Missions for better health

Reflections from system-wide innovation in North West London

Acknowledgements

Missions are a collective endeavour. There are too many people involved to name here – however, we would like to thank all past and present Imperial College Health Partners (ICHP) colleagues and system partners who have contributed to the mission approach.

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Foreword

Health and care are at a critical juncture. Costs are rising, demand is increasing and the legacy of the pandemic continues to stretch our workforce and our services. The challenges are complex and interdependent and not problems that can be solved in isolation.

In parallel, the pace of innovation in health, life sciences, and technology has never been greater. From digital tools that improve care delivery to breakthroughs in diagnostics and prevention, they hold great potential to improve outcomes and productivity. Recent work by Frontier Economics and the Health Innovation network estimates that investment in health innovation could generate £278 billion in economic value for the UK by boosting NHS efficiency and productivity, improving population health and attracting global investment.[1] The NHS 10 Year Plan recognises this potential, calling for a greater focus on innovation and stronger collaboration across health systems to unlock common barriers to transformation.[2]

However, experience and evidence tell us that innovation alone is not enough. The real challenge lies in how to organise, adopt and scale approaches across large complex systems. Over the past three years at ICHP, the Health Innovation Network for North West London (NWL), we have been exploring how a 'mission-led' approach to innovation can accelerate this. This aligns to UK Government embracing a mission-led approach through its five health missions, and UK Research and Innovation preparing to adopt a similar framework.

> ***A mission-led approach provides a way of connecting innovation with purpose and translating ambition into tangible and system wide improvement.***

In this report we share what has worked, what didn't and where future effort might be best placed. If we are serious about realising the full value of innovation for patients, communities, staff and the health system then we must move beyond isolated projects and short-term gains. A mission-led approach provides a way of connecting innovation with purpose and translating ambition into tangible and system wide improvement. But it's not a panacea. It requires a change in ways of working and the support of the whole system to realise the scale of impact and shared ownership.

We hope this open account of our learning serves as a valuable resource to support others who are navigating how to best adopt and scale innovation in complex systems.

Dr Dominique Allwood, CEO, Imperial College Health Partners

Executive summary

Since 2023, ICHP, working in partnership with the NHS in NWL, has tested how a 'mission-led' approach to innovation might help overcome common barriers and enable the local health and care system to innovate more effectively and at a greater scale.

> **This report sets out what we did, what we learned, and what this means for how other health systems and leaders can adapt their approach to innovation.**

"Mission-led"?

This refers to focusing the collective innovation efforts within a system on a smaller number of bold, longer-term goals. Whereas discrete innovation projects are often delivered in isolation, at a small scale and to short timeframes, missions are designed to align innovation partners and resources across organisational boundaries around shared outcomes. We were inspired to change our way of working by the increasing adoption of mission-led approaches in national and international policy, alongside learning from the pandemic, which demonstrated that it is possible to innovate services at pace and scale when the health and care system is properly aligned to pursue a shared goal.

What did we do?

In 2023, ICHP and the NHS NWL Integrated Care Board (ICB) jointly established three missions focused on major system challenges:

- Preventing heart attacks and strokes by improving prevention, detection and treatment of cardiovascular disease
- Enabling more days at home, reducing avoidable hospital stays and supporting recovery
- Improving children and young people's mental health, particularly preventing crisis presentations

We sought to bring together NHS leaders, clinicians, patients, researchers, innovators and industry partners around clear ambitions, supported by shared governance, real-world data, and iterative testing in live settings. NWL ICB became the first in the country to establish a Research & Innovation Board to provide oversight and governance in how each mission should be delivered.

This approach has begun to deliver tangible benefits, including:

- **Stronger system alignment:** Despite changing operational pressures and contexts, our goals have not changed.
- **Improved collaboration:** We have been able to work as "one team" across organisational boundaries, with stronger clinical and patient involvement.
- **Early impact:** For example, work within the "enabling more days at home" mission contributed to a 23% reduction in 'no criteria to reside' bed days in participating settings.

- **Increased leverage:** Mission-led working helped attract over £2.5m of additional funding and investment in NWL.
- **Cultural change:** Teams shifted from delivery against fixed plans to testing, learning and adapting in real time.

What did we learn?

This transition in ways of working has had its challenges and we have had to continually adapt and refine our approach. Our key takeaways for other Health Innovation Networks, ICBs or other organisations within the health and care system looking to adopt a mission-led approach include:

Shared ownership must be designed in from the start

- The mission needs a clear, compelling ambition that people recognise as their problem to solve, not someone else's programme.
- Senior leaders must actively back the mission and align it to system priorities rather than positioning it alongside existing programmes – it needs to become 'the work'.
- Identifying a small number of named senior responsible owners, alongside a coalition of the willing ready to act, helps move quickly from intent to delivery.
- A mission only gains traction when there is collective accountability, not just sponsorship.

Missions only work when the whole system is involved

No single organisation can deliver mission-level change on its own.

- Collaboration needs to happen before solutions are defined, not once projects are already underway.
- Looking at who is at the table, who needs to be at the table and who's missing helps to identify which partners should be involved but may not have been included to date.
- Asking "what will feel different in how we work because of this mission?" helps surface the wider changes needed not just technical interventions.

Mission-led working requires a deliberate shift in culture and ways of working

Adopting a mission-led approach requires a cultural shift as well as structural change to become business as usual.

- Successful missions demand a move from organisational ownership to system stewardship, where progress towards shared outcomes matters more than individual institutional gain.
- Time spent on partnership working and system leadership needs to be valued, not treated as discretionary. Teams need permission to work across boundaries, challenge established ways of working.
- Cultivating trust, psychological safety and shared purpose particularly across matrix teams and those working beyond their organisations are essential conditions for collaboration at pace, not optional extras.

- Leaders need to actively model the behaviours required, including openness to learning, comfort with uncertainty, and a willingness to let others lead when this best serves the mission.

Scaling what works must be planned from day one

Missions succeed when they move beyond pilots.

- From the outset, teams should be clear about what evidence is needed, by whom, for an innovation to become business as usual.
- Experimentation is essential, and not everything will work. Missions need permission to test, learn and stop activity that is not delivering value.

Sustainable impact needs dedicated resource

Mission-led change cannot be delivered off the side of existing roles.

- Clear funding routes and resource commitments are needed to support delivery and, crucially, to scale effective approaches once impact is demonstrated.

Data and governance are enablers, not afterthoughts

Access to timely, high-quality data underpins credible decision-making and learning.

- Proportionate governance and shared data infrastructure allow missions to track progress, demonstrate impact and adapt over time without slowing delivery.

What does this mean for systems and senior leaders?

Mission-led innovation is not a quick fix or guaranteed win, but it can offer a credible way to tackle complex, long-standing challenges at scale. For leaders, success depends on:

- Backing a small number of clear, outcome-focused missions
- Actively championing collaboration across organisational boundaries
- Accepting managed risk, failure, iteration and learning as part of delivery
- Aligning funding, governance and incentives to support scale

What is next for NWL?

ICHP and our partners are already starting to apply these lessons to the selection of the next mission for NWL and remain committed to missions as both a delivery model and a leadership mindset.

We share this learning openly to support others seeking to adopt mission-led approaches and to contribute to a growing national conversation about how health innovation can deliver real benefits for health outcomes and economic growth.

