Business case development workshop: Collaborating to benefit the system and the supplier (Findings and recommendations)

Introduction

On the 21st May 2025, we brought together a select group of stakeholders from across the NHS (including the NHS Insights programme), from a range of our fellows from the NHS Innovation Accelerator (NIA), and from The Health Foundation and universities to consider a range of challenges that both sides frequently face when attempting to propose the use of technology in the NHS.

The objective of the day was to recognise the growing mutual interdependence between the NHS system and tech suppliers, and to consider pragmatic ways that the NHS could meet in the middle in anticipation of an increased focus on technology, innovation and better decision-making in the NHS 10-Year plan.

However, whilst this paper will consider areas where national colleagues can solve problems, the challenge set by the session chair was to instead focus on collective action, and collective solutions (across NHS providers and with industry) to work better together.

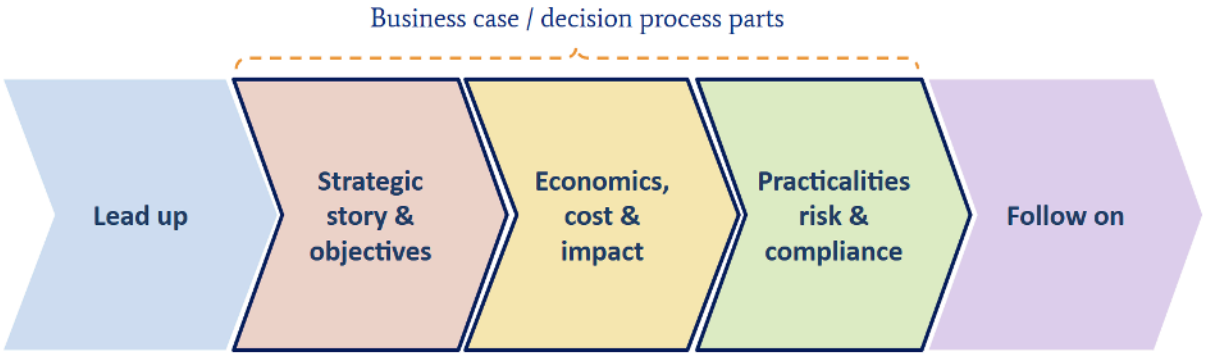
The context of this story

The core focus of the day itself was to consider before, during and after the NHS decision-making process, often consisting of the development of a **business case** to support decision-making by NHS organisations, and consideration of the most important factors in order to support decision-making, and then investment.

This was thematically broken down into 5 areas where challenges, uncertainties, unknowns and friction may occur:

1. During the **lead up** to decision-making, and engagement period.
2. **The case** - The **strategic story and objectives** that would underpin commitment and investment, that strategic progress would be measured against.
3. **The case** - The **cost and impact** (or 'health economics') in order to establish the return on investment that may occur in various forms.
4. **The case** - The range of **practicalities** to support more pragmatic understanding, planning and assurance, especially around risk mitigation and compliance with requirements.
5. And finally, things or activities that may **follow-on** - happening after a business case has led to a decision.

Whilst we were initially seeking to focus on the business case itself, when we conducted research interviews to derive experiences it was clear that we also needed to consider the important before and after beyond the case itself.



The second lens that we shared during the day, and need to lay out as context here is that there are different levels of company, especially the 'made in the UK' healthtech companies, that fit within the portfolio of being worthy of procurement and deployment. The vast majority of companies on the NIA are not huge multinational corporations, but UK-based Small to Medium Enterprises (SMEs) many set up by people (usually clinicians) within the NHS looking to solve a problem.

Whilst it is formally unclear to what degree the NHS acknowledges its responsibility in supporting companies transitioning from pilots to paid contracts and how, or whether, approaches should be more proportionate or even lenient to help them grow we do know two things: firstly, that the transition from pilot to contract is one of the most widely known hurdles companies face, which continues to evolve until a certain threshold of NHS contracts is reached. Secondly, that the NHS has long sought to commit to home-grown healthtech companies and valued the spread of innovation.

