London Health Mission: Summary of LOTI Workshops

4 March 2026

About this document

This paper has been prepared by LOTI, for consideration at the 11 March 2026 Health Mission Board. It sets out the key insights from six workshops held in February 2026.

Board members are asked to:

1. Endorse the initial insights;
2. Share their views, building on the insights generated at the workshops and;
3. Agree the next steps for the Theory of Change workstream.

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LOTI's approach - the 4 Walls Method

The 4 Walls Method enables many different stakeholders to work together on the early stages of mission-based work, involving them in building a common understanding of:

1. The desired mission outcomes (**Future**)
2. Where we are now (**Now**)
3. What barriers stand in the way (**Problems**)
4. Opportunities for solutions (**Opportunities**)

Key insights

As part of the workshops, LOTI engaged with over **80 leaders and practitioners** from across the public sector, including boroughs, the voluntary and community sector organisations, NHS and health.

Using the 4 Walls Method framing, we asked participants to share their views on the Health Mission goal: "**By 2035 we will have significantly closed the gap in health inequalities in our city, utilising London's innovation and digital transformation opportunities**." being clear that the focus was on the digital exclusion aspects of health inequalities.

Throughout the workshops, two parallel themes emerged, one relating to **digital inclusion**, the other relating to **wider systemic changes** - in the absence of which, digital solutions would have limited benefits.

Here's a summary of views shared.

1. Future

The aim of this activity was to envision how Londoners and practitioners would be better off as a result of work undertaken as part of the Health Mission.

Digital Inclusion

a) **Londoners** are healthier, happier and empowered as active participants in their own health and care because they have seamless access to their health records, understand what their data means for their health, and can navigate services in their preferred language/format. Digital tools are co-designed with communities — including those historically excluded — so they are intuitive, trustworthy, and genuinely useful, rather than an additional barrier.

b) **Practitioners** are supported by the latest technology and inclusive digital tools to handle routine triage, translation, and reminders, reducing the administrative burden. This allows practitioners to effectively engage with disadvantaged communities without communication barriers and to support people in a holistic way.

c) **Community organisations and voluntary sector partners** are properly resourced and represented in digital design decisions. This ensures that staff who work in the frontline and Londoners who need to access health and care services have a real voice in shaping the tools and services that affect them.

Wider System

d) **Londoners** receive tailored, holistic care instead of being bounced back and forth between siloed departments. Housing, social care, and clinical services work together around the person, with no wrong front door regardless of where someone first seeks help. Their overall life expectancy and daily well-being vastly improves due to healthier urban environments and proactive preventative health and care. Mental health is treated with the same urgency and resource as physical health.

e) **Practitioners** are part of a collaborative, strategically aligned and well funded health and care system that focuses on preventative measures as much as addressing needs when they arise. They are supported and fulfilled in their roles because they finally have the time and data needed to make informed decisions. With interoperable systems and a multidisciplinary approach, they can treat patients holistically.

2. Problems

The aim of this activity was to explore the barriers preventing us from achieving the envisioned futures for Londoners and practitioners. Here is a summary of key insights.

Digital inclusion

a) **Barriers to Access and Skills:** Many patients are digitally excluded due to the cost of equipment and data (lack of affordable connectivity), as well as a lack of digital literacy, trust and confidence. Skills building is needed for both patients and the workforce, including training for practitioners on what digital tools exist and how to promote them effectively.

b) **Impact on Vulnerable Groups:** A “digital by default” approach leaves behind marginalised groups, including older adults, non-English speakers, refugees, the homeless, and those with physical limitations like arthritis.

c) **User Experience and Trust:** Existing digital tools, such as the NHS App, are often not consistently integrated with the wider health and care system, creating fragmentation, confusion and overall poor experience. Additionally, there is a deep mistrust of technology, fear of data sharing, and anxiety over the use of AI. This is compounded by misinformation that is often widespread and easily mistaken for trusted sources, eroding confidence in official health guidance and digital services.

