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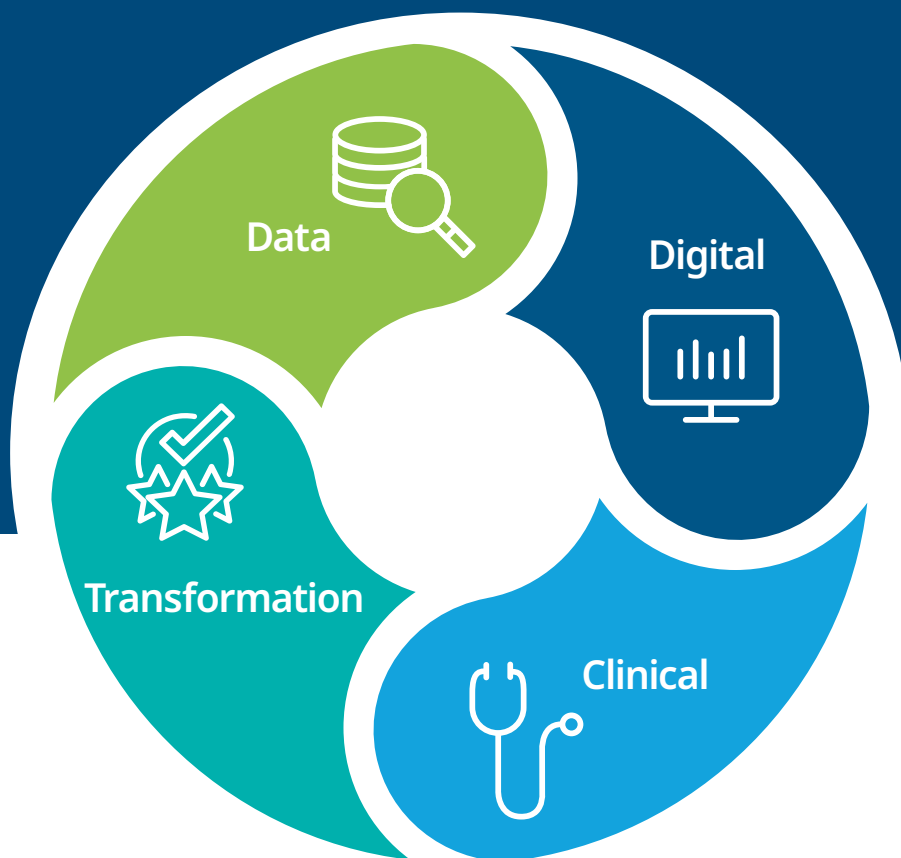
***Sprint Four
Workshop Report:***
Capacity Building for GP
Access and Neighbourhood
Placemaking

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Contents

| | |
|---|----|
| Foreword | 2 |
| Attendees | 4 |
| Summary | 6 |
| Strategic Enablers: What Needs to Change Nationally | 8 |
| In Partnership with IQVIA | 10 |
| Draft Implementation Strategy | 11 |
| Conclusion | 17 |
| About Us | 19 |

Foreword

Across the health and care landscape, a quiet but transformative shift is taking root – one that moves care closer to where people live, connects services around communities rather than institutions, and rebalances power through collaboration, prevention, and co-production. The insights captured in this report reflect not only the vision of Sprint Group Four but also a collective readiness across the system to do things differently.

For too long, general practice has operated under immense pressure, shouldering rising demand while navigating legacy structures not built for the complexity of today's needs. Meanwhile, the communities we serve are not just grappling with ill health – they are facing interconnected challenges tied to housing, employment, isolation, and inequality. It is within this context that the concept of neighbourhood placemaking and integrated community teams becomes not a policy aspiration, but an operational imperative.

This report documents the learning from a dynamic and deeply honest discussion, bringing together voices from across the NHS (including NHS England, Integrated Care Systems, Trusts, Arm's Length Bodies, Health Innovation Networks, and NHS Innovation Accelerator), local government, the voluntary and community sector, academia, and frontline services. It explores the potential of place-based partnerships and neighbourhood teams to ease the burden on GPs, unlock preventative capacity, and build a more responsive and resilient system of care.

The commitment of all involved in the delivery of transformative change was/is inspiring. The relationships that have been established informed by shared principles/values point to the resilience of place based working partnerships. Against a backdrop of significant change across the NHS these underpinnings will be crucial for the successful delivery of their work on behalf of the communities that they serve.

