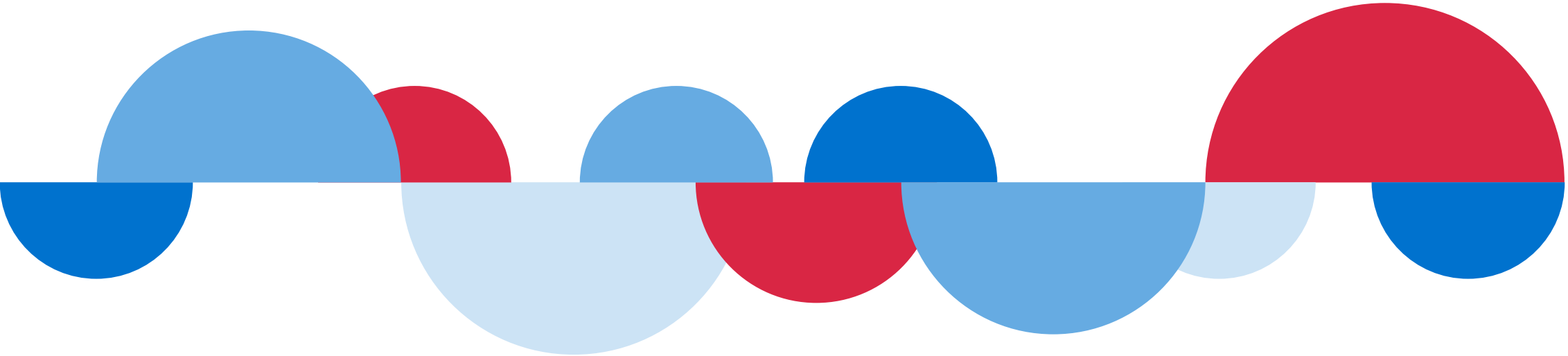
Hammersmith & Fulham
Health and Care Partnership
Better Together.

10 Year Health Plan: summary and update for the Hammersmith & Fulham Health and Wellbeing Board

10 September 2025



Summary

This paper provides an update to the Health and Wellbeing Board on a number of significant changes and developments in national health and care policy, including changes to the structures and governance of NHS commissioning organisations.

Key documents include:

"**Fit for the Future: 10 Year Health Plan for England**" published on 3 July 2025, setting out national policy and ambitions for the NHS and related services over the next ten years.

A **Model ICB "Blueprint"** was published in May, setting out the future role of ICBs, following the announcement in March 2025 that ICBs should reduce their costs by 50% nationally. It outlined a range of existing ICB functions that should transfer, over time, to provider organisations as ICBs become smaller organisations focused on strategic commissioning.

Also published in May, the "**London Target Operating Model**" for a neighbourhood health service for London set out the requirement for a place-based system 'Integrator' to support and drive forward neighbourhood working, working to Place-based Partnerships organised along local authority boundaries.

In late July, North West London ICB approved a proposal for a merger with North Central London ICB, in order to respond to the changes in the NHS operating model and reduction in costs.

In mid-August, NWL ICB asked all place partnerships to confirm arrangements for an integrator organisation until April 2027.

Discussions are ongoing within the partnership about the nomination of an integrator organisation, and the role and contribution all partners may make to this arrangement.

In the meantime, partners remain focused on working together for the benefit of the population and communities of the borough.

Case for change

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Lord Darzi's Investigation published on 12 September 2024 identified that the NHS is at an existential brink:

- many cannot get a GP or dental appointment
- waiting lists for hospital and community care have ballooned
- staff are demoralised and demotivated
- outcomes on major killers like cancer lag behind other countries

Public satisfaction has fallen from 70% in 2010 to 21% and productivity is down 20-25% post-COVID.

The service is financially unsustainable with the NHS consuming 38% of government spending, which is projected to reach 50%.

Added to this, the service faces the demographic challenge of an ageing population, with 25% of the population having long-term conditions accounting for 65% of NHS spending. These challenges mean the NHS risks becoming a poor service for poor people.

However, there is transformational opportunity: the NHS has unparalleled population health data, single-payer efficiency, and the potential for a digital healthcare revolution driving genomics leadership and a new era of patient choice.

The plan has been informed by extensive engagement including events involving over 4,000 staff and members of the public and 1.9 million visits to the Change NHS website, where 250,000 experiences and ideas for change were shared. Voluntary organisations, community groups, MPs and healthcare organisations ran 650 events with 17,000 members of the public. Expert working groups were consulted made up of NHS and care staff, Royal Colleges, trade unions, think tanks, patient representatives, frontline NHS and care leaders, charities, economists, scientists, and tech entrepreneurs.

