North Central London
Integrated Care Board

North West London

NHS NC Central London and NHS NW London

Board Meeting in Common

28 January 2026

Report Title	Strategy Development: update and discussion	**Date of report**	January 2026	**Agenda Item**	2.2
Lead Director / Manager	Richard Dale, Chief Strategy Officer	**Email / Tel**		Richard.dale@nhs.net	
Board Member Sponsor	Not applicable.				
ICB	**The paper sets out the work the develop the future strategy of the newly merged West and North London ICB**				
Report Author	Richard Dale, Chief Strategy Officer	**Email / Tel**		Richard.dale@nhs.net	
Name of Authorising Finance Lead	Not applicable.	**Summary of Financial Implications** The draft strategy is based on a multi-year set of planning assumptions being finalised as part of the NHS planning round.			
Recommendation	The board is asked to: • **NOTE** the progress to date, the future work to develop the full five year strategy and • **DISCUSS** the strategic themes and shape the next phase of work.				
Report summary	As part of continuing to develop the five year strategy for the newly forming West and North London ICB as a strategic commissioner, this paper sets out the work underway to develop a five year strategy, the strategic themes and high level feedback from partners and committees. Extensive work is now underway with system groups and partners to test/refine and develop the next version of this strategy. As an example, integrator colleagues are supporting shaping the next level of detail with regards to the development of neighbourhood teams. To support oversight of the development of the strategy and discussion on next steps, this paper provides an update to the board on the following: - The overarching narrative and priorities - The guiding set of strategic insights and analysis - Assurance for the board in terms process and requirements - The work underway in response to the comments from the strategic commissioning committee. - Key questions to steer the next phase of work The current draft strategic narrative is included as an appendix – noting that this is a work in progress.				

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Identified risks and risk management actions	Not applicable to this report directly. Following discussion, the new ICB risk register will be updated in line with the aims of the organisational strategy.
Conflicts of interest	Not applicable.
Resource implications	Not applicable to this report directly. Following discussion at the board work will progress on delivery planning in line with the new strategy and financial trajectory.
Engagement	The board paper has been the result of review and enhancements of NWL and NCL population health strategies which had extensive engagement. Following the board discussion the next stages will involve a planned programme of engagement with partners and residents to shape the plans.
Equality impact analysis	Not applicable to this report directly. The board paper has been the result of review and enhancements of NWL and NCL population health strategies which had EQIA screenings. As part of the development of the full plan a further EQIA will be undertaken.
Report history and key decisions	This draft strategic narrative and set of priorities reflect: • Discussions at the Board Away Day (10 November) • A review of strategies and plans across NWL and NCL • Population health needs assessments • Health economic analysis of current utilisation and future risk • National guidance on strategic commissioning and medium-term planning • Discussions at the Strategy and Commissioning Committee 12 January 2026
Next steps	Next steps are set out on slide X in terms of the development of the full strategy
Appendices	Appendix 1. The proposed approach to strategy development and review across the new organisation Appendix 2. DRAFT - STRATEGIC NARRATIVE AND AREAS FOR CHANGE

North West London Integrated Care System
Working together for better health and care

North Central London Health and Care Integrated Care System

Strategy Development: Update and Discussion

West and North London ICB

January 2026

Contents

Overview of strategy development

Developing the five-year strategy

Work continues to develop the West and North London five-year strategy, working with system partners and professional groups to test and refine the analysis and principles underpinning the strategy, while beginning to build the detail of plans to take this forward.

The work is informed by detailed population needs assessments across our communities and supplemented by local qualitative insights on what residents have told us.

The Board has given a strong steer to base the strategy on a multi-year shift of spend from acute and crisis care towards proactive, preventative care in the community.

The work is closely aligned with the operational planning approach, and the principles set out in relation to financial strategy, capacity planning and new models of care are reflected in this work.

Economic analysis and constitutional standards

The next stage of analysis will focus on two critical aspects:

- First, an overall economic assessment of the full £12bn system spend, including analysis of the scale and composition of structural costs and spend that could be repurposed and shifted over time. This will support the Board in maximising the pace of change and inform wider conversations about how the system and NHS providers operate.
- The second will support a clearer understanding of the link between health equity, value and delivery of the NHS constitutional standards (see slide 9 for further detail), to embed a health equity approach in all decision making.

Equity, Outcomes and Value

All new models within the strategy have at their core a focus on defined population segments, a better understanding of current and future risk, and proactive, person-centred interventions to improve outcomes and value. While the scale of the shift is important, improvements in technology and data mean equal weight must be given to the accuracy of segmentation and risk prediction, to ensure interventions deliver positive impact and value.

Strategic investment and benefits case

All work within the strategy builds on good practice across the two ICBs and accelerates delivery at scale. In parallel, extensive work is underway to develop a clear strategic investment and benefits case for neighbourhood and planned care shifts, which will be brought through ICB and system governance during February.

Guiding insights and analysis (1 of 2)

Equity and outcomes

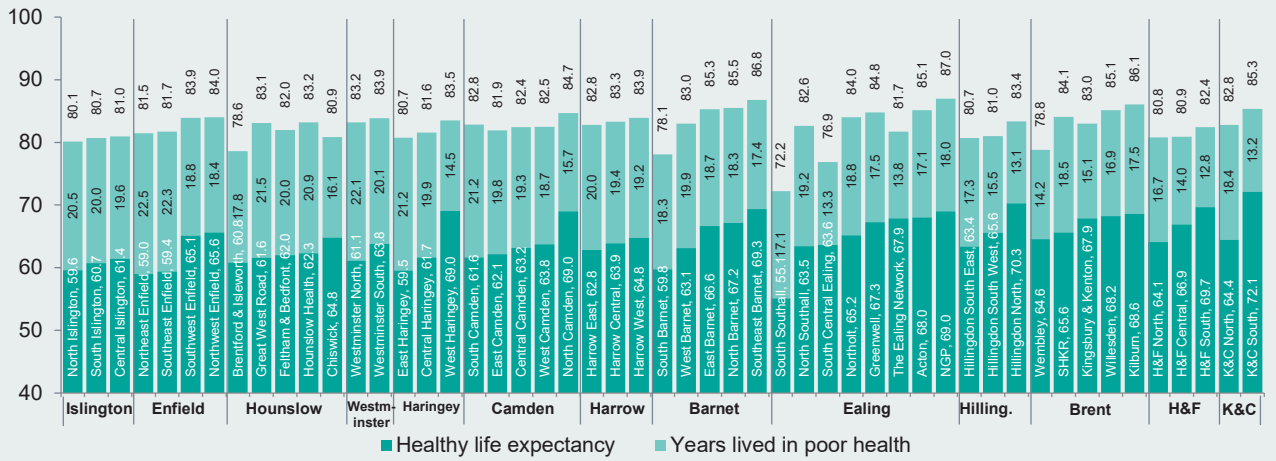
The current configuration of health and care across North and West London is unsustainable and is **failing to deliver equitable outcomes.** There is a **17-year gap in healthy life expectancy** between neighbourhoods across the new ICB footprint. These inequalities are deep-rooted and complex.

At the same time, national and local analysis highlights that we allocate a **disproportionate share of resources to high-cost acute and crisis care**, while underinvesting in prevention, primary care, community services, and planned care. Significant future population health risk – identified through improved modelling and analytics – therefore remains unaddressed.

Our analysis and data show that **certain communities experience poorer outcomes and higher use of emergency care**, for example deprived communities and adults with severe mental illness (SMI). Across West and North London, the excess under-75 (all-cause) mortality rate in adults with SMI is 379% higher than in adults without SMI, with significant variation at borough level, ranging from 291% in Camden to 496% in Hillingdon (Source: ONS, MHSDS, Fingertips).

