellist argued.

It was agreed that the focus of point solutions and using technology to only transform one hospital group or system, means that the NHS can never diagnose and solve the whole problem across the entire organisation. To do this there needs to be additional capacity in the system, both internally and contracted externally to deliver this. As one panellist explained:

> *"We need to be putting the infrastructure, both workforce and technology, in place to do that now, otherwise, the NHS is probably gone."*

Having the capacity to change was considered by some panellists to be one of the biggest barriers to the wholesale adoption of technology, rather than there not being a strong business case. This stems from people working in healthcare often being too busy to implement the required technological transformation. One panellist argued: "There needs to be more of a stick around that change." However, much of the rhetoric about adopt or explain to encourage change has disappeared now, he said, and replaced with the message that healthcare just needs a larger workforce.

While it was agreed that investing in workforce was necessary to implement technological solutions, it was also essential to ensure quality by setting up structures whereby there is a mutual understanding of investment, of research, of post-market surveillance.

Furthermore, there is a lack of tolerability when it comes to technology not always performing as successfully as it was expected to. One panellist said: "I do think you have to disentangle that in terms of 'is the business case really crystal clear' or do you have to be really pragmatic and say that might not work? So how do we get to the point to set up the appropriate structures so we know it will?"

However, when attempting to get NICE approval for a digital treatment, the key factor was cost saving, purely looking at same GP appointments and generic prescriptions, rather than quality, the round table heard.

It was agreed that if technological transformation is to be achieved in healthcare, it needed to be done at scale, picking a couple of sufficiently large regional areas or specialism and accelerating its roll out there.

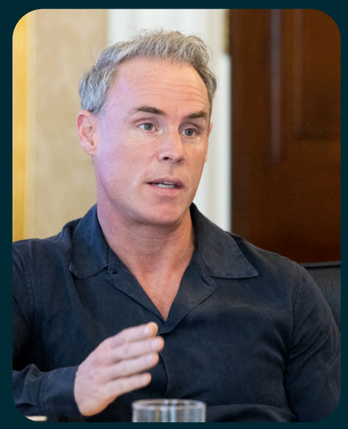
This might be hampered by capital investment in UK hospitals, which one panellist suggested would require tens of billions of investment to try and get things up to a fit state.

He said that the same is true for technology investment, and this problem is not going to be solved in a month or six months. This would require billions of pounds of investment, money which does not currently appear to be there.

> *"These things feel like they need real leadership, real change and a multi-year outlook, but the outlook is that everything needs to be fixed tomorrow, and it just isn't going to happen."*

He said trying to take sensible steps and making practical investments is the only way to have a sustainable system in ten years' time, but the current situation is still going to be painful for many years to come.

One significant change that was suggested at the round table was the NHS taking on a purely commissioning role.



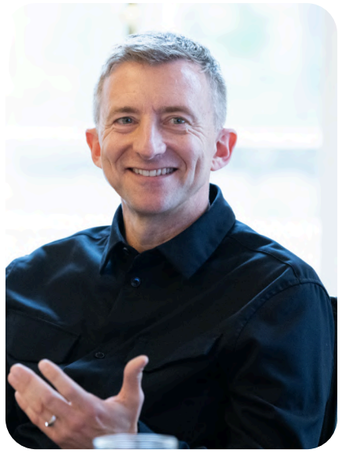
> *"I see this as an enormous opportunity to unlock that open market in terms of services, not just nationally but internationally."*

> *"Make commissioning the NHS' superpower, work out the central needs and make it pull not push, don't horizon-scan what's out there, see what people want to sell you, see what you need and then clearly state on a website that you will pay 60-70% of whatever it is currently costing to anyone who can reliably deliver it."*

This would be workable as the numbers at ICB level are big enough to be globally important, the round table heard. Furthermore, by starting in areas where there aren't services right now, a fruitful testing ground for some of these principles could be trialled. Evaluation should be very stringent and clear and consistent with awards shared but only for value delivered.

> *"The NHS has the opportunity to set the rules of the game, absolutely in its own favour."*

In this scenario of the NHS being solely a commissioner, it would have to be very strong procurement structures within a framework, it was argued. If you simply let the market run, and not look at what the costs should be under optimum delivery, including lots of technology, then you are going to spend a lot of money on poor care and not actually know if its substandard.



