

Re:State

Re:Imagining Health

Monday 30 June 2025

London

@restate_thinks

@re-state.bsky.social

#ReimaginingHealth



UCB have provided financial support to Re:State Trust for the organisation and delivery of the conference

Lilly UK have also provided financial support to Re:State Trust for the organisation and delivery of the conference

Agenda

9.30 - 10.20	Registration and refreshments
10.20 - 10.30	Welcome and introduction Charlotte Pickles, Director, <i>Re:State</i> Simon Eccles, Chief Health Officer & Vice President, Salesforce
10.30 - 11.15	'In conversation' with Hospital Chief Executives This 'in conversation' will bring together innovative, ambitious and future-focused Chief Executives of NHS Trusts to discuss the challenges and opportunities facing hospitals. Richard Mitchell, Chief Executive, University Hospitals of Leicester NHS Trust and University Hospitals of Northamptonshire NHS Group Nnenna Osuji, Chief Executive, North Middlesex University Hospital NHS Trust
11.15 - 12.20	Panel one – From sickness to prevention: shaping tomorrow's NHS With rising demand, an ageing population, and stretched resources, the case for prevention and early intervention has never been clearer. This panel will explore the practical steps needed to deliver the Government's ambition to shift from sickness to prevention. Khalil Asmar, Vice President, Cardiometabolic Health, Lilly UK Dr Jeanette Dickson, Chair, Academy of Medical Royal Colleges Professor Kevin Fenton, London Regional Director, Public Health, Office of Health Improvement and Disparities Kevin McKenna MP, Officer, All-Party Parliamentary Group for Health
In partnership with 	
12.20 - 13.15	Lunch
13.15 - 13.45	Keynote address Stephen Kinnock MP, Minister for Care, Department of Health and Social Care
13.45 - 14.50	Panel two – From hospital to community: reimagining care delivery As people increasingly live with a complex and long-term conditions, the need to provide care outside of a hospital setting has become urgent. This panel will discuss the practical reforms needed to decisively deliver the Government's ambition to shift care into the community. Dr Amanda Doyle OBE, National Director, Primary Care and Community Services, NHS England Dr Alec Price-Forbes, National Chief Clinical Information Officer, NHS England Nico Reynders, General Manager UK & Ireland, UCB Kirsten Watters FFPH, Director, Public Health, Camden Council
In partnership with 	
14.50 - 15.00	Closing remarks

Our mission

While 2024 delivered a new Government, Britain continues to face the same – era-defining – challenges. In fact, in many respects they are even more acute. Geopolitical tensions and risks continue as the backdrop to domestic decisions. Demographic and technological change, already reshaping the nation, continues at pace. And economic growth, the number one mission of the new Labour Government, remains elusive.

At *Re:State*, we believe that Britain's prosperity is inextricably linked to the health of our public services and the effectiveness of the State. Yet the public service institutions and approaches we rely on remain modified versions of those built as part of the post-war settlement. The aims and ambitions of those who designed them were inspiring, but the challenges that faced 1940s Britain are not those of today. Continuing to tweak a broken system, hoping for radically different outcomes, won't work.

Instead, we want to see a public service model that reduces demand rather than simply manages it. We want to see a settlement that recognises that the welfare of the people cannot – and should not – be delivered by the State alone.

In practice we think that means overhauling the centre: dismantling top-down bureaucra-

cies and building local capabilities; rethinking outdated institutions; and challenging existing models.

That is precisely what our 'Re:Imagining the State' programme is focused on: putting forward bold but implementable ideas to transform how our state infrastructure works.

I am delighted to welcome you to our 'Re:Imagining Health' conference, bringing together reform-minded leaders, experts and practitioners. The Government has ambitious plans to reform the health service, underpinned by three key shifts. This ambition must be matched with specific, implementable plans that radically rethink the NHS model for current and future demand.

That is exactly what *Re:State* is focused on. *Close enough to care* reimagined a health and care model rooted in place. *Prescription for prevention* put forward detailed proposals for a new model of primary care. And *Hospital of the future* provides a blueprint for radically reconfiguring acute care. We are excited to discuss and build on these ideas today.

Thank you for joining us.



Charlotte Pickles
Director
Re:State

Our team



Rosie Beacon
Research Manager &
Head of Health



Cory Berman
Researcher



Florence Conway
Researcher



Sean Eke
Researcher



Joe Hill
Policy Director



Dr Simon Kaye
Policy Director



Sylvie Macdonald
Events & Partnerships
Officer



Joe Martin
Senior Researcher



Alice Semark
Researcher

Re:Imagining Health

For the past three years, our ‘Re:Imagining Health’ programme has proposed radical yet sensible ideas which are reshaping how we understand, deliver, and reimagine health and care services.

