IMPERIAL COLLEGE HEALTH PARTNERS

Impact Report

2025/26





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Key themes

There are three key themes running through this report, reflecting what ICHP does to create lasting value for the North West London (NWL) system.

Theme 1

Testing and scaling

Taking ideas from promising to proven to adopted at scale, across cardiovascular disease, discharge, community detection, and neurodevelopmental pathways.

Stories include:

- **Neighbourhood health:** Treating people differently
- **Discharge optimisation:** How can we fix the 15% problem?
- **Needs-led support and rapid diagnosis for neurodivergence:** Change is coming, you are being heard

Theme 2

Data and real-world evidence

Generating the evidence that helps the system understand what works, for whom, and why at population scale.

Stories include:

- **Discover-NOW / London Secure Data Environment:** North West London's pioneering health research hub is now being scaled to the whole of London
- **North West London Networked Data Lab:** What six years of research partnership looks like in practice

Theme 3

Partnerships

Building the relationships and coalitions that make system-wide change possible, across the NHS, industry, academia and community.

Stories include:

- **Clinical Effectiveness Group:** What's the story behind achieving high performance?
- **Scaling quality improvement across the region:** Designing systems that protect by default
- **Office for Life Sciences / Innovation Exchange:** Getting an innovation approved is just the start – the journey is getting it to the people who matter
- **A system-wide approach to obesity:** Not a programme, but a movement

Foreword



Three years ago, we decided to do fewer things, for longer, with greater impact. This report celebrates what that decision made possible.

Health and care in North West London (NWL) face the same pressures as every system across the country. Demand is rising. Resources are constrained. The workforce is stretched. And the pace of innovation in medicines, technology and data is accelerating, creating opportunity and complexity in equal measure.

In this context, the temptation is to spread effort across many priorities, to demonstrate activity, and to respond to every challenge. We have deliberately resisted that temptation. Instead, we have focused on fewer bold, system-wide missions, and committed to them with the depth and duration real change requires.

It is not a complete account of ICHP's work. It is a selective, honest, and, we hope, useful account of the work that has moved furthest, reached most people, and generated evidence and momentum reaching beyond NWL.

Across nine stories, organised into three themes, you will find clinicians and communities working to detect cardiovascular disease where people already gather. Teams of analysts and research partners generating evidence on the questions that matter most to local people. Partnerships between the NHS, innovators, industry and the voluntary sector producing results none of us could reach alone.

You will also find honesty about what has not been easy. Good ideas taking longer than they should to find a home in the system. Funding mechanisms that still do not fully support preventive, long-horizon work this approach demands. The persistent gap between evidence and adoption that the health innovation sector is working to close.

We share both progress and challenges because that is more useful than a report that only celebrates. The NHS and its partners do not need more glossy summaries of innovation in theory. They need honest accounts of what it looks like in practice, including where the system makes it harder than it should be, and what we are learning about changing that.

What gives me most confidence is not any individual result, though some results here are genuinely significant. It is the quality of the partnerships behind this work. Our Integrated Care Board (ICB) colleagues, co-owners of these missions. The clinical leads who have shaped our work from the inside. The community organisations and resident voices who bring perspective no dataset alone can provide. And the industry and academic partners whose investment in NWL reflects a belief that serious innovation can happen here.

The next chapter is already forming. A new mission on obesity is being built with and for communities. The London Secure Data Environment is now opening research possibilities unavailable a year ago. A Clinical Effectiveness Group is demonstrating what population health improvement could look like when properly resourced and led. And in communities across our eight boroughs, people are being reached and supported who the system would not have found a few years ago.

As one of 15 health innovation networks in England, we are committed to ensuring what we learn locally contributes to national progress. Local change, national scale: that is the standard we hold ourselves to.

We share this not as a conclusion but an invitation. If you are working on challenges that require the same focused, long-term, collaborative approach these pages describe, we would like to hear from you.

Dr Dominique Allwood MBE
Chief Executive Officer,
Imperial College Health Partners

Our year in numbers

#1 in England for hypertension treatment

+10m people in London Secure Data Environment (from April 2026)

£6.5m direct revenue and investment leveraged for system and industry stakeholders

+1,000 people and organisations involved and engaged in our work

Revenue and investment leveraged includes:

£3m
in NIHR research infrastructure investment

£2.5m
to support real-world evidence validation of innovation in real-world settings

£375k
industry funding to support co-design of holistic cardiorenal metabolic clinics

£250k
to support implementation of digital solution to enable faster diagnosis for neurodevelopmental conditions

£50k
to support placement and evaluation of health kiosks

People and organisations involved and engaged in our work includes:

270	clinicians upskilled via our Patient Safety Collaborative events across Maternity and Neonatal
224	innovators supported through our Innovation Exchange function, with 60 of these directly supporting the NWL Missions
165	colleagues across NWL's innovation ecosystem brought together via our partnership events with Paddington Life Sciences
150	stakeholders involved in two Innovation Forums
125	patients and members of the public engaged in our work, including 6 Lived Experience partners
+125	colleagues attended the launch of our Mission Learning report
37	NWL residents involved in deliberating priorities for the NWL mission on obesity

How the health innovation networks are contributing nationally:

+7m
patients have benefited from our national and local programmes since 2020 (2.1m benefiting in 2025/26)

+740k
hours of healthcare staff capacity released through our programmes and initiatives since 2020

+£4.4bn
in investment leveraged for places, regions and innovators since 2018

+12,600
jobs created or safeguarded through our support to innovators since 2018

3:1
return on investment through our support to innovators (using Treasury Green Book methodology)

Theme 1

Testing and scaling



Neighbourhood health

Treating people differently

From waiting for patients to turn up when something has gone wrong, to supporting people holistically with the multiple health challenges they face. In NWL, a mission-driven approach to cardio-renal-metabolic (CRM) health is showing what happens when the system decides to work differently.

> ***"I was once given a gym membership and told to exercise more, but that doesn't solve everything. It doesn't take into account real-life challenges, like childcare or being a single mum, or what actually works alongside daily responsibilities.***
>
> ***Hearing patient stories makes teams think more outside the box. That's why it's so important to have patients in spaces like the Innovation Forum, to show how different our lives are and to really reinforce that it's not one size fits all."***
>
> Ayọ, Lived Experience Partner, NWL CRM Innovation Forum

Ayọ spoke at the NWL CRM Innovation Forum, one of a growing number of lived experience partners whose voices are shaping how the system thinks about cardio-renal-metabolic care. Her experience of being given a gym membership when what she needed was someone to ask about her actual life is not unusual. It is, in fact, the gap that the entire CRM mission was designed to close.

Around 580,000 residents of NWL are estimated to be living with CRM conditions. For years, the conventional approach has been to manage these conditions separately: one appointment for blood pressure, another for diabetes, another for cholesterol. It works reasonably well for the people who can show up. However, many people have interconnected conditions with the same risk factors and treating those conditions in siloes instead of holistically does not benefit the patient or staff.

Who the CRM mission is built for

Residents with CRM conditions do not arrive in a simple clinical category. They arrive as a person with a family, a job, a commute, a list of competing priorities and, often, a long history of feeling that the health system was not quite designed with them in mind.

Preventing worsening conditions

Davide, 45

Sole earner. Works long shifts in a manual job. Has a two-year-old who wakes frequently at night. His partner is managing her own health issues. He knows he is at increased risk of heart disease and kidney problems – recent check-ups have shown concerning trends. He wants to act, but work demands are unpredictable, he often misses meals, and he rarely has uninterrupted time to focus on himself.

Davide needs practical support that fits into his hectic life, not advice that assumes he has time, energy, or money to spare.

The CRM mission exists to respond to this reality, not with a single intervention, but with a coordinated approach that brings together NHS teams, voluntary organisations, community groups, pharmaceutical partners, and residents themselves.

The Harrow model: a different kind of appointment

In 2024 the London Borough of Harrow co-designed, developed, and piloted a new model of cardio-renal-metabolic care to help tackle the rise of chronic kidney disease (CKD) and CVD events. Instead of the standard 10-minute GP appointment (see one condition, prescribe, move on), patients with two or more risk factors were offered two 30-minute slots. Time to talk about what actually mattered to them. Time to connect their diabetes management with their blood pressure, their weight, their lifestyle.

ICHP supported the design of what those clinics could look like, working alongside the clinical team to shape the model from the outset. The approach drew on personalised care and lifestyle medicine principles, training staff to have holistic conversations that went beyond individual conditions.