For this reason, the workshop and this report splits companies who are legitimately contractually ready, but are at different stages in how established they are, into three stages or levels[1]:

- **Level 1** - has enough to warrant the transition from pilot to contract, and is making the case to NHS providers / systems in order to win that first important secure NHS contract.
    - Evidence is early but compelling enough.
    - Need to be fully situated to more definitively evidence full impact.
    - Likely needs to secure something to be able to progress as a company.
    - Highly reliant on case study from first site.
- **Level 2** - has small handful of 1-5 contracted sites that they have intensively focused on as early adopters. They can demonstrate impact within these settings, and are looking to repeat with less hyper-individualisation.
    - Growing base of evidence and case studies. Clearer economic story.
    - Some ability to show nuance within different deployments, orgs / areas.

[1] The defined stages originally derived from published content by Liam Cahill.

    - Have some examples they've used with others for decision process.
- **Level 3** - has a number of secure, established contracts. Case studied and able to demonstrate value, and is looking to scale across viable NHS areas.
    - Well evidenced with growing nuances and possibly variations. Likely longer term view.
    - Enough case studies to justify their existence.
    - Have been through many different local processes, tenders and contracts.

Throughout this work we sought to understand and validate the different ways that companies at these different stages experience challenges, through a series of unstructured interviews.

On the day of the workshop we divided the attendees into three groups, with each group focusing on a different level: selecting, discussing and then ideating (working together to find ways that NHS organisations and industry could partially or fully address the issue). We made it very clear that the objective was not about giving things for the Department of Health and Social Care to fix, but seeking to keep ownership and see where collective responsibility and thinking could alleviate challenges.

As we now shift to the summary findings, both the 5 areas in, and around, decision making, and the three levels of NHS establishment, will feature heavily.

What we found (themes and recommendations 🔥)

During the workshop we gave our tables a handful of different quotes to represent candid experiences founders at different stages face, and asked them to select one and discuss the challenge (the full list can be found in Appendix A).

Below we would like to represent these specific manifest challenges, and the big ticket topics (*particularly* *Economics, cost and impact*), but very quickly a number of themes emerged that spanned the different issues and became points of reference as the tables shared amongst one another.

This is the story we would like to detail below.

The NHS keeps so much critical information hidden from view

Many discussions began with the view that hugely important information that could help suppliers to interface at all stages of the decision making process were hidden from view, with a feeling that this is withheld, perhaps for reasons of trust. One quote selected (below) articulated this well:

Lead up *"There's no support, consistency or clarity on who the right people are, key people are inaccessible and hidden from view, job titles vary and differ, the contracting relationships between commissioner and providers differ, the internal processes and timescales" ... "there's so much we're expected to know but how do we get it? Hammer them with FOIs?"*

Below are some direct examples:

- **What an NHS organisation actually does and doesn't want as a tangible priority** - leading to huge numbers of companies attempting to sell to all NHS organisations, without the ability to filter - or even validate whether there is actually a market or interest.
- **Who are the key people responsible for decisions around digital, technology, innovation etc** - while the groups acknowledged that it can really vary given how expansive digital is, the experience was that there were usually key individuals, or partner organisations (such as CSUs), or important local configurations that mattered when engaging but had to be uncovered over time. In more than one instance individuals commented that this information was available but took significant effort to find out over time.
    - A particular area of focus was that certain individuals within the decision-making process made all attempts not to engage, or were guarded from being engaged with, during active decision-making, such as those in governance or finance roles that could significantly impact the outcome of a decision.
- **Documents used or required throughout the decision-making process** - Similarly, documents such as DPIAs and Business Case templates were unavailable other than through force (e.g. FOI) making it difficult to be more useful and provide the right things in the right way as a good prospective partner.
- **The decision-making process itself, and key factors** - most organisations will have internal processes, deadlines for key next-FY decisions and sometimes specific requirements or thresholds for internal cases. In contrast to tenders where the process makes it clear, there is very little for proactive engagement.
    - An increasingly important factor within this is the needs, thresholds and requirements around what is sufficient ROI and impact to warrant investment, and also then to enable to shift from capital (on-off) investment to revenue (recurring investment).
- **Approach to industry working, commercial arrangements, providing case studies, earlier stage pilots** - particularly in the early stages when companies are looking to use those first contracts as a springboard to impress and attract other NHS organisations after. These factors can be really important for finding the right sites for closer partnerships.
- **What their current technology is, and supplier contracts are, and ability to integrate, or conditions for doing so** - whilst primary care is a bit more transparent in general, secondary care is more challenging to navigate, and lots of extra work has to happen to find out what is available.

