The Improver Podcast | Episode 7 | Have you fallen in love with the problem?

(00:00)
Welcome to The Improver, the podcast that explores ideas in healthcare improvement and participatory change. Hosted by Dr Na'eem Ahmed and Lara Mott.

Na'eem Ahmed (00:14)
Hello and welcome to The Improver podcast. I'm Dr. Na'eem Ahmed, clinical lead and co-founder of ImproveWell

Lara Mott (00:23)
and I'm Lara Mott, CEO and co-founder of ImproveWell.

Na'eem Ahmed (00:27)
and today we are really excited to be joined by Hassan Chaudhury. Hassan, hello.

Hassan Chaudhury (00:36)
Hey guys, how are you?

Lara Mott (00:39)
We're good thank you!

Na'eem Ahmed (00:40)
We are good, we are good. And just a bit about Hassan: Hassan promotes the UK digital health sector abroad at Healthcare UK, which is a joint initiative of the Department of Health and Social Care, NHS England and the Department for International Trade. He is part of the commercial team at Great Ormond Street Hospital for Children, a member of HIMSS Innovation Committee, the PM society, the Institute for Engineering and Technology healthcare sector executive committee, and holds an honorary research post at Imperial College London for his work in data science. We are very privileged and honoured to be joined by you, Hassan, thank you.

Hassan Chaudhury (01:20)
A real pleasure and honour to be here with you guys.

Na'eem Ahmed (01:22)
Hassan so as you know, as part of The Improver podcast, we are really excited to bring to our listeners, people who are the forefront of healthcare technology, which you so obviously are. And we know that you've been doing a lot of work with healthcare UK, and we just wondered if you could just open with, you know, what you've been doing there, what you're excited about And what you're really looking forward to.

Hassan Chaudhury (01:52)
Thanks so much Na'eem. I've got this story that I tell people that when I was a founder, I didn't use any of the help that you could get from the government. I didn't go for Innovate UK didn't do SPRI didn't use the HSN network, like a complete lone wolf is what it feels like, digital health, and we bootstrapped. We didn't have any venture capital, no, nothing at all right friends and family, got all the way to the end, had a trade sale. And then everyone tells me 'Well, why didn't you do some private equity and why didn't you use the HSM network?' So now I'm the guy doing all of those things, telling all the companies that want to come into the UK, this is what the landscape is. This is what HDR UK. This is Francis Crick, this is Alan Turing. I'm like a show guide, explaining to everybody what to do. So I worked with Office of Life Science to make the global sales pitch for digital health and data. So we could explain why you should come to the UK and set up, increasingly important because of Brexit. And I'm also the person that helps the UK health sector export, whether that's the NHS, whether that's academia, or whether that's digital health firms, startups scaleups. So for example, before COVID, I went on a trade mission, I led back to Saudi Arabia. And I took Great Ormond Street, and I took Moorefields, and I took Imperial and a bunch of startups.
So, in a nutshell, what I do Healthcare UK, I'm a matchmaker, I'm trying to build propositions and offers, so people can see the value of working together. And I'm trying to make us stop making the same mistakes over and over that we've done in healthcare. So the big offer we make to the rest of the world is, look at what we've done wrong. Work with us, we'll help you avoid them, and capture the future together. And I think that's what's really exciting about it.

Na'eem Ahmed (03:41)
And I mean, we know firsthand, Lara and I, about the amazing support that you provide startups, I think your description of them being a, of yourself, being a guide in this vast kind of ecosystem that we have here and how easy it is for you to get overwhelmed. I think one of the things I don't know Lara, what you think, but there's so many different offerings now and where to go for help. I don't know Lara, how you found it.

Lara Mott (04:10)
Yeah, it's an interesting one, isn't it? Because where do you start? I remember. Hassan, you know, our story quite well. This originated with Na'eem's idea. And we were very lucky to be on the first cohort of the Digital Health London accelerator. So when we co founded the company, it was, I suppose, easy for me because I had this 12 month programme with the digital health London accelerator, which gave me the network and the meetings and a bit of structure. Because on day one, you know, I had no idea what I was doing. And obviously, I had Na'eem support being entrenched in the NHS, we knew what problem it was we were trying to solve, but without that accelerator, I actually don't didn't know where I would have started. So what is the starting point for people, you know, you work, obviously, with a range of companies across the spectrum. Now, we can touch on the first 100, a little bit as well. But if someone came to you with, you know, I've got this idea. And I've got this concept, and I need to build an MVP. What advice would you give people from the beginning? Because that accelerator for me really helped guide in the first instance.

