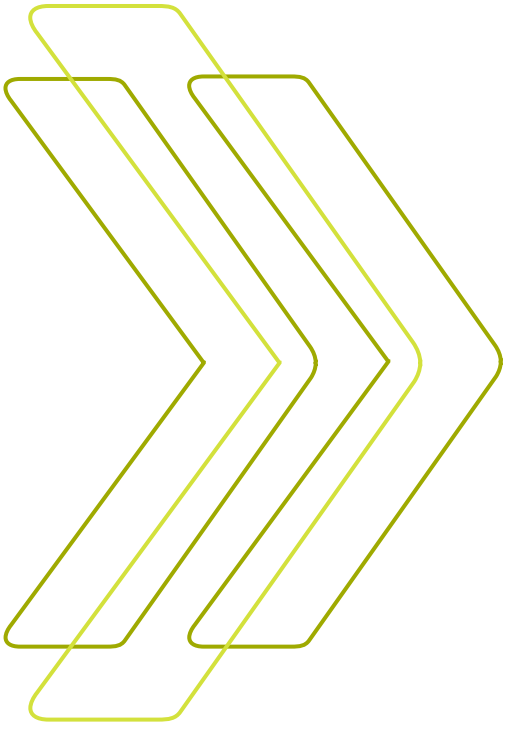
The King's Fund

Ideas that change health and care

Integrated care systems in London

Challenges and opportunities ahead



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This independent report was commissioned by the Greater London Authority (GLA). The views in the report are those of the authors and all conclusions are the authors' own.

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Key messages

- The development of integrated care systems (ICSs) across England is the latest step in a series of policy measures intended to encourage closer partnership-working between local NHS organisations, local authorities, voluntary sector organisations and others. Over time, these partnerships will have greater collective responsibility for managing NHS resources and performance and for changing the way care is delivered.
- The five systems that now cover London have their roots in partnerships established in 2016. Over the five years since then, relationships and trust between local leaders have strengthened, and the ways of working and governance arrangements that underpin the partnerships have matured significantly.
- Lessons appear to have been learnt from the shortcomings in the process of developing the original system plans in 2016. When new plans were developed in 2019, there was much greater emphasis on clinical involvement and patient and public involvement. Importantly, local government leaders now report being more involved in the work of ICSs and shaping their priorities, a significant shift since the early days of the partnerships.
- Responding to the Covid-19 pandemic required organisations to work together more closely than ever before. Leaders report that having a shared sense of purpose, more frequent contact, and the temporary suspension of some national requirements all helped to create the conditions for rapid progress. More work will be needed to sustain this progress beyond the pandemic and ensure it is not undone by the re-emergence of long-standing barriers to integration.
- Some changes to NHS services were introduced rapidly during the pandemic to help the system cope with the additional pressures created by Covid-19. Where these may become permanent, they will need to be subject to appropriate democratic scrutiny and consultation.
- The pandemic response led to rapid adoption of digital technologies in health and care. In building on the progress made, there are issues that will need to be addressed such as information governance and digital exclusion.

- System partners are now more focused on tackling the major health inequalities that exist in London, creating a moment of opportunity for lasting change. The priority should now be to move from ambition to delivery, with action needed at a borough, ICS and London level. The Mayor has a crucial role to play through his leadership of the London Health Inequalities Strategy.
- Workforce constraints remain the biggest risk for health and care in London. With many workforce responsibilities being passed to ICSs, bold and co-ordinated action is needed to ensure that initiatives to address these constraints add up to a comprehensive plan that ensures health and social care services across the city have access to the workforce they need for the future.
- The state of London's health and care estate also remains a key strategic issue and will need to be a major focus for collaborative working going forward.
- ICS leaders should strengthen efforts to involve local authorities in ICSs and develop integrated approaches to health and social care. Fundamental weaknesses in the social care market require a regional and national response, while the pandemic has underlined that investment in and reform of social care are more urgent than ever.
- Public finances are under enormous pressure as a result of the pandemic, with local government finances under particular strain following a decade of budget cuts. There is a significant risk that these pressures will make it harder for organisations to continue working together to make the best use of NHS and local government resources.
- It will be critical that London's ICSs build on the progress made to ensure that collaborative working becomes a reality for all parts of the system, including clinicians, social care providers and communities. Ongoing evolution of structures and governance arrangements will be needed to underpin this in the longer term and to reflect developments in national policy, particularly the emerging roles of provider collaboratives and local place-based partnerships, and the prospect of ICSs being placed on a statutory footing.

1 Introduction

Back to the future

2020 was not a good year for long-term planning. At the start of the year, London's five integrated care systems (ICSs) and sustainability and transformation partnerships (STPs), like the other ICSs and STPs across England, were poised to publish their responses to the NHS Long Term Plan, setting out their local ambitions for partnership-working and detailing how the national strategic vision would be put into practice. The arrival of the Covid-19 pandemic meant that those plans were never formally published, although many individual plans had already been made available on the websites of the organisations involved.

The pandemic will continue to be the most urgent priority for the capital's health and care organisations over the coming months as the system responds to continuing high rates of Covid-19 infection and hospitalisation, and grapples with the logistical challenge of delivering the largest vaccination programme the country has ever seen. However, health and care leaders are also looking to the future beyond the immediate crisis. As they do so, attention is focusing on the role that ICSs will play in overseeing service transformation and improving population health.

By April 2021, all areas of England will be covered by an ICS bringing together local NHS organisations with local authorities, voluntary sector partners and others. These partnerships have the task of collectively planning and integrating services that better meet the health needs of their population. They do so at a time when the value of working together is clearer than ever, with closer collaboration across organisational boundaries being seen (in at least some cases) as one of the few positives to have emerged from the pandemic.

About this report

As the development of ICSs gathers pace, this report examines the state of play in London, focusing on the following:

- the current state of partnership-working in London's five ICSs

- the strategic direction these systems have identified for the long-term future of health and care in London
- how these plans and priorities have been changed by the response to the Covid-19 pandemic.

The report was commissioned by the Greater London Authority (GLA) and is based on independent research conducted by The King's Fund. It builds on two previous reports which examined the development of sustainability and transformation partnerships (the predecessors of ICSs) in London (Kershaw *et al* 2018; Ham *et al* 2017). Following the publication of the first of these reports, the Mayor outlined six tests he would expect to be met before giving his support to any major health and care transformation or service reconfiguration proposals in London (see page 16 for further details) (Mayor of London 2017). These six tests, together with issues identified in our previous reports, were used to inform the scope and key areas of focus for this work.

Our approach

Due to the impact of the Covid-19 pandemic, this work was conducted in two phases.

- The first phase was conducted before the outbreak, between January and February 2020. This explored the long-term plans and strategic priorities of London's five ICSs, and how the partnerships had developed since our previous reports.
- The second phase was conducted after the first wave of Covid-19, between October and November 2020. This explored how partners in London had worked together to respond to the initial phases of the pandemic, and how Covid-19 has had an impact on the longer-term priorities for London's five ICSs.

Across these two phases, our research consisted of the following components.

- Documentary analysis of the strategic plans produced by each partnership in late 2019 in response to the NHS Long Term Plan.
- Twenty-seven in-depth qualitative interviews with health and care leaders across London. Interviewees included ICS executive leads and other senior leaders from each of the five systems, local authority representatives from each ICS area and representatives from local Healthwatch organisations,

Londonwide LMCs, the NHS England and Improvement London region, and NHS acute, community and mental health trusts. There were 22 interviewees in total as some individuals were interviewed in both phases.

- A roundtable discussion in November 2020 attended by 15 senior leaders from across the London health and care system. Attendees included representatives of several pan-London bodies (the GLA, Public Health England and NHS England and Improvement London region), local authorities, ICS leads and ICS independent chairs.