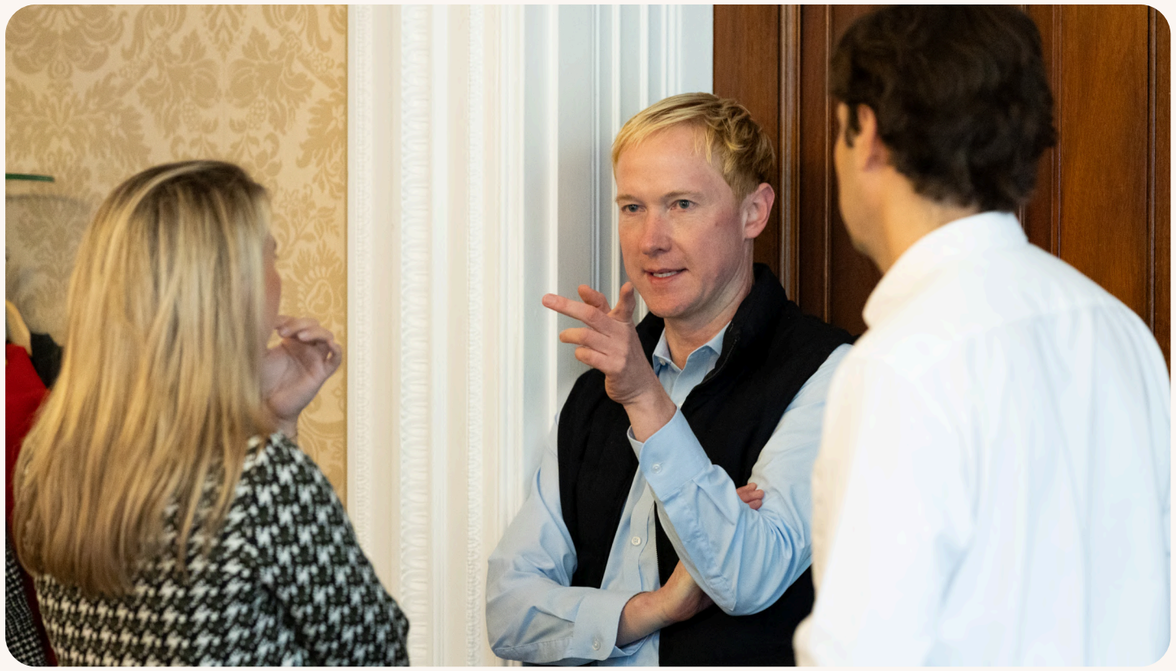
Running these programmes would have to be done at scale, for example, with a population size of, South Yorkshire, Greater Manchester or East Anglia. One scenario suggested was getting ICBs to commission a smart phone and a data package, using AI to identify the right population. As one panellist put it:

> *"We have to go big and we have to go with ambition, otherwise we are going to be doing the same thing in five years' time."*

Moorfields Eye Hospital was suggested as a potential model after it established an end-to-end pathway across 20 sites, with a triage function at the front end. It has reduced unit costs by 50%, the round table heard. One panellist asked: "So how do you take that to scale across London? One part is you have got to know what your baseline is, and that is one element we are not fully grasping. And the second is I think we need better demand and capacity modelling. It is very hard to get rid of staff but there is a churn. And there has to be a multi-year solution."

Patient choice could be one path to achieving this, it was suggested, but the systems would need to be in place to prevent the duplication of

services. There would also need to be communication systems between hospitals because what works in trials at one hospital would not necessarily transfer, the round table heard. If technology is scaled up without these fundamentals in place, it could be prone to failure in the long term.



“One of the challenges if you go too big, you just get branded a failure and get set way back in how to make a change”.

