Imperial College Healthcare NHS Trust has submitted the following organisational response to DHSC and NHS England's Change NHS consultation, which is intended to inform the UK Government's upcoming 10 Year Health Plan.

We have drawn on our workforce and wider partnerships to highlight changes we believe can deliver significant and sustainable improvements if implemented in the health plan.

Please contact Hannah Fontana, strategy, research and innovation manager via hannah.fontana@nhs.net with any questions regarding the submission.

Q1. What does your organisation want to see included in the 10-Year Health Plan and why?

Imperial College Healthcare is one of the largest NHS Trusts in the country, with nearly 16,000 staff and 1.4 million patient contacts annually. We provide acute and specialist care from five major hospitals in north west London and a growing range of community facilities. We host the largest NIHR biomedical research centre with our academic partner Imperial College London, lead Paddington Life Sciences, a life sciences cluster centred around St Mary's Hospital, and our Hammersmith Hospital forms part of Imperial College London's White City Innovation District.

We have drawn on our workforce and wider partnerships to highlight changes we believe can deliver significant and sustainable improvements if implemented in the health plan.

1. A whole-system approach to integrated care and population health management

We need to move from fragmentation to integration. Currently, most specialist care is provided in hospitals, and most primary care is provided in GP practices, with patients 'handed-off' between primary care and hospital clinicians. This model is essentially unchanged since Victorian times. With significant increases in need, complexity and demand over recent decades, the relationship between these two groups, and wider mental health, community and social care services, has become transactional, making it difficult to provide efficient, joined-up, care. We need to incentivise collaboration and outcomes-focused ways of working across organisational boundaries.

1.1 Integrate specialist care into community settings

Integrating the delivery of more specialist care with general practice and community health services, including through the emerging integrated neighbourhood teams, will better use skills and resources and improve outcomes.

Specialist advice and care can be drawn out of hospitals within existing organisational structures. This builds learning for everyone, with acute and specialist providers contributing specialist expertise, research and management-at-scale, and GPs bringing their more holistic clinical understanding, management of risk, and community-centred practice.

The emergence of secondary care-led community diagnostic centres (such as our Wembley and Willesden centres), often already co-located with existing general practice or community health services, provides additional opportunities to develop more integrated models of care.

One long-standing example of a successful specialist and generalist integrated care model is Connecting Care for Children, a partnership between GP practices in north west London and Imperial College Healthcare. Over the past 16 years, GPs and specialist paediatricians, with specialist nurses, practice nurses, health visitors, children's centres and schools, have come together in an expanding number of child health hubs run out of local GP practices. They run a monthly multi-disciplinary meeting and 'outpatient' clinic as well as enabling open access to specialist advice at any time, underpinned by strong engagement with patients and their families.

Peer-reviewed analysis demonstrates positive impacts, including an 81% reduction in hospital outpatient appointments. If scaled to a typical ICS footprint, it delivers £2.4m of efficiencies a year and reduces health inequalities. Read more about the child health hub ICS value analysis. We are part of other successful integrated services for respiratory, cardiology, frailty and renal medicine across north west London, demonstrating that the model is widely applicable. However, spread has been slow, relying on the commitment of individual clinicians, often in opposition to wider system incentives and processes. We need to address barriers around rigid approaches to 'payment by results' and challenges around contracts and job plans.

1.2 Integrate urgent, acute primary care into hospital settings

A similar approach but in the other 'direction', with primary care integrated into hospital services, could benefit urgent and emergency care.

Despite multiple campaigns and new approaches in primary care, many patients continue to attend hospital A&E departments for acute but non-life-threatening issues. Like many acute hospitals, our Charing Cross Hospital already hosts a GP practice near A&E services. We would like to explore formally integrating our range of urgent and emergency care services (including same day emergency care, urgent treatment centres and emergency departments) with extended-hours GP services.

In urban hospitals serving relatively dense populations, this could provide a more cost-effective, higher-quality service. Patients get the care they need quickly; it offers more of a 'one-stop-shop' approach, reducing the number of individual appointments; and staff can be deployed more efficiently across the whole pathway. It would also allow local GP practices to focus more on supporting patients with complex health needs who need continuity of care.

