NOTICE OF MEETING

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday 18th September 2026, 10:00 a.m.
ENFIELD COUNCIL, Conference Room, Civic
Centre, Silver Street, Enfield, EN1 3XQ

Contact: Fola Irikefe, Principal Scrutiny Officer

E-mail: fola.irikefe@haringey.gov.uk

Councillors: Zahra Beg and Caroline Stock (Barnet Council), Larraine Revah (Chair) and Arun Kumar (Vice-Chair) (Camden Council), Alev Cazimoglu and Dino Lemonides (Enfield Council), Lucia das Neves (Vice Chair) and Anne Gray (Haringey Council), Joseph Croft and Kiran Prasad (Islington Council).

Quorum: 4 (with 1 member from at least 4 of the 5 boroughs)

AGENDA

1. FILMING AT MEETINGS

Please note this meeting may be filmed or recorded by the Council for live or subsequent broadcast via the Council's internet site or by anyone attending the meeting using any communication method. Members of the public participating in the meeting (e.g. making deputations, asking questions, making oral protests) should be aware that they are likely to be filmed, recorded or reported on. By entering the 'meeting room', you are consenting to being filmed and to the possible use of those images and sound recordings.

The Chair of the meeting has the discretion to terminate or suspend filming or recording, if in his or her opinion continuation of the filming, recording or reporting would disrupt or prejudice the proceedings, infringe the rights of any individual, or may lead to the breach of a legal obligation by the Council.

2. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

3. URGENT BUSINESS

The Chair will consider the admission of any late items of Urgent Business. (Late items will be considered under the agenda item where they appear. New items will be dealt with under item 10 below).

4. DECLARATIONS OF INTEREST

A member with a disclosable pecuniary interest or a prejudicial interest in a matter who attends a meeting of the authority at which the matter is considered:

(i) must disclose the interest at the start of the meeting or when the interest becomes apparent, and
(ii) may not participate in any discussion or vote on the matter and must withdraw from the meeting room.

A member who discloses at a meeting a disclosable pecuniary interest which is not registered in the Register of Members' Interests or the subject of a pending notification must notify the Monitoring Officer of the interest within 28 days of the disclosure.

Disclosable pecuniary interests, personal interests and prejudicial interests are defined at Paragraphs 5-7 and Appendix A of the Members' Code of Conduct

5. DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS

To consider any requests received in accordance with Part 4, Section B, paragraph 29 of the Council's constitution.

6. MINUTES (PAGES 1 - 10)

To confirm and sign the minutes of the North Central London Joint Health Overview and Scrutiny Committee meeting on 17th July 2026 as a correct record.

7. WEST AND NORTH LONDON CORPORATE STRATEGY AND INVOLVEMENT FRAMEWORK (PAGES 11 - 48)

To consider and comment on the West and North London Corporate Strategy and Involvement Framework.

8. WORKWELL - WEST & NORTH LONDON UPDATE (PAGES 49 - 58)

To consider and comment on the WorkWell – West and North London Update.

9. WORK PROGRAMME 2026-27 (PAGES 59 - 62)

This paper provides an outline of items for consideration as part of the 2026/27 work programme for the North Central London Joint Health Overview and Scrutiny Committee.

10. NEW ITEMS OF URGENT BUSINESS

11. DATES OF FUTURE MEETINGS

To note the dates of future meetings:

27 November 2026
29 January 2027
19 March 2027

Fola Irikefe, Principal Scrutiny Officer
Email: fola.irikefe@haringey.gov.uk

Fiona Alderman
Head of Legal & Governance (Monitoring Officer)
George Meehan House, 294 High Road, Wood Green, N22 8JZ

Friday, 11 September 2026

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Agenda Item 6

MINUTES OF MEETING NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE HELD ON FRIDAY 17TH JULY 2026, 10.00am - 13.00pm

IN ATTENDANCE:

Councillors Larrain Revah (Chair), Zahra Beg, Lucia das Neves (Vice-Chair), Arun Kumar (Vice-Chair), Kiran Prasad and Caroline Stock.

ALSO IN ATTENDANCE:

- Natasha Benn, Chair, Joint Partnership Board, Trustee of Disability Action Haringey
- Fola Irikefe, Principal Scrutiny Officer
- Nicola Kay, Director of Strategy, West & North London (N&WL) ICB
- Chloe Morales Oyarce, Head of Communications and Engagement, West & North London (N&WL) ICB
- Sarah Morgan, Chief People Officer, West & North London (N&WL) ICB

Attendance Online

- Councillor Chris Jainedes attended online.
- Nicola Sands, Deputy Chief Nurse, Whittington Health NHS Trust

FILMING AT MEETINGS

Members present were referred to agenda Item 1 as shown on the agenda in respect of filming at this meeting, and Members noted the information contained therein'. The Chair informed those present that the meeting was being recorded for the purpose of accuracy.

APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Alev Cazimoglu and Joe Croft.

URGENT BUSINESS

None.

DECLARATIONS OF INTEREST

None.

DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS

Nove were received.

Introductions and Nominations of Chair and Vice Chair

The Principal Scrutiny Officer invited nominations amongst the councillors of who would like to Chair the Committee for 2026/27. Councillor Lucia das Neves

nominated Councillor Larraine Revah to chair the Committee considering her experience having been on the Committee for a while and more specifically having been Vice-Chair. Councillor Arun Kumar seconded the nomination and Councillor Revah accepted.

Councillor Revah then requested nominations for the Vice-Chair/s to which Councillor Kumar nominated himself and in turn Councillor das Neves. The nomination of the two Vice-Chairs was seconded by Councillors Revah, the Chair and Councillor Prasad.

Declarations of Interest

None were received.

Terms of Reference

The Chair invited comments from the committee in respect of the terms of reference. Councillor das Neves commented that it was an important time of transition in the health environment and that the terms of reference should be centred around the voice and the work of the community and questioned whether this came across strongly enough in terms of reference. Natasha Benn, Chair of Haringey Joint Partnership Board and Trustee of Disability Action Haringey and the Chair of the Committee agreed that the terms of reference needed to be community centred with a specific paragraph referencing this element.

In line with this, the Chair expressed that she was keen to have people from other organisations attending the meetings to work in partnership and in turn strengthen the work of the Committee. Councillor Prasad explained that in her role as Trustee for Voluntary Action Islington the voluntary sector is underestimated in terms of the value they provide and in particular the role of the Place Specialist and how it translates in terms of the budget.

The Chair of the Joint Partnership Board specifically requested to be co-opted onto the board as she represents a wide group of voluntary organisations and this could be done for the other boroughs as well. Councillor Reevah expressed that it would be useful to have similar attendance from the other boroughs. The Principal Scrutiny Officer briefed the committee that it would have to go through each Overview and Scrutiny committee in each of the boroughs if they were to have the Joint Partnership Board (or equivalent) formally referenced in the terms of reference and co-opted to the committee. The Principal Committee Officer reminded the Chair that the previous committee had agreed to consider relevant people to include on the mailing list and then invite those people regularly to meetings.

Councillor Prasad enquired over how often the Chair/ Vice-Chair/s are appointed and the committee heard that its annual but the previous Chair, Councillor Connor was in the role for a long period, and staying in post for a couple of years is helpful for continuity. Councillor Stock enquired about clarity on support arrangements as Barnet was not in a good position financially. The Principal Scrutiny Officer confirmed that Barnet had not agreed to a financial contribution for the role but did agree to the annual rotation of officer support.

Councillor Revah expressed that there is nothing in terms of reference with regards to disabilities and felt that this should be included. The Chair also added that disability is also very rarely mentioned in NHS reports unless its specifically focussed on disability. The Chair of the Joint Partnership Board further re-iterated that it would be helpful to be co-opted and attend the meetings and speak at meetings. Councillor das Neves expressed that the committee should take time to think through who should attend from their respective boroughs in time for the next committee.

Councillor Kumar expressed that the inclusion of the Equalities Act in the terms of reference to cover all the protected characteristics would be useful.

FOLLOW UP: Principal Scrutiny Officer to follow up with Democratic Heads of Service in the five boroughs regarding the idea of including key voluntary sector organisations in the terms of reference and Councillors to think about who they may want to invite.

Councillor Beg enquired about the number of deputations and the outcomes and the Principal Scrutiny Officer explained that it depended on the issue and subject to meetings.

West & North London ICB Update

Sarah Morgan, Chief People Officer, NHS West and North London ICB introduced the item and provided an overview of where they were regarding the merger and the background to the merger. It was explained that the impetus for the merger was to reduce staffing costs by 50% and the model ICB blueprint directed transition for them to be a strategic commissioner. This blueprint then led to the NCL and NWL ICB's merger on 1st April 2026, covering 13 boroughs which amounts to 48% of Greater London with a commissioning budget of 12 billion, supporting 4.5 million residents. The ICB are currently in the process of the change programme with colleagues filling roles in the merged organisation.

The Committee were briefed that most of the senior roles had been appointed to and this would help to alleviate some of the challenge for partners in terms of who to liaise with. The changes to the way they work was briefly described with the move from borough level to Integrators with 53 neighbourhoods within the W&N London ICB patch. The committee heard the ICB is trying to work more effectively with the 18 provider organisations, 500 GP practices and a wealth of voluntary and community sector organisations. The ICB is no longer the system convenor and in control of the finances, choices will be made on needs-based allocation and the best outcomes for the population.