Crucially, the programme recognised that kidney disease sits at the heart of the CRM picture: early intervention in CKD, combined with better management of cardiovascular and metabolic risk, addresses one of the most pressing but least visible challenges in NWL's primary care. What followed wasn't just better patient experience, it was measurable clinical improvement. Weight came down. Cholesterol levels improved. Patients and staff were more satisfied. The model worked.

- statistically significant reduction in BMI (-2.6 units)
- modest but significant changes in cholesterol measures
- 7.2 percentage points more likely to be prescribed SGLT2 inhibitors and 5.0 percentage points more likely to be prescribed ACE/ARB medications, indicating optimisation of cardio-renal-metabolic management (i.e. more likely to be prescribed best-practice medications)

What mattered equally was what happened next. In 2025/26, working with NWL ICB colleagues across the region, ICHP supported conversations that helped the Harrow approach shape thinking beyond one borough. An enhanced service specification, incorporating elements of the Harrow model, was developed by the NWL ICB. And through a pharmaceutical partnership, funding was secured to support more Primary Care Networks (PCNs) to deliver this new type of care.

> ***"It's about bringing new ways of working into the system. Not new technology – just a better way of doing things."***
>
> Clare Thomson,
> Innovation Lead, ICHP



The CRM mission in numbers

~580k

NWL residents estimated living with obesity-related CRM risk

6

Additional PCNs now testing the CRM care model

~350

Staff supported through system-wide CRM education

2,500

People treated in a holistic CRM clinic, with significant reductions seen in BMI and cholesterol levels

£375k

Pharma funding figure leveraged into the system

Building capability across the system

Clinical change doesn't happen just because a model works in one borough. It happens when clinicians across the system understand it, believe in it, and have the skills to deliver it. That's why education and workforce development have been a core part of the CRM mission from the start.

Around 350 staff have been supported through system-wide education and skills development, spanning webinars, non-promotional educational events supported by pharmaceutical partners, and hands-on clinical training. An Innovation Forum, held in February 2026, brought together around 75 people from across primary care, secondary care, public health, innovators, residents and the ICB to explore self-management and CRM care.

The goal is "collaboration, accelerating and embedding – really getting things embedded into business as usual," as ICHP Innovation Lead, Clare Thomson, puts it. That is harder than it sounds in a system that moves fast and has limited bandwidth. But it is the only measure of success that really counts.

A movement, not a programme

The connections the mission has created extend beyond any individual workstream. Cross-borough conversations that wouldn't otherwise have happened. A collaboration on evaluation design between NWL boroughs that is generating shared evidence neither could produce alone.

Conversations are also underway about a London-wide CRM academy for clinicians – working with other London health innovation networks to explore whether training and learning can be pooled across the capital rather than developed independently in every patch. Sponsorship is being sought to support this. It is an aspiration in active development, not yet a confirmed programme.

"There's a sense of us growing together and evolving," Clare reflects. "The whole system is moving towards this CRM approach."

Education and workforce development have been a core part of the CRM mission from the start. Around 350 staff have been supported through system-wide education and skills development.



Discharge optimisation

How can we fix the 15% problem?

When one in seven hospital patients no longer needs to be there, the question isn't whether to act, it's how to solve this growing problem. At Chelsea and Westminster Hospital and Hillingdon Hospital, a digital discharge platform and a determined team proved that real-time data changes everything. Now the model is ready to travel.

The challenge

On any given day across NWL's hospitals, around 15% of inpatients no longer meet the clinical criteria to remain in hospital – what the NHS terms 'no-criteria to reside' (NCTR).

These patients are medically fit to leave. But without a clear, real-time picture of where each person is in their discharge journey, delays accumulate. Beds stay occupied. Capacity is lost.

The approach

Platform	OPTICA – a digital discharge coordination tool built on the NHS Federated Data Platform (FDP) was deployed at Hillingdon Hospital to give discharge hub teams real-time visibility of patient journeys, pathway status and what was holding up each discharge.
Evaluation	ICHP led an evaluation of OPTICA deployment, published November 2025. The evaluation measured NCTR bed day reduction across P1 and P3 discharge pathways, decision-making quality and staff experience.
Tools produced	The evaluation generated three practical outputs for the system: an evaluation report, an implementation toolkit, and a lessons learned document, all designed so that other trusts can replicate the approach without starting from scratch.
Scaling mechanism	Because OPTICA is built on the NHS FDP, it can be adopted by any trust using the same infrastructure, in NWL or beyond, without significant rework. Build once, deploy many times.

The outcome

At Hillingdon, the results of the OPTICA deployment were clear: NCTR bed days fell by 23% for patients on P1 and P3 discharge pathways. Decisions were made faster. Communication between teams improved. Patients went home sooner.

Beyond the numbers, the evaluation revealed something equally important: the conditions that made it work. A discharge hub team that could see the full picture. A champion with the authority to act on it. And a platform that could carry the learning forward.

When we get traction, it's because someone inside sees it aligns with something they already want to do and has the courage to take a leadership role in it.

The implementation materials produced through this work are now available across the system. Any acute trust facing similar NCTR pressures can draw on the evaluation findings, the deployment toolkit, and the lessons learned, without needing to commission new work from scratch.

What comes next

The next step of this work was to scale the use of OPTICA across all acute trusts and their respective local authorities in NWL. To support this, North West London ICB commissioned The Public Service Consultants (PSC) as a delivery partner to roll the approach out across the system.

OPTICA's impact on staff time spent on discharge planning was clear. However, whilst some discharge metrics were positive, some findings were mixed. Despite the 23% reduction (p = 0.031) in NCTR bed days at Hillington, at Chelsea and Westminster, our results were mixed with differences in impact at patient and aggregate-level. This indicates the need for longer-term study.

Partners

- **Hillingdon Hospital and Chelsea and Westminster Hospital**
  OPTICA evaluation sites
- **Chelsea and Westminster Hospital**
  Length of stay prediction pilot site
- **NHS England**
  Partner in developing predictive length of stay tool
- **NHS Federated Data Platform**
  Shared technical infrastructure enabling portability
- **ICHP**
  System coordination, evaluation lead, implementation toolkit, UX research



Discharge optimisation in numbers

23%

reduction in unnecessary bed days at Hillingdon Hospital

Patients on P1 and P3 discharge pathways – OPTICA evaluation, November 2025

+990

staff hours freed up annually at Hillingdon Hospital

3

implementation tools published and ready to use

>£62k

estimated annual productivity savings for Hillingdon Hospital



Needs-led support and rapid diagnosis for neurodivergence

Change is coming, you are being heard

For thousands of children across NWL, the wait for a neurodevelopmental (ND) assessment can be years. A new approach – one that puts support before diagnosis, and children before bureaucracy – is changing that.

The week of the NWL ND Needs Profiling Innovation Forum in February 2026, a new government white paper, 'Every child achieving and thriving', on neurodevelopmental support landed. For many parents of children with ADHD, autism, and other neurodevelopmental needs, it brought more anxiety, more uncertainty, and a familiar sense of being buffeted by change rather than feeling progress.

Carol Foyle, parent representative, arrived at the forum feeling that weight. She left feeling lighter, and more hopeful that good change is on its way.

That feeling was the result of months of careful, deliberate work, mapping the system's pain points, designing a new approach to neurodevelopmental support, and building the coalition of clinical, educational, and community partners needed to make it real.

A broken system and why patching it is not enough

NWL's ND waiting list continues to grow, with more than 8,000 children and young people waiting for assessment. While non-recurrent funding can temporarily reduce the backlog, demand quickly returns.

The challenge is structural. Many children and young people do not need a diagnosis to access school support, benefits or help at home, yet families often feel it is the only route to getting support.

"The system reinforces a situation where families feel they need a diagnosis in order to access support," says ICHP Innovation Lead Catherine Fraher. "What we're trying to do is change that."

In response, North West London is taking a two-pronged approach: improving the existing diagnostic pathway while expanding early support options that help families get the support they need sooner, reducing demand for assessment where it is not required.

Branch one: Neurodevelopmental pathway solution

A digital tool that streamlines and automates the referral and assessment pathway, removing unnecessary administrative tasks such as manual questionnaire scoring, chasing information from schools and GPs, and managing ineligible referrals. This frees clinicians to focus on assessment and support, while giving service managers real-time oversight of pathway performance. Designed to fit existing processes, it integrates with multiple electronic patient record (EPR) systems rather than requiring infrastructure changes. Go-live is planned for Autumn 2026, with evaluation in early 2027.

