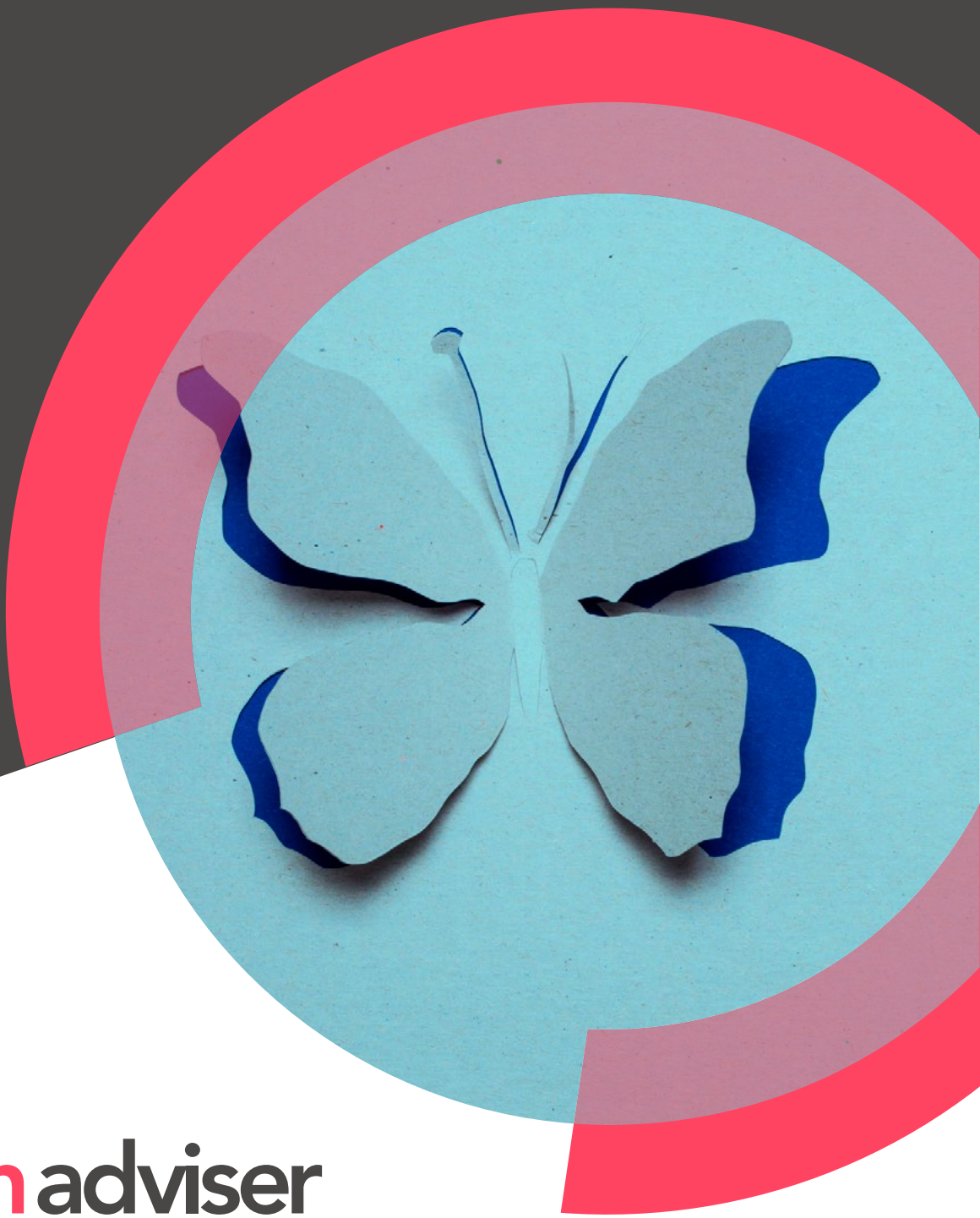
DAC BEACHCROFT

THE TRANSFORMATION OF HEALTHCARE



Health adviser

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FOREWORD

For going on two years, our sector has found itself at the epicentre of a pandemic that has dominated lives and news headlines the world over. In the process, it has thrown into question many of the norms and 'rules' of daily life which we had become accustomed to.

Thanks to the deft response of healthcare workers on the frontline, and the collaborative spirit which has endured throughout the crisis, we are now at a stage where people are able to enjoy the return of greater freedoms. The current prognosis, however, comes with a healthy dose of caution.

Efforts to combat new variants and develop our understanding of COVID's long-term medical effects continue apace, while the global vaccination rollout has seen more than 5 billion doses administered worldwide. With one eye on sustaining these efforts, and one eye fixed on the future, we find ourselves at a crossroads for healthcare service provision.

With that in mind, this issue of Health Adviser is focused on the theme of 'transformation' in healthcare.

Transformation should always be the goal in the wake of a turbulent period. Many issues have taken deeper root, or been highlighted more prominently, and these must be dealt with accordingly. Inequalities have widened, and pre-existing diversity, equity and inclusion efforts must be redoubled to close those gaps. Mental health demand has soared due to social and economic uncertainty, and delivery of care must continue to adapt in order to meet that demand.

Across the sector, improvements have been made which must not be undone. From the discovery of new efficiencies in everyday working methods, to greater appreciation of the power of local autonomy to drive population health management, and a reassessment of what cross-border healthcare service looks like, progress abounds.

Part of this progress comes down to non-healthcare professionals, with expertise and innovation flooding into the sector to meet rising demand. Innovators and dealmakers have been kept busy as existing healthcare services and new healthtech solutions attract investor attention and in turn contribute to economic recovery.

On the governance side, a new era of regulation awaits. This new era is built not only on the fundamental principles of standard-setting, risk assessment and safety, but on regulators being a positive and complementary guiding force for transformation through culture change and achieving a sense of common cause.

As emergency frameworks continue to make way for more sustainable roadmaps for reset and recovery, committed action towards that common cause is what will bind us to ensure that healthcare emerges from disruption stronger than ever. At DACB we continue to work hard to support our clients so that they do emerge stronger, and to help shape the future of health and social care. We must not forget, and should never underestimate that, our ability to transform delivery translates to an ability to transform lives.

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THINKING LOCAL:

THE POWER OF LOCAL AUTONOMY IN DELIVERING HEALTHCARE

Emerging from the command-and-control model that existed during the coronavirus pandemic, the power of local autonomy is now being realised, boosted by the Health Bill's emphasis on subsidiarity and place-based leadership. **Charlotte Burnett** explores how local and central control can be balanced for the good of all.

As the Health Bill makes clear, policymakers want to build a modern health and care system that provides better care for communities. Reducing bureaucracy, increasing accountability and promoting integration are not new concepts. Empowering local figures, and harnessing the power of local autonomy is going to be crucial in delivering on these goals within the new framework. But there is an inherent tension between centralised action and activity, versus the concept of subsidiarity. There will remain a need for coherent central strategy to avoid inconsistency and the exacerbation of health inequalities, while too much room for manoeuvre at local level would run the same risks, with high degrees of variation emerging.

> *"In my 30 years of experience, the NHS always delivers better when there is absolute clarity on what the centre does around rules and policy, but where people are liberated to work within those rules with their own local flavour,"* says Sir James Mackey, Chief Executive of Northumbria Healthcare NHS Foundation Trust. *"The price of not doing that is levelling down and slowing up. We have to accept a degree of variation that comes with liberation, because the value of liberation massively outstrips the consequence of things being too standardised and centrally controlled.""*

It is clear that a delicate balancing act is taking place. The solution lies in working together to marry the respective benefits of central and local.

KYC – KNOW YOUR COMMUNITY

After a period involving lockdowns and travel restrictions, the term 'local' has never had more significance and one of the powerful positives to emerge from COVID was the community response.

> *"People wanted to help out and look after their friends, family, neighbours. That connection and energy is lost if you take away the local element,"* says Mackey. *"We're part of the community. The community is part of us. It's in all of our interests to work together."*

Working together to overcome the tension, or disconnect, between central command and frontline, locality-based principles must

involve understanding and accountability. Tracey Vell, Clinical Director at Health Innovation Manchester and Medical Executive Lead for Primary Care at Greater Manchester Health & Social Care Partnership says the best way to navigate this is via a focus on 'earned autonomy'.

> *"If we get localities showing great relationships and delivery, becoming peer-based assurance vehicles, then we should have less command-and-control, and they should have earned autonomy to deliver in a bespoke way,"* says Vell.

Everything still needs to be knitted together but, to deliver truly bespoke care, central policymaking has to build in flexibility to be agile – and accountable – at a local level.

> *"You expect the NHS to deliver clarity at a national level on the big issues, whether that's elective recovery, cancer, getting ready for winter or outcomes for people with heart disease. That's the 'what'. But the 'how' has to be different to reflect local context and circumstances,"* says Mackey.

This appreciation of nuance is vital when you consider localities may cover several hundred square miles, and what works in one area may be wholly unsuitable elsewhere. Vell's Greater Manchester umbrella, for instance, covers 10 localities and the scale of 'localities' or 'neighbourhoods', 'communities' and 'Place' must also be understood.