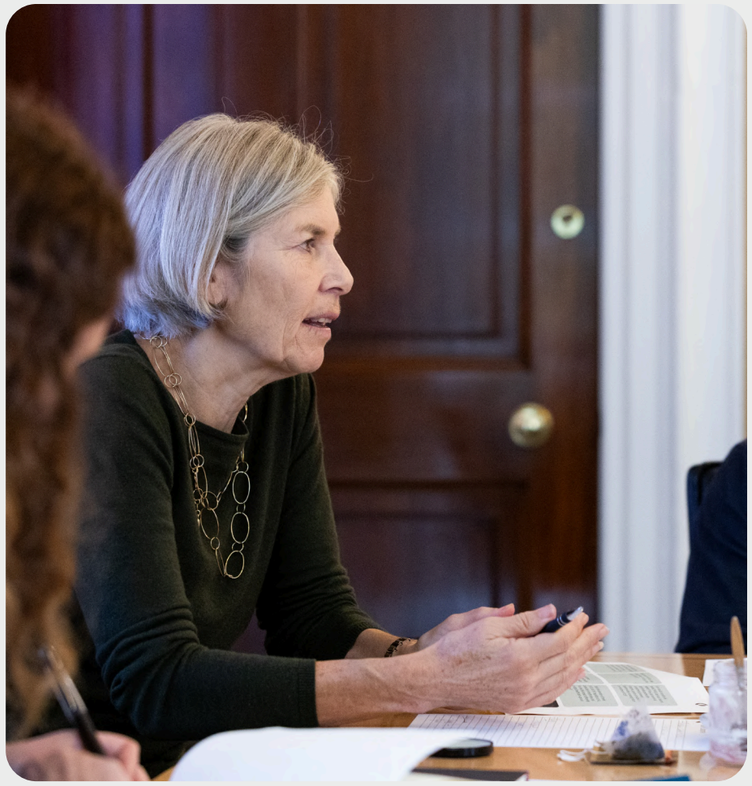
The NHS should be commissioning solutions, and technology is the means to achieve that goal, the panel heard. A lot of the technology that has been built has been focused on areas such as diagnosis, which is not a problem that doctors report. The problem is how to increase capacity for that delivery, rather than deciding what sort of treatment a patient needs. “I think if you were commissioning or asking for a solution to a capacity problem, that would also be the tech”, one panellist argued.

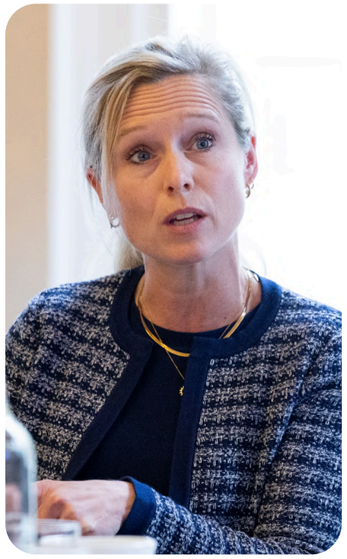
However, one panellist pointed out that the NHS would still be fundamentally responsible for the patient experience and appropriate patient choice. This would need sophisticated commissioning structure that has to sit behind it which the NHS is not currently geared to do.

This would take world class commissioning and strict guard rails, the round table agreed. Part of this commissioning excellence must be evaluating solutions and ensuring that technology providers take all the risk, while getting a good return once they have demonstrated the value of their products.

One potential hurdle is that the data to do this is often not there, nor the systems or processes for maintaining that accountability. It was suggested that picking a single ICB or group of ICBs in a disease area where there is good data or an easily recordable event that correlates with a lot of cost, would be a good start to building up that commissioning experience.

From an investment perspective, there are many innovators which want to get their technology into the NHS and there is no shortage of capital if the NHS “got its act together as a





commissioner,” the panel heard. Currently the NHS isn’t not open to these investments, so innovators are choosing to try their luck in Germany or the US instead, one panellist said.

While the capital is flowing, there are solutions being offered that are not fit for purpose which damages the whole ecosystem as well, according to another panellist. To be successful, understanding the eco-system is critical to ensuring that the right capital goes towards the right things.

A US system like Medicare Advantage, where there is a price on offer to look after a patient, was mooted as a potential model to open up health eco-systems to get technological solutions approved, paid for and measured once implemented. As one participant put it: “If you can prove at an actuarial level that you can deliver that value and improve care, it all opens up.”

However, the round table heard that the incentive structures are not necessarily in the right place to deliver this in UK, and if a solution did get scaled, there were concerns about the ability to measure what impact it had.