Hassan Chaudhury (05:20)
I've got lots of time for the Digital Health London crowd. They're really cool. And I think they have done a fantastic job five years, but just had a birthday recently didn't they?

So, the first thing I would say to people, and this is true, all business is that, before you scale, you've got to get your hands dirty, you've got to know what that problem is, and live it, you know, sit there in the dirt. And only then when you feel that problem and understand it, can you scale it. And in healthcare, that's multifaceted. You know, I've seen people in healthcare. And forgive me, I'm not naming names here, but they only see their part of it. You know, whether you're a nurse or a doctor, whether you're nonclinical, we all have our bits of healthcare that we see in touch. So you've got to make sure that you see the workflow the whole way through. And you see where the touch points and the pain points are. And this is a problem that we find in healthcare, that person who pays, isn't necessarily the user, and isn't necessarily the beneficiary. So only when you're really down about level the weeds, will you know, the problem. And then when you've got it right, then you can solve it. And that's why I insist I need to see an industry co-creation, I need to see that you've done it the right way. And then I'm looking for standards, which I'm lucky I'm at the IET for us engineering standards. I'm also looking for evidence, which is part of my background anyway, how can you make sure that we validated that you proved it in the real world? The first thing has to be: Have you fallen in love with the problem?

Na'eem Ahmed (06:58)
Yeah. But sometimes, I guess, the problem may feel like the most important to you. And I guess that's where you're, you're saying that they need to have some real world evidence, because it might not be actually a problem that is a burning issue that needs solving from the from the NHS, and that part I think is quite important in terms of how have you seen organisations provide that real world evidence? Because the truth is that, if it's innovation, it might not be there, you know, and you're kind of sometimes building the plane as you're flying it. So how do you how do you square those things?

Hassan Chaudhury (07:47)
I like the question.I know that there are people all over the healthcare system that will agree that there's a problem, but they won't agree on the solution. So you can't just focus on is this a problem? You also have to ask, Would somebody pay for the solution? Right? And the way you ask that question shouldn't be in a blasé manner. Because people say, 'yeah, sure, I'll pay for it.' But they don't mean it. Because they've got no budgetary responsibility, and they've never done it before. So over and over, your skill and ability to elicit those questions, and work out from people what the real problems are. That's the validation that you have to get into your MVP. The reason why real world evidence is important is for a very technical issue that I'll try not to bore anyone to death. But it's because we have this principle of efficacy. So something has to be in ideal conditions, clinical trials, a good example. How do you know that translates into the messiness of the real world? That's what the real world evidence is for? can you bridge the efficacy to effectiveness gap? And that's why real world evidence is important. It validates your claims, it means that you're able to do this, that your claim you can do, even though you're working in a district general hospital in the southwest, right? That's what you want to do, in a football analogy. Have you done it on a Tuesday night in Stoke, you've got to prove that you can do it. Don't make the claim.

Lara Mott (09:11)
I agree with that. It's just very daunting, isn't it? I take myself back five years. And it's a tall mountain to climb. You're the healthcare specialist at DIT. Do you have a view on how hard it is to innovate in the NHS versus other sectors? Is there ever any kind of cross fertilisation with other sectors? Because sometimes people approached me, friends, family, investors, whoever it might be and say 'you've picked the hardest customer? And why on earth? Would you would you try?

You know, there's no money in the NHS? There's no, they can't make decisions. It's full of inefficiencies.' Whereas, you know, Na'eem and I are obviously, very passionate about healthcare for probably similar and different reasons. What's your view on it? Is this the hardest sector to innovate in? Maybe that's my question.