Population density and other demographic measures are varied, so the provision of care must be, too. Some argue that an over-reliance on the 'local' breeds too much variation within the NHS, but the size, reach and unique makeup of the NHS must be taken into account.

> *"That view is understandable, but the NHS as an organisation cannot be compared to the 'Tesco's or 'Marks and Spencer's of the world,"* says Mackey.

As such, variation should not be viewed as inconsistency but, rather, as flexibility – something which the complex NHS and wider health system requires. True transformation relies on connecting with all parts of the system.

> *"As leaders, you're always looking for things to latch onto which give energy and create motivation. You have to have a local feel for those things, in order to truly connect,"* says Mackey.

This connection goes both ways. Leaders connect with communities and communities connect with their leaders. Local figures have a closer connection, meaning trust and impact are more keenly felt at this level, and even beyond.

Vell points out that 'place-based' represents local authority or Clinical Commissioning Group (CCG) constructs. She says that might be too broad, and ward- and neighbourhood-level approaches could be better harnessed. Delivering vaccination messaging via faith leaders is one example of this in practice. Local figures have the reach and trusted influence to get to the point of need.

> *"To reach certain demographics, we started vaccinating in BetFred in Wigan,"* says Vell.

Whether it's issuing prostate screening leaflets in the high street, or giving messages to the youth in McDonald's, community connection requires a smaller footprint to work on. But Vell thinks this can go further, still.

> *"Why aren't we doing lung screening programmes in benefits offices? Screening while you wait. Make every contact count,"* she asks.

Vell wants to see a culture change to leadership by influence and equity. A culture that supports trust in on-the-ground, frontline neighbourhood-level relationships, where someone knows community members' names, and can open doors (including to those perceived as 'non-health' areas).

> *"For those that sit with the frontline, our job is to connect up and down from that frontline,"* says Vell. *"The frontline is where population health comes alive and the data becomes meaningful. Inequality reporting data can be sent to PCNs, so they have a better understanding of whether it's obesity, smoking, jobs, environmental issues that a given population is dealing with."*

GOING BEYOND HEALTHCARE

When wider determinants that impact people's lives beyond healthcare are stabilised, better outcomes emerge.

This is precisely what Rupert Dunbar-Rees, Chief Executive Officer at Outcomes Based Healthcare (OBH), focuses on. OBH is a health data analytics organisation providing insights for population health management. Dunbar-Rees welcomes the move to increase local autonomy and the scope that place-based leadership allows for looking beyond individual care settings to encompass wider factors.

OBH conducts population segmentation analysis, and Dunbar-Rees says this shows that the most important change in health state which people experience is when they first move from being healthy to a different health state – in other words, when they first acquire a long-term condition. The key is to keep people in the healthy state for as long as possible.

> *"The longer we can help people remain in that 'healthy / well' segment, every outcome improves, including lower overall cost of care,"* says Dunbar-Rees. *"If there is one outcome that it's vital to measure, it's the moment of leaving the healthy group. That's the outcome to rule them all."*

More local, place-based approaches allow deeper analysis of who is in the healthy group, who is leaving that group, and why.

> *"You have to acknowledge that the drivers of people leaving the 'healthy / well' segment are typically non-health factors,"* says Dunbar-Rees, adding that this can usually be linked to quality-of-life factors like income, access to green space, prevalence of crime, access to education and housing. Each of these factors is local.
>
> *"Precarious housing and precarious employment are strongly associated with a person's first major health status change. Critical factors putting strain on the health system lie in solving issues like access to green space, housing and local jobs. These are difficult to impact at central level, but can be managed more effectively at local level."*

INNOVATING, LOCALLY AND NATIONALLY

Innovation holds the power to accelerate transformation, in part by smoothing the cogs between local and central control. But to maximise its potential, innovation itself must by analysed through those same two lenses.

Innovation relies on clearly defining the problem you are trying to solve, and having a mechanism or a process to surface that problem. In healthcare, the most important problems find their roots in issues related to local, frontline delivery.

> *"Local autonomy drives priorities for innovation. Then when it comes to delivering innovation, that needs to be at scale,"* explains Vell. *"Digital innovation often has massive infrastructure needs, which need to be connected. Doing things by each locality brings additional cost. There should be local discovery and identification of issues, then local participation in solutioning, but a central procurement and delivery mechanism."*
>
> *"If it's all place-based, there's no at scale delivery, there's a postcode lottery for citizens, there's a lack of return on investment because its more costly,"* adds Vell. *"It's an up and down process, and the new Health Bill is forcing people to think more carefully about getting the balance right."*

THE ROLE OF DATA

The NHS Long Term Plan and Health Bill can't be delivered without timely, comprehensive data that spans organisational boundaries to complement the rise of Integrated Care Systems'. Dunbar-Rees notes that at single care setting level, data quality has improved. But individuals rarely receive care from one single setting.

> *"It's essential to think beyond and get data that extends beyond individual siloes, otherwise it is presenting a partial view of the truth and of the cost,"* says Dunbar-Rees. *"If you shine a light on the cost caused by the links between health-span and deprivation, and make the findings clear and digestible, you can create a compelling case for change and for central policy to address some of the*

issues. But people need the metrics to measure and understand this."

Mackey agrees that data is a valuable instrument for managing healthcare and population health, but warns it is only useful if it influences or impacts a decision – not just for the institutions involved, but for the patient and for society as a whole.

While measurement is ever-improving, data discipline has to remain high and Mackey believes a considered, but less risk-averse approach to data – including greater public ownership – will enhance the utility of data further.

"We need to find a way to unleash the power of data. Maybe we need to take a few more risks in making data available," says Mackey. *"Customer pressure and accountability can be a useful tool. We need to take a more disruptive approach to data and allowing consumer behaviour to change our behaviour. We're only playing half the game if we don't activate the consumer."*

Local-level trust and tangibility can once again be powerful tools in activating and engaging, with Vell observing that people opt out of data-sharing less if they can see where that data is being used, and how it is impacting care in their environment.

"With the Greater Manchester care record permissions, people allow sharing because they see the results. It becomes more academic and less relevant if its national and people don't have line of sight on everything," says Vell.

For the NHS, comprehensive population coverage, a high degree of digitisation, and single patient identifier provide a strong data foundation upon which to build.

"Those are the 3 golden characteristics and the UK has all three in a good state," says Dunbar-Rees. *"This puts us on a good footing to look beyond organisational boundaries to measure outcomes and direct resources."*

Definitions and standards are a key part of driving good data quality and discipline, providing the rigour that makes data useful. During the pandemic, there was a temptation to try and compare how different jurisdictions were dealing with the virus, but without standardisation of datasets, that quickly becomes a fruitless exercise. The same is true within national boundaries.

"Central and local need to have good, two-way feedback mechanisms. Granular local level data is great, but ultimately it needs to be comparable out-of-area on a like for like basis, on national scale. Otherwise it's hard to know what good or bad looks like," says Dunbar-Rees, who knows that, for national comparability of outcomes measurement, standard definitions and criteria – such as what constitutes a 'long term condition' – must be applied.

A MOMENT FOR REALIGNMENT

Data and digital advancement and adoption have been at the forefront of dealing with the COVID-19 pandemic, but so too have healthcare's local leadership figures. The role they have played reinforces the power of a hybrid approach, and has surely provided the earned and trusted autonomy Vell describes.

The healthcare ecosystem would be wise to embrace instances of greater local autonomy flourishing, while delivering what is expected from a central policy perspective.

"It's really important that, whatever happens at one level also makes its way through to the other in the right way. You have to have a hybrid approach between national and local – otherwise the system will grind to a halt," says Dunbar-Rees.

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TRANSFORMING WELLBEING:

MENTAL HEALTH PROVISION IN A POST-PANDEMIC WORLD

To say the past two years have been a testing time for population wellbeing and mental health would be an understatement. For transformative progress to be made, the focus must be squarely on solutions. **Gill Weatherill**, partner at DAC Beachcroft, analyses how delivery and service provision is responding to swelling demand.

Everybody in the healthcare sector is acutely aware of the problem and, while the focus is rightly on responding to that problem, it is important first to measure its scale and extent.

Tees, Esk and Wear Valleys (TEWV) NHS Foundation Trust has worked behind the scenes with institutions including the University of York and International Centre for Mental Health Social Research in trying to forecast demand, to understand how best to respond. This has included looking at the fallout from natural disasters and conflicts and using that as a basis for modelling.

> *"The demand is anywhere between 20% and 60% higher, depending on the type of mental health care and treatment, and you have to factor in existing patients suffering worsening conditions on top of the wave of new people experiencing mental health issues. Careful thinking has therefore been required to formulate our response,"* says Brent Kilmurray, TEWV Chief Executive.

Part of that response is to 'move upstream' and think in a more preventative manner. For TEWV, this has involved a range of new activities, from working in schools to greater investment in digital platforms like Kooth, which has seen a huge increase in log-ons during 2021.

> *"Those mechanisms are important for us to be able to steer people towards access and support, in a way that is available to them earlier on, as wellbeing concerns begin to surface,"* says Kilmurray. *"We've got to do that more with the general population."*

Getting upstream includes harnessing the benefits of both the environment and the community within which people live. For instance, Kilmurray is chairing a green social prescribing scheme in Humber, Coast and Vale, which uses the natural environment to promote wellbeing. The group and individual activities involved contain work, training and pleasure aspects.

