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West and North London corporate strategy and involvement framework

September 2026

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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

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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

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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

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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

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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

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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

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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.

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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

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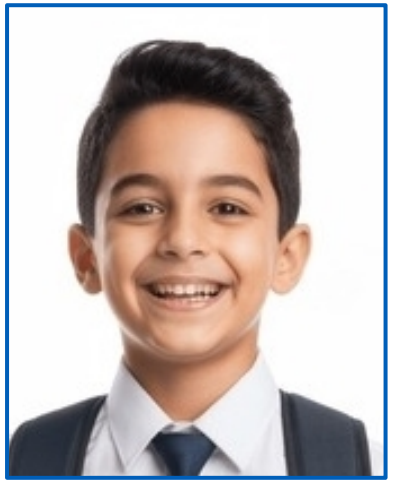

Amir, 9, lives with mum in Southall. Suspected ADHD and autism, on CAMHS waiting lists.

- **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

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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.

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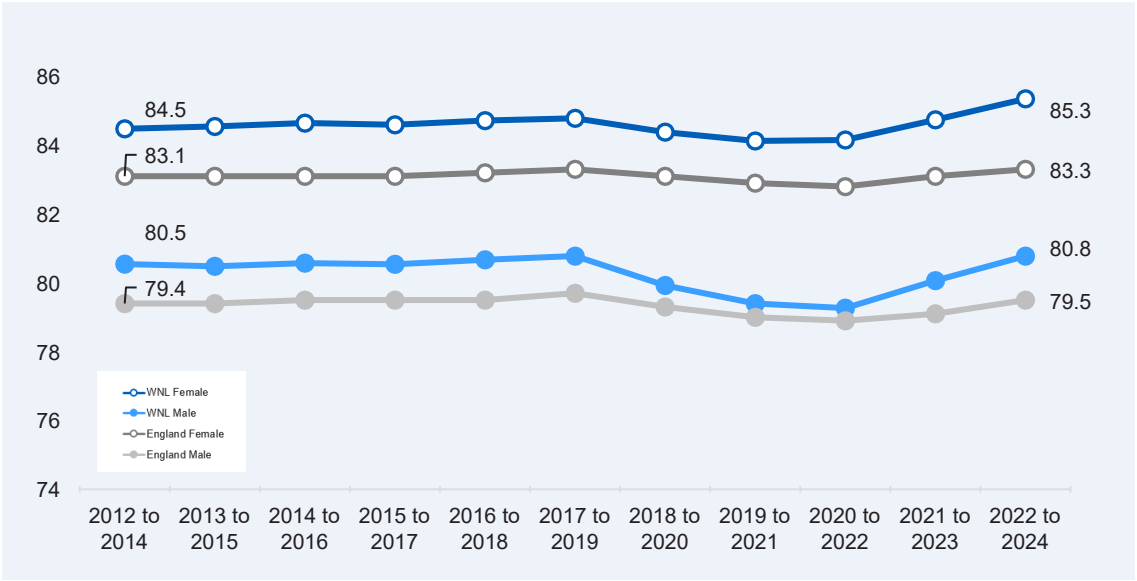
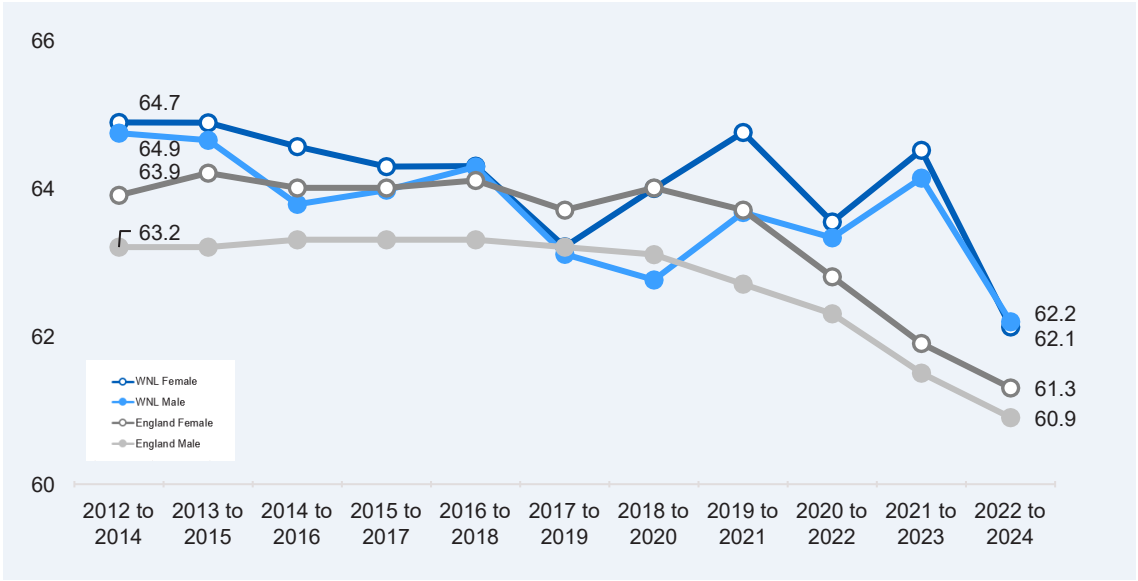
Life expectancy: 10-year time series for WNL and England