At a glance:

- Automates and digitises the referral and assessment pathway
- Reduces administrative burden, freeing clinicians and frontline teams to focus on care and support
- Works alongside existing pathways and integrates with multiple electronic patient record (EPR) systems
- Provides service managers with real-time visibility and oversight
- Go-live: Autumn 2026
- Evaluation: Early 2027

Branch two: Needs Profiling – shifting where support begins

A needs-led approach that focuses on support rather than diagnosis as the starting point. Young people, their parents or carers, and school Special Educational Needs and Disabilities Coordinators (SENDCo) work together to identify strengths, unmet needs and the support required, creating a holistic needs profile and practical action plan. Clinical assessment remains available where it adds value, but early evidence suggests many children and families benefit from earlier support without entering a diagnostic pathway. NWL will pilot a fully evaluated, technology-enabled model, capturing outcomes from day one. Go-live is planned for the end of 2027.

At a glance:

- Needs-led conversation involving the young person, parents or carers, and school SENDCo
- Provides practical support without requiring a diagnosis first
- Pioneer sites have reported indicative reductions in new referrals of up to 40%
- North West London will pilot a fully evaluated, technology-enabled approach
- Pilot go-live: End of 2027

From forum to pilot: a shift in mood before a shift in system

The NWL ND Needs Profiling Innovation Forum, held in February 2026 was designed to test whether the system was ready for this change. The answer was unambiguous.

Eighty-two leaders from across NWL's health, education, local authority, and voluntary sectors gathered at the end of a week in which the government's ND White Paper had unsettled and energised in equal measure. The forum was deliberately structured around borough tables, so the question of whether to pursue ND profiling was answered collectively – by the people who would have to deliver it. Every table clustered towards "explore this here."

"I thought we were going to get quite a spread of votes," Catherine recalls. "I was wrong. They all clustered near 10." The feedback that followed – from clinical leads, parent representatives, heads of inclusion and NWL ICB directors – was more than professional endorsement: families who'd felt the weight of the white paper came away believing change was possible, clinicians came away with a shared direction, and the system felt like it was creating momentum.

So, what comes next

NWL boroughs are moving towards readiness to pilot Needs Profiling, and ICHP's commitment of significant funding – to develop the pilot design, scope the evaluation and technology, and build the business case for sustained change – has helped unlock further investment across the system. The technology matters too: no formally evaluated, fully technology-enabled Needs Profiling tool yet exists, so NWL intends to build one – letting the young person shape and edit their own profile, the school SENDCo review and contribute, and outcome data reveal, for the first time, the pattern of unmet needs and which support has the greatest impact. That evidence base does not exist yet; NWL will create it.

The pathway solution goes live Autumn 2026; the profiling pilots will be supporting children and young people in their schools by the end of 2027. The evaluation includes generating real-world evidence to shape neurodevelopmental support not just in NWL but across London and beyond.

> ***"That is what our job is: to understand a problem and the theory of change. To use that to map out where the energy is, who is pushing the different levers, and to connect them. To build the energy and the belief that change is possible."***
>
> Catherine Fraher,
> Innovation Lead, ICHP

The NWL Needs Profiling Innovation Forum – February 2026

82

leaders from 8 boroughs attended, spanning health, education, local authority, parent carer forums and the voluntary sector

10/10

On every borough table the voting clustered around 10/10 to "explore this here" giving a decisive mandate to explore Needs Profiling across NWL

71%

of NWL attendees (48 out of 68) signed up to take the work forward

2

boroughs (Brent and Ealing) to pilot Needs Profiling

Theme 2

Data and real-world evidence



Discover-NOW / London Secure Data Environment

North West London's pioneering health research hub is now being scaled to the whole of London

In 2019, ICHP became one of seven organisations in the country selected to pioneer a new approach to health data research. Six years later, the model it helped build is scaling to cover the whole of London, 10 million people, one of the broadest health data assets anywhere in the world.

A national selection, a NWL foundation

When Health Data Research UK established seven national Hubs in November 2019, NWL had already spent a decade building the data infrastructure that would make serious research possible. First with Whole Systems Integrated Care (WSIC), joining up patient information to support direct care, and then with the Discover dataset itself, a de-identified, linked record of over 2.9 million people, spanning primary care, secondary care, community services, mental health and local authority data.

Discover-NOW is the research wrapper built around that dataset: a hosted hub, funded through UKRI, designed to give NHS, academic and commercial partners a rigorous, governed route to access and use real-world data for research and development. From its first year, the questions it helped answer ranged from rare disease identification and treatment pathway evaluation to comparative population analysis that would have been impossible through any other route.

The breadth and depth of the data mattered. But so did the diversity of the population it represented. London's complexity, the range of ethnic diversity, deprivation levels, health conditions and care pathways across its boroughs, makes NWL's dataset something that genuinely cannot be replicated elsewhere.

> ***"The linkage across GP, hospital, mental health and community use and the diversity of our population; that's what makes this dataset different from anything else available."***
>
> Hannah Fontana, Associate Director of Strategy and Insight, ICHP

Discover-NOW and the London SDE in numbers

2019

Discover-NOW founded, 1 of 7 national HDR UK Hubs

2.9m

NWL population in Discover dataset

+10m

people in London SDE from April 2026

7

Real-world evidence projects completed in 2025/26

Six years of evidence, and what it built

As the momentum to scale Discover-NOW to a London-wide Secure Data Environment (SDE) was realised this past year, the case for ICHP's team leading that work was built on six years of delivered research. The partnerships below represent a fraction of what was produced, but they illustrate what real-world evidence looks like when it has genuine clinical and commercial purpose.

This is not a list of research projects. It is a track record of trusted partnerships with major NHS, academic and commercial organisations, each of which required rigorous data governance, analytical expertise and the kind of credibility that takes years to build. It is also the foundation on which the London SDE now stands.

Partner	What the data enabled
Novartis	Redesigned the Inclisiran care pathway to enable community-based administration of a six-monthly lipid-lowering injection, shifting care out of hospital and into GP practices, changing how a novel therapy reaches patients.
Boehringer Ingelheim	Analysed de-identified data from 91,000 patients with Chronic Kidney Disease (CKD) to identify gaps in early diagnosis and confirmed the feasibility of a machine learning model to predict CVD and renal outcomes at CKD onset.
Royal Brompton / NWL ICB	Evaluated de-identified data from over 76,000 patients with coronary artery disease to understand how secondary prevention methods affect mortality rates.
Alzheimer's Society	Investigated patterns in dementia diagnosis and staging across NWL and explored whether early-stage diagnosis is associated with different healthcare resource utilisation from later-stage presentation.



The scale-up: from 2.9 million to 10 million

The London SDE became operational on 1 April 2026. It will eventually provide controlled access to a de-identified linked dataset covering more than 10 million people across London – the largest and most diverse health data asset of its kind in the country, and one of the most significant anywhere in the world.

The London SDE is designed as a 'first-to-trial, first-to-deployment' pipeline, so that effective solutions can be rapidly tested and adopted across London's health and care system, not merely researched and published. That distinction matters. Health data research has historically suffered from a gap between insight and action, studies completed, papers published, and pathways unchanged. The London SDE is designed to close that gap, with ICHP as one of three health innovation network partners commissioned to translate data into real-world innovation at scale, alongside UCLPartners and Health Innovation Network South London.

The governance sits with Health Data for London, a new formal partnership between NHS and university leaders that provides the strategic coordination for London's health data agenda. Every application to access data is assessed by a London SDE governance pathway which includes an independent information access group, and local data access committees that include public members, ensuring that approved projects demonstrate clear public benefit.

Already in motion: the driver projects

Three NHS driver projects – first to access the London SDE

Antimicrobial resistance

Predicting and reducing 'bug-drug' mismatches that lead to avoidable and serious infections in hospitals and care home settings. One of the most pressing challenges in patient safety, now with a London-wide data foundation.

CVD prevention

Building on the cluster-randomised controlled trial for an AI-powered stethoscope, which has already involved 12,000 patients across 200 GP surgeries in the UK. The London SDE provides the population scale to generate evidence that can change how CVD is detected and prevented across the capital.

Children and young people's mental health

Developing a much richer picture of demand for services and building methods for proactive care and early intervention, by joining data across care settings including the new Mental Health Support Teams based in schools. This work is being led by ICHP and is directly connected to North West London's Children & Young People's Mental Health mission.

The ambition behind all of this is stated explicitly in the founding documents: to underpin London's goal of becoming the world's healthiest global city.



What remains in NWL and why it matters

The scale-up to London did not mean ICHP stepping back. The analytical team remains within ICHP, continuing to deliver real-world evidence work using the NWL dataset for NHS, academic and commercial partners. That continuity is significant: the six years of expertise, relationships and analytical rigour that made the London SDE possible are still active and available in NWL.