This report brings together our findings from both phases of the work – as well as drawing on wider literature and policy documents – to provide a progress report on ICSs in London.

2 Context

National policy context

Sustainability and transformation plans and integrated care systems

In December 2015, NHS planning guidance announced the introduction of sustainability and transformation plans (STPs) (NHS England 2015). Forty-four areas of England were identified as the geographical 'footprints' for the STPs, tasked with bringing local NHS providers and commissioners together along with local authorities to develop plans for the future of health and care services in their area. STPs were expected to outline how they would implement the agenda of the NHS Five Year Forward View (NHS England 2014) and how they would achieve improved efficiency and financial balance.

STPs had difficult beginnings; they were heavily criticised for lacking transparency and engagement in their development and for proposing unrealistic financial savings and reductions in hospital capacity (Ham *et al* 2017; Alderwick *et al* 2016). Over time, the emphasis shifted towards developing collaborative-working arrangements across local organisations and STPs were later rebadged as sustainability and transformation partnerships (NHS England 2017).

STPs are now evolving into integrated care systems (ICSs), a closer form of collaboration in which NHS organisations and local authorities take on greater responsibility for collectively managing resources and performance and for changing the way care is delivered. In contrast to the introduction of STPs, there has so far been a phased introduction of ICSs based on the maturity of local systems, although there is now a clear national target for all areas to be covered by ICSs by April 2021 (see below).

There is no blueprint for developing an ICS; so far, their development has been a locally led process with significant differences in the size of systems and the arrangements they have put in place. There is also wide variation in the maturity of partnership-working across these systems. The NHS national bodies have adopted a permissive approach meaning that, in contrast to many previous attempts at NHS reform (and to the initial introduction of

STPs), the design and implementation of ICSs has been locally led within a broad national framework (Timmins 2019). A common feature across many systems is that much of their work is being delivered through activity in local places and neighbourhoods, with the ICS supporting this and leading on functions that are best performed at scale (Charles *et al* 2018).

ICSs and STPs are part of a fundamental shift in the way the health and care system is organised. Following several decades during which the emphasis was on organisational autonomy and competition, ICSs depend instead on collaboration and a focus on places and local populations as the driving forces for improvement (Charles 2020). The central aims of these partnerships are to integrate care across different organisations and settings; to improve population health, including addressing health inequalities; and to ensure the sustainability of services through collective action to enhance productivity and make the best use of available resources (NHS England and NHS Improvement 2020a).

The NHS Long Term Plan

In June 2018, the government announced a new five-year funding settlement for the NHS (a 3.4 per cent average real-terms annual increase in NHS England's budget between 2019/20 and 2023/24). To unlock this funding, NHS national bodies were asked to develop a long-term plan for the service. Published in January 2019, the plan set out key ambitions for the next ten years. It built on the policy platform laid out in the Forward View, emphasising the need to integrate care to meet the needs of a changing population. It also identified clinical priorities including cancer, cardiovascular disease, maternity care and mental health, and set out a greater role for digital technologies (NHS England and NHS Improvement 2019a).

Among the many commitments in the plan was a target for ICSs to cover the whole of England by April 2021. The plan outlined several core requirements for ICSs but stopped short of setting out a detailed blueprint for their size or structure. It also indicated that systems should streamline their commissioning arrangements, 'typically' meaning a single clinical commissioning group (CCG) across each ICS (Charles *et al* 2019).

The plan also contained a list of potential legislative changes to accelerate progress towards integration. These included proposals to reduce competition and streamline procurement in the NHS, and to strengthen joint-working

between organisations through new joint committees. The proposals were subsequently further developed (NHS England and NHS Improvement 2019b), receiving widespread support from senior health and care leaders and national representative bodies (Augst *et al* 2019).

STPs and ICSs were tasked with developing five-year system plans setting out how they would implement the ambitions of the NHS Long Term Plan. In June 2019, an implementation framework was published setting out the approach STPs and ICSs should take to create these plans (NHS England and NHS Improvement 2019c). It required systems to provide two core elements:

- a strategy delivery plan – including: a description of local need; what service changes will be taken forward and how; how 'system infrastructure' will be developed, including workforce, digital and estates; how efficiency will be driven; how local engagement has been undertaken to develop the plan; and how financial balance will be delivered

- supporting technical material – including financial, activity and workforce plans.

The initial intention was that these plans would be developed and published by autumn 2019, but this timeline was repeatedly pushed back due to external events including the 2019 general election and, later, the Covid-19 pandemic. By the time the first wave of the pandemic took hold in March 2020, systems had completed the development of their plans and many had published draft versions on their websites (subject to final sign off). But as local and national health and care leaders rightly focused their efforts on the pandemic response, the final stages of this process inevitably took a back seat, meaning that in most cases final plans were never published (including the five London plans).

Recent developments in the national reform agenda

The case for collaborative-working across the health and care system has been strengthened by the experience of Covid-19. Following the first wave, policy-makers were keen to embed progress made in organisations working more closely together by accelerating the development of ICSs and putting them on a more formal footing. This led to the publication of *Integrating care: next steps to building strong and effective integrated care systems across*

England (NHS England and NHS Improvement 2020a), which set out an updated vision for how NHS England and NHS Improvement sees the NHS moving forward on the integration agenda with its partner organisations, and signals significant shifts in ICS governance and how organisations will be expected to work together in the future. The document sets out four elements that will underpin the future structure of the health and care system:

- **ICSs**, bringing together commissioners and providers of NHS services with local authorities and other partners to collectively plan and improve health and care
- **place-based partnerships** between local organisations that contribute to health and wellbeing in smaller areas within an ICS – for most areas (but not all) 'places' will be based on local authority boundaries
- **provider collaboratives**, bringing together NHS trusts and foundation trusts within places and across ICSs to work more closely with each other. The form these will take and their function remains to be seen, with further guidance expected in early 2021
- **the national and regional bodies**, including NHS England and NHS Improvement, the Care Quality Commission (CQC) and the Department of Health and Social Care, which will increasingly work through systems rather than individual organisations.

These will build on work at the level of local neighbourhoods, where primary care networks (PCNs) will join up primary and community services.

While giving further clarity on the structures underpinning the future health and care system, the document still left room for local determination and flexibility, for example, around the size and boundaries of places, the division of roles and responsibilities between place and ICS levels, and the scale, scope and membership of provider collaboratives. However, one area where there is no flexibility is that CCGs will be required to merge and become co-terminus with ICS footprints before April 2022 (Murray and McKenna 2020).

The document also put forward options to put ICSs on a statutory footing, initiating a short engagement process around these proposals (The King's Fund 2021). The Government subsequently published *Integration and innovation: working together to improve health and social care for all*, a White Paper setting out legislative proposals for a Health and Care Bill (Department of Health and Social Care 2021). This built on the proposals already set out by

NHS England and NHS Improvement, including proposals to establish ICSs as new statutory bodies which would subsume the functions of CCGs.