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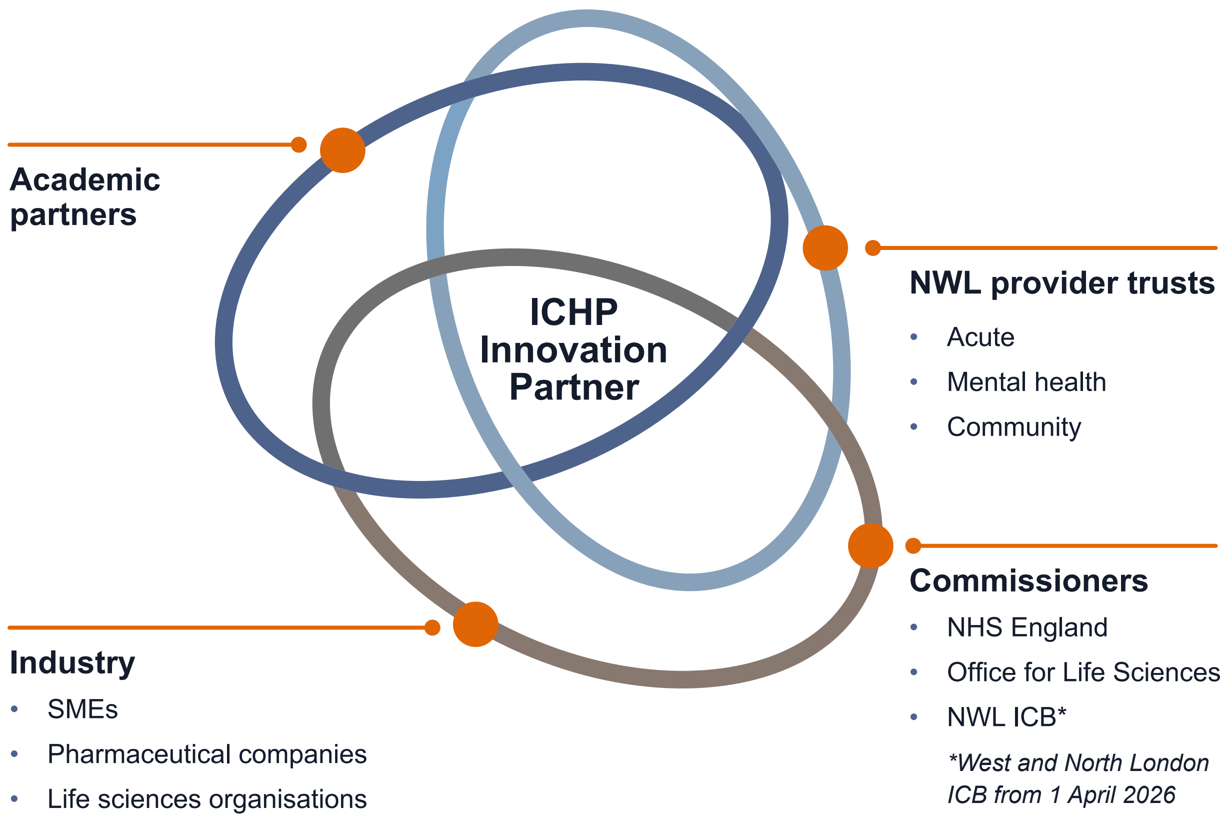
Introduction

Introduction

About us

ICHP was established in 2013 as one of 15 health innovation networks in England (previously known as Academic Health Science Networks). We were created as a **partnership organisation** in NWL to support the spread and adoption of innovation at pace and scale to improve health outcomes and generate economic growth for our diverse population of 2.8 million people.



We are proud to have had impact working with partners, and supporting numerous innovation projects, programmes and organisations. We have also led the creation of Discover-NOW which is enabling the system-wide use of de-identified linked real-world data across 10 million London residents to generate evidence and support the adoption and spread of innovation[3]

However, we recognise that the scale of transformation required to improve population health, tackle health inequalities exacerbated by COVID-19, and support the long-term sustainability of the NHS requires a greater collective effort to have population-level impact of the magnitude we need to.

The establishment of the NWL Integrated Care System (ICS) in 2022 created an opportunity to take a more strategic, whole-system approach to innovation. ICHP began exploring possible ways to do this and in 2023 ICHP and the NWL ICS began a mission-led approach to innovation delivery.

Here we describe the journey ICHP have taken to establish a mission-based innovation approach over the last two years.

Our mission-based approach journey

We studied several approaches defined as 'mission-led' and the common features were focussing on fewer priorities, for a longer duration, with greater cross-sectoral action to deliver more impact (see Figure 1).

Figure 1: Core components of mission-led innovation

We believed this approach, while challenging in many ways, would be more conducive to enabling deeper, sustainable impact than traditional programmatic working.

We set out to undertake this approach for two years and have since reflected internally and with our partners to understand what has gone well, what we have learned, and what might be helpful to share with others.

We have divided our reflections into the following stages that mirror the mission lifecycle:

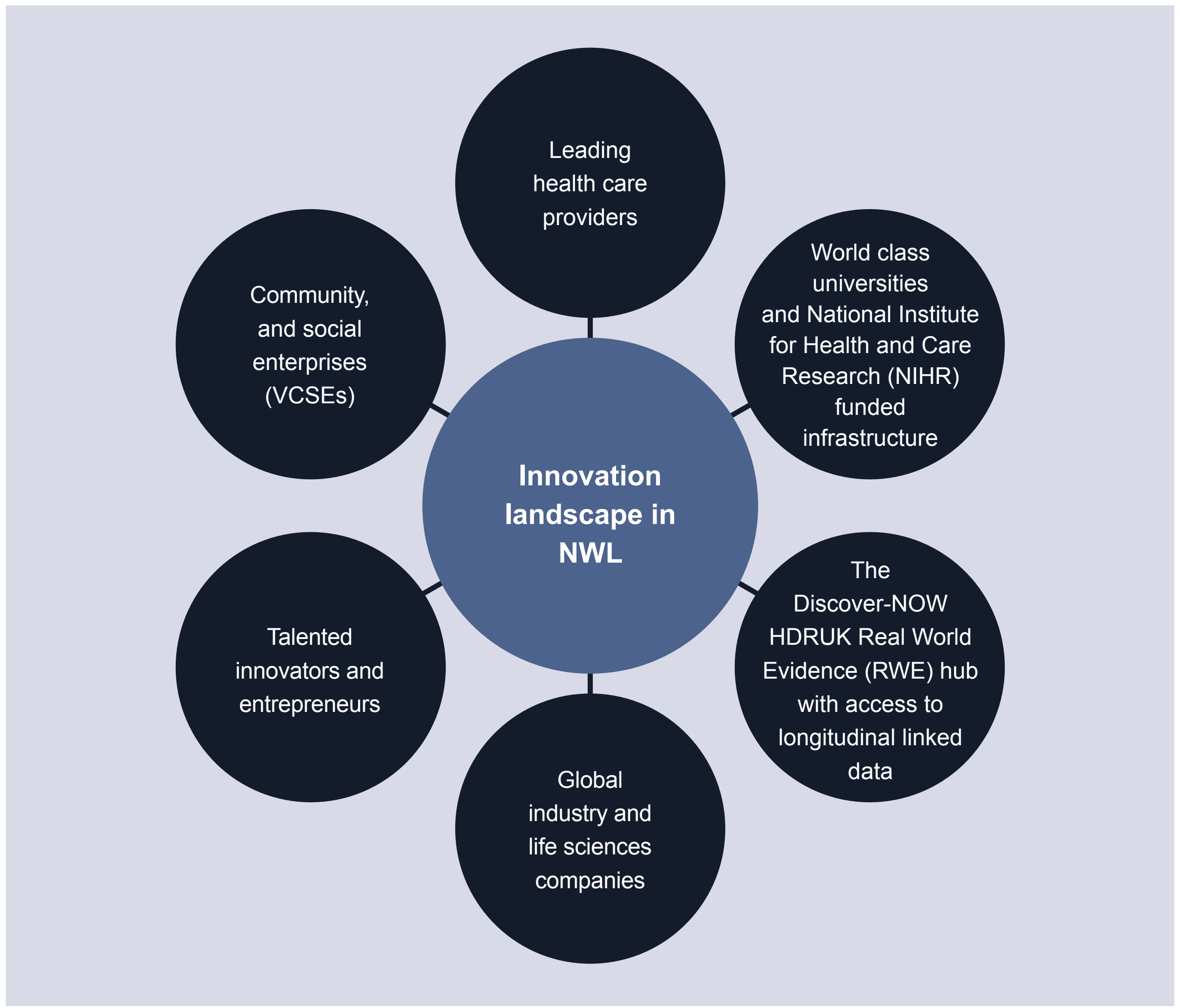
- **Discovery:** How did we set our initial priorities? What went well during our scoping and discovery phase? What would we do differently next time?
- **Delivery:** What techniques and approaches worked to deliver on our mission ambitions? What could have been improved upon, and what would we do differently if starting again?
- **Scale and sustain:** Where have we been able to realise and demonstrate impact? How does a mission-led approach support this, and what are the challenges and barriers?

Why did we choose a mission-led approach?

Why did we choose a mission-led approach?