In these communities, l**ower investment in proactive and planned care in high-need areas results in higher-cost reactive care later**. As the chart to the right shows, a far greater proportion of spending in our most deprived populations is on reactive care compared with our least deprived populations.

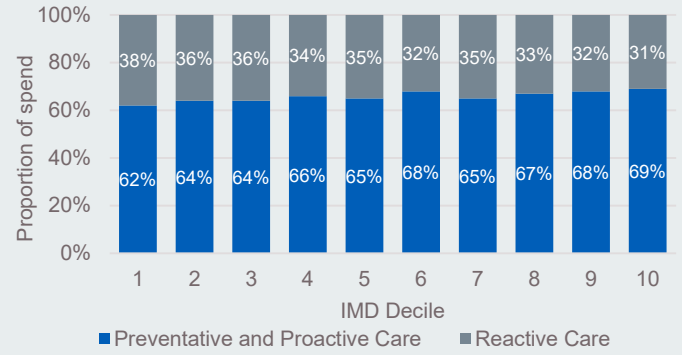
Fig. a: Life Expectancy and Healthy Life Expectancy by neighbourhood, 2022



At a neighbourhood level, the healthy life expectancy gap increases to **17 years of ill health**, with the greatest disparity seen between South Southall (55.1) and K&C South (72.1).

The chart to the right demonstrates how residents in deprived neighbourhoods such as South Southall may have **lower levels of access to proactive care**.

Fig. b: Proactive vs. reactive spend, 2024/25



Sources - HLE / LE Source: ONS data using ONS methodology; Spend: WSIC

Guiding insights and analysis (2 of 2)

A focus on multi-morbidity, building trust and patient activation

- True equity cannot be achieved without addressing multi-morbidity. Our data shows **clear gaps in the number and severity of LTCs between different deprivation levels and ethnic groups**, with people in our most deprived neighbourhoods and from ethnic minority communities developing poor health earlier in life.
- People with m**ultiple LTCs continue to experience fragmented, poorly coordinated pathways, typically interacting with eight or more services each year**, yet **very few have a shared care plan**. A review of frailty services in one borough identified 40 different services that a frail person might need to interact with.
- **Low levels of trust**, partly due to poor experiences of and access to care in our more deprived neighbourhoods and ethnic minority communities, lead to conditions being diagnosed later and poorly managed, with preventable complications, for example amputations in diabetes.

A shift to proactive, community-based, integrated care enabled by technology

- **Over-medicalisation, variation, and fragmentation in planned care pathways** lead to low-value interventions. This drives poorer outcomes and higher costs across groups, especially those with multiple LTCs and older adults.
- **The current system trajectory is financially unsustainable and operationally fragile** at a time when expectations of delivery are high. An **ageing population** (a 12.7% increase in over 65s - equivalent to 60,000 people) across will give rise to even greater levels of multi-morbidity, service demand, and financial instability. Therefore, no change is not an option.
- Our underlying assumption is that by **shifting the proportion of spend** from acute and crisis care into community-based, proactive, primary, and planned care, aligned to need and building trust – we can **achieve better outcomes and reduce the higher healthcare costs** that arise later when patients deteriorate in acute care pathways. Crisis pathways need standardising and work to reduce fragmentation, but should not be the focus for additional recurrent net investment during this period.

Fig. c: Multi-morbidity by deprivation and ethnicity

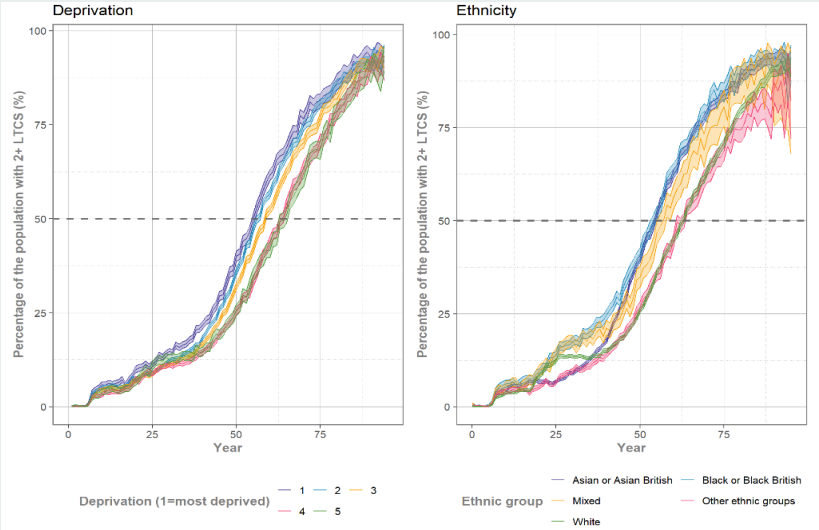


Fig. d: Population projections across WNL

- 5.1% in CYP (-36k) by 2030	**+ 1.4%** in adults 18-64 (+ 35k) by 2030	**+ 12.6%** in adults 65+ (+ 60k) by 2030

Sources: WSIC, ONS, GLA

Our strategic mission and approach

Our mission: Reduce variation in healthy life expectancy – supporting everyone to have a good start in life, more years lived in good health, and a dignified death.

Problem statement: The problem statement for the ICB and system is therefore, within these constraints, how do we strategically commission for population health, deliver integrated neighbourhood care models and ensure financial sustainability while:

- Meeting constitutional NHS standards across commissioned services
- Reducing the variation in health life expectancy across our communities, from 17 years to 12 years
- Increasing the number of years lived in good health for our most deprived quintile, from 55-59 years to 65-69 years
- Reducing the number of cancers diagnosed in A&E to zero
- Investing in a way that not only accounts for but reduces future population healthcare need

Our strategic approach: As commissioners, we will focus on where transformation delivers the greatest value. This means directing attention and investment towards areas with high utilisation, poor access, experience, or outcomes, and ensuring redesign translates into measurable improvements in these areas.

Reducing inequalities is our number one priority. Recognising that wider determinants of health drive these inequalities, we will work in partnership across the NHS, local authorities, and other local partners, including the VCSE. This requires a bolder, more innovative, and more trusting approach to delivery. We will reshape how we work around population cohorts and outcomes, using capitated budgets and the neighbourhood health model to rewire service delivery around our population. We will use longitudinal data and analysis to better understand and mitigate risk, suppress future costs, and improve outcomes, and implement new contractual approaches to align incentives and support providers to develop new care models that improve value for population cohorts.

In line with the new operating model we will work closely with providers, who will lead detailed pathway optimisation, reduction of unwarranted variation, and productivity improvement.

1: We will understand rising risk within communities and take a proactive, preventative approach to supporting people to stay well, identify conditions early, and self-manage LTCs. Over time, this will reduce the flow of people into high-utilisation, poor-outcome cohorts. Services will be co-designed with communities in ways that build trust.

2: We will prioritise population cohorts with high utilisation but poor outcomes or low value. These patients often interact with multiple parts of the system due to fragmented or inefficient pathways. By understanding their needs and the drivers of avoidable activity, we will work with them to redesign care so it is proactive, coordinated, and delivers better outcomes at lower cost.

3: We will drive a step-change in planned care pathways using 'should-cost' analysis. This means moving away from historic delivery patterns and modelling what pathways should cost if designed around best practice, efficient staffing, digital triage, and optimised flows. This creates a shared benchmark for improvement and a clear basis for investment and reinvestment decisions.