> *"This is all part of the preventative work being done. We are also building on the work we have been doing with the voluntary and community sector and community groups, or organisations like MIND, to provide different levels of intervention and support for people, so it's accessible locally and people can get hold of it when and where they need it."*

For mental health, determinants go far beyond healthcare and symptoms or conditions. Providers are therefore thinking more holistically about their response. Teams

are being configured to think local, taking into account factors such as employment, welfare, debt advice and financial support.

> *"Wellbeing recovery has to include working with people to support their entire life journey,"* says Kilmurray. *"When we think more holistically about the causes of problems, and provide support in other aspects of people's lives, they have greater stability and bandwidth to be more receptive to treatment."*

Social intervention is a key part of the puzzle when it comes to responding to heightened mental health demand. Better understanding of technology and population health management is game-changing, here, and Kilmurray praises the more "actuarial" way of thinking around social issues rather than medicalising everything. This will prevent demand, as well as promoting recovery.

The drivers for place-based focus that are built into the Health Bill and ICS help in the appreciation for more local, social factors, while Kilmurray says another key change has been the incentives system.

> *"There is a new sense of realism, thanks to contractual changes and, for instance, moving away from payment by results. This is key to fundamentally transforming things,"* says Kilmurray.

DIGITAL DRIVERS

Alongside the explosion of digital health products and solutions seen over the past few years and accelerated further during the pandemic, the digital policy drive is also taking effect. Former Secretary of State Matt Hancock was very keen on promoting digital technology, while it also featured heavily in the Long-Term Plan.

Indeed, Gary O'Hare, Executive Director of Nursing at Cumbria, Northumberland, Tyne and Wear (CNTW) NHS Foundation Trust, says he was in awe of the resilience shown by health and social care staff, but adds that the digital policy drive was also crucial in facilitating that response.

> *"In the first wave there was a real challenge in delivering our services, but we were able to keep our services open and, really, that was on the back of the digital revolution of the NHS,"* says O'Hare, who adds that he was pressing leaders to go even further, and faster.

National and international bodies – from the National Institute for Clinical Excellence recommending digital-first approaches for young people experiencing mental health issues, through to wider messaging on a global scale from the World Health Organisation – are also pushing the sector to maximise the potential of technology.

As a result, end-user adoption and take-up have been strong, with a greater embracing of tools that might previously have been viewed as 'add-ons', as well as the emergence of new innovations.

> *"Digital health has rapidly increased, and people are more readily using those solutions. In fact, 25% more than they were pre-COVID, when we saw about 4 million downloads of digital health technology every day. Now it's more like 5 million,"* says Liz Ashall-Payne, Co-founder and CEO of ORCHA, the leading provider of digital health accreditation and distribution services.

The spike in digital uptake is occurring across all parts of the healthcare system. ORCHA reviews app technology and creates libraries which healthcare professionals use to recommend apps directly to service users, and has seen those recommendations increasing by a staggering 6500%.

> *"That means more healthcare professionals are recommending these solutions to their patients,"* says Ashall-Payne. *"We needed this to cater to the rising mental health demand."*

GOVERNANCE

Key to adoption, and finding the best solutions amidst the telehealth explosion, is satisfying a high level of governance. The inherently risk-averse nature of many healthcare professionals meant that, in the past, there has been a hesitancy around digital health solutions.

> *"Clinicians probably had, if anything, an overly cautious approach to this. Governance thresholds have stayed*

the same, but readiness to consider and openness to adoption has improved. Needs-must has opened people's eyes," says Kilmurray.

With a stronger appetite for adoption, the role of organisations like ORCHA has never been more critical in assessing quality. Under ORCHA's review criteria, quality is assessed against four key elements: data privacy, data security, clinical and professional assurance, and usability and accessibility.

Ashall-Payne notes that the overall quality of solutions is less than desirable, with ORCHA research showing that despite the volume of new digital health solutions, only 20% meet quality standards.

"In mental health, 29.3% of products meet the quality criteria. And mental health is a complicated area, encompassing anything from obsessive compulsive disorder (OCD) through to anxiety. In OCD, the volume that meets the quality threshold falls to 5%," explains Ashall-Payne. *"If only 5% meet the necessary requirements, and five million people are downloading these tools daily, we have a huge problem."*

Good solutions are out there, but end users need to know which solutions they are, and have comfort that they not only provide medical support, but do so in a way that is easy to interact with, and which protects data security and privacy. Safety – on all these fronts – is paramount.

This is where regulation comes in. Ted Baker, Chief Inspector at the Care Quality Commission, says CQC is very open to new and different approaches, but warns that technological solutions can have unpredicted effects, so regulator involvement can help to alleviate issues.

"We encourage people to talk to us early on and we can support them in getting things right from the outset," says Baker. *"We don't just look at services for the care they provide, but crucially are they providing the care the population needs, and can the people who need it, access it? Otherwise you exacerbate inequalities."*

HYBRID APPROACH

Aside from leveraging digital advances, developing and upskilling practitioners is going to be key to transformation. Partly thanks to the pandemic prompting a surge in demand, workforce supply is a challenging issue. The time lag between hiring new talent and preparing them to make an impact must also be kept in mind, so the response must focus on attracting new workers, improving training processes and extending the scope of practitioners.

"We need innovative ways of getting people in and training them, getting their skills and accreditation sorted," says Kilmurray. *"We need to get more creative in skill-mixing and maximising the skillsets we have, so people operate within the boundaries of, but also to the limits of their license, in different roles. This will also create rewarding career paths for people."*

Training is also at the forefront of ORCHA's thinking. It has frontloaded its account aimed at clinicians with a digital health academy which runs CPD-accredited training.

Clearly, an adequate supply of mental health service provision will be founded in balancing the efficiency and flexibility of 'digital' with the trust, experience and appreciation-for-nuance of 'human'.

The human element is important for both physical and digital healthcare. Physically, there will always be a need and role for people to play in delivering healthcare. But people also play a crucial role as digital ambassadors. Based on a practitioner's medical experience and trusted relationship with a patients, their considered selection – and promotion – of digital aids is a powerful tool.

"There will always be a want and a need for face to face, but digital allows access for those that want it and frees up space elsewhere. It's a real win-win. The thorny issue is knowing which ones to trust and avoiding unsafe products," says Ashall-Payne. *"If a clinician recommends a product to you, you are 70% more likely to download it and this is how we activate people to use digital health technology."*

The hybrid of human and digital in healthcare is central to transformation. A measured approach is needed, especially when you consider that modern society often looks to digital to solve everything and be all things to all people. Richard Graham, Clinical Director at digital mental wellbeing organisation Good Thinking, says there is a greater need for respect and curiosity on both the technological and non-technological side.

> *"It's like if I try to do some tiling. I can do it, but there is someone who does it better and faster,"* says Graham. *"In the pursuit of one-stop-shop platforms, this nuance can be overlooked. Revealing Reality talks about the idea that we use smartphones like Swiss Army knives and forget there may be something better which is separate and distinct."*

When the goal is engagement with hard-to-reach communities, one bad experience can prove costly. Poor user experience (UX) on one digital solution can put people off that specific tool but also alienate them from all digital tools, so digital mania has to be kept in check.

In a field of healthcare with such a broad spectrum of variation as mental health, the choice provided by a patient-led approach both caters to, and empowers individuals. In turn, the opportunity to prevent, treat and promote recovery from mental health issues is increased.

> *"We had a blended model where we had video consultations, we had telephonic support and we maintained face-to-face,"* says O'Hare.

Kilmurray echoes this view, saying that "choice is the key in any therapeutic relationship".

> *"We're trying to keep the hybrid approach going and think more sensibly about how we continue to transform, for the benefit of patients and the workforce,"* adds Kilmurray.

Mental health is also an area where positive sub-sector transformation will help to drive broader economic recovery and transformation. This comes through obvious channels like care improvement and increased investment in new solutions, but also through acknowledging the impact of wellbeing on productivity and output.

Ashall-Payne says there is more to be done in changing mindsets in this regard.

> *"We do still think in siloes. This isn't just a health issue and, particularly as mental health issues surge, employers across all sectors have a vested interest because of cost and productivity – they have to support the workforce,"* says Ashall-Payne.

CREATIVE THINKING

Thinking beyond siloes requires thinking outside the box. In light of rising demand, creative solutions are necessary. Part of this is raising awareness of digital tools while being careful not to exacerbate digital divide problems. Using community assets, including non-healthcare figures from teachers through to religious leaders, will help to bridge this gap and also ensure people are being communicated with in terms they understand. Over time, 'community assets' can expand to include patients themselves. This is the thinking behind ORCHA's testing programme for teenagers to assess already-assessed services and products.

> *"We must learn from them, in terms of their wants, needs and preferences and, in turn, they can recommend the best solutions for their peers,"* says Ashall-Payne. *"I don't know much about SnapChat or TikTok, but teenagers do, and there could be lessons to learn from those platforms, so the input is valuable."*

This creativity of thought is vital if mental health service provision is to rise to the challenge of unprecedented levels of demand.