London policy context

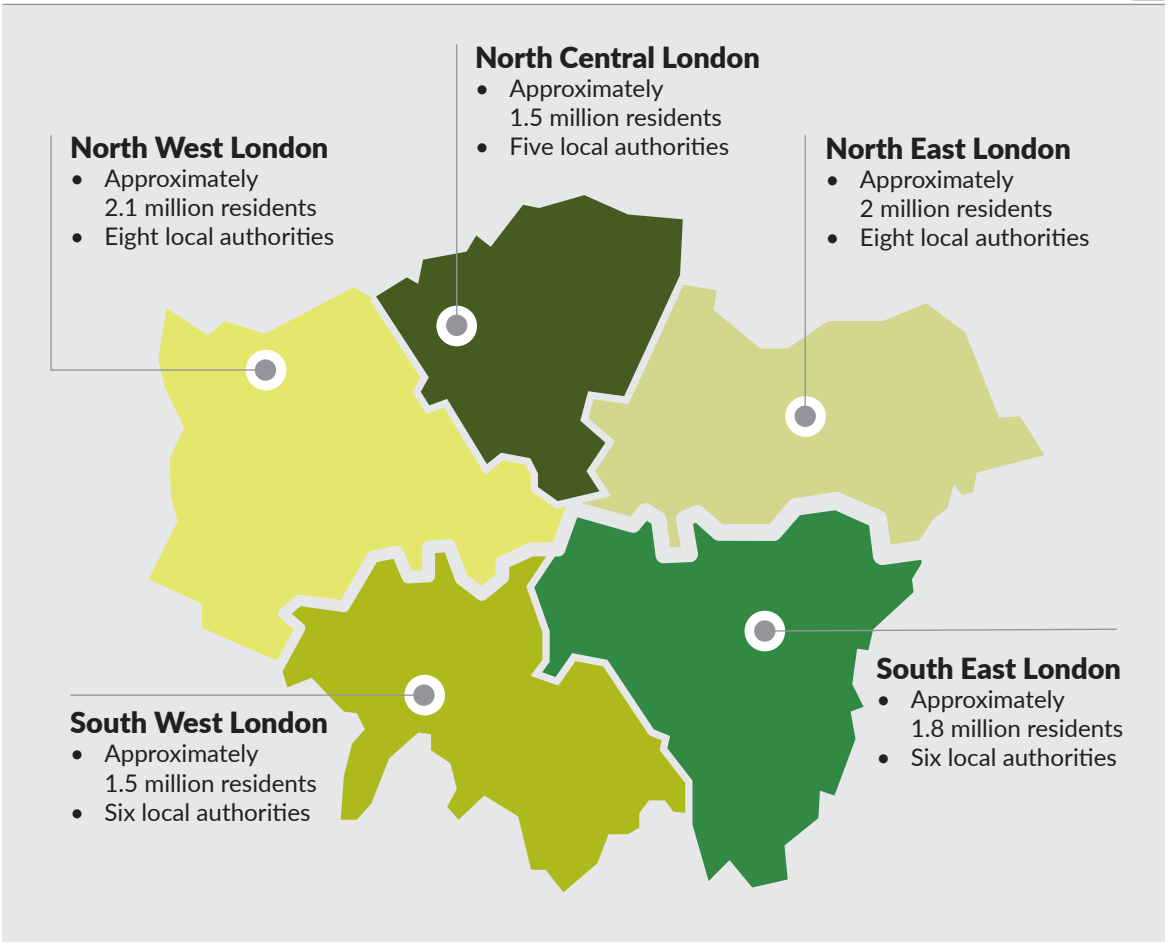
London is unique in terms of its population and the challenges is faces. It is by far the largest city in western Europe, with almost 9 million people living in Greater London and many more in the surrounding metropolitan area. Its economic output is the fifth largest of any metropolitan area in the world (Berube *et al* 2015) and yet there are also high levels of poverty – it contains seven of the ten local authorities with the highest levels of deprivation among older people in England (Department for Communities and Local Government 2019). There are stark health inequalities, with healthy life expectancy varying between boroughs by as much as 15 and 19 years for men and women respectively (Greater London Authority 2017). The population is highly diverse, with more than 300 languages spoken and more than a third of residents being born outside the UK (Office for National Statistics 2013). Rapid population growth is taking place in some parts of the city – North East London has the fastest growing population anywhere in the UK (Office for National Statistics 2020).

London is also a highly complex system institutionally, with a large number of organisations playing a role in relation to health and social care, including but not limited to the 33 local authorities, NHS commissioners, NHS providers and voluntary sector organisations, as well as various pan-London organisations and representative bodies (*see* Naylor and Buck 2018). A longstanding question is how this large and changing cast of organisations can best work together in the interests of improving health and care in London.

In recent years a number of important steps have been taken towards greater system-working and collaboration in London. In 2017 a memorandum of understanding was signed by all the main players in the capital and key national bodies, agreeing that some control over health and care will be delegated to the capital. The intention is to give the Mayor, local authorities and London health leaders more control over key decisions, with political oversight and leadership through the London Health Board. A number of new arrangements have been put in place to oversee key strategic issues, such as the London Workforce Board (since replaced by the London People Board) and the London Estates Board.

At a sub-regional level, London developed five STPs to support partnership-working in North West London, North Central London, North East London, South East London and South West London respectively, all of which had achieved ICS status by December 2020 (*see* Figure 1).

Figure 1 Footprint of ICSs/ STPs in London



The King's Fund's previous reports on London's STPs explored the experience of establishing the five systems. Our initial analysis in 2017 (Ham *et al* 2017) highlighted the following.

- There were common ambitions across the systems to give greater priority to prevention and early intervention and to strengthen and redesign primary care and community services, as well as plans to reconfigure hospital services.
- Some proposals to reduce the use of hospitals and cut bed numbers were not credible on the scale proposed, particularly in the context of predicted population growth.

- Plans to close the expected financial gap were also questionable, with a lack of detail on how this would be achieved and unrealistic expectations regarding efficiency savings.
- Much more needed to be done to engage with partners in local government and other sectors and to involve patients and staff in the work of STPs.

In response to the publication of this report, the Mayor outlined six tests against which he would require assurance before supporting any major health and care transformation or service reconfiguration proposals in London. These tests covered: health inequalities and prevention, hospital capacity, financial investment and savings, impact on social care, patient and public engagement, and clinical support (Mayor of London 2017).

Our subsequent progress report on London's STPs in 2018 (Kershaw *et al* 2018) found the following.

- STPs in London had spent much of the past year trying to overcome the challenging process by which they were introduced. Their main focus had been on the internal workings of the partnerships, building external relationships and addressing gaps in staff and public engagement
- STPs had moved away from the bed-modelling and financial positions set out in or inferred from their original plans in recognition of the fact that some of these plans were unrealistic in the face of rising demand for care and anticipated population growth
- While there were some signs that local government involvement in STPs was improving, this remained variable and, in a small number of places, non-existent.
- The report also identified concerns across the system about a strategic vacuum in London-wide leadership for health and care resulting from the abolition of the strategic health authority in 2013 and fragmentation in regional NHS leadership.

Recent policy developments in London

The Mayor of London has a statutory responsibility to produce a health inequalities strategy, which aims to provide a common set of goals for

organisations in London to work towards together. The current strategy focuses on five key themes: children; mental health; places (including air quality and housing); communities (with a particular emphasis on social prescribing); and healthy lives (including food, tobacco and alcohol) (Mayor of London 2018).

A significant recent milestone was the publication of the 'London Vision' in 2019 (Healthy London Partnership 2019). Signed by the Mayor of London, London Councils, and the regional offices of NHS England and NHS Improvement and Public Health England, this document outlines a shared vision for the future of health and care in London framed around an ambition to make London the healthiest global city. The Vision identifies 10 priorities for pan-London collaboration where the case for working in partnership at London-level is seen to be strongest:

- reducing childhood obesity
- improving the emotional well-being of children and young Londoners
- improving mental health and progress towards zero suicides
- improving air quality
- improving tobacco control and reducing smoking
- reducing the prevalence and impact of violence
- improving the health of homeless people
- improving services and prevention for HIV and other sexually transmitted infections
- supporting Londoners with dementia to live well
- improving care and support at the end of life.

During the Covid-19 pandemic the regional office of NHS England and NHS Improvement has played a significant leadership role in London. In April 2020, a document produced for ICS leaders – *Journey to a new health and care system* – described the actions that would be needed from the five ICSs over an 18-plus month period both to respond to the immediate challenges posed by the pandemic and to emerge from it with a system capable of recovering swiftly and delivering the ambitions set out in the London Vision (NHS England and NHS Improvement 2020b).