At the heart of this conversation is a recognition that culture change is fundamental. Delegates spoke compellingly about the need to move from a transactional, target-driven approach to one rooted in shared values and trust. Comparisons with policing's shift toward community-led containment and prevention provided a powerful analogy: health must now take the same journey – shifting focus from crisis response to early intervention, from institutional dominance to shared neighbourhood leadership.

The challenges are real. Existing contractual frameworks often disincentivise integration. Information governance remains opaque and inconsistent. The voluntary sector continues to be undervalued despite its critical reach and responsiveness. Digital innovation is not evenly distributed, and where deployed, too often risks leaving the most marginalised behind.

But the opportunities are equally clear. We heard from areas like Wolverhampton, Dudley, and Nottinghamshire where local contracts, community co-production, and academic partnerships are already driving innovation. We heard that long-term relationships – not structural reform – are the bedrock of successful integration. We heard that what communities want is not more services imposed from above, but a genuine role in shaping the care and support that surrounds them.

The implementation strategy outlined in this report provides a practical route forward. It identifies clear workstreams – from neighbourhood team development and digital inclusion to VCSE integration and data infrastructure – and proposes actionable timelines, risks, and enablers. It is not intended as a top-down blueprint, but as a scaffold upon which local leaders can build bespoke, place-driven solutions.

Critically, the strategy reflects a shared call to reimagine the role of general practice – not as a lone gatekeeper of care, but as part of a broader, multidisciplinary effort that wraps around communities and tackles root causes. It asks Integrated Care Systems to lead boldly, enable experimentation, and commit to the long view.

If we are to succeed in this shift, we must also be honest about the conditions it requires: flexible funding models, regulatory support, aligned leadership, and a willingness to embrace risk in pursuit of transformation. The demand for urgent care access will not diminish overnight. But by investing in neighbourhood models now – with the humility to learn and the courage to persist – we can begin to change the tide.

This report captures more than a conversation. It reflects a movement – one grounded in practice, sustained by partnership, and driven by the belief that better is possible. We hope that this report provides leaders across the NHS with inspiring ideas to deliver change differently.

We commend the contributions of all those who shaped this work and invite systems, leaders, and communities to take this forward, together.

Sprint Co-Facilitators



Paul Henderson
Director of Consulting, IQVIA



John Williams
**Chief Scientific Officer, Epilepsy
Research Institute and former
Managing Director, Birmingham
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Attendees

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| Dr. Ryan Hobson | GP Chair | Black Country Primary Care Collaborative |
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| Tracey Daniels | Clinical lead for innovation | Humber and North Yorkshire ICB |
| Aidan Rave | Non Executive Director | NHS Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board |
| Dr. Naresh Rati | GP | Modality Partnership |
| Dr. Nick White | Medical Director | Former Medical Director ICB / Independent Sector |
| Cllr. Angela Archer | District Councillor/Vice Chair | South Derbyshire District Council |
| Cllr. Shade Adoh | Nurse and Councillor | Umbrella.co.uk |
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| Darryl Magher | Chairman | Yew Tree and Tamebridge Community Centre |



Paul Henderson, Director of Consulting at IQVIA, co-facilitating Sprint Group Four.

Summary

Sprint Group Four focused on the potential of integrated neighbourhood teams and place-based partnerships to reshape how health and care is delivered across communities. The session drew from the experience of leaders from local government, primary care, the NHS, voluntary organisations, and academic institutions to examine how partnerships can build capacity, relieve pressure on GP services, and embed prevention at the heart of community health.

The session built around the utilisation of the Pharmacy First initiative, community hubs, and digital innovation as focal points to explore opportunities and barriers to integration, sustainable resourcing, and long-term transformation.

Cultural Change: Reimagining Health as a Shared Endeavour

Participants consistently returned to the theme of cultural change. A compelling comparison was made with the police service, which has embraced a community-based ethos of early intervention and containment. Health, it was argued, must follow suit. This shift involves not just service design but rebalancing power: moving from top-down, provider-led delivery to a model built on mutual accountability, citizen engagement, and shared outcomes.

Local government colleagues highlighted that many local authorities have been working this way for years, co-producing with communities and focusing on place-based outcomes. Health representatives acknowledged that NHS bodies have often felt like latecomers to the table. The challenge is to close this gap and build trust through sustained collaboration.

Aligning Around Shared Priorities and Population Needs

A critical part of the discussion centred on the importance of data sharing and joint insight generation. Participants discussed how meaningful integration requires aligning different organisational priorities into shared ambitions. For instance, while health systems may focus on frailty and long-term conditions, local authorities may prioritise housing, education, or unemployment. Using data and community intelligence to identify overlapping needs can uncover opportunities for shared investment and delivery.