Author note - One very unfortunate fact here that I raised during the open room discussion is that many, if not most, of the factors detailed above are things that 1. Would be subject to Freedom of Information requests, and I have reluctantly advised many companies to follow this route even if this is unideal for both sides (especially for the NHS fielding this numerous times from different

suppliers), and 2. becomes something that larger, well funded or incumbent companies can do, so it becomes more about resources and less about the merit of the solution itself.

At this stage, we should clarify that the discussion was not a wishlist of fixes or gripes for the NHS, but a really positive exchange.

A lot of the discussion and input from NHS attendees, particularly when actively thinking about ways this could be addressed, was candid admission that internally much of the above might not be fully mapped or known, or might happen organically. While the sentiment may have initially felt like 'withholding' one senior NHS leader responsible for innovation stated "*if I'm really honest I've really struggled to understand what money is currently available within our system and for what, and I really have tried to get this*".

Furthering this, there was inferral of other internal elements at play:

- The complexity of services and breadth of healthtech solutions means the stakeholders involved could frequently change based on the scenario.
- The challenges around having enough dedicated 'bandwidth' for innovation roles and facilitators.
- The fact that a decision for shifting a solution from capital to revenue funding may be hard to do in a rational and formulaic way, given budgetary tradeoffs and changing (or escalating) financial circumstances will affect what is funded, transitioned or even de-funded.
- That quite simply, in many areas, NHS organisations simply may not have a clear idea on the factors that might contribute to a decision - e.g. what rationally is good ROI % and productivity %, amongst wider benefits.

There are probably more we could extract but the overall sentiment was that although it would be ideal if the NHS had very clear, perfect and rational approaches, there are lots of unknowns and decisions are, more often than not, a messy and imperfect science. One NHS leader suggested that there may be a degree of reluctance, embarrassment, or risk of backlash, if this were to be clearly articulated.

Recommended solutions

The following themes will add further dimensions and colour that we need to explore to provide the full picture, but there were some valuable ideas that emerged during the discussions, largely focused on cultural disconnect. Both sides (sic) acknowledged the need for one another, and the dynamic of actually being on sides represented an impediment, and in many cases created more difficulty and work for everyone involved.

The NHS perspectives are important to remember, and especially in extremely challenging circumstances we cannot expect them to have all of the answers and be perfect, but in many cases above there is valuable information and intelligence that could be worked through, improved over

time, and ultimately made available to suppliers in a fair and consistent way. If most or all NHS organisations published information that was known openly, such as internally agreed templates and processes, then this could really help suppliers to approach and work with NHS organisations.

Therefore as a primary recommendation, the more that could be done across the NHS to **make this information available**, and feel safe in doing so, the more that it would help both parties to collaborate better.

Some more specific recommendations include:

- **Clearer accepted entry points** - for example - Alder Hey Children's Hospital Trust uses a single portal for applying to a Trust that is triaged weekly and innovators are given a quick response.
- A greater normalisation and acceptability of **running workshops with stakeholders** to help clarify the who, the what and the how - outside of the direct decision process - especially when pilots are seeking to understand transition towards commissioning.
- **Publication of areas with the highest need** / receptiveness for solutions - ideally the top ones that might have been raised within strategy or board minutes or internal priorities.
    - Additionally there could be the publication of receptive innovation areas where teams might not be lowest in terms of need, but are suitable for innovative pathfinding projects and evaluations.e.g. If a neurology department was heavily involved in academic research activities.
- A guide or **guidance on working with them** / selling into them - for example detailing evaluation processes and requirements.

There is a lot here that would need to be untangled and built upon over time, but there is a lot here that would be low hanging fruit, if there were a greater commitment to working in the open by the NHS. Naturally there is more that industry could, and would do, but the general sentiment from industry is: “tell us what you want and what you need and we’ll do it”.

The topic of visibility is not a problem in isolation, and is arguably compounded and make more complex by the next theme.