The *Journey to a new health and care system* aims to make faster progress with system-working, stepping up the role of the five ICSs so that these become 'the primary level at which the new health and care system [is] designed and delivered'. It continues the strategic direction set out in the London Vision and elsewhere but argues that further action is needed 'over and above those that we planned in the London Vision and our ICS plans' in order to limit the impact of Covid-19, address widening health inequalities and close the gaps between supply and demand. The expectations for ICSs described include bringing about the following:

- new community-based approaches to managing long-term conditions
- new approaches to minimise hospital stays, eg, through discharge models that maintain reductions in delayed transfers of care
- building on the shift to online delivery seen during the pandemic – 'virtual by default unless good reasons not to be' for primary care, outpatients and diagnostics
- further consolidation of specialist services and sharing of clinical support services such as pharmacy and pathology
- an enhanced focus on tackling health inequalities.

The impact of Covid-19 on the health and care system in England

The health and care system faced significant challenges before Covid-19 hit. NHS performance had deteriorated following a prolonged period of funding restraint, leaving more people waiting longer for care; social care was in urgent need of investment and reform and was struggling to meet the needs of those who rely on it; workforce shortages across the NHS and social care were having an impact on services and increasing pressure on staff (The King's Fund 2020c, d); years of cuts to public health funding had taken a toll on vital services (The King's Fund 2020b); and improvements in life expectancy had slowed and health inequalities were widening (The King's Fund 2020a).

Covid-19 exposed many of these issues and in some cases exacerbated them further (Charles and Ewbank 2020).

- People who have been worst affected by the virus are generally those who had worse health outcomes before the pandemic, including people from some ethnic minority communities and those living in poorer areas.
- Weaknesses in the social care sector, caused by years of underfunding and neglect, were laid bare by the impact of Covid-19, with tragic consequences for service users, families and staff.
- The health system entered the crisis already stretched to the limits following the longest funding squeeze in its history; to prevent hospitals being overwhelmed, the only option was to temporarily suspend or reduce the provision of non-emergency care.
- Already under enormous strain, staff have now had to work through the demands of the pandemic, taking a significant toll on their physical and mental wellbeing.

As well as responding to current and future waves of the virus, the health and care system now faces the challenge of tackling soaring waiting lists caused by a backlog of elective care, responding to the longer-term consequences of the pandemic on people's health and wellbeing, and delivering the largest vaccination campaign in its history. Steps that NHS organisations were expected to take in response to these and other challenges were set out in a national letter to health system leaders (the 'phase 3' letter) published in August 2020. This highlighted the need to urgently restore non-Covid health services, prepare for future surges of Covid-19 infections, support staff and take action on inequalities (NHS England and NHS Improvement 2020c).

Meanwhile, local government finances are under severe strain. Over the past decade, local authority budgets have been cut despite growing demand for social care (Bottery and Babalola 2020). These pressures are now even greater as a result of Covid-related spending pressures and a reduction in income from business rates and other sources (Ogden *et al* 2020).

Beyond the immediate impact on health and care, national and local lockdowns to control the virus have caused deep damage to public finances and the wider economy. The social and economic consequences will undoubtedly have an impact on the population's health and mental wellbeing in the longer term.

Added to this are challenges and uncertainties presented by managing the impact of the UK's exit from the European Union (Holmes *et al* 2021).

3 How are London's ICSs developing?

In this section, we explore how the five local systems across London are developing. First, we consider progress before Covid-19, including the process by which systems developed their five-year plans. We then consider the impact the pandemic response has had on partnership-working in London.

How were systems developing before Covid-19?

Since our last assessment of London's STPs in 2018, all five systems have continued to develop their joint-working arrangements and the underpinning governance and leadership arrangements. In all five systems, it is clear that governance arrangements and ways of working are still developing and that there will be further iterations of these as the systems evolve.

A prominent feature in all five plans was the emphasis on establishing 'systems within systems'. This means that the systems are centred around smaller local partnerships within them, based around well-established geographical footprints of boroughs and local neighbourhoods. While this is a feature common to ICSs and STPs across England, interviewees highlighted it as being particularly important in London given the size and complexities of the five systems and the strength of identity and relationships at borough level. Some of the plans set out the broad activities they expected to be led at system, place (ie, borough) and neighbourhood levels; typically, this would involve partnerships at borough level leading changes to the way local services are delivered (particularly community-based services) with the wider system leading changes which benefit from a larger scale such as changes to specialist hospital services, digital, estates and the workforce.

There is variation in how local systems describe their arrangements, for example South East London refers to its borough-level partnerships as 'local care partnerships' while North Central London describes its partnerships as 'integrated care partnerships'. It is clear that these local partnerships, and the dynamics within them, will not be entirely consistent across London, as each ICS is adapting this model to their unique context and circumstances (*see*

Table 1). North East London has a fourth geographical level of partnership-working between the system and borough level based on three areas with a long history of partnership-working, and North West London has two clusters that group its boroughs into inner and outer London boroughs.

Table 1 Overview of system, place and neighbourhood arrangements in London

Systems	South East London ICS	South West London ICS	North East London ICS	North West London ICS	North Central London ICS
Additional geographical levels of organisation			3 'local systems'	2 'clusters' (inner and outer North West London)	
Places	6 'local care partnerships	6 'integrated care partnerships'	7 'place-based systems'/ 'integrated care partnerships'	8 'integrated care partnerships'	5 'integrated care partnerships'
Neighbourhoods	35 PCNs	39 PCNs	48 PCNs	51 PCNs	30 PCNs

In the plans and in our interviews with ICS leaders, there was a clear ambition to devolve much of the activity down to borough level in line with the principle of subsidiarity. This was most prominent in the plan for South West London, which was built up from six borough-based plans, with their local priorities taking prominence. Across all systems, there remains some uncertainty about how the delegation of roles and responsibilities from ICSs to borough-based partnerships will work in practice and there was also a strong recognition among those we spoke to that this will evolve in different ways and at a different pace depending on the system and borough in question.

CCG mergers had either been completed or were planned in all systems to align commissioning footprints with the five ICSs, marking a major structural change for commissioning in London, which previously had 32 CCGs roughly matching the boundaries of the borough councils. These proposals have progressed at pace since the documents were produced; in October 2020, North West London became the final London system to approve its CCG merger (Serle 2020), meaning that by April 2021, there will be just five CCGs across the capital, each co-terminous with an ICS.

The merger of CCGs onto ICS footprints means that there will no longer be a one-to-one relationship between CCGs and boroughs. Some systems are therefore putting in place new borough-based arrangements to sit alongside their newly merged CCGs, for example South East London is establishing 'place-based boards' to build on joint commissioning arrangements across CCGs and local authorities, and North Central London is planning to appoint senior leaders for each borough within the newly merged CCG.

There are ambitions to develop deeper collaboration between providers and commissioners over time, including suggestions that some commissioning functions may be undertaken by provider collaboratives in the future. In relation to specialised commissioning, a number of pieces of work have been initiated to test out new approaches that would give local systems (including providers) a greater say in how specialised commissioning budgets are spent in their area, in keeping with changes that are taking place elsewhere in England (Wenzel and Robertson 2019).

There was also strong evidence in the first phase of our work of increasing collaboration between providers across the capital, including through the establishment of clinical networks and group models (where multiple provider organisations come together under shared leadership arrangements), and the appointment of joint chairs across provider organisations. Interviewees highlighted this as being a significant change in ways of working, underlining the cultural shift from competition to collaboration that is taking place; one provider told us that these changes would have been 'inconceivable' only very recently.

Interviewees highlighted the establishment of PCNs as another significant change in the provider landscape, and these were seen as key delivery vehicles for many of the systems' ambitions. There was therefore a major focus in the plans on supporting the development of PCNs, with the types of support described including leadership programmes for PCN clinical directors, organisational development support, and bringing together data to develop population profiles for each PCN.