NWL's world class health and innovation landscape

ICHP is fortunate to work in (and to have been created by) a large and complex health and care system. NWL is one of the largest ICSs in the country, with a diverse population of almost 3 million people from 200 different ethnicities. Our population is generally younger than elsewhere in England and projected to be one of the fastest growing. It is also home to a rich ecosystem of research and innovation partners, including:



Despite this wealth of assets, it was recognised that this rich ecosystem was fragmented, and that there was potential for greater collaboration and alignment between entities working towards common goals to transform health and care.

The changing local context

Changes in the organisation of local health and care system meant there was an opportunity to reform our approach to innovation delivery across NWL, with the aim of broadening and deepening our impact and to move beyond project and programme by programme approaches to innovation that had traditionally been employed.

The creation of ICBs, provider collaboratives and Primary Care Networks (PCNs) meant that structures were in place to potentially enable better system working, greater decision making at scale and the design and delivery of new care models across larger geographies. With ICHP leading or supporting on a large and diverse range of innovation programmes and projects, the external and internal context was a strong starting point to adapt our way of working to be more focused on a smaller number of ambitious longer-term goals.

The COVID-19 pandemic showed that the health system was capable of innovating at pace when there was a clear mission and aligned support to make change happen. As the worst impacts of the pandemic subsided, colleagues across the NHS were left with a better understanding of the scale and pace of possible change, what enablers are needed, and the conditions required on the ground for this to happen.

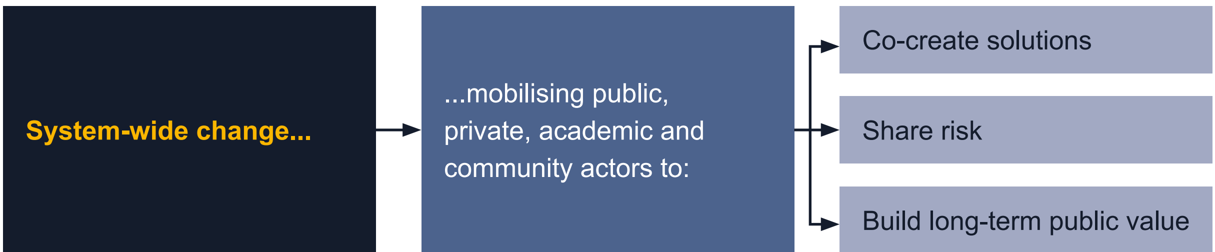
The growing evidence base for mission-led approaches

There has been growing attention on taking a mission-based approach to policy and practice in recent years. Missions are intended to set a clear, ambitious goal which can be used to mobilise a portfolio of projects and policies delivered by multiple partners to achieve it. We drew inspiration from Mariana Mazzucato's work, an economist and academic whose theory is that a 'mission-led' policy approach is the most effective way to tackle major societal challenges.

> **Mazzucato describes a mission as *"a bold, problem-oriented goal that directs research and innovation toward solving a major societal challenge, while fostering cross-sector collaboration and bottom-up experimentation."*** [4]

The mission-based approach is a way of tackling complex societal challenges by setting clear, ambitious missions that cut across organisational and sectoral boundaries. Rather than funding isolated projects or pilots, missions define a shared outcome to be achieved within a defined timeframe, and then align policy, funding, innovation, and delivery efforts around that goal.

Missions focus on:



Success is measured not just by individual initiatives, but by progress towards population-level outcomes, sustained capability, and reduced inequalities.

Public and private sector organisations have increasingly begun adopting this approach. The **UK Government** described a mission-led approach in its 2017 Industrial Strategy, which included 'Grand Challenge' missions with ambitious targets related to utilising artificial intelligence, supporting an ageing society and achieving clean economic growth.[5]

Through researching the mission based approach, we found several examples to draw learning from.

The **Dutch Government** launched a national Mission-Oriented Innovation Policy (MOIP) in 2017, across a number of themes, including health and care. These have since been adopted by a range of other countries, particularly in relation to delivering Net Zero.[6,7]

Nesta has launched three innovation missions in 2021, including a healthcare focused mission to halve obesity by 2030.[8] Initial reviews of this way of working by the **Organisation for Economic Co-operation and Development** (OECD) have found it can lead to positive outcomes in relation to agenda setting and mobilising resources.[9] We sought advice and guidance from Nesta to learn more about the approach when we established this work.

Whilst testing our mission approach we have come across others who have also trialled this approach and have exchanged learning. **Vision Zero Cancer**[10] is a mission-based initiative in Sweden that treats cancer as a whole-system societal challenge rather than a set of isolated problems. Inspired by Sweden's Vision Zero approach to road safety, its mission is grounded in the principle that no one should die unnecessarily from cancer, and it aligns diverse actors across healthcare, academia, industry, policy-makers and patients around this shared outcome. Rather than relying on hierarchical authority, Vision Zero Cancer operates through coalition-based leadership built on trust, and shared principles, enabling coordinated action across Sweden's health system. It manages a portfolio of interconnected initiatives spanning prevention, precision medicine, clinical trials and implementation, supported by national funding and international collaboration. Over time, the initiative has transitioned from an innovation-agency programme to a government-embedded national mission hub, demonstrating how mission-led leadership can mobilise ecosystems, accelerate implementation and deliver sustained population-level impact.

We have also been sharing our approach with others as we have gone. The ICHP NWL mission approach was featured by The Innovation Unit and The Health Foundation[11] as an example of good practice.

Examples of mission approaches

System-wide missions, shared outcomes – UK Government (Industrial Strategy, 2017), UK

Mission-Oriented Innovation Policy (MOIP) – Dutch Government, Netherlands

Innovation missions for public good – Nesta, UK[8]

Mobilising ecosystems & resources – Organisation for Economic Co-operation and Development (OECD)[9]

Whole-system cancer mission – Vision Zero Cancer, Sweden[10]

Designing a mission-led innovation approach for NWL

Designing a mission-led innovation approach for NWL

Before agreeing to move towards this approach, we worked with our partners to describe what this could look like, contextualising what we had learnt to understand 'what does this look like in NWL'.

The main approach we wanted to draw from our learning around missions was that the local health innovation ecosystem should focus on fewer areas, each for a longer duration and with a focus on delivering more impact. It was thought that this would lead to more sustainable innovation by enabling the following.

At its core, a mission-led approach in a health and care context is about solving complex, systematic challenges through focused, collaborative and iterative innovation. Through our exploratory work we identified six key components required for successful implementation of a mission approach:

Figure 2: Components for successful implementation of a mission-led approach to innovation

Components for successful implementation of a mission-led approach to innovation

	Component	Description
1	**Clear mission goals**	Defined challenges that align efforts across the whole system.
2	**'Living labs' and 'innovation networks'**	Real world environments where teams formed of different stakeholders and providers can test, learn from and refine innovation collaboratively.
3	**Iteration**	Innovation is not linear; it involves cycles of discovery, design, deployment and learning.
4	**Innovation and implementation science**	Taking a more methodological approach to innovation adoption and deployment.
5	**Creating a learning health system**	Enabling a continuous feedback loop to evaluate and improve interventions in practice.
6	**Systematic alignment**	Missions are supported by aligned levers and incentives, funding, and regulation.

Whilst recognising the health challenges we wanted to tackle through missions would not be solvable with a few months or a year, we initially proposed a two-year mission cycle. We structured it around key activities such as problem definition, human centred design, and evaluation. We anticipated that these activities would be carried out collaboratively with relevant partners to support the spread and scale of innovation, while maximising long-term sustainability.

