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

NHS
North West London

The Integrated Needs Assessment and Aligning Resource to Need project

Bringing the intelligence and insights together to support planning, service design and decision-making

The Health of North West London

NW London has a young and relatively healthy population compared to some systems, but significant inequalities exist across ethnicity, gender, age, and deprivation.

We have significant inequality in our Healthy Life measure, driven by earlier onset of multiple long term conditions in deprived communities and in Black, Mixed and Asian communities

73% Of all patients are healthy/ Well, 9.9% higher than then national average

65% Of Asian patients are healthy/ Well , 3.4% lower than then national average

60% Of Black patients are healthy/ Well , 4.6% lower than then national average

North West London has a higher life expectancy than England, however, there is significant variation

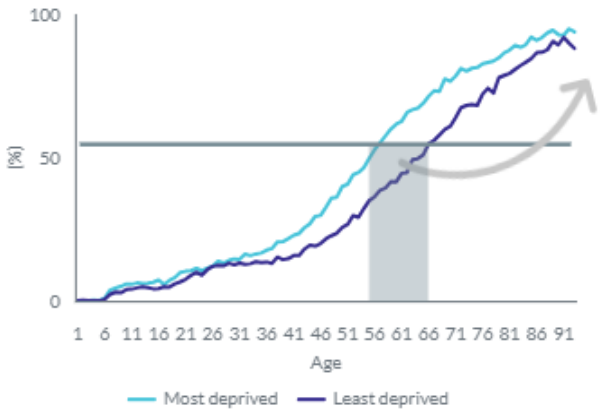
The latest data is from the ONS 2024 for years 2021-2023)

85 Females have a life expectancy of 85 years (England: 84)

80 Males have a life expectancy of 80 years (England: 80)

20 There is a gap of 20 years between some areas of NWL

Percentage of the population in ill-health

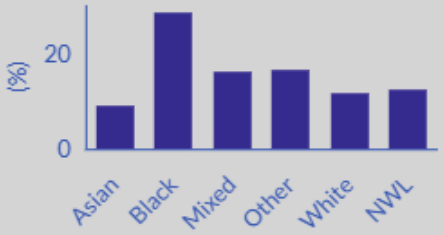


There is a 9-year difference in healthy life between the least of most deprived

Our most deprived community (our Core20 population) reports 50% of its population being multiple long term conditions at age 56, whereas the least deprived community reports this statistic at age 65

Based on 2025 WSIC data

Proportion of population living in the Core 20

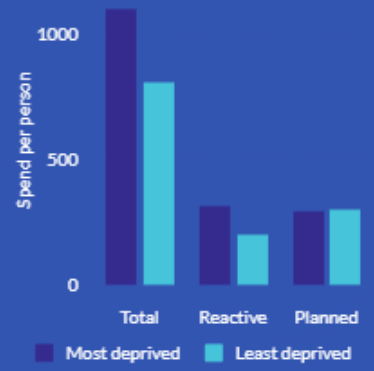


Our Black population is the most likely to live in deprived areas.

Our Black, Mixed and Asian population are more likely to experience multiple long term conditions even when controlling for deprivation, and feedback evidences experiences of systemic racism and poorer interactions with the health system

Likelihood of having multiple LTCs

Inequalities in spend per person



Average spend per person on reactive care is £1,100 in the most deprived areas of NWL compared to c.£800 per person least deprived areas. This is creating 38% of spend in reactive care in the most deprived areas vs 31% in the least deprived.

Based of 2024 ERNI data

The context in which we are working

We know that some of our residents and communities experience unequal access to services and that their experience and outcomes are poorer

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Introduction: to help us collectively understand and describe our residents the PHM team have focused on delivering two complimentary pieces of work – the Integrated Needs Assessment and the Aligning Resource to Need insights report

The Integrated Needs Assessment

What is it?

- The Integrated Needs Assessment (INA) is a health needs assessment for North West London.

What does it do?

- Identifies areas of need in North West London
- Provides a picture of the variation in need between different population segments
- Highlight areas of priority considering burden inequalities and impact
- Ultimately helps the ICB sharpen priorities and influences planning

The Aligning Resource to Need insights report

- *What is it?*
  - An insights report based on mapping of WSIC activity and associated spend
- *What does it do?*
  - focusses on activity and associated spend at a sector level (primary and secondary care, community care and mental health services)
  - delivers insights on activity and spend through a demographic lens (age/gender/ethnicity/deprivation)
  - provides data granularity to PCN level
  - helps us understand and attribute need to provide a more holistic picture of where and how we should be allocating our funds (phase 2)

These 2 pieces of work, whilst generated separately are complimentary and have been created to be used in partnership to support planning and decision-making at all levels across the organisation

Our focus on methodology: we have developed this to help us meaningfully and consistent apply data and intelligence led insights to the planning, design, delivery, monitoring and evaluation of our interventions and programmes