How systems developed their plans

There were significant differences between the development of this set of plans and the original STP plans in 2016. The core ask from the NHS national bodies was different; in 2016, there was a strong focus on delivering financial

savings and the consequences of this for service provision, whereas in 2019 local systems were tasked with setting out how they would deliver the priorities of the NHS Long Term Plan and how they would develop as systems. While the focus on efficiency and finances still featured, this was a much less prominent objective than in 2016.

The process of developing plans was also markedly different due to the differing starting point for local partnerships. In 2016, partners in STPs were coming together for the first time, defining geographical boundaries and establishing purpose, roles and ways of working. By the time responses to the Long Term Plan were developed, local systems had been working together for over three years, and partnerships were generally considered to be much more mature (although this varied between and within the systems). In contrast to the original STP plans, these plans largely brought together and built on work that was already underway.

The five systems differed in whether they saw their plan primarily as a response to the national Long Term pPan or as a comprehensive local health and care plan setting out the full priorities and ambitions of their local partnership. Some systems – particularly North West London and South East London – were clear that the document was a response to the Long Term Plan with a flavour of their wider priorities and that their plans therefore didn't reflect the full range of work their partnerships are doing. In contrast, South West London's plan was seen first and foremost as a local document, bringing together the priorities and ambitions for the local health and care system (based around local health and care plans developed in each borough) while ensuring the priorities of the Long Term Plan were also covered.

Interviewees stressed to us the importance of understanding the documents as 'plans among many other plans'. Although the documents were long and detailed (in the region of 150–250 pages), we were told that much of the detail sat elsewhere, for example in separate estates strategies or in documents detailing planned service reconfigurations. Interviewees also told us that they had not been able to plan in detail beyond 2021 for key areas such as workforce and social care due to uncertainty about national plans and funding in these areas. We were therefore told that the plans were best seen as 'living documents' (rather than detailed implementation plans) and that the specifics would be developed and revisited over time.

In our interviews with local leaders, we heard that the process of developing the 2019 plans had been far more collaborative and inclusive than in 2016. While in most cases NHS organisations were still the lead partners in drafting the plans, we were told by the NHS and local government leaders interviewed for this work that there was much stronger involvement among key partners and stakeholders including local government, patients and the public, and clinicians.

Local authority involvement varied significantly between areas but in all cases, there appeared to have been marked improvement since 2016. Most of the local authority leaders we interviewed appeared not to have a sense of full ownership over the plans, arguing that they were fundamentally still 'NHS plans' rather than jointly owned plans, but in general they said that they had been able to influence the things that mattered to them and that they had been involved to the extent they felt they needed to be.

The plan produced for South West London was distinctive in terms of the prominence of local authority perspectives. Many of the actions committed to were joint actions to be undertaken by the NHS and local authorities and there was greater emphasis on issues that are priorities for local government (eg, housing, social care and creating 'compassionate places').

A variety of mechanisms were being used to support local authority involvement across the five systems, including:

- joint NHS/local authority leadership of work programmes
- local authority representation on ICS governance bodies
- involvement of health and wellbeing boards and overview and scrutiny committees.

In terms of the process for signing off the final plans, some interviewees suggested that taking these through formal local authority processes involving a full council or cabinet would help to secure buy-in from elected members and that this might help colleagues in local government to be able to get the traction needed to implement the plans. On the other hand, some interviewees suggested that was not felt to be necessary given that there had been local authority input throughout the process.

Most of the examples of local government involvement we heard about involved chief executives, directors of adult social services, directors of public health and other senior officers from councils. There was limited evidence of involvement from those providing local authority-funded services, such as social care providers.

Some systems are now looking to deepen local authority involvement through their formal governance, for example South East London has changed its ICS leadership group to have equal representation from NHS and local government, and there are plans to make joint NHS/council appointments in all six of their boroughs by the end of 2020/21. Some systems described an ambition to deepen the involvement of elected council members, and in some cases, the role of the ICS independent chair was seen as being important in building relationships with local political leaders.

Patient and public involvement was also more evident than in 2016. Plans included specific sections describing engagement activities that had taken place, and in several cases quotes from members of the public were included throughout the plan to illustrate 'what people have told us'.

Mechanisms used to involve patients and the public included:

- citizens panels
- engagement events
- working with partners in the voluntary and community sector and local branches of Healthwatch
- public representation on leadership boards and working groups
- outreach at public events and in public places such as shopping centres
- commissioned research including interviews and focus groups
- establishing a formal engagement working group to have oversight of engagement activities.

It is difficult to assess how successful these activities have been in reaching all of the diverse groups and communities that make up London's population, or the extent to which the content of the plans was shaped by the insights gathered, but in general our interviews suggested that public engagement activities have become a more central part of the planning process (this is

based on the views of the Healthwatch organisations and local health and care leaders interviewed for this research, as the scope of the work did not include interviews with patients and the public). All five systems indicated that public engagement would continue after the publication of the document, particularly around how their high-level ambitions would be implemented in practice.

Many of the engagement activities listed above were supported by local Healthwatch organisations. There are some challenges for local branches of Healthwatch to establish how they can best facilitate public engagement in system level decisions (as they are organised on a borough basis). Chief executives from South West London Healthwatch organisations now meet regularly, and in South East London they have appointed a joint role (funded by the CCG) to work across the ICS and ensure their insights can be translated to inform decisions at this level.

Clinical involvement was necessary to ensure system plans were informed by clinical evidence and best practice, and to engage local health and care professionals in the implementation of the plans. We heard that the mechanisms for engagement were significantly better developed than they were in 2016 (we were not able to speak to a broad range of clinical leaders within the scope of this work, so this assessment is based on the views of the local health and care leaders involved in this research, a small number of whom were also clinicians).

Three broad approaches have been taken to clinical engagement.

- Senior clinical leads have been designated to lead work programmes within each system alongside wider groups of other clinicians involved in shaping the programmes.
- Every system has some mechanism to gain broader clinical input outside of specific work programmes. For example, in South West London the full set of work programmes is overseen by a Clinical Programme Board, while in South East and North East London Clinical Senates play a key role in supporting programmes and plans to be safe, effective and clinically sound. In several areas, attempts have been made in recent years to redesign these forums to ensure they function effectively. Specific mechanisms have also been developed to engage GPs and other primary

care professionals, for example a Primary Care Board in North East London.

- Engagement events, conferences and workshops have been used to get input from frontline professionals as well as people in clinical leadership roles. For example, in April 2019 South West London held their first clinically led conference attended by over 250 health and care professionals, as well as local people. There have also been engagement events for specific work programmes, such as the Outpatient Transformation Summit in North Central London in May 2019.

While these three mechanisms may help to ensure that clinical leaders are bought into the process, it is less clear how far this filters through to frontline health and care staff, and we heard concerns that primary care clinicians have felt disengaged from the work of ICSs. As with public involvement, questions about the strength of clinical support may become increasingly pertinent – and the issues at stake more contentious – as systems move from agreeing high-level strategy to developing the detail of specific proposals and putting these into practice.

How regional collaboration was evolving

All five plans acknowledged the need for some functions to be led at a London-wide level and referenced the health and care vision for London (known as the London Vision – *see* London policy context). We heard that mechanisms have been put in place to bring together the five ICS leads with leaders from the NHS England and NHS Improvement London regional team, and interviewees told us that relations between systems and the region had vastly improved. We were told that, since NHS England and NHS Improvement had been brought together, the new regional teams had largely overcome the previous issue of contradictory messages being issued to providers and commissioners, and that the relationship had become more collegiate, shifting from a directive approach to a two-way conversation, although we also heard that there continue to be some examples of people's behaviours failing to align with this new approach.