A multi-year financial trajectory to drive improved outcomes and value

The financial challenge and case for change

Both legacy ICBs **delivered balanced financial positions between 2022/23 and 2024/25**, supported by **non-recurrent measures**. This masks **structural challenges**, including the rising burden of chronic disease and a continued drift towards acute activity.

Acute expenditure has increased from **50% of total spend in 2019/20 to 54% in 2024/25**. In order to improve the value of healthcare we need to **change the profile of this spend** back to improve access, better coordinate care and intervene earlier to mange risk and deliver higher healthcare utility for the money we spend.

The **NHS Medium-Term Planning Framework** requires systems to adopt multi-year planning horizons, reduce reliance on non-recurrent funding, and rebalance investment into preventative and community-based care.

Principles guiding our financial strategy

Our financial strategy will set out a multi-year trajectory that will follow the following principles:

- A plan for a **sustainable financial position** and balanced plan in each year
- We will **target investments** that ensure ICB resources are invested against the **highest need**, noting that neighbourhoods are the ICB unit of delivery.
- All investment decisions will be based on the **analysis of data to estimate need** and be subject to a business case/value proposition process to evaluate positive impact.
- We will look to develop **capitated budgets and commission by outcomes** – to reduce inequalities in these outcomes through connecting and delivering services that span traditional healthcare boundaries, aligned to need in our communities.
- We will **invest in activities that reduce** emergency demand in secondary care, reduce unnecessary clinical variation, reduce follow-up outpatient appointments, reduce health inequalities, and we will **disinvest in activities that are not delivering** the intend value or outcomes.
- We will **reduce unearned income** by commissioning higher levels of activity (elective) to **reduce waiting lists inside and outside of hospital**.
- We will **target capital investment at transformation and neighbourhood development.**

Overview of priority areas

Note: more detail is available in the accompanying strategic narrative document (appendix 3)

Strengthening Relationships and Building Trust with Communities

Low activation is associated with **18% more GP contacts** and **38% more emergency admissions**, and disproportionately affects deprived and ethnic minority communities.

Patient activation must become core to care delivery, to shift care from reactive to proactive.

Neighbourhood Health as a Core Delivery Model

Health life expectancy varies by >17 years between neighbourhoods in West and North London. Rising multi-morbidity and an ageing population require local, coordinated, preventative care.

Neighbourhoods will become the core unit of delivery through integrated teams.

Planned Care Transformation Through Digital and Community-First Pathways

Planned care referrals are **growing by 8% annually** and are driving longer waits and unsustainable pressure. Pathways are complex and hospital-centric, delaying access.

Redesigning major pathways using self-referral, digital triage and community-first models will ensure patients are seen in the right place, first time.

Integrated Care for Children and Young People

An estimated **107k** children and young people have complex health needs across West and North London – around **2.1k** per neighbourhood. Fragmented services delay diagnosis, particularly for boys and disadvantaged groups.

An integrated health offer and consistent neighbourhood model will reduce duplication and improve outcomes for children and families.

Improving Outcomes for Adults with Serious Mental Illness

Adults with SMI have an under-75 mortality rate **379% higher** than those without SMI, and despite using healthcare services **over seven times more**, outcomes remain poor.

Strengthening community, acute and crisis pathways will reduce unwarranted variation and improve physical health outcomes. Through neighbourhood teams we will target investment where inequalities are greatest.

Deploying Genomics and Precision Medicine

Genomic medicine can reduce diagnostic delays from **four years to three months** for some rare diseases and cancers, and polygenic risk scores can identify individuals with higher lifetime risk for certain long term conditions.

We will deploy genomics where evidence shows clear value, and genomic insights will be embedded into real-time clinical decision-making.

Supporting a Dignified Death

Each year, **10k-11k** patients are admitted to hospital in their last year of life, with around **1.2k** experiencing three or more admissions in their final 90 days. **53%** of deaths occur in hospital compared with **45%** nationally, contrary to patient preferences.

We will redesign end-of-life pathways and strengthen community and palliative care to reduce avoidable admissions and enable more people to die in their preferred place.

Developing Robust Digital Infrastructure

Fragmented systems and poor interoperability limit information sharing and integrated working, restrict proactive care and contribute to variation in outcomes.

To support our ambitions for neighbourhood health, patient activation and data-driven decision-making at scale, we will invest in interoperable systems, real-time analytics and population health capability, aligned to the London SDE.

Next stage analysis is now underway

Work package 1: Financial analysis
How the 1% shift in spend is a catalyst for driving better value for our overall £12bn budget

A profile of the **full £12bn West and North London spend** and the extent to which we understand the pace and quantum of spend that can be changed over the next five years to achieve financial sustainability and improved outcomes.

This will include **high-level mapping of system spend**, structural costs, and the extent to which productivity improvements and re-provision into higher-value models can support the pace of change required over a multi-year trajectory within a fixed financial envelope.

Further details are provided in a proposed storyboard over the next two pages.

Work package 2:
Accomplishing our equity mission and hitting constitutional standards

A set of analyses to better understand the **link between delivery of constitutional standards and equity**, and the alignment between the two. This will be based on the following:

1. We know **deprived communities consume more reactive care**, as shown in the graph on slide 4.
2. We know these communities are **overrepresented in the longest waiting patients**, as demonstrated in both the NW London and NC London annual reviews of healthcare inequalities [NB: NWL analysis is here, and NCL analysis is here]
3. We know that these **communities are also diagnosed with serious illness**, such as cancer, at **a later stage** and this results in poorer health outcomes [NB: same reference point as point 2]
4. We know **black mothers are more likely to suffer complications in childbirt**h than other women as demonstrated in both the NW London and NC London annul reviews of healthcare inequalities and in a range of national reports [for example, see here]

Failure to meet constitutional standards drives inequality and vice versa i.e. delayed care, increasing crisis use, worsening outcomes, and entrenching higher costs in deprived communities. Therefore, **focusing on equity** improves performance against constitutional standards because it targets the populations and pathways that are often experiencing long waits, high acuity, and avoidable demand.

Financial analysis: proposed high-level storyboard

How the 1% shift in spend is a catalyst for driving better value for our overall £12bn budget

#	Slide title	Key message
1	**What is driving our cost pressures?**	"Cost growth is structurally driven by reactive care, fragmented pathways, and misaligned capacity — not a single factor and not short-term inefficiency."
2	**The 'do nothing' financial challenge**	"If current care models continue, the system faces a widening five-year financial gap that will need to be closed through £xm allocative efficiencies and £xm technical efficiencies."
3	**Building the allocative and technical efficiency opportunity**	"A structured, end-to-end analysis shows there is a significant, quantifiable opportunity of £xm to reallocate spend through prevention, productivity and pathway redesign."
4	**The 1% shift to neighbourhoods as a delivery mechanism**	"A disciplined 1% annual shift of the total system budget is the 'engine' that funds transformation and suppresses future demand growth."
5	**Strategic transformation: what changes on the ground?**	"Sustainability is achieved by redesigning pathways to prevent escalation, activate patients, reduce duplication and improve productivity at every stage of care."
6	**Performance impact: unlocking system flow**	"Performance against constitutional standards improves when capacity is freed from low-value activity and redirected to pressure points in care pathways."
7	**Leadership, governance, and the 'feedback loop'**	"Closing the gap requires sustained leadership, protected transformation funding and multi-year governance focused on convergence over time, not annual 'quick-fixes'."

Slide 3 detail:

A. What is the £ opportunity for allocative efficiency?

- **Baseline and growth analysis:** analysis of total spend and activity by: pathway; setting; population identify where growth is structural vs episodic (separating unavoidable trauma/ emergency care from "preventable" exacerbations of LTCs.
- **Demand and utilisation:** analysis of reactive vs. proactive care (by neighbourhood); analysis of the cost of inequalities; preventable escalation; over-medicalisation and low-value activity; the cost of fragmentation and duplication across settings.
- **Redesign:** including prevention; primary prevention (risk reduction, behaviours); secondary prevention (earlier diagnosis, proactive management); patient activation and self-management; right-size capacity at each pathway stage.