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SHIFT 1: Hospital to Community

- Providing better care close to or in people's own homes, helping them to maintain their independence for as long as possible, only using hospitals when it is clinically necessary for their care

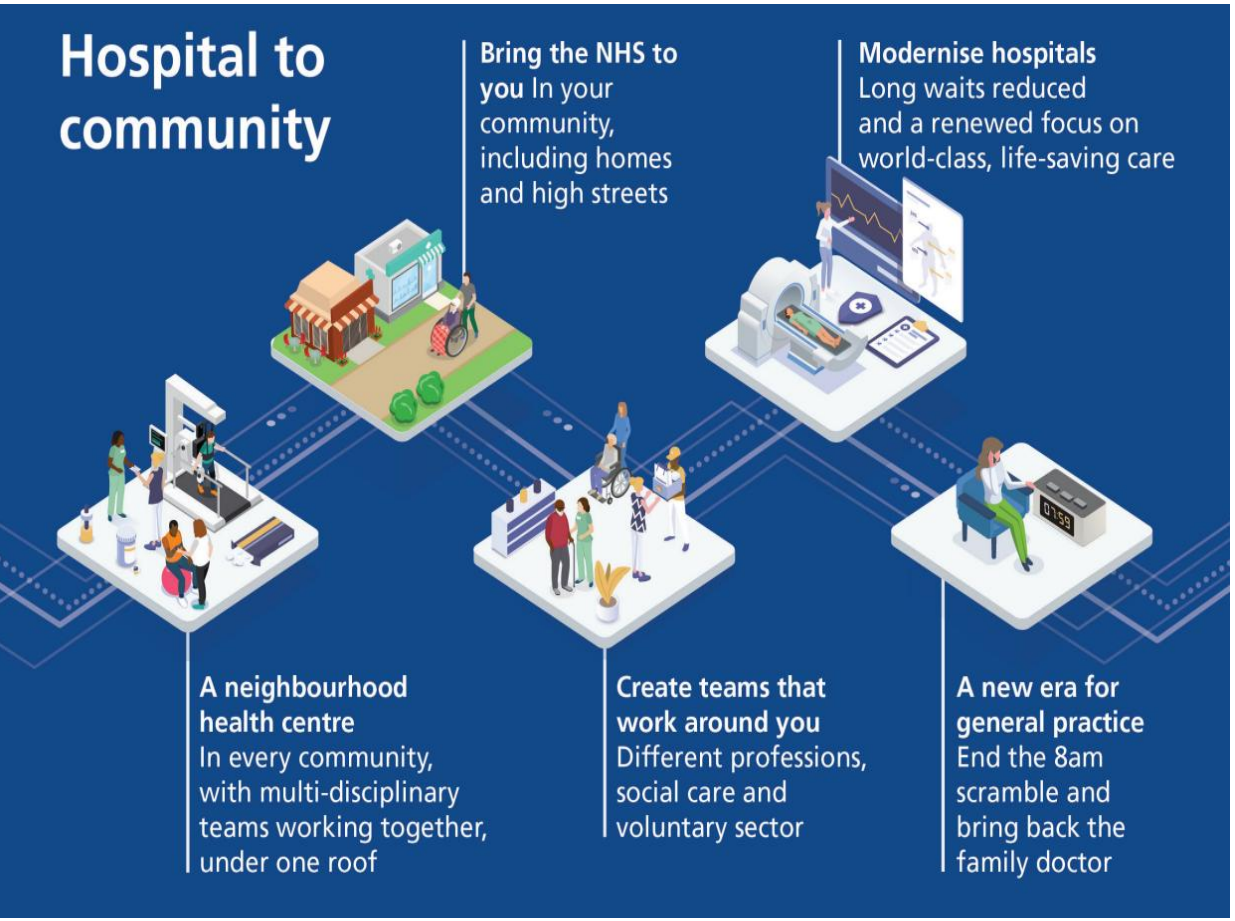
SHIFT 2: Analogue to Digital

- Greater use of digital infrastructure and solutions to improve care and empower patients

SHIFT 3: Sickness to Prevention

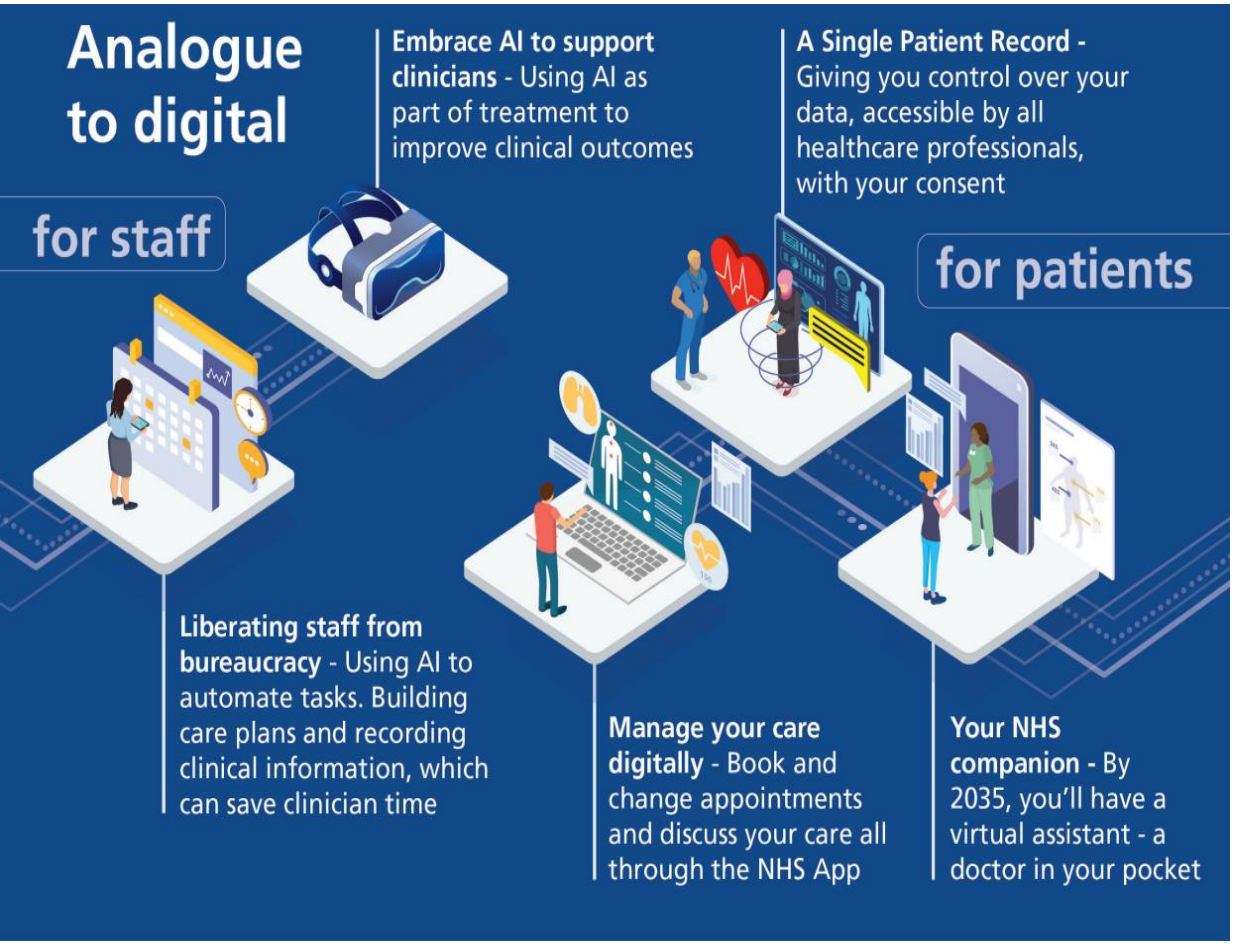
- Promoting health literacy, supporting early intervention and reducing health deterioration or avoidable exacerbations of ill health