The committee heard that there is a 17-year gap in life expectancy across the different boroughs. The ICB aims to reduce demand, and they are trying to work more collaboratively with Integrators to improve outcomes. The regulation of the provider sector is with NHS England, and with the Health Modernisation bill currently going through parliament will determine the future of NHS England so although progress is being made regarding what West and North London ICB will look like, it is within the parameters of national uncertainty.

Councillor Beg expressed that as they were aware of where the inequalities are, how does their insight translate into reconsideration of how the money will be allocated and different commissioning models. Nicola Kay, Director of Strategy, West and North London ICB explained that although they are aware of where they inequalities and the most need is, they were working on what future demand would look like for the communities across west and north London. The Director of Strategy stressed that they were looking at things from both a quantitative and also qualitative perspective. The objective is to move to a proactive space to know where best to put resources that are closer to home for residents and value add with a move towards investing in acute services. This will be considered at their board meeting in the coming week.

Councillor Beg stressed that there has already been lots of information already so what will make the difference? The Director of Strategy explained that NHS England are trying to empower providers when it comes to commissioning and inequality can be very complex, for example there can be disparity on a street-by-street basis within the same area. Councillor Beg explained that the prevention work that's carried out by the voluntary and community sector and the positive aspect in terms of neighbourhood working need to be recognised.

Councillor das Neves further enquired over how decisions will be made over which organisations they work with as the voluntary and community sector although do a great job, may not be ready to work and deliver services the way the ICB would commission. The Councillor emphasised that although the VCS may be the best to deliver a beneficial social model - they are often not ready and resourced to be ready and as distant commissioners, how are they going to recognise the best bodies and organisations for certain services she queried.

The Chief People Officer, NHS West and North London ICB responded that they were talking to a range of different organisations through *'Lets Talk'* and so they are focussed on how to understand the resident voice. The committee heard that they also recently commissioned a piece of work looking at the impact of their commissioning practices on the VCS. The results were not positive and some of the insights included the challenges with annual commissioning, disproportionate scrutiny, a tendency to favour large trusts in the past (whereas a smaller organisation may better serve the community) etc are all things they are taking into account and hence the new approach with the Neighbourhood model. The committee heard that the full strategy will be out in October to which the committee can contribute to. It was explained that time needs to be invested to build up neighbourhood model and that Haringey was one of the accelerator sites. Neighbourhood partnership is something that has been in place for a while for local authorities, but it is new for the NHS.

Councillor das Neves enquired over what success will look like in future and how it will be measured. In line with this, Councillor Kumar commented that in terms of governance, local authorities have been involved in neighbourhood health already and he enquired what the path forward was in terms outcome-based treatment and how it was to be measured. The timeline for implementation was also queried as the point was made that whilst everything is in the development phase, there will clearly

be some slippage in other areas. Councillor Kumar expressed that smaller organisation won't necessarily be up to speed and linked into the digital systems that will support monitoring and this will be a problem.

The Chief People Officer explained that the population health outcome framework is the baseline with indicators for the outcomes that we want to see. In respect of governance, governance integrator workshops have been held with details of which organisations sit in each area. It was reported that they were setting up system wide governance across the 13 boroughs, chaired by non-executive members. In terms of data and platforms, the Director of Strategy explained that they would not be micromanaging providers, and measures of success will be built on key outcomes from each individual's perspective and they were working on what this would look like.

Councillor Kumar sought clarity on how they were working with local authorities and boards and how this engagement was being carried out. It was explained by the Chief People Officer that they were not in the implementation phase yet and they were currently focussed on getting the Strategy right so as to know how to make commissioning decisions. The Strategy will be for ten years and refreshed annually as they progress. The Strategy will now have to consider the Health Bill and the new Prime Minister so there will be a constant state of fluidity in terms of the plan. Strategic commissioning decisions will sit with the ICB's and delivery of care accountability sits with providers and Trusts.

Councillor das Neves expressed that we haven't always got it right regarding population health and there is a need to look at the whole as opposed to just the extreme side of those in need. It was further added that if Integrators and providers are key, they should be setting the baseline and targets as they know their communities best and every area is different. Councillor das Neves stressed that the consistency in all the change is the community.

The Chief People Officer explained that the challenging reasons mentioned is why they are moving into the neighbourhood model. The model will facilitate a localised and joined up integrated approach, expanding work at a granular level as has been done in much of NCL. The focus going forward will be on patient reported outcomes, impact on life and after effects all managed in the community.

Councillor Prasad expressed that GPs are increasingly moving away from the localised frontline primary care approach. The Councillor emphasised that although she understood the political and strategic flux within the NHS, the need for quality of care remains the same. Councillor Prasad expressed that the change towards community is clearly prompted by the need to save money in line with the aging population and increasing demand, nevertheless without the structures in place things will fall short as they are not set up and joined up properly. The Councillor also asserted that there are limitations to the training of the VCS and so the burden can't be solely placed on them. Councillor Prasad suggested looking at what isn't working presently as the reality for the delivery of the aspirations set out in the 10 year plan.

In respect of digital services, there is not enough emphasis on the actual delivery because there sometimes isn't the join up between systems. Councillor Prasad

expressed her reservations that more care can be delivered with the responsibility being placed on a community level. The Chief People Officer said that the example of the disjoin in the system was the key reason to move to the neighbourhood model and it is at the heart of the strategy.

It was further stressed that the digitisation of services was not moving the community closer and a prime example of this is that GP's (which did at times act as a community centre for lonely individuals) and GPs are currently empty due to the triage nature of GP services. Councillor Prasad emphasised the need to bring back human interaction. The Councillor expressed that digital efficiency is about efficiency and is taking away choice. The committee all concurred that the voluntary and community sector has limited resources and budgets to actually deliver the aspirations set out in the 10-Year Plan.

Councillor Stock said that in terms of safeguarding, thought needs to be given to the impact of an increasing digitized service for vulnerable people who aren't actually able speak to a real person as this can be frustrating. Digitisation can be a challenge for those that are hard of hearing, depressed or with other special needs. The Chair emphasised that there needs to be good back up for all the digitisation of services. Councillor Stock also made the point that there are security and safeguarding concerns with digitisation as well.

In respect of consulting and engaging with the community over what is needed, Councillor Stock also emphasised the need to be careful as it can often be the same groups and individuals that we are consulting as they are the engaged members of the community.

Councillor Stock briefed that she had arranged ad-hoc diabetes testing for one hundred people with a HB1 kit. The diabetes spot testing took place in Brent Cross Shopping Centre which resulted in 50% of those tested being diabetic or pre-diabetic. The Chief People Officer explained that going into the community into trusted places in NWL was something that they have started to do as there are low levels of trust amongst some communities. Councillor Prasad explained that the role of GPs has shifted and they are now referral points as they are no longer joining the dots for supporting their patients.

The Chair of the Joint Partnership Board informed the committee about her expertise due to her lived experience, she explained that during the eight-year period that she was bed-bound, her care wasn't joined and professionals weren't coming together and she took on the responsibility of ensuring that the dots were joined. The Chair of the Joint Partnership Board expressed that close working relationships would be essential as she is aware that the whole system is even less co-ordinated now. The Chair of the Joint Partnership Board said that those in poverty, the ageing population and unpaid careers are those that we need to hear from but often the ICB and also local authorities are just picking the same voices and there are real gaps in diversity and equalities when it comes to co-production. The Chair of the Joint Partnership Board also emphasised that a lot of community sector organisations are also not necessarily trained to work with a diverse group of people and are the most ideal to manage and deal with a said issue, she expressed it will would be useful to know

how this will be addressed and how any gaps in their need to deliver a service will be met.

The Chair of the Joint Partnership Board emphasised that the approach to co-production has to be different for everyone and it really needs to take place in order for the most need can be identified and this needs to be evidenced in the strategy. The Chief People Officer explained that this was to be covered as part of the Strategy and upon enquiry about how it could be accessed by public, the committee were re-assured that all board papers were published online. **ACTION:** link to board papers to be sent. Information on groups they are talking to as part of the co-production process to be provided along with data.

The Chief People Officer explained that there is a focus on youth opportunity and children and young people's mental health and understanding what it is to have complex needs from a neighbourhood perspective. The Committee were informed by the Director of Strategy that consultation workshops are currently being carried out and along with work looking into how to break down the strategy so that it user friendly and can be co-produced in a dissected format. The Director of Strategy expressed that they are cognisant of the need to hear real voices and ensure quality in the consultation phase. The Chief People Officer expressed that they were keen on patient activation to support services.

The Chair enquired how the merger and changes will affect the boroughs in reality and how is it being publicised to residents. The Chief People Officer informed the committee that the main change is the delegation of complex care which has moved to central London Community Health Partnership. The Chair expressed that further information on this would be very helpful. Central London Community Health is responsible for any day-to-day challenges. The Chair of the Committee was also keen to know how lay members could also possibly get on the public board. **ACTION**: Head of Communications and Engagement to send the details of the board meeting.