Hassan Chaudhury (09:56)
Lara, amazingly difficult question to answer. So, thank you. I'm going to begin by saying I love the NHS, right, having worked in the NHS, and in health and social care, broadly, there's a really big BUT here in this conversation. Innovation happens, despite the NHS, amazing people within the NHS trying to do good things, even though it isn't built for it, even though the system makes it difficult. When COVID happened, there was some innovation that took place. And I remember someone joking, saying boys, because all the blockers went home. Right? It's the people that were blocking it. And so it's not just a structure and assumptions, the mentality, not as a culture, but there's some people who are just so risk averse. And they're risk averse, because their target sets are just so dominant in their minds that all they're going to do is get their performance to a certain level. And they don't care about anything else. They don't care about innovation, they just need to survive to the next financial year to the next quarter. And that's antithetical to the idea of innovation. You know, we can talk about DARPA and island bridge, can you move and completely different team out there somewhere far away and their own culture to innovate and bring that into the NHS? We can try. And I think there's some great examples CW Plus as a very good example. But what I'd really like to focus on, is that innovation happens despite the NHS. So we now need to find ways to remove those barriers. And so for example, Professor Tony Young, the NHS clinical entrepreneur programme, trying to help those people lift themselves up. That's one way. But I do think that the NHS does very badly at recognising good innovation when it's coming to it. And that's one of the reasons why we formed Tech for CV 19, which became more for health and care.

Na'eem Ahmed (11:53)
So I think that was important point about COVID being the really, really unfortunate catalyst, probably the wrong word, but you know, force, real unfortunate force for change in terms of digitization, you set up the Tech for CV 19. But what it did show us is that change is possible right? So you saw you know, even in my practice seeing you know, being people to be able to report away from hospitals you were able to see people working remotelyc and doing MDT is multi for those that don't know, multidisciplinary meetings - having been able to do those. So the potential is very much there. Right. And we did see amazing pockets of that happening. And we obviously hope that some of that good and positive change can persist, and I'm sure it will do. So what are the good things did you see, I guess, with Tech for CV 19, that you would like to see continuing in the NHS? And what was it that had made people, was it just the fact that it was a national crisis that we needed to move? What was the other things that made it such a force for change?

Hassan Chaudhury (13:19)
But the I think the credit goes to a few other people. So James Norman, who's CIO at Dell, he had a WhatsApp group full of people. And they were all making that same point. Professor Rachel Danskin, Nicola Heywood Alexander and others who are at that time, were saying, we need to gather this. So we ended up with a Slack channel, and 1000 people go into that slack channel. And we built a little community of people who still have lots of contact together now. And what we found was that there was an atmosphere of, even if we don't pass them the game, we want to help.

That really came out what the government might call the big society, stuff really came out there. Even though Tech for CV 19 changes to offer health and care looking at a much smaller organisation, the idea that we can come together to make sure the right technology is put forward as an important one. So we have CIOs, at least at Emory at the Marsden. And if you've got people who are really influential on the buyer side, as well as buyer side, you're able to make things happen. That's what I think the real lesson is when COVID hit, we weren't selfish, we tried to come together. it felt at times it was about your connection, and that's not how it should be. It should be based upon how big a problem you're solving, have you correctly solved it in a way that makes sense? Does that solution fit within the workflow? Do you have the evidence? Do you have the standards, and we're trying to fight back with that. So you can see, NHS X has made a big move with d-tec, the digital technology assessment criteria But I don't think there's an answer yet.

Na'eem Ahmed (14:58)
And one of the other ways, apart from the Tech for CV 19, was the First 100 publication, which you got a lot of praise for. And we saw all over social media. Tell us a bit about why you helped bring that together. And the purpose of it, and what you're hoping to achieve from that publication.

Hassan Chaudhury (15:19)
Thank you Na'eem. The joke that someone made was that they think 'Thank You Hassan Chaudhury' is going to start trending on Twitter, that sort of thing. So, this wasn't just me. But my role is very unusual. I'm supposed to be able to advise commercial teams and embassies across the world. So something like 109 countries, right, and some of those countries have got multiple Consulate Generals, China's got four. So there's commercial teams sitting there, each of those embassies trying to win deals for British companies. So DIT Singapore, a lady called Bausa. She said to me very early on in my role. Do you know a company that was immersive tech, something to do with surgery, and is also interested in Singapore? And that the last one, I thought, well, how am I supposed to answer that? I have to know that company well, I have to know their export plans, their maturity level, and get to the point where I yeah, of course they want Singapore. I can't answer that for a company. So then that taught me that one question taught me what my job really was, right? I have to be able to build relationships with the supply chain. So I went through the supply chain, and I did the visits that you'd expect, you know, I went up to over the park and I went to the different HSNs. And went across the country, I spoke to lots of experts, it's very small world and digital health, right? Very small. So you ask people who's good and who's rubbish, you know, who is it that screwed Northampton over the other day? Right? What was the name of that company? So once that's all in my head, I then interviewed 188, I think it was, companies. And I whittled it down to what I call the First 100. That's because the DIT said to me, you couldn't call it the Top 100 Because we'll get in trouble. So we call it the First 100. And we put 25 ones to watch the first 100 or picked on the basis that they were serious about export at a C suite level, that they were responsive. So there's no point me getting your opportunity. And then three weeks later, we don't hear from you, right. And we also needed to make sure that they were credible. So do they have something where they've done a lot of work in the in the UK and the NHS? Or are they perhaps representative of the trajectory that we want, you know that the way that we want to see the future, this is what it represents cloud based agile digital transformation, public code, whatever it is, right? And when I put that together, some of them were obvious, right? You knew Babylon, we're gonna make it in, right? You know RL Datix we're going to make it in. Because they had relationships with the DIT already, they were already exporting already working with us doing a good job aboard. But I wanted to make sure I went to Northern Ireland, went to Wales, went to Scotland, went to the regions.