Huge illogical variation in ‘how it’s done’ exists across NHS organisations

If processes, templates, thresholds and structures from trust-to-trust or system-to-system were largely similar then the scarcity of information could partly be mitigated. However, the reality as the saying goes is that “*once you’ve worked with one NHS trust… you’ve worked with one NHS trust*”. Or as one of the Level 3 experiences articulated:

Practicalities (incl. process) “We’ve got a number of contracts already, but it’s so hard to systematise the approach. Every time it’s like we’re selling it for the first time.”

This was the joint, most commonly occurring theme which came up in all groups, especially the more established Level 2 and 3 companies, where the impact of the variation is not just huge, and sometimes existentially problematic, for the tech supplier, but also creates a direct impact for the NHS organisations themselves (the key point highlighted below):

Practicalities (incl. process) "When it takes 18-24 months to go through a sales cycle and procurement with each individual trust, and so little is collective or regionalised, this time is effectively a cost that we need to factor into the subscription for the NHS. **If procurement was more streamlined, we could cost the NHS less**."

Author note - In the source interview the founder expanded that as a business the workload created by everything being hyper-individualised in the NHS equals cost, and that this needs to be transferred onto the NHS buyer in the final cost. If we take that point logically this could materially affect the ROI (efficiency) that the NHS gets, and is also a point of productivity, in that for the NHS this also equates to time and capacity by WTE staff on NHS bands plus their on-cost etc.

Drawing again from the 'experiences' considered by the groups, the example below, strongly validated during the session, illustrates the areas where there are issues that are particularly illogical.

Practicalities (incl. process) "We have IG acceptance that's good enough nationally and at an EU level, but then there are 215 different versions across trusts, each with someone in a role to interpret their own version. This adds so much time for both sides to navigate, when it could be so much better streamlined." (Level 3)

Whilst the three experiences above were focused on the pragmatic elements, perhaps because they were seen as the most illogical and solvable, it is worth emphasising that the variation described applies **not just to the pragmatic factors but to all of the areas provided as examples in the theme above**: priorities, people, roles, processes, key documentation, positions around partnerships, and technology, and beyond. Many of the other experiences outlined in Appendix A directly reference or infer the significant level of variability that exists.

Earlier in the workshop, Fiona McKenzie, Policy Lead & Deputy Portfolio Director for NHS InSites, introduced the programme's work to accelerate innovation adoption across the NHS. The NHS InSites programme is a network of 18 NHS organisations working together to share learning, test practical tools, and strengthen innovation capability. Fiona outlined how the programme is developing tools like a shared triage framework, evaluation guide, and an innovation passport to help tackle duplication, complexity, and variation in adoption. Her presentation helped to set the context for the day, prompting reflection on how learning from the programme could support local decision-making and spread.

Recommended solutions

Naturally steering any discussion around variation can be a challenge, as the immediate, logical conclusion is that 1. this is a problem for the centre to solve, and 2. that some form of enforced standardisation and consolidation is the desired fix. When generating ideas this was understandably voiced by the tables. Examples such as national bodies for IG (80% national; 20% local criteria proposed to support genuine variation), evaluation of evidence and commercials were raised.

Author note - many of the comments were echoed a few weeks later by Sam Roberts, the CEO of NICE in an interview with the HSJ[2], and NICE was referenced in questions raised around why they don't already provide some of these consolidative functions.

However, given the day's mantra was about not creating a national wishlist, but about building collective agency, there were some broad areas where recommendations emerged:

Firstly there was clear enthusiasm for **how valuable the NHS InSites programme could be across a wider footprint**, and direct interest voiced from some of the NHS attendees, especially in relation to the big pragmatic challenges. Additionally there were other considerations within the decision process (e.g. how decisions are made) where attendees asked "*couldn't InSites do that too?*".

It was also recognised that more open information (as previously suggested) would benefit all, and potentially encourage forms of consolidation organically: if NHS organisations know what others are doing, then it could put what they are doing themselves more into focus (see GIRFT[3], NHS Right Care etc.) and possibly influence change.

Similarly the role of the NHS Innovation Accelerator was also seen as a route to help support acceptability of information about the companies, such as case studies, evidence, demand signalling and also potentially some of the more cultural elements.