> ***"The expertise and relationships we have built over six years don't disappear when a programme closes. They are exactly what makes the London SDE possible and what we bring to every new partner we work with."***
>
> Heather Fitzke, Senior Quantitative Manager, ICHP

For partners considering working with ICHP's real-world evidence offer, the question is not whether the infrastructure exists. It does, at both NWL scale and London scale. The question is what research questions are worth asking of the most comprehensive health dataset in the country, and what would it mean to answer them?

> ***"Working with ICHP on the CLAN-OSA project enabled us to generate insights that would not have been possible otherwise. The collaboration with the Real-World Evidence team strengthened our evidence base and supported more informed decision-making, demonstrating the real value of cross-sector partnership."***
>
> Kevin Pollock, Director, VEO International Business Unit, Cardiometabolic Health





North West London Networked Data Lab

What six years of research partnership looks like in practice

The best research partnerships are built on shared curiosity: a genuine desire to understand more, together, than any single organisation could discover alone. Over six years, the North West London Networked Data Lab brought together three organisations, 38 contributors, and the voices of patients and residents across our region to do exactly that. It has been recognised nationally, winning the Royal Statistical Society's Florence Nightingale Award for Excellence in Health and Care Analytics 2026.

A partnership built to go further

The North West London (NWL) Networked Data Lab (NDL) was part of a national programme funded by The Health Foundation, bringing together the country's leading analytical teams to generate independent evidence on the health challenges that matter most to communities. Being part of that network was a recognition of NWL's collective analytical ambition, and a chance to bring that ambition to bear questions that deserved more rigorous, sustained attention.

In NWL, the programme was built on a partnership of three organisations: ICHP, Imperial College London's Institute of Global Health Innovation (IGHI), and the ICB. Each brought something the others needed. ICHP provided programme leadership and analytical grounding. Imperial College London brought academic research expertise in both qualitative and quantitative disciplines. The ICB contributed system knowledge and the connections to ensure findings could reach decision-makers.

Together, across six years and 38 contributors, they produced a body of work that was stronger, richer, and more practically useful than any of them could have created independently.



The NWL NDL in numbers

~£1m

revenue generated for the NWL system

99

patients and residents engaged

38

contributors across 3 organisations

22

publications

6 years

programme duration

Research that reflected what communities care about

What a programme chooses to investigate reveals what it values. The NWL NDL consistently chose topics that were significant to the communities living with the challenges being studied, and where a rigorous evidence base could genuinely improve how the system responded.

Unpaid carers were one such focus. The millions of people who provide care to family members or friends, often without pay are one of the health system's most important and least visible resources. The NDL's research gave both NWL and national audiences a clearer, more evidence-based picture of this group: their health needs, the pressures they carry, and the opportunities to support them better.

Children and young people's mental health was another area where collaborative research made a real difference. The NDL's post-pandemic work in this space built the quantitative and qualitative case for treating CYP mental health as a system priority. Crucially, that evidence did not remain in a report: it directly informed the development of ICHP's CYP mental health mission, demonstrating what can happen when research and system leadership work closely together.

> ***"The research we did on children's mental health helped create our mission and helped inform its first stages. It helped make the case that this was an important healthcare topic that healthcare systems should think about."***
>
> Matthew Chisambi,
> Director, ICHP

An approach that put patients at the centre

One of the things the NWL NDL was most committed to was genuine Patient and Public Involvement and Engagement (PPIE) throughout the research process. For every topic the programme worked on, a patient representative group was established at the outset and involved throughout, not consulted at the end of a process that had already reached its conclusions, but as active contributors to the questions being asked and the way findings were interpreted.

> ***"Our public partners have worked with us every step of the way, reminding us of the real people behind the numbers we analyse. Their insights have ensured our research addresses what matters most to patients, and their impact is a testament to the value of public involvement within data analytics."***
>
> Jodie Chan, Public Involvement Officer,
> Imperial College London

Through this approach to PPIE, the NDL developed a genuinely integrated approach to qualitative and quantitative evidence. Rather than treating these as separate streams, the programme brought them together throughout: the lived experience of patients and communities shaped what data analysis was asked to answer, and data findings were understood in light of that lived experience. The result was research that was both analytically rigorous and deeply grounded in the realities it was describing.

Looking ahead

The NDL programme has formally closed this year, and the housing and health report – now published – is its final major output. But the collaborative spirit that sustained it, and the model of research partnership it demonstrated, continue to shape how ICHP works with system partners across NWL.

The Health Foundation has funded a learning and sharing phase so the key lessons from the Networked Data Lab can be shared nationally. It has four themes:

Learning and sharing phase

- **Effective stakeholder engagement**
- **Best practices for analytical collaboration**
- **Data capability and IG for multi-agency data linkage**
- **Public involvement**



Research is most powerful when it is co-created with the people and organisations who will act on it. That is what the NWL NDL proved over six years, and it is the foundation on which future partnerships will be built.

Research topics: impact and reach

Research topic	What it found or changed	Where shared
COVID-19 and the clinically extremely vulnerable population	Found that shielding patients in North West London experienced reduced service use and worsening mental health, prompting deeper local analysis to understand unmet need and inequalities.	Health Foundation national briefing and NWL partner analyses using Discover-NOW data and local engagement outputs.
Children and young people's mental health	Identified growing demand and inequalities in access across NWL, with local linked data used to explore service use patterns and inform priorities shaped with young people and community stakeholders.	Health Foundation briefing plus NWL workshops and partner outputs.
Unpaid carers	Highlighted the need to better identify and support unpaid carers in NWL through linked data, enabling improved understanding of their health needs and service interactions.	NDL programme outputs and partner-led analyses feeding into Health Foundation learning and local system discussions.
Intermediate care	Showed variation in delivery and access to intermediate care across NWL boroughs, with linked data revealing differences in pathways and supporting service improvement and discharge planning locally.	NDL analyses and academic outputs, alongside NWL partner work informing ICS-level service design discussions.
Waiting lists for elective care	Found that waiting times and healthcare use varied across NWL populations, informing local analysis and recommendations on coordination, patient support and pathway management.	NWL-specific NDL report alongside Health Foundation publications and wider dissemination.
Housing and health	Demonstrated in NWL that poor housing conditions (e.g. damp, mould) are linked to worse health outcomes, with linked data enabling more targeted local interventions.	Health Foundation briefing with contributions from NWL analysis teams using linked housing and health datasets.

Theme 3

Partnerships



Clinical Effectiveness Group

What's the story behind achieving high performance?

In 2025/26, NWL was named the best-performing region in England for identifying hypertension. It took four years, two rejected business cases, a government restructure, and one team that refused to walk away.

Start with the result

In 2025, North West London (as of March 2025) is the best performing Integrated Care Board (ICB) for all age controlled blood pressure. Whilst this is a collective achievement for all of primary, community care and residents, a significant contributor to that achievement has been the Clinical Effectiveness Group (CEG), launched in 2024. Its go-live is the result of hard, focused work across several organisations, and the system being willing to learn about what has worked elsewhere.

Hypertension, high blood pressure, affects a significant proportion of the adult population and is one of the leading risk factors for heart attack and stroke. Many people who have it do not know. Finding them, and ensuring the people who are already diagnosed are getting the best possible care, is exactly the kind of work that falls between the gaps of a system organised around acute episodes rather than proactive management.

The CEG closes that gap. Modelled on an approach that originated in North East London and spread to South East London, it brings together GPs to focus on a question the system often neglects: for the patients we already know, are they receiving the best possible care? Structured reviews of medicines, care pathways, and clinical outcomes generate improvements, not through new technology or new funding, but through applying clinical judgment systematically, at scale.

How ICHP made it happen

ICHP did not build the CEG model. It spotted it, made the case for bringing it to NWL, and sustained that case over four years of institutional friction.

The story begins in 2022, with a workshop ICHP convened to introduce the CEG model to NWL. The meeting brought together system colleagues and invited counterparts from North East and South East London – places where the model was already running and generating results. The response in the room was positive.

Yes, North West London should do this too. The next steps seemed clear. What followed was less straightforward.



The road to best in England

2022

ICHP convenes a workshop introducing the CEG model to NWL

Strong positive response in the room. Agreement to pursue adoption.

2023

First business case submitted and rejected

The system's structural bias toward sickness services makes it hard to fund preventive, quality-improvement work.

2023-24

Second business case developed, with PPL

ICHP and partners persist. PPL's (management consultancy) support to the successful case is acknowledged

2024

Business case approved

Originally intended to be hosted by the ICB.