1.3 Pool budgets to incentivise integrated care and improve population health

We support a more radical approach to incentivising joined-up care across organisational boundaries, including by pooling budgets (and other resources), joint needs assessments and co-production of a shared set of outcomes. This means clinicians can be genuinely patient-centred and 'institutionally agnostic' when determining what care is needed and where.

Pooled budgets would support the integrated care models outlined above, especially if underpinned by the sort of outstanding data assets we have in north west London (whole systems integrated care (WSIC) dashboard). And they could be trialed first, across primary and secondary care, and without moving real money.

Pooled budgets would also encourage a systematic approach to 'making every contact count'. Hospitals and specialist clinicians can play a bigger role in supporting patients to make lifestyle

changes to improve their health, and public health specialists can make greater use of hospitals' millions of patient contacts each year to offer evidenced health interventions.

In the past year, with NHSE support, we have implemented tobacco dependence treatment services in inpatient services, with dedicated health improvement advisors supporting patients to stop smoking. Early data shows that over 80% of eligible patients agreed to be supported to be smokefree, with 60% agreeing to the recommended NHS intervention (1-2-1 specialised support and pharmacotherapy). One in three patients have remained smokefree 28 days after discharge. There is huge potential for a similar approach to other health issues such as obesity and alcohol misuse.

2. A strategic approach to investment and planning

2.1 Create long-term plans for delivering modern healthcare facilities that maximise the potential for life science partnerships

All our main hospital sites are part of the Government's New Hospital Programme, a recognition of our urgent need for modern facilities to provide high quality care more cost-effectively and sustainably. We spend around £30 million a year on urgent backlog maintenance and estimate around 15% of staff time is wasted on creating workarounds to failing estate. Over past decades, the lack of a strategic capital plan and investment commitments has led to the failure of previous redevelopment projects and means we now have a real crisis that will cost several billions of pounds to fix.

As well as facilitating improvements in health and healthcare, hospital redevelopments can deliver economic growth, by maximising the potential for life and data science partnerships. Just the prospect of a new St Mary's Hospital is catalysing investment in Paddington Life Sciences, the life sciences hub we established just over a year ago.

A whole-system approach to integrating care will encourage NHS organisations, and potentially local authority and voluntary sector partners, to work together to better use existing facilities and to create joined-up investment plans.

2.2 Create long-term plans for securing and maintaining state-of-the-art equipment and technology

One of the biggest bottlenecks in NHS care pathways is diagnostics, especially the various imaging modalities. 30 per cent of our imaging equipment is over eight years old, the normal lifespan of these machines. Without a strategic capital plan, we rely on a piecemeal, often opportunistic, approach to updating and replacing scanners. In the meantime, as equipment gets older, it becomes harder to maintain and more expensive to get it repaired (from April to October we had 359 hours of downtime for CT machines and 1836 hours of MRI downtime).

As a response, we have been leading the development of a strategic imaging asset management plan across our sector. We have developed an approach that involves procuring a multi-year agreement with a commercial partner to deliver a rolling replacement, upgrade and maintenance programme for our imaging equipment. It involves working across organisational boundaries to make the best use of our collective imaging assets and providing more diagnostic capability within community health facilities to support cost-effective, integrated care. However, because of the scale and multi-year commitment required, we are now struggling to get sign-off through existing governance routes.

We want to develop a similar approach for other types of equipment, especially for where rapid technological advances mean we struggle to respond quickly and cost-effectively, such as surgical robots.

2.3 Create long-term workforce plans that reflect new models of care and ways of working, and respond to the needs of our people

To move from fragmentation to integration we need to train, learn and work together in a more multidisciplinary way, both between professions and across organisational boundaries.

We need to get better at identifying and responding to new requirements for our workforce, whether that's new or more flexible roles or upskilling within existing roles. For example, we need to help all our people make the most of new technology, especially AI, and we need to think about how we address patients' health needs more holistically and support co-production in service change.