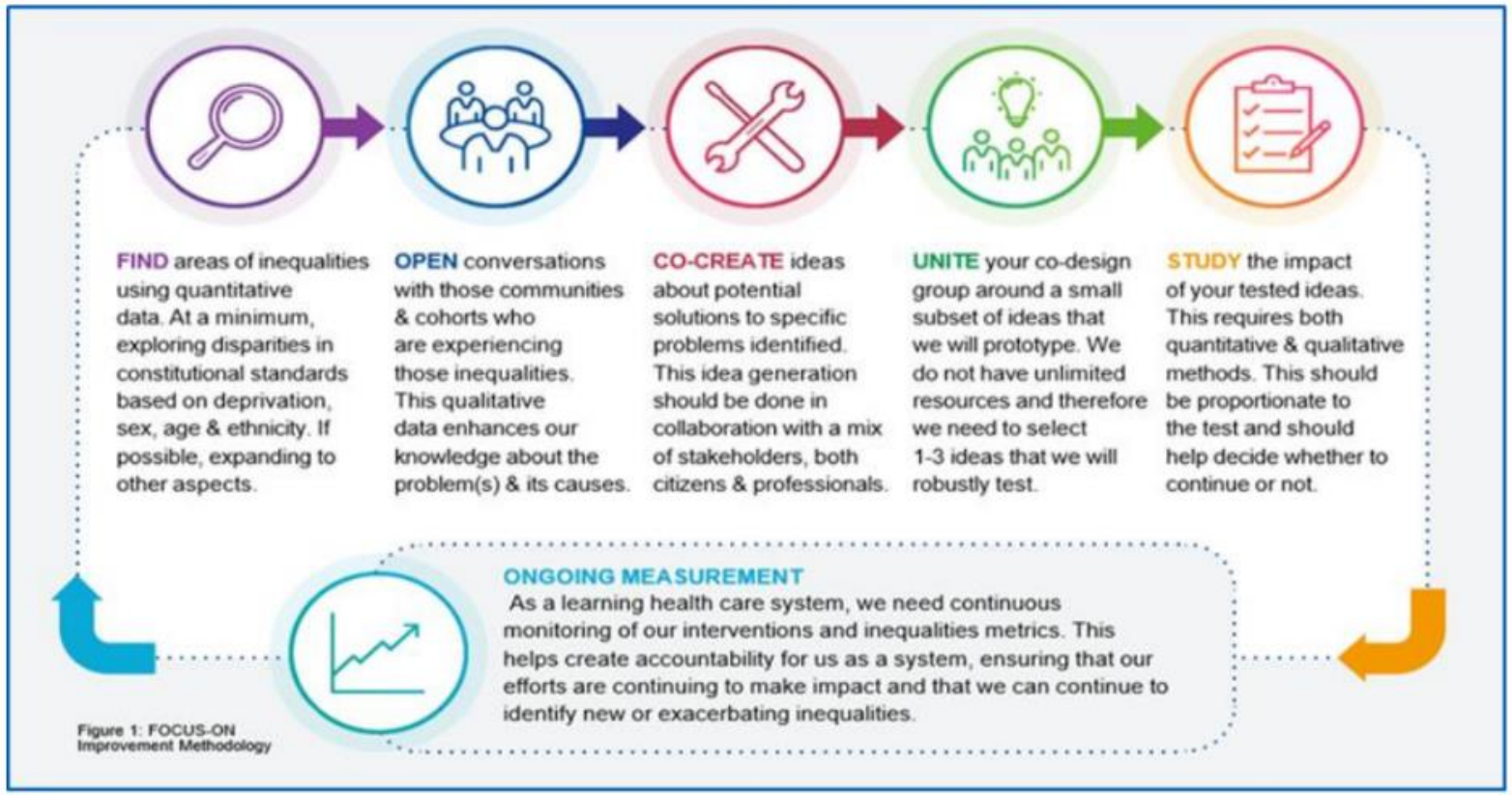


Figure 1: FOCUS-ON Improvement Methodology

The Focus-On methodology gives us a structured approach to delivering effective population health management.

The ability to find, analyse and describe the right data and intelligence are key components to delivering Focus-On, alongside other essential skills and approaches such as partnership working and communication, critical thinking and evaluation.