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REGULATION REIMAGINED:

SUPPORTING TRANSFORMATION

While healthcare undergoes transformation, regulation too must be reimagined. **Corinne Slingo** explores how regulatory change can support the transformation agenda across the sector.

The process of successful transformation requires retrospection, positive learning, ambition and a commitment to improvement. Regulators reimagined their approach during crisis mode, with the Health and Safety Executive (HSE) and the Care Quality Commission (CQC) shifting away from set-piece inspections to a remote oversight model.

> *"During the peak of the pandemic, we were very conscious of the fact that services were under enormous pressure and needed to focus on providing care, as well as of the need to limit infection risk by minimising the number of inspectors going into care settings,"* says Ted Baker, Chief Inspector at CQC. *"But the fundamental standards we regulate against have not changed during the pandemic."*

It was a move Brent Kilmurray, Chief Executive at Tees, Esk and Wear Valleys NHS Foundation Trust, describes as a proportionate response.

> *"It worked well, and staff appreciated it,"* says Kilmurray. *"It was right to keep that oversight and involvement, while getting to the bottom of asking the right questions."*

Since then, the proportionate response has been to consider how to sustain the changes that worked, whilst evolving the approach to ensure it is fit for purpose in modern health and social care provision.

> *"As healthcare delivery advances, so must regulation,"* says Dawn Hodgkins, Director of Regulation at the Independent Healthcare Providers Network (IHPN).

Baker, who has long been a champion of transformation, agrees, and welcomes the opportunity to deliver it.

> *"If we are going to be part of this change, we need to change ourselves,"* says Baker. *"We needed transformation anyway and the pandemic has writ that large."*

SUPPORTING REGULATION

The CQC has been a strong advocate in recent years of the need for joined-up care, encouraging different providers to work together to make sure care is provided in a way that is responsive to people's needs and where quality of care crosses multiple care settings.

> *"In line with the health service's wider move towards Integrated Care Systems and delivering more joined-up care,*

the CQC are keen to mirror this approach and work towards assessing healthcare on a systems-level," says Hodgkins.

Improving the entire care pathway is clearly important and squarely in-focus, and Baker welcomes the move to Integrated Care Systems (ICS).

"It is down to all of us – regulators, providers, ***the whole wider system – to make these Integrated Care Systems successful,"*** says Baker.

To that end, CQC has published its 2021 strategy document, setting out its ambitions for the next five years. The strategy is built upon four key themes: People and communities; Smarter regulation; Safety through learning; and Accelerating improvement.

While part of the equation is that services need to transform, the strategy pillar of 'Smarter regulation' promotes regulatory introspection and makes clear that CQC recognises the need for it to transform, too: "our purpose and our role as a regulator won't change – but how we work will be different".

Embracing the ongoing digital healthcare revolution is one element of this, alongside a continual assessment model, and the development of strong partnerships with providers.

"Seeing ourselves as having a common purpose – ensuring people get the high-quality care they need – and understanding our roles and contributions to that, is where we want to go to," says Baker. *"We want to be a supportive regulator."*

Part of that support involves listening to people receiving services and the communities in which they live. Recent reports from the Paterson Inquiry to Ockenden all contain the common theme of a system not listening to patients well enough.

"We have to be better at listening, so that our regulation is informed by their experiences. We also, of course, want to see providers responding to user's needs," says Baker, who also wants to emphasise the importance of encouraging providers to contribute to tackling inequalities that have been exacerbated through the pandemic – from inequalities in access to care, through to outcomes.

"We will be focusing on inequalities much more and essentially take the view that quality has to be about equity and equality of care," says Baker. *"Everyone should have the chance of having good quality outcomes, otherwise we haven't got it right."*

NURTURING A CULTURE OF TRANSFORMATION, SAFELY AND AT SPEED

Accelerating improvement is a regulatory goal focused on supporting provider improvement through its own interactions with providers, while facilitating the availability of improvement support. NHS Improvement supports NHS bodies in this regard, but many independent sector providers do not have external improvement support available to them. While regulation must accept it is confined by conflict of interest when it comes to improvement support, Baker says CQC wants to work with organisations such as IHPN to help ensure it is available.

"Proposals to provide more clarity on standards of care, increase engagement around improvement and increase benchmarking data are to be welcomed," says IHPN's Hodgkins. *"From the sector's perspective, we are keen for this to go further, with more opportunities to share best practice around safety and quality, and the ability to ask for guidance without fearing this will affect ratings, with CQC potentially providing a framework to support providers with a 'requires improvement' rating."*

Improvement support being seen as a positive area for development, rather than a mark of compliance issues, speaks to the culture and mindset change that Baker wants to promote across the sector. This culture also applies to the fourth goal of safety through learning.

"There is a sense we have looked at safety predominantly through a

process-driven lens," says Baker. *"That is important but not sufficient. We need to get the right expertise and culture in place. We have to make our approach to regulation of safety more about a culture of safety and not just about process. It shouldn't be a transactional approach to safety."*

Healthcare – where it is clear that safety is an absolute necessity – can learn from other industries when it comes to safety culture and managing risk.

"Other industries are ahead of the game in their focus on culture and creating teams ***and processes that are safe, understanding human and team dynamics, which can be safety risks,"*** says Baker. ***"We can learn from them, while working with other regulators and NHS England and NHS Improvement."***

This speaks to developing a safety approach based on strong frontline learning, with leadership figures driving a culture of two-way dialogue, transparency and learning.

The rapid establishment and set-up of Nightingale hospitals is an example to draw from, according to Baker. Those sites were set up almost overnight, and diverse clinical teams were assembled and brought together at short notice. Learning how to make the sites 'better' and safer was done on a daily basis.

"This typifies the culture of learning we want to create. A culture that doesn't see things going wrong as a failure, but as an opportunity to learn. This is tricky for healthcare, but we don't want a culture of defensiveness when things go wrong, we want honesty, transparency and learning," says Baker. *"We don't expect perfection; everyone is fallible and all services have problems. We want a service that understands those problems and does its best to learn and improve. My concern as a regulator is not services that have problems; it's services that are defensive about those problems."*

With a shared focus on how services can respond if things go wrong, CQC hopes to establish a mature and open partnership with providers, rather than the relationship being arm's-length. Sir James Mackey, Chief Executive of Northumbria Healthcare NHS Foundation Trust, stresses that providers must play a driving role in nurturing the right culture and relationship.

"We need regulation as a safety net, maintaining minimum standards. But it should not be expected to intrinsically be an improvement mechanism, on its own," says Mackey.

COLLABORATION BETWEEN REGULATORS

The CQC action plan provides a robust roadmap towards regulatory transformation, but CQC is not the only regulatory body within healthcare, of course. The likes of HSE and the Medicines and Healthcare Products Regulatory Agency (MHRA) clearly have a role to play.

Aside from the individual roles of the various regulators, collaboration between and among them will be a key to unlocking transformation. Smarter, more dynamic regulation that is driven by people's and communities' needs requires regulatory organisations to foster an aligned approach and support provider attempts to improve care.

"The regulatory environment can be complex, but if we work closely with other regulators, we can make sure things are consistent and coordinated," says Baker. *"It's really important that we are speaking with a common voice."*

If providers face a problem and various regulator all arrive on the scene at once, the risk of being pulled in different directions could compound the problem. A joined-up approach should help providers solve things as quickly as possible.

Data and technology play a role in making joined-up thinking easier, as well as in making the regulatory environment less complex.

"CQC is undergoing a digital revolution at the moment. In a year or so, we'll have a new digital platform to allow us to be more fleet of foot and using information in a smarter way," says Baker. *"There are great opportunities to use novel technologies and we as*

a regulator need to recognise and support that. But innovation has to be safe and done in a way that is properly risk assessed and managed."

"Technological change at pace can sometimes lead to health and safety considerations being forgotten," notes Professor Andrew Curran, Director of Research and Chief Scientific Adviser at the Health and Safety Executive (HSE), in its Annual Science Review 2021. *"If these considerations are made early enough in the technology journey, they can help to increase the pace of deployment."*

Hodgkins notes that regulators' ability to provide a timely and accurate picture of quality in the health system will be key to them delivering on their goal of dynamism. Regulators must respond to data around how services are functioning, but also promote data and information sharing, with appropriate privacy safeguards in place.

"Importantly, dynamism and digitalisation will make it easier for services as well as patients to exchange relevant information with regulators," says Hodgkins.

The ongoing digital revolution must be accompanied by continued regulatory evolution. Mackey observes that there is a real opportunity, now, to seize the moment for change, building on what has worked well, and learning from what hasn't, through the course of the pandemic.

"The most energising part of last year was the feeling of liberation from constraints – whether real or perceived, and most aren't actually real. But there's a power in the liberation that was felt," says Mackey. *"Necessity is the mother of innovation. A lot of meaningful medical advancement comes during wartime or pandemics, in times of extremes. That has certainly been evident in this last 18 months or so and we need to harness this."*

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M&A:

HEALTHCARE TRANSFORMATION DRIVES DEALMAKING RESURGENCE

After a pandemic-induced pause, strong investment appetite once again abounds in the healthcare sector. As the transformation of healthcare continues, **James Reed** explores how this is driving M&A activity, looking at the key areas in which investors are seeking to deploy funds. On the digital health side, he asks ORCHA how to spot the truly transformative solutions, and analyses the lifecycle of one such solution, S12 Solutions.