As the Messenger Review (Health and social care review: leadership for a collaborative and inclusive future - GOV.UK) highlighted, the NHS needs to rebuild its investment in leadership development. There is evidence that high performing teams come from a leadership culture that focuses on kind, encouraging and nurturing behaviours that create psychological safety (Google's Project Aristotle). These approaches are key to tackling issues of productivity (Demos) as well as staff morale, engagement and retention. It's vital that this is done with a focus on inclusion and equity.

3. A clear expectation to develop person-centred services and to understand and measure how well we do this

The NHS is a people business. Yet it remains uncommon for NHS services, processes, or strategies to adopt person-centred design – building an understanding of the needs and preferences of patients, staff, or partners and ensuring those needs are met. The time required upfront is vastly outweighed by the benefits, making services more effective and reducing waste. When patients, local communities and staff see that organisations are genuinely person-centred, they also feel more valued and willing to engage in and support change.

We have been building organisational infrastructure to make it easier for everyone to apply the basics of person-centred design. Key developments are summarised below. Similarly to integrated care, these developments already exist in some form in many NHS organisations but have not been mainstreamed as they rely on the commitment of individual staff and patients, often in opposition to wider system incentives that favour outputs and not outcomes.

There should be an expectation that all NHS organisations embed person-centred design approaches, and evaluations of quality should always include how well we are meeting the needs and, wherever possible, the preferences of the people we serve.

3.1 Establish a clear organisational framework for patient and public involvement

We have around 50 lay partners, local people and/or patients who work at a strategic level to help ensure we understand and respond to user needs. We have committed to having lay

partners involved in all our major developments and they meet as a strategic lay forum to oversee our person-centred approach and hold the Trust to account.

Lay partners do not tell us what patients want but make sure that we find out and respond. Alongside drawing on data and research, we do that by working directly with patients, people with lived experience and local residents to get their views and ideas, co-design solutions, and test improvements. In the past year, we have been working with the Helix Centre, to establish evidence-based approaches to co-design, and working with them on two major programmes – improving our end-to-end outpatient administrative processes and making our cancer care pathways more user-focused.

We have also developed a framework to ensure clarity and consistency in our approach to patient and public involvement. This includes being clear on different involvement roles and having clear and consistent enabling policies. For example, we are consolidating ad hoc approaches to remunerating individuals for the time they spend helping us. Not everyone wants to be remunerated but, for some, it is the difference between being able to get involved or not.

3.2 Gather, analyse and measure insights on 'person-centredness'

NHS organisations measure and report on many indicators but few give a good sense of 'person-centredness'. We do report on some patient experience measures, primarily complaints and the friends and family test. But generally, this is at a very high level and/or focused on outputs (the number of complaints), not outcomes (the main causes of complaints and how they have been used to drive or shape change).

We are developing reports and dashboards, tailored for ward to board, that triangulate and analyse data and insights to build a clearer picture of whether our users are getting the services that work for them. We are also piloting a new 'what matters to me' measure and the use of AI to analyse thousands of free-text comments. This work is especially important with the expansion of digital services where patients are increasingly expected to interact with several different, overlapping digital platforms, often to a point of confusion. We are also integrating this work into our wider improvement methodology and health equity strategy.

3.3 Holistic patient relationship management

Whilst our electronic patient administration system has transformed our ability to join up clinical data to inform care, these systems are not designed to incorporate patients' needs and views or to link their use and experience of care. We are working to specify requirements for a patient relationship management system – similar to customer relationship management systems used in most businesses. We will use the system to have a single view of our patients, linked to our administrative, clinical, involvement and communication processes. It will transform 'customer care' and make us more joined-up in how we engage and respond to our patients across the many services they may be using.

Eventually, we would like to extend this approach to research. With over a million patient contacts a year, we would like to offer every patient the chance to be part of our Imperial Health Knowledge Bank, contributing to clinical research where possible and research breakthroughs across our teams.