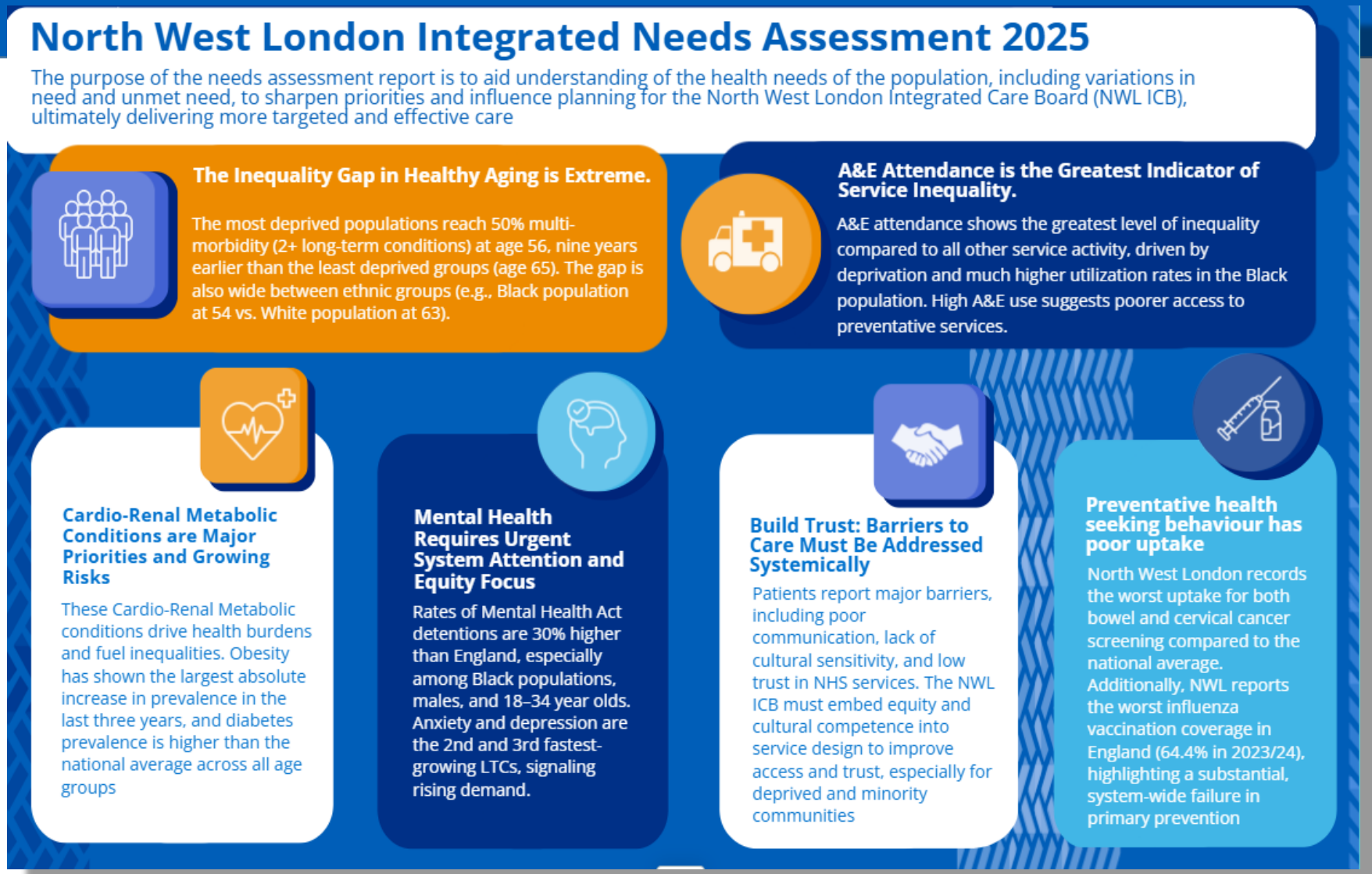
Our data and intelligence resources (e.g. the INA, the ARtN project and wider WSIC tools and products) helps us identify specific populations who are likely to benefit from services or are experiencing inequalities.
Our collective data and intelligence offer is an essential part of delivering the Focus-On methodology at all stages but is particularly important in stages **F**OCU**S**-**ON**

Hear more about PHM and the Focus-On methodology in our podcast

North West London Health Needs Assessment

[Integrated Needs Assessment 2025]

Shared Needs Assessment 2024



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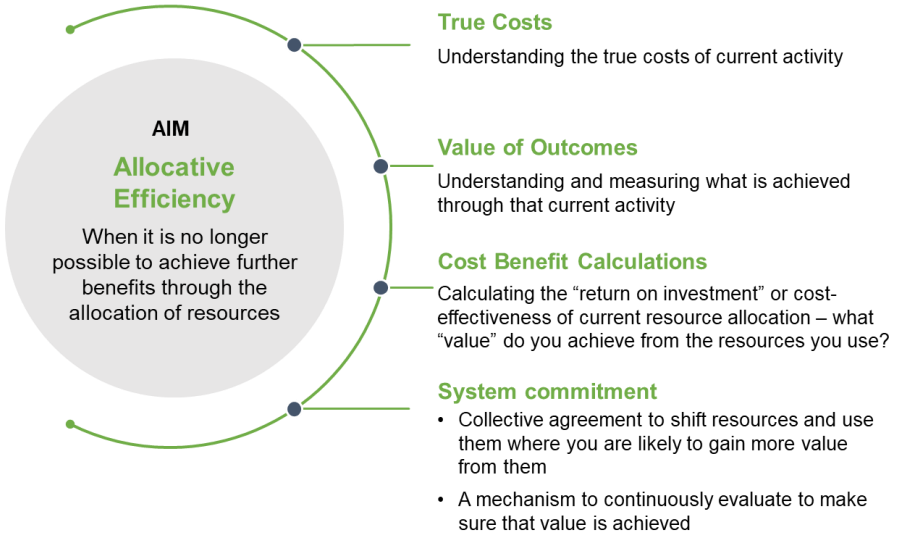
Aligning Resource to Need
Key project messages and insights