Following a peak of healthcare M&A activity in 2019 (see Figure 1), the early months of 2020 saw dealmaking volumes drop-off significantly, as the pandemic caused havoc for corporate decision-making. Uncertainty followed, and many transaction plans were put on hold as resources were focused on dealing with operational matters and putting in place measures to deal with the pandemic. This was true for dealmaking across almost all sectors. But with the return of postponed medical treatments, and an acceleration in the trend towards digital transformation, healthcare M&A activity is rebounding strongly. Add into the mix private equity firms and other investors with accumulated capital to spend, and it is clear that appetite matches opportunity.

As recovery continues and transformation occurs, companies will have renewed confidence to spend as a means of achieving scale and growth. The importance of healthcare has clearly been reinforced during the pandemic, while the sector's resilience throughout economic downturn has also contributed to deal activity and valuations running high.

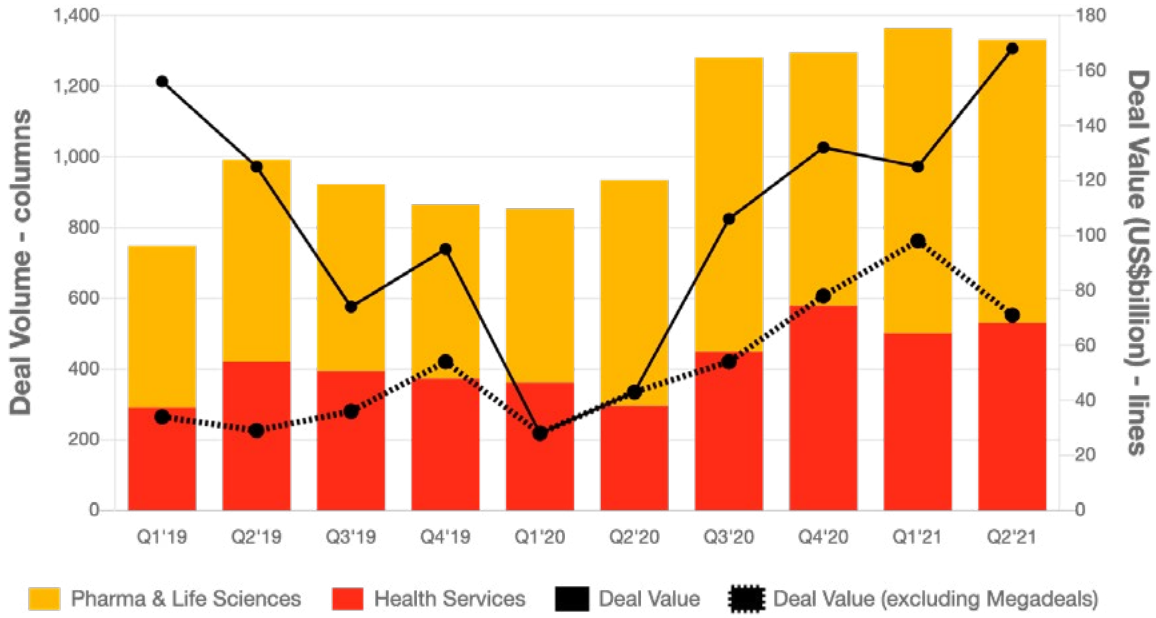
In terms of the sub-sectors proving popular for investors, organisations offering vaccination-related services are an obvious target, while consumer health products are in vogue due to people's desire to take more proactive steps to protect and enhance their immune system. The ease of marketing consumer health products – for instance, supplements and vitamins – only adds to their attractiveness.

Biotech and life sciences remain a growing area, with big pharma retaining the interest and spending power to make major moves for biotech companies, while PwC's 'Global M&A Trends in Health Industries: 2021 Mid-Year Update' points to the fact that wealthy individuals worldwide have been able to bolster their savings during the pandemic and that this could therefore prompt a spike in non-urgent procedures such as cosmetic surgery and laser eye treatment.

THE DIGITAL HEALTH REVOLUTION

A large proportion of investor interest, particularly in the UK, is focused on the fact that healthcare business models are adapting to digital. Digital solutions that have brought efficiencies during the pandemic are set

Figure 1: M&A trends in the first half of 2021 – Global health industries deal volumes and values (Source: Refinitiv, Dealogic and PwC analysis)



to stay, while the mental health legacy of Covid-19 means that personal health, self-care and wellbeing innovations and app technologies are required more than ever to deal with surging demand. More broadly, the popularity of healthtech organisations among the investor community is likely to remain high, as healthcare continues to focus on improving its **digital capabilities as a means of delivering greater consumer choice**.

Digital health – and investment in digital health – is a prime example of an area that was rapidly developing anyway, but which has been turbo-charged by the world being thrust into crisis mode.

Recent years have seen a strong upward trajectory in terms of technological development and capital flowing into the healthcare sector. But when you consider that every day since the start of the pandemic, between 30 and 40 new digital health products have come to market, it is clear that investor excitement has never been stronger. The digital health revolution is in full swing.

The size of the opportunity is huge, but there is a premium on finding quality. Quality is the ultimate mark of success. It is the key to adoption and uptake, and therefore provides the best return on investment, while changing the lives of end-users.

Innovators have clearly led the way in the technological revolution, but healthcare professionals have also played a role in the pandemic taking digital health from tentative consideration to solid investment opportunity. Experimenting with new methods and products has made clinicians more aware of, and open to embracing, the benefits of digital. This includes medical professionals themselves using technology to improve their working methods and facilitate the delivery of treatment and care, while also recommending other services or products for their patients to use.

The types of technology are extremely varied, from solutions that improve the patient-clinician relationship through more streamlined dialogue and efficient interface, to at-home app technologies that give people the power to take greater control of their own health and wellbeing. In disciplines such as mental health, this has been transformative. Swelling demand means that such solutions are not just beneficial, but necessary, if the sector is to adequately cater to patient needs.

One such transformative solution that is helping to respond to the increased mental health demand is S12 Solutions.

THE STORY OF S12 SOLUTIONS: START-UP TO ACQUISITION

Founded in 2017 by Amy Manning, an Approved Mental Health Professional (AMHP) who had grown weary of the inefficiencies that plagued Mental Health Act (MHA) assessment team organisation, S12 Solutions sought to streamline support for – and better connect – AMHPs, section 12 doctors and the people they support.

Manning had seen slow paper processes drive delays and distress and, convinced that technology could help, developed a platform to bring together the right people, in the right place, at the right time. The application ensures and streamlines secure and compliant operations, automating processes to ensure quicker access to treatment while giving professionals peace of mind and more time to focus on patient care.

The company's goal was to assess the crisis care pathway and identify where technology could remove inefficiencies so that highly skilled professionals have more time to focus on using those skills to support people being assessed.

> *"A patient in mental health crisis needs help now. S12 Solutions reduces avoidable delays which put pressure on the rest of the crisis care pathway, and frees up time for professionals by allowing technology to do the heavy lifting where appropriate,"* says Tim Webster, Co-Founder and Operations Director. *"It's about finding the best assessing team for the person, contributing to the best outcome for that person, and reducing the likelihood that the person will quickly return to services."*

The service was born out of the fact that crucial hours and even days can be lost sourcing doctors for MHA assessments. With a number of forms then required to be filed, depending on the patient's circumstance, more precious time passes.

> *"Our process takes those forms on a digital journey so the right people receive the right documents, electronically,"* explains Webster.

The antiquated journey of the paper form goes via multiple individuals, so digitisation also improves the integrity and security of the data it transmits.

S12 Solutions has a link that checks the Department for Health & Social Care's Mental Health Act Register database of section 12 approved doctors in real-time to ensure doctors have active section 12 approval. The hub is looking at how to integrate transport booking into the application's offer and has started incorporating payment of claims for doctors, too.

Having evolved with changing health and social care needs, S12 Solutions has found its niche as the only platform providing MHA assessment team organisation, electronic statutory MHA forms, electronic claims and video calling.

> *"We're a connection device and we bridge health and social care, which is in line with UK policy goals of bringing things closer together in a more integrated way,"* says Webster.

S12 Solutions is now used by approximately 75% of England's Mental Health Trusts, supporting 5,000+ AMHPs, doctors and claim processors. It was selected for both the NHS Innovation Accelerator and NHS England's Innovation and Technology Payment programmes, which recognise and support promising emerging innovations.

This dynamic – being able to showcase real-world impact and a unique point of difference – meant the company began to attract wider investor attention. A vision of going global has inspired its connection with Canada's VitalHub, which acquired S12 Solutions in April 2021.

With the shared goal of simplifying user experience and optimising outcomes, the organisations are looking to expand and roll-out the S12 Solutions offering in countries with similar MHA processes, such as Canada and Australia.