Figure 3: Summary of mission phases and timeframes

<table>
<tr><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th><th>Q5</th><th>Q6</th><th>Q7</th><th>Q8</th></tr>
<tr><td colspan="2">Discovery</td><td colspan="4">Delivery (adapt, adopt and learn)</td><td colspan="2">Scale</td></tr>
<tr><td colspan="2">1 Describe the space and key problems
2 Define the priority areas of focus of the missions</td><td colspan="4">1 Create innovation networks comprised of implementation sites
2 Try out different solutions to the problems discovered
3 Evaluate which innovations are best placed to deliver impact
4 Design the absorptive mechanisms for innovation at scale</td><td colspan="2">1 Scaling innovations with high confidence of impact
2 Transfer to sustainable business as usual delivery</td></tr>
<tr><td colspan="2">• Problem definition
• Engagement with sector
• Human centred design (end user insights)
• Consulting (including project management)
• Analytical (qualitative and quantitative)
• Setting briefs for specialist teams
• Innovation horizon scanning
• Policy literature review</td><td colspan="4">• Implementation site selection
• Network creation
• Engagement with industry
• Innovation horizon scanning
• Human centred / service (re)design
• Systems engineering
• Evaluation (rapid / pragmatic)
• Procurement compliance
• Business case and grant writing</td><td colspan="2">• Agile implementation / quality improvement
• Evaluation (retrospective)
• Business case and grant writing
• Standard Operating Procedure development
• Benefits realisation</td></tr>
</table>

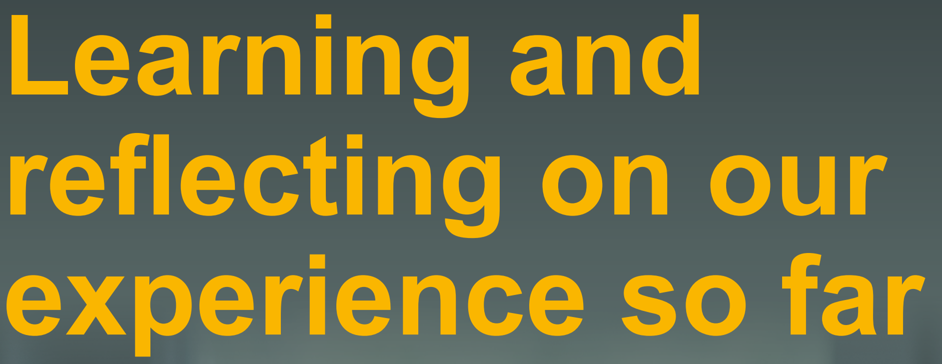
Why did this approach make strategic sense?

Over the past decade our approach to delivery has varied from individual, discrete, short-term projects to longer programmes. Each has been closely aligned with organisational, system or national priorities. However, while these projects delivered meaningful outcomes in their own right, they were often undertaken separately. This limited the opportunity to realise the collective benefit of aligning the efforts and impact and 'the sum greater than parts'. In some cases projects lacked broader system endorsement when commissioned by single lead clients often with specific, pre-determined delivery priorities.

This model often resulted in individual point transformations and often didn't always have the time or mandate to create whole pathway change, or to deal with the underlying systemic barriers to innovation. Operationally, there was also a significant management and leadership overhead to running projects in this way. We therefore viewed moving to a mission-led approach to be a positive step as it could enable us to focus our efforts on creating and influencing sustained impact across the health and care system while helping to bring partners together around clear and shared ambitions. We anticipated that changing to a mission-led approach would potentially bring changes across six key themes, as outlined in Table 1.

Table 1: Themes of mission-led working vs traditional programme approaches

Theme	☆ Mission-led approach ☆	Traditional programmatic approach
Focus	Solving a major challenge through a portfolio of integrated projects	Delivering discrete, often siloed projects
Scope	System-wide, cross-sectoral, long-term	Narrow, often time-limited and organisation-specific
Methodology	Iterative, adaptive, collaborative	Linear, planned, and often rigid
Structure	Innovation networks, living labs, shared learning	Project teams, themes, KPIs
Evaluation	Real-world testing, hybrid effectiveness-implementation studies	Traditional performance metrics and reporting
Culture	Curiosity, humility, co-production	Delivery-focused, often top-down
Resource	Expansive mindset to grow the resource for addressing the problem	Delivery within preset budgets and constraints



Learning and reflecting on our experience so far

Learning and reflecting on our experience so far

We initially established three mission areas concurrently. As we conclude one of our initial missions, we have reflected on our learning, capturing key insights, lessons learned, and practical recommendations for partners and others who may be interested in deploying a similar approach to learn from.

We have structured our learning across the following areas:

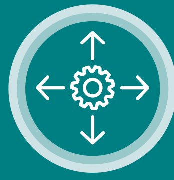
Selecting initial priority areas

Discovery phase

Describing the key problems, long term impacts and key innovations

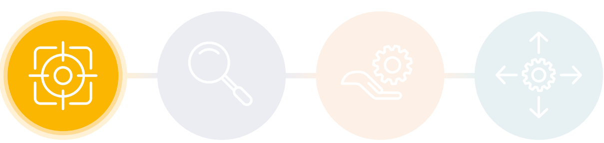
Delivery phase

Adapting and adopting



Scale and impact

For each section we have included what went well and we learned which includes what could be improved, or changed to incorporate into the next missions we stand up and to share learning for those thinking of pursuing this approach.



Selecting initial priority areas

The choices made in the early stages of a mission can set the direction of years of work and significantly shape priorities, partnerships, and investment.

Getting this right was crucial to ensuring that missions helped address the most pressing needs of the system and population and to creating the conditions required for successful delivery.

The first step we took to mobilise missions was to initially convene a group of senior leaders from across the health and care system to select broad areas of focus.

As this was a new way of working across the system it became apparent that there was a need for a forum which could coordinate these discussion and mobilise research and innovation activity at a system level. NWL ICB became the first ICB in England to create a Research and Innovation (R&I) board, which brought together senior leaders from the NHS, the research infrastructure (NIHR) and the innovation infrastructure (ICHP) to formally consider how to progress R&I collectively. It was through the development of this board that the move to a mission-based approach was agreed and established as the key decision-making body for the missions through which delivery and collaboration was managed.

Given the health and care system was emerging from the pandemic, a decision was made to favour pragmatism over perfection. The Board recognised that there were multiple ways the topics for missions and selection could be approached and there would likely be significant variation among stakeholders on the most appropriate areas to focus on. The number of people involved in decision making was therefore initially kept intentionally smaller to enable a focused, agile approach that still represented key constituents. Whilst they represented a broader range of perspectives than we might previously have drawn from as part of more siloed programmes or projects, we have reflected that we needed to better directly engage patients and the public in this stage. We describe later how we did this including working with lived experience partners.

The aim of the selection process was to create a clear and feasible set of priority areas to choose from. The group's decision-making considered success criteria when exploring priorities that could benefit from mission-led innovation (Figure 4).

Taking into account these criteria, three areas were identified:

Population health management and chronic disease

Children's and young people

Acute pathway inefficiency (e.g. discharge)

Each presented the system with a knotty innovation challenge and aligned to an area of pressing need. As a collective, they offered a breadth of focus and opportunities for collaboration with multiple parts of the system.

Figure 4: Long list of priorities, key factors considered in selection and final shortlist (2023)[14]

Long list of ICS priorities

- Population health management and chronic disease e.g. CVD
- Primary prevention
- Address urgent system priorities in acute care e.g. COPD/Resp/Cancer
- Paediatrics/CYP
- Acute pathway inefficiency (e.g. discharge)
- Unplanned care
- Primary care/local care model
- Employment
- Mental health
- Maternity

Success criteria

- High priority issue that we will be able to align work of research, innovation and ICS ecosystem around
- Energy to make a change, defined by there being an existing ICS programme in that area
- Ripe for innovation – know innovations (tech or improvements) in the area
- Route to impact – such as available funding to support the project management and implementation

Top three priorities for R&I to focus on

Population health management and chronic disease

- Focus on CVD and, in particular, hypertension:
- Find undiagnosed cases
- Overcome hesitancy in our various populations to come forward/comply with treatment interventions
- Develop more/better ways of improving adherence to interventions that free up capacity in primary care

Children and young people's mental health

- More effective prevention/early diagnosis, particulary for CYP

Acute pathway inefficiency (e.g. discharge)

- Focus on understanding of issues in discharge and barriers to change and innovation in this area

What went well?

Using this approach, we were able to effectively engage system leadership and build the mechanisms needed to align the research and innovation ecosystem around a set of shared goals. Our approach was pragmatic but inclusive, meaning partners felt their views were taken into account. We brought in data where possible but also left space for further analysis and investigation in order to identify specific target areas within these priorities.

What did we learn?

Our challenge

Whilst being experimental at this stage helped leadership to move quickly and select missions that had buy-in at a senior level, this approach did create some problems.

A perceived lack of systematic method about how mission areas had been selected made initial communications and engagement about the approach more challenging with some stakeholders. This was compounded by a wider lack of understanding about the mission approach from partners, despite early engagement about the decision to move to this approach. Likewise, the system had not worked on shared priorities for research and innovation together in this way before. This meant the relationships, forums and culture for doing this were therefore not necessarily well developed enough for us to easily secure wider agreement on these initial priorities.