Councillor Revah explained that having a named link for ICB and having access to the right people and individuals for certain subjects was really useful and all boroughs needed that link person that they could still approach. In response ICB colleagues explained that roles were still being developed and appointed to but once recruitment was finalised it would be provided. **ACTION**: N&W London ICB to share details of key people once established.

Councillor das Neves suggested that it would be useful in future to hear more about co- production and the outcome of 'Let's talk' as work between primary care and residents was lacking that real democratic inclusion. The Chief People Officer suggested that the Committee may wish to consider the Involvement Strategy due at their board in January 2027. **FOLLOW UP:** Add Involvement Strategy to work programme.

Whittington Health NHS Trust Quality Account

Nicola Sands, Deputy Chief Nurse, Whittington Health NHS Trust provided an outline of the Trusts 2025/26 Quality Account. The Deputy Chief Nurse explained that the

Trusts objective was to deliver *'outstanding, safe and compassionate care in partnership with patients'.*
The following priorities were outlined:

- Ensuring patients receive safe and effective care that is delivered with kindness, compassion and in collaboration with patients and carers
- Improving the Trust Environment to enhance Patient Experience
- Reducing health inequalities in our local population by ensuring that when patients need to access our services, they have clear guidance, accessible routes and supported and listened to throughout
- We will continue to develop services to meet the needs of our population

Councillor das Neves expressed an interest in knowing more about the role of the financial issues and deficit on improving the building. **FOLLOW UP.** The Councillor enquired about community services and where Whittington is delivering them, hospital discharge and maternal health, all of which she felt was lacking in detail.

The Chair enquired about the plans to move Royal Free Hospitals maternity ward to the Whittington. The Deputy Chief Nurse explained that the move is part of the StartWell programme and that there was a long lead for it to ensure the organisations have the capacity. **FOLLOW UP:** Update on StartWell programme including maternity and recommendations from the Amos review and how it is incorporated and Community Services including the Haringey District Nursing Service.

Councillor Beg enquired if the Whittington Trust was satisfied with the number of complaints they had received. The Deputy Chief Nurse explained that the number of complains was increasing as with other Trusts and in turn there are a number of complaints that are generated by AI and hence are complex and long and require a detailed response and review. The Trust is happy with the number but would like to de-escalate them earlier by talking to patients sooner once a complaint is put through. The Deputy Chief Nurse explained that the threshold to respond is within 25 days, and they are currently at 60- 70% in terms of meeting this and the target is at 80%. The Trust is trying to focus on learning from the complaints to see where they can do better and this is the challenging part.

Councillor Stock enquired about End-of-Life Care and whether it was something the committee could consider in the future. The Committee heard that the End-of-Life care team and the Palliative Care Team work with other staff but there is a challenge in terms of beds and there is still some fear around it. **FOLLOW UP**: Councillor das Neves suggested that the panel could have a further session on End-of-Life Care including inviting North London Hospice, looking at a number of issues including hospice at home and what it looks like at home.

Councillor das Neves explained that more detail is required of the Quality Account as it was a little too light and hence in future, more information should be provided in order to allow for proper scrutiny. The Chair re-iterated that further details should have been added in order to fully scrutinise the Quality Account properly. Councillor Stock suggested a paragraph with succinct information notifying an upward/downward trend with some information would be helpful.

Councillor das Neves enquired if there was any best practice in Quality Account and what it looks like. **FOLLOW UP**: schedule in some time to consider what a good Quality Account will look like in advance of those that will be considered in the summer 2027.

Work Programme

- Councillor da Neves suggested moving the winter planning item forward from November
- The Chair requested a report to look into the is increasing heat and the impact in line with the Winter Planning.
- The Chair requested ICB merger and changes to remain a standing item at each meeting. Councillor Prasad agreed that there were rapid changes planned with implementation via the community sector without any information to support the aspirations.

The meeting ended at 12.25

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NHS
West and North London

West and North London corporate strategy and involvement framework

September 2026

NHS
West and North London

What has happened since July

- At the July meeting of WNL ICB's Board meeting and we had endorsement of our draft 10-year strategy,
- We launched a “call for evidence” to partners, as experts, for examples of the innovations, interventions or ways of working that have delivered positive results.
- We received contributions from more than 75 organisations, including local authorities, NHS providers, primary care, community pharmacy, voluntary and community organisations, research partners and people working with residents.
- We have held a series of deliberative workshops with residents and VCSE partners and a workshop with system partners
- We are reviewing these insights and wider research to identify the approaches with the greatest potential to improve health outcomes for the six population groups emerging as priorities.
- The contributions will help strengthen the evidence to inform our strategy.
- Through the **Let's Talk** programme we have also sought views to help us shape a new approach to involvement, working with staff, residents, patients, carers and our voluntary and community sector partners.

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Priorities for West and North London ICB's first year

Deliver operational commitments and financial plan

Agree and monitor commissioner financial plan for 26/27, support providers with efficiency, deliver NHSE performance requirements, and statutory commitments.

Set the new organisation up for success

Delivery of 'day 1' executive commitments, **complete staff recruitment**, ensure clear comms to partners, **establish governance** structures, align legacy systems and develop values.

Invest the 1% for impact

Prioritise **high-impact population health interventions**, learning lessons about how we take forward the longer-term strategy. In 2026/27, this investment amounts to £60m (£120m full year effect), with plans to increase this by this by 1% annually up to 5%.

Develop a clinically-led strategy

Understand population needs **through segmentation and variation in outcomes,** set a clear plan for change in spend for **greatest impact in outcomes, demand and cost.**

We want to improve outcomes for the 4.5 million people living across our 13 boroughs

NHS
West and North London

1 Healthier lives for everyone

- Help people stay well for longer
- Prevent illness, not just treat it
- Reduce health gaps between communities

2 Less pressure on services

- Support people earlier and closer to home
- Focus help on those who need it most
- Make it easier to manage health day-to-day

3 Make the best use of our money

- Spend where it makes the biggest difference
- Reduce waste and variation
- Keep services affordable for the future

Three connected goals guide our strategy — improving outcomes, easing pressure and making the best use of resources.

Outcomes and inequalities are not improving, and some people are already looking elsewhere for support

West and North London
West and North London

Outcomes and inequalities

People are living longer, but not healthier lives — and where you live shapes how long and how well you live.

≈3 year
fall in healthy life expectancy over the last decade

17-year
gap in healthy life expectancy between WNL neighbourhoods

1 in 3
five-year-olds have tooth decay; mental health needs continue to rise

Seeking alternatives — but not equally

Access to private, digital and AI-enabled support is easier for people with resources, leaving those with greater need less able to benefit and widening inequalities.

14%
of UK adults now hold private medical insurance (7.6m people)

24%
already use AI tools or social media for health guidance

32%
lower uptake of private GLP-1 prescriptions in most deprived communities despite significantly higher obesity rates

Why this matters

Without change, there is a risk of a **two-track health system** emerging: people with the means, confidence or digital access increasingly find alternatives, **while others spend longer in poor health and become more dependent on increasingly pressured health, care and community services**.

FCA Financial Lives 2024; Broadstone/Burges Salmon 2025; Semble 2025; King's College London 2026. GLP-1 drug prescriptions for obesity - The Health Foundation

More resources are being absorbed by hospital and crisis care

West and North London
West and North London

Funding is shifting

51% → 56%

acute spend share increased between 2019/20 and 2025/26

≈£600m

of 2025/26 budget linked to acute-share rise

Reactive demand persists

13% emergency inpatient activity potentially preventable through community care

16% A&E attendances with no investigation or significant treatment

The trajectory is unaffordable

>£1bn

projected “do nothing” deficit by 2035/36

Cost drivers

Demography, inflation, drugs and workforce costs continue to rise

Why this matters The system cannot spend its way out of the problem. We must change where and how support is delivered — shifting from reactive treatment to proactive, community-first care and support.

Change is needed now across the health and care system

NHS
West and North London

Growing pressures and rising expectations are widening the gap between need and what the health and care model can deliver.

West and North London has world-class assets and a £12bn budget — but demand, complexity and expectations are now moving faster than the system is designed to respond.

Growing pressures

Need is rising in scale, complexity and acuity.

- More years spent in poor health
- Demand exceeds capacity
- Increasing health inequalities
- Financial pressure continues to grow
- A care model weighted to reaction

Patient expectations

People increasingly expect care to feel joined-up, digital and personalised.

- Instant access and convenience
- Personalised care and advice
- Digital-first experiences
- Joined-up services around people
- Greater control over their health

Our ambition for the future health and care system: bend the three curves simultaneously

NHS
West and North London

Our strategy must start with what changes for our residents and communities: earlier support, care wrapped around the whole person, and services that help people stay well.

1 Bending
the outcome curve

Improve population health and equity by preventing progression of long-term conditions and narrowing disparities across 4.5m residents.

Population health outcomes improve by 2035

2 Bending
the demand curve

Reduce avoidable acute demand by intervening earlier, closer to home, and moving from reactive treatment to proactive care.

Avoidable demand growth reduced vs do-nothing

3 Bending
the cost curve

Optimise value from the £12bn budget, reduce unwarranted variation and move onto a sustainable financial trajectory.