Our premise is clear: the current health and care model must be radically redesigned to reduce and divert, rather than simply manage, demand. From how health is created, to the way resources are allocated, and how care is delivered; a bold, systemic rethinking is not just desirable – it’s essential.

As our first ‘Re:Imagining Health’ conference, it’s a great opportunity to reflect on our recent work:

- *Close enough to care* – published in April 2024, called for NHS England to be abolished and the Department of Health and Social Care to take a more strategic role under the direction of the Secretary of State, as part of a wider programme of health devolution. A year later, the Government announced the abolition of NHS England to bring NHS England’s functions into DHSC, under the Secretary of State’s control.
- *The power of prevention* – set out practical steps to help keep the UK protected against vaccine-preventable diseases, reducing unwarranted variation in health outcomes while also freeing up valuable, limited resource in the rest of the health system and recently, the Government announced they are implementing some of the measures we proposed in this paper.
- ‘Prescription for prevention’ series – published last year, argued for a new model of primary care oriented around three core principles: to intervene earlier, respond faster, and avoid decline. Our three-paper series explored a new structural model, funding model, and enhanced digital capabilities in the primary care system.
- *Hospital of the future: A framing paper* and *Hospital as a service, not a building* – the first two papers in our ‘Hospital of the future’ series, proposed a fundamental reset in the approach to

secondary care and outlined a model that radically changes the configuration of the modern hospital. A significant number of our recommendations have been trailed ahead of the release of the 10 Year Plan and we look forward to continuing the impact from this work as we soon launch the latest paper in this series.

- *A helping hand* – this explored the advantages of robotic assisted surgery and steps that can be taken to ensure they are scaled equitably across the health system. We were delighted to see that NHS England recently set a target to increase the use of robotics in surgery and conduct a GIRFT review, as we recommended.
- *Innovating for independence* – set out practical actions that can be taken on a local, regional and national scale so that emerging technologies can significantly improve the delivery of social care in the short-term and we are looking forward to publishing a comprehensive paper focusing on rewiring the funding model for social care later this year.
- *Designing a neighbourhood health service* – identified examples of best practice of accessible, proactive and patient-centred care from across the UK and suggested how these should inform the Government’s approach to shifting care decisively out of hospitals and into communities. It has been great to see the emphasis on this coming from the Department of Health and Social Care ahead of the 10 Year Plan.

The stakes have never been higher. The Government’s *Plan for Change* – and much of their public budget – is heavily weighted on transforming the health and care system. Yet, while expectations rise, the reality on the ground is stark: population health continues to decline and demographic shifts are amplifying the strain on a system close to breaking point.

Looking to the year ahead, we intend to continue advancing the health and care debate with radical, implementable ideas.

REFORM	REFORM	REFORM	REFORM	Re:State
LOOKING OUTWARD International lessons for health system reform	CLOSE ENOUGH TO CARE A new structure for the English health and care system	PRESCRIPTION FOR PREVENTION A new model of primary care	HOSPITAL OF THE FUTURE A framing paper	HOSPITAL OF THE FUTURE Hospital as a service, not a building
Sebastian Rees Patrick King Hashrath Hassan April 2023	Rosie Beacon March 2024	Rosie Beacon Patrick King Florence Conway September 2024	Rosie Beacon Florence Conway Alice Semak December 2024	Rosie Beacon Alice Semak Florence Conway May 2025

Why our digital future excites me



Richard Mitchell
Chief Executive
University Hospitals
of Leicester NHS Trust and
University Hospitals of
Northamptonshire NHS Group

I am excited to be joining *Re:State's* 'Re:Imagining Health' conference. Their work on redefining healthcare delivery is extremely relevant for what we are doing at the University Hospitals of Leicester NHS Trust and University Hospitals of Northamptonshire NHS Group (UHL UHN).

Re:State's vision for Remote General Hospitals particularly resonates with me. Our digital transformation is fundamentally rethinking how we deliver care. It is not just about moving appointments online, it is redesigning entire pathways around what people need and at UHL UHN, our ambition is clear: by 2027, no time will be spent on a task that digital could do better, quicker or to the same standard.

We are already seeing glimpses of this future. Our teams are pioneering AI-powered tools to help clinicians make better decisions faster. We are building systems that let specialists support colleagues remotely, breaking down the barriers between sites. And through our work with partners, we are creating the infrastructure to make remote care seamless and safe.