> ***"Trying to land this idea to the system was a challenge. There was limited knowledge or understanding of what this was beyond the R&I board."***
>
> Senior ICB stakeholder

> ***"Previously it felt very top down, people didn't feel shared ownership."***
>
> Mission team member

Our solution

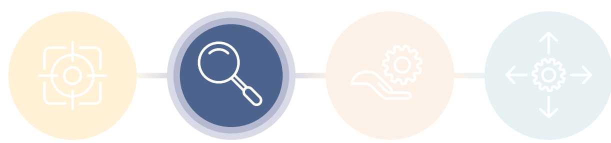
Greater involvement of clinicians, patients and other system partners at this early stage could have helped us hone down our areas of focus more quickly and develop more of an engaging partnership approach. This is an area we prioritised subsequently by bringing in clinical fellows and lived experience partners more explicitly into the scoping and delivery phases.

As we have now embarked on selecting our next mission, we have taken this learning into the process. This includes having a more inclusive and systematic process for selecting missions. We have ensured we have learnt from the previous process.

> ***"We ended up having to convince people that this area makes sense."***
>
> Mission team member

The steps have included ensuring:

1	**Outcome-driven**	Start with a small number of bold, population-level outcomes rather than individual projects, explicitly targeting system-wide change.
2	**Strategic alignment to place**	Prioritise missions that align with local system priorities, and the scale of unmet need and inequalities in NWL.
3	**Evidence-informed but pragmatic**	Used national and local data, stakeholder insights, and learning from prior missions, recognising data gaps and time constraints.
4	**Ecosystem mobilisation**	Test each mission's ability to convene partners across NHS, local government, academia, industry and communities, with shared risk and shared value.
5	**Innovation readiness**	Feasibility testing to assess whether there is a credible innovation pipeline, data and digital enablers, and realistic funding routes to move from pilots to scale.
6	**Adaptive governance**	Iterative scoping, stakeholder sense-checking and research and innovation board oversight to refine options and commit to the mission with the greatest potential for impact at scale.
7	**Inclusive, transparent and time-bound process**	Staged approach, creating a longlist, developing a shortlist, detailed scoping and engagement, final research and innovation board decision made up of range of system stakeholders.



Discovery phase

Once stakeholders had selected these priority areas, we worked through a discovery process to describe the key problems and long-term impact the system wanted to see and identify innovations and interventions which could contribute to achieving this.

To do this, each mission team kicked off a period of consultation with frontline clinical staff, patients, and senior stakeholders to better define the problems currently being experienced and consider the solutions and innovations that could be deployed to address these. We coupled this with rich local data, drawing in particular on the Discover-NOW linked dataset, a de-identified longitudinal linked dataset in NWL, to understand the current issues and draw up ambitions that the system could work towards collectively. The missions spanned both population health and system challenges which was helpful in engaging a range of stakeholders from the provider and commissioner perspectives. There were debates as people grappled with making missions recognisable to their constituent part and solvable vs system wide and ambition e.g. a moonshot. Eventually consensus was reached and the missions were developed with ambitions that had SMART objectives, with definitive themes.

This resulted in each mission focusing on the following themes:

Mission	Ambition	Themes
Improving care for long-term conditions, starting with Cardiovascular Disease (CVD)	***"By March 2029, we will have prevented 25% of heart attacks and strokes in NWL, whilst actively addressing health inequalities."***	Use innovation to improve: • Primary prevention of cardiovascular disease • Detection of CVD risk factors in different settings • Treatment effectiveness, adherence and efficiency
Enabling more days at home	***"By 2026, the NWL health and care system aims to enable 50,000 residents to spend 180,000 more days at home where clinically appropriate, with the right support for them and their families."***	• Identify and evaluate approaches to optimise patient discharge • Use data science and AI to predict people who are most likely to have a long length of stay to enable proactive interventions • Explore tools and approaches to mitigate avoidable deterioration in health status for frailty cohorts
Children and young person's mental health	***"By 2026 we will reduce the number of children and young people presenting in crisis to acute settings by 25%."***	• Understand and address the barriers to quick neurodiversity diagnosis and treatment • Improve the prevention of and care for children and young people entering into crisis through changing models of care

What went well?

We maintained a needs-led approach

While our work was naturally influenced by existing programmes and priorities, we remained committed to a needs-led approach throughout this phase. By grounding our efforts in local data and engaging widely across the system, we were able to shape bold mission ambitions that reflected real improvements to patient care and outcomes. These statements were designed not only to guide delivery, but to inspire collective ownership and momentum.

> ***It was important that we focused on stuff we actually care about solving, on problems that are tractable, and where there's already some energy and resource.***
>
> Senior ICB stakeholder

We consistently used methodology

We felt it was important to be as structured and rigorous as possible during this phase, including to our approach to quantifying and communicating our ambition. We applied a variety of approaches to help us gain a deep understanding of the mission areas, the problems, and to help us to define mission statements, such as: quantitative and qualitative analysis, stakeholder interviews, literature reviews, systems mapping, logic models, and horizon scanning. This enabled us to better generate buy in and signal our ambitions to the rest of the system. To support learning in this area, ICHP is developing a toolbox outlining this methodology and how to apply it when moving to a mission-led approach.

One tool which was used to help select innovations to focus on within missions was the **RICE framework**.

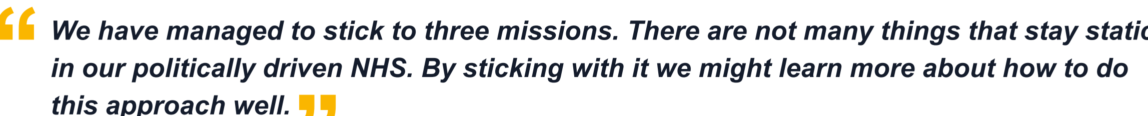
Teams used this in combination with qualitative engagement with implementation sites and senior stakeholders to quantify the respective value of and effort required for different opportunities.

*RICE Prioritisation Framework = Reach **x** Impact **x** Confidence / Effort*

	Reach	Impact (quantitative)	Impact (qualitative)	Confidence	Effort
Explained	Total patient cohort affected	Quantifiable impact that can be had on the cohort	Qualitative level of impact on patients and staff	Level of confidence in achieving the reach and impact	Time and resources required
Example	Number in 000s	Number of bed days impact per head	Score 1 - 5	Score 0% - 80%	Score 2 - 9

We achieved lasting endorsement of our areas of focus

Despite external pressures and shifting priorities, we have been able to continue focusing on our initially identified mission areas for the past two years. Senior sponsors from the ICB in particular have been committed throughout the mission journey so far, which has helped us generate interest and commitment in our work from other partners. We believe this focus has been achieved by selecting the right people to be part of the mission review teams (i.e. bringing in representation from providers alongside the ICB), giving them regular space to meaningfully contribute to the mission direction, taking onboard feedback where provided, and continuously linking our work back to our long-term ambitions.



We have managed to stick to three missions. There are not many things that stay static in our politically driven NHS. By sticking with it we might learn more about how to do this approach well.

Senior ICB stakeholder

What did we learn?

After reflecting on this discovery process, we have identified several lessons that we would apply to the discovery and scoping phase in the future.

Establish clearer criteria once initial priorities have been set

Our challenge

Discovery phases varied greatly in length and complexity for different missions, partly due to the fact that the availability and quality of data varies significantly across parts of the system. Whilst we could often quantify need and benchmark NWL against other regions, data limitations meant it was sometimes much harder to make evidence-based decisions about which innovations to deploy or to measure our impact after implementation. In addition, the type and maturity of available innovations differed greatly between areas.

Sometimes the teams were stuck in a loop of trying to “boil the ocean” and generate sufficient new evidence to justify an approach, rather than move towards delivery.

Our solution

This could be avoided in future by ensuring that a mission’s broad area of focus meets a minimum criteria of data availability and innovation maturity before it is selected. Our internal capabilities also played a role in this, and organisations should review their skills and capacity before starting missions to make sure the team is made up of people with the correct capabilities to deliver a successful discovery phase.

I think we got stuck in a sort of a paralysing loop of trying to do too much analysis or diagnosis before we were brave enough to get on into the doing.