Wider System

d) **Need for Non-Digital Options:** Digital solutions are not appropriate for everyone; there is a strong need to maintain in-person service offers to prevent widening health inequalities.

e) **Fragmented Systems and Siloed Data:** Health and social care suffer from poor integration, with different IT systems that do not talk to each other. There is a lack of data sharing between primary, secondary and social care, leading to fragmented clinical pathways and often poor outcomes for people.

f) **No Shared Vision:** Organisations in the wider health and care system often work in silos, and lack a shared vision. The culture is frequently defensive or resistant to change, and decision-making is often not truly grounded on people's lived experience.

g) **Funding and Commissioning Shortfalls:** Funding is short-term, distributed in silos, and heavily focused on addressing acute crisis care rather than proactive holistic prevention. This limits long-term outcomes and benefits and leads to fragmented support.

h) **Lack of Holistic Care:** The current system focuses on treating the symptoms rather than providing preventative, holistic care that accounts for mental health, physical health, and wider social determinants like housing. Services are rarely co-designed with (seldom-heard) communities, meaning the people most affected have little say in how care is delivered.

i) **Workforce Capacity and Leadership:** The healthcare workforce is overwhelmed, understaffed, and burdened by high caseloads. Strategic progress is frequently hindered by constant organisational restructuring, and a disconnect between leadership vision and frontline delivery. Senior leadership of public sector organisations in London does not reflect the diversity of the city, limiting cultural insight, lived-experience perspectives and the credibility needed to design and lead effective responses to digital exclusion and health inequalities.

3. Opportunities

The aim of this activity was to explore the opportunities that can address the challenges and help achieve the envisioned futures.

Digital Inclusion

This section focuses on key opportunity areas that can help ensure equitable access to technology and build the skills necessary to navigate digital healthcare.

a) **Accessibility and Hardware:** Opportunities include providing facilities and hardware to enable access to online services and improve digital literacy. There was a strong sense that offering free Wi-Fi in NHS settings would increase uptake of online services and help build confidence. Using levers such as Section 106 and Community Infrastructure Levy funds could help embed free Wi-Fi in new building developments. For the most excluded residents, including those experiencing homelessness, providing free mobile devices and data should be treated as a baseline, not an exception.

b) **AI and Digital Technology:** This was a substantial theme where participants referenced real promise in AI — particularly Ambient Voice Technology (AVT), multilingual translation tools, and AI agents that help patients navigate complex referral pathways and identify service gaps — but with clear conditions: human oversight/leadership throughout, robust ethical considerations, guardrails, and co-design with the communities who need to access these services. The consistent framing was that AI should free up clinicians for richer human conversations, not replace them. A key consideration/discussion was that of how we could harness AI's potential while preserving the human touch that makes care effective.

c) **User-Centered Design and Standards:** Digital platforms should be co-produced with users, be culturally sensitive, meet accessibility standards and multilingual. Participants recommended establishing a minimum digital inclusion standard for all NHS digital services and creating a dedicated "Digital Inclusion Lab" to proactively engage communities. Designing for inclusion also means accounting for non-digital users from the outset.

d) **Education and Support:** There is a need to educate and empower people to use ‘digital front doors’, supported by community Digital Champions and staff who are trained to be confident with digital tools. Libraries were frequently mentioned as underused assets —

participants envisioned every library having staff able to connect people to health and care services. Another idea was that of peer-to-peer and intergenerational skills exchange models

e) **The 'Human in the Loop:** An important insight was that digital tools should not be the only option. Services must ensure there are always non-digital alternatives or a person to talk to, so that those unable to use digital means are not disadvantaged.

