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West and North London ICB Finance Update

JHOSC Meeting



What has changed since last year?

The financial position now sits within a different organisational and commissioning model

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2025/26	2026/27	What this means in practice
NCL ICB	West & North London ICB	The ICB now serves 13 boroughs and around 4.5 million residents, rather than the five NCL boroughs alone.
5-borough footprint	13-borough footprint	Decisions draw on the needs, inequalities and experience of a much larger and more diverse population.
NCL budgets & contracts	WNL budgets & contracts	Budgets and provider contracts are set for the combined area. Figures are therefore not directly comparable with last year's NCL position.
System coordination	Strategic commissioning	A sharper focus on understanding need, setting priorities, buying services and testing outcomes and value, while continuing to work with councils and providers.
Collective NHS system position	Clearer organisational accountability	The ICB balances its commissioning budget; trusts remain accountable for their own finances, with continued joint work on service and financial sustainability.
Greater use of fixed funding	More activity-related payment	More provider income responds to care delivered, including a blend of fixed and activity-related funding for urgent and emergency care.
Plan for the NCL population	Plan across WNL, deliver locally	The wider footprint supports comparison and shared learning, while borough and neighbourhood partnerships continue to shape local services.

Larger footprint, same local focus: local needs, local accountability and partnership with councils remain central.

25/26 Financial Outturn Summary

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North Central London System

- The NCL system have reported a surplus of £0.8m in 25/26 against the original system balanced plan.
- Despite a difficult start to the financial year with unfunded industrial action from July 2025 and difficulties to deliver in-year savings on pay, the system agreed a recovery plan where we confirmed the system's intent to deliver a balanced position in 25/26.
- Mitigating financial recovery actions throughout 25/26 have included MARS at a number of providers, closure of unfunded capacity and vacancy freezes amongst the main interventions
- GOSH (£4.9m adv) – Reported pressures on Pay due to efficiency savings under delivery and private patient income underperformance driving the £4.9m adverse YTD variance.
- MEH (£5m fav) – Reported a £5m surplus primarily due to slippage in major projects Oriel, EPR and IT schemes.

	M12 – North Central London System		
Org	Annual Plan	YTD Actual (excl DSF)	YTD Variance
	£'000	£'000	£'000
GOSH	-	(4,980)	(4,980)
MEH	-	5,000	5,000
NLFT	4,868	4,868	-
RFL	(42,663)	(42,663)	-
RNOH	-	77	77
T&P	-	6	6
UCLH	12,029	12,031	2
WHIT	(1,426)	(1,176)	250
Trust Total	**(27,192)**	**(26,837)**	**355**
NCL ICB	27,192	27,591	399
System Total	**-**	**754**	**754**

W&NL ICB – 26/27 Financial Plan

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26/27 Financial Planning Overview

- West and North London Integrated Care Board (W&NL ICB) submitted a **breakeven financial plan for 2026/27** as part of the final national planning submission on **12 February 2026**. The plan was developed in the ICB's role as a **strategic commissioner**, rather than as an operational system convenor, and there is no expectation that the ICB ensures a balanced position for all hosted providers.
- Despite this, the ICB remains committed to creating the best possible financial environment within its resource limit to support delivery of system priorities.

Strategic Priorities and 1% Transformation Investment

- The plan reflects a clear strategic intent to **reduce reliance on secondary care** and to increase investment in **neighbourhood, community and mental health services**.
- This transformation of care is central to improving long-term sustainability, reducing demand on acute services and addressing health inequalities. The approach ensures that investment decisions align with the system's strategic aims while avoiding financial destabilisation of providers.
- **£120m has been earmarked for transformation investment in neighbourhoods**. Around **£60m** has been committed in-year to mental health (£20m) and community services (£40m).
- The remaining transformation funding will be held as a **trading reserve** to manage in-year pressures, particularly within acute services.
- Growth allocations to urgent and emergency care, CNST, high-cost drugs and devices, the Better Care Fund and independent sector provision will result in a **£10.7m deterioration in the underlying position**, which is managed within the overall breakeven plan.