Senior ICHP stakeholder

Design clearer processes to change direction at an early stage

Our challenge

Missions are supposed to be an agile way of working, with teams empowered to take risks and learn from failure. A process should therefore be designed ahead of time whereby stakeholders can agree to pivot if needed. This is especially true where a mission or project has an extended discovery phase due to limited data or available innovations. Sometimes, the best option could be to agree a different priority area where we think we can move more quickly or generate more impact. Teams often feel pressure to deliver once a workplan has been agreed, which can make changing course feel uncomfortable and artificially extend projects or reduce their quality and impact. It is important to remind teams that this is a mission, whilst intended to be stuck to over a longer period, is not a traditional programme with set workstreams, and we have the freedom to change direction to achieve our goals as we are working in complex changing systems.

For example, our long-term conditions mission began with a focus on primordial prevention of cardiovascular disease. However, from the outset, we could not establish a shared understanding of what primordial prevention meant in practice. This lack of clarity led to an extended scoping and testing phase, during which we struggled to identify a viable innovation to implement. After trialling a small test project, we revisited the theme and engaged more deeply with stakeholders to find a better fit. Ultimately, we concluded that while primordial prevention is a critical part of the broader strategy for CVD, it was not an area where we could make a meaningful impact through innovation. We therefore shifted our focus to supporting people already at risk of CVD.

Our solution

Looking back, this definitional challenge had been present since the start of the discovery phase. If the team had felt more confident and empowered to pivot earlier, we could have avoided the prolonged scoping process. Clarifying our position sooner would have sharpened our efforts and created a clearer pathway for engaging other parts of the system in this important area of prevention.

Delivery phase

Once areas of focus for the missions had been agreed, we moved onto delivery. This section reflects on how we approached this, what worked well, and the lessons that would strengthen future implementation.

What went well?

Investing in strong partnerships and leadership

Each mission was provided system leadership by self-nominated Senior Responsible Officers (SROs), who were c-suite executives at either NWL ICB or within provider organisations. The aim of this role was to provide senior stewardship to the mission, support the mission lead and drive the monthly mission review meetings which brought together stakeholders from across the system. We maintained strong buy-in and working relationships with our SROs, ensuring we were aligned with their emerging priorities and connected with the right teams and individuals. In many cases, we developed a "one team" approach to relevant teams in the ICB, with high levels of collaboration between our organisations.

> ***It has been very rewarding for me and my colleagues at NWL ICB to have been able to develop a strong working relationship with ICHP. We have the same priorities, and I have found the mutually supportive approach and openness with each other has meant we have truly come together as one team. We have really enjoyed this partnership so far and are looking forward to continuing to work together.***
>
> NWL ICB Mission SRO

This strong partnership and long term commitment to mission priorities has started to produce real direct benefits for NWL for example in mission 2, there has been a 23% reduction in 'no criteria to reside bed days' (previously known as medically fit for discharge). More broadly, ICHP and the wider sector have been able to leverage significant resources and investment from grants and other sources which would have been much more challenging to realise if working in a more siloed way, or on discrete projects or programmes.

Bringing in clinical and patient voice throughout

We purposefully involved those with expertise to co-design, support and guide us. We designed a Clinical Fellowship scheme, which involved recruiting frontline clinicians working within our mission priority areas to join our delivery teams, provide advice and guidance and sense check our work against operational realities on the ground. We continuously engaged with patients and people with lived experience in the delivery, recruiting lived experience partners to work with us and ensuring they were compensated for their time and expertise. We also undertook engagement while we designed and delivered themes, for example by holding regular patient focus groups, interviews and surveys.

> “***Clinical fellows have been really good… working with innovators, providing support for them through innovation surgeries.***”
>
> Mission Delivery Lead

> “***We've had quite a lot of input into where the Mission goes… our decisions have been taken into account.***”
>
> Lived Experience Partner

Connecting innovators and the system

We designed our teams and processes to stay close to innovators and adapt quickly as new solutions emerged. Each mission team included dedicated roles for horizon scanning and running support sessions for innovators with products relevant to our mission areas, including those not directly linked to our mission themes. We also hosted regular innovation forums, bringing together innovators, patients, clinicians, and system leaders to showcase solutions and signal where demand exists.

What did we learn?

Build teams with the right capabilities at the right time

Our challenge

While missions were designed to be delivered in partnership from across the R&I landscape, dedicated support to lead and coordinate was provided by ICHP. ICHP led the delivery function and supplied dedicated teams to deliver mission priorities. Senior team members from ICHP stayed on missions for the duration, with more junior members being offered the chance to work on multiple missions or rotate around them. Recognising this shift in working, colleagues were empowered to express their preferences and this was taken into account when teams were selected. However, it also meant less attention was given to the particular skills needed at different stages of the mission lifecycle.

Our solution

Consideration should be given to which capabilities are needed at the right time, for example by creating a team with more of a strategy focus to work through missions while they are at an ambiguous early stage, bringing in those with implementation skills as the mission progresses.

Ensure all teams understand and apply the methodologies

Our challenge

Not everyone felt confident explaining what makes a mission different from a traditional programme, nor the core components of mission-led delivery. Building this understanding is essential for consistency as without it projects can tend to revert to traditional structures and approaches.

Our solution

Future missions should emphasise using resources such as the mission tool box, and training (including refreshers and sense checks) to make sure that everyone involved can articulate the approach and its benefits, and ensure that the way work is delivered aligns with this approach, for example by putting the creation of "living labs" at the centre of project planning.

Balancing energy and capacity for a new way of working and philosophy

Our challenge

There was significant debate about the best way to launch a mission-led approach as we moved into the delivery phase. Some thought that it was best to be ambitious and generate the maximum amount of energy by launching all three missions simultaneously in a 'big bang' approach. Others thought a gradual start with a staggered timeline would work best, helping to manage capacity and to enable learning between teams. We chose to launch all three missions simultaneously, which generated interest but stretched resources thin. The scale of change was underestimated – it required an overhaul of ICHPs operating model to orientate around missions and different approaches and culture with ICHP and the system.

Our solution

In future, staggering the start of missions and considering the optimal number to run at any given time could potentially help reduce pressure on staff who are also working through changing the way they work, and create opportunities to apply lessons from earlier missions to subsequent ones.

Ensure the data landscape is strong enough

Our challenge

Robust data availability is non-negotiable for mission success. Without comprehensive, high-quality data, teams cannot make evidence-based decisions, monitor progress effectively, or credibly demonstrate impact. Past missions have faltered due to fragmented, incomplete, or inaccessible datasets, particularly for example in relation to children and young people's mental health where things are less digitised.

Our solution

To ensure future success, data readiness should be assessed as a foundational criterion during mission planning and selection. This includes verifying the availability, accessibility, and relevance of key data assets. Where gaps are identified, concrete remediation plans must be developed and agreed upon early, with clear ownership and timelines.

Turning governance and culture into enablers

Our challenge

While the mission-based approach is designed to foster experimentation, governance structures within the health and care system can inadvertently create a risk-averse environment that inhibits innovation. Furthermore, varying levels of cultural maturity around innovation more broadly and maturity of collaboration around a mission approach across systems and organisations at times led to tension, misalignment, and delays in decision-making.

Our solution

One of the biggest areas that systems need to focus on is recognising how the governance, partnership working, and leadership approaches and culture including the ability to take a longer term view on benefits might need to change. This has required and continues to require changes to business as usual with some work still to do.

Senior sponsors and leaders play a critical role in overcoming these barriers. By championing flexibility and cultivating a culture that embraces experimentation within clearly defined safe boundaries, they can help unlock the full potential of mission-led innovation. For example, when trying to kick off a small-scale pilot with a provider, it took over six months to secure the required approval from the Trust, which was forced to treat the project as a full procurement and change to service delivery as opposed to a short-term test. Trust policies such as teams not being able to use any medical devices which the Trust has not directly procured are rightly designed to ensure safety and value for money, but do not lend themselves to teams testing new and clinically validated solutions which could save time and money in a small, safe and controlled way. In an ideal world, colleagues in partner organisations would be actively engaged in the mission review process and use this space to air this challenge and get support to resolve it.

Visionary leadership

Our challenge

Leaders from within the health and care ecosystem are critical in driving the mission work forward as they bring credibility, context, and momentum that external direction alone could never achieve. Their deep understanding of local challenges and organisational dynamics means they can translate high-level mission goals into practical, actionable steps that resonated with teams on the ground and met the needs of their patients and local communities. Whilst we had system SROs in our first missions, we could have done more to ensure that through their leadership we created a genuine sense of shared ownership across the system – so that people feel that the mission was owned by them, not something being imposed from outside.