Hospital to community



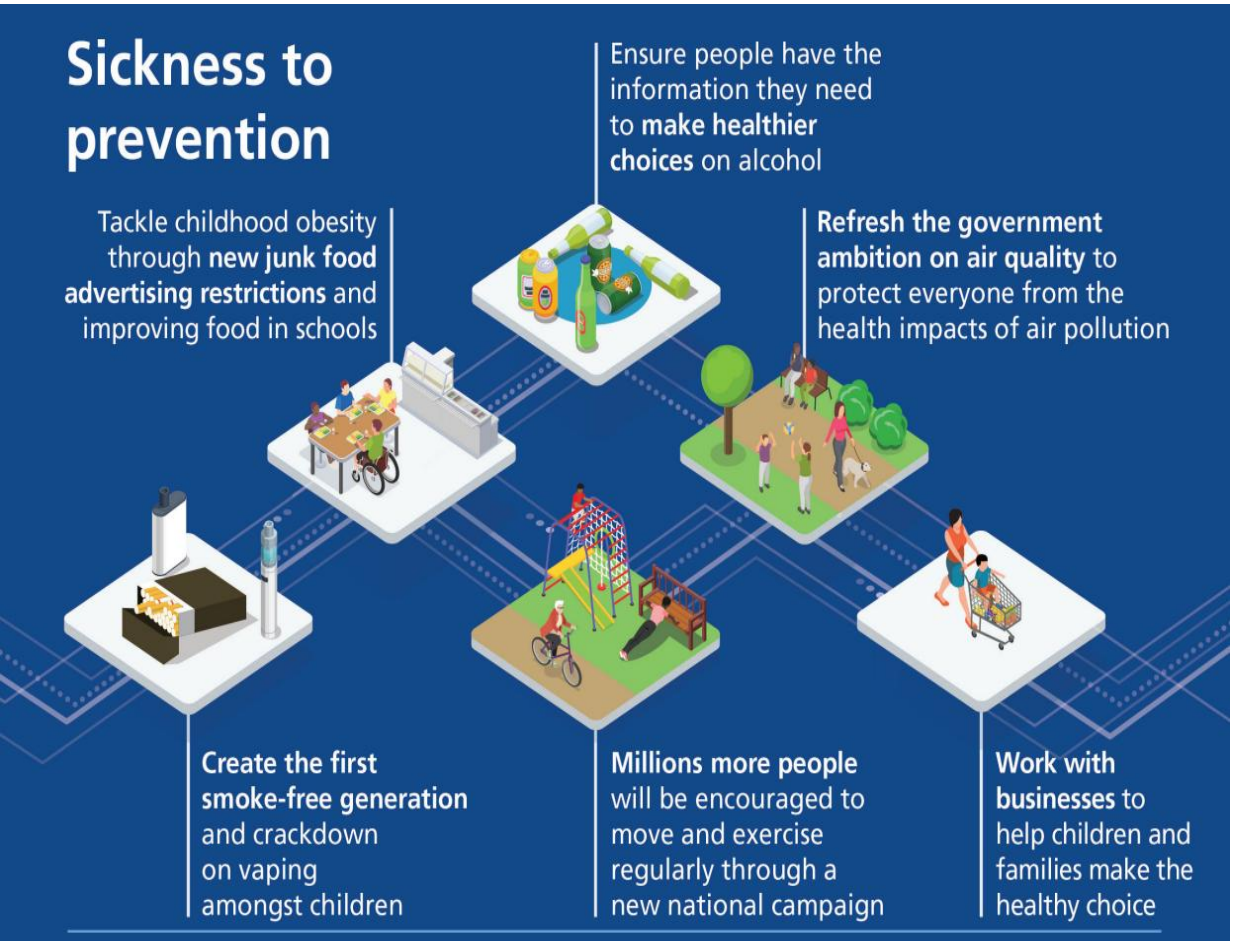
- **Neighbourhood health service:** to bring care into the places people live. Will restore GP access and introduce 2 new neighbourhood provider contracts ('single' and 'multi' neighbourhood serving 50,000 and 250,000+ people)
- **Infrastructure**: Neighbourhood Health Centres open 12hrs/day, 6 days/week, 'one stop shop' for patient care, co-locating NHS, council and voluntary services.
- **Patient empowerment:** 95% of people with complex needs to have care plans by 2027; 1 million personal health budgets by 2030
- **Digital transformation:** 2/3 of outpatient appointments (costing £14bn a year) to be replaced by digital advice
- **Mental Health:** £120m to ensure 85 Mental Health ED's to be in place by 2030, co-located with A&Es
- **Dental:** aiming for increased numbers of NHS dentists (new contract in place for 26-27), reduction in low value activity (checkups) and improving access to dental care for children
- **Financial reallocation:** By 2035 the % of NHS budget spent on hospital care will be reduced with the difference shifting to community services
- **Community Pharmacy:** to increase offer of clinical services, increased role in prevention (vaccination and screening), to be linked to single patient record