I wanted female founders, I wanted LGBT, I wanted to make sure that I had full representation of what's going on in those small nuggets of gold, right. And then I managed to put together 100 really, really good companies into this playbook. And then what's gone on is, we've got a microsite. All across the world, you see health systems are looking at it, venture capital looking at it, and we're expanding it now. But forever, those who made it into the First 100 will have that designation, those were the first 100 that we put forward, and the others, they'll just be in the playbook. Right. And that's a good thing to be. But for those first 100, when we put them forward to the Asian Development Bank, I did a workshop with them, or recently with the health service executive for Ireland. And they had this thing called Shift Left Stay Left, right, where they're trying to move all of their care, closer to patients away from hospital, expensive settings. And they went through that 100 with us. And we said these are the ones we think you should go for. They picked them and did a close pitching session. So they could do pilots. There's been a move, I'm trying to move British innovation into real life adoption. And that's what the First 100 really is.

Na'eem Ahmed (19:27)
That is a big ambition, which is obviously something that we welcome, and I think it's good moment to say that ImproveWell, we're really delighted to be as part of that First 100. But, but there is that other question which we spoke about before we started recording, which is that how do you move, as part of your programme to for adoption, how do you move into and beyond these pilots stages, you know, as in, someone said that the NHS is suffering from pilot-itis, you know, like there is a lot of pilots and, and rightly so in a way because it's the taxpayers money and they need to be able to get that right. But if it is, how do we get beyond that quickly? What's your diagnosis, doctor, in terms of that problem?

Hassan Chaudhury (20:20)
Thank you. I've had it called Irritable Pilot Syndrome, as well. I think there's a challenge where you need to prove in your savings and you need to prove that the ROI is available because the NHS is cash strapped. Now, this isn't the same as every other market in the world, but just to focus on the NHS for a second. If you go in and say we want you to spend to save, the people you're speaking to are not stupid, right? They understand the value of what you're trying to do. And they cannot pull the funds out necessarily to spend to save, so a lot of the time, they're saying, can you come in and give me some wins, give me some quick wins. So because they're under so much pressure, their window of opportunity is much smaller, which is why they're thinking about pilots. So, this is why I think a lot of digital products fail. They're just trying to do the same thing. But with a digital layer, a digital wrap you used to send out in the mail. And now you're just going to ask people to go to a kiosk, right? Is there really much difference between the two? I need you to see that digital transformation is really about upending, whatever you were doing, because you've now got new capability. And when people think of it like that, their window expands. They're no longer just thinking about this one issue and the short termism goes. we've got to take stock, take a deep breath and think, if we want to achieve this long term goal, and use digital the right way, this is the right way to do it. Put in a two year investment. We'll prove it to you. We'll do a phased deployment, no problem. So you can do milestones of your payments. And let's not call it a pilot. Because as soon as they do a pilot with you then Newcastle will say, well, let's do a pilot with you and then Glasgow and say the same. And then you're doing one in Dorset, you've done 74 pilots, you've not achieved a single contract. It's not worth it. And then your runway goes. And then what happens? You go to VCs and say, well our runways in trouble, and they devalue you. And what does that do? The whole thing starts to fall apart. So if we want innovation to work, we cannot allow startups and scaleups to fail. We've got to give them a chance to get their test beds and their phased deployment. We've got to think longer term.