September 2025

The Aligning Resource to Need project was set up to help NW London understand where our resources are currently spent and help to move resources to where they have the potential to achieve the biggest impact on outcomes

- We commissioned Optum to analyse the NW London data to understand where we are currently spending our resources (i.e. current patterns of service demand). They have worked closely with finance and BI as well as health equity to connect activity and finance data to draw out insights in the pattern of spending, enabling us to make effective, informed decisions about funding
- Separately, we have also analysed methodologies to objectively measure need in our communities and have a clear plan to more fully understand the best fit for NW London
- This approach builds on the common core offer, which has mainly focussed on 'one size fits all', to start to target our resources to where they are most needed, enabling services to be tailored and aiming to achieve equivalent access, experience and outcomes between different communities
- This work can use opportunities around Neighbourhood Health to invest in models that can take a more proactive, preventative approach to working with communities. It is not just about moving money – it is about delivering activity in the optimum places, spanning boundaries, building on local assets, knowledge and expertise to help make better use of resource, and taking our communities with us on this journey, building trust through co-production
- Better targeting of resources should create more sustainability, having a significant impact on downstream activity and helping to mitigate the currently unaffordable cost trajectory



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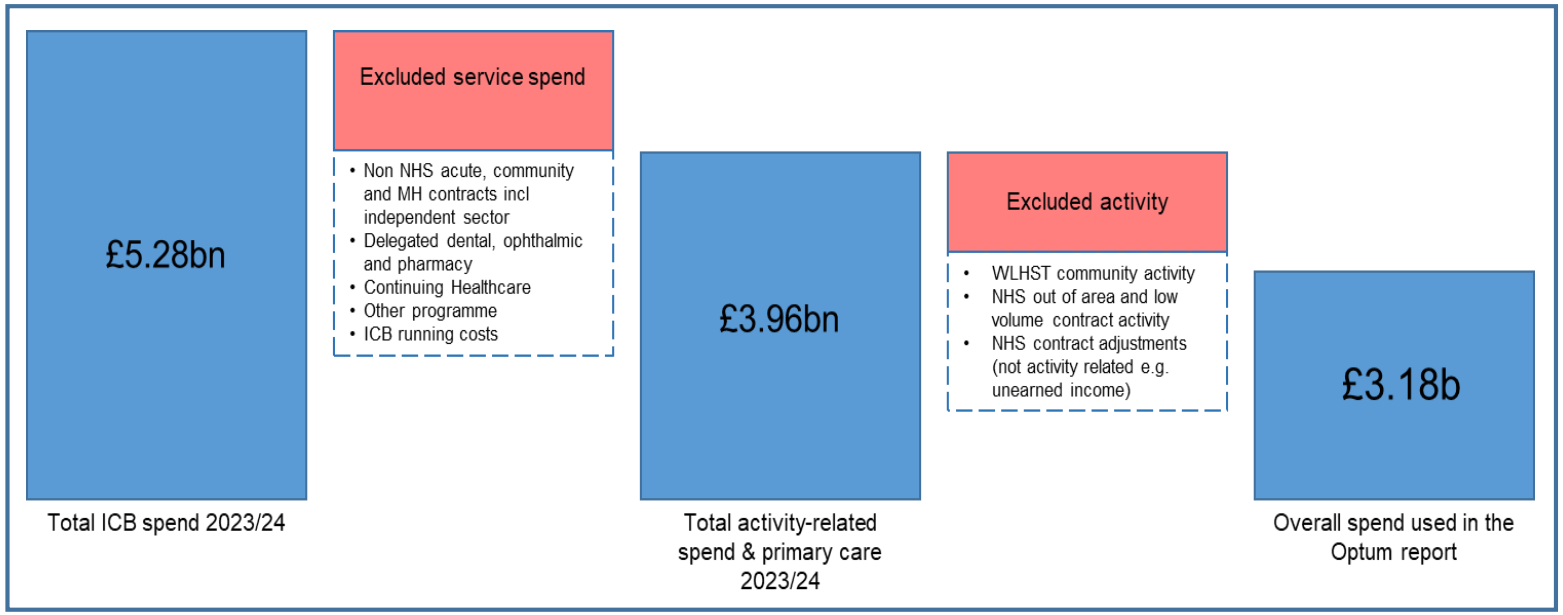
This work has helped to clarify where the NW London data gaps are that we need to work on

- At the start of this project it was found the WSIC data was not sufficiently robust to use. There were data gaps and issues reconciling activity to the contracting and commissioning datasets. BI team instead provided Optum with aggregate files covering 2023/24 activity from the contracting and commissioning server 'ERNI' which houses the SUS, SLAM and PLD from providers
- The finance team worked with Optum to ensure the activity and finance in the aggregate files could be reconciled to the 2023/24 ICB reported spend. The datasets from acute providers include activity and price. Non-acute data sets do not include price and so a set of unit price assumptions for MH and community data were provided by the finance team based on the core offer and contract true-up work for 2023/24
- The diagram to the bottom right attempts to summarise the data exclusions. Note that we have not included any adult social care data (does not form part of the £5.28bn ICB spend) in this analysis and have had to exclude WLNHST Community data as it was not considered robust enough to include at this stage. Of the data that has been included some is incomplete, in particular for key health inequity fields and demographics, and which may impact the outputs and insights
- In the intervening period, some improvements have been made internally to WSIC and we are currently working to incorporate these into next steps alongside the additional developments required to improve data quality and help with this type of work in future