Analogue to digital



- **NHS App** as "front door": shifting power to patient via AI-powered 24/7 advice, appointment booking, self-referral, medicines management and care plans. It will be supplemented by HealthStore: a marketplace for approved digital health apps for patients to manage and treat their conditions
- **Single Patient Record:** Patients to control their data, accessible via NHS App by 2028, starting with maternity. Supplemented by advances in genomic data for personalised and predictive care. Data included within SPR to be enhanced to provide a better summary of patient information
- **Digital liberation**: Ambient voice technology to be used to reduce paperwork by 51% and releasing time to care. New AI tools being tested on the Federated Data Platform, which connects information across healthcare settings and links siloed sources, increasing productivity
- **Neighbourhood Health Service** - A new platform for proactive and planned care to be nationally procured to support community-based services

Sickness to prevention



- **Tobacco**: the Tobacco and Vapes Bill along with further restrictions on vapes will create smoke-free generation
- **Alcohol:** increased information about health risks; increasing 'alcohol free' threshold to 0.5% ABV to promote NoLo option.
- **Obesity:** Expand Healthy Start scheme, free school meals (Sep 2026), increase soft drinks levy and restrictions on energy drinks. Collaborations with industry to test weight loss service delivery models. Digital NHS points scheme to reward people taking healthy actions
- **Mental health:** national coverage of mental health support teams in schools and colleges by 2029/30
- **Genomics Population Health Service**: for predictive and personalised medicine. Universal access (via SPR and NHS app) by 2030; 150,000 adult sequencing study; babies and all cancer patients to be offered genomic analysis
- **Vaccinations and screening -** increase uptake via Neighbourhood Health Service. Aim to eliminate cervical cancer by 2040; end HIV transmissions by 2030; 10,000 cancer vaccines to clinical trial patients in next 5 years

Expected delivery by 2028/29

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HOSPITAL TO COMMUNITY

- **Same-day digital and telephone GP appointments will be available and calls to GPs will be answered more quickly – ending the 8am scramble.**
- **A GP led Neighbourhood Health Service** with teams organised around groups with most need.
- **Neighbourhood Health Centres in every community; increased pharmacy services and more NHS dentists,**
- **Redesigning outpatient and diagnostic services**.
- **Redesigning urgent and emergency care,** allowing people to book into UEC services before attending via the NHS App or NHS 111.
- People with complex needs will have the offer of a **care plan by 2027** and the **number of people offered a personal health budget will have doubled.**
- **Patient-initiated follow-up will be a standard approach.**

ANALOGUE TO DIGITAL

- **The NHS App** will be the front door to the NHS, making it simpler to manage medicines and prescriptions, check vaccine status and manage the health of your children.
- **'HealthStore' to access approved health apps:** Enabling innovative SMEs to work more collaboratively with the NHS and regulators.
- **A Single Patient Record** will mean patient information will flow safely, securely and seamlessly between care providers.
- **Digital liberation for staff** with the scale of proven technology to boost clinical productivity.

SICKNESS TO PREVENTION

- **Health Coach will be launched** to help people take greater control of their health, including smoking and vaping habits later this year.
- **New weight loss treatments and incentive schemes to help reduce obesity.**
- **The Tobacco and Vapes Bill will be passed, creating the first smoke-free generation.**
- **Women will be able to carry out cervical screening at home using self-sample kits from 2026.**

NHS and local government partnership

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Key areas highlighted within the plan which relate to the partnership between the NHS and local government include:

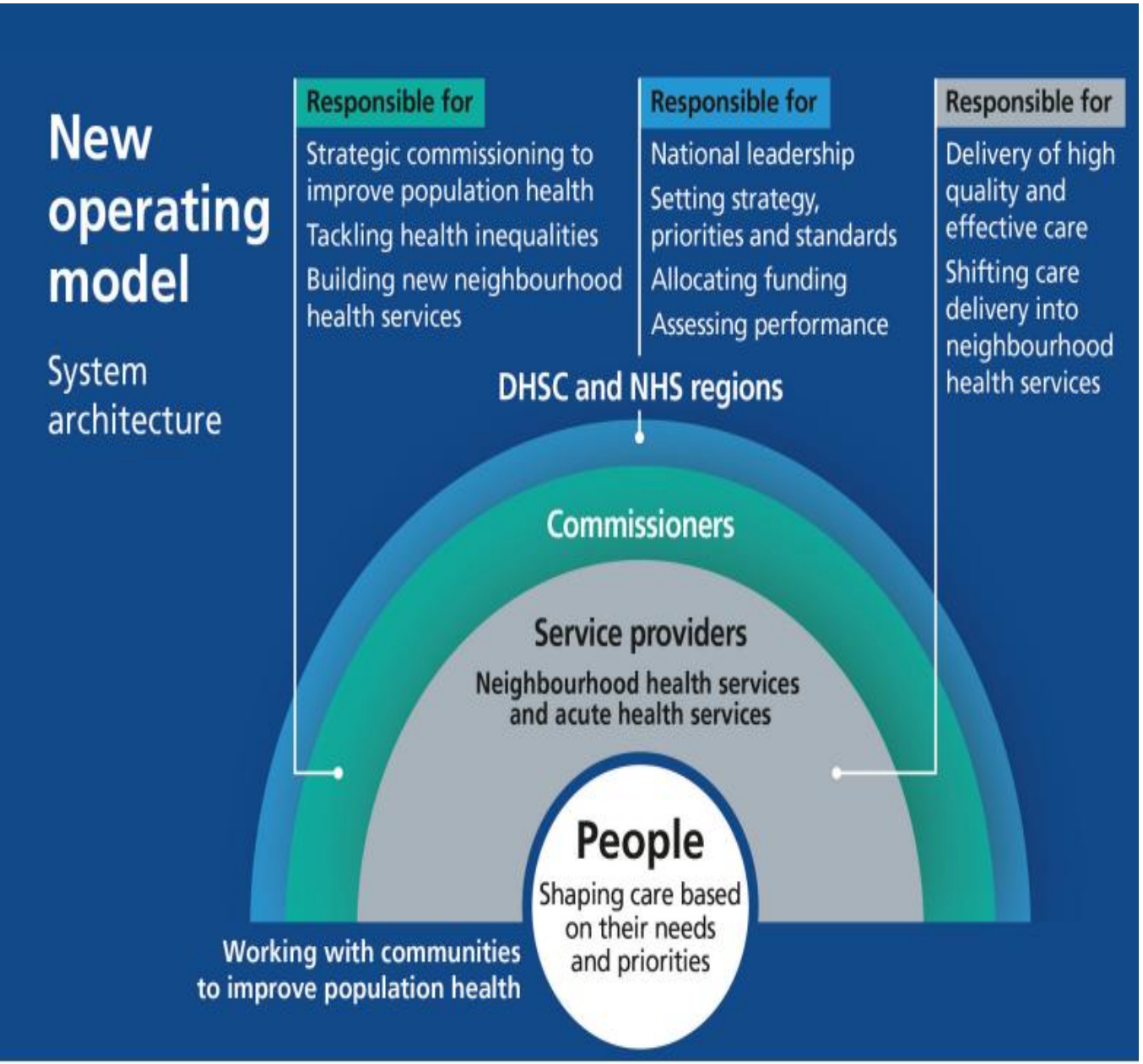
- Closer partnership between NHS and local government to drive integrated, personalised services and prevention
- Health & Wellbeing Boards at single/upper tier local authority level will lead the development of neighbourhood health plans, incorporating public health, social care and the Better Care Fund
- Social care professionals as part of neighbourhood teams with deeper involvement in rehabilitation, recovery and frailty prevention
- Social care professionals to be enabled to carry out more healthcare activities
- New organisational/contractual forms (Integrated Health Organisations holding population health budgets from 2027) and financial mechanisms promoting integration and the shift of investment and care from hospital to community
- Integrated Care Partnerships will be abolished
- Better Care Fund to be reformed from 2026-27
- Real-terms increase in the public health grant for 2025/26
- Public Health to be peer reviewed every 5 years
- National work with strategic authorities as prevention demonstrators, starting with Greater Manchester
- ICBs should be coterminous with strategic authorities “wherever feasibly possible”

“…pushing power out to places, providers and patients…”

Although the plan is positive about the opportunities for closer partnership between the NHS and local government, there are no specific commitments on how this will work in practice. The Baroness Casey Independent Commission on Adult Social Care is not due to report fully until 2028, with an interim report by 2026.

While partnerships at single/upper tier local authority level will lead the development of neighbourhood health, strategic commissioning will sit with the ICB at sub-regional level in London – it is unclear where joint commissioning will sit.