Some interviewees emphasised the crowded landscape of pan-London bodies and initiatives and suggested that more could be done to join these up and to clarify roles and responsibilities.

How did this change as a result of the response to Covid-19?

Among those interviewed in the second phase of this work, the vast majority spoke positively about how system partners had worked together through the pandemic response. We heard that there had been a noticeable acceleration of collaborative working between organisations within boroughs, within ICSs and across London as a whole. These sentiments were equally reflected among the NHS and local government leaders we interviewed. Examples included:

- collaboration between NHS organisations, with providers supporting each other through mutual aid and temporarily reorganising how and where some services were delivered (this marked a significant acceleration of the provider collaboration already underway)
- joint working between different councils, for example to co-ordinate care home capacity across boroughs
- greater coordination between NHS and local government teams to manage discharge and community support
- statutory organisations working more closely with voluntary and community organisations and local pharmacies to support people who were shielding.

We heard that the focus of partnership working shifted towards 'getting on and doing things' and 'making real changes'. Meanwhile, efforts to further develop system governance arrangements were largely put on hold. One interviewee described how, for the first time, 'this actually feels like a system rather than a forum talking about what a system might look like'.

The relationships and dynamics between partners were also felt to have shifted. While ICSs and STPs were previously perceived as being predominantly focused on NHS services (particularly acute hospitals), through the response to Covid-19 systems operated as more equal partnerships across the NHS and local government in order to respond to the challenges they faced. We heard that there was generally now a more optimistic view among those working at borough-level about the opportunities and relevance of work being led across ICSs.

On the NHS side, systems were previously viewed as being heavily commissioner led, but providers played a much greater role during the pandemic. There was a sense that this will be reflected in longer-term changes to the way systems are operating, with providers increasingly stepping into leadership roles within ICSs.

Interviewees also reflected positively on the role played by some pan-London bodies. In particular, some highlighted the role of Public Health England London, praising the quality and strength of leadership it had offered over the course of the pandemic.

A number of reasons were given for the acceleration of collaborative ways of working described:

- the challenge of responding to Covid-19 forged a strong sense of common purpose across system partners.
- suspension of some of the usual governance requirements allowed organisations and partnerships to be more flexible and fleet of foot
- barriers that usually stand in the way of integration, such as different funding arrangements and information governance requirements, were temporarily suspended
- through working together on initiatives to bring about practical changes, partners learnt about how best to work collaboratively and established trust and relationships
- greater regularity of contact between leaders from different organisations was an effective means of problem-solving and helped to build relationships. There were many examples of groups of leaders meeting weekly or even daily in the acute phase of the response
- Covid-19 highlighted critical interdependencies between different parts of the system and shone a light on the contribution of sectors that are usually less visible, particularly social care, community-based services and voluntary and community sector organisations. This had led to greater appreciation among system partners of their role and the challenges they face.

While Covid-19 accelerated progress, some interviewees felt this had been made possible by the work done to strengthen local partnerships over a number of years.

None of this is to say that partnership working in this period has been easy. Challenges and differences of opinion have arisen, and there were examples of organisations focusing inwards on their own priorities at times (partly driven by central asks from national NHS bodies). One interviewee described the experience as 'three steps forwards and one step back at times', but that overall 'it's been going in the right direction over time'.

It is also important to note that some of the positive joint working over the period was essentially damage limitation following earlier mistakes, for example sharing PPE supplies to manage shortages, and supporting care homes following an initial national push to free up NHS beds with little attention given to the risks of this. In addition, the approach from national and regional NHS bodies was perceived as having been unhelpfully centralised at times and overly focused on acute hospital services.

The focus of this research makes it difficult to assess the extent to which the progress described is reflected across the system or whether it is limited to strategic collaboration between senior leaders. However, we did hear some concerns that some primary care clinicians have felt disengaged from the work of systems and wouldn't recognise the benefits described by those interviewed for this work.

Looking to the longer term

While there have been leaps forward in the strength of partnership working, it remains to be seen whether these changes will hold in the longer term. What has developed over this period is a set of collaborative relationships and ways of working, largely in the absence of structures designed to underpin collaborative working. This rests on individual leaders and the relationships between them, so is inherently fragile.

Moreover, some of the most important factors that supported better collaboration will be hard to replicate outside the context of a crisis of this scale. Interviewees expressed some anxieties about whether new ways of working would be maintained when traditional barriers such as funding constraints re-emerge (particularly given the extremely challenging state of some local authority finances). There will also be difficult decisions ahead about what service changes should be maintained and what the trade-offs might be.

Finally, there is a recognition that changes were made quickly through Covid-19, and understandably without the usual scrutiny or attention to process. In due course, process and governance will need to catch up with the changes made, not least to ensure appropriate accountability for public spending. Some systems already have plans to alter their governance arrangements in the wake of Covid-19 – South East London is making changes to strengthen local authority involvement in its governance, and North East London has plans for their ICS board to meet in public and to include direct involvement from local people.

4 How are services changing in London?

In this section, we explore how services are changing across London. First, we summarise the key changes set out in the systems' five-year plans and how these compare to changes signalled previously. We then consider how the prospects for service change have shifted over the course of the Covid-19 pandemic and how this might impact on services for Londoners in the future.

Key service changes set out in the system plans

Acute services

Some of the most contentious points in the original 2016 STP plans related to proposed changes to acute hospitals, ranging from plans to centralise some acute and specialised services to larger-scale reconfigurations involving substantial reductions in the number of general and acute hospital beds and, in some cases, closing entire hospital sites. In contrast, the plans produced in 2019 were nowhere near as far reaching. Proposals to reduce hospital beds had disappeared, replaced instead by an emphasis on managing within the existing bed base or, in some cases, slight increases to bed numbers. This is in keeping with a shift in assumptions about how bed numbers will need to change nationally over the coming years (Carding 2019; Ewbank *et al* 2020).

Although they didn't propose reductions in the numbers of beds or hospital sites, the plans did propose some changes to where and how services will be delivered. This included proposals to consolidate some services onto fewer sites and to create new centres of excellence for some specialist services and complex surgery. All five plans contained proposals for hospitals to co-ordinate the provision of some services through clinical networks, mostly in specialties seen as being fragile due to capacity constraints, particularly in relation to workforce shortages.

In South East London, an Acute Based Care Board had been formed to oversee the development of these changes, while in South West London, the four acute trusts had come together to form an Acute Provider Collaborative. As part of this, the trusts had established a joint referral unit to better

manage waiting times and a joint improvement programme to standardise clinical pathways and reduce unwarranted variation in care.

While the system plans did not contain detail on more significant hospital reconfigurations, some made reference to existing reconfiguration proposals where decisions were still pending (such as the planned reconfiguration of Epsom and St Helier University Hospitals NHS Trust in South West London). Detailed engagement and consultation on these proposals were being led through different channels.

Some of the most notable service changes signalled in the plans related to the delivery of outpatient services. All five plans included proposals to significantly reduce the number of face-to-face outpatient appointments, in line with the national ambition in the NHS Long Term Plan to reduce these by a third (NHS England and NHS Improvement 2019a). Proposed measures to achieve this included expansion of telephone and video appointments, patient-initiated follow-up replacing regular appointments, virtual clinics to support remote monitoring of long-term conditions and specialist advice and support for GPs.

The plans described changes to urgent and emergency care including expansion of same-day emergency care, acute frailty services and better support for people experiencing mental health crises. All of the plans provided detail on planned improvements in cancer and maternity services, outlining how local systems would go about delivering key national commitments identified in the NHS Long Term Plan. For cancer services, key priorities include increasing screening coverage and uptake, faster access to diagnostic tests and improving access to treatments including personalised interventions. For maternity services, key priorities include neonatal intensive care provision, personalised care during pregnancy and improving perinatal mental health services.