An alternative model would use the characteristics of an investment fund, with private providers picking the solutions to use. One participant explained:

“There is access to capital, it could be a multi-year process, and if you are doing it at scale, but not national, there is a really good incentive to get value for money for the NHS.”

The start-ups that get the most traction are the ones that are tactically smart and offered a small but symbolic amount of equity in the business, the panel heard, so that the NHS Trusts have an incentive to implement this solution. “All of sudden they have got a bunch of CEOs and CFOs on their side, and they tell the clinician what to do”, one participant said.

Another big challenge is multiple tech companies offering end-to-end solutions. The only time they can be successful is if they can effectively modularise the technology so it can slot into the environment where it is required, the round table heard.

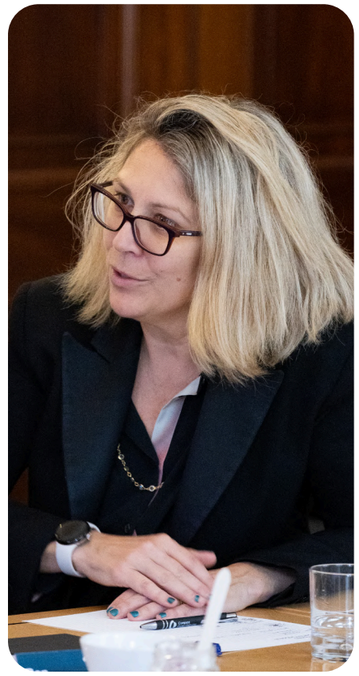
There also need to be a reframing of the NHS relationship with providers so it is not a constant race to the bottom, the panel agreed. According to one panellist both parties need to ask how they can work together effectively on cost and quality, and what are those metrics, and what are the outcomes both parties are looking for? Providers also need to work with each other and share data together, it was agreed.

Furthermore, legal and regulatory obstacles acting as an impediment to take up of healthcare technology are no longer the barriers they once were, one panellist suggested, with the EU leading the way in terms of AI safety and data protection. As far as the latter is concerned the EU is starting to recognise the contradiction between the frameworks they have got in place and innovation. This may provide an opportunity for smaller start-ups in the UK, outside of this legal framework. The panellist said:

> *“In the UK at the moment we have got an opportunity, a mini sandbox if you like, to try and foster innovation before our regulatory framework ends up getting more and more aligned with the EU.”*

> *“We need to be bold individually and collectively to achieve these fundamental shifts.”*

Furthermore, while monitoring predictive AI is relatively straightforward, generative AI, where foundation models are changing on almost a daily basis, is expected to be more problematic.



> *“There are guard rails that can easily be put in place, but people are so unwilling to do so. If we are unwilling to do this on a single point solution, how are we going to do the things that could transform healthcare. Until there is the political will from Wes Streeting or Peter Kyle, and Keir Starmer, that makes some potentially politically toxic decisions.”*

Executive Summary

It was a wide ranging discussion covering the following points:

Technology offers enormous potential to improve health, improve the quality of healthcare, drive productivity in delivery and accelerate research and innovation.

That said, moving from concept to implementation and realising the benefits continues be challenging. Specifically:

- There can be reluctance /resistance amongst clinical staff to adopt new solutions.
- Within the NHS, long timescales to make investment decisions and to implement technology can make it difficult for start-ups / providers to work with the system.
- It is often hard / people are reluctant to remove redundant processes and assets due to political resistance.
- Legal and regulatory obstacles can act as an impediment with technological errors treated more harshly than human ones.
- Concerns around data ownership.

These could be addressed / overcome in a number of ways:

- Private providers (who can innovate and adapt more quickly) demonstrating the art of the possible – and bringing integrated care pathways to the market, underpinned by new technologies.
- Greater use of top down mandates e.g. HealthTech stack in India, clearer messaging from SofS and senior leaders.
- Increasing investment - no shortage of capital if the NHS "got its act together as a commissioner".
- The NHS acting as a commissioner with open competition around services.
- Increasing the capacity to change.
- Operating at scale, picking a couple of sufficiently large regional areas or specialism and accelerating its roll out there.
- Using the characteristics of an investment fund, with private providers picking the solutions to use.
- Shifting the national narrative to more positive messaging.

Penny Dash Discussion Chair

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