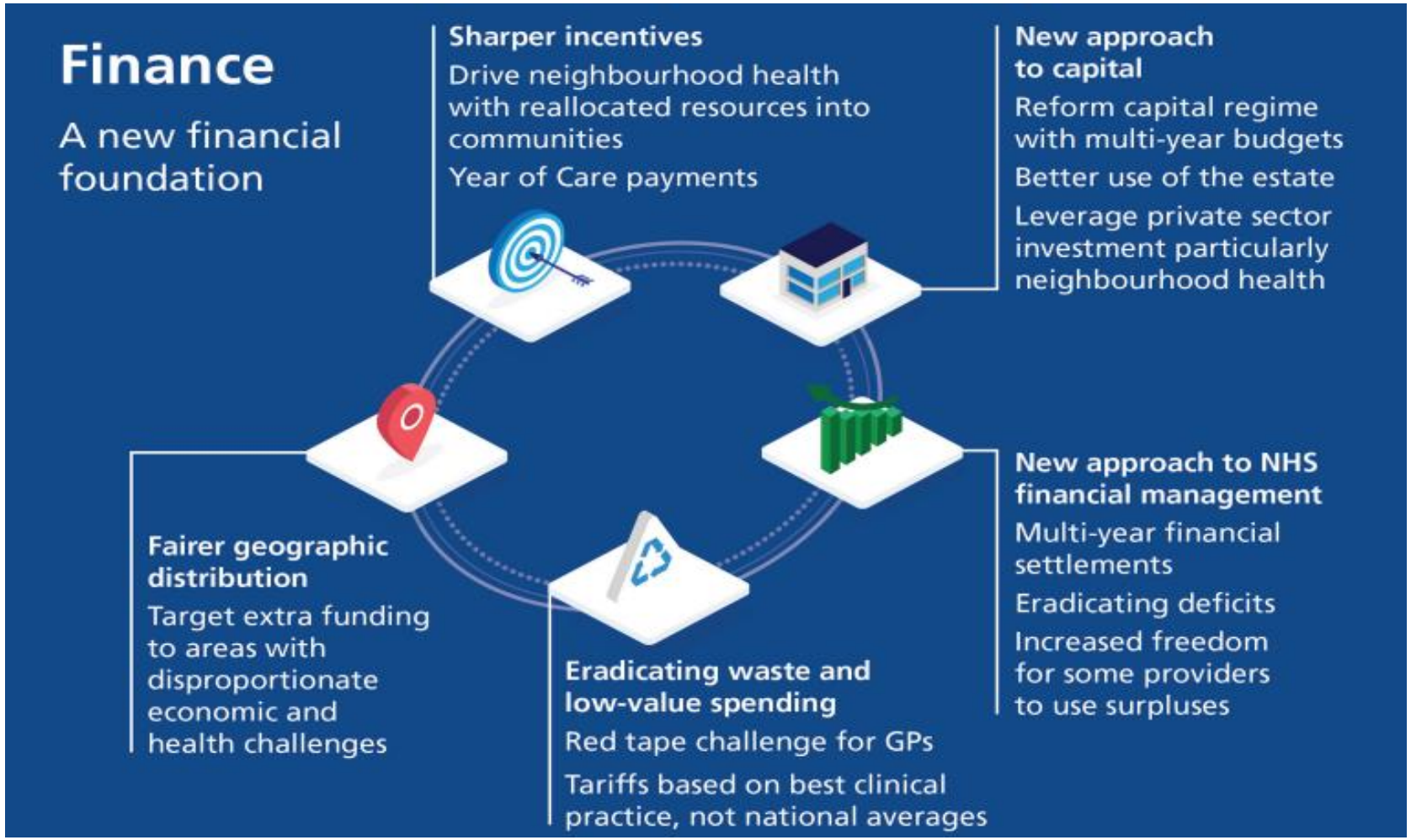
New operating model



- Merge NHSE with DHSC, central headcount halved by 2027
- Reintroduce earned autonomy; every NHS provider to be a Foundation Trust by 2035. Some to be Integrated Health Organisations (from 2027) holding population health budgets
- Integrated Care Boards to be strategic commissioners; close Commissioning Support Units. ICBs to aim to be coterminous with strategic authorities
- Providers will no longer be on ICB Boards

Finance

- 2% annual productivity gains; return to pre-pandemic levels by parliament end
- Phase out deficit funding from 2026/27
- Introduce multiyear budgets and require 3%+ of budget for service transformation
- Best practice tariffs and testing Year of Care payments to support hospital to community shift
- Patient Power Payments: patient satisfaction to influence provider payments
- New capital models including private finance and pension fund partnerships



Other enabling reforms

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Transparency of care

- League tables of providers and patient reported experience measures to be published, to make data easier to understand and more accessible (NHS App) to providers and patients. Maternity care to be a priority
- National Quality Board to be revitalised and be single authority on quality
- AI led warning system building on Federated Data Platform, to identify services at high risk, based on clinical data

Workforce transformation

- Fewer staff than previous projections but better equipped (including AI training for all), releasing £13bn through technology-enabled productivity
- Advanced practice roles for nurses/AHPs; reduce international recruitment to under 10% by 2035
- Ultra-flexible employment contracts; eliminate agency staffing by parliament end; prioritise staff wellbeing to save £12b cost of poor wellbeing among NHS staff

Innovation & technology

- Five "big bets": Data, AI, Genomics and predictive analysis, Wearables, Robotics
- Global Institutes for each bet (NIHR funded) to drive global leadership; Regional Health Innovation Zones to bring together ICBs, providers, and industry
- Clinical trial set-up: 250→150 days by March 2026; participant volunteering via NHS App
- Pro-innovation regulation: MHRA and NICE joint process (Apr 2026) to improve speed of medicines access
- £600m Health Data Research Service

New operating model – Model ICB Blueprint

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As part of the new operating model, changes to the role of ICBs have already been announced with the Model ICB "Blueprint" published in May, designed to support ICBs in the ambition to reduce running costs to £18.76 per head of population. In order to deliver these changes, **North West London ICB agreed in July to merge with North Central London ICB**.