Our solution

We need to pivot the role of SRO from an accountable officer to a visionary leader – their role being to champion the missions, bridging organisational boundaries, aligning incentives, and sustaining collective focus when the work becomes complex or ambiguous. Mission leaders need to actively model the behaviours required to deliver a successful mission, including openness to learning, comfort with uncertainty, and a willingness to let others lead when this best serves the mission.

Strengthen collaborative delivery to build trust

Our challenge

Although missions were intended to be system-wide, in practice they often felt driven by one or two organisations. ICHP was consistently involved in leading and delivering, having provided leadership for the approach and resources to support delivery. Early on, ICHP fell into a default position of reporting on progress and seeking steers when speaking with SROs, as opposed to genuinely collaborating and sharing delivery responsibility across different organisations.

Our solution

Future missions should involve all relevant stakeholders from the start, with strong efforts to ensure engagement and ownership, with clarity on roles, responsibilities and expectations. This needs to include all partners involved including academic and commercial. Specific focus needs to be on building trust across partners and stakeholders, this will help improve communications and ways of working. Ultimately, strong collaborative and trusting relationships will cultivate shared purpose and result in more successful mission delivery.

Agree a route to funding adoption early on

Our challenge

Securing sustainable funding was a significant challenge. Several senior stakeholders in the ICB have reflected that we shouldn't embark on these missions without a clear route to funding for scaling innovation.

Our solution

With learning about how to leverage the mission approach, future missions should adopt a systematic approach to funding from the outset matching funding types to mission stages and leveraging the whole system to identify and apply for opportunities. Focus should always be placed on how tested innovations and interventions can be funded through business as usual (BAU) funding streams if deemed to be successful and effective. Some mission work delivered to date have focused purely on effectiveness and impact but without sufficient thought on which funding streams, levers and partners would need to be brought in to procure or deliver interventions on a BAU basis. Projects also need to be aligned with existing NHS budget planning timeframes.

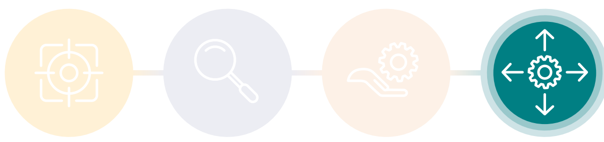
Identify and agree implementation sites early

Our challenge

Throughout all of our missions to date, identifying sites to trial and evaluate innovations has been a challenge despite the 'system' saying they had signed up to NWL missions. Calls for expressions of interest from providers have not always resulted in sites signing up, or significant delays in getting sites up and running.

Our solution

Ideally, SROs would nominate sites and teams from their organisations who could be selected to work with us on the mission and identify them early on in this process.



Scale and impact

The fourth component of our mission approach is to scale innovations that we have identified to be effective.

Since adopting this approach, it has become clear that the timeframes we initially planned with relation to scaling innovation were ambitious (Figure 3). This is reflective of the challenging context currently at play within the local health and care system and the learning points this report has already highlighted. This is also unsurprising for the scale of the challenges we have set ourselves. However, we have remained focused on measuring and describing our impact where possible using leading and lagging indicators. For example in how we have:

What went well?

Keeping an eye on longer term impact

We recognise that for some of our work, the impact we will realise will not come into effect in the short to medium term. This is a key feature of the mission approach and avoids a tendency for some projects or programmes to focus on less helpful or less relevant metrics that can be reported on in year.

What did we learn?

The flexible, experimental nature and long-time horizon of a mission-led approach means demonstrating impact can be hard

Our challenge

By being encouraged to fail and pivot where required, sometimes we have not been able to hit original deadlines or timescales. This is a feature, rather than a fault, of the mission approach – but it can make demonstrating impact harder than with regular programme or project based working.

Our solution

Spending time at the beginning of embarking on the mission approach to air these tensions is important. Ensuring leaders are committed to support work happening in this way is vital. Building energy through connections, sharing learning within the system and beyond, and celebrating progress are all important features of this type of work.

Developing metrics to measure impact over time is challenging

Our challenge

We have put significant effort into identifying metrics that can demonstrate the impact we are having. However, despite the strength of the local data landscape, we have sometimes been slow or unable to create useful metrics, particularly ones that are directly linked to and can show progress through our logic models or theories of change. We have also found it difficult to rigorously demonstrate the efficacy of the mission approach through data.

Our solution

In future missions, more focus on this will need placed on this from the start ensuring we test the outcomes and related metrics with key stakeholders from the onset, so we are all working towards the same vision of success. Capturing the qualitative changes as well as the quantitative ones e.g. improvements in ways of working and relationships is also extremely useful.

We have not yet been able to remove some of the barriers to innovation that still exist, despite moving to a mission-led approach

Our challenge

The mission approach has led to some system level work to address common barriers. For example, we have created an online evaluation toolkit for NWL to help enable the effective evaluation of projects, programmes and innovations across the health and care system. However, further work with key stakeholders is required to improve how the system adopts innovation when it is proven to be beneficial, for example reforms to procurement or making the funding required for spread and scale more readily available.

Our solution

These interdependencies are important and should be mapped at the outset of the journey. Taking a systems view and understanding the incentives, power and influence and other aspects of the system is critical.

The shifting political and operational climate continues to have an impact on our ability to deliver

Our challenge

Regardless of the energy generated through a mission-based approach, colleagues in other parts of the system deal with shifting political priorities and operational realities which can reduce their focus on innovation and their capacity to support our work.

Our solution

The only constant in our work is change. It is important to acknowledge that the context within which we are all working will continue to change and by staying informed and providing support to our key stakeholders as they navigate changes, the mission team can remain focussed on the challenge whilst the time to commit to the work may ebb and flow.

Summary of our learning to date

Summary of our learning to date

Our experience of testing a mission-led approach shows that success depends on the following:

1

Shared ownership must be designed in from the start

The mission needs a clear, compelling ambition that people recognise as their problem to solve, not someone else's programme.

Senior leaders must actively back the mission and align it to system priorities so it becomes the work, not an add-on.

A small number of named senior responsible owners, alongside a coalition of the willing, helps move quickly from intent to delivery.

Missions gain traction through collective accountability, not sponsorship alone.

2

Missions only work when the whole system is involved

No single organisation can deliver mission-level change on its own.

Collaboration needs to happen before solutions are defined, not once projects are underway.

Being explicit about who is at the table, who should be, and who is missing helps identify gaps in system involvement.

Asking "what will feel different in how we work because of this mission?" surfaces the wider system changes needed, not just technical fixes.

Mission-led working requires a deliberate shift in culture and ways of working

Adopting a mission-led approach requires cultural as well as structural change to become business as usual.

Successful missions demand a move from organisational ownership to system stewardship, prioritising shared outcomes over institutional gain.

Time spent on partnership working and system leadership must be valued, with teams given permission to work across boundaries and challenge the status quo.

Trust, psychological safety and shared purpose across matrix and cross-organisational teams are essential, not optional.

Leaders need to model the behaviours required, including learning, comfort with uncertainty, and letting others lead when this best serves the mission.

Scaling what works must be planned from day one

From the outset, teams should be clear about what evidence is needed, and by whom, for approaches to become business as usual.

Experimentation is essential, with permission to test, learn and stop activity that is not delivering value.

Sustainable impact needs dedicated resource

Mission-led change cannot be delivered off the side of existing roles.

Clear funding routes and resource commitments are needed to support delivery and to scale effective approaches once impact is demonstrated.

Data and governance are enablers, not afterthoughts

Access to timely, high-quality data underpins credible decision-making and learning.

Proportionate governance and shared data infrastructure allow missions to track progress, demonstrate impact and adapt over time without slowing delivery.

What does this mean for systems and senior leaders?

Mission-led innovation is not a quick fix, but it offers a credible way to tackle complex, long-standing challenges at scale.

For leaders, success depends on:

Backing a small number of clear, outcome-focused missions

Actively championing collaboration across organisational boundaries

Accepting managed risk, failure, iteration and learning as part of delivery

Aligning funding, governance and incentives to support scale

We have already taken this learning into account as we move forward to identify a new mission.