Wider System

This section captures broader structural, financial, and organisational changes needed to improve the health and care system.

f) **Funding Reform:** There was a consensus that funding needs to be long-term and collaborative. Suggestions included moving from 12-month grants to longer term (e.g. at least 3-year) planning and pooled funding across health, social care, and Voluntary, Community, and Social Enterprise (VCSE) sectors. Budgets should be ring-fenced specifically for innovation and preventative measures.

g) **Data and IT Integration:** Rather than massive new IT projects, the focus should be on inventing ways for different existing systems to integrate better. This includes shared medical records, and transparent data sharing between the NHS, local authorities, and VCSEs. Equally important was the patient-facing dimension: participants were clear that patients themselves should have control over their own data and health records, with the NHS App functioning as a passport across primary and secondary care — a single, accessible place where a Londoner's full health picture lives.

h) **Organisational Structure and Workforce:** Systemic improvements include removing organisational boundaries across the NHS and with other public sector organisations, by for example, establishing Memorandums of Understanding (MOUs) between agencies. A standardised approach should also be adopted to ensure consistent remuneration for people with lived experience who contribute to programme design and delivery. In parallel, public sector organisations

should accelerate targeted programmes to improve diversity at senior leadership level, with clear accountability, measurable milestones and active sponsorship from system leaders, to ensure leadership better reflects and responds to London's communities. Crucially, this also means investing in the workforce itself — addressing change fatigue, building confidence beyond digital skills, and ensuring staff have the capacity to sustain long-term transformation rather than just manage day-to-day demand.

i) **Community and Holistic Care:** The system should shift toward proactive prevention and address the wider determinants of health - employment, housing, and financial security. Prevention interventions should sit at the heart of Neighbourhood Health Plans, with social prescribing and investment in the VCSE sector treated as core infrastructure. The principle of - making every contact count — equipping every interaction between a resident and a service as an opportunity to connect them with the right support —was a theme that came up a few times.

j) **The "No Wrong Front Door" Model:** Instead of relying on a single point of access, the system should adopt a "No wrong front door" approach. This ensures that wherever a Londoner presents for help, that specific 'front door' is equipped to support them in a way that meets their whole needs, even if the issue falls outside their direct remit. This model could involve Voluntary, Community, and Social Enterprise (VCSE) organisations—rather than just primary care—serve as the primary access point.

Next Steps

The workshops have identified many different competing and complex issues and pressures that will impact on the Health Mission goal. This reveals a clear need to create ways for colleagues, practitioners and service users from across the system to come together to jointly envisage the future they want to create and the solutions that can lead there. To that end, LOTI recommends:

1. Engaging with the London Youth Partnership Board, Chief Medical and Nurses Officer Networks, to get their perspective on the mission goal and desired outcomes.
2. Conducting “day in the life” studies in three settings to include a GP surgery, a community health centre and a hospital. “Day in the life” studies involve researchers spending time alongside both patients and practitioners, observing how health services are navigated within the reality of everyday workflows and lived experience. This generates rich, contextual insight that surveys and interviews cannot capture — revealing the hidden barriers, workarounds, and unmet (digital exclusion related) needs that drive health inequalities.
3. To accelerate the 'Design' stage of the Theory of Change, in a cost-effective way, LOTI proposes working with a university partner to achieve the following:

   Testing concepts/solutions through simulations
   This would involve rapidly testing existing and new hypotheses (including ones that have emerged as part of the workshops) between April and July 2026, through simulations and scenarios, mocking up solutions with practitioners from across the public and VCSE sectors, using the latest tools, methods and technologies.

   Developing quick-wins and a blueprint for Year 1-3
   By the end of that period, we should have an early set of quick wins, as well as defined work packages that outline solutions that have merit in taking forward.

   Between September - December 2026, LOTI will host a large-scale event (approx. 100 people) where practitioners from across the public and VCSE sectors as well as academics, experts and innovators will come together to input, review and give feedback on the work so far. This is an opportunity to engage with a wider audience to further shape the work packages and iterate mocked up solutions.

Board members are asked to approve the next steps for this workstream.

End