The key insights from the Optum analysis are four areas of focus around reactive spend in areas of deprivation, access by gender, ethnicity and mental health disparities

Focus area 1 – tackling health inequalities in areas of deprivation

There is higher spend in people from the most deprived parts of NW London predominantly in reactive services such as mental health admissions and acute emergency care. Spend per head on reactive care is £1,100 in the most deprived areas of NW London compared to c.£800 per head in the least deprived areas. This is creating **38% of spend in reactive care in the most deprived areas vs 31% in the least deprived.**

Deprivation drives earlier and more complex illness, with high levels of recorded prevalence in Depression, Obesity, Diabetes, multi-morbidity and variation by ethnicity

Elevated emergency care costs and lower GP appointment spending in the most deprived communities may reflect unmet primary care needs and/or treatment delays.

Focus area 2 – design for gender and future demand

There is higher spend in all areas on females than on males, apart from Mental Health admissions

Spend per head on females in NW London is c.£1,100 and for males is c.£800. **Disparity in share of spend is seen highest in Acute Planned (61% vs 39%) and Mental Health Non-Admitted (55% vs 45%). Conversely, for Mental Health admitted the % spend for males is 59% vs 41 for females.**

Across ethnicities women use more planned/preventative care (especially in childbearing ages), whereas men access care in more reactive service (likely due to delay in seeking help), particularly those in non-White ethnic groups.

Men aged between 15 -24 have high mental health spend.

Focus area 3 – close gaps by age & ethnicity

Spend rises with age, with increased spend across all age groups in more deprived areas. Spend per head on those aged 85+ is nearly 3x that of younger groups

Asian and White–Other ethnicity groups have low spend per head and disproportionately lower than average spend across nearly all care settings. The percentage share of spend for these groups is also lower than the population share.

Per head expenditure varies by ethnicity, with **the White British/Irish population spend at £1,174, compared to £698 per head for the Asian population.**

Black and Mixed ethnic groups exhibit higher-than-average spending in Mental Health and Acute Activity, indicating greater utilisation or a higher demand for reactive or crisis services

Focus area 4 – mental health inequalities

Black adults represent 18% of the population and 26% of mental health admissions compared to Asian adults who form 28% of the population and 17% of mental health contacts (non-admitted)

Spend normalises for the Black Ethnic group in areas of low deprivation, however spend for the Mixed Ethnicity group remains high across IMDs with those **residing in IMD 9&10 areas demonstrating more than twice the normalised spending.**

Whilst the age group 25-34 shows the highest total expenditure for Mental Health - Admitted (£15.5m), the average spend and proportion of total spend is greatest among those aged 70-84.

The spend per head for non-admitted interventions is £96, however spend per head in IMD1 is £166.

Further data analysis has shown spend in the populations living in the most deprived parts of North West London is significantly higher than in the least deprived parts

- The highest cost per head (around £1,100 per person) is for those populations living in decile 1*, and 38% of this spend is in reactive care – associated with mental health and acute emergency services. This compares to around £800 per person and 31% of spend on reactive care in the least deprived areas
- Elevated emergency care costs for our most deprived may reflect unmet primary care needs or delays in treatment: GP appointment spend is the most skewed towards our least deprived communities out of all categories of care setting analysed
- Focussed investment in preventative and proactive care for those communities living in deciles 1-3 could drive down demand for high cost reactive services and contribute to better health outcomes for communities (Communities living in deciles 1-3 make up 31% of overall spend and constitute 28 % of the total population)

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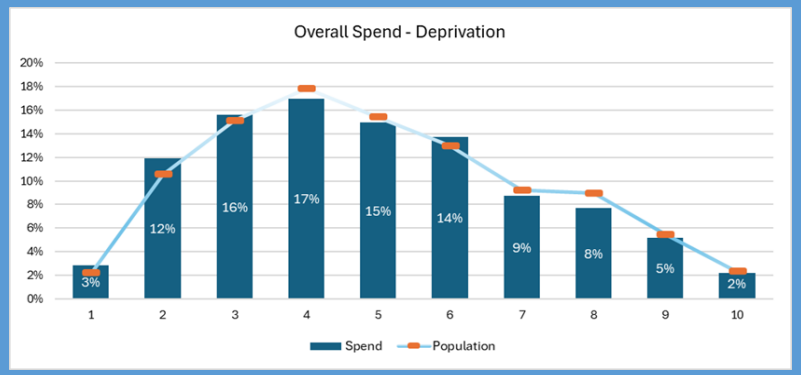