The breadth of the variation, particularly in the more cultural areas of what approaches, arrangements and agreements are appropriate, defining acceptability and criteria for decision-making raised the question of who would do this and how would or could that scale.

Many specific areas were raised in relation to the above (engagement and commissioning workshops, as above, financial decisions and thresholds, acceptability criteria in relation to more strategic elements and so on), but zooming out they fell into a few different forms of variations:

- **Everyone is doing something differently.** e,g, IG, process. Solution questions:
    - Where and how can we make this more open; where and how can sites share, or be required to share, what each other is doing?
    - Who is best placed to help consolidate and standardise, or at least encourage it?
- **There is an absence of clarity so everyone has a different version of muddling**. For example positions on endorsement and case studies, commercial arrangements and value exchange,

[2] New technology should be paid for 'like medicines', says NICE chief executive | News | Health Service Journal
[3] https://gettingitrightfirsttime.co.uk/

good practice for pilots, considerations on acceptability of economics and ROI, etc. Solution questions:
    - Who can take a role to help offer clarity and confidence?
    - Who can, at the very least, offer a scale so NHS organisations can be more clear about what is and isn't a 'risk'?
    - Who can convene and share good practice on the less high profile things that matter so everyone can work in a better way during decision-making and engagement?
    - How would they do these things?
- **Everyone is doing something similar but differently, and it creates workload and cost for all involved**. e.g. commercials and pricing. Solution question:
    - What could national or NICE legitimately do to reap these easy / obvious wins for NHS and industry?

Subplot: Money matters!

So far we've considered the two potent overarching dynamics of opacity and variability. But within the preceding interviews and the workshops, there was a topic that dominated discussions: **money, and arguably the NHS as a financially functioning market**.

Progressing through the levels the story shifted from:

- To what degree there is any ability to know that a clinically or operationally attractive solution is actually attractive enough to get a paid contract - even if the economics stack up.
- Whether it is possible in the Level 1 phase to get enough capital or payment to keep the business alive until it has met the {usually undefined} desired threshold for funding.
- Whether the continuation is guaranteed to continue should it achieve the agreed aims, or whether the environmental risk of savings drives means that tech is always at high risk of discontinuation.
- Never knowing what the ideal ranking of importance would be, in the absence of any guidance, on different parts of a cost, economic and ROI story would be, from site to site.
- Getting into sites and then being blocked or not supported in being able to prove the ROI. "It's so hard to get hold of the data to give them the financial assurance they're asking us to provide from a plot".
- At what point or stage of coverage and evidence any technology would be normalised and standardised in the same way a medicine would. "You wouldn't go to ICB X and find out that they don't commission inhalers or statins".

Without repeating the suggestions in the last two potent themes (opacity and variability), and acknowledging that the topic of funding is much wider and more complex: 1. This was recognised by both NHS and Industry as a really difficult one, but 2. could still be alleviated with better transparency, consistency and clarity across areas. Thus, from the perspective of an enabled community there was agreement that things can be improved in spite of the bigger picture.

Relationships don't start with trust or are driven by one side

Returning to the overarching themes, a number of the wider elements that were articulated considered the cultural factors of the relationship. Particularly in relation to trust, risk and collaboration.

This is arguably natural when considering the relationship between a buyer and a seller, but multiple conversation points described the relationship in terms of gateways, where there are known and unknown fixed requirements, particularly through the tendering mechanism, but that limits the ability to collaborate.

One attendee raised that the nature of the NHS working with companies offering technology is that there can often be "unknown unknowns for both sides" which introduces the perception or reality of risk. For level 1 companies this represented a large biggest hurdle manifesting in different ways, exemplified below:

Strategic story and objectives *"To get a first contract, we're being asked to demonstrate things that we could only demonstrate with a secure and established contract - how do we get through this?"* (Level 1)

Given the sentiment of the workshop, and visible within the room, was that "both parties would ideally enter into conversations with the aim to build trust and co-working - so everyone in the room is working to solve the same problem" (even if at least initially in principle), but in many regards the ability to address, mitigate or alleviate some of the perceived risks is limited by "the process being the process".