B. What is the £ opportunity for technical efficiency?

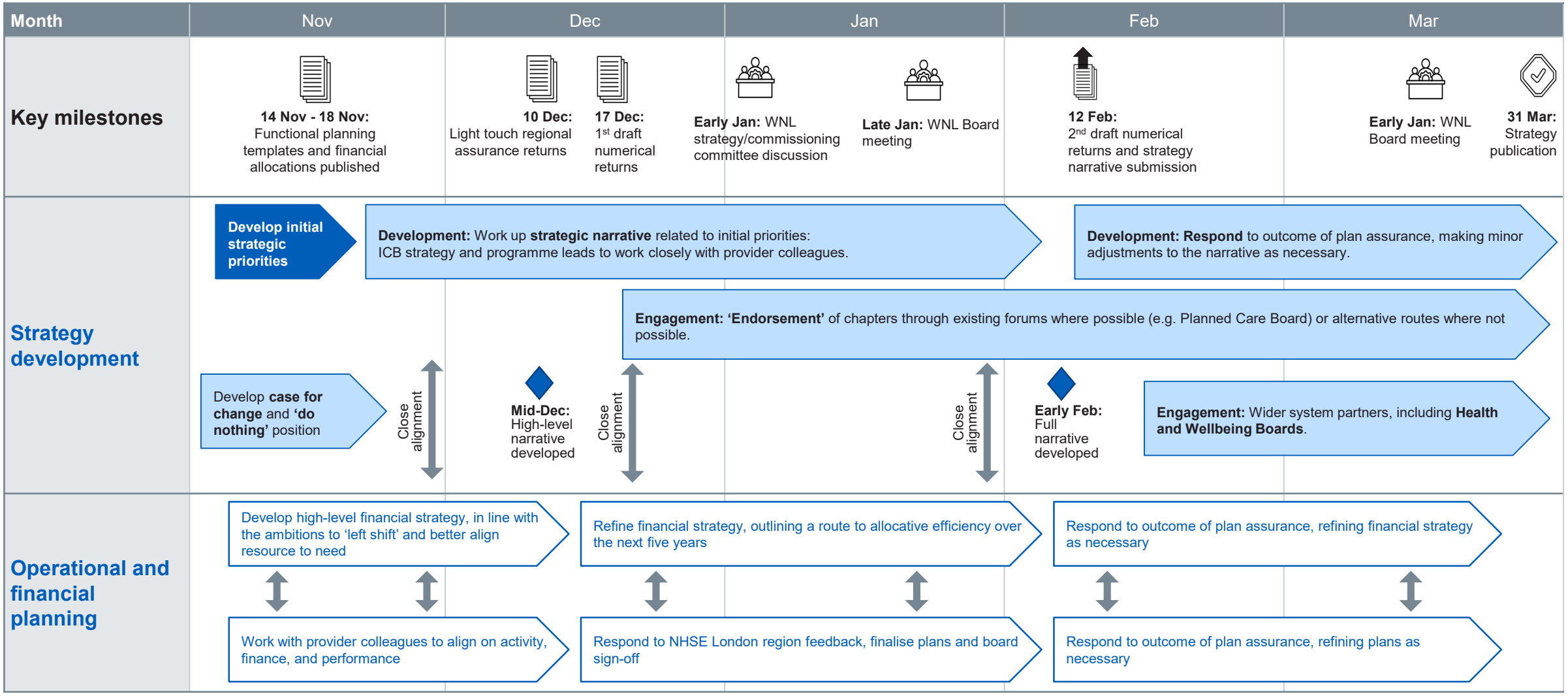
- **Productivity opportunities:** (e.g. unit cost; length of stay; digital substitution; workforce configuration, etc.)

C. What is the required financial trajectory?

- **Phasing analysis:** model realistic ramp-down and ramp-up of interventions; avoid assuming immediate acute capacity release.

Output: a single, aggregated estimate of: total efficiency opportunity; what is shiftable outright vs what requires productivity; phased delivery over five years, including likely position by sector.

Timeline to completion and wider system engagement



Key feedback themes and reflections for further work

Through a period of continued NHS and wider public sector change, how do we:

- Ensure strong partnership working through a period of change for Local Authority colleagues, including the Fairer Funding Review?
- Best work with provider alliances and influence provider business plans through the next phase of work, to support aligned provider transformation?
- Support and develop VCSE and other non-statutory delivery models via developments at place?
- Ensure the right focus on children through a multi-agency approach?

How do we make the most of the assets and specific capabilities of organisations and communities across West and North London to:

- Work with communities to support engagement with critical proactive, preventative services, such as screening and vaccine uptake?
- Maximise the impact of the work and health agenda for local communities?
- Work with the life sciences, research and innovation agenda on an international footprint?

North West London Integrated Care System
Working together for better health and care

North Central London Health and Care Integrated Care System

Appendix 1.

West and North London strategy development

Purpose and role of Integrated Care Boards (ICBs)

ICBs exist to lead population health improvement and steward NHS resources for long-term value.

Our purpose (why we are here):

"To strategically commission healthcare services that improve the health and lives of West and North London residents, both now and in the future"

What does a 'Model ICB'[1] look like?

- ICBs exist to **improve their population's health** and ensure access to consistently high-quality services.
- They hold the **accountability** for ensuring the best use of their **population's health budget** to improve health and healthcare, both now and in the future.
- ICBs provide **system leadership for population health**, setting evidence based and long-term population health strategy and working as healthcare payers to deliver this, maximising the value that can be created from the available resources.
- This involves **investing in, purchasing and evaluating the range of services and pathways** required to ensure access to high quality care, and to improve outcomes and reduce inequalities within their footprint.
- ICBs not only commission services but also **align funding and resources strategically** with long-term population health outcomes, and manage clinical and financial risks.

What does this mean in practice?

Going forward, ICBs need to refine their role and focus on being a **strategic commissioner**. This is an opportunity to take another step towards the model of Place and Neighbourhood-based leadership that our partners have been working towards – a **lighter touch commissioner** with delivery-focused, provider-led partnerships that best understand the local context and the needs of communities. This means we will:

- **Commission local and delegated healthcare services** for our population.
- **Convene the system** to ensure aligned strategic direction and an integrated plan.
- **Shape the provider market**.
- Ensure providers **deliver high-quality services** in with their contracts.
- Work with partners to **address the wider determinants of health** and to **secure innovation.**

Source: 1. Model ICB Blueprint, May 2025, NHS England

Strategy hierarchy

Different strategies serve different purposes – a clear hierarchy avoids duplication, clarifies ownership, and enables a manageable annual planning cycle and delivery.

Strategic

ICB 5 Year strategy

Sets long-term vision and priorities, and includes: population health outcomes and equity goals; high-level care models and system design; and resource allocation principles and investment intent.

Population-based, longitudinal activity and finance model

Supports strategy development with robust finance and activity analysis, including future projections of demand, ability to flex capacity in different areas, and model through the consequences of potential strategic decisions.

Tactical

Service-level, detailed delivery plans

Strategic-to-tactical planning, translating strategy into care models, pathways, and detailed implementation plans.

- Primary Care
- Planned Care (Acute Sector)
- Mental Health (Adults)
- Maternity & Women's Health
- Health Equity
- Urgent and Emergency Care
- Planned Care (Community)
- Mental Health (CYP)
- Specialised Services

Enabling function delivery plans

Detailed strategic-to-tactical planning, ensuring ICS-wide delivery is feasible and sustainable.