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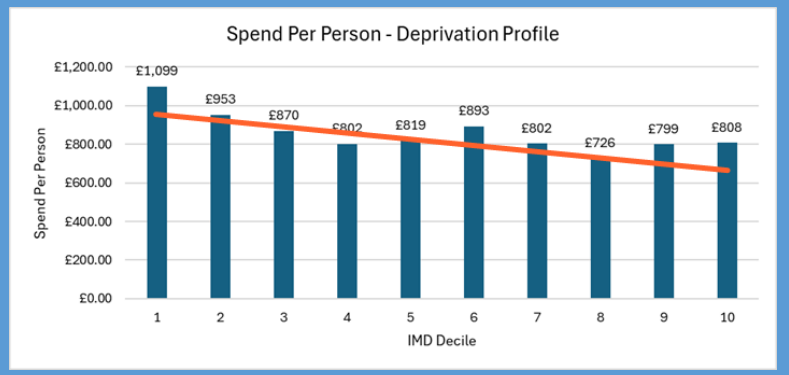

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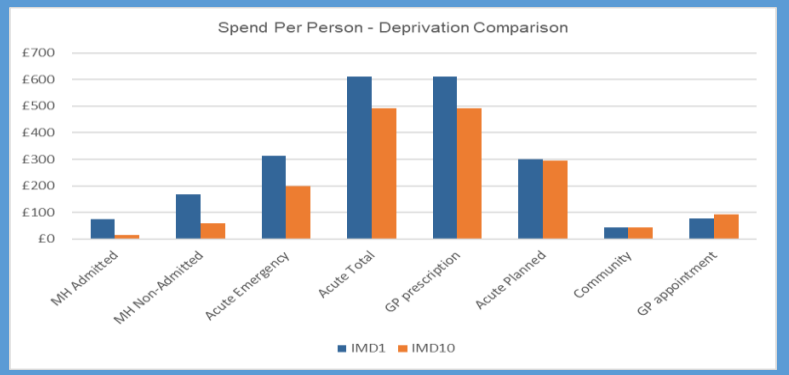
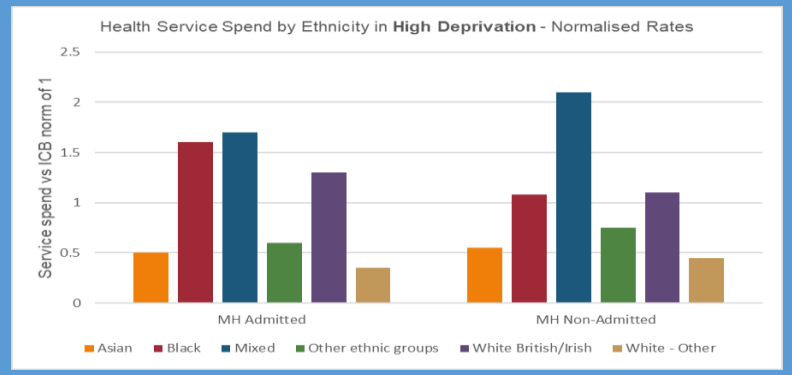


* Decile 1 (HIGH deprivation) – Decile 10 (LOW deprivation)

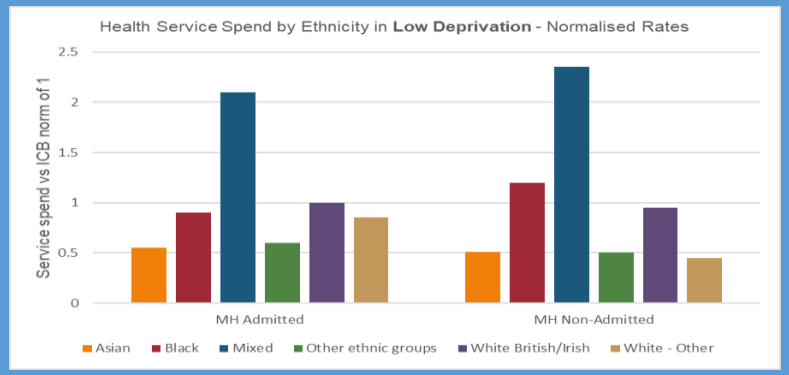
For mental health, we are seeing higher levels of spend on admissions for our black and mixed communities

- Expenditure on Mental Health (MH) admissions and MH contacts (non-admitted) is significantly above average within deprivation deciles 1-3
- Our NW London black population is overrepresented in mental health admissions (26% of spend but only 18% of the population), which is particularly falling in our most deprived communities. There is high spend in *both* high and low deprivation areas in our Mixed Ethnic groups (in areas of low deprivation this group exhibit more than twice the normalised spending on mental health services, a pattern similar to that seen in the most deprived areas but with even greater deviation from the norm)
- MH admitted services is the only care setting where there is greater expenditure on males than females
- Conversely, for non-admitted mental services, females account for 66% of the total spend despite constituting 49% of the population. This trend is observed across ethnic groups, with the disparity being more pronounced in less deprived areas – 72% female spend versus 28% male in IMD deciles 8-10. This implies that the upstream mental health investment is not targeting the right population groups
- For non-admitted mental health services, 15-19 year old spend is high compared to the population share, with expenditure in this group representing 12% of the total spend whilst comprising only 5% of the population
- 25% of the total spend in non-admitted mental health services is allocated to individuals in the Mixed ethnicity category, despite this group representing only 4% of the population

