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> **Unless we fix adoption, we won't be able to bring more innovation in**

Q1 You are chairing the Innovating NHS Systems Congress at Global Innovation and New Technology (GIANT) Health 2025. From what you've heard on the stage so far, where do you think the NHS is making the most meaningful progress in system-level innovation right now?

I don't think the NHS is making as much progress as it wants to. And if we're being very honest, progress when it comes to innovation is made up of two parts: one is bringing innovation in, and the second is a system transformation. There is a broad understanding that they both cost about the same in terms of money and the effort needed to adopt it at scale. But we have often put all of our eggs into the basket of 'how do we bring it in and pay for it?', and then disregarded how much effort it requires to adopt the innovation at scale.

Q2 What do startups most commonly misunderstand about what it really takes to sell into and scale within the NHS?

I think most startups have an innovator bias. The argument is, you as an innovator can see the problem, you see your solution, and you think everyone else will love it. You think that your work is beautiful. It might not be able to win the contest, but you think it will, and that's the problem. But in healthcare, no one really cares about the technology. Instead, we care about our workflow, our barriers, and the pain that we see, and we want someone who will help us solve them. Don't bring me your technology, but work with me on the problem I have and the pain I'm feeling, and help me overcome it.

There's a methodology in user-centred design that says if you can truly get to the problem and help someone with it, they will 'hire' your product. That's what vendors often don't do. They don't think about the problem people are actually feeling or associate themselves with that problem. Instead, they just say, 'here's my great technology'.

Q3 How do large health-tech firms need to rethink their strategies to work more effectively with the NHS?

I think we're now in something I would call convergence. I'm old enough to remember when a phone was just a phone. But now, you no longer get technology that just sits alone; it converges. What we're now seeing is that larger health-tech firms are saying, 'Here's a platform or technology that's a wearable device that also has AI and also does telemedicine', rather than just offering one of these features. The challenge with convergence is that products can become too generic. They're designed to work reasonably well across dozens of different situations, but not particularly well in any specific clinical workflow or setting.

Companies will say that their technology supports 50-plus use cases, and then clinicians respond, 'Yes, but my workflow is different'. In healthcare, those differences really matter. That's why the NHS will often choose a startup, because it's built around a very specific problem and can adapt to how care is actually delivered. The large companies say, 'Here's my technology, we can't make it bend for all of you, because we've got to apply it to 45 countries, but

just take it'. The reality is that large firms would never deliver a perfect fit for every use case. Meanwhile, startups often can, but they struggle to scale. The opportunity sits in between: startups need to become more scalable, and large firms need to be more flexible. AI can help bridge that gap. Without it, you end up with solutions that are either too narrow to work across healthcare systems or too generic to work well anywhere.

Q4 Turning to your own work at DATA-CAN, London, UK, what's the biggest challenge you want to overcome in the next 12 months?

I am the Commercial Director for the Cancer Hub of Health Data Research UK, called DATA-CAN. I'm also part of the national trainer pool for Health Data Research UK, which is the National Institute of Health Data Science. Health data is so important for better innovation. I believe that unless we focus on individuals and their lived experiences, we risk leaving them behind, which is why I am part of The Equity Charter. You may have heard of the London Institute for Healthcare Engineering (LIHE), based at King's College London, UK. It is the national asset for med-tech translation, including software as a medical device.

Our argument is that if we want more innovation in the NHS, we have to focus on adoption early; build it into the development process. Unless we fix adoption, we won't be able to bring more innovation in.

And the question of how we drive adoption is the biggest problem I want to solve.

Q5 If you were asked to pick one takeaway from this year's GIANT Health event that NHS leaders should act on immediately, what would it be?

During the panel session 'Routing Smarter, Not Harder: AI Triage in the NHS App and the Future of Access to Care', James Friend, Director of Digital Strategy, NHS England London Region, UK, said that vendors need to stop coming along with their technology and pushing it onto the NHS. Instead, they should be thinking about the NHS agenda.

Similarly, in the session, 'A Brighter Future for joined up London', Caroline Clarke, Regional Director, NHS London, UK, emphasised the need to focus on productivity and how to improve it. But Friend's point was very clear: it doesn't matter how good your technology is if it doesn't fit our agenda. When it does fit, then we can make it work in the NHS.

Q6 Looking ahead 5–10 years, what do you think will define whether NHS systems transformations are ultimately a success or a failure?

I have two answers for your question. The first is whether we have something that I call invisible, seamless solutions. When you remove friction, you get seamless solutions. And when something is invisible, you don't even notice it.

That means that the innovation is nice to use. Can we move to invisible infrastructure and seamless experience? Rachel Dunscombe, CEO of openEHR International and former CEO of the NHS Digital Health Academy, UK, explained to me that this is the answer that we need; we need invisible infrastructure. Infrastructure that you don't see, don't think about, and that just works. That's number one.

The second is about outcomes. Some people argue for value-based healthcare, where value is outcomes divided by cost. That implies a trade-off. However, the Institute for Healthcare Improvement (IHI) argues that it shouldn't be a trade-off at all, but a flywheel. When one part moves, the rest moves with it.

They referenced the Triple Aim: improving per-capita cost of care, patient experience, and outcomes. Others pointed out that caregiver experience was missing, leading to the Quadruple Aim. Then, health equity was added, creating the Quintuple Aim.

The idea is that if you improve health equity, patient experience, caregiver experience, outcomes, or per-capita cost of care, any one of these will drive the others. No trade-off, but a flywheel. I genuinely believe that we need the Triple Aim to evolve into the Quintuple Aim, underpinned by invisible infrastructure and a seamless, frictionless experience.

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