Sustainable trajectory by 2035/36

Success means bending all three curves together — not trading outcomes, demand and cost off against one another.

Residents and communities are clear about the changes they want to see

NHS
West and North London

Make it simpler	Access is difficult, services are hard to navigate, information is inconsistent, and people do not know where to go for help.
Make it fairer	Some communities experience greater barriers, lower trust, discrimination and poorer access to services.
Make it work together	People experience fragmented care, repeated assessments and poor coordination between services.
Focus on prevention	People want support earlier, closer to home and before problems reach crisis point.
Build trust and relationships	People want to be listened to, involved in decisions and treated as individuals.

West and North Londoners are clear about what they need from us

Feedback from engagement with our communities, staff and other stakeholders highlights that people want simpler access; fairer, joined up services; a greater focus on prevention and proactive care; and trusted relationships with their care teams.

NHS West and North London

Theme	Views from our: Residents and communities	Staff and clinicians	Partners and stakeholders	Implications for our 10-year strategy
Make it simpler	Access is difficult, services are hard to navigate, information is inconsistent, and people do not know where to go for help.	Pathways are complex and fragmented, creating inefficiencies for both staff and patients.	System structures and organisational boundaries can make services difficult to access and coordinate.	**Design around people's lives**, not organisational structures — with simpler access, clearer navigation and seamless pathways.
Make it fairer	Some communities experience greater barriers, lower trust, discrimination and poorer access to services.	Services need to be more inclusive, culturally competent and responsive to differing needs.	Reducing inequalities and improving outcomes for underserved populations must be a core priority.	**Make equity core design principle** rather than a standalone programme, targeting resources where need is greatest.
Make it work together	People experience fragmented care, repeated assessments and poor coordination between services.	Integrated teams, continuity of care and neighbourhood working are essential for quality and sustainability.	Stronger collaboration across health, local government and the VCSE sector is needed to improve outcomes.	**Shift towards integrated neighbourhood models**, with shared responsibility for outcomes and stronger partnership working.
Focus on prevention	People want support earlier, closer to home and before problems reach crisis point.	Rising demand cannot be met through treatment alone; prevention and self-management are critical.	Wider determinants, community resilience and long-term population health are key concerns.	**Rebalance investment towards prevention**, early intervention and community-based support.
Build trust and relationships	People want to be listened to, involved in decisions and treated as individuals.	Stable teams and continuity of relationships improve outcomes and staff experience.	Trusted community organisations play a vital role in engagement and service uptake.	**Put relationships, co-production and trusted community** partnerships at the centre of delivery.

To develop our strategy, we are using data to understand the needs of our residents

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Strategy development approach

1 Understand people's needs

- Population data (age, health conditions, inequalities)
- Service use (GP, hospital, community)
- Resident and patient feedback

2 Look ahead to future demands and needs

- Population growth and ageing trends
- Changes in illness and long-term conditions
- Forecasts of service use and capacity

3 Check how resources are being used

- Current spending across services and areas
- Differences between places and groups
- Benchmarks vs other healthcare systems

To develop our strategy, we are using data to understand the needs of our residents

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Strategy development approach

4 Find opportunities to improve

- Where outcomes could be better
- Where demand can be reduced or prevented
- Where money could be used more effectively

5 Agree actions and priorities

- Evidence of what works
- Input from residents and staff
- Clear choices on what to invest in or change

Shaped by resident and patient insight

Our methodology combines engagement with evidence and analysis

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Residents and staff shape the strategy throughout; a five-step approach turns that insight into priorities.

ENGAGEMENT THROUGHOUT

Residents & service users

Review of existing engagement across West and North London

800+
engagement events

160,000+
residents engaged or reached

WNL health & care system staff

System-wide call for evidence and workshops shaping the vision and detailed strategy

ICB staff

Internal call for evidence and all-staff drop-ins as the strategy develops

EVIDENCE-LED DEVELOPMENT APPROACH

1	**Understand people's needs**	Population, service-use and resident insight
2	**Look ahead**	Growth, ageing, illness and demand forecasts
3	**Check resource use**	Spend, variation and external benchmarks
4	**Find opportunities**	Better outcomes, prevention, demand and value
5	**Agree priorities**	Evidence of what works and clear investment choices

Engagement and evidence come together at every stage — from understanding need to agreeing priorities.

Note: these are **emerging** priorities and subject to further refinement.

Six population groups are emerging as strategic priorities

Our strategy is framed around the life course, putting people at the heart, with a clear strategic shift towards prevention, proactive care and neighbourhood delivery and a focus on reducing disease progression, demand and inequalities.

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Healthier beginnings
Pregnancy, babies, children and young people

Healthier lives
Working-age adults

Healthier ageing
Older adults and end of life

POPULATION PRIORITIES: where need and the case for change are greatest

1. **Early years and family support:** Give every child the best start in life, targeting support where families face the deepest inequalities.
2. **Young people:** Support young people to build healthy, independent lives, with a focus on mental health and employment.
3. **People at risk of, or living with, early-stage LTCs:** Prevent LTCs, detect them earlier (if not prevented), and manage them more effectively.
4. **Adults with complexity:** Deliver integrated care for adults with significant bio-psycho-social need, i.e. multiple LTCs inc. MH needs
5. **Adults with serious mental illness (SMI):** Improve health and life outcomes for adults living with SMI.
6. **End of life:** Support a dignified death for all.

CARE-MODEL SHIFTS: applied across the life course

a. **Neighbourhood health:** Primary care, community, and mental health provision at its heart, initially focused on residents with increasing bio-psycho-social complexity.

b. **Planned care transformation:** Community-first pathways, digital self-care and remote specialist advice models.

KEY FOUNDATIONS: the capabilities everything else is built on

c. **Trust and engagement:** Building trust with residents and communities, improving patient activation and creating health.

d. **New technology:** AI-enabled triage and risk targeting, digital navigation, genomics and precision medicine, and new drugs such as GLP-1s and their descendants.

e. **Commissioning and workforce:** Commissioning for outcomes and value, delivered through an engaged and skilled workforce.

Our Commissioning Principles

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These principles guide how we are targeting investment to population need and delivering neighbourhood-based care at scale

1 Commission strategically	Invest in **population cohorts** (adults with complexity, CYP with complexity) built from data capturing a range of need and risk factors
2 Commission coherently	Move away from siloed providers. NBHs as unit of delivery. **Net costs** used to create **scaled integrated pathways**, aligning interventions, contracts and shared outcomes. Providers to deploy resources in line with need and neighbourhoods
3 Invest boldly	Scale **evidence-based big bets** over new pilots or approaches not delivering. Keep focus on de-medicalisation, non-statutory roles and population health management
4 Build gradually	**Modular approach** and multi-year transformation. Boroughs must have **foundational infrastructure to hold a caseload** before scaling
5 Prove concept	Start with higher complexity and risk, and **reduce pressure in most challenged** parts of the system. Prove neighbourhoods "work", **generate faster ROI** and **reinvest to scale**

Together, these principles ensure investment is aligned to **need**, **supports neighbourhood delivery**, and **generates impact at scale** over time

What will be different for patients? 1/2

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Maya, 67, lives alone in Tottenham. COPD, type 2 diabetes, osteoarthritis and heart failure

- **Health conditions:** COPD, type 2 diabetes, osteoarthritis and heart failure, managed across multiple separate appointments
- **Housing:** Ground floor flat with damp and inadequate heating, worsening her respiratory condition
- **Income:** Pension credit, no regular carer support, daughter visits weekly
- **Health challenges:** Two A&E attendances in the past year for breathlessness, one unplanned admission after a fall
- **Social isolation:** Relies on walking frame, limited mobility, rarely leaves home

Proactive identification and coordinated care

Maya's rising frailty score is flagged at her long-term condition review. Her GP refers her to the local Integrated Neighbourhood Team. A community matron visits at home, completes a holistic assessment, and coordinates a shared care plan across all professionals. Maya does not have to repeat her story.

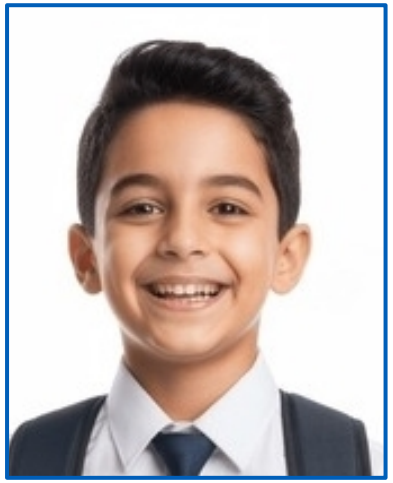
Wider determinants considered

The INT social prescriber refers Maya to a local exercise group and pairs her with an Age UK befriender. The matron raises an urgent environmental health referral so that the heating and damp repairs are completed quickly. A geriatrician reviews her frailty score and adjusts her heart failure and diabetes management.

Staying safely at home when things go wrong

When Maya has a minor fall, her GP requests a rapid response falls assessment rather than sending her to A&E. When her COPD exacerbates, the team escalates her to a virtual ward for 72 hours of remote monitoring. Over six months her conditions stabilise and she gains confidence managing her health at home.

