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West and North London 10-year strategy: Health and Wellbeing Board discussion

17 September 2026

A new organisation creates the opportunity to think and commission differently

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Bringing together the legacy North Central London and North West London footprints creates a £12bn budget to improve health and care across our population. This organisational moment gives us the opportunity to set a clear long-term direction as the strategic commissioner responsible for improving the health of our population.

Combining scale with a sharper focus on place, population and outcomes.

THINK DIFFERENTLY	Combine insight, relationships and strengths across both legacy systems — while staying rooted in borough and neighbourhood needs.
COMMISSION DIFFERENTLY	Use population evidence, outcomes and value to shape priorities, resource decisions and the services needed for the future.
FOCUS RELENTLESSLY	Put inequalities at the centre, targeting action and investment where need is greatest.

The pressure on our health and care system is converging across outcomes, access and cost

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WNL is a £12bn system facing widening health gaps, rising expectations for, convenient access, personalised care and advice, digital-first experiences, joined-up services, and greater control over health — while costs shift toward crisis care.

OUTCOMES & INEQUALITY

17-year
gap in healthy life expectancy between WNL neighbourhoods

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

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

ACCESS IS SHIFTING

14%
of UK adults hold private medical insurance — 7.6m people

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

32%
lower private GLP-1 prescription uptake in the most deprived communities

HOSPITAL & COST

51% → 56%
acute share of spend, from 2019/20 to 2025/26

13% / 16%
potentially preventable emergency inpatient activity / low-intervention A&E attendances

>£1bn
projected "do nothing" deficit by 2035/36

Why this matters Without change, unequal access will grow while more of the budget is absorbed by avoidable hospital and crisis care.

Sources cited in the evidence base: FCA Financial Lives 2024; Broadstone/Burges Salmon 2025; Semble 2025; King's College London 2026; The Health Foundation.

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.

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.

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.

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.

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 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.

Strategy development roadmap: from final strategy to delivery

	Completed work ***May – July***	**Analysis & refinement** ***Late July – mid-September***	**Final strategy & governance** ***September – October***	**Mobilisation & delivery** ***October onwards***
Strategy development	• Draft strategy and priorities • Interim IHNA evidence base • Guiding principles agreed • Initial delivery approach	• Final IHNA and inequalities analysis • Finance/activity model to align resource to need • Cohorts, enablers and delivery framework	• Final strategy documentation • Leadership socialisation • ICB governance preparation	• Strategy delivery plan agreed • Priority programmes and delivery teams mobilised • Strategy informs the provider planning round
Engagement, OD & enablers	• Staff engagement approach in place • Stakeholder survey issued • Residents forum complete • Further engagement plan	• Analyse call for evidence • Ongoing staff and stakeholder engagement • Additional resident engagement	• External communications materials as needed • Staff engagement on final strategy and implications	• OD work begins to build a high-functioning strategic commissioner • Enabling work mobilised to support delivery • Staff, provider and partner engagement continues

Health and Wellbeing Boards: Translating the strategy into action

WNL direction of travel should help to focus borough priorities, shared delivery and the actions needed locally.

Actions for Health and Wellbeing Boards

1. ### Anchor the strategy in borough priorities

   Test the direction against the JSNA, local health inequalities, prevention priorities and wider determinants.

2. ### Align shared delivery

   Identify where local government, place partnerships and the ICB need to act together – particularly on neighbourhoods, children and young people, mental health, prevention and left shift.

3. ### Define local commitments

   Surface the specific actions, owners and dependencies needed locally to implement the strategy – including what the Board can help unlock.

How this should work in practice

Common direction	Use one shared narrative about the direction of travel
Borough lens	Ask what the strategy means for this borough, where shared delivery matters most and what needs to change locally.
Clear accountability	Ensure leadership for action, with sufficient structure to identify issues, actions and ownership.
One feedback route	Feed agreed issues and actions into the ICB through a clear route, avoiding multiple parallel conversations.

The ask today Where is shared delivery most important for this borough – and what can the Board help to unlock?

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Appendix / archive

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.

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

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.

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