Some examples that were raised were:

1. Working together to access a specific funding stream.
2. Options around how risk & reward could be shared through financial mechanisms.
3. Solving specific technical problems such as integration together.
4. Ways to develop sufficient evidence to justify a switch to BAU funding streams internally.

As a recommendation, perhaps the simplest and also most challenging suggestion is that the relationship and interdependence between the NHS and the technology industry is seen as one of necessary collaboration and working together. The recent mood music from the government and DHSC leadership was seen as welcome to help underpin this. However, as many acknowledged throughout the day it's the detail that counts.

One suggestion was that NHS organisations having designated internal facilitators / navigators could begin to support the above. It was also recognised that in some areas the HINs play such a role for or on behalf of the NHS provider (although that not all have the proximity and internal relationships to do it well).

Telling the right stories, about the right companies, at the right time, and over time.

From listening to the three distinct groups we created (Levels 1-3) it was clear, and validating, that the challenges they face as they grow do change and evolve.

However, many of the expectations presented to them represent a high wall, with little consideration of the size of the company and stage of growth once they are at a stage to seek commissioning. This includes support to properly legitimise that they have done enough to be worthy of consideration (again supporting trust building), and to help them continue to build up their legitimacy (established enough → used within the NHS → well integrated with the NHS.

One of the discussion points was around "sharing good practice" where in some cases successful use of tech companies is treated as endorsing a private sector company (often seen as inappropriate) instead of sharing something that works and has been impactful with others (generally encouraged but not joined up within the NHS).

This topic drew questions and ideas around the role that the NHS Innovation Accelerator could expand to endorse what has been objectively proven, how and for what. Since all companies attending were legitimate companies (having been through a robust filtering process) who have been fellows and alumni of the programme, attendees from all parties were keen to understand how the NIA can offer greater bridging in order to help NHS organisations access 'good practice'. Whilst this would differ from the kind of validation you would see from NICE, attendees were unable to suggest what other organisation would be more suitable to provide this support, especially with the planned abolition of NHS England and resulting reduction in central function.

One recommendation equally to both sides was the need for learning and good practice sharing around tech companies to be valuable, realistic and helpful, and not sanitised. The suggestion was that it would be helpful for a convening organisation, such as the NIA, to provide some guidance on what a helpful format would be to help offer more authentic learning (lessons learned) and build trust, in a way that gives both sides more confidence that this information is necessary.

Subplot: Computer says no - challenges in tech integration

The final piece of the puzzle in representing the day was around the unique circumstances and requirements faced when technology is the offering. Introducing technology creates specific needs, challenges, uncertainties and pre-requisites, particularly around integration. If you frequent tech conferences it will usually be high on the list of frustrations and blockers, particularly where there isn't a clear facilitated integration mechanism, such as is the case for primary care integration.

One of the key experiences tackled on the level 1 table was:

Practicalities (incl. process) "Everyone wants us to integrate - I get it - but without them we have no power to influence the EHR that holds the keys, and won't talk to us directly. The process feels so binary - but I'm sure we could work together to solve this issue."

Initially this was discussed as a circle of needs where the integrating supplier cannot, without offering unreasonable amounts of money, influence the supplier of the main IT systems (such as the EHR), yet often being able to integrate is a condition of adoption in the NHS site. A classic Catch 22 scenario.

Naturally the proposed solution would be collaboration, as we have covered above.

NHS attendees within the workshop, however, suggested that circumstances were more complex. Whilst in some areas that may be possible, and whilst an NHS organisation is generally able to submit a request for integration to take place, "it will usually go on a list and there is no guarantee of how and when that will be actioned". When considering the purchase of, or collaboration with, a supplier this becomes a material blocker within the decision-making as high uncertainty arises, along with the prospect of additional difficulty and workload for all involved.

This specific yet well recognised challenge was one where attention quickly shifted to national in order to break this complex dynamic amongst parties. Although there were some valuable suggestions on what could be done to partially mitigate the issue.

The recommendation to national colleagues was that this perpetual issue will always exist if there is no required accountability for integration by the systems suppliers. The example where this is done successfully was in the 21st Century Cures Act, in the U.S.A. mandating open APIs and empowering third-party access via SMART-on-FHIR, enforced through national EHR certification.

Returning to the NHS provider lens there were two specific areas that were referenced.