2024-25

Government reform disrupts hosting plan

ICB unable to host due to implications of national reform. Central North West London NHS Trust (CNWL) steps in. Team smaller than original business case but operationally sound.

2025

CEG operational with Dr Perviz Asaria as clinical lead

Right person, right moment. The CEG begins running structured reviews across NWL primary care.

2026

NWL named best-performing region in England for controlled blood pressure

A milestone reached through collective system effort.

Two rejections and a restructure

The first business case was rejected in 2023. NWL ICB commissioned PPL (a management consultancy specialising in NHS commissioning) to work alongside ICHP to develop a second iteration of the business case, which was eventually approved. Then the government announced the reform that would reshape ICBs across the country, and the plan to host the CEG team at NWL's ICB fell away.

Central North West London NHS Trust (CNWL), one of ICHP's member organisations and a community provider, stepped in to take the hosting role. The team that emerged was smaller than the original business case had envisaged. But it had something that mattered more than size: the right clinical lead.

Reflections on why this took so long

The CEG model was proven. North East London had the data. South East London had adopted it. The case for NWL was clear to almost everyone involved.

And yet it took four years from the first workshop to the CEG running at pace. Two business cases. A hosting plan that fell through. A team smaller than originally designed.

This is not a story about failure. It is a story about what happens when the NHS tries to fund work that improves care for people already in the system, rather than treating acute illness. There are no clear mechanisms. The incentives point elsewhere. Good ideas require champions with staying power.

ICHP was that champion. That tenacity, rather than any single piece of work, may be the most transferable lesson here.

The clinical lead who made the difference

Dr Perviz Asaria was appointed as the CEG's clinical lead. ICHP Director, Matthew Chisambi, is direct about the significance of this appointment: the right person, with the right expertise and the right relationships in NWL's primary care community, was the condition that made everything else possible.

The CEG model works because GPs trust it. That trust is not given automatically to a new programme, however well-designed. It is earned by clinical leaders who understand the pressures of primary care, who can speak the language of their colleagues, and who can make the case for structured quality review in terms that resonate in a busy practice.

Dr Asaria brought that credibility. And the results, nine months in, reflect it.

> ***"Good ideas can emerge despite the system. But it takes individuals with the courage and authority to really turn them into better outcomes for our residents."***
>
> Dr Perviz Asaria, CEG Clinical Lead

What the result means and what it asks

Being the best-performing region in England for hypertension identification is not an end point. It is a baseline. The question the result raises is: what is possible if this model is sustained, properly resourced, and extended?

The CEG's focus is not only hypertension. Structured reviews of medicines and care pathways can be applied across a range of conditions where the gap between what is known and what is delivered is significant. The infrastructure is now in place. The credibility is established. The clinical lead and the team are in post.

ICHP's role going forward is the same as it has always been in this work: not to deliver, but to support the conditions for delivery. To make the case for sustained investment. To connect NWL's experience with the national conversations about how the NHS improves care for the patients it already has, rather than only finding the ones it is missing.

The result is the best in England. And the work is just beginning.



Scaling quality improvement across the region

Designing systems that protect by default

Patient safety is a key NHS priority. Sustaining and scaling safety improvement practices requires consistency, a shared patient safety lens, and the connective tissue to turn isolated good practice into system-wide improvement. This is the work ICHP has been leading through the NWL Patient Safety Collaborative (PSC) for nearly a decade.

What the Patient Safety Collaborative actually does

ICHP has hosted the NWL Patient Safety Collaborative (PSC) for approximately 10 years, commissioned by NHS England and anchored in the National NHS Patient Safety Strategy. That tenure matters: patient safety culture is not built quickly, and the relationships, trust and shared language that make improvement possible across complex systems take sustained investment to develop.

Shakti Dookeran, who leads the PSC at ICHP, is clear about the nature of the role. The PSC convenes the system to augment and scale good practice, providing a suite of support to overcome key challenges. Its role is to drive higher quality, greater consistency and a shared patient safety culture across priority projects system-wide.

The PSC's offer is organised around four areas of activity, each of which supports a different part of the system's journey toward safer, more consistent care.

> ***"The PSC plays a vital role in driving systemwide collaboration, consistency and learning – strengthening patient safety through a focus on quality improvement and culture."***
>
> Shakti Dookeran, Innovation Lead, NWL Patient Safety Collaborative

Running through all four areas is a shared aspiration: to make patient safety everyone's business. Not the responsibility of a specialist team or a commissioned programme, but a live, embedded part of how every clinical team thinks and works.

Discovery	Identifying the local landscape – the challenges, the stakeholders, the common barriers. Understanding where the PSC can make its biggest impact before any intervention is designed.
Implementation support	Building quality improvement (QI) capability, safety culture and leadership across the system. This is where the work of culture change actually happens: coaching teams, developing communities of practice, helping multi-disciplinary teams (MDTs) get comfortable with quality improvement approaches and data.
Communities of practice	Bringing together MDTs to share, learn, iterate, and develop shared ownership. Making patient safety everyone's business, not just the responsibility of a specialist team.
Impact measurement	Tracking outcomes that matter: health outcomes and patient safety events avoided, staff confidence in delivering care, improvements in communication within MDTs and leadership. And capturing the patient voice through vignettes and direct engagement.

Martha's Rule: from tragedy to transformation

Martha Mills was 13-years-old when she died from sepsis in hospital in 2021. Her family had raised concerns about her deteriorating condition. Those concerns were not acted on. The inquiry that followed found that she would probably have survived had she been moved to intensive care earlier.

Martha's Rule, introduced across NHS acute trust pilot sites in May 2024, is the response. It gives every patient, family member and carer a clear right to trigger a rapid review of their condition if they feel something is wrong and concerns about deterioration are not being acted on. It has three components: structured daily patient check-ins, staff escalation pathways, and patient and family escalation routes. Not just a policy addition. Creation of a clear pathway built around the principle that concerns from patients, families, carers and staff should be listened to and acted on.

In NWL, ICHP has supported the piloting of Martha's Rule across all four acute trusts, providing Quality Improvement expertise, shared learning infrastructure, and the culture change support that turns a new policy into an embedded practice.

The data from one site, London North West University Healthcare (LNWUH), gives a clear picture of what Martha's Rule looks like in practice. Over 250 calls in 2025. Around a quarter clinical. Of those, nearly one in five related to true clinical deterioration, triggering interventions that prevented further deterioration. And the demographic profile of callers closely mirrors the trust's diverse population: Martha's Rule is being accessed across ethnic backgrounds and deprivation levels.

That equity dimension is important. A safety measure that only reaches the most confident or connected patients is not a safety measure at scale. ICHP's culture change work, including MOMENTS training to build psychological safety and encourage speaking up, aims to ensure that the pathway would work for everyone.

> ***"Sharing learnings in the wider Acute Provider Group and receiving support from the Imperial College Health Partners PSC community of practice has been valuable for improving, sharing and scaling learnings."***
>
> Isatu Kargbo, Head of Nursing Critical Care Services, London North West University Healthcare

>250
Martha's Rule calls at LNWUH in 2025

25%
of calls were clinical escalations

>18%
of clinical calls identified true deterioration

>150
staff and patients engaged through roadshows

Safer births: the maternity and neonatal programme

Patient safety in maternity services is one of the most scrutinised and most consequential areas of NHS care. The NWL PSC's maternity and neonatal programme, commissioned by NHS England, spans four workstreams.

The Avoiding Brain Injury in Childbirth (ABC) programme was launched in 2025 and has moved from strength-to-strength. Avoidable brain injury during childbirth has devastating, lifelong consequences for children and families, and carries an enormous financial cost: reducing it to the level achieved by the top 20% of trusts could reduce national litigation costs by between £860million and £1.4billion per year.

ICHP's approach has been relationship-led and context-specific, beginning by understanding existing practice at each trust before building training that genuinely fits the clinical environment. Train the Trainer sessions have now been delivered across three of the four NWL trusts, with the fourth imminent. The impact is already visible: average clinical confidence among participants rose from 3.35 before training to 4.5 afterwards.