4. Cross-sector anchor strategies with key roles for large NHS organisations

4.1 Embed anchor principles into employment and procurement

We have been forward thinking in fulfilling our role as an anchor across north west London. One example is collaborative work with the North West London Health and Care Skills Academy (funded through the Mayor's office) to attract, recruit and develop local people as support workers. This has successfully placed 1,816 Londoners in healthcare employment and apprenticeships. We need a mandate to embed anchor principles into operational activities such as procurement and employment (eg prioritising local suppliers) to amplify these positive impacts.

4.2 Recognise and reinforce environmental sustainability as a vital enabler

Climate change and air pollution have direct and immediate consequences for health and wellbeing, with a disproportionate impact on the most vulnerable populations. We have achieved a 17.3 per cent reduction in our carbon footprint since 2019/20 and are committed that, by 2026/27, our carbon footprint will be 34 per cent lower than in 2019/20.

A bold commitment to environmental sustainability will be a vital enabler of the health plan by improving health outcomes, reducing costs, and ensuring long-term operational resilience. Reframing carbon as a currency with equal weighting as other domains of quality, alongside a coherent operating model and financial architecture will enable us to reach net zero.

4.3 Recognise the role of the wider determinants of health and allocate resources accordingly

Research shows that clinical care only accounts for 20 per cent of health outcomes and it is the wider determinants of health, such as housing, education and socioeconomic factors, which have more impact. It's important that acute hospitals are supported to play their part in addressing these wider determinants. For example, we support homeless patients who attend our emergency department to gain access to a mobile phone so they can be contacted by housing organisations following discharge to support their route into stable accommodation. Projects like this need core funding and support.

5 Promote translational research and innovation through partnership with life sciences and academic organisations

5.1 Cultivate partnership across the health care system and life science organisations

Partnerships between health care and life science organisations allow co-production of new innovations with patients and staff, improve access to clinical sites for real world testing and increase access to cutting edge interventions for patients.

We have developed Paddington Life Sciences, a partnership of 19 NHS (acute and specialist Trust, NIHR ARC, Health Innovation Network, GP Federation), industry, community and academic organisations, with a shared commitment to generating healthcare innovation, alongside health, economic and social value, through a new life sciences cluster centred around St Mary's Hospital. Industry partners include technology companies Microsoft and Oracle Health, with whom we are testing the impact of AI technologies on care, and pharmaceutical companies Takeda, Vertex and Ipsen with whom we are working to increase access to clinical

trials. To maximise the benefit of partnerships we need stronger contracting, procurement and intellectual property expertise within the NHS.

5.2 Demonstrate the wider social value of partnerships

There will also be an opportunity to generate social value for local communities through these partnerships. Paddington Life Sciences has facilitated focused work between partners and schools and further education organisations that is helping upskill and recruit people into local industry. In addition, place-based partnerships help ensure that CSR initiatives are targeted towards activities that can really benefit the surrounding communities.

Q2. What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

1. Changing attitudes to primary, acute and specialist and community care 'silos'

Within the NHS we have built these unhelpful and divisive structures "primary care", "acute trusts", "community providers" where too often the incentives drive siloed working rather than connected care. The development of integrated neighbourhood teams, responsible for the outcomes and care of a defined population of people, is a golden opportunity to establish an approach where multi-disciplinary teams, working in and close to communities are able to "pull" on the specialist expertise and resource that is available to them within our acute and specialist services.

As an acute trust, we run two community diagnostic centres, one ophthalmology diagnostic centre, ten renal satellite units and the Ealing community cardiac centre, as well as many clinics within communities (eg 10-15 community cardiology clinics a week in Hammersmith and Fulham, and renal MDTs in local boroughs). We have consciously opened community diagnostic centres in areas of highest need, to ensure care comes closer to those who need it.

We need to think of the services that patients need, where they need it and what expertise is needed to deliver, and pull that together, rather than create anything new. This will be across our traditional boundaries of care and will enable care to move into the community, even if delivered by skilled clinical staff employed by acute trusts. We need specialists (consultant, specialist nurses, specialist allied health professionals) to provide specialist care in community, as well as hospital settings, connecting care as they work across different parts of the system.