What excites me most is this is not about technology for technology's sake. It is about giving our 30,000 colleagues the tools to deliver better care, and as the largest provider of patient care in the NHS, this is really important. When a dermatologist reviews images remotely

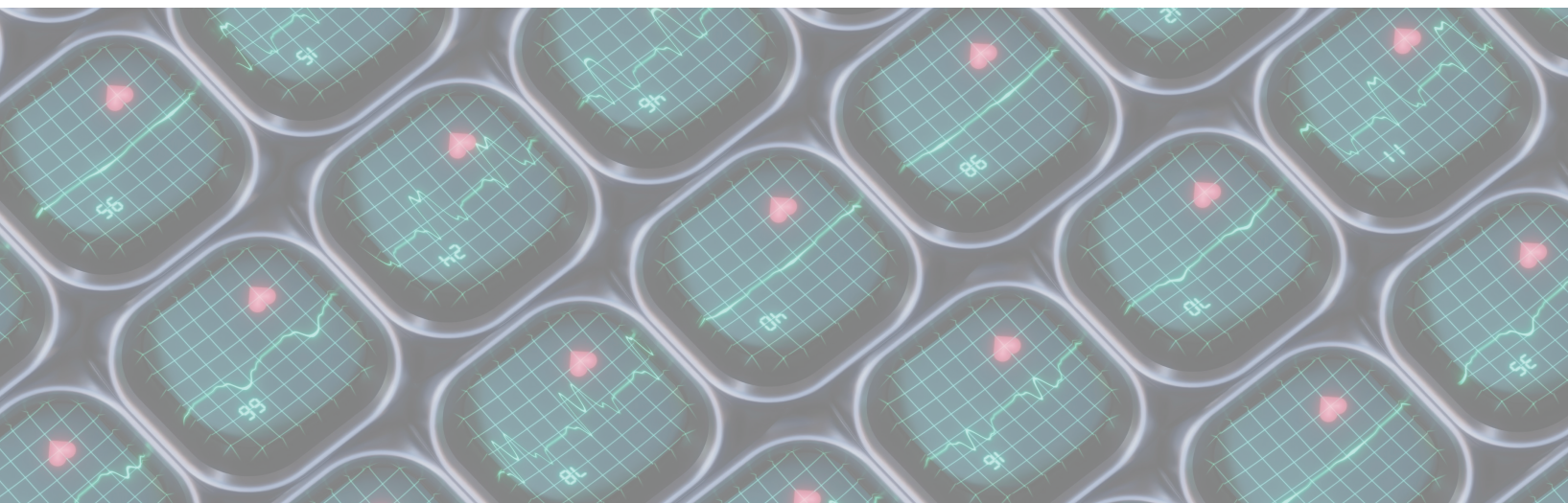
and people get treated faster, that is real impact. When our A&E teams consult with specialists without moving critically ill patients, that saves lives.

Re:State's recommendation about virtual A&E capabilities strikes a chord. We know our emergency departments are under pressure. Remote consultation is not just a nice-to-have – it is essential for sustainable emergency care. We are already exploring how ambient AI and remote monitoring will support our emergency teams, freeing them up to focus on the people who need hands-on care most.

The focus on training is also important. We cannot just drop new technology on clinicians and expect magic. That is why we are building our AI Academy and investing heavily in digital skills.

What *Re:State* is proposing is not some far-off dream. We are building it now across Leicester and Northamptonshire. Yes, it is challenging. Yes, it requires us to think differently. But when I see what our teams are already achieving – from our pioneering Federated Data Platform work to our automation programmes – I know we are on the right path.

Whilst we cannot be certain about the future, and some of it will be challenging, I am excited by our future. As Alan Kay, American computer scientist said "The best way of predicting the future is to invent it".



From sickness to prevention: shaping tomorrow's NHS

Prevention: here comes the tricky part



Dr Simon Kaye
Policy Director
Re:State

With rising demand, an ageing population, and stretched resources, the case for prevention and early intervention has never been clearer. The Government's stated ambition to shift the health system's focus from treatment to prevention is the right one. Who would disagree?

But now that has been said, I'm afraid the easy part is already over.

After years of warm words, the NHS remains overwhelmingly geared towards acute, clinical interventions. Making prevention a central organising principle – in governance, funding, workforce and practice – is a far more difficult task. Doubly so because our system has been designed, from the ground up, to treat illnesses rather than to help people to create and own their own health.