> ***"The ABC programme represents a long-awaited national initiative that will address one of the most devastating outcomes in childbirth: when a baby is born in poor condition. I believe this unified approach will have a significant impact, greatly reducing the incidence of intrapartum foetal adverse events."***
>
> Dr Millicent Nwandison,
> Consultant Obstetrician,
> Chelsea and Westminster Hospital

Workstream	Focus
Perinatal Culture and Leadership (PCLP)	Building positive safety culture, psychological safety and QI capability across maternity teams using the MOMENTS framework.
Avoiding Brain Injury in Childbirth (ABC)	Reducing avoidable brain injury by improving recognition and response to foetal deterioration and managing impacted foetal head at caesarean birth.
Deterioration	Supporting prevention, identification, escalation and response to maternal and neonatal deterioration using MEWS and NEWTT2 tools.
Optimisation	Enhancing care pathways for preterm infants through the British Association of Perinatal Medicine's Perinatal Optimisation Pathway and data-driven QI, with a target of reducing pre-term birth rate to below 8%.

Building capability that spreads

The PSC's role as a community builder extends beyond NWL. A pan-London QI and Safety training day, co-led by ICHP, brought together over 80 colleagues from across London's maternity and neonatal services. ICHP led the QI module, which received a strongly positive response, and the day directly led to two NWL Trust Perinatal Maternity Advocates approaching ICHP to support local improvement and cultural safety work using QI methodology.

That is what building communities of practice looks like in practice: not a conference where people listen and leave, but an event that generates new relationships, new requests and new momentum for safety improvement across the system.

In addition, as culture underpins every safety ambition, ICHP has supported building system resilience, facilitating challenging culture conversations to build staff and system awareness of human factors and wellbeing.

> ***"Reflecting on the past months of work with ICHP, the support has been genuinely impactful for our service and, importantly, has brought a strong sense of doing to what is often a difficult and abstract area of work. Culture is notoriously hard to shift, but this programme moved beyond conversation alone and translated cultural insight into practical action. That has been pivotal for our escalation work, where behaviours, confidence and relationships matter as much as processes and tools."***
>
> Dilan Chauhan, Trust Quality Lead Midwife for Maternal Safety, The Hillingdon Hospitals NHS Foundation Trust

Patient Safety Collaborative in numbers

~10 years

ICHP hosting the NWL PSC

4

NWL acute trusts supported through Martha's Rule

3.35 to 4.5

confidence increase post ABC training

>80

colleagues at pan-London QI training day

£860m-£1.4bn

potential annual litigation saving

Safety by design, not by exception

What runs through all of this work – Martha's Rule, the maternity and neonatal programme, the QI training days, the communities of practice – is a single design principle. Safety should be built in from the start, not added as a layer when something goes wrong. The systems that protect patients should make the safe choice the obvious choice. The culture that enables speaking up should exist before it is needed.

That is what ICHP is working to build across NWL: not a set of interventions, but the conditions in which safety is genuinely everyone's business.



Office for Life Sciences / Innovation Exchange

Getting an innovation approved is just the start – the journey is getting it to the people who matter

Getting an innovation approved by NICE as a medical device is not the end of the journey. For most innovators in life sciences, it is where the hard part begins. ICHP is the partner that helps bridge that gap, between proven and adopted, between sitting on a shelf and reaching a patient.

The problem approval doesn't solve alone

There are, right now, approximately one million people in NWL who are eligible for treatments that could reduce their risk of CVD. Around 300,000 of them are receiving those treatments.

That gap is not a clinical failure. It is a system design problem. The NHS does not always automatically absorb innovations, however well evidenced, however clearly recommended. Approved drugs sit unused. Effective technologies don't reach the front line. Clinicians who would want to use a solution don't know it exists, or don't have the pathway infrastructure to deploy it, or don't have the time to navigate the procurement and adoption process on top of everything else they already carry.

This is the problem that Matthew Wyatt, ICHP's Partnership and Innovation Lead, spends most of his time thinking about. He describes his role as: "The matchmaker of ICHP. I find the partners, I find the innovations. I don't deliver anything."

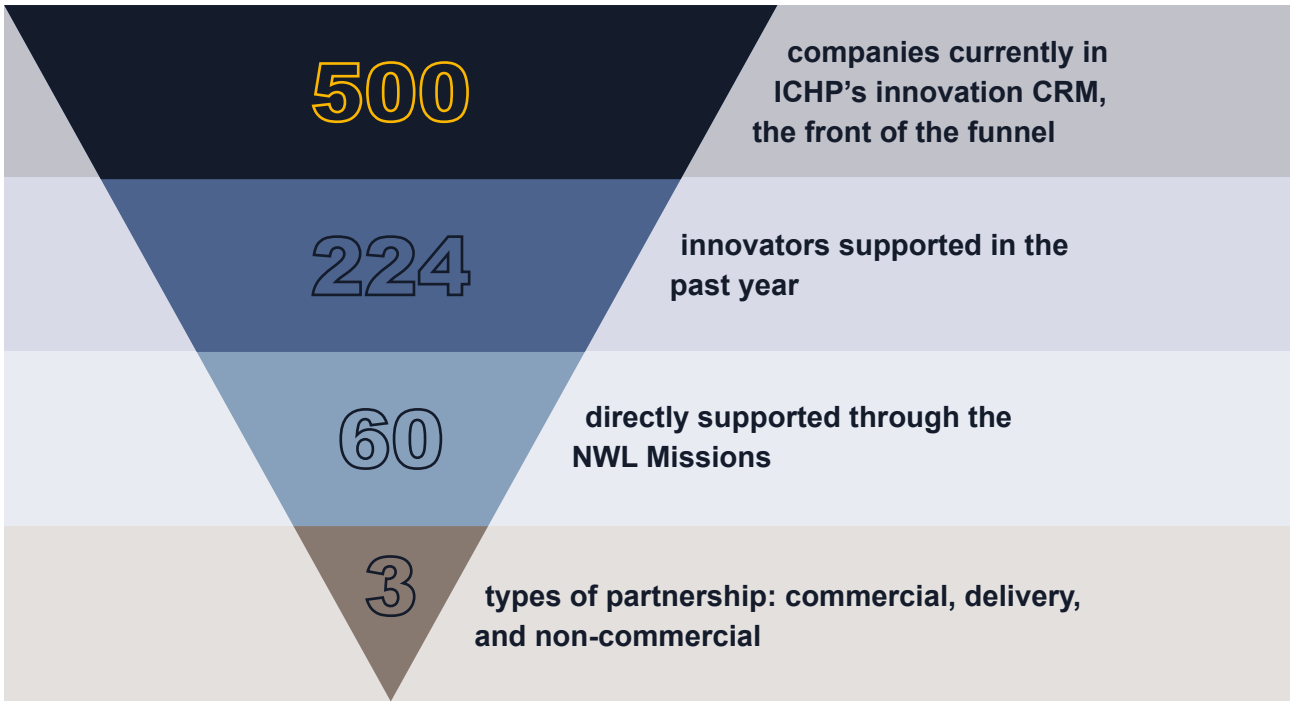
That description undersells the role. What Matthew actually does is sit at the intersection of two worlds that rarely communicate well: the commercial organisations with products and resources, and the NHS system with needs and pathways – and makes the connections that help innovation travel.

Most of ICHP's NHS members, the trust leads, the innovation managers, the clinical directors – let alone the frontline delivery teams – have no idea the pipeline below exists. When Matthew tells them there are 500 companies in ICHP's CRM, the response is consistent: 'Wow.' They have not necessarily recognised ICHP as a gateway to 500 potential solutions for their problems.

Making that gateway visible is key: 'We probably don't illuminate people's view of what we can do for them,' Matthew says. 'They look at what we've done, but they can't pivot from that to understanding what we could do for them.'

The new partnership role Matthew has built in 2025/26 is specifically designed to change that. Three types of partnership. A clear offer for each. And an Innovation Exchange function that turns the 500-company funnel into practical support for innovations that align with NWL's priorities.

The pipeline most people never see



What the Innovation Exchange actually does

When an innovator comes to ICHP, or when ICHP's horizon scanning identifies a technology that could serve NWL's needs, the process is structured and bespoke.

It begins with alignment: does this innovation match a real system priority? Then it moves through a series of practical steps designed to accelerate the journey from 'proven somewhere' to 'adopted at scale'.

The Innovation Surgery is often the entry point: a focused 60-minute session with ICHP's expert team, including Clinical Innovation Fellows who bring frontline clinical perspective on whether a solution is genuinely workable in practice. From there, ICHP can broker introductions to commissioners and clinicians, support funding proposal development, and provide the kind of trusted intermediary role that makes adoption conversations easier for all parties.

PocDoc: the matchmaking model in practice

Case study: PocDoc and the NWL Cardio-Renal-Metabolic (CRM) Mission



Horizon scan identified PocDoc's community cholesterol testing technology as aligned with NWL's Cardio-Renal-Metabolic (CRM) mission priorities.