What will be different for patients? 2/2



Amir, 9, lives with mum in Southall. Suspected ADHD and autism, on CAMHS waiting lists.

- **Health conditions:** Suspected ADHD and autism spectrum condition, referred at age 8 and still waiting for neurodevelopmental assessment. Increasing anxiety and emotional dysregulation
- **Education:** At risk of permanent exclusion. Has an Education, Health and Care Plan request pending but no assessment completed
- **Housing:** Overcrowded rented flat, no quiet space, disruptive home env. worsening ability to regulate
- **Income:** Mum works part time, on Universal Credit, no recourse to additional support. Has had to reduce hours to manage school exclusions
- **Social isolation:** Few friendships, mum increasingly isolated and exhausted with no carer support

Earlier identification and a single point of contact

Amir's school flags concerns and a single coordinator brings together education, community paediatrics and CAMHS for a holistic assessment. Amir's wait is significantly reduced, a timely assessment unlocks the right school and home support. Rather than his mum navigating each service separately, there is one person holding the thread.

Support that reaches the family, not just the child

A community-based therapist works with Amir through his school, so his mum no longer has to take time off work for clinic appointments. The coordinator connects her to a parent carer support group and helps her access financial support she was not previously claiming. The family feel held, not just the child.

Reduced waits and earlier intervention

With support in place earlier, Amir's anxiety and school difficulties are addressed before they reach crisis point. Through increased CAMHS capacity, Amir's anxiety and emotional dysregulation are picked up. His attendance stabilises, his EHCP assessment moves forward, and his mum has someone to call when things get hard.

We will be seeking ICB Board approval of the 10-year strategy at the October meeting

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MAY–JULY

Foundations set

- Draft strategy and priorities
- Interim evidence base
- Guiding principles and initial delivery approach

LATE JULY–24 AUGUST

Evidence tested

- Call for evidence complete and analysed
- Resident, staff and stakeholder input
- Leadership and system engagement

LATE AUGUST–SEPTEMBER

Strategy refined

- Final IHNA and inequalities analysis
- Finance and activity model completed
- Priority populations, enablers and delivery framework refined

OCTOBER

Final approval

- Final strategy documentation
- Leadership socialisation and governance
- Communications and staff engagement

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A new public involvement framework: 2027-30

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Developing a new involvement framework

As a new ICB, with a new remit, a new population, new resource and changing infrastructure, we must consider our approach with communities, stakeholders and partners. **This engagement work will help form a new involvement framework.**

We have a **statutory duty** to involve people and communities in helping to shape and improve health and care services together and our ambition is to work in partnership with patients, carers, community groups, and local residents to shape health and care together

We have been working with residents, community organisations, stakeholders and staff to find out what meaningful involvement means to them, and we want to seek JHOSC's reflections as we build our approach to reaching communities often furthest from decision making.

Let's talk

Health and care starts with **you**

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3-year public involvement framework will set out:

- how the organisation will listen to people and their feedback on health and care
- how the ICB will make involvement more inclusive and meaningful, particularly for people who experience the greatest health inequalities
- how public involvement can support the ICB's 10-year strategy and **'left shift'** - capturing insight into the causes of demand and drivers of ill health
- how public insight will influence decisions within the commissioning cycle, and how evidence this is evidenced.

The insight we receive from residents is important data which sits alongside population health and performance data, patient experience data, clinical expertise and financial information. Taken together, it should inform decision making and strategic commissioning.
We need to consider how our organisation does this well.

Engaging on the involvement framework

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Phase 1: May-June 2026

- Reviewed existing insight and engagement evidence
- Attended community events, forums and meetings
- Identified gaps, barriers and opportunities for improvement
- Explored what meaningful involvement should look like

Phase 2: July-August 2026

- Launched the Let's Talk campaign
- Residents' survey online and in print
- 125 residents attended the Residents' Forum
- Deep conversations with community leaders across all 13 boroughs
- Co-design workshop

Phase 3: August-October 2026

- Identify key themes from engagement findings
- Develop draft involvement principles
- Test emerging ideas through co-design workshops
- Share progress updates with key internal and external stakeholders

Phase 4: October-November 2026

- Share draft principles for feedback
- Agree how feedback will be provided back to residents and communities
- Refine the framework based on feedback
- Socialise internally and prepare final version for Board approval,

Who we have heard from so far

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Survey:

- Almost 700 responses (majority online).
- The largest proportion from residents of Hounslow and Hillingdon, while Brent, Ealing and Islington were less represented.
- The highest number of responses came from women and older people (65+).
- **53% of respondents had never previously been involved in decisions about health and care services.**

In-depth conversations

- 36 in-depth conversations with community and faith leaders from organisations across all 13 boroughs – with the aim of reaching **those less likely to respond to a survey**.
- Broadly level split between male and female respondents.
- We intentionally reached out to communities identifying as Black British or Black African, or Black Caribbean and this shows in the higher response rate.

Workshops

- Carers and organisations that support and advocate for carers.
- Young adults aged 18 to 25 and organisations that work with them.
- Patient group and resident group members.
- Healthwatch and voluntary and community sector colleagues.
- Residents experiencing health inequalities.
- ICB staff.

Ongoing programme of internal and external stakeholder engagement

How Will These Findings Be Used?

These findings will now inform:

- development of draft framework principles
- further co-design activity
- discussions with partners and stakeholders
- the draft involvement framework

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Emerging themes from the engagement:

- Early involvement and co-production
- Lived experience as expertise
- Closing the feedback loop
- Trust, transparency and accountability
- Inclusion, accessibility and reducing Inequalities
- Community partnerships and trusted local relationships
- Multiple ways to participate
- Recognition and support for participation

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We are interested in JHOSC members' views

- Do these findings reflect what you hear from residents?

- How can we work together more closely on future engagement with local authority partners?

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Contact us:
nhsnwl.adcomms@nhs.net

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Appendices

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The needs of our population: our overall case for change

West and North Londoners are clear about what they need from us

Feedback from engagement with our communities, staff and other stakeholders highlights that people want simpler access; fairer, joined up services; a greater focus on prevention and proactive care; and trusted relationships with their care teams.

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Theme	Views from our: Residents and communities	Staff and clinicians	Partners and stakeholders	Implications for our 10-year strategy
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Our strategy draws on two years of engagement with our communities

The views of our people were compiled from extensive engagement over the past two years – providing us a strong evidence base on their priorities. We will continue to engage meaningfully with residents as our strategy and plans develop.

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Scale of engagement

800+ engagement activities

160,000+ residents engaged or reached

18 programmes and engagement initiatives

13 boroughs covered

Engagement methods

- Public drop-ins and outreach events
- Community discussions and focus groups
- Online and paper surveys
- Citizens' panels
- Faith-based engagement
- Workshops and stakeholder events
- VCSE-led community conversations

Priority communities reached

- Areas of high deprivation
- Global majority communities
- Refugees and migrants
- Faith communities
- Older people and carers
- LGBTQ+ communities
- People with long-term conditions
- Homeless adults
- Prison-experienced communities
- Parents and carers of children

100,000+ responses to the **Primary Care Access Survey** | **31,000** contacts through the **Winter Vaccination Campaign 2025/26**

10,047 residents engaged through **NWL community events** | **10,000** people reached through **faith-centred engagement**

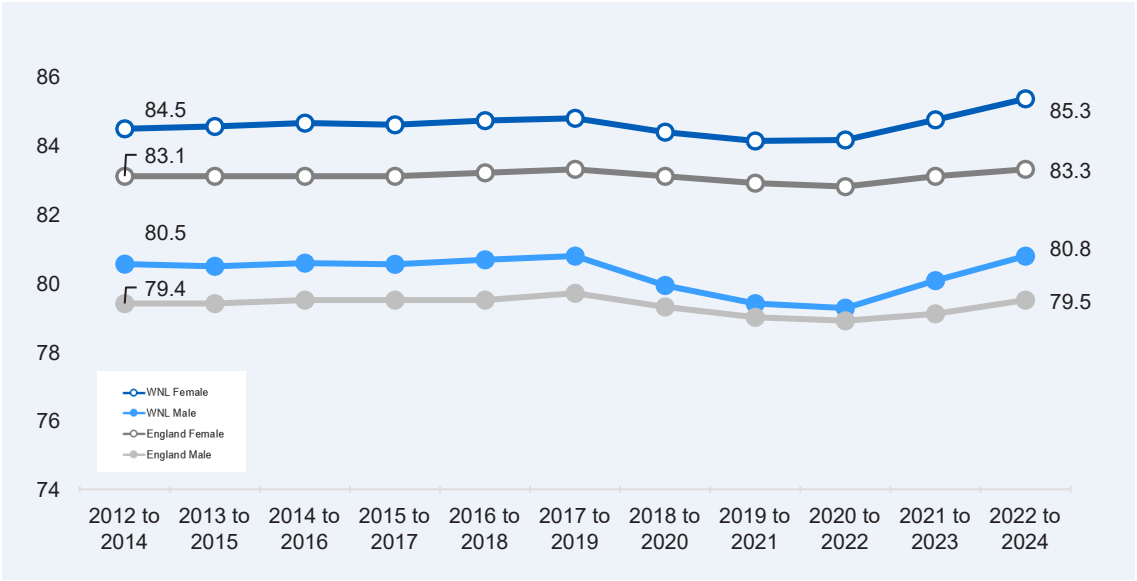
Extensive engagement supporting **service transformation**, **prevention**, **vaccinations**, **end-of-life care** and **children's services**.