Lara Mott (22:36)
We wanted to come on to the topic of data with you Hassan, because you are a self-confessed data geek. One of our core values is building evidence-based solutions. We are all about the data. The point about pilots, we don't really call pilots, pilots anymore with ImproveWell. And I guess that's because we've got a five year track record now. We do very much back the, kind of, land and expand strategy. So, start small start in a department and then roll out. But with our partner organisations, we are focused on that strategy from the start. So absolutely start small, but we will have to have the intention that, that's just to learn what works and what doesn't work for the local contexts, and then apply those learnings to scale out. So I wanted to say we're lucky, I guess it's not luck. It's, you know, I guess, five years of, of working on that evidence base in the data. But specifically on the real world data side of things. And we said we were going to come back to this, what is your view on real world data? And, I guess, what are the benefits of that for companies at the various stages?

Hassan Chaudhury (23:42)
When I first heard the phrase ‘real world data’, it was a pharma company telling me this and I put the phone on mute, I turned to my co-founder, ‘what the hell is that?’ We had no idea what that was. And that's because the company that we founded together, Health IQ was about taking NHS data and analysing it but not giving the data to pharma companies and other corporates, so that we will be able to solve certain questions. And they were specifically talking about real world, as opposed to clinical trial data. But real world data, in essence, is data that's reflective of routine clinical delivery. What's actually happening? How many bariatric surgeries have you had in Wales, right, it’s asking those questions. And if you can't work out the real world data, you won't know the impact of your intervention. Digital health isn't going to have the same level of rigour in its clinical trials that you'd expect drugs and devices to have. You can do clinical trials, you know, big health, and a few others quit genius, have managed to do clinical trials. But where you're going to get the real value in proving the intervention is effective, is going to be in real world data. So I made a bet three years ago, when I left Health IQ when we'd been acquired, and that was a real world evidence startup, to move to digital health, because I could see them converging. And that's what I think the future is, if you're a digital health company, and you don't have real world evidence, you can't prove the value of interventions.

So that's what you need. And that's why whatever this is, is critical. So an example that's irrelevant to ImproveWell, if you come in to an environment, and you change everything radically, you're adopted, everyone loves it. How are you going to prove the value of what you've done? There's pre and post right before it was like this. Now it's like this. And someone will argue from methodology perspective, pre and post isn't effective. And that's not the gold standard. So, you're going to need to know, as a digital health company, what would be the model that you're going to use? What are the endpoints that you look for? I think we all need to be better. And we talk about health economics a lot. Health Economics is built upon the real world data, you've got to get good with that real world data to prove your value.

Lara Mott (25:58)
I mean, I think that's, it's a challenge for all small businesses, because certainly for the businesses that we are the organisations we work with, ImproveWell is not the only thing they're introducing.

So I think for organisations that are solving slightly different problems that aren't directly correlating to, ‘we saved you a million pounds’ or, you know, ‘we radically improved this particular outcome for this particular disease indication’, it can be quite challenging. So we often focus on KPIs, I guess, what baseline metrics do you have at the moment when you introduced us? And then you know what comes out of it. So it's very much about data, because then you're not wearing the rose tinted glasses and relying on someone to say, well, we love that product. And it was great. And it's just anecdotal. It's trying to find a way to sort of objectively assess exactly as you say, what was it like before? And what was it like after, it might not be the gold standard, but it can certainly work for a product that isn't necessarily it doesn't necessarily need to adhere to nice guidelines or, or that kind of thing. So given the vast variety of companies and products in digital health, I think people need to find what works for them, perhaps.

Hassan Chaudhury (27:20)
I completely agree. And pre and post is going to be the thing that you do when you look to the other models, and they don't work for your venture. But if people aren't educated on what they have to do the first place, people are going to chooses inappropriately. And they're going to find that commissioners and clinical teams are going to rip that apart. Because they used to looking at this, they used to looking at evidence arguments, maybe those seven o'clock in the morning routines that you get more loving, you get the consultants together and saying, let's do an evidence review. So I really think that digital companies need to bone up on those will be stronger in them, and the future is going to lie with companies with the right evidence. And increasingly those with d-tech, you could argue the last 12 years has seen lots of companies, which didn't have really good technology, but they managed to get there first get some scale, get some adoption, get some VC funding, and then they made their exits and they made lots of money. That next wave of companies that are coming are going to be scientific discoveries. Those who are precision medicine, those who using AI, genuine AI, not AI, everywhere, like it would have seems to say, right, you're going to see those companies come in. And they're the ones are going to have to make sure that they're not just using clinical evidence. They're using real world. It's not just what was happening in the lab. It is about the deployment. And that's where I see the future.