- Finance
- Workforce
- Research & Innovation
- Estates
- Digital & Data
- Comms. & involvement

Ad-hoc strategic commissioning

Designed to address specific system issues or statutory duties as and when they arise.

Operational

Place and neighbourhood-level plans

Tactical-to-operational planning, translating and tailoring system-wide strategy and planning to local needs over a relatively short time-horizon.

Place-level delivery plan	Place-level delivery plan	Place-level delivery plan	Place-level delivery plan	Place-level delivery plan	Place-level delivery plan	Place-level delivery plan	Place-level delivery plan	Place-level delivery plan	Place-level delivery plan	Place-level delivery plan	Place-level delivery plan
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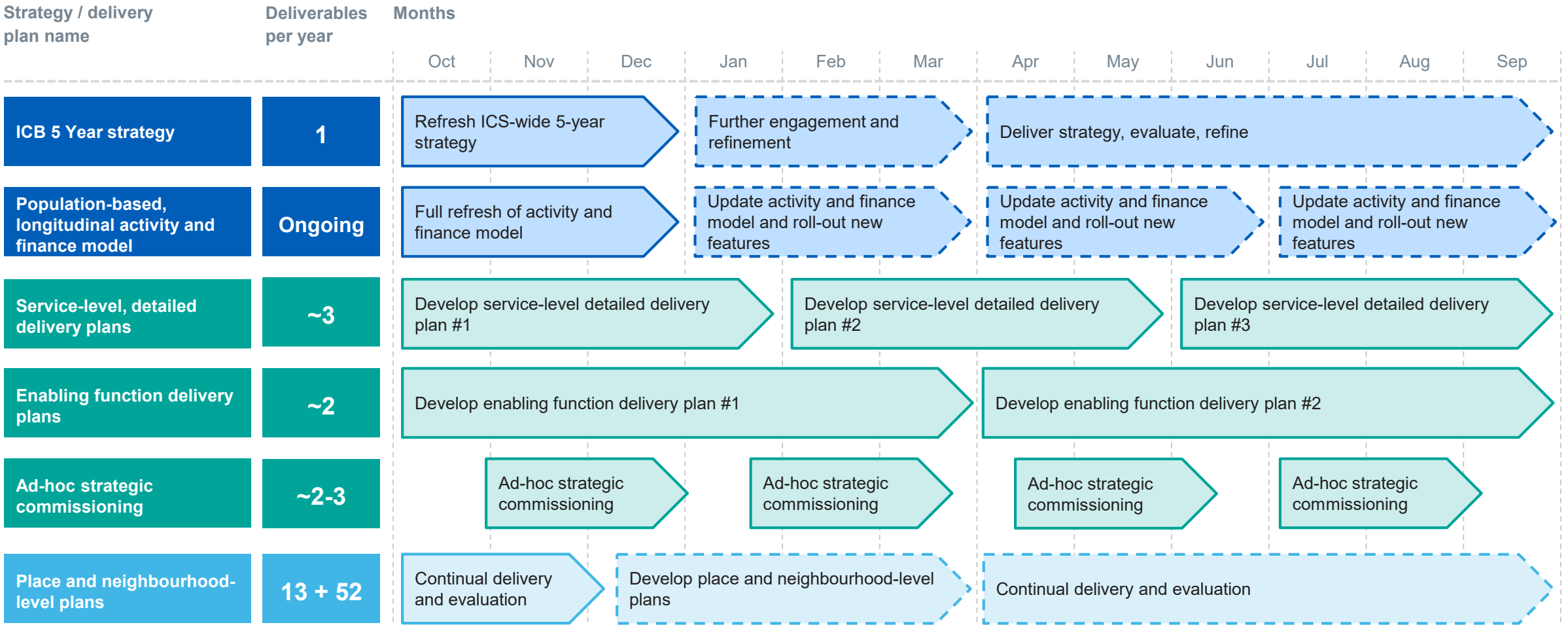
Strategy types, scope and ownership

A single system strategy, translated through aligned delivery plans and operational plans with clear ownership and accountabilities.

Strategy / delivery plan name	Type	Description	Accountable lead / support	Time horizon	Cadence
ICB 5 Year strategy	Strategic	Sets long-term vision and priorities.	Strategy team, with support from other ICB teams and system partners.	**3-5 years**	Refreshed annually as part of annual planning cycle.
Population-based, longitudinal activity and finance model	Strategic	Supports strategy development with robust finance and activity analysis.	Wider Strategy directorate, with support from other ICB teams (e.g. finance) and system partners.	**3-5 years**	Refreshed constantly as part of ongoing strategy development, delivery planning and data refreshes.
Service-level, detailed delivery plans	Strategic-to-tactical	Translating strategy into care models and pathways.	Joint ownership between Strategy team and appropriate ICB team (e.g. Transformation, Medical, etc.), with input from enabling functions as appropriate.	**3-5 years**	Refreshed every ~3 years.
Enabling function delivery plans	Strategic-to-tactical	Detailed strategic-to-tactical planning, ensuring ICS-wide delivery is feasible and sustainable.	Led by appropriate ICB team (e.g. Finance, Estates, etc.) with input from Strategy team and other ICB teams.	**3-5 years**	Refreshed every ~3 years.
Ad-hoc strategic commissioning	Tactical	Addresses specific system issues or statutory duties as and when they arise.	Led by Transformation team with input from the Strategy team and enabling functions as appropriate.	**1-3 years**	Refreshed as and when required.
Place and neighbourhood-level plans	Tactical-to-operational	Tactical-to-operational planning, translating and tailoring system-wide strategy and planning to local needs over a relatively short time-horizon.	Led by Place-based Partnerships, Integrators, and Neighbourhood teams.	**1-3 years**	Refreshed annually

Strategy as a continuous annual cycle

Strategy development is iterative, evidence-led and aligned to NHS planning timelines.



PART A. STRATEGIC NARRATIVE AND AREAS FOR CHANGE

1. Purpose of Paper

As we establish the new West and North London Integrated Care Board (ICB) and develop our role as a strategic commissioner and intelligent payor, it is essential that we clearly set out how we will better use public resources to improve outcomes and deliver better value for our population.

It is important to note that this strategy is being developed at a time of significant public sector reform both within and outside the NHS. In addition to NHS operating model changes, Local government partners are entering a period of substantial financial challenge, including the impact of the Fair Funding Review, which will reshape resource distribution across boroughs and place intense pressure on wider public services. These changes reinforce the need for us to work differently as an integrated system, focusing our collective resources where need is greatest and enabling prevention, earlier intervention and population-level change.

Nationally, the NHS Strategic Commissioning Framework and the NHS Medium-Term Planning Framework set a clear expectation that ICBs must take a longer-term, population-focused, value-driven approach. This includes strategic commissioning based on outcomes, reducing disparities in access, experience and outcomes, and shifting investment from reactive to proactive care. The direction set out in this paper is fully aligned with the national direction of travel.