Community services

All five plans included ambitions to deliver more proactive care in the community and in people's homes, and to better co-ordinate services around people's needs. These ambitions are strongly aligned with those set out in the original STP plans although, in contrast to 2016, the 2019 plans generally didn't assume that reductions in acute hospital use would result from this in the short-term. Specific changes proposed included:

- integrating primary and community health services so that people with long-term conditions or complex needs receive joined-up care. The plans described ambitions for community providers to work alongside social care services and primary care, with PCNs often acting as the geographical footprint around which teams and services would organise

- delivering more proactive and preventive care for people living with frailty or multiple long-term conditions to keep them well at home

- ensuring more support is available to care home staff and residents from community and primary care services

- delivering rapid response community services for older patients and those with complex health needs, including community crisis services within two hours of referral and reablement services within two days of referral.

Again, these reflect requirements set out in the NHS Long Term Plan and subsequent guidance (including service specifications for PCNs).

Some of the plans set out ambitions to create a consistent model of community-based services across a whole system, while others put more emphasis on local models being developed in boroughs or groups of boroughs. In many cases, the proposals focused on spreading and building on models already operating in pockets within their system. For example, the North East London plan described the development of a new community mental health service model, based in part on enhanced primary care services already available for people with severe mental illness in City and Hackney, Tower Hamlets and Newham, which have reduced secondary care caseloads by 19 per cent.

All of the plans featured detailed sections on mental health, including commitments to improve community mental health provision in line with the NHS Long Term Plan and NHS England and NHS Improvement's community mental health transformation framework (NHS England and NHS Improvement and the National Collaborating Central for Mental Health 2019) National commitments include further expansion of psychological therapy services and the development of new models of community mental health care integrated more closely with primary care.

In a similar vein to the groups and networks forming between hospitals, there was also evidence in the plans of collaborations emerging between providers of community services. For example, in South East London the four community providers were working in partnership to address workforce shortages, share innovation and benchmark their services to deliver a more consistent offer.

There were also examples of clinical networks forming beyond individual ICS footprints, for example, mental health providers across South London are working together to improve services (NHS England and NHS Improvement 2019d).

Changes during Covid-19

The response to Covid-19 has rapidly accelerated some services changes that were already planned. Most notably, it led to a massive expansion in remote access, including virtual outpatient appointments and digital access to primary care (*see* Section 5). Shifts that would usually be expected to take months or years happened in the space of weeks or even days.

In the early stages of the pandemic, many service changes were made to protect the capacity of acute hospitals to treat the surge of acutely unwell Covid-19 patients. This included expanding core critical care capacity in central London Trusts – efforts which were coordinated across the region as a whole.

There was a renewed emphasis on hospital discharge and preventing unnecessary admissions, with community-based services directing their efforts to streamline and support these pathways. Rapid response community services were stepped up and integrated discharge teams expanded. There were also efforts to prevent avoidable presentations at A&E among people experiencing a mental health crisis, for example the West London Mental Health Trust worked with the London Ambulance Services to develop different ways to meet the needs of individuals with mental health needs who were regularly calling 999 to provide better community support and avoid unnecessary transfers to A&E.

Changes were also made to reduce the risk of Covid-19 transmission in care settings by separating out routine care and Covid care. This included the development of 'hot' and 'cold' hubs in primary care, with hot hubs seeing suspected Covid-19 cases, and cold hubs seeing non-Covid patients when face-to-face care was needed.

In many areas, local authorities set up community hubs to bring together and coordinate support offered by the council and various voluntary and community organisations, helping to signpost and connect residents to the advice and support they need.

In London, as elsewhere across the country, the suspension of most elective activity in the first wave of Covid-19 led to significant backlogs, meaning people are waiting longer to receive care. Measures to address this include buying capacity from the private sector to treat NHS patients and setting up surgical hubs to undertake high volumes of low complexity surgery in Covid-free sites (for example, Moorfields Eye Hospital NHS Foundation trust will be undertaking a large volume of cataract surgery). Cancer services across London are being coordinated by a specialist 'Cancer Hub' led by The Royal Marsden and University College London Hospitals to maximise capacity and ensure as much cancer treatment as possible can be delivered across the capital.

Over this period, the process of service change has been markedly different as changes had to be implemented at unprecedented speed. One consequence of this was that changes were made without the usual level of public consultation and engagement. While it was generally understood that this was unavoidable in the circumstances, some concerns arose that if these changes become more permanent then they will not have been subject to sufficient public engagement and democratic scrutiny. These concerns are less prominent for changes that are likely to be temporary, for example those made purely for short-term safety and infection control reasons. But there are some suggestions that it may be desirable to maintain some of the different ways of coordinating and delivering services in the longer term.

Commitments have been made to allay concerns in relation to these potential changes, for example North East London ICS has said that any changes they plan to keep in the longer term will be brought to their overview and scrutiny committees for approval, and the NHS England and Improvement London Region has committed to a consultation on the surgical hubs model if it is

needed for longer than six months. While statutory public engagement took a back seat in the early days of the pandemic, interviewees from Healthwatch were generally positive about the efforts made by CCGs to resume this as soon as possible. For example, in South East London, task groups have been set up to explore issues of digital exclusion with patient groups.

5 How do ICSs aim to address key challenges in London?

In this section we focus on five of the most significant challenges facing the health and care system in London, examining how ICSs seek to address each issue and how this has changed as a result of the Covid-19 pandemic:

- health inequalities
- digital technologies
- workforce
- estates
- social care.

We identified these issues as areas of focus as they represented the key longer-term strategic challenges facing London's ICSs at the point this research was initiated. The selection was based on our understanding of the wider policy context and challenges facing local health and care systems, as well as being informed by the Mayor's six tests and the findings from our previous work on London's STPs.

In several of these areas, the pandemic has shifted the current situation in London in important ways. In broad terms, the strategic direction remains consistent with the vision described before the pandemic. However, what the pandemic has done is to change the emphasis. For example, progress has been accelerated in areas such as digital health, and the need for determined action to reduce health inequalities has become considerably more prominent.

The pandemic has also created new challenges that will be dominant concerns for some time to come, notably the need to respond to current and future waves of the virus, deal with mounting backlogs in planned care and the deterioration seen in the health and wellbeing of some of those whose usual support and care arrangements have been disrupted. Added to this is the

enormous logistical challenge of delivering the largest vaccination programme the country has ever seen, which will be a major priority throughout 2021. These more recent challenges create an additional set of demands on top of the five long-standing issues we focus on here.

Health inequalities

The need to tackle health inequalities was already rising up the strategic agenda before the arrival of Covid-19. One of the most striking differences between the 2016 and 2019 system plans was the explicit focus on reducing health inequalities in many of the latter. Several of the plans identified reducing health inequalities as being one of the major goals for system working. For example, in South East London this was one of the two overarching goals for the system, alongside achieving financial sustainability. This reflects the emphasis given to health inequalities regionally (for example in the London Vision and the Mayor's Health Inequalities Strategy) as well as locally identified priorities.

While the challenges related to inequalities were acknowledged in all of the plans, some went further than others in committing to specific targets. The plan for South West London contained a commitment to close the gap in healthy life expectancy between the richest and poorest groups by 2035, while in the plan for North East London there was a target to reduce inequalities in sexual health outcomes.

Common measures proposed in the plans to reduce inequalities included:

- taking a data-led approach, including using population health management tools to identify high-risk groups to target for preventative interventions
- building stronger relationships with voluntary and community sector organisations to extend the reach of services and help harness broader assets in local communities
- providing targeted support for specific vulnerable groups e.g. homeless people, socially isolated people.