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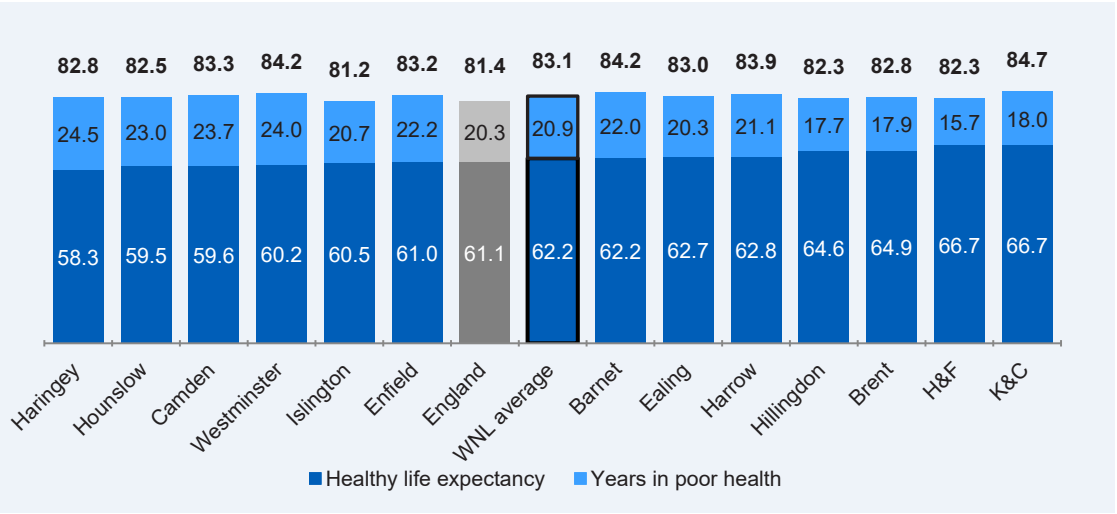
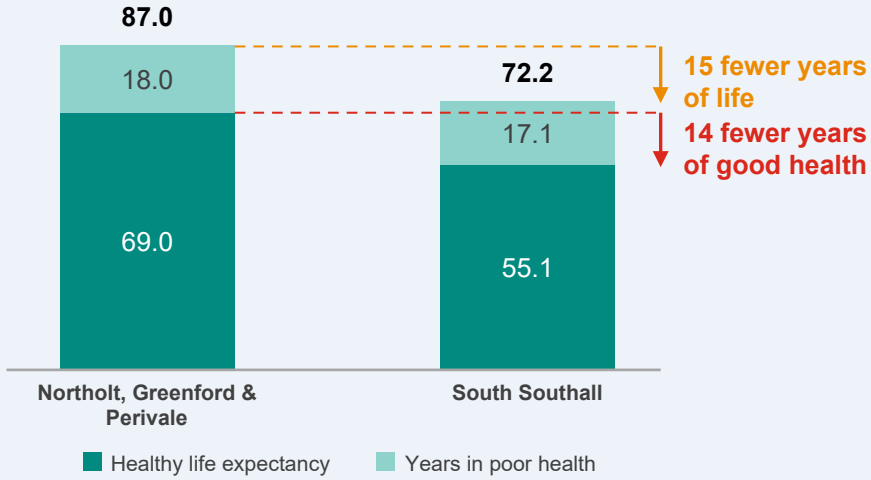
The borough-level HLE and LE gap: 2022-2024



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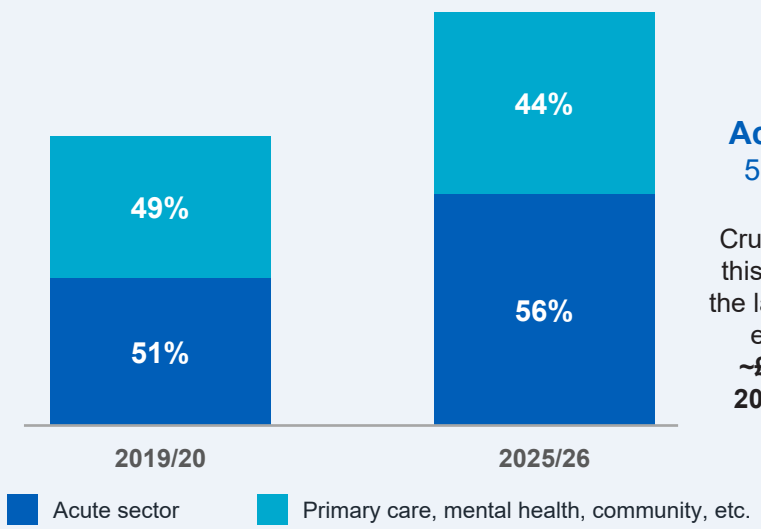
Where the money is going: share of ICB spend by care sector



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.

NHS West and North London

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.

NHS West and North London

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

NHS
West and North London

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.