This draft strategic narrative and set of priorities reflect:

- Discussions at the Board Away Day (10 November)
- A review of strategies and plans across NWL and NCL
- Population health needs assessments
- Health economic analysis of current utilisation and future risk
- National guidance on strategic commissioning and medium-term planning

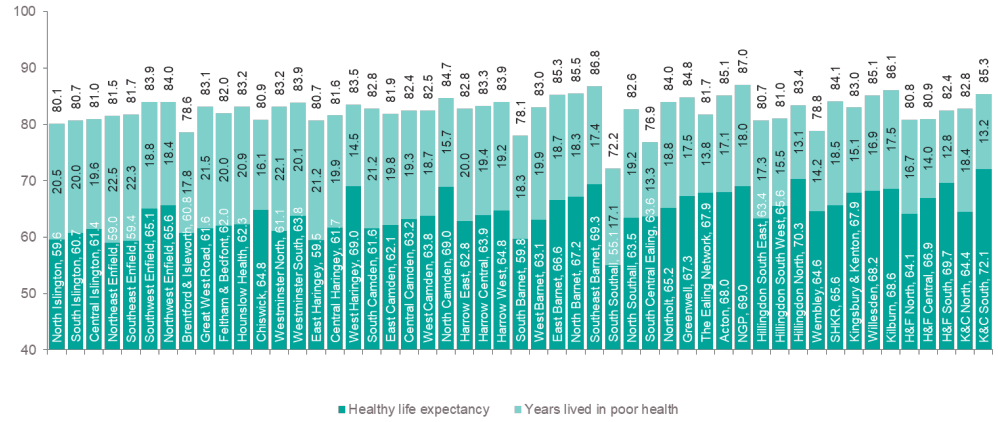
It is presented for discussion at the 4 December Board meeting. The strategy will be further refined through the Joint Strategy & Commissioning Committee on 12 January, with a final draft to the Board in late January ahead of formal adoption in February.

2. Strategic Narrative

2.1 Case for Change

The current configuration of health and care across North and West London is unsustainable and is failing to deliver equitable outcomes. There is a **17-year gap in healthy life expectancy** between neighbourhoods across the new ICB footprint. These inequalities are deep-rooted and complex in nature.

Fig. a: Healthy life expectancy and life expectancy by neighbourhood:



Healthy life expectancy (HLE) gap: At a neighbourhood level, the healthy life expectancy increases to **17 years** of ill health, with the greatest disparity seen between **South Southall** (55.1) and **Kensington & Chelsea South** (72.1).

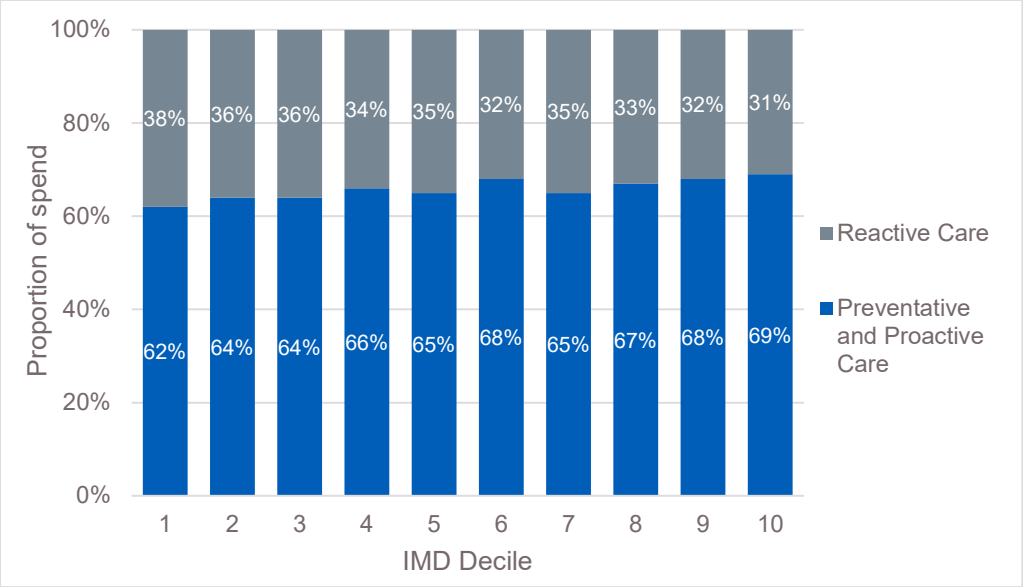
HLE / LE Source: ONS data using ONS methodology for healthy life expectancy (survey-based); age-standardised. All values relate to life expectancy at birth. Values derived from **2013** MSOA-level estimates provided by the ONS and uplifted to 2022 using borough-level, validated figures. HLE and LE values mapped from MSOA to neighbourhoods through weighted averages using Oct. 2025 registered population figures.

At the same time, national and local analyses highlight that we allocate a disproportionate share of resource to **high-cost acute and crisis care**, while underinvesting in prevention, primary care, community services, and planned care. Significant future population health risk – identified through our improved modelling and analytics – remains unaddressed.

Our analysis and data shows that:

- **Certain communities are experiencing poorer outcomes and have greater emergency care use** e.g. deprived communities and adults with SMI. Across West and North London the excess under 75 (all cause) mortality rate in adults with SMI is 379% greater than for adults without SMI – with significant variation at borough level - ranging from 291% in Camden to 496% in Hillingdon (Source: ONS, MHSDS, Fingertips).
- **In these communities, lower investment in proactive and planned care in high-need areas results in higher-cost reactive care later.** As the chart below shows, a far greater proportion of spending in our most deprived population goes on reactive care, compared with our least deprived population.

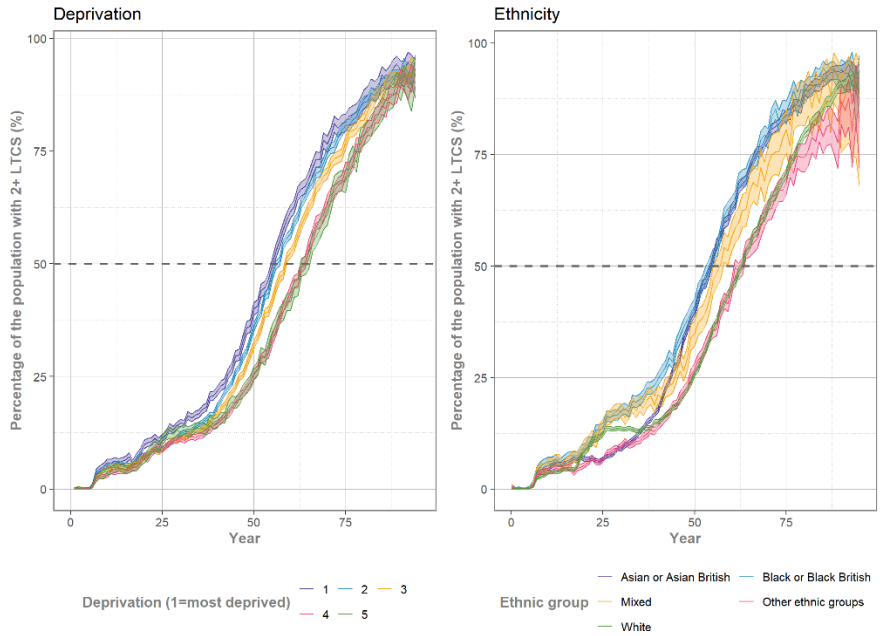
Fig. b: Proportion of spend split by type of care



Source: Optum, Total Cost of Care Data Pack, NWL. Note: further work required to accurately categorise care into these categories

- **True equity cannot be achieved without addressing multi-morbidity** – our data shows clear gaps in the number and severity of long-term conditions between different deprivation levels and ethnic groups, with people in our most deprived neighbourhoods and from ethnic minority communities developing poor health earlier in life.

Fig. c: Percentage of the population in ill-health by age



Source: WSIC, NWL Integrated Needs Assessment

- **People with multiple long-term conditions continue to experience fragmented, poorly coordinated pathways** – typically interacting with eight

or more services each year, yet very few have a shared care plan. A review of frailty services in one borough identified 40 different services that a frail person might need to interact with.