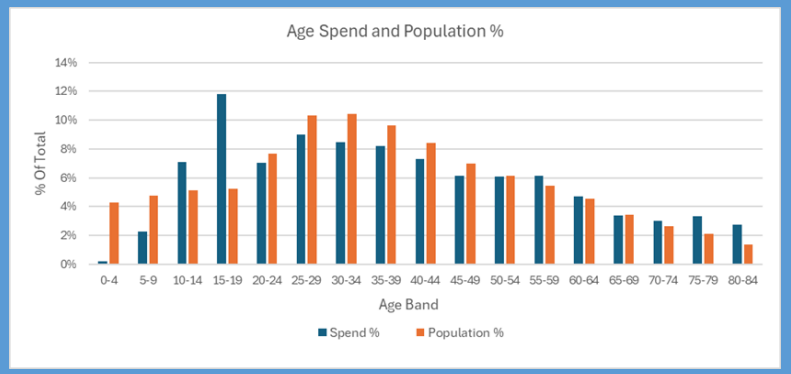
1 – MH admitted



2 – MH admitted



3 – MH non-admitted



Our highest per person spend is on our White and Black ethnic groups, with our Asian and White–Other groups having low spend

- Asian, Other Ethnic Groups and White–Other ethnicity groups have lower than average spend across nearly all care settings, with the percentage share of spend being lower than the population share
- Mental health services exhibit the most inequalities, particularly affecting Black and Mixed ethnic groups, as shown on the previous slide
- White–Other ethnicity group (mostly from Eastern Europe) has low relative spending across health services, other than for GP appointments where it is above the normalised rate of 1.0. Understanding this better may inform particular behaviour patterns or perceptions of services
- The low relative spending among Asian and Other Ethnic Groups may reflect cultural or language barriers, mistrust, lack of awareness or systemic inequalities in access. Further investigation will help us understand this better and triangulate with other key lines of enquiry around quality and consistency of data capture, use of private/non-NHS services, etc. In addition, the ethnicity group inclusions for these categories may be too generic, and further sub-analysis will help identify specific community needs

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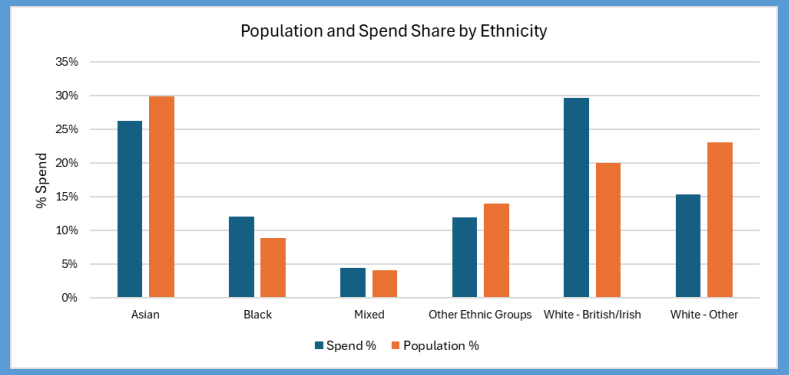

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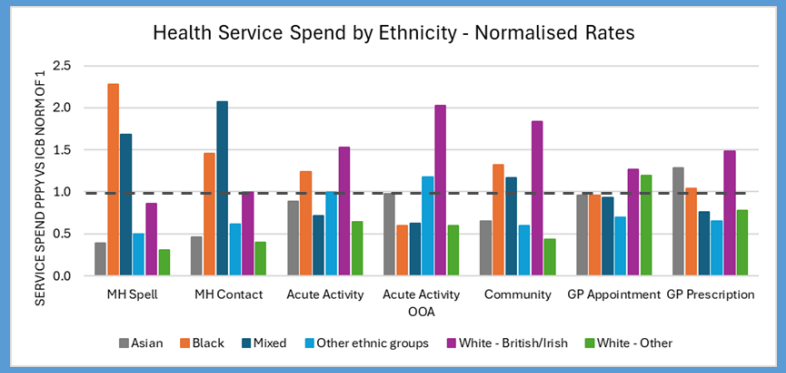

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Ethnic Group	Acute Emergency	Acute Planned	Acute Total	Community	GP Appt.	GP Prescription	MH Non-Admitted	MH Admitted
Asian	£165	£212	£377	£35	£64	£142	£58	£22
Black	£257	£259	£516	£72	£64	£115	£182	£127
Mixed	£121	£181	£301	£64	£62	£85	£259	£93
Other Ethnic Groups	£209	£216	£425	£33	£47	£72	£77	£27
White - British / Irish	£330	£323	£652	£100	£84	£165	£124	£48
White / Other	£118	£152	£270	£23	£79	£86	£50	£17
Whole Population	**£200**	**£224**	**£423**	**£50**	**£69**	**£119**	**£91**	**£39**

Spend rises with age, gradually increasing from 45 onwards and then rising rapidly from 75 onwards