Future role for ICBs

As strategic commissioners ICBs are expected to fulfil four core functions:

1. Understanding the local context.
2. Developing a long-term population health strategy.
3. Delivering the strategy through payer functions and resource allocation.
4. Evaluating impact.

ICBs are also asked to develop into 'sophisticated and intelligent healthcare payers'.

Functions which could be transferred to providers

- local workforce development and training
- green plans and sustainability
- digital leadership (enabled by national data and digital infrastructure)
- development of neighbourhood and place-based partnerships (with ICBs retaining their commissioning role for neighbourhood health services)
- primary care operations and transformation (including primary care, medicines management, estates and workforce support)
- medicines optimisation (with ICBs retaining overview as part of their commissioning role)
- pathway and service development programmes (ICBs retaining strategic overview)
- estates and infrastructure strategy.

Infection prevention and control, safeguarding, SEND, NHS Continuing Healthcare and General Practice IT will also be considered for transfer, although details about where these will go are not shared at this point.

London Target Operating Model

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A Neighbourhood Health Service for London: The Target Operating Model was published in May 2025. It was developed in partnership between London's five integrated care boards, NHS England London Region, and the wider London Health and Care Partnership (including London Councils and the Greater London Authority, with others). There is strong alignment between the London document and the 10 Year Health Plan.

The neighbourhood health service in London builds on two simple ideas – we need to do things better, and we need to do better things. The Case for Change for London highlights the importance of having sufficient organisational capacity and capability in each Place to be able to enable all local partners to deliver proactive and preventative neighbourhood health for the population, if London is to address growing health inequalities and risks across all parts of the current health and care system.

The London TOM sets out the concept of an organisation with responsibility at Place-level for enabling neighbourhood working across health, care and other partners for all neighbourhoods in that Place. This enabling organisation is termed the "**integrator**" working to that Place Partnership.

The role of the integrator is not to lead, but instead to be accountable to the Place Partnership Board in enabling the operationalisation of integrated care across related neighbourhoods and communities, working in partnership with other providers, organisations and communities themselves.

The existing Place Partnership Board will continue to hold overall leadership and accountability for neighbourhood health and care services across that Place.

The integrator role cannot operate in isolation or remove individual accountability from partnering local organisations, including health, local authorities and the voluntary and community sector, at place or system level.

Integrator form

The London TOM suggests that the integrator should be:

- ❑ Drawn from existing organisations working within the Place partnership.
- ❑ Able to provide support in alignment with the geographical footprints of the Place and all of its constituent neighbourhoods.
- ❑ Organisationally mature with stable leadership and a track record of working in partnership and at a scale of a 250,000 plus population.
- ❑ Able to deploy leaders and managers who are credible across the partnership, to build trust amongst partners, navigate and support the partnership as it develops further; all whilst recognising that this role is about hosting and facilitating, not leading.
- ❑ An organisation with “skin in the game” but which is prepared, where appropriate, to ignore short-term self-interest for the interests of the partnership and population as a whole.
- ❑ Able to demonstrate an internal separation of functions between the integrator role and its core role in order to engender confidence that conflicts of interest are appropriately managed.
- ❑ Ability to drawn on ICB / regional / national functions and capabilities where relevant to support local infrastructural requirements.
- ❑ Able to hold and manage related budgets including pooled budgets such as section 75 agreements on behalf of the Place partnership.
- ❑ Have the capacity and capability to identify and hold risks to neighbourhood delivery, to work proactively with partners to mitigate those risks, and to step in if a provider fails in co-ordination with the system and wider partnership to ensure that the local population do not experience a loss of neighbourhood services.
- ❑ Able to provide the infrastructure, operational management and co-ordinate solutions to shared data, HR and workforce, estates, digital and governance

The integrator is not…

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This is not about duplication or introducing extra layers of senior leadership, management or assurance.

Systems cannot afford this, and **any additional resource which becomes available to local partnerships needs to be focused on supporting frontline delivery**. In London, the integrator could potentially coordinate any transformational funding made available, but would be doing so on behalf of the Place partnership.

The integrator is not about taking away from individual roles and responsibilities within integrated neighbourhood working.

Scaling integrated neighbourhood working to become "the norm" for how Londoners experience health and care requires organisational infrastructure and support. However, no set of enabling functions, however well managed or resourced, will succeed without the **active engagement of professionals and communities, and ownership and leadership from all local partners.**

The integrator model is not replacing existing system leadership or organisational responsibilities.

The integrator is **designed to work with existing system and Place leadership structures**, including with local authority, NHS, VCSE and primary care partners, to ensure agreed local priorities are being implemented in day to-day delivery of health, care and related services.

The role of the integrator is not about integration around "just the top of the pyramid".

It is a **whole population approach** which focuses on improving the lives of all Londoners, including children and young people, working-age adults, and older people, whatever their current level of capabilities, assets or needs.