Examples were shared of using housing data to address respiratory conditions or co-designing services to address social isolation. These partnerships require a mature approach to data governance, including the ability to re-identify and act on population-level analytics, which was repeatedly highlighted as a system blocker.

Building Trust and Relationships Over Time

One of the clearest messages from the sprint was that relationships matter more than structures. Participants repeatedly returned to examples of trust built over years – and lost through short-term funding or policy churn. Several described promising neighbourhood partnerships that had withered due to non-recurrent funding or national reform cycles.

One delegate put it succinctly: “You can’t build trust in two years. You need five.”

Local design teams and community leadership models were cited as effective mechanisms for embedding relationships. These teams bring together faith leaders, local service providers, and community members to co-design solutions. Yet their success hinges on long-term resourcing and autonomy.



Attendees, ranging from councillors to ICB Directors, found the session engaging and insightful.

From Digital Enablement to Digital Equity

Digital tools – from remote triage to shared care records – are increasingly central to neighbourhood models. But the group warned against assuming digital solutions are a panacea. While many innovations are already improving access and efficiency, there was a shared concern about digital exclusion and system fragmentation.

Participants called for a more nuanced, needs-based digital strategy that avoids a one-size-fits-all approach. One participant described a pragmatic model in which digital tools are deployed to serve the 60 per cent of the population who benefit from them, with tailored support for those excluded. The key message: “don’t let perfection prevent progress but never lose sight of those at the margins.”

Making Contracts Work for Integration

The session explored the limits of current contracting models. GPs, for instance, are often disincentivised from participating in neighbourhood working due to inflexible national contracts. Several participants argued that to embed place-based care, local systems need permission to experiment with contract reform – particularly around shared outcomes, pooled budgets, and delegated authority.

Examples were shared where local contracts had supported weekly multi-disciplinary meetings, consultant outreach, and cross-sector collaboration. But scaling these models requires new financial mechanisms and a stronger role for ICBs in facilitating innovation.

Role of the Voluntary and Community Sector

Multiple voices raised concerns about the undervaluing of the voluntary sector. Several participants recounted instances where charities were defunded despite delivering essential frontline services, particularly for mental health and social care. One attendee remarked: "Charities are treated like they'll do everything for free. That's not sustainable."

There was consensus that integrated models must resource voluntary partners properly, recognising their reach, trust, and flexibility. Participants called for VCS organisations to be treated as equal partners – not afterthoughts – in neighbourhood planning and delivery.

Strategic Enablers: What Needs to Change Nationally

Discussions culminated in a set of strategic asks:

- **Information Governance Reform:** National clarity is needed to enable secure data sharing at neighbourhood level. Current IG rules were described as opaque, inconsistent, and a barrier to collaborative action.
- **Contractual Flexibility:** ICBs need scope to develop local contracts with providers, allowing shared incentives and integrated delivery. Participants noted that the lack of incentives in GP and community contracts is a structural blocker.
- **Leadership Focus:** Participants voiced concern that senior NHS leadership is preoccupied with targets and finances, rather than systems change. Leadership for place-based care must be visible, consistent, and rooted in shared purpose.
- **Sustained Resourcing:** From community engagement to workforce development, short-term pots of money were seen as disruptive. Long-term transformation requires long-term investment.
- **Embedding Academic Partners:** Universities and research institutes were seen as underused enablers. Programmes like Born in Bradford were cited as models of how longitudinal data and academic insight can support place-based strategies. Participants called for a more deliberate partnership between ICSs and civic universities.



Examples of Innovation

- **Wolverhampton:** Described a model of neighbourhood teams focused on prevention, digital care, and population segmentation. They emphasised tailoring services to micro-geographies, even within a relatively small urban footprint.
- **Dudley:** Shared how they embedded place-based working in GP contracts, aligning incentives and fostering local leadership.
- **Humber and North Yorkshire:** Highlighted strong relationships with academia and a commitment to integrated community hubs.
- **Nottinghamshire:** Discussed the creation of local design teams and partnership models centred around co-production with communities. They emphasised bottom-up design over top-down structures.



In Partnership with IQVIA

IQVIA UK was a platinum sponsor for the conference. IQVIA has played a pivotal role in enhancing place-level collaboration and stakeholder engagement through its involvement in the national lipids programme, addressing health inequalities in cardiovascular disease (CVD), and supporting respiratory patients in accessing the latest respiratory guidelines.