Our second mission selection process was purposefully designed to avoid some of the pitfalls we encountered in our first, and encompassed the following key criteria:

New mission selection framework – based on learning

Strategic importance

✓ **Strategic alignment, for example:**

- Local priorities
- National policy and strategy

✓ **Member endorsement and local prioritisation, for example:**

- Number of interested Trusts
- Existing interest from other sectors of health and care system

✓ **Scale of need, for example:**

- Qualitative insights
- Quantitative insights
- RICE framework

✓ **Economic value, for example:**

- Return on investment (ROI) per £1 of investment

Feasibility

✓ **Partnership potential, for example:**

- RICE framework

✓ **Funding opportunities, for example:**

- Grants and awards
- National investments / commissioning

✓ **Innovation landscape maturity, for example:**

- Existing innovations
- Market readiness

✓ **Implementation capability, for example:**

- Local data landscape
- Number of suitable implementation sites

This framework ensures that NWL identifies a mission area with the required data, energy and buy-in from the system to meaningfully test innovations and scale them where effective.

Conclusion

Conclusion

Over the past three years, we have seen how a mission-led approach can enable more focused, collaborative and impactful working across NWL. For ICHP, this has meant shifting away from delivering isolated projects towards acting as a system integrator and convener, helping partners come together to tackle bigger, more complex challenges that matter most to our population and health and care system.

We are now starting to see clear dividends from this approach. Through missions, ICHP has supported stronger partnerships, helped maintain alignment with system priorities, and created the conditions for the system to test, learn and adapt in real time, rather than relying on rigid, pre-defined plans. By the end of year two, we are beginning to see deeper impact on long-standing challenges (as reflected in our evaluation of OPTICA), reinforcing our collective commitment to this way of working. We have therefore selected a new mission towards the end of 2025/26, which we will communicate in due course.

This way of working has not always been easy, but it has demonstrated the value of ICHP's role in **orchestrating collaboration, holding a shared line of sight to outcomes, and supporting a culture of learning and delivery at pace**. For these reasons, we remain committed to missions both as a delivery model and as a mindset that shapes how we approach change across NWL. We will continue to share our learning and progress, and welcome reflection and dialogue with others who are also adopting mission-led approaches.

Finally, we are delighted North West London's mission-led approach has been highlighted as a Case Study in a guide produced by the Innovation Unity and funded by The Health Foundation – **Time to be Bold: A guide to driving innovation adoption through strategic commissioning**.

If you'd like to learn more about the mission approach or work together on our current or new missions, please contact ICHP:
ea@imperialcollegehealthpartners.com

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Appendix

We are the Innovation Network for NWL

"Our ICS needs to become a learning system that applies best evidence to make sure we are doing the right things, avoiding the pressure to defend the status quo or expend effort implementing ineffectual and unevidenced initiatives. Doing this relies on a much more systematic use of research and innovation as a fundamental feature of how our ICS does its work. To enable this, we will focus R&I efforts on a small number or priority missions..."

NWL ICB Strategy, 2023

Mission 1

Optimising care of Long Term Conditions

(starting with Cardiovascular Disease)

We will maximise the experience and outcomes for residents with chronic disease and improve value for money by preventing, diagnosing and treating a person's needs.

Mission 2

Enabling more days at home

(starting with the acute pathway)

We will take action to minimise the harm suffered by patients being in the wrong care setting with the aim of seeing people in the right place at the right time, every time.

Mission 3

Supporting Children and Young People's (CYP) Mental Health

We will take action to ensure that children and young adults have the best start in life with a particular focus on promoting positive mental health and enabling an appropriate range of support to enable early and effective intervention.

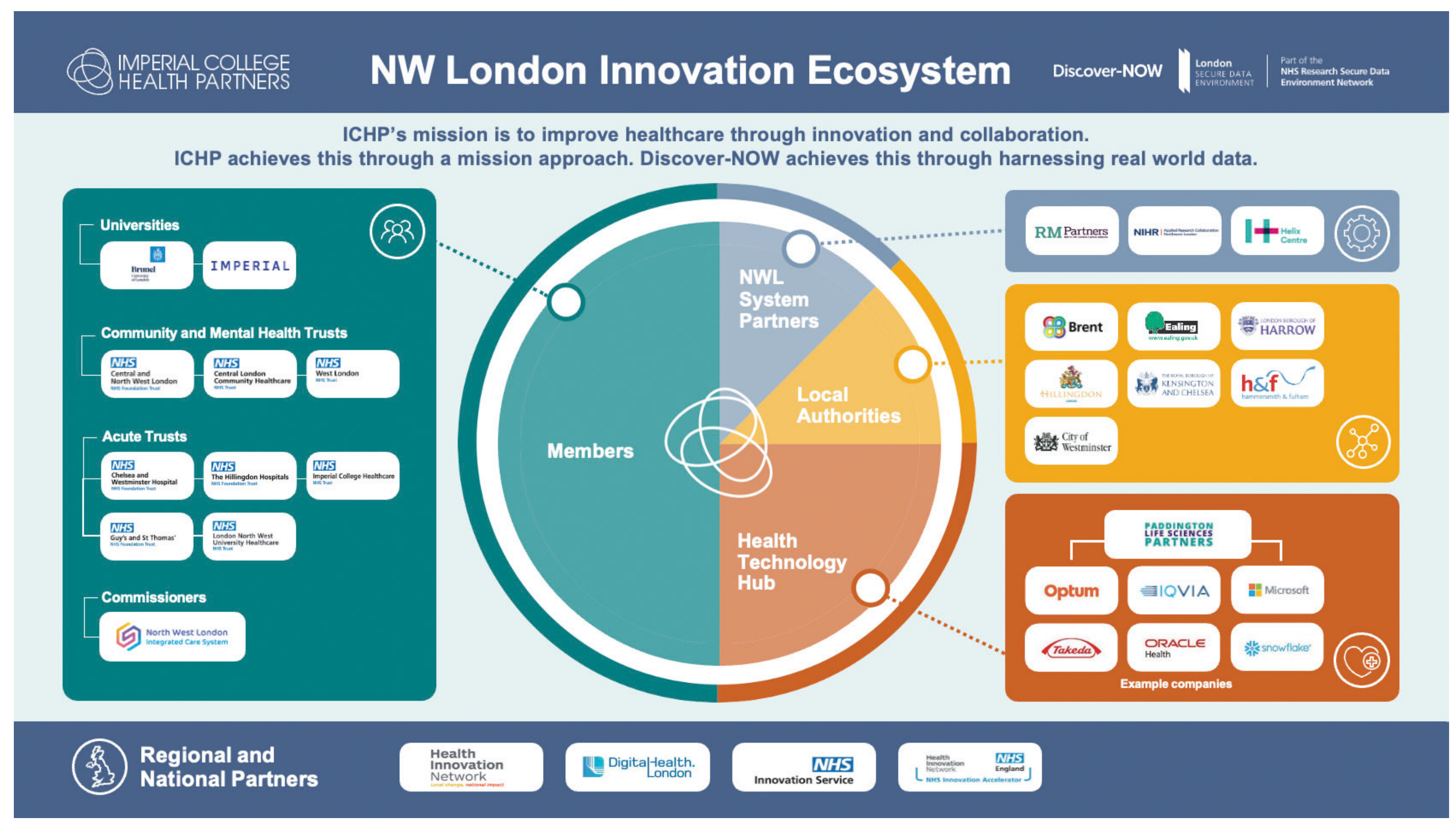
Enabling capability: Data and intelligence platforms

We will take action to maximise health and wealth through the intelligent use of data, supporting North West London to turn clinical interactions into data, data into information, information into insight and insight into action.

Overview initial mission priority areas

Mission	Sub-mission priority	Description
Cardiovascular disease	Detection	Identify individuals at risk or with undiagnosed CVD by implementing, evaluating and scaling digital community detection initiatives in different settings.
	Prevention and optimisation	Manage risk factors and optimise care for those with/at risk of CVD by testing and evaluating CRM models of care, implementing novel therapies at neighbourhood level.
Enabling more days at home	Predictive Length of Stay	Apply artificial intelligence to predict people most likely to be at risk of long Length of Stay, enabling proactive interventions.
	Optimising discharge	Implement technology enablers to optimise discharge coordination (OPTICA, Federated Data Platform).
Children and young person's mental health	Crisis presentation in acute settings	Deliver reduction in the percentage of CYP presenting in crisis to EDs and reduce reattendances.
	Neurodevelopmental disorders	Provide screening, signposting, and support to a percentage of children on neurodevelopmental waiting lists.

NWL Innovation Ecosystem



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