- **Low levels of trust, partly due to poor experiences and access to care within our more deprived neighbourhoods and ethnic minority communities,** leads to conditions being diagnosed later and being poorly managed
- **Over-medicalisation and excessive variation lead to low-value interventions.**
- **The current system trajectory is financially unsustainable and operationally fragile at a time when expectations of delivery are high.**

Therefore, our underlying assumption is that by shifting the proportion of spend from acute and crisis care into community-based proactive, primary and planned care, in a way that is aligned to need and builds trust we can start to achieve better outcomes and reduce higher healthcare costs consumed later when patients deteriorate in an acute care pathway.

2.2 Our strategic mission

In response to this challenging context, the ICB is setting its mission as:

Reduce the variation in health life expectancy, supporting everyone to have a good start in life, increasing the number of years lived in good health and support healthy aging

The problem statement for the ICB and system is therefore, within these constraints, how do we strategically commission for population health, deliver integrated neighbourhood care models and ensure financial sustainability while:

1. Reducing the variation in health life expectancy across our communities, from 17 years to 12 years
2. Increasing the number of years lived in good health for our most deprived quintile, from 55-59 years to 65-69 years
3. Reducing the number of cancers diagnosed in A&E to zero
4. Investing in a way that not only accounts for but reduces future population healthcare need.

2.3 Our strategic approach

As commissioners we will focus on where transformation delivers the greatest value. This means directing attention and investment toward areas with high utilisation, poor access, experience or outcomes, and ensuring that redesign efforts translate

into measurable improvements in equity, access, quality, experience and cost-effectiveness.

Given that reducing inequalities is our number one priority, and we know that the wider determinants of health and health behaviours drive these inequalities, we will work in partnership across the NHS, Local Authorities and other local partners including the VCSE to take a bolder, more innovative and more trusting approach to delivery. This means fundamentally reshaping the way we work around population cohorts and outcomes, using capitated budgets that span traditional healthcare barriers and using the neighbourhood health model to rewire how services are delivered, with our population at the heart. We will use longitudinal data assets and analysis to better understand and mitigate risks to suppress future costs and improve outcomes. As well look to implement new contractual forms to align incentives for providers to develop new and novel care models to improve value and outcomes for population cohorts.

We will also work closely with our providers who will lead on detailed pathway optimisation, reduction of unwarranted variation and productivity – they hold the clinical insight, operational levers, and day-to-day accountability.

In terms of our approach we have three critical steps to take, these need to happen in parallel:

1. We will work to understand rising risk within our communities and take a proactive, preventative approach to designing services to support people to stay healthy and well, identify conditions early and support people to self-manage conditions. This will reduce the flow of people moving into the high utilisation, poor outcome cohort. These services will be designed in collaboration with communities in a way that builds trust.

2. We will prioritise population cohorts with high utilisation but poor outcomes or poor value. These are the patients who repeatedly touch multiple parts of the system because pathways are fragmented or inefficient. By understanding their needs and the drivers of avoidable activity, and working with these patients to redesign care so that it is proactive, coordinated, and genuinely improves outcomes at lower cost.

3. We will drive a step-change in planned care pathways by using ‘should-cost’ analysis. This means moving away from historic patterns of delivery and instead modelling what each pathway ‘should-cost’ if it were designed around best practice, efficient staffing models, digital triage, and optimised flows. That creates a shared benchmark for improvement and a clear basis for investment and reinvestment decisions.

Underpinning these changes shifts are two critical enablers:

- Digital infrastructure, which enables better access and consistent triage, risk stratification and personalisation and seamless information-sharing between providers; and
- Patient activation and support, to enable people to engage in their health, be confident to self-manage where appropriate, choose the right service at the right time, and engage effectively with a fundamentally transformed NHS.

This model enables the ICB to focus on the highest-value priorities and ensure consistent delivery, while providers lead the operational transformation.

3. A Multi-Year Financial Trajectory to Drive Value

Both legacy ICBs delivered balanced financial positions between 2022/23 and 2024/25, supported by non-recurrent measures. This masks structural challenges, including the rising burden of chronic disease and a continued drift towards acute activity. Acute expenditure has increased from **50% of total spend in 2019/20 to 54% in 2024/25**. In order to improve the value of healthcare we need to change the profile of this spend back to improve access, better coordinate care and intervene earlier to mange risk and deliver higher healthcare utility for the money we spend.

The NHS Medium-Term Planning Framework requires systems to adopt multi-year planning horizons, reduce reliance on non-recurrent funding, and rebalance investment into preventative and community-based care. Our financial strategy will set out a multi-year trajectory that will follow the following principles:

- A plan for a sustainable financial position and balanced plan in each year
- We will target investments that ensure ICB resources are invested against the highest need, noting that neighbourhoods are the ICB unit of delivery.
- All investment decisions will be based on the analysis of data to estimate need and be subject to a business case/value proposition process to evaluate positive impact.
- We will develop capitated budgets and commission by outcomes, to reduce inequalities in these outcomes through connecting and delivering services that span traditional healthcare boundaries, aligned to need in our communities.
- We will invest in activities that reduce emergency demand in secondary care, reduce unnecessary clinical variation, reduce follow-up outpatients, reduce health inequality and we will disinvest in activities that are not delivering the intend value or outcomes.
- We will reduce unearned income by commissioning higher levels of activity (elective) to reduce waiting lists inside and outside of hospital.

- We will target capital investment at transformation and neighbourhood development.

4. Population based cases for change

Health economic modelling identifies population cohorts across West & North London that experience the poorest outcomes and account for disproportionately high system costs. Added to this there are areas of planned care that require radical transformation based on the need to rapidly improve access and deliver step change in costs enabled by technology.

These insights have informed eight proposed priority areas for change. Each aims to shift spend from reactive to proactive care, improve equity and deliver better value.

The following section sets out the proposed areas, an overview of the scope and links to existing work underway across the current ICBs.

Each priority will be developed into a detailed value proposition for further Board review, supported by SMEs and system partners.

4.1 Strengthening Relationships and Building Trust with Communities Experiencing poor outcomes (Including resident activation)

Patient activation – people's knowledge, skills, and confidence to manage their health – is not a nice to have. There is a strong evidence base to support the fact healthcare costs are better and outcomes improved when patients are engaged in their health. Other industries take this very seriously, and we now need to do this within healthcare. Patient activation must become a core element of our model of care, not an optional add-on.

Activation varies significantly across West and North London. Data from North West London shows that 21% of people are 'disengaged or overwhelmed' when it comes to their health (i.e. least activated), 27% of people are 'becoming aware' of their health, 33% are taking action, and only 19% of people are 'maintaining healthy behaviours' (i.e. most activated). The evidence shows that people with the highest levels of activation have lower usage of GP and A&E services than people with the lowest levels of activation (18% fewer GP contacts and 38% fewer emergency admissions).

We must do more to improve activation across our communities. We will:

- Use the NHS App and digital tools to support self-management
- Deploy localised health coaching, navigation and behavioural interventions, and invest in peer support
- Use population health analytics and risk stratification to identify residents most likely to benefit

- Tailor interventions to levels of activation and specific groups experiencing the greatest inequities
- Increase levels of health literacy and focus on clear communication and shared decision making

Patient activation and trust in services are mutually reinforcing. Our communities have told us that in order to build trust they value compassionate care, community involvement and voice in service design, effective communication, equitable access and holistic care.

We must do more to increase levels of trust. We will:

- Work directly with communities to build trust and empowerment through greater participation and co-production
- Continue to build the VCSE infrastructure across the system to help deepen relationships with communities
- Invest in community in-reach models that meet people where they are and take an asset-based approach, as a core part of neighbourhood health
- Invest in workforce development, including cultural competency and active listening skills, to improve people's experiences of interacting with health services

This work will build on existing community partnerships and our equity programmes.