1. Cardiovascular Disease Health Inequalities

IQVIA is actively collaborating with over 50 primary care networks (PCNs) to mitigate health disparities in Cardiovascular Disease (CVD). The focus is on patients residing in Core20 postcodes, where efforts are concentrated on assembling multidisciplinary teams. These teams comprise GP practices, local councils, and the voluntary, community, and social enterprise (VCSE) sector.

2. Respiratory Health

IQVIA has made significant strides in improving access to technology for respiratory diagnosis, particularly in asthma and chronic obstructive pulmonary disease (COPD). By ensuring the adoption of the latest respiratory guidelines through one-on-one training sessions for PCN pharmacists, IQVIA has facilitated a digital-first approach. This approach accommodates both digital and non-digital means, ensuring inclusivity and accessibility for all patients.

Additionally, IQVIA has implemented a machine learning arrhythmia detection algorithm, which has resulted in a substantially higher diagnosis yield compared to traditional methods. This innovative technology underscores IQVIA's commitment to leveraging advanced tools to enhance patient outcomes.

Through these initiatives, IQVIA has demonstrated its dedication to reducing health inequalities and improving patient care. By fostering collaboration among various stakeholders and integrating cutting-edge technology.

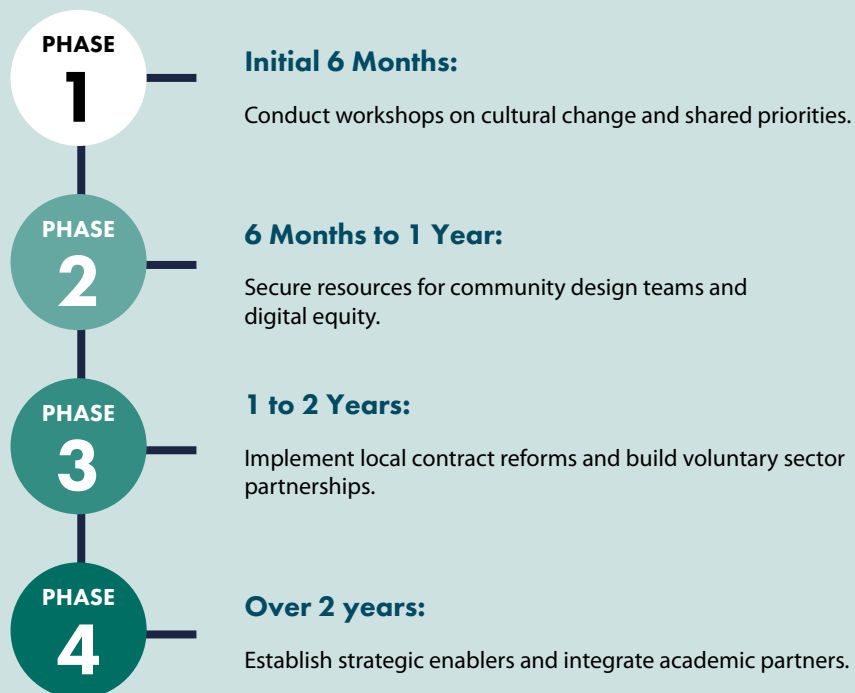
Draft Implementation Strategy

Capacity Building for GP Access and Neighbourhood Placemaking For: Integrated Care Systems (ICS)

1. Purpose and Strategic Intent

- To operationalise the recommendations from Sprint Group Four, this strategy sets out a framework for ICS to build capacity in General Practice and develop neighbourhood-level place-based partnerships that deliver preventative, person-centred, and community-embedded care. This strategy aligns with the NHS Long Term Plan and supports integrated neighbourhood working as a core tenet of ICS development.

Capacity Building for GP Access and Neighbourhood Placemaking





2. Implementation Objectives

- **Strengthen Primary Care Capacity** through neighbourhood-based integrated teams.
- **Embed Prevention at Neighbourhood Level** via co-produced community activation.
- **Foster Cultural Change** to enable shared leadership, mutual accountability, and citizen engagement.
- **Enable Contractual and Financial Flexibility** to incentivise cross-sector collaboration.
- **Leverage Data for Shared Insight** while reforming IG processes for safe and effective collaboration.
- **Integrate Voluntary, Community and Social Enterprise (VCSE)** Sector as equal delivery partners.
- **Strengthen Academic and Industry Partnerships** to support place-based innovation and evaluation.