Delivery of Constitutional Standards and Productivity

- The financial plan supports delivery of **constitutional standards**, including RTT and A&E performance, through consistent commissioning approaches and contractual mechanisms.
- A **1% productivity requirement** has been applied to acute providers, alongside improvements in first-to-follow-up ratios and a consistent approach to earned and unearned income.
- The **Mental Health Investment Standard** is fully met, ensuring continued growth in mental health investment.

Area	Annual Plan
	£m
Allocation	**12,002**
Acute Services	5,505
Mental Health Services	1,255
Community Health Services	911
All-age Continuing Care Services	535
Primary Care Services	714
Other Programme Services	68
Primary Medical Services	950
Delegated Primary Care (POD) Services	480
Delegated Specialised Commissioning Services	1,520
Running Costs	63
Total Expenditure	**12,002**
Surplus/(Deficit)	**0**

W&NL ICB – M6 Financial Position

West and North London

Month 6 (September 2026)

- As of Month 6 (Sep '26), the ICB reports a year-to-date and forecast break-even position against plan.
- The forecast includes a £15m overspend within Acute Services, primarily driven by higher than planned activity across NHS and independent sector providers, and a £16m overspend within Continuing Care arising from activity and inflationary pressures.
- These pressures have been offset by favourable forecast variances within Specialised Commissioning (£11m), Running costs (£19m) and Primary Care (£3m).
- Release of non recurrent measures of £15.2m (reported within Other programme services) supports delivery of the overall forecast break-even position.

	M6 Year to Date			26/27 Full Year		
Area	YTD Plan	YTD Actuals	YTD Variance	Annual Plan	Forecast Outturn	Variance
	£m	£m	£m	£m	£m	£m
Allocation	**5,887**	**5,887**	**0**	**12,054**	**12,054**	**0**
Acute Services	2,712	2,725	(14)	5,491	5,506	(15)
Mental Health Services	612	613	(1)	1,243	1,243	0
Community Health Services	442	443	(1)	913	912	1
All-age Continuing Care Services	267	275	(8)	535	551	(16)
Primary Care Services	344	343	1	719	718	0
Other Programme Services	53	45	8	136	140	(3)
Primary Medical Services	443	444	(1)	952	952	0
Delegated Primary Care (POD) Services	238	234	3	480	476	3
Delegated Specialised Commissioning Services	746	744	2	1,521	1,511	11
Running Costs	32	20	12	64	45	19
Total Expenditure	**5,887**	**5,887**	**0**	**12,054**	**12,054**	**(0)**
Surplus/(Deficit)	**0**	**0**	**(0)**	**0**	**0**	**0**

Our strategy aims to help people live longer, healthier and more independent lives

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Our ambition
More children get the best start in life, more adults stay healthy and well, and more older people remain independent and connected to their communities for longer.

To achieve this, we want to achieve three connected things:



Improve outcomes and equity

Help people spend more years in good health, with the fastest improvements in communities experiencing the greatest inequalities



Reduce avoidable demand

Prevent illness, identify needs earlier and provide proactive support before people reach crisis.



Create financial sustainability

Use every pound of our £12 billion budget for greater value and shift resources towards prevention, community-based care and mental health.

We must move from a system organised around illness and crisis to one built around prevention, earlier support and healthier lives.

Six population priorities, two care-model shifts, nine key foundations

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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.

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 independent lives, focused on mental health and employment.

3 **People at risk of, or living with, early-stage LTCs:** Prevent LTCs, detect them earlier, and manage them more effectively.

4 **Adults with complexity:** Integrated care for adults with multiple, interacting health, care and social needs.

5 **Adults with SMI or LD:** Improve health and life outcomes for adults with serious mental illness (SMI) or learning disabilities (LD).

6 **End of life:** Support a dignified death for all.

CARE-MODEL SHIFTS: applied across the life course

A **Neighbourhood health:**
Health and care organised around our **53 neighbourhoods**, not institutions: health, care, voluntary and community services working as one to keep people well, act earlier and join up care close to home, starting with adults with complexity.