Innovation Surgery held: 60 minutes with ICHP's expert team and Clinical Innovation Fellows to assess value proposition and local fit.



Carbon baselining of the pathway completed to demonstrate sustainability credentials.



Key introductions brokered: commissioners, clinicians, and academics with CRM interest.



Funding proposal developed collaboratively, guiding both PocDoc and local system partners through the process.

Result: PocDoc secured funding to deploy 2,000 rapid testing kits across community settings in NWL, with a focus on underserved populations. 80% of people tested had never had a cholesterol test before. 40% had elevated cholesterol levels. 17% would qualify as having undiagnosed cardiovascular disease.

PocDoc already had a proven product. What they needed was a trusted partner who understood NWL's system, could make the right introductions, and could help them navigate the funding and adoption landscape. ICHP provided all three.

How ICHP partners with the life sciences industry

Commercial partners

Pharma and life sciences companies that bring money, people and resources. The relationship generates resource / capacity for ICHP and the system, and opens pathways for their products to reach patients.

Delivery partners

Organisations with complementary capabilities that co-deliver funded work alongside ICHP. Can be commercial companies or charities. Often involve joint bids on grants or contracts.

Non-commercial partners

Mutually beneficial relationships built on two-way signposting and shared goals. No money changes hands, but both organisations become stronger for the connection.

For pharma and life sciences companies looking to work with the NHS, the question is not whether NWL has the right infrastructure. It does. The question is whether their product genuinely serves a population need and whether ICHP is the right partner to help them do it well.

This is where the Innovation Exchange matters. We provide a structured route in, a clear front door, and a way to connect innovators, industry and NHS teams around defined system demand. We focus on four things: identifying need and communicating priorities, signposting and supporting innovators, enabling real-world validation, and supporting adoption and spread.

Matthew's invitation to commercial partners is direct, but it is grounded in practical conditions rather than comparison. We can help partners work in a way that fits the system: through mission-led programmes where clinical and operational ownership is clear, through demand signalling that reduces noise, and through data and evaluation capability that helps the system make confident decisions.

That is the value proposition. Not "do a pilot". Do the work that makes adoption possible.



A system-wide approach to obesity

Not a programme, but a movement

The clearest direction for North West London's obesity mission did not come from a boardroom or a strategy document. It came from listening to 37 residents from across all eight boroughs sharing what it actually feels like to live with obesity, and what support could make the greatest difference. Those discussions set the mission's focus and its priorities.

Why obesity, and why now

Obesity is not a new problem. Around 600,000 residents in NWL are living with it. It costs the NHS more than £11.4 billion annually. It is growing. And it is not evenly distributed: Our most deprived communities – the national Core20 group defined by NHS England as the 20% most deprived areas – in NWL are nearly twice as likely to be affected, and Black residents face significantly higher prevalence than white counterparts. If a health challenge demands a mission response, obesity is it.

There is also something new in the landscape. GLP-1 medications are generating significant attention, and rightly so. Tech-enabled weight management platforms are changing how people engage with support. The evidence base on what works, in clinical settings, in communities, in the conditions that shape people's environments, is developing rapidly. NWL has both the need and, through its data infrastructure and system partnerships, the capacity to be at the frontier of what comes next.

The NWL Research and Innovation Board's decision to focus ICHP's next mission on obesity was not just a recognition of the scale of the problem. It was a signal that NWL intends to approach it seriously, rigorously, and in a way that generates evidence and momentum that can travel beyond NWL.

> ***"Obesity aligns strongly with our system's priorities and with what matters locally to residents, clinicians and partners. That's why it's been selected as NWL's next Mission."***
>
> Adam Ashworth, Innovation Lead, ICHP



Obesity in NWL in numbers

~600k

NWL residents living with obesity

£11.4bn

annual cost to NHS nationally

70

stakeholders engaged to date

37

residents across 8 boroughs involved in deliberation

A different kind of mobilisation

Building a mission from scratch takes time, but it doesn't have to take long. In the space of four months (January – April 2026), ICHP mobilised a programme of evidence-gathering, stakeholder engagement and resident deliberation that would, in a less agile system, have taken years.

The resident deliberation was the culmination of all of this. It mattered not just as a final step but as a statement of intent: the mission's focus would be shaped by the people whose lives it is designed to improve.

"This wasn't a consultation or a workshop", Adam Ashworth, ICHP, reflects. "It's shared decision-making. We brought together a balanced cross-section of NWL, people living with obesity, carers and parents, residents affected by long-term conditions, communities most affected by inequalities, and asked them to help us determine where change could make the greatest difference".

The discussions were open, thoughtful and, at times, challenging. They covered stigma, access to services, the social and environmental conditions that shape weight, and the gap between what clinical settings can offer and what people's lives actually look like. The insights from the deliberation will directly shape the mission's focus as it moves into its discovery phase.

How the evidence base was built	
Desk research	Significant quantitative data analysis and policy review to build the evidence base on obesity in NWL.
Stakeholder interviews	Over 40 interviews with residents with lived experience, ICB colleagues, GPs, clinicians, and others across the system.
Three roundtables	One with medtech and commercial partners, one with voluntary and community sector organisations, one with a clinical panel. Over 70 qualitative conversations in total.
Stakeholder panel	10–12 system leaders – experts in obesity or accountable for population health – helped filter the emerging themes.
Resident deliberation	37 residents from all 8 NWL boroughs. A structured deliberative process, not a consultation. Participants engaged with the evidence, reflected on lived experience, and helped determine where the mission should focus.

Articulating the goal of the mission

The mobilisation phase culminated in the agreement of a clear, shared and ambitious mission:

By 2030, stop the rise in obesity in North West London and set it on a sustained path towards reduction, starting where need and inequality are greatest.

This goal signals a collective commitment to long-term change. It recognises both the scale of the challenge and the urgency of acting now, while grounding ambition in equity, prioritising those communities most affected by obesity and its consequences.

To give this mission practical focus, three priority themes were agreed to guide the next phase of work:



1. Children and young people family-based prevention – reflecting the importance of acting early and supporting families in ways that fit with real life.



2. Equitable access to weight management services, addressing long-standing gaps in availability, experience and outcomes for different communities.



3. Access to GLP-1 treatments with wraparound care, recognising the growing role of pharmacological interventions when they are delivered safely, ethically and alongside holistic support.

These priorities are a direct reflection of what residents told us during the deliberation process. Residents spoke powerfully about the pressures facing families, the lack of awareness and challenges of accessing services, and the frustration of being unable to access available treatment on the NHS. They called for prevention to start earlier, for services to be easier to access and better joined up, and for new treatments to be introduced responsibly, with care, information and support around them. The mission statement and its themes translate those lived experiences into a clear system-wide direction.

With the mission goal and themes now agreed, the work moves into a Discovery phase. Each of the three themes will be taken forward to explore where innovation can have the greatest impact and how the system can act differently in practice. This discovery phase will continue the partnership approach established during mobilisation, bringing residents together with clinicians, local authorities, voluntary organisations, industry partners and innovators.

The aim is to build on the mandate created through resident deliberation, turning shared priorities into focused, credible areas for action that can be carried forward into delivery.

From delivery vehicle to orchestrator

There is something worth saying about how this mission is being built differently from those that came before.

The early NWL missions used a top-down model: important people with authority set the direction, ICHP delivered. It generated results, but it also meant ICHP carrying a weight it could not sustain alone. The mission model works when the system shares the ownership, not when one organisation carries it for everyone else.

This new mission is being designed from the outset with shared ownership at its centre. ICHP is the orchestrator and convenor. Our mission team will deliver some of the work. Others in the system will deliver some of it too. And ICHP will actively support things happening in the system that serve the mission's goals – even when ICHP isn't the one leading them.

That is a significant shift. It is also, Adam believes, the only sustainable model for work at this scale. "It's about us together realising these goals and supporting each other to be able to deliver on the issues and initiatives that are important to us."

The commercial opportunity

Obesity is also a space that is attracting significant commercial interest. The challenges are real, the scale is enormous, and the innovation potential, from GLP-1s to digital therapeutics to population-level behaviour change approaches, is genuine.

ICHP's invitation to commercial partners is direct and explicit. 'Our door is not only open but actively wanting to invite people to come and talk to us,' Adam says. He comes from a pharma background in strategic partnerships, and he understands what commercial organisations need: evidence that is credible, a system that is genuinely embedded, and a partner that can help their innovations reach the patients who need them.

NWL's linked Discover dataset makes ICHP a compelling evidence partner for obesity innovation. The ability to track outcomes across the full care pathway, across NWL's diverse and complex population, is not something most systems can offer.