3. Core Delivery Principles

- **Place-led, system-enabled:** Design and delivery should be locally driven and nationally supported.
- **Co-production with communities:** Embed local voice at all stages of planning and delivery.
- **Equity-focused digital enablement:** Implement digital solutions while addressing exclusion.
- **Sustainability and long-termism:** Transition from short-term pilots to embedded, enduring models.

4. Programme Workstreams

Workstream 1: Neighbourhood Team Development

Objectives:

- Establish multi-disciplinary teams tailored to neighbourhood footprints.
- Support co-location where possible, and virtual integration where necessary.

Actions:

- Map existing provision and gaps.
- Define team composition by local need (e.g. PCNs, social prescribers, community nursing, VCSE reps).
- Commission leadership development and OD programmes for integrated working.
- Develop shared care plans and information systems to support continuity.

Workstream 2: Community Activation and Prevention

Objectives:

- Mobilise communities to engage in their own wellbeing.
- Focus on upstream, low-cost interventions (e.g. group activities, community navigators).

Actions:

- Create community design teams to identify local needs and assets.
- Co-design neighbourhood health improvement plans.
- Provide micro-funding or grants for grassroots initiatives.



Workstream 3: Digital Equity and Enablement

Objectives:

- Improve access through technology, while supporting those digitally excluded.

Actions:

- Roll out remote triage, digital front doors, shared records where applicable.
- Develop digital inclusion strategies (e.g. device lending, training).
- Assess digital maturity across neighbourhoods.

Workstream 4: Data and Insight Infrastructure

Objectives:

- Build a shared data platform to generate insight and target interventions.

Actions:

- Negotiate place-level data sharing agreements with re-identification clauses for clinical use.
- Develop dashboards that combine health, housing, employment and other determinants.
- Invest in data analyst capacity at neighbourhood level.



Workstream 5: Contract and Finance Reform

Objectives:

- Create mechanisms that reward integration and shared outcomes.

Actions:

- Pilot pooled budgets across neighbourhood teams.
- Co-develop local contracts with GP practices, mirroring Dudley model.
- Incentivise participation in neighbourhood MDTs and care planning.

Workstream 6: Embedding the VCSE Sector

Objectives:

- Ensure the VCSE sector is properly resourced and represented in planning and delivery.

Actions:

- Develop formal partnership agreements with key VCSE providers.
- Include VCSE representatives in governance structures.
- Commission services from VCSEs based on local need.

Workstream 7: Academic and Research Integration

Objectives:

- Use academic insight to support planning, evaluation, and innovation.

Actions:

- Partner with local universities on evaluation frameworks and health equity research.
- Embed research roles within neighbourhood teams.
- Participate in longitudinal studies like Born in Bradford and its derivatives.

5. Enabling Conditions

- **Leadership Development:** Support senior and place leaders to champion neighbourhood integration.
- **Governance Reset:** Align ICB, PCN and local authority planning cycles.
- **Strategic Planning Horizon:** Implement 1/3/5-year goals with measurable outcomes.
- **Long-Term Funding Frameworks:** Replace non-recurrent funding with sustainable financial plans.

6. Evaluation and Monitoring

- Establish a cross-sector evaluation framework.
- **Track indicators including:**
 - GP appointment access
 - ED conveyance rates
 - Health inequalities and digital inclusion metrics
 - Community engagement and trust scores
 - Integration maturity measures
- Report to ICB and local health and wellbeing boards quarterly.



Following the workshops, each group had the opportunity to present their discussions.

Conclusion

Sprint Group Four illustrated the energy, insight, and frustration of local leaders trying to build stronger communities through integrated care. Participants shared a vision for neighbourhood health that is inclusive, preventative, and co-produced. But they also highlighted the gap between local ambition and national constraint.

This sprint group focused on the transformation of care delivery into communities, and the cultural, contractual, and strategic shifts needed to support it.

Discussions highlighted:

- **Cultural Shift:** Parallels were drawn with police reforms, suggesting healthcare should similarly embrace containment and early intervention in community settings instead of default hospital admissions.
- **Governance and Incentives:** Current consultants and GP contracts often disincentivise digital and community-based management. Revisiting these frameworks is essential.
- **Relationships:** Co-location and pre-Covid cross-sector collaboration had benefits that need rebuilding, even in hybrid working environments.
- **Shared Priorities:** Health and local authorities should find mutual goals – such as tackling unemployment – to align data and joint delivery efforts.