B **Digitally-enabled care at scale:**
Care that comes to residents: **one front door, same-day urgent access**, prompt specialist advice and problems picked up earlier.

KEY FOUNDATIONS: what we need in place to deliver the priorities and shifts across the whole life course

a **Building trust and empowerment:**
Building trust, reducing barriers and empowering residents.

b **Digital, data and artificial intelligence:**
Connected data, proactive care and responsible AI.

c **Commissioning for our population need:**
Outcomes-based, place-based commissioning arrangements.

d **Research, innovation and evaluation:**
Generating evidence, adopting and scaling what works.

e **Finance and contracting:**
Aligning money, incentives and risk behind the strategy.

f **Workforce development:**
Building the workforce for future models of care.

g **Estates:**
Co-location and neighbourhood health centres.

h **Communications, involvement and insight:**
Decisions informed by data and lived experience.

i **People, culture and organisational development:**
A fit-for-purpose strategic commissioner.

Note: Inclusion health is a lens through which we will design, commission and evaluate services for every population priority cohort, ensuring that people experiencing the greatest disadvantage are visible in our data, considered in our decisions and benefit proportionately from improvement.

We will invest an additional £360m in proactive care by year 3

Recurrent investment in community-based care and mental health will rise over three years, equivalent to around 1% of the commissioning budget redirected incrementally each year.

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£360m by year 3

£120m recurrent in **year 1**, rising to **£240m** in **year 2** and **£360m** by **2028/29**.

Around 1% of our commissioning budget each year.

How the shift will be funded

Allocation growth

Directing growth towards proactive and community-based care.

Cost avoidance and productivity

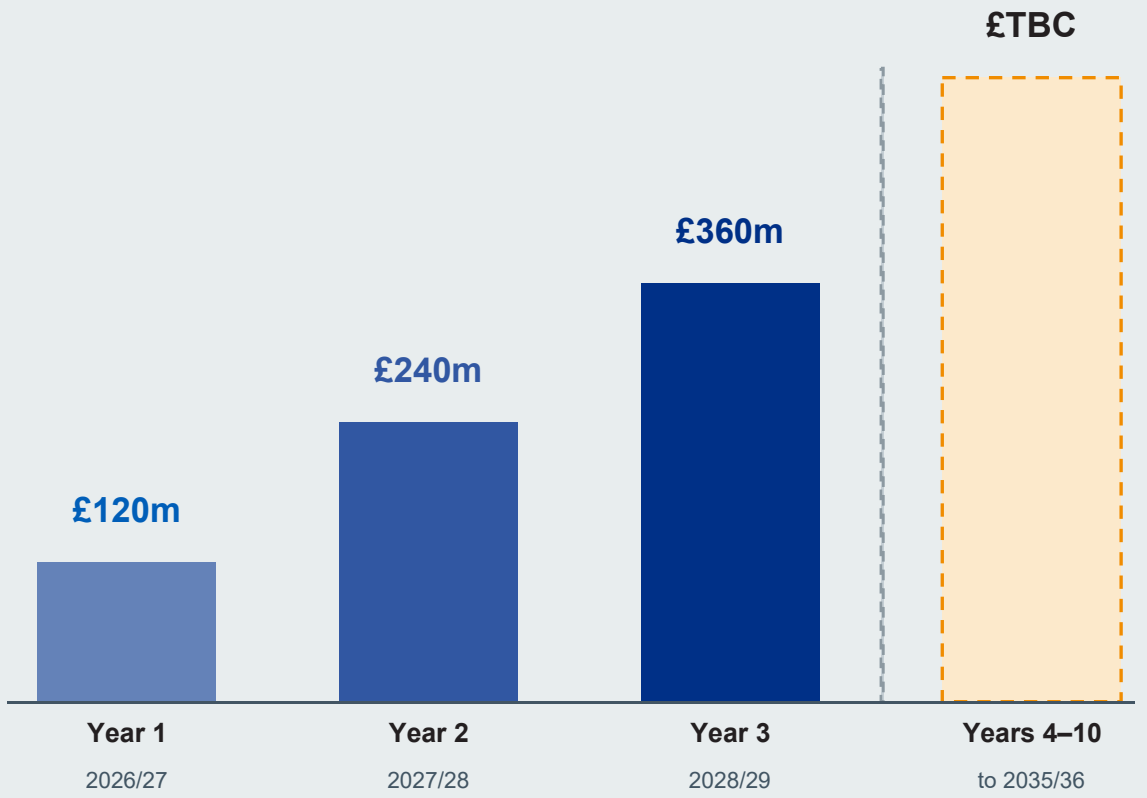
Avoiding future demand and using resources more effectively.