> *"The big advantage of being part of VitalHub is that we can access global markets. By combining their knowledge and resources with ours, we can expand internationally but also in our live markets,"* says Webster, who highlights home-care, among others, as an area where S12 Solutions could

provide a simple, effective solution by making better use of direct patient connections.

ORCHA: HELPING INVESTORS AND USERS SEE WHAT GOOD LOOKS LIKE

An acquisition like VitalHub's deal for S12 Solutions would never occur if there wasn't a sound business case and growth strategy in play. Start-up healthcare companies do not get acquired unless they provide quality solutions to improve health and care delivery.

When it comes to identifying those quality solutions, investors and users alike need to know that innovations are not only useful and usable, but also data-secure and regulation-compliant.

In healthcare, there is no shortage of standards and regulations to comply with, but this is because the stakes are so high. With the goal of ensuring the same regulatory rigour applies in the digital health market, ORCHA was established to provide access to, and encourage adoption of, trusted technologies.

The ORCHA review process, which applications must go through in order to reach healthcare professionals (and ultimately patients) via an ORCHA app library, classifies healthcare standards into four main areas which digital solutions are measured against: data privacy; data security; clinical and professional assurance; and usability and accessibility.

> *"The first part of the puzzle is assessing which regulations need to be applied to which digital health solutions. Some apps are low-risk while others are dealing with things where, if something goes wrong, it can result in death,"* says Ashall-Payne, ORCHA's founder and CEO. *"Innovators need to know which regulations apply to them. The tricky part is that those regulations keep changing, and so too do the products."*

To solve this puzzle, ORCHA has reviewed digital health standards on a global scale and built an underpinning assessment framework. Digital solutions must satisfy all four of ORCHA's review standards, but the key overarching element Ashall-Payne's teams look at is impact – and, crucially, evidence to show that impact.

> *"You might have the most data-secure product in the world, but if it isn't going to have an impact for anybody, what's the point?"* she asks. *"Clinicians and patients want to know whether tools are going to help them."*

Depending on the risk profile established, evidence-gathering may include clinical trials and peer-to-peer reviews. This may be time-consuming but, from an investor perspective, impact is the hallmark of a transformative solution.

> *"When you know the impact, you can show ROI to the system,"* says Ashall-Payne. *"Then the system won't go back; the genie is out of the bottle."*

New technologies have to pass muster when it comes to the manner in which they handle data. Understandably, people want to know where and how their data is being used, stored and shared. Similarly, potential investors want reassurance that data and governance protocols are in place.

Part of ORCHA's assessment is therefore to compile the possible 'side effects' of any given digital solution, and provide this information to users much like the side effects of a medicine or treatment.

> *"This allows people to exercise personal preference. You might be happy for your data to be used in a certain way as a trade-off for using a product, but someone else may not be,"* says Ashall-Payne. *"We put the information into digital health libraries which are promoted to end-users so that people can see what's out there, what's good and what's safe,"* says Ashall-Payne. *"But we also want to help innovators, so we share information to help them become compliant."*

The number of new digital health solutions coming to market shows no sign of slowing down, but investors need to be able to separate the wheat from the chaff. Healthcare transformation has changed in light of the pandemic, but even before Covid-19 and the innovation boost provided by a needs-must mentality, digital health was starting to explode.

"When I started ORCHA, there were around 30,000 digital health apps. Now there are nearly 400,000," says Ashall-Payne. *"It's really accelerated in the last six years and there remain huge opportunities."*

These opportunities are certainly catching the eye of the investor community, and will drive continued dealmaking momentum, with digital health contributing strongly to rising deal volumes and deal values. PwC notes that across the EMEA region, an elevated level of M&A activity is being driven by healthcare services, diagnostics, and medical devices companies as the region recovers from the setback and subsequent backlog of elective medical procedures due to the pandemic. As the backlog is dealt with, and transformation continues, so too will M&A activity.

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EQUALITY, DIVERSITY AND INCLUSION:

PROMOTING DIFFERENCE AND REDUCING INEQUALITY ACROSS HEALTHCARE

Covid-19 has impacted communities in different ways and exacerbated health inequalities, but at the same time a new social contract between healthcare services and local communities has emerged. **Udara Ranasinghe** looks at how equality, diversity and inclusion (EDI) will play a crucial role in the transformation of healthcare.

After a period of immense strain and enforced change due to Covid, the UK healthcare system faces a perhaps once in a generation opportunity to reset and transform the system to tackle health inequalities. The pandemic did not create these inequalities but it exacerbated them and shone a spotlight on the need to tackle them as part of rebuilding the system after Covid. None of that is likely to be controversial but what are the levers to affecting change which for so long has eluded the system?

LEADING FROM THE FRONT

Leadership is of course crucial when it comes to delivering on EDI. Leadership figures from public and private practice carry the decision-making authority to drive and enact change, while also serving as sources of inspiration and examples to follow.

The NHS Leadership Academy duly acknowledges that "diversity and inclusion leads to improved health and greater staff and patient experiences of the NHS; and [they] welcome the challenge of enabling staff from all backgrounds to develop and excel in their roles".

Greater leadership diversity creates better decision-making and attracts a more diverse range of people to healthcare professions across all levels, while making a more diverse range of people comfortable in seeking or accessing care. It means that EDI issues infiltrate recruitment and hiring decisions and brings positive challenge and accountability to the wider system. Diverse leaders are more likely to develop new ways to inspire broader groups, and so the snowball effect takes hold.

Whether through having diverse figures in leadership positions, or via leaders of any background serving as EDI champions, the visibility of transformation around EDI is pivotal. Visibility is both powerful and inspirational. Showing that inclusion is being prioritised in visible ways empowers and inspires others to take action and to believe that change is possible.

"It's really important that we think about a workforce and leadership that reflects the community it serves," says Phil Wood, Chief Medical Officer and Deputy Chief Executive at Leeds Teaching Hospitals. *"Leadership that is more recognisable to communities enhances the sense of connectivity and encourages engagement."*

In Leeds, Wood is working with providers to better understand the barriers people face in terms of getting into leadership positions.

"It's a bit of a chicken and egg challenge," says Wood. *"You want to avoid tokenism, because that isn't effective. What we need is a pipeline of talent development, linked to a conscious effort to recognise and address some of the EDI issues we need to work on. Senior leaders being very visibly committed to addressing those challenges is an important and powerful message."*

RELATABILITY AND REFLECTING THE EVOLUTION OF COMMUNITIES

Another critical element of the health inequality challenge has ironically been the (lack of) participation of the communities most affected. This focus on not just promoting EDI, but on promoting – and celebrating – it in a visible way, is likely to boost community engagement and allow patients to relate to and trust the healthcare system better.

Nnenna Osuji, Chief Executive of North Middlesex University Hospital and formerly Medical Director and Deputy Chief Executive at Croydon Health Services, as well as Joint Clinical Lead for South West London, notes that North Middlesex is a hospital where roughly 60-70% of staff come from a minority ethnic group. Those staff members are also members of the local community.

"It's the very definition of an anchor organisation," says Osuji. *"So when we serve our staff, we also serve our local community."*

Osuji says the richness of a workforce helps to attract staff committed to making a difference.

"The opportunity to level-up care is there for us to take. That said, the historical and current experiences of our staff from diverse backgrounds has been challenging," says Osuji. *"Look at the fact that certain ethnic characteristics and gender characteristics pre-dispose a poorer outcome from Covid. But equally there is a hesitancy among people from within these communities to take up the vaccine. That poses a risk for the future in how we manage and dialogue with staff."*

Through open conversation with staff members and community members alike, breakthroughs can be made. Osuji's emphasis on "dialogue" is important here – the conversation is two-way. Being visible and speaking to the community is not enough. Listening is as important – if not more so. Only through listening and learning can true understanding (and improvement) take place.

"One element which has been particularly enjoyable has been having direct outreach conversations with our populations. Not through the interface of a hospital appointment, but through an interface that is uniquely theirs," says Osuji. *"To be able to hear first-hand some of the real, lived experiences of what diversity means and what the history of that diversity means in terms of confidence in the system."*

The healthcare ecosystem must hear, understand and reflect the real world around it.

"It all comes back to the question of need and mutuality in serving the needs of the populations we're responsible for. That cultural shift is enshrined in some of the legislation particularly picking up on health inequalities, so in terms of how we

distribute resources and assets to deliver, that is an important incentive, indicator and driver of change," says Osuji. *"Those cultural aspects are going to be big drivers as we move forward."*

As Osuji alludes to, healthcare policy and legislation contained in the white paper, the Long Term Plan and regionally through things like the London Vision, is geared towards facilitating this cultural shift. On the workforce side, one of NHS England's core equality objectives is to improve the recruitment, retention, progression, development and experience of its employees to enable it "to become an inclusive employer of choice".

The Institute for Public Policy Research (IPPR), a policy thinktank, argues that improvement will come from the NHS developing its service, finance and workforce plans by focusing on questions such as "what skills mix is needed for ICSs to improve population health and reduce inequalities?".

IPPR identifies the growth of new roles as key to tackling workforce challenges in the long term, alongside reforming education and training so that all staff have a broader range of skills enabling them to work across different care settings. It also suggests measures including widening entry routes to clinical professions, adopting shorter and more skills-focused training requirements, and increasing access to learning throughout careers.