Firstly, in alignment with the openness we covered above, making integration processes public or more easily documented and accessible would again reduce the guesswork for organisations, and allow companies to spend less time and energy engaging with unsuitable partners.

Secondly, touching back upon the sharing of good practice, and community knowledge, it was suggested that a convening organisation could host a repository documenting successful integration examples across different systems (Epic, Cerner, EMIS, etc.) in order to help tech companies learn and be better prepared for co-working.

Closing remarks

In structuring the day, within research discussions, and from observing the day, there are so many nuanced parts to the discussion that also could have been included, and ways these recommendations could have been presented. Yet in synthesis, although the devil is very much in the detail, there are some really strong themes that came up time and time again.

Hopefully, as we prepare for a new configuration of the NHS this year, and given the loud commitment to growing and adopting tech within the NHS from the government, the detail within this report will be welcomed by national colleagues, and offer ideas for improvement as we seek to actively recognise the mutual interdependence between the NHS and the tech industry - large and small - and bridge what is currently a significant chasm.

However, given the contemporary challenges faced within the NHS, the real opportunity that well considered adoption of tech in the NHS presents, and the high levels of organisational autonomy within the NHS, the workshop challenge that this needs to be tackled collectively and collaboratively feels very necessary. It is well within the power of NHS providers to offer greater transparency and to collaborate with other NHS organisations in efforts to enhance consistency. The attractiveness of the NHS InSites programme offers a promising illustration of exactly this, as does the evolving role of the NIA.

To summarise some of the main themes, topics and lessons learned from the interviews and workshop, I'd like to offer some objectives derived from, and validated during, the day.

1. **Bringing more clarity on working with each NHS organisation into the open benefits all sides and enables better partnerships, including across and between NHS organisations.**
2. **Reducing unnecessary and sometimes illogical variation from NHS site to NHS site is a productivity win, could improve confidence, collaboration and uptake. Some areas are more complex but there are many quick wins available.**
    a. Mainstreaming and adopting the NHS InSites programme offers and excellent place to start, and one of those quick wins.
3. **The 'money matters' topic matters so much that, the clearest and biggest gains would be located in better transparency, cohesion and clarity in this area, and across a number of areas: actual demand and financial aspects; early stage commissioning; what is realistic and matters as a tier of financial priority in order to be acceptable; enablement of proving ROI; stages where system-wide economic acceptability is attained (e.g. 50% coverage).**
4. **Supporting mechanisms to help build trust, gain confidence and define acceptability criteria could help NHS organisations tap into the wisdom of the crowd, and ascertain which suppliers are legitimately ready to be commissioned.**
    a. Specifically, ways to better share and access non-sanitised and helpful best practice could help reduce informality and inconsistency, help tech companies to legitimise credible case studies, and alleviate concerns around inappropriate endorsement.
    b. In many regards the NIA serves much of this purpose and could be a credible arbiter bridging the two parties.
5. **Recognition that new and emerging technologies, and the companies that provide them, will not be able to offer perfection, and may need some support to build wider evidence, case studies, legitimacy over time. Understanding and sharing this objective in an appropriate way benefits everyone involved (eventually even if not immediately).**

    a. Additionally, a huge amount of tech offered and supplied to the NHS is small founder led businesses (often clinical entrepreneurs from the NHS itself) which function as SMEs. A collective approach to considering an SME approach for companies that are at a legitimately ready stage offers longer-term value to the NHS and the UK economy.

6. **More openness and best practice around tech integration would offer value, but the need to enforce other large system suppliers to integrate absolutely needs to go 'up the chain' for national levers**.

The above are high level points, derived from the greater detail in the report. If you would like further ideas on how our attendees felt that the NHS and industry could work together to solve this, please review the relevant sections that the high level points are mapped to.

Finally, bringing together the NHS and Industry together to work together on problems with candidness and a desire to solve functional problems together may seem an obvious activity and something we would expect to happen. However, one of the broad takeaways from the day, supported by attendee feedback, was how unique and uncommon the workshop was. The problems experienced when considering technology affect both sides, and improvements will require change and improvement by the NHS and also by industry, ideally done together.