Na’eem Ahmed (28:43)
So you've spoken about the future, I guess, for health tech, and actually technologies improving the healthcare sector, what would you say are your personal, I guess, ambitions for the next few years? Before we wrap up, it would be interesting to know where you're going to be positioning yourself in terms of all of this. And what were the things that you've kind of focused on or would like to very much achieve?

Hassan Chaudhury (29:10)
There's a phrase Master of None, I think is the is the phrase, right? So I've managed as you as you gave in my brief intro, to have an academic position. So I'm honorary at Imperial. But I'm also at UCL at the Global Business School of Health, which is the world's first business school dedicated to health care. Having that perspective helps me in one sense, another is that I'm at Great Ormond Street, so on the NHS side, but I'm also with the National Association of Primary Care. And then I'm also at the government. So you're probably thinking, why is he doing all of those roles? And I wanted to have 360, I wanted to see what was going on? Because I think the future is a bit uncertain. Is it about trying to find the next monster deal, you know, the big digital health company that's going to make it. That doesn't interest me. What interests me is making the system more conducive to the adoption of innovation. And that's really what was behind Tech for CV 19. And for health and care, that's what's really behind what I do at the DIT.

That is actually the role of NAPC, How do we get the right digital technology into the ICS's? It's what we do at DRIVE, the Digital Research and Informatics and Virtual Environments Unit at Great Ormond Street, how do we get the right technology and innovation in an area with no patients, so that we can use the data and the technology, bring it together and then feed it into adoption? I believe that, unless you get that bit right, all the way down the chambers at work. And my life has really changed by not becoming a doctor. As you can imagine, culturally, that would have been the big win for me if I was a doctor, right. But I didn't, I didn't make it sadly.

So then what I became was someone who was an adjunct, someone who made the clinical process easier, that made it easier for clinicians and physicians. And that's where I see my role. And I'd like to think in a couple of years time, adoption will be easier, more adoption will have been made. And I'm lucky at the DIT that I get to travel the world, pre-COVID I got to travel the world and find out what everyone is talking about. And it was always the same thing. What exactly is the right innovation that we need? What's the what's our benchmark? How do we work out what is good innovation? From South Africa to the Philippines, to Thailand to Saudi, and I visited them all for the DIT. I visited Finland, I've visited Orlando and I've gone through all these conversations with them. And I hope I can make some difference.

Na'eem Ahmed (31:42)
That's a very noble ambition. And you've made, you know, just from your bio and the conversation, you know, and our personal obviously, friendship with you has demonstrated that you've made some fantastic inroads into that. We have a segment in our podcast, which we call 'small but mighty'. And in this section, we ask our guests to think about a small but powerful idea really that they think could be transformative. And usually this would be a staff member in a healthcare organisation using the ImproveWell app, to put in a great idea which they think can change the way we're delivering care for our patients. And what so, just to put you on the spot, really what would you say your small but mighty idea might be?

Hassan Chaudhury (32:40)
I'm going to go against type. I think certain digital technology actually creates more burden for people. It creates burden for clinical, non clinical teams, but they don't have a way of telling you that it's creating more burden for them. And it helps them in their daily lives, and then their it bleeds out in their interactions, whether it's people sideways of them, to the patients to the carers, and then the people who procure this technology, all crowing about how great we've got this technology, and it's wonderful, and the staff are actually having a harder life. I think we need something that evaluates the perception, the burden created by new technology and a system within a certain time period. So if you're going to implement digital, you've got to make sure you listen to the people to hear from them, what their feelings are about that technology.

Na'eem Ahmed (33:36)
Thank you so much for this. For taking the time to come and talk to us, we appreciate it. You would usually be flying around the world, but you are now grounded but that's great for us now that we can have this conversation, so thank you again Hassan.

Hassan Chaudhury (33:56)
Genuinely honoured to be here with you guys and glad to have you as part of the First 100, hope to take you around the world with me.

Lara Mott (34:02)
Oh yes, next time it's Thailand, I'll be there for sure!

(34:10)
The Improver is a production of ImproveWell limited. Thank you to today's guest, Hassan Chaudhury. To find out more about the ImproveWell solution, visit improvewell.com. Subscribe to The Improver at Apple Podcasts, Spotify, or wherever you're listening.