2. Aligning funding and incentives around patients and outcomes not organisational boundaries

Our key issue in delivering integrated care is the way funding is distributed. Current arrangements for funding specialist time within community or primary care, where payment by results incentivises specialists to stay in their outpatient clinics, are not fit for purpose and incentivise siloed working.

An integrated approach needs to be built into contracts, both in primary and secondary care. This should focus on individual clinicians, managers and multi-disciplinary teams moving to

where they are needed, rather than moving organisational budgets or creating new structures to employ people. This will also reduce transactional cost. For example, building time working in communities into consultants' job plans and ensuring primary care incentive schemes support specialist clinics.

3. Upskilling the workforce to deliver care in multiple settings and build trusted relationships with colleagues across organisational boundaries

We need to build the culture, skills and attitudes in our staff to deliver this new way of working. Our successful integrated programmes (see case studies) have been built on investing in trusted professional relationships over time. We need to make time for relationship building through shared goals and projects, not just focus on structures, systems and processes.

Upskilling and education need to be a key focus. Our consultants who work in the community emphasise that they develop better clinical skills working both in hospital and in the community compared to working in one setting alone. Formal training models need to adapt: a respiratory specialty trainee cannot undertake a rotation in a community clinic due to rigid specialist training structures. They will need this experience in the community during training to be effective future consultants.

We will also need to ensure workforce planning takes account of this shift, with more flexible roles that can deliver care across different settings and sectors.

4. Use non-clinical expertise that already exists

This new way of working will require management and operational skills too, most importantly project management to deliver a new way of working. Acute trusts have many non-clinical skills to offer for integrated community teams to 'pull in'. For example, the management structures that we have built around specialties in secondary care or HR, IT and education expertise. Shared systems are important to make this work, with shared digital tools and interoperable IT systems to support seamless care.

You can see examples of how we how we deliver integrated care.

Q3. What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

1. Investing in education and training for staff

We cannot just use technology to replicate inefficient processes but need to digitise them to make them work better. Extensive staff training is needed to make best use of technology, including for work process redesign, so that dashboards and data driven insights are central to clinical teams' workflow. Organisations like ours, in partnership with our university collaborator Imperial College London, and industry partners like Microsoft, are well placed to lead on these initiatives.

2. Realising the value and potential of NHS data

Current software and practice lead to inconsistent data quality which hinders analysis. To properly maximise the efficacy of new technology such as AI, we need to invest in better quality data and data platforms.

We need new technologies to seamlessly integrate with current systems and systems to be standardised and interoperable across sectors and settings. This helps cross-cutting services like pathology or imaging who may otherwise need to link into many different systems.

Scale is an enabler for using data more effectively. In north-west London, we have Whole Systems Integrated Care dashboards (WSIC), a linked integrated summary of patient's health and social care. By pooling data across such a large area, we have 2.4 million patient records in the system and can undertake large-scale data analysis to derive insights. We could not do this with the records from a single trust and there is a role for the regional and national NHS to support this data use. We also support a clear view of the monetary value of NHS data for companies and researchers to enable best value for patients, communities and research.

3. The role of digital inclusion in supporting patient acceptance and uptake

Digital inclusion is a challenge with many factors driving a digital divide– a lack of access to devices and equipment, tailored education for people of all ages and who speak many languages and explanations about how a digital health approach can benefit them personally and not increase risk or harm, given concerns around confidentiality and data security.

Through work with local authorities, we are connecting residents and patients with training in their own homes or community spaces such as libraries to help them better understand how to use and benefit from the NHS app. Through Paddington Life Sciences, we can give large tech firms access to challenges faced by staff and patients to help co-design new solutions for the future.

4. Overcoming barriers to working in partnership with tech companies to support user centred design

We have found industry partnerships valuable in deploying new technology. We have developed Paddington Life Sciences, an influential partnership group centred around St Mary's Hospital in Paddington.

With industry partners such as Microsoft and Oracle we are planning to pilot two different ambient AI technologies, which can record consultations for clinicians and input the outcomes into structured notes, saving clinicians' time and giving more accurate notes. To do this effectively, we need strong contracting, procurement and intellectual property expertise within the NHS, which is not always abundant.