Information governance was flagged as a barrier to collaboration. The group called for national attention on data sharing to unlock local insight and decision-making.

Some of the funding mechanisms as key enablers were highlighted. Scaling innovation requires:

- Shared financial incentives.
- Potentially new tariffs and contracts.
- Redesigning roles and shifting budgets.
- Focusing on value creation and outcome-based rewards

In summary, this group called for structural reforms, sustained collaboration, and courage to tackle "crunchy" national issues – particularly around IT and contracts – to realise the vision of effective place-based care.

Overall Themes Across the Sprints

- **Culture matters** – whether it's curiosity in leadership, listening in care, or shared values across partners.
- **Data is a recurring enabler** – driving service design, evaluation, and accountability.
- **Sustainability and embedding** – innovation should be ongoing, not episodic or pilot-driven.
- **Co-production** – with staff, patients, and communities – improves relevance, adoption, and success.
- **System-level alignment** – through contracts, incentives, and strategy – is needed to embed innovation into the fabric of care.

These sprints demonstrated how different parts of the system are tackling common challenges with creativity, collaboration, and a strong desire to move from ideas to implementation.

The key message: integrated neighbourhood care is not a new idea, but this time, we must give it time, flexibility, and trust to succeed.

About Us



Since 2015, the NIA has played a pivotal role in helping innovations scale and delivering insights to the health and social care system.

The NIA offers a dual focus on developing the individual through a bespoke learning programme as well as supporting the innovation to spread.

The NIA's mission is to spearhead the national acceleration of innovation and business growth of health and care innovators to help enhance patient experiences and outcomes, improve our NHS and grow employment in the UK. The NIA does this by helping its Fellows solutions to extend their footprint in the NHS and further afield as well as supporting their business growth.

The NIA places a dual focus on both the innovator ('Fellow') and the innovation. The ethos of the accelerator is to provide a range of support in response to the needs of each Fellow and the barriers to uptake their innovation faces within the NHS. This includes a bespoke learning programme, mentorship and networking opportunities to equip Fellows with critical knowledge, relationships and skills to scale innovation in the NHS.

During their three years on the accelerator, each NIA Fellow is provided with:

- Access to a pool of mentors
- Networking opportunities with the Health Innovation Network
- Quarterly learning events
- Peer-to-peer support
- Ad hoc specialist information sessions, as required (e.g. procurement, NHS commissioning, health economics, business case development, media training, etc.)
- A tailored support package to develop their skills in patient and public involvement and engagement.
- A tailored support package to develop their understanding of health inequities and how their innovation can better help to address them.

At the end of the first year, each Fellow should have the following in place:

- A robust diffusion plan: A critically appraised, robust diffusion plan for the NHS, which they have made progress on implementing (e.g. new contracts signed, resources secured).
- Expanded networks: Built a network of decision makers, 'critical friends' and other key stakeholders.
- Navigation of innovation opportunities: The ability to navigate innovation initiatives, support infrastructure and national levers.
- Expanded knowledge: Addressed critical knowledge gaps as agreed with their mentors/lead HIN/NIA core team at the programme outset.

The NIA cannot offer a guaranteed route to widespread adoption across the NHS. Being on the NIA does not offer preferred supplier status.

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IQVIA believes that the value of unlocking data is in the clinical and strategic decision-making it can inform and, as a trusted partner to health systems and providers, we use our extensive data and analytics capabilities to transform health outcomes and deliver pioneering biomedical research.

An example of this is how, through using our data analytics capabilities and clinical expertise, we have risk assessed populations and implemented targeted interventions, resulting in reduced emergency admissions and improved patient outcomes - addressing a key challenge faced by all health systems.

95 per cent NHS organisations already use one or more of our services including costing, coding, benchmarking and data warehousing and our insights and feedback expertise is widespread across a range of healthcare systems.

Demonstrating our ability to deliver at speed, within two weeks of the request, IQVIA operationalised and ran the UK Government COVID Infection Survey, underpinned by our real-world data platform and the mobilisation of 4,000 field workers to undertake testing, enabling real-time population health data that informed national emergency responses.

Also, as a major investor in UK life sciences we consistently attract commercial clinical trials in cancer, neurology, paediatrics, and rare disease to the UK, making IQVIA the third largest life sciences employer and contributing over £2.2 billion to the UK economy.

IQVIA's success is enhanced by creating these valuable connections and collaborations between life sciences and the wider HCS. Our expertise and unique capabilities mean we are best placed to partner with the HCS to deliver improved outcomes.

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