For companies working in the obesity space, the question is not whether North West London is the right place to generate real-world evidence. It is whether now is the right moment to get involved. The answer, with a mission being shaped in real time, is yes.





How to work with us

The stories in this report share a common thread that sits at the heart of what we do: complex problems, solved by the right people working together. This is our foundation.

We sit in a unique position in the health system. We are part of the NHS family, grounded in its values and accountable to its goals, but sufficiently removed from the daily pressures of frontline delivery to bring fresh thinking, honest challenge, and genuine headspace to the problems that matter most. We bridge the gap between the NHS, industry, academia, and the voluntary sector, and we make connections that count.

If you have read this far and found yourself thinking "ICHP could help with that" or "we face exactly that challenge", the ICHP Team would love to hear from you.

If you are...

an NHS organisation or ICB	We work with commissioners, providers, and system leaders across NWL and beyond. Whether you need support developing a strategy, redesigning a pathway, understanding your population through data, or engaging clinicians and communities in change, we bring experienced teams who know the NHS from the inside. **We do not just define the problem and hand it back. We stay with you through implementation.**
a pharmaceutical company or life sciences partner	We offer a trusted route into the NHS for responsible, evidence-generating collaboration. Through the NWL Discover dataset, one of Europe's most significant longitudinal linked health data platforms, we enable real-world evidence studies that can inform clinical development, support access conversations, and demonstrate value in a way that regulators and commissioners find credible. **We develop joint working agreements where appropriate, with full transparency about funding and governance**.
an innovator or SME	We support companies at different stages of maturity, from refining your evidence base and understanding the NHS adoption landscape, to connecting you with clinical champions and running pilots that generate the proof points you need to scale. **We are genuinely agnostic about the source of a good idea, and our international innovation networks mean we can find and broker solutions as well as help develop them.**
a charity or voluntary sector organisation	Some of our most meaningful partnerships in recent years have been with charities, community groups, and voluntary organisations who hold trust and reach that the NHS alone cannot replicate. If you work with communities experiencing health inequalities or represent people who are underserved by the current system, we want to work alongside you. **In every case, what we bring is the same: deep expertise in data and real-world evidence; a team that understands both the policy landscape and the lived reality of delivering change; a collaborative style that keeps the right people in the room; and a commitment to impact that lasts beyond the project.**

Have a conversation with us

Get in touch: **ea@imperialcollegehealthpartners.com** or visit **imperialcollegehealthpartners.com**

The future

The work in this report is not the final destination. It is evidence that the approach we are taking is the progress needed and the foundation for what we believe is possible over the next three years.

This report reflects a period of significant change, for the NHS and for ICHP. The merging of NHS England functions into the DHSC, ongoing consolidation of integrated care systems, sustained pressure to reduce costs and generate efficiencies: the conditions in which health innovation has to find a way forward have rarely been more demanding.

Against this backdrop, ICHP has been doing two things simultaneously. Delivering the work you have read about in these pages. And building the strategy, the partnerships, and the operating model that will define the next chapter.

In March 2026, the ICHP Board approved a new three-year strategy. This section sets out what it means in practice, for the partners who work with us, for the members who commission us, and for the residents of NWL whose health it is ultimately designed to improve.

What we are working towards

Our vision

A healthy and productive population, with equitable access to innovative health services.

This is not a new aspiration. It has underpinned everything ICHP has done since its founding. What is new is the precision with which we are now able to describe what it requires, and the confidence, earned through three years of mission-led working, that we know how to pursue it.

The strategy is organised around four moves: create, advance, shape and sustain.

None of these is new territory. The nine stories in this report touch all four. What the strategy does is sharpen the focus bringing greater clarity about where ICHP concentrates its energy, and how we measure whether that energy has been well spent. These four moves are not independent programmes. They are four facets of a single ambition: to be the organisation that makes health innovation in NWL genuinely work, for the system that needs it, for the partners who invest in it, and for the residents whose lives depend on it.

The four strategic moves

1. Create

The best system for the end-to-end testing and scaling of innovation, becoming a national and regional exemplar for how proven solutions travel from pilot to practice.

2. Advance

Data-driven change, harnessing world-leading capabilities and assets across the innovation lifecycle, from discovery through delivery to scale.

3. Shape

Investment in advanced technologies, genomics, artificial intelligence, digital pathology, that will define health and care in the decades ahead. If WSIC and Discover-NOW were our big bet five years ago, we are now identifying what we are betting on next.

4. Sustain

Support for members with the challenges of today: driving optimal digital infrastructure for care pathways and providing the research and innovation expertise the system needs right now.

How we will organise ourselves: MissionsPlus

One of the most consistent pieces of feedback we heard as we developed the strategy was that ICHP's offer was not always easy to see from the outside.

Members and partners could not necessarily point to things ICHP had done. They struggled to articulate what ICHP could do for them.

That is a problem we have designed a solution for. Our operating model going forward is MissionsPlus: a deliberate combination of the long-term, system-wide mission work that has generated the results you have read about in this report, and a set of bespoke, commissionable service lines that partners can access directly.

Our mission approach is not changing. Three years of evidence have given us confidence that this approach to organising around complex, long-horizon challenges, with ICHP as convenor rather than sole deliverer, is right. Cardio-renal-metabolic conditions, children and young people's mental health, and obesity remain the focus. The aim is to achieve more impact by doing fewer things for longer, pooling funding and expertise across the system rather than fragmenting effort across too many priorities.

The Plus service lines represent something new: a more systematic, visible offer for members and external partners who want to commission ICHP's capabilities directly. Real-world evidence. Qualitative insights. Evaluation. Service transformation. These are not new capabilities; the work in this report demonstrates them in action. What is new is the clarity and accessibility of the offer.

For commercial partners, this matters particularly. The question we hear most often from pharma and life sciences companies is not whether NWL's data and innovation infrastructure are excellent. It is how to access them. MissionsPlus answers that question with a structured, transparent framework.

Missions

Convening our ecosystem to achieve greater impact through multi-year efforts on the most complex healthcare challenges.

- **Cardio-renal-metabolic conditions**
- **Children and young people's mental health**
- **Obesity**

Plus

Supporting partners with today's challenges through bespoke commissioned services.

- **Real-world evidence**
- **Qualitative insights**
- **Evaluation**
- **Service transformation**



The context we are operating in

The next three years will be shaped by forces that are significant and, in some cases, genuinely uncertain. The 10-Year Health Plan and the Life Sciences Sector Plan set out a compelling vision for an NHS and a UK economy driven by innovation. ICHP is well positioned to contribute to that vision, and HIN funding has been confirmed through to 2028.

But the context also includes the ongoing consolidation of integrated care systems, an NHS under sustained financial pressure, and a public whose confidence in health services has been tested. The system that ICHP is trying to support is simultaneously reforming itself, managing immediate demand, and trying to invest in a different future. That tension is real and the strategy has been designed with it in mind.

The NWL and NCL ICB merger now bringing together two of London's integrated care systems creates both opportunity and complexity. ICHP will expand its partnerships within the larger combined system and deepen its collaboration with UCLPartners and Health Innovation Network South London, to ensure that innovation support is aligned across both geographies rather than duplicated or fragmented.

And beyond London, there is growing recognition that the approaches NWL has pioneered – mission-led working, data-enabled real-world evidence, community-based detection, and shared ownership of health challenges – are the right approaches for the NHS at scale. Part of ICHP's role in the next three years is to make sure that what works here is visible enough to travel.

Year one: a foundation, not a finish line

The three-year strategy is underpinned by annual themes. Year one, 2026/27, is about preparation: building the operating model, the partnerships, and the internal capability that will support delivery in years two and three. It is the year in which ICHP becomes more systematic and more legible, to itself and to the partners it serves.

That is not modest ambition. The organisations that grow sustainably are the ones that invest in their foundations at the right moment. ICHP is doing exactly that.

The work in this report is not the conclusion of a chapter. It is the evidence on which the next chapter is built. The CEG is best in England for hypertension identification after nine months. The London SDE is operational, covering 10 million people, from April 2026. The NWL obesity mission is being shaped with and for communities in real time. The neurodevelopmental pathway is being redesigned at two levels simultaneously. The community detection programme is reaching people the system has never found before.

Each of these is both a result and a starting point. What they demonstrate together is that a system that chooses to focus, to persist, and to work in genuine partnership can achieve things that would not otherwise be possible.

That is what ICHP exists to make happen. And the next three years will take it further.

Work with us

If the work in this report reflects challenges you are working on, or opportunities you want to explore, we would like to hear from you.

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