As *Re:State* has argued, achieving this shift requires more than marginal policy tweaks. It demands a reframing of how we think about health: not as a service to be consumed, but as something shaped by people's environments, relationships, and choices over time. A system designed around treatment needs to become one capable of supporting health, and of acting before problems become crises, across whole realms of policy like housing, employment, and transport.

To do this, prevention cannot be the job of the NHS alone. It demands shared responsibility across public services. Services that are integrated around individuals and communities of need rather than the (mostly) arbitrary borders of service directorates or Whitehall departments.

It also means a different mindset when it comes to efficiency: a very hard ask indeed. We cannot afford for preventative practice to be the first thing that gets cut when budgets get tighter.

Technology has a role. *Re:State's* work on data and AI points to how predictive tools can support earlier intervention, particularly in areas like mental health. But insight only matters if the system has the relationships, capacity and incentives to act on it. Technical solutions are not a panacea, and are no substitute for structural change.

This is because place matters enormously. A genuinely preventative model will revolve around the radical decentralisation of our health system, so that services are integrated within places. When prevention happens, it happens in streets, homes, and communities. It is shaped by local economies, social capital, and community assets. Regional and local health structures are better placed to build the partnerships and trust needed to act early, support people holistically, and tailor responses to the realities on the ground.

That shift also means a change in our very concept of health. So long as health is seen primarily as a service – a product that is made in our hospitals and health centres, and “bought” through taxation – the opportunity for more co-productive models is limited. A preventative approach requires shared responsibility and greater personal agency, with more direct ownership of health and willingness to participate in producing wellbeing in those around us.

All of this will remain a fairy tale, and nothing more, until the system itself is more responsive, relational, and inclusive in how it operates. There are entrenched interests, institutional inertia, and limited room to manoeuvre given the national finances. But without change, the system will stay stuck in a feedback loop of reactive crisis response: unsustainable demand being chipped away with tools that were never designed for the task.

A new paradigm for prevention



Dr Jeanette Dickson
Chair
Academy of
Medical Royal Colleges

Where does prevention actually begin? Where does the responsibility lie? Is that key to why we struggle to deliver prevention equitably across the population? The health service, both in funding and structure, with few notable exceptions, is transactional. I go to the service to get 'health'. Health is not co-created by us, with us, as a society.

How can the health and care system help? Could we 'prevention proof' services? Not just train all health care professionals to deliver evidence-based prevention in every encounter, but build the service to promote prevention, e.g. dedicated child appointments outside school hours?

When you add the fact that around 80 per cent of health outcomes lie outside the direct impact of health and care services, it becomes startlingly obvious that prevention is a truly cross-government phenomenon. It is inextricably intertwined with housing, education, work and communities. But do we undertake a 'prevention assessment' in those projects which impact population health, i.e. everything?

We know that left to its own devices nature takes the easiest path. People are no different. How do we ensure the easiest path we all encounter in everyday living is the one which maintains our health best, for the longest time? Kicking the can down the road leads to later 'fire-fighting',

increasing demand (and cost) on an already over-stretched health system.

Which raises another question. What actually is prevention? Is it the absence of a recognised disease? Is it catching future life-limiting illnesses before they become so? Is it minimising the collateral damage when folk have made poor health choices or had bad luck?

In preventative terms, vaccination seems like low-hanging fruit. Is measles a trivial childhood illness best seen as a rite of passage or is it a scourge which kills children, especially those who are malnourished and deprived? There is a huge body of literature on the safety of vaccination. Why would anyone refuse it? At heart, the answer lies in trust, which informs perception of risk. How we engage with those who have little trust is key to improving prevention but also removing health inequalities.

To fully support the health of our population, we need to adopt a much broader definition of prevention, which encompasses proven public health approaches, preventative social care and responsive NHS community services. But we need to proactively go outside health and use innovative housing and care models that build support with and around individuals, strengthen social connections and maintain well-being that enables people to live good lives for longer.



From hospital to community: reimagining care delivery

The hospital is not the enemy



Rosie Beacon
Head of Health &
Research Manager
Re:State

For decades, successive ministers have evangelised about the importance of shifting care away from hospitals and into the community. And for decades, this shift has failed to materialise. Yet as the NHS nears a critical juncture, the urgency of realising this transition has never been greater.

There are varying diagnoses attempting to understand why this shift is seemingly impossible to achieve. Political prioritisation, short-term thinking, uneven resource allocation, and organisational culture and mindset are just a handful of the reasons apportioned to the elusive shift to community care.