4.2 Neighbourhood Health as a Core Delivery Model

Neighbourhoods will be the foundation of our future model and unit of delivery. We will develop **integrated neighbourhood teams** delivering a consistent core offer across primary care, community services, mental health, local authorities and the voluntary sector.

As shown in section 2, healthy life expectancy varies by more 17 years between West and North London neighbourhoods just a few miles apart, with a 14 year gap even within the same borough. This demonstrates that the variation is local, immediate, and most actionable through neighbourhood-based care models.

We also know that the nature of the care our population requires is changing: from acute and episodic to chronic and continuous – driven by an ongoing rise in multi-morbidity that occurs earlier in our more deprived and ethnic minority communities (as demonstrated again in section 2). Care must increasingly be generalist, lower-intensity, and long-term in nature, rather than specialist and short-term. According to projections by the Greater London Authority (GLA), The over 65 population in West and North London is expected to increase 36% by 2040, compared to a 3% increase in working age population and an 8% reduction in 0-17 year olds. This demographic

change indicates significantly increased need for health and care that is best served through neighbourhood-based care models.

The neighbourhood model will:

- Fundamentally rewire local service delivery to be population centred, with contracts and incentives designed around outcomes for population cohorts and population segmentation and risk stratification driving decision making
- Be the core vehicle for delivering priority 1 above – bringing together local services to support people to stay well, investing in proactive, preventative approaches that address the wider determinants of health including employment and social welfare legal advice, co-locating services wherever possible
- Reduce variation in access, experience and outcomes, targeting resources on our most deprived communities and enabling personalised, multidisciplinary care planning
- Help set the foundation for a new type of NHS focussed on a deep understanding of and connection with residents and thriving communities.

4.3 Planned Care Transformation Through Digital and Community-First Pathways

Across the system, we have seen 8% annual growth in referrals for planned care, translating to a 5% annual growth in first outpatient appointments. This level of growth is unsustainable and leads to longer waiting times for our population. A radically different approach to planned care is needed to improve access and successfully deliver the government's commitment to achieving the 92% target for referral-to-treatment times under 18 weeks.

We will redesign major pathways to make planned care access simpler and better coordinated, reducing avoidable demand on acute outpatient services. This will support the recovery of elective performance with more patients seen in the right place first time without adding pressure onto primary care. This includes:

- Self-referral, digital triage and NHS App-enabled journeys
- Community-first pathways
- Standardised referral support and communication
- Integration with neighbourhood teams for ongoing support

Specialties we will target first will be:

- Dermatology (digital pathways)
- CYP mental health and ADHD assessment (digital pathways)

- ENT (community first)
- Gynaecology (community first)
- MSK (community first)

This builds on NWL's planned care strategy and NCL's elective recovery programme.

4.4 Integrated Care for Children and Young People

Initial estimates show that we have 107,000 children and young people across West and North London with complex physical and/or mental health needs – this is equivalent to approximately 2,100 patients per neighbourhood – all likely requiring multi-agency support. We also know that there is a significant gap in diagnosis – particularly in mental health. According to our data, we also know 4% of our children and young people have a recorded mental health condition, but we also know from recent surveys that the real prevalence is likely closer to 20, having increased significantly over the last few years (Source: Mental Health of CYP Survey, NHSE, 2023). We also know that support for low level mental health conditions in our communities has higher access and success rates for girls than boys, and see boys developing higher rates of severe mental illness.

We will strengthen support for children and young people through integrated models that bring together physical and mental health, acute and community services, as well as wider partners such as schools and social care. Bringing all these services together around children makes it easier to spot problems early, coordinate help, and avoid families having to navigate a fragmented system – where they can often face delays, repeated assessments, and inconsistent advice.

Developing an integrated model for children will help lead to better outcomes and more efficient use of resources across the system.

We will:

- Work to develop a unified Integrated Health Offer (IHO) for CYP through strong links with schools, local authorities and VCSE partners
- Define a consistent neighbourhood offer across the ICB

This will build on Child Health Hubs and the NWL CYP Mental Health Strategy.

4.5 Improving Outcomes for Adults with Serious Mental Illness

Adults with serious mental illness experience significant inequalities in life expectancy, access and outcomes.

As described in section 2, the excess under 75 (all cause) mortality rate in adults with SMI is 379% greater than for adults without SMI – with significant variation at borough level – ranging from 291% in Camden to 496% in Hillingdon (Source: ONS,

MHSDS, Fingertips). People with SMI use healthcare services at more than seven times the rate of people without SMI (Source: WSIC, NWL Integrated Needs Assessment), yet their health outcomes remain significantly worse – evidenced most starkly by these markedly higher mortality rates. This imbalance highlights both unmet need and systemic gaps in how care is organised for this group.

Our strategy will:

- Improve community, acute and crisis pathways
- Reduce unwarranted variation in care and physical health outcomes
- Expand personalised, preventative and recovery-focused support
- Strengthen earlier intervention through neighbourhood teams, targeting resources on groups that need greater investment in earlier intervention

This aligns with the NWL Adult Mental Health Strategy and equity work on SMI.

4.6 Deploying Genomics and precision medicine to Deliver High-Value Personalised Care

Advances in genomic medicine offer significant opportunities for earlier diagnosis, targeted treatment and improved population-level prevention. According to the 10 Year Health Plan, genomics can reduce the time it takes to get a definitive diagnosis from 4 years to 3 months for some rare diseases and certain cancers. Genomics have also proven to better support risk stratification – according to some studies, polygenic risk scores for conditions such as coronary artery disease, diabetes and some cancers can identify individuals at 3-5× higher lifetime risk even when conventional risk factors appear normal (Source: UK Biobank)

To support this ambition, we will:

- Deploy genomics where evidence shows clear value
- Focus on communities with the worst outcomes
- Embed new tools into real-time clinical decision-making
- Invest in tailored interventions that support people to understand their diagnosis and support a healthy lifestyle

This work will be led with genomics network partners.

4.7 Supporting a Dignified Death

Data across West and North London shows that every year, approximately 10–11,000 patients are admitted to hospital in their last year of life, and approximately 11% of these patients (c. 1,200) have three or more admissions in their last 90 days of life. As a result, more of our patients are dying in hospital which is not what the

majority of patients and families want. Of all deaths in West and North London, 53% tend to take place in hospital, compared to 45% in England overall.

This misalignment between people's preferences – with most wishing to die at home or in non-hospital settings – is wider in our deprived and ethnic minority communities. The reality of high acute-care use in the final months of life highlights the need to redesign our end-of-life pathways to support care closer to home, reduce avoidable admissions, and honour what matters most to patients and families.

We will redesign end-of-life pathways to ensure that people experience:

- Earlier conversations and advance planning
- Clearer, smoother transitions between services
- Personalised and culturally tailored support across acute, community and mental health
- More choice and dignity in place of death

This builds on the NWL Specialist Palliative Care model and NCL's end-of-life transformation work.

4.8 Developing Robust Digital Infrastructure

A digitally enabled system is essential to delivering our strategy. We will:

- Improve interoperability and real-time information sharing
- Strengthen analytics and population health capability, increasing the integration of wider data sources to better understand our population and levels of risk
- Invest in analytics skills for non-analysts, to enable data driven decision making at all levels of the system
- Optimise the NHS App for patient journeys and activation
- Enable staff to work flexibly and in integrated teams, supporting the development of Neighbourhood Health teams

This aligns with the London SDE, NWL digital strategy and relevant NCL programmes.