You can see examples of how we are using technology in healthcare.

Q4. What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

1. Support secondary care providers to focus on prevention

Acute care providers have an important role in prevention. For example, cardiac or pulmonary rehabilitation programmes to support people with disease are effective but underutilised. There needs to be focus on making these programs widely available and tailored to different patient populations.

Secondary care providers are well placed to encourage healthy and safe habits (exercising regularly and not smoking) by Making Every Contact Count. Alongside implementing this through our tobacco dependency services, there are opportunities to expand this approach to alcohol care teams and an improved weight management offer to those with a high BMI.

2. Personalised data-driven interventions to spot illness early

Personalised, data-driven interventions are an enabler to support prevention. This includes using data analytics and artificial intelligence to identify individuals at high risk of disease progression or complications. For instance, patients with early-stage cardiovascular disease could be closely monitored and receive tailored interventions based on their specific risk factors. Integrating data from wearable technologies that help patients track symptoms into secondary care would allow healthcare providers to act quickly on signs of deterioration.

This is hindered by a lack of integrated data platforms for sharing patient information across organisations, we need single databases with population health and clinical assessment data, available across the system.

3. Integration of preventative services

To effectively deliver primary prevention, we need to connect with other local services. Within the North-West London ICS there are now tobacco dependency services delivered by four acute NHS providers, two community NHS providers, eight local authorities and many local pharmacies, with varying offers and approaches. This fragmentation leads to inconsistent care, poor continuity in support, barriers to access and resource duplication. We need a consistent integrated service offer across the system and better integration with the national pharmacy Smoking Cessation Service.

We have expertise in adoption of innovation and with breakthroughs such as new obesity drugs being approved by NICE, we need to work as an integrated system to find ways to implement those treatments at scale.

You can see examples of how we are preventing ill health.

Q5. Please use this box to share specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivered in, for example:

Quick to do

- Align incentives to encourage work that is a 'connecting' or integrating, e.g. amend funding and contractual models to support acute staff working in community and vice versa
- Deliver a communications plan which changes the narrative on organisational boundaries – we are one NHS
- Give clarity that there will be no tolerance of bullying and harassing behaviours that have been synonymous with performance management in the NHS to date
- Develop clear training modules and a skills map that staff (clinical and managerial) will need to meet the new vision of integrated working.
- Commit to funding the redevelopment of our failing estates through the New Hospitals Programme
- Add anchors framing to NHS procurement and employment processes to support local recruitment and purchasing (e.g. quotas for local recruitment)
- Integrate preventative healthcare within other clinical pathways (e.g. vaccination in paediatric clinics to address low uptake of childhood immunisations) and expand upon health improvement work to other public health challenges (e.g. obesity and alcohol misuse).

In the middle-term

- Transform the process for capital investment to reduce inefficiencies and increase the pace of the work using a lean approval process instead of multiple sign off layers
- Develop a strategic approach to capital funding for equipment including a plan for buying new equipment, assessing when equipment needs to be upgraded and maintaining equipment whilst in use.
- Ensure integrated neighbourhood teams focus on making the current system work better and actively leading in public health, prevention and self-care, and 'pull' in specialist resource and expertise from acute and specialist trusts.
- Better integrate preventative healthcare (health improvement) services across and within ICS regions.
- Invest in education and training of staff to support use of technology and data within their work.
- Amend formal training pathways (e.g. medical specialist training) to support integrated care, e.g. ensuring specialty trainees rotate within community settings.
- Promote partnership between NHS and life science industry to support translational research and co-production of interventions, focusing on increased equity of access to clinical trials and new innovations.

Long term change

- New approach to education and training embedded for all professions, to enable the strategic shifts.
- Shift healthcare budget towards other governmental bodies such as housing, work and pensions and education to show commitment to addressing the wider determinants of health.
- Strengthen the impact of the UK's life sciences strategy through the development of several interconnected life sciences ecosystems, that are co-located with leading research-focused NHS organisations (e.g. Oxford, White City Innovation District, Paddington Life Sciences).