W&N Londoners are living longer, but in relatively poor health

Life expectancy in WNL has been broadly flat while healthy life expectancy has fallen by almost three years in the last decade – ill health now arrives earlier and lasts longer.

West and North London

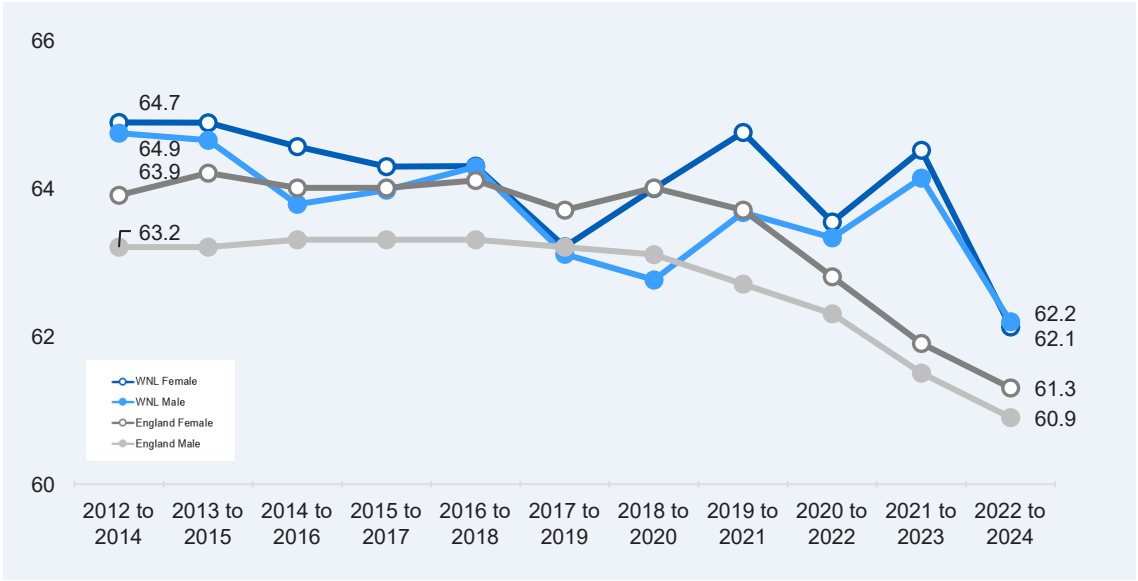
Life expectancy: 10-year time series for WNL and England



- **Life expectancy in WNL remains above England** and has recovered from the pandemic — women (85.3 years) are now half a year above their pre-pandemic peak, while men (80.8 years) have only just returned to their 2017–19 level, with essentially no net progress since 2012–14.

- **Source:** ONS, December 2025. Note that WNL figures are population-weighted averages of the 13 borough estimates (ONS; GLA population weights). Healthy life expectancy is derived from self-reported health in the Annual Population Survey and carries wide confidence intervals at local level; the direction and scale of the decline are robust, but precise values and small year-to-year movements should not be over-interpreted.

Healthy life expectancy: 10-year time series for WNL and England



- **Healthy life expectancy has moved in the opposite direction**: down from around 64.8 years to 62.2 for both sexes – a loss of almost three healthy years in a decade, mirroring but slightly outpacing England's own decline.
- **The gap between lifespan and healthspan is widening.** The average West and North Londoner can now expect to spend **18–23 years** (roughly a quarter of their life) in poor health, and to **enter poor health at around 62**, before State Pension age. Every additional year lived in ill health rather than good health is a year of accumulating LTCs, rising complexity and growing service dependency.

- **Note:** estimates of HLE for England carry confidence intervals of ~±0.1–0.2 years; the national decline in HLE is therefore **statistically significant** and the WNL trend is consistent with it.

Strategy Development: Methodology and Planning

Overall inequalities in health outcomes are substantial

Healthy life expectancy (HLE) varies by 8.4 years, up to 14 years between neighbourhoods within boroughs, and up to 17 years across all our neighbourhoods. Life expectancy (LE) varies by 3.5 years between our boroughs

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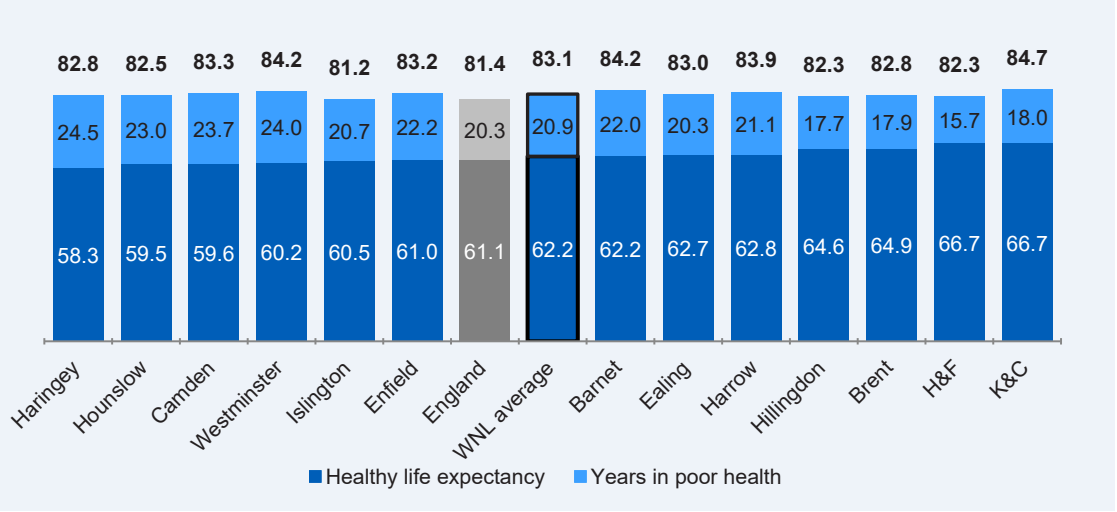
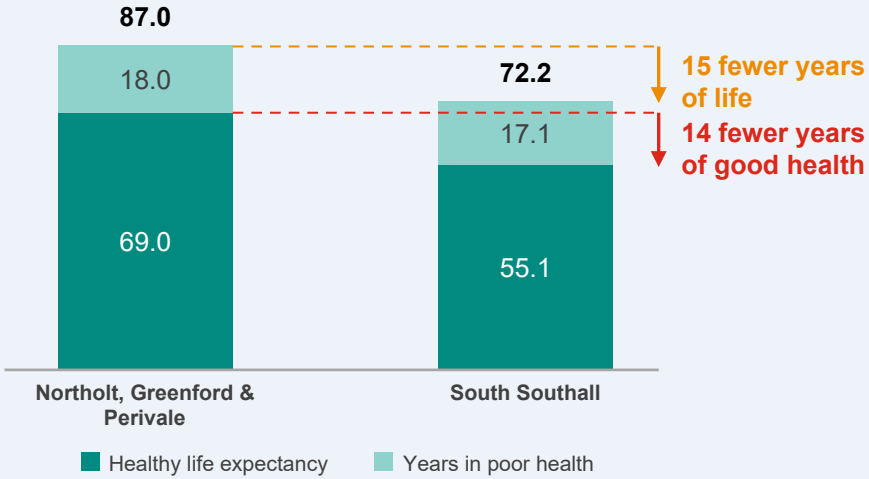
The borough-level HLE and LE gap: 2022-2024



- The **gap in life expectancy** between our boroughs is **3.5 years**; the gap in healthy life expectancy is 8.4 years — from 58.3 in Haringey to 66.7 in Hammersmith & Fulham and Kensington & Chelsea. Six of our thirteen boroughs sit below the England average. Residents of our worst-affected boroughs spend up to a quarter of a century — nearly 30% of life — in poor health. Nor is this static: over the past decade healthy life expectancy has fallen by five years or more in some boroughs while rising in others, so the gap is widening.

- **Sources:** ONS, December 2025, Health state life expectancies, local authority estimates, 2022 to 2024 (healthy life expectancy); ONS, Life expectancy for local areas of the UK, 2022 to 2024 (life expectancy); GLA 2022-based population projections (WNL weighted average). Overall figures are averages of published male and female estimates; WNL is a population-weighted average of the 13 boroughs

The intra-borough HLE and LE gap: HLE in Ealing, 2021-2023



- **Borough averages conceal starker differences.** Within Ealing alone, residents of **Northolt, Greenford & Perivale (NGP)** can expect **69** years of good health; in **South Southall**, **55** – a 14-year gap a few geographical miles apart. A person in South Southall has to live in poor health for 11 years before retirement, whereas a person in NGP retires in good health (on average).
- **Kensington and Chelsea South** is the neighbourhood with the highest healthy life expectancy – 72.1 years of good health. Therefore across WNL, the HLE gap is approximately **17 years** of good health.
- Inequality within boroughs is as large as inequality between them: this is why we will **understand need, and target investment**, at **neighbourhood level.**

- **Sources:** ONS, using HLE data for 2021-2023, rather than 2022-2024.