Recommissioning for value

Moving funding from lower-value and reactive care, where clinically and financially appropriate.

Cumulative recurrent investment

Proactive, community-based care and mental health



Four key links between the 10-year strategy and the 2027/28 planning round

The key commitment in the strategy is £360m to be invested in proactive, community-based care and mental health by 2028/29. Beyond that, we have several suggestions to ensure the operational and financial plan aligns with the strategy.

1 Incentive schemes for at least three cohorts

For example:

- **Adults with complexity (Cohort 4), e.g.** emergency admissions and bed days per 1,000 weighted population; care plan and named contact coverage.
- **Children (Cohort 1) and young people (Cohort 2), e.g.** recorded against expected prevalence of mental health conditions; access to support; transition plans; neurodevelopmental waits.
- **Adults with serious mental illness (Cohort 5), e.g.** health checks acted on; crisis and emergency admissions per 1,000; smoking; employment and housing.
- Full measures: see the full strategy at the following link (summary of measures on page 10 and full sets in section 3B).

2 Do nothing and do something positions

- **A robust 'do nothing' position** for each sector and point of delivery, built on *long-term* historic trends (or similar evidence) in the planning model.
- **A clear 'do something' position that balances,** with activity, finance and performance triangulated so the three reconcile.
- **A productivity assumption of at least 2% a year** in all contract negotiations, in line with national planning guidance, varied only where evidence supports it.
- **The remaining difference is what the SCP schemes must deliver,** each tagged to a cohort or care-model shift.
- **All schemes must have evidence of effect on one of the three curves** (outcomes, demand, cost).

3 Clear one-page summary per strategic initiative:

Each strategic initiative needs a clear summary of:

- **How it supports achieving the 'five resident tests'** (making services simpler, fairer, more integrated, more preventative and more relationship/trust-based)*.
- **Which of the six cohorts or two care-model shifts** it serves, and executive owner responsible for the scheme.
- **Which of the six ambition measures it is likely to affect,** with a clear stated logic for how it will improve that ambition measure.
- **Impact on each of the three curves** (outcomes, demand, cost).
- **Payment basis** and contract type.
- **Evidence** and level of confidence in it.
- **Evaluation plan,** with a 'stop-or-scale' date.
- **Health equity check:** which groups it reaches, to what extent it narrows the gap, and how we will check.

4 Evidence of the left shift

- **Left shift:** spend by setting, 2027/28 against 2026/27; acute share down, other settings up.
- **Proportion of spend on proactive care and prevention,** up in 2027/28 compared to 2026/27.
- **'Shadow budget' per neighbourhood:** a notional need-based budget for each neighbourhood, published with the plan to show where spend currently sits (or should sit).
- **Low-value services that will be reviewed:** named in the commissioning intentions, giving a year's notice before changes in 2028/29.
- **Cost of change:** the plan is open about any double-running or stranded costs, how long we will carry them, and what the new service must show before the old one is stood down.

Further 10-year strategy related work that needs to be in place before the next planning round:

- **Local needs formula by sector, patient demographic, and neighbourhood,** with a clear trajectory for aligning resource to those needs.
- **Outcome-linked payment extended to all six cohorts and both care-model shifts,** each with a shared activity baseline, shared outcome baseline and agreed targets.
- **Triangulated workforce plan** aligned to the care model, reconciled with activity and finance.