Integrator functions

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- Bridging organisational and sectoral fragmentation
- Flexing to local needs
- Enabling consistency
- Helping to identify and address population health needs
- Channelling shared learning
- Mediating challenges
- Supporting inclusive decision-making
- Providing essential infrastructure, including for the “three shifts”
- Improving system sustainability

Selecting an integrator

Establishing new organisations to provide such enabling infrastructure in each place or in each neighbourhood is considered to be prohibitively expensive and potentially highly disruptive of current health and care partnerships and the progress they have achieved to-date

As such, London is looking to existing organisations working at Place to develop and host these new functions

In some places, these functions may be hosted within a single organisation which has the capacity and capability to support neighbourhood working across all neighbourhoods

In others, a lead organisation may work with one or more local partners to provide the full range of required support. In this latter case, it will be important that there is still a clear line of organisational accountability to the Place Partnership Board for ensuring the neighbourhood health service can function effectively, efficiently, and sustainably, across the Place as a whole

The London TOM does not specify which type of organisation or organisations could fulfil the integrator role

In mid-August, **NWL ICB** asked all place partnerships to confirm the integrator arrangements until April 2027, including guidance and a form for nomination (by the end of September) of an integrator organisation or joint arrangements for each place.

The integrator will provide delivery leadership and coordination across the full scope of the place agenda – spanning neighbourhood health, borough-wide priorities, and cross-sector enablers. This is a practical next step towards fully integrated neighbourhood models, consistent with the London Neighbourhood Operating Model and the 10 Year Health Plan.

NWL integrator nomination

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The integrator is a place-level delivery and coordination role (not a commissioner or direct provider) and accountable to the Place-Based Partnership for enabling neighbourhood health. The Integrator function will:

- Coordinate delivery across Place priorities, including but not limited to the NW London neighbourhood health models of care (e.g. proactive care for adults with frailty and the emerging children's health model).
- Align and coordinate enablers such as workforce, digital, estates, and population health management to support delivery at scale.
- Drive equity in access and outcomes, using data and local partnerships to address inequalities.
- Facilitate collaboration and problem solving across sectors, partners, and Integrated Neighbourhood Teams (INTs), ensuring alignment between neighbourhood and borough-wide delivery.

Arrangements may involve a single host organisation or a joint model, reflecting local context and relationships, but there must be clear accountability to the Place-Based Partnership. This ensures local context, capacity, and relationships can be reflected in the design.

Each Place-Based Integrator must be an NHS body, Local Authority, or other statutory partner (e.g. a community or mental health provider, GP federation, or acute trust with the infrastructure, accountability, and local credibility to coordinate system partners and lead borough-wide transformation).

Opportunities and challenges for the H&F HCP

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Opportunities

- Strong focus on the shifts from hospital to community, and sickness to prevention, with enabling mechanisms highlighted to support these shifts in the plan
- High degree of alignment between the 10YHP and the London Target Operating Model, with thinking progressing regionally about how neighbourhood health and the three shifts could be supported in practice
- Clarity on the local authority footprint being the primary organising principle for integration, and the re-casting of the ICB as a strategic commissioner, together bring the potential for greater delegation and decision-making to place partnerships
- ICB transition provides opportunity to shift resource to support delivery of the 10YHP
- Strong, high-quality providers with capability in the NHS landscape
- **Supports the partnership with its agreed purpose and priorities**

Challenges

- Level of financial challenge across organisations makes it difficult to invest in transformation to a new model
- Lack of detail for implementation leaves us with multiple unknowns while we navigate a way forward – for example the new neighbourhood contracts for general practice, the financial reforms, the alignment with future social care reforms, and the development of Integrated Health Organisations
- Fragmentation of the NHS provider landscape may make it difficult for providers to organise on a borough footprint, and for any single organisation to act as an integrator
- Risk of the diversion of focus from the primary ambitions, due to the level of change in the NHS operating model, reduction in capacity, and transfer of functions to providers
- No GP federation within the borough to support scaled provision of general practice delivery and take on delegated functions from the ICB

Our partnership purpose and priorities

The plan and wider direction of travel will support the partnership to take forward its purpose and priorities

We will work together as partners in Hammersmith and Fulham to improve health and wellbeing and reduce inequalities.

We will develop more integrated, connected services that deliver tangible improvements that are better for our population and more sustainable for our organisations.

We will focus on tackling the wider factors that influence health and wellbeing.

We will work with local people to develop trusting relationships, empower communities and co-produce service changes.

Integrating Services

By this, we mean we will:

- Join up our services for people with more complex needs
- Understand and share care and risk collectively, rather than perpetuating a referral culture
- Develop more accessible services and support
- Improve quality of care
- Reduce repetition and duplication
- Address functional overlaps and gaps

Creating Health

By this, we mean we will:

- Focus on the wider determinants of health and wellbeing
- Work on reducing health inequity
- Empower communities to create health
- Leverage our social capital
- Support self-care and independence
- Ensure a focus on children

We will be guided by the more detailed priorities listed in the **Hammersmith & Fulham Health and Wellbeing Strategy**

Conclusion

This is a time of great change and transition within the NHS, with wider implications for place partnerships and their constituent organisations, including local authorities.

The ICB operating model changes will further clarify over the next few months future resources for place and neighbourhood development.

Discussions are ongoing within the partnership about the nomination of an integrator organisation, and the role and contribution all partners may make to this arrangement.

While this process is disruptive, it also brings potential opportunities to build on our partnership and progress delivery of the three shifts envisaged in the 10 Year Health Plan, which are aligned with and support delivery of our local ambitions.

Throughout this period, partners remain committed to working together for the benefit of people and communities of Hammersmith and Fulham, and maintaining our focus on improving health and wellbeing outcomes.