At the same time, spend has drifted to acute and crisis care

Rising avoidable admissions and heavily concentrated urgent care use are indicative of a system managing complexity reactively – need being managed it its most expensive form.

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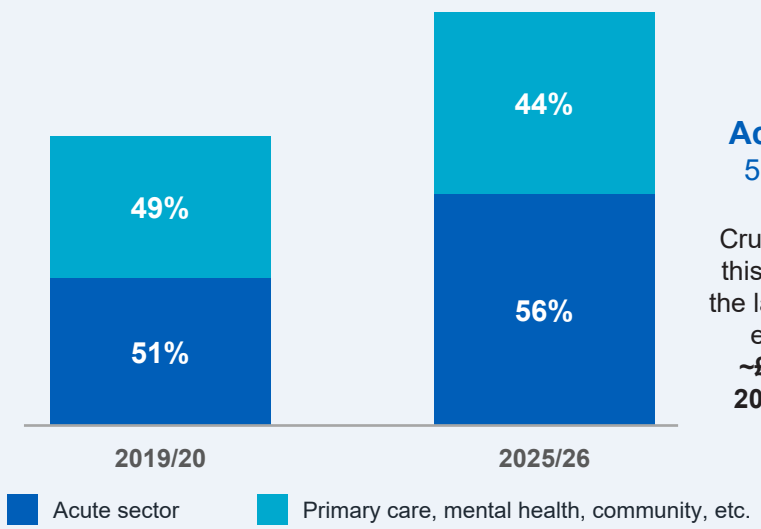
Where the money is going: share of ICB spend by care sector



Acute share:
51% → 56%

Crudely speaking, this increase over the last five years is equivalent to **~£600m** of our **2025/26** budget

- **Between 2019/20 and 2025/26**, WNL acute sector spend rose from **51% to 56%** of our yearly budget.
- Growth is concentrating in the **most expensive care setting**, leaving proportionately less for the primary, community and preventive services that will reduce tomorrow's demand.
- Crudely speaking, this increase over the last five years is equivalent to **~£600m** of our **2025/26** budget.

What the money is buying: avoidable acute activity

13% of emergency inpatient activity is related to **ambulatory care sensitive conditions** – preventable through better care in the community – rising for five years*.

8% / 5%
annual growth in referrals / outpatient appointments – specialist advice referred out, rather than pulled in*.

16%
of A&E attendances end with no investigation and no significant treatment*.

28%
of A&E capacity is used by 5% of individuals; ~4x more frequent attenders in our most deprived areas*

11x
higher emergency admission rate for people with 3+ long-term conditions vs none*.

- People with multiple LTCs will always need care – the question is what form it takes. Managed proactively, need arrives as planned, lower-cost contacts in primary care and community services. Managed reactively, the same need arrives later and more intensely as A&E attendances and emergency admissions.
- The same pattern can be seen in planned care: rather than specialist advice being pulled into primary care to keep patients managed by their GP and care team, patients are referred out into the hospital system. Shifting from reactive to proactive care – and from referring out to advising in – is how we will bend the demand and cost curves.

- **Source:** WNL Financial Plan 2025/26
- *NCL or NWL legacy footprint analysis — WNL-wide figures will be provided in the full IHNA.

Our needs assessment highlights six priority needs we need to address (1 of 2)

The findings from the WNL Integrated Health Needs Assessment highlight at least six priority population groups where need is greatest and where targeted investment could significantly improve outcomes from today's baseline.

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1 Too many children start life in poor health

Only 60%
of pregnancies involve early maternity care.

- Health accumulates from before birth. A **life-course approach** is foundational.
- There is **stark inequality at birth** – Nationally, Black women are **2.3x** more likely to die during or within a year of pregnancy and have a **2x** higher neonatal admission rate[1].
- **1 in 3** five-year-olds have **tooth decay**; WNL has the worst rates for **MMR vaccination** in London (only **67%** have had both doses by age 5); **EHC plans** have increased by **a third** in five years, pointing to major unmet complexity[1].
- Obesity rises from **10%** in Reception to **23%** in Year 6[1].
- **15%** of children across WNL are now living in poverty, a **1.5ppt** increase from 4 years ago; and **30%** of children do not achieve a good level of development by the end of reception (**school readiness**)[1].

Early years and family support
Give every child the best start in life, targeting support where families face the deepest inequalities.

2 Rising mental ill health is costing young people their livelihoods

1.6 - 2.3x
rise in the probable prevalence of mental health disorder in CYP nationally (2017 - 2023).

- The **recorded prevalence** of mental health conditions in CYP is **5% in WNL** – well below the **20% national estimate**, pointing to substantial **unmet need.**
- Nationally, **13%** of those 16–24 are now **NEET**[2] ~ c. 80k in WNL. **44% of this group** now report a work-limiting health condition, up **1.7x** from a decade ago. **20%** of the NEET group report a mental health condition, up **2.5x** from 2012[3].
- **1 in 5** CYP who are NEET are now **inactive** entirely because of **ill health** – which can compound across a lifetime into worse health, and greater deprivation[1].
- People in deprived areas are **twice** as likely to develop mental health problems and **ten times** more likely to die by suicide[1].

Young people
Support young people to build healthy, independent lives, with a focus on mental health and employment.

3 Too many people die early from preventable and treatable causes

24%
rise in the probable prevalence of mental health disorder in CYP nationally (2017 - 2023).

- **Early diagnosis consistently falls below target** – e.g. early-stage cancer diagnosis is ~60% across WNL vs the 75% target; better management could reduce downstream demand[1].
- Up to **8% of residents** may have **undiagnosed hypertension**; treatment-to-target (71.5%) is consistently below the 80% national target[1].
- **86%** of COPD deaths are caused by **smoking** (one of the highest causes of death in England) [1].
- **Preventable mortality** is around **3-4x** higher in our most deprived communities, and **CVD outcomes** are consistently worse for Black and South Asian residents[1].

People at risk of, or living with, early-stage LTCs
Prevent LTCs, detect them earlier (if not prevented), and manage them more effectively.

- *NCL or NWL legacy footprint data — WNL-wide figures will be provided in the full IHNA.
- **1. Source:** West and North London Integrated Health Needs Assessment – See Appendix A attached separately. **2. NEET:** Not in education, employment, or training. Note: NEET status does not necessarily imply a person is inactive – inactivity depends on whether they are actively looking for work. **3.** Around 48% of NEET young people report a disability, but this describes health status, not the primary cause of NEET status – many are still actively seeking work. Mental health is now their most commonly cited main condition (43%, up from 24% in 2011). 22% of NEET young people are economically inactive because of ill health. These two measures are frequently conflated; the first is more than double the second.

Our needs assessment highlights six priority needs we need to address (2 of 2)

The findings from the WNL Integrated Health Needs Assessment highlight at least six priority population groups where need is greatest and where targeted investment could significantly improve outcomes from today's baseline.

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4 Adults with long-term conditions are living longer in ill health (on average)

60 & 70%

of non-elective and elective admissions (respectively) are driven by adults with long-term conditions, despite being 35–40% of the population*.

- By **2035**, WNL's **over-65** population is projected to grow by **26%** (around 146,000 more people, from 560,000 to over 700,000), while nationally the proportion of over-65s living with four or more conditions is set to nearly **double**[2]**.** Therefore demand growth will be driven mostly by increasing complexity[1].
- **Healthy life expectancy (HLE)** varies by **more than 17 years** between WNL neighbourhoods just a few miles apart. In recent years, WNL has seen **greater reductions** in **HLE** than other London ICBs[1].
- The **most deprived** population group gains two more LTCs by **age 56** compared to **age 65** in the **least deprived** population group – almost a decade earlier[1*].

Adults with complexity

Deliver integrated care for adults with significant bio-psycho-social need, such as multiple LTCs and/or frailty.

5 Adults with serious mental illness die years earlier, from preventable causes

4.8x

more likely to die before 75 than those without SMI - mostly from preventable physical illness, not the SMI itself.

- The recorded **prevalence of SMI** in WNL is high – at approximately 1.2% (or 57k people). The prevalence is concentrated in particular boroughs – for example, **Islington** has the highest prevalence in London and joint highest nationally*[1].
- People with SMI have significantly high rates of **healthcare utilisation** – up to 7x greater by some estimates[1].
- Adults with SMI in WNL have a **4.8x greater risk of dying** under the age of 75 from any cause than adults without an SMI[1].
- Some of the most significant inequalities are seen in how people with SMI are treated - **Mental Health Act detentions are 2-4x higher for Black people** than for White people[1].

Adults with serious mental illness (SMI)

Improve health and life outcomes for adults living with SMI.

6 Hospital remains the default place of death, even where people have expressed a wish to die at home

48%

of deaths in WNL occur in hospital - over five points above the England average (42%) – not what the majority of patients and families want.