But there are two core issues undermining this transition that are rarely noticed but collectively significant.

First, the term ‘community’ means everything to everyone. It’s used as a byword for almost anything outside of the hospital – general practice or community nursing or social care or all three or none. This failure to define what is meant by community means that resources are rarely allocated where they need to be, and policy interventions end up being imprecise or misguided because we don’t always know what it is we want, other than a rebalancing of resources across the system. Rebalancing to where and to who and for what?

Second, to achieve this shift we must accept that not only does the communi-

ty need to be improved, so do hospitals. The prevention agenda tacitly assumes that once demand on hospitals is reduced through earlier intervention, hospitals will magically transform into a bastion of productivity once again. But the same problems would persist – hospitals would remain disconnected from the rest of the system, clinical staff would continue to hyper specialise, patient flow would be poorly understood, buildings would continue to fall apart – the list goes on.

The main reason this is so important for the shift to community is that hospitals absorb the bulk of NHS funding. Even slight improvements in their financial sustainability would unlock much needed cash for the community. And a fraction of the cash involved in secondary care goes much further in primary care. The entire cost of general practice for the country in 2022-23 was £9.7 billion – whereas the cost of one large hospital trust is around £1 billion, and we already spend significantly more than comparator countries on hospitals and the acute sector. So long as hospitals need more and more cash, naturally less will be available for the community.

For this Government to prove that they will be the ones to finally re-orientate the health system towards community, it is crucial they identify their position on these challenging but necessary policy questions.

From the ground up: prevention and neighbourhood health



Kirsten Watters FFPH
Director of Public Health
Camden Council

There is broad consensus on the potential of neighbourhood health to bring the services that people need closer to where they live. They are not merely the vertical integration of acute and community provision, but something far more radical enabling an NHS fit for the future.

There is evidence that geographical variations in health outcomes are shaped by both the context (the characteristics of the neighbourhood) and composition (the characteristics of people living there) of place, and that there is a reciprocal relationship between these.

The English health system has a long history of structural change, much of which has focused on what and where, and less attention on the how. Indeed, while there have been positive shifts towards neighbourhoods – which have continually emphasised doing more and better interventions at this level – more steps must be taken if we are to ensure neighbourhoods move beyond health *integration* to health *creation*.

For neighbourhoods to realise their potential in health creation we need to change the relationship between local government, the third sector, and the NHS (in all its organisational forms); and between them and citizens.

Relational approaches to governance, for example, create meaningful system ownership of outcomes, genuine power sharing with communities, and decision-making as close as possible to those it impacts. This is the core of mission-based government – and can move neighbourhood approaches beyond health system transformation

to health creation.

Simply put, in isolation, top-down approaches to improving population health and reducing health inequalities have had limited impact.

While integrated care systems have made some progress in the joint ownership of population health, the decision-making environment of local government and ICBs combined with a genuinely difficult operating environment, have incentivised both to retreat from joint accountability, greater transparency and risk-taking.

There is significant potential for neighbourhood approaches in health creation, but it is not without challenge. Genuine power sharing necessitates a degree of organisational and system comfort in variation. ‘Bottom up’ citizen-led approaches truly rooted in place will, by definition, be heterogeneous.

We have a collective challenge for an outcome and accountability framework that can provide assurance without managerialism. Neighbourhood integrators should be at the forefront of relational, purpose-led partnerships, rooted in place, sharing power with citizens. This may require considerable culture change.

Moving beyond a focus on ‘things to deliver’ and reconsidering ways of working will strengthen population health systems, and has a greater prize. When there are no clear paths of delivery – pandemics come to mind – we will have created the necessary conditions to better respond to our known unknowns.

Join us

As an educational charity, *Re:State* produces robust, evidence-led research with innovative but implementable policy solutions; and we convene reform-minded people from across the political spectrum to advance open debate and generate fresh thinking.

In a nutshell, we are home to bold ideas and big conversations.

We bring together like-minded individuals and organisations who share our commitment to finding innovative solutions to public policy challenges. Our Corporate Partnership programme is part of this impactful network.

We value the commitment of our partners very highly. We pride ourselves on building strong and mutually beneficial relationships, and work with our partners so they can get the most out of joining our network.

To find out more, please contact sylvie.macdonald@re-state.co.uk.



Re:State

info@re-state.co.uk
www.re-state.co.uk
[@restate_thinks](https://www.instagram.com/restate_thinks)
[@re-state.bsky.social](https://bsky.app/profile/re-state.co.uk)