- **Children and Adolescents (0-24 year):** there is high use of GP appointment and acute emergency services, especially among the youngest age groups (0-4). Mental health non-admitted care spikes in ages 15-24, highlighting rising mental health needs during adolescence and early adulthood. In ages 0-19, expenditure remains relatively stable across deprivation levels, although the highest average spend is still observed in the most deprived group at [3] over £400 per person
- **Working age adult (25-64 years):** there is balanced service use across GP appointments, acute planned care and community services compared to other age groups. Overall spending gradually increases from around 45 onwards, likely reflecting the emergence of chronic conditions and greater reliance on reactive care. Higher costs for women primarily due to maternity and gynaecological care. Expenditure averages £755 per person in the most deprived decile (IMD1) compared to £536 per person in the least deprived decile (IMD10), indicating a 30% reduction.
- **Older adults (65-84 years):** there is a marked increase in community and acute planned service use, reflecting elective procedures, rehabilitation, and chronic disease management.GP appointments are higher than earlier ages. Older adults consistently incur the highest expenditures by a substantial margin across all deprivation levels. Spending peaks in the most deprived areas, averaging approximately £2,400 within the top three deprivation deciles, while it declines with increasing affluence, reaching around £2,100 in the least deprived areas
- **Elderly (85+ years):** dominated by community care and in increase in acute emergency services, with per person spending nearly 3x that of younger groups

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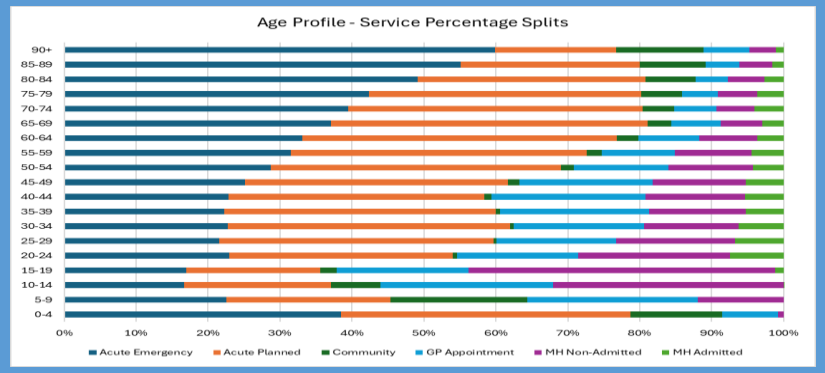

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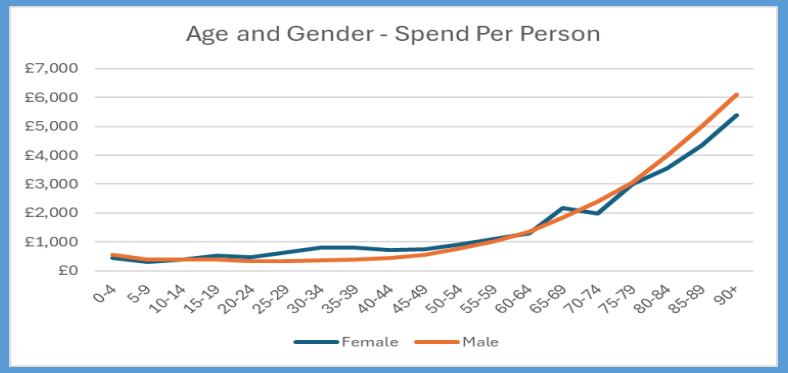

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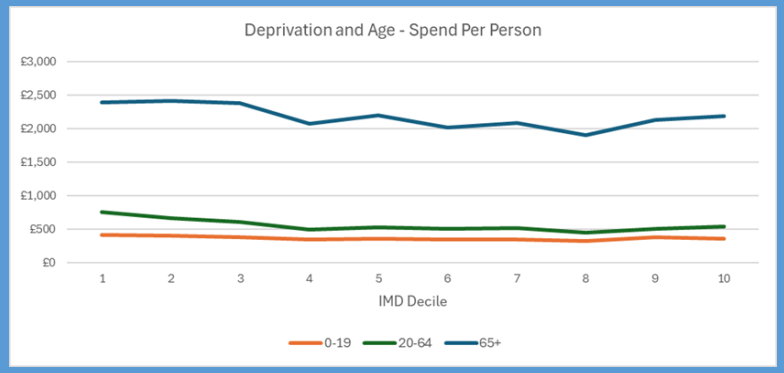

A brief summary and some key questions for the group

Summary

- These resources are designed to help partners across the system with planning, service design and decision-making
- They provide different lenses on various data sets relevant to NW London
- They will not provide all the answers and are designed as a system wide point of reference to then prompt questions, inquisitiveness and additional key lines of enquiry
- This data should be used in compliment with additional data analysis and both wider qualitative data and the rich local data that you have available at place

Some questions for the group

- Are these reports useful? Is this data useful? If so, how might it help you in your role? How would you use it and where would you take it?
- Does any of the data/insights come as a surprise?
- Is there something else that you'd like to be able to see from these two pieces of work?
- What else can we do to help you use these reports effectively?