"These reforms will increase the quantity and the diversity of the workforce in the long term," says the IPPR's 2021 State of Health and Care report.

Potential reform of legal frameworks around employment policies might also improve recruitment and workforce issues, says Ben Morrin, Deputy CEO of Barking, Havering and Redbridge University Hospitals NHS Trust.

"Positive action allows us to think about improving how we bring talent on. Unless we are more radical in how we think about that, we are more likely to take incremental steps in improving diversity and leadership across our systems, as opposed to the more radical options which the best organisations, within and beyond the UK, are taking," says Morrin.

However while the 2010 Equality Act allowed a slightly broader approach to positive action, it is still very much curtailed under current UK law and so employers need to approach positive action with care (or be on the wrong side of discrimination claims from those disadvantaged by positive action policies).

NO ONE-SIZE-FITS-ALL

On the care provision side, delivery must be responsive to the needs of the local population. As my colleague Charlotte Burnett explores, successful healthcare delivery requires an appreciation for nuance. Sometimes, even local isn't local enough.

"The city's overall ambition around health is to improve the health of the poorest, the fastest, so actually just to talk about Leeds as an amorphous city is itself not local enough if we want to address health inequalities and improve outcomes," says Wood.

For figures like Wood operating across a large city, the needs of the most deprived communities are very different to those in the least deprived communities, so engagement and service provision must cater to that.

"The pandemic and its repercussions have widened those inequality challenges. The ability to work-from-home, to self-isolate, to look after children who aren't in school," says Wood. *"The pandemic has highlighted the vast gap within a city like Leeds, let alone between cities around the country."*

The link from diversity and inequality challenges to health inequalities is easy to see. Communities that are excluded on the grounds of ethnicity, income or other equality metrics are in turn more likely to suffer widened health inequalities because of a failure to reach and engage them.

The vaccination programme highlights some of these issues, as well as showing the shortcomings of broad-brush labels. Terms like Black, Asian and minority ethnic (BAME), risk obscuring the appreciation of nuance discussed earlier. While, for example, Pakistani, West African and Caribbean communities

would be captured by the term 'BAME', those communities do not function and operate in the same way.

> *"Setting up a model which was never going to be one-size-fits-all inevitably produced disparities between different groups,"* says Wood. *"Talking about the BAME community was in itself unhelpful because, when you break the data down, vaccine uptake levels were vastly different within different communities."*

Vaccination engagement has been boosted by linking with the power of local community leaders, harnessing voices and locations that those communities trust and are comfortable with. Wood says this can be extrapolated to apply in other health and care settings.

"At the moment we have a one-size-fits-all model – you go to a GP, to a hospital or community service centre. But we have to think about the different community issues that make people more or less likely to engage with those locations. The vaccine programme has shown us how important that is if we are to make a difference."

Richard Graham, Clinical Director at digital mental wellbeing organisation Good Thinking, agrees that the pandemic has shone a light on this potential pivotal moment.

> *"There is an opportunity to look at the dark side of health – the bit we don't see because it doesn't come to the door or make the appointment,"* says Graham. *"That's the opportunity, if we are to have a substantial and positive public health response to Covid."*

'Bridge-building' – both generally and in relation to digitisation – is a key phrase that must be a core tenet and not a mere buzzword. If access and engagement are to improve, the sector cannot be preaching to the converted – that is, directing resource and effort towards those people who already want to access services. Awareness, access, trust and comfort are key to engaging harder to reach communities. This means diversifying tactics and services, rather than trying to provide more of the same to areas which are perceived to suffer from health inequalities. Graham notes the impact of this in relation to mental health service provision.

> *"Good Thinking, with support from Public Health England, took a stance of asking why we weren't more curious about the 75% who weren't already engaging. It isn't simply a matter of capacity,"* he says.

Greater tailoring of service provision to 'new' users is required, and it has to strike a chord.

> *"People have a preference for different types of support. People want something that is specific to their life – their time or stage of life, the issues they face,"* says Graham.

TRACKING SUCCESS

There is more bridge-building to be done to create environments where people don't fear judgement, and can co-create solutions. But what do successful solutions look like and how can progress be measured? There is a role for data, and bodies like the Race and Health Observatory and Equality and Diversity Council not only keep eyes fixed on the issue through advocacy, but also through the provision of survey and experience data.

Cold, hard facts provide a powerful mandate for change.

> *"It's one thing to have awareness of an issue and say 'something must be done' but another thing to be faced with the clear reality of people's experience of discrimination, particularly within your own organisation,"* says Wood. *"It's powerful for senior leaders to see the reality of people working within the organisation and to challenge ourselves to improve that experience."*

Such non-adversarial challenges to authority are helpful, and metrics (whether that is data or anecdotal information) bring the accountability that is needed to break down echo chambers and draw in external viewpoints. Osuji notes the impact of greater information sharing during the height of the pandemic.

> *"Working in a knowledge void, there was a shared problem but also, as a result, a shared hunger and want for knowledge, as well as sharing of knowledge. The facilitation of information being shared with the right purpose was a great enabler of how everyone worked together at*

place and system level," says Osuji. *"Those open, honest, challenging conversations allowed us to compare and better understand if inequalities were developing in terms of what we were delivering, so we could redress and take action."*

This type of behaviour that is organisation-agnostic and includes the entire healthcare system is critical to avoid unwarranted variation. Morrin echoes this sentiment around the formation of strong alliances being formed with openness and information-sharing at their heart.

"When you have united working, focus and the mood to inspire, you can best utilise the resources you have for populations," says Morrin.

CELEBRATING AND RAISING THE BAR

Promoting difference and reducing inequality is clearly a work-in-progress and celebrating diversity and approaching it with a positive mindset is an important part of the cultural transformation process.

"I'm excited but cautious," says Osuji. *"I hope this isn't a flash in the pan, and actually something that is embedded in how we move forward and captured in the way we think and measure what we do. EDI must be right at the centre of recovery when it comes to the contribution to economic and social development of place, borough, community and of the whole system."*

Osuji adds that, too often, people speak about diversity as if it's a problem.

"It's an opportunity, and one that brings with it amazing celebration, richness and difference," adds Osuji. *"Difference always raises the bar in the way we think, approach and solve problems."*

The UK Healthcare system is at a pivotal point. The pandemic combined with structural changes to focus on population-based health solutions, provide a once in a generation opportunity to tackle long-standing health inequalities. While the problems may appear daunting, it's clear that many of the answers are out there already.

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CROSS-BORDER HEALTHCARE PROVISION:

HEALTHCARE SANS FRONTIÈRES

The Covid-19 pandemic is the latest example of a truly global health crisis. International collaboration – or protectionism on the part of some jurisdictions – has been seen in the sharing of intelligence to understand and combat coronavirus, including in the development and rollout of vaccines. But long before the pandemic, the internationalisation of healthcare was already taking place. **Hamza Drabu** assesses the keys to successful cross-border provision of healthcare.

From a UK perspective, the healthcare sector has long been a jewel in the country's crown. The NHS has been a prominent point of national pride for decades, and healthcare provision in the round has ranked alongside political and socio-economic stability, and the quality of the legal landscape, as markers of the nation's international standing and reputation.

With such a reputation comes overseas interest and intrigue. An interest to observe potential best practice, and a desire to replicate it where appropriate. Alongside resultant efforts to export the NHS brand to other jurisdictions based on foreign appetite, there is interest in pursuing win-win scenarios as overseas interest provides the opportunity to tap into new funding streams around the world.

This interest is longstanding. The UK has the largest integrated health system in the world, and its expertise is in demand globally. International interest is piqued by both the public and private provision of healthcare in the UK. Over many years, London's Harley Street has become synonymous with high quality healthcare service providers, and many foreign nationals routinely fly into the UK for medical treatment. In more recent years, the concept of taking the UK's offer abroad has gained more traction.

> *"Even under previous UK governments, there was this argument for the NHS going global,"* says Hassan Chaudhury, digital health sector specialist for Healthcare UK, a joint initiative of the Department for International Trade, Department of Health and Social Care, NHS England and NHS Improvement which launched in 2013 to strengthen the NHS and improve global healthcare.

From an NHS funding perspective, it remains an attractive avenue to explore given there are limits on revenues from other sources such as taxation or public borrowing.

> *"Those routes aren't possible, and the model is built on the principle of not charging for client care. That's why every hospital has to have paid-for parking, along with a Boots or a*

Costa," says Chaudhury. *"The export idea is part of NHS trusts looking elsewhere to help solve funding conundrums."*

While the interest and the appetite from both sides is strong, the difficulty comes in crystallising a product that can be properly packaged and exported around the world. There are lessons that could be learned from the large consumer brands in this regard.

"Starbucks is very good at what you might call 'proposition development'. You walk in and you know what you're getting. So a challenge for the NHS has been to improve how it packages its offer," says Chaudhury.

PASTURES NEW

One example of a UK healthcare institution launching overseas is Moorfields Eye Hospital, which has a presence in both Dubai and Abu Dhabi. Moorfields Dubai opened in 2007 and operates in the Dubai free trade zone as a private commercial hospital which is wholly owned by Moorfields London. It operates as a circular model whereby profits generated in Dubai can be returned to the parent entity and invested in Moorfields' NHS services.