Written by Liam Cahill, as the chairpersons report, on behalf of the NHS Innovation Accelerator.

Appendix A - Innovation Personas

Please note that these are a mix of paraphrased and direct wording / very specific examples that we have received. Where repetition existed, these examples were combined in a way that sought to stay true to the experience.

🔥 - *indicates multiple sources raised same issue*

Level 1 company

Tech company has enough to warrant the transition from pilot to contract, and is making the case to NHS providers / systems in order to win that first important contract.

Lead up "They were actually keen and suggested we pitch via the Health Innovation Network (HIN) as part of a regional profile - but then the HIN had no real influence and just kept us in a holding position"

Strategic story and objectives "To get a first contract, we're being asked to demonstrate things that we could only demonstrate with a secure and established contract - how do we get through this?"

Economics, cost and impact "Shifting from short term interim funds to a BAU discussion is really hard - understanding what they need is challenging and varies - many don't really have a process, checklist or framework for shifting to BAU funding." Selected 1st

Practicalities (incl. process) "Everyone wants us to integrate - I get it - but without them we have no power to influence the EHR that holds the keys, and won't talk to us directly. The process feels so binary - but I'm sure we could work together to solve this issue." Selected 2nd

Follow on "We had buy-in and (set term) funding at all levels but then a technical manager said tier [integration point] was changing so we had to wait nearly a year until that was in place. All that work and we couldn't deliver anything."

Level 2 company

Company has a small handful of 1-5 contracted sites that they have intensively focused on as early adopters. They can demonstrate impact within these settings, and are looking to repeat with less hyper-individualisation.

Strategic story and objectives "If we can access the the senior leaders they often get it, but then often it's handed over to someone inexperienced and green, who may or may not understand us, to write the business case" … "we just have to cross our fingers and hope that they get it right, because we're usually blocked out of contributing to the case."

Strategic story and objectives "Some trusts totally guard their whole process, business case and other documentation and what they want, such as qualifying criteria. But others are hugely open about all these things and it's so much easier to work with and help them. This kind of variation is killing [tech] companies." Selected 1st

Economics, cost and impact "We've gone for the gold standard economic institute but the wider health economic impact we got offering QALY, ICERs and wider health benefits doesn't seem to match with the specific budgetary considerations that the ICB wants. Nobody made this explicit when buying this - there's no national guidance." Selected 2nd

Practicalities (incl. process) "One trust has inflexible requirements that aren't justified - e.g. we've been asked to do very costly work around the modern slavery act, which is only legally needed if your annual turnover of £36 million or more, we're smaller but they want it for everyone - this stuff locks out SMEs"

Practicalities (incl. process) "When it takes 18-24 months to go through a sales cycle and procurement with each individual trust, and so little is collective or regionalised, this time is effectively a cost that we need to factor into the subscription for the NHS. If procurement was more streamlined, we could cost the NHS less."

Level 3 company

Tech company has a number of secure, established contracts. Case studied and able to demonstrate value, and is looking to scale across viable NHS areas.

Lead up "There's no support, consistency or clarity on who the right people are, key people are inaccessible and hidden from view, job titles vary and differ, the contracting relationships between commissioner and providers differ, the internal processes and timescales" … "there's so much we're expected to know but how do we get it? Hammer them with FOIs?" 🔥 Selected 2nd

Economics, cost and impact "Expectations around ROI differ from area to area - one says that tech needs to produce in-year savings of X, another has a totally different view - there's literally no guidance for them or us on what is possible or realistic, and sometimes the expectation seems highly unrealistic." Selected 1st

Practicalities (incl. process) "We've got a number of contracts already, but it's so hard to systematise the approach. Every time it's like we're selling it for the first time." 🔥

Practicalities (incl. process) "We have IG acceptance that's good enough nationally and at an EU level, but then there are 215 different versions across trusts, each with someone in a role to interpret their own version. This adds so much time for both sides to navigate, when it could be so much better streamlined."

Follow on “After we’ve managed to successfully engage it gets passed on to tendering and procurement - where a requirements gathering exercise has created a messy, often contradictory list of requirements that no supplier can do - I’m sure many just ask staff what they want, or they look at all suppliers and pick the bits that they like from all of them - you wouldn’t get this in any other place.