- Every year across WNL, approximately **10-11,000** patients are **admitted to hospital** in their **last year of life**[1].
- **More of our patients are dying in hospital** – over five percentage points above the England average (42%) [1].
- **Dementia** accounted for **12.1%** of registered deaths nationally in 2024, with **formal diagnosis** rates in WNL still **below target at 66%**[1]**.**
- **Access to a dignified death is unequal** – several ethnic minority groups are more likely to die in hospital, even after adjusting for other factors[1*].

End of life

Support a dignified death for all.

- *NCL or NWL legacy footprint data — WNL-wide figures will be provided in the full IHNA.
- **1. Source:** West and North London Integrated Health Needs Assessment – See Appendix A attached separately. **2. Source:** Health Foundation

WNL patch and communities

Across West and North London, **we spend around £12 billion a year** on health and care serving 13 boroughs with a population of approximately 4.5m people.

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NHS
West and North London

West and North London update

WorkWell

September 2026

NHS
West and North London

What is WorkWell?

A DWP-funded, ICB-commissioned programme:

- a **health and employment support service** providing integrated holistic **early help** for people with health-related barriers to work
- aimed at anyone with a **disability or health condition** who is in work or who could move into work with the right support
- **Voluntary** support open to people whether they are in work or not, and regardless of benefit entitlement.
- **Open** to self-referrals or referrals or signposting via their GP, local Jobcentre Plus, employer, other local services'

Source: WorkWell National Guidance

NHS
West and North London

What's been delivered in North Central London to date?

- Pilot Phase 1 Oct 2024 – 31 Mar 2026
  Delivered health-focused employment support to **3018** local residents across 5 NCL boroughs on the WorkWell programme, over 100% of the agreed target.

44% of starts were referred to WorkWell from Job Centre Plus

32% were referred from GP practices

11% were self-referred, often after a visit to a GP practice

13% were referred from voluntary and community organisations, NHS secondary care services, local authority services or employers

NHS
West and North London

What has been delivered in North Central London to date?

Each resident has received:

- A **health-focused assessment** by a work and health coach to inform a tailored action plan to support the individual to be in work
- Development of a **Positive Health Declaration** to support discussions with employers on reasonable adjustments if required
- **Tailored interventions** to enable the person to be in work despite a disability or health condition. This could include a reduced fee gym membership, access to specific equipment or a short course of health treatment.
- **1:1 work and health coaching** for 6-8 weeks to support someone back into work, with referrals to longer term employment support if then required. This could include, for example, Connect to Work.

Who gained support?

Primary health barrier to work:

- **34%** of residents accessing WorkWell identified **depression or anxiety** as their primary health barrier to work. This is higher in young people.
- **23%** of residents accessing WorkWell identified **musculoskeletal** conditions as their primary health barrier to work. This is higher in people aged 50+.

Secondary health barrier to work:

- **27%** of residents accessing WorkWell identified either **depression / anxiety** or **musculoskeletal** conditions as their secondary health barrier to work.

NHS
West and North London

What are the outcomes for residents?

1. Short-term: Dialog+ scores

92% of residents accessing WorkWell achieved improvements in Dialog+ scores from the beginning to the end of the programme, measured across 11 categories:

Mental Health	**Physical Health**	**Safety**	**Job**	**Leisure**	**Relationships**
Friendship	**Accommodation**	**Medication**	**Support**	**Meetings with clinicans**	

2. Longer-term: National evaluation

- DWP has commissioned a national evaluation partner to monitor the longer-term impact of WorkWell on these residents, including tracking of earnings to measure return on DWP financial investment. Initial findings indicate a positive return.

NHS
West and North London

Outcomes for residents: local example (1/2)

Lauren is a full-time Teaching Assistant. Lauren was referred to WorkWell via the Fit Note Pilot MDT based in her GP Surgery.

Lauren has Sickle Cell Disease, which was having a significant impact on her day-to-day life, causing fatigue, pain and considerable challenges in managing her physical symptoms. Lauren was also struggling with her mental health – which further impacted her confidence, wellbeing and ability to sustain her employment.

Lauren received a wide range of tailored support, including referrals to NCL Red Cell Community and the Sickle Cell Society for support in managing and discussing her symptoms with other individuals impacted. Lauren was supported to access NHS Talking Therapies, but as there was a waiting list, WorkWell were able to support with interim therapy for immediate, short-term support. Lauren received help with Mindfulness exercises, and a personalised nutrition plan to support her wellbeing. A referral was also made to BOOST Barnet, to support Lauren in further enhancing her employability skills to help meet her longer-term employment goals.

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West and North London

Outcomes for residents: local example cont… (2/2)

Lauren was supported to produce a Positive Health Statement, empowering her to communicate her health needs in the workplace with confidence. She received support with Adjustments, Disciplinary, and Occupational Health Assessment.

With support, Lauren made significant progress across all key life areas. She successfully returned to full-time employment. Through interim therapy, she saw improvements in her mental health. Lauren also established a consistent sleep and rest routine, reporting feeling physically and emotionally stronger than she had in a long time.

"I honestly cannot express how grateful I am for everything my coach and the Work Well Programme have done for me. In such a short period of time, I have received all the support I needed to truly change my life. I feel so much better as a person – mentally, physically and emotionally. My Coach gave me so much knowledge about myself and my health that I didn't have before, and I now feel fully equipped to manage my condition and thrive in my job. Joining the Work Well Programme is one of the best decisions I have ever made."

NHS
West and North London

WorkWell rollout 1 April 2026 onwards

- North Central London and North West London legacy ICBs both delivered a successful WorkWell pilot. Funding has been secured to continue delivery from 1 April 2026 until at least 31 Mar 2029
- WorkWell will be rolled out nationally from Nov 2026 to all areas of England
- DWP has agreed a transition year in 2026/27 for WNL ICB including:
  - WorkWell to continue to be delivered by Shaw Trust in NCL boroughs.
  - WorkWell to continue to be delivered by Ealing Borough Council (West London Alliance subregional partnership) in NWL borough
  - The Council subcontract Shaw Trust to deliver.
- WNL ICB aims to commission one WorkWell service across all 13 boroughs from 1 April 2027 onwards

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2026/27 NCL JHOSC - DRAFT WORK PROGRAMME

Friday 17 July 2025 – HARINGEY

Item	Purpose	Lead Organisation
JHOSC ToR & Membership		JHOSC
West & North London ICB Update		W&NL ICB
Whittington Health NHS Trust Quality Account		Whittington Health NHS Trust
Work Programme		JHOSC

Friday 18 September 2026 –ENFIELD

Item	Purpose	Lead Organisation
West & North London ICB Update ➢ Strategy Integrators		W&NL ICB
Work Well Strategy		W&NL ICB
Work Programme		JHOSC

Friday 27 November 2026 – CAMDEN

Item	Purpose	Lead Organisation
Winter Planning Update including impact of Increased Heat	TBC	W&NL ICB
London Ambulance Service Update	TBC	NHS LAS
West & North London ICB Finance Update	TBC	W&NL ICB
ICB Estates & Infrastructure Strategy	TBC	W&NL ICB

Friday 29 January 2027 – BARNET

Item	Purpose	Lead Organisation
NCL Health Inequalities Fund		W&NL ICB
North Middlesex & Royal Free Hospital Merger Update		
West & North London ICB Update		

Monday 19 March 2027 – ISLINGTON

Item	Purpose	Lead Organisation
West & North London ICB Update		W&NL ICB
St Pancras Hospital Programme Update		W&NL ICB

Usual standing items each year:

- **Estates Strategy Update**
- **Workforce Update**
- **Finance Update**
- **Winter Planning Update**
- **West & North London ICB Update**
  - Clarity and key contact list following the merger to be shared with the Committee
  - Paper marking out responsibilities of Trust, ICB and NHS England to be scheduled into work programme

Possible items for inclusion in future meetings:

- Digital Service Provision in the NHS

- JHOSC to ask for an update with information as to why some of our hospitals are reluctant to sign up with Palantir. It will be important to have clear evidence regarding their concerns in order to make an informed recommendation.
- The committee to ask hospitals within the JHOSC area if they are using Palantir to run their data sourcing for them and if not, what was the reason behind their choice not to use them.
- Once the information is retrieved by various Trusts on if they are using the platform, the next stage would be to contact NHS England and express concerns and seek re-assurances that our resident's data was being protected.

- NHS 10 Year Plan & Neighbourhood Health

  - Health and Wellbeing Board – strengthened role
  - Pooled NHS & Social Care Budgets (discussion with ICB & Heads of Social Care)
  - Integrators – Information on who they are and how they are progressing in all 5 boroughs, information on the memorandum of understanding about how they will work together.
  - Training and development for the VCS – ICB colleagues to liaise and seek advice from the Joint Partnership Board to support this work.
  - People's Strategy – pick up on the work undertaken in NWL and whether it can also be implemented in NCL
  - Virtual Wards – work underway monitoring carers to be presented to the Committee including information on unpaid workers packages
  - Update on Inequalities work being carried out by Imperial University.

- St Pancras Hospital update
  - Royal Free merger with North Mid, clarity about savings plans in its entirety and what makes up the deficit and is causing it and should form an action when considering finances in 2026/27.

- Health Inequalities Fund – See details of January 2027 action tracker

- NMUH/Royal Free merger