The Abu Dhabi model is slightly different, having been built in partnership with an Emirati company, United Eastern. Moorfields holds a 51% stake of the partnership, and the Abu Dhabi venture carries Moorfields branding and hosts Moorfields clinicians.

"Wherever Moorfields' name is associated with something, we viewed it as important that Moorfields had control on clinical governance, clinical care, clinical staff appointments and so on," says David Probert, former CEO of Moorfields Eye Hospital NHS Foundation Trust and current CEO at University College London Hospitals NHS Foundation Trust. *"While these are private, commercial hospitals, we always wanted to run them with the same Moorfields values and ethos, which includes encouraging and valuing education and research."*

When it comes to expanding overseas, geographical location has to make sense. Due diligence and scoping exercises must be completed before any decision to start building can be made. For Moorfields, Dubai and Abu Dhabi made sense for a number of reasons. Many patients based in the Middle East region would previously visit London for treatments, so the hospital had an existing consumer base and demand for its services, while the locations also provide further growth potential via access to the North African and Indian subcontinent markets.

"It's a good model, and Moorfields underwent structural changes to ensure the right level of care, as well as profitability, was being delivered," says Probert. *"Everybody worked hard to ensure that those hospitals were self-sufficient, as well as benefitting from Moorfields specialists in London – including via technology."*

The different models used for Dubai and Abu Dhabi are testament to the flexibility of the expansion and exporting model. But Moorfields isn't necessarily eyeing further expansion right now.

"Pre-pandemic, we were receiving enquiries every other month from jurisdictions interested in discussing the possibility of Moorfields setting up there," Probert says. *"We didn't pursue those models. At the end of the day, Moorfields is an NHS body. So expansion wasn't at the forefront of our minds. It could be a distraction, and the primary focus was on being a very good NHS hospital."*

Another, lower-risk exporting model involves the provision of consultancy and advice to other jurisdictions. Moorfields has also pursued such opportunities, which provide a strategic injection for those overseas, while also offering interesting extra-curricular options for Moorfields staff.

"It has to be strategic. There has to be a market-driven business case with commercial support," says Probert. *"Ultimately you want to operate in a low-risk environment and not jeopardise the top-level service associated with your brand, so any expansion decision must be considered very cautiously and very seriously."*

While adaptability is a necessary element of entering new markets or territories, quality and authenticity cannot be compromised.

> *"You should never expand for the sake of expansion,"* he adds. *"There's a danger that you can dilute the very things that make your brand so powerful if you do things for the sake of it."*

Brand dilution is not the only risk of expanding internationally. The resources required to run a centre in another jurisdiction are immense.

LOOKING IN THE MIRROR

Part of the effort of setting up in a new territory is a rigorous scoping exercise to assess the nature, strength and depth of the overseas interest and ensure that the level of demand is sufficient and sustainable. Then comes the task of making sure the UK 'offer' will translate to another healthcare system and the intricacies of how it operates. Chaudhury notes that demand differs depending on geography. The NHS brand is particularly popular in south and south-east Asia, for instance.

> *"There is a pull, but that depends where in the world you look,"* he says.

The ethos of education, teaching and research which Probert refers to should not be underestimated in this regard. That ethos is responsible for much of the international interest in UK healthcare.

> *"A large part of the pull is usually linked to education and training,"* says Chaudhury. *"Royal Brompton and Royal Marsden do fantastic work abroad, and most of this is because the UK has clinical expertise based on having some of the best medical schools in the world."*

The UK must recognise this, in order to 'sell' it internationally. In an even broader sense, to export successfully and be a major player on the international scene, the UK must acknowledge its strengths and weaknesses – and act accordingly.

Education and training are strengths, while healthtech may be less of a point of difference. While Great Ormond Street Hospital, Sunderland Royal Hospital or Cambridge University Hospitals may be very digitally mature and lead the way in the UK, the majority of hospitals that are rated level 7 (outstanding) according to the Healthcare Information Management Systems Software (HIMSS) criteria for digital maturity are based in the US. In the same way the UK can guide best practice for teaching and education, internationally, it should not be afraid to import technological learnings from overseas. GOSH leadership figures acknowledged this when the HIMSS stage 7 recognition was awarded, which was itself the result of a concerted effort to improve digital capabilities.

> *"We knew what could be achieved by looking at our international peers in places like Melbourne, Toronto and Boston, we also knew what was missing,"* Neil Sebire, Professor and Chief Research Information Officer at GOSH, told Digital Health News at the time.

Public and private collaboration is key to helping the UK incubate innovation and take the next step in its digital maturity journey. Chaudhury explains that the NHS Export Collaborative at Healthcare UK is focused on how consortia can be formed to achieve this.

> *"If there's an opportunity, it shouldn't be about one hospital bidding against other NHS hospitals,"* says Chaudhury. *"We're shifting the focus onto questions like 'how do we help UK plc win?' This will help the right opportunities go to the right hospitals, rather than to the bidder with the best business development team. We can make more compelling offers with private sector involvement, too."*

ALL THE WORLD'S A STAGE

According to Chaudhury, the conversation about international and cross-border healthcare is centred on the word 'platforms'.

"Everyone wants to move to a platform, and the buzzword is 'PAAS' (platform as a service). There are separate data and application layers, which must be independent but consistent and compatible. You need a platform in the cloud that has an application layer, structure and data, and then above it the UI and UX. The whole world is moving to that; it's a platform world. We have to recognise that it's the future – and not just in healthcare."

Probert agrees. Moorfields has the largest collection of eye images in the world, and has been looking at better harnessing the cloud to store such data. But the benefits of investing in healthtech and PAAS are not confined to data storage, security and management. Technology will aid teaching, learning and research, too, amongst others.

"One of the reasons Moorfields formed the Department of Digital Medicine and got involved with Health Data Research UK was that we saw digital data and technology as the future when it comes to globalisation, commercial opportunities and focusing on better research to deliver better care," says Probert, who adds that his former colleagues are putting vigour and energy behind such efforts and making sure governance issues are dealt with. *"Medicine will change, probably forever, as a result of some of the things being done around data."*

Digital health group HealthHero is one such platform, providing a virtual primary care ecosystem for businesses and patients in the UK, France, Germany and Republic of Ireland. HealthHero offers a suite of healthcare services delivered 24/7, with digital triage and communications tools directing user to the right practitioner or course of treatment.

"This approach makes it easier for people to manage their health, with more convenient access to a holistic range of health services and better outcomes for patients," says Aseem Sadana, HealthHero COO. *"A digital front door improves patient experience while improving system inefficiencies."*

To achieve a more seamless and efficient future for healthtech, Sadana says you cannot simply digitise various steps of the patient journey while preserving the same inefficient structure. That's where platforms come in.

"A platform approach allows for configurability for different user situations while reusing core components," he says.

HealthHero has used M&A as part of its corporate growth strategy, with international expansion via acquisition of Qare in France and Fernarzt in Germany, while it has bolstered its UK operations by acquiring online consultation provider Doctorlink. Amidst this dealmaking activity, platform services remain a core component.

"Our acquisitions are with a clear purpose – a target state where the component parts enhance the whole. The combined technology platform as well as the holistic proposition is a sum of these parts," says Sadana.

Of course, while users in France or the UK will have a similar experience, data governance and service provision – including any consultation or clinical content – is locally delivered in the relevant language. In this way, HealthHero can overcome the national versus international challenge. Like Moorfields, the organisation's modus operandi and values cross geographical boundaries while service provision is catered to each jurisdiction in which it operates.

FRAGMENTATION AND INTEROPERABILITY

When it comes to technological investment, another consistent challenge comes in the form of fragmentation. Platforms have to enable different parts of the system to communicate. Chaudhury says the best model is to have a consistent platform into which other things can 'dock'. He also notes that, for technological platforms to be a success, the ideal model is open by design and secure by design. Open source allows digital transformation to thrive.

Healthtech entrepreneur Mindy Daeschner talks about these interoperability challenges, which are so important when it comes to technology that applies to an ecosystem as sprawling and complex as healthcare, with many moving parts. Again, consumer brands are highlighted as examples to follow, with Daeschner pointing to Amazon and Salesforce as organisations that have thrived in adapting to a platform world.

> *"They have a really well-designed core system that is service based. They use open web standards and therefore are simple to integrate with and build upon, supporting multiple parties working at scale as part of a consistent approach,"* says Daeschner.

For Daeschner, the comparison is particularly poignant for the NHS given its makeup, which she describes as "…not just one organisation. It is thousands. It was described to me early in my time at the NHS as 'a shoal of fish rather than a whale'."

The internationalisation of healthcare is well underway. If technology can be better harnessed and interoperability challenges can be overcome, cross-border healthcare will be transformed and the game-changing results Probert references can be realised.

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Hamza specialises in commercial law, regulatory and governance matters. Hamza has advised on a number of projects with an international focus, including advising clients on inward investment projects into the UK, as well as leading on multi-jurisdictional projects alongside an international team of lawyers.

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