Much of the work to reduce health inequalities will continue to be led by public health teams in local boroughs. The plans suggest that partnership working at ICS level could add value to this locally led work in a number of ways, including the following:

- identifying collective priorities and opportunities for co-operation across boroughs
- tracking changes in health inequalities across the system over time
- supporting the development of consistent approaches across providers
- strengthening data systems for measuring and monitoring inequalities
- overseeing delivery of specific national NHS commitments
- reviewing training opportunities and identifying economies of scale
- linking with London-wide initiatives on prevention and health inequalities.

In our second phase of interviews we heard a clear message that tackling health inequalities has become an even higher priority as a result of the pandemic. Covid-19 and lockdown measures have illuminated and exacerbated existing inequalities, and system leaders told us that discussions on a range of issues now start with inequalities in a way that would not have happened as consistently before the pandemic. An example given was taking inequalities into account when looking at waiting lists for hospital care – giving consideration to groups in the population at greatest risk of poor health outcomes when deciding how to go about clearing backlogs, as emphasised by the national 'phase 3' letter (NHS England and NHS Improvement 2020c).

Some interviewees also told us that their system work on health inequalities is now taking a 'broader lens' as a result of the pandemic, taking in the wider social determinants of health. For example, we were told that there is now greater recognition among NHS partners that "if we are worried about asthma outcomes then we need to connect with what the council is doing to address damp housing and improve air quality".

Unsurprisingly there is a particular focus on groups that have been strongly affected by the pandemic, including some Black, Asian and minority ethnic communities, people experiencing homelessness and people with a learning disability. Increased data sharing between organisations that has taken place as part of the pandemic response has also brought to light groups of vulnerable people that the system was not previously aware of, for example people who are not clinically high-risk but who are vulnerable to rapid escalation in their health needs as a result of financial precarity or limited social support networks.

We also heard that many hospitals and other large NHS organisations in London are now exploring how they can help to reduce health inequalities by taking up their role as 'anchor institutions' in local places – harnessing their power as major employers and procurers of goods and services to address the wider determinants of health. ICSs are exploring how they can support this, for example by encouraging partner organisations to target job opportunities at people living in deprived wards.

Digital technologies

Using digital technologies to enhance health and care services and to support improvements in population health has been a key priority in London for some time. Areas emphasised in the 2019 system plans included the following.

- Developing **population health management tools** that bring together data from acute, community, primary care and other sources and apply algorithms designed to predict individual and population health needs. For example, the Whole System Integrated Care dashboard in North West London provides a suite of tools that allows clinicians and service planners to identify people who may benefit most from proactive, multidisciplinary support and to make investment and prioritisation decisions. Similar tools are being developed elsewhere, eg, the Discovery East London platform in North East London and the HealtheIntent platform in North Central London. These platforms are being used to perform a number of functions, including highlighting where best-practice care is not being provided at individual or population level, and identifying unwarranted variation.
- Supporting **real-time data sharing** between health and care providers via a health and care information exchange, with the aim of developing a person-held digital health and care record. This includes participating in the 'OneLondon' local health and care record exemplar programme.
- Promoting **digital access to primary care**, including providing online and video consultations in all GP practices in line with national targets. Primary care is also a key area of focus for other digital work, eg, improving the digital infrastructure of practices.
- Expanding the use of **digital self-care and self-management tools** in primary and community care. For example, the plan for North West London stated that there will be access to digital self-care and self-management tools by 2022/23 for all patients with diabetes, chronic obstructive pulmonary disease (COPD), asthma, heart failure, mental

health problems or learning disabilities, as well as for people using maternity or urgent care services.

- Using **telecare and telemedicine tools in care homes**. New approaches to this are being piloted in South East London and elsewhere.
- Providing **online mental health support**. For example, a range of services are being made available to young people in North East London through the 'Kooth' platform.
- Building **knowledge and capabilities** around digital health and care. For example, in North West London there is a workforce education programme to help staff develop the digital skills they need, as well as a Digital Citizen programme seeking to educate the public on digital health services.
- Using digital technologies to support **innovation and research**. In North West London, a digital innovation hub is being developed to enable researchers, innovators and industry to access anonymised patient data to support the development of new treatments and interventions.

Alongside these specific commitments, system partners have been investing in increased digital capacity and capability at ICS level. For example, systems have appointed chief information officers and chief clinical information officers, paving the way for more active leadership on the digital agenda from ICSs.

The pandemic response has meant that some of these commitments have been rapidly accelerated. Digital service delivery in primary care and outpatient settings has been implemented at breath-taking speed, far surpassing the ambitions in the 2019 plans. Telephone consultations, e-consultations and video appointments have become the norm in primary care and many other services, and digital technologies have been used as an enabler for multidisciplinary working and accessing specialist advice and guidance (for example, virtual geriatrician support). There has also been a less cautious approach to data-sharing between organisations, with partners seeing a need to quickly resolve long-standing concerns about information governance.

The rapid progress made on digital is seen as a largely positive development, with system leaders keen to maintain and build on the changes that have been put in place. However, there are also a number of concerns that will need to be resolved in the medium-term. There are significant concerns

around digital exclusion, and an acknowledgement that digital-first approaches are not suitable for everyone or everything. In some cases more evidence will be needed to ensure that new arrangements are clinically effective and appropriate. In relation to data sharing, it is unclear whether information governance issues have been fully resolved or rather temporarily side-lined – in which case more work will be needed once the immediate crisis has passed.

Workforce

In our phase one interviews, workforce was consistently identified as the biggest risk to delivery and as the main practical constraint that will shape the direction of service changes in London over the next few years.

There are particular concerns about the primary care workforce, in part because of the potential knock-on effects for the rest of the system. This includes concerns regarding the age profile of GPs and practice nurses, many of whom are approaching retirement age (for example, 50 per cent of practice nurses in South East London are over 55).

The wider nursing and social care workforce are also key areas of concern, with significant shortages in London as in other regions. The vacancy rate for adult nursing across London stood at 14 per cent in 2019, with low retention rates for nurses under 25 being identified as a significant problem in some systems. High staff turnover rates in social care are also significant problem in London and elsewhere.

The cost of living is recognised as a key contributing factor in London, in addition to wider issues such as the impact of the UK's exit from the EU on international recruitment (with London having high levels of staff from EU countries).

The 2019 system plans describe a number of approaches towards addressing NHS workforce shortages, including:

- improving retention by offering greater flexibility, portfolio working options and development opportunities, and by improving workplace cultures
- exploring how best to use new clinical roles (eg, clinical pharmacists in primary care, nursing associates, physician associates) and non-clinical roles (eg, care navigators and social prescribing link workers). In South

East London, a training and competency framework has been developed for the latter to facilitate skills development and career progression

- joining up efforts to promote international recruitment, for example through London-wide international recruitment programmes for GPs and nurses
- encouraging the development of a local workforce pool, including by targeting people that already live in the area and by working with schools and colleges (for example, through a 'jobs that care' board game for schools in South West London)
- providing apprenticeships, including seeking to make better use of the apprenticeship levy.

There are also encouraging signs of some systems working collaboratively across health and social care to take a more place-based approach to workforce planning and development. For example, in North Central London, organisations spanning the health and social care sectors are working in partnership to promote recruitment and retention of staff, and to support workforce modernisation.

In our phase two interviews, there was a perception that progress had been made on some fronts during the pandemic, including developing 'passporting' arrangements to increase staff mobility across organisations, and establishing joint recruitment, workforce development and training processes. Much of this has been achieved by providers working with each other more collaboratively, for example through shared staff banks.

We also heard that there was a more concerted focus on supporting staff well-being in light of the significant impact that Covid-19 has had on many people working in health and care professions (and in line with the emphasis given to this in the NHS People Plan). For example, some mental health trusts in London have provided mental health support to NHS and social care staff during the pandemic.

While there are numerous initiatives underway to address the major workforce issues in London, there is more work to do to ensure that these initiatives add up to a comprehensive plan that allows systems to have access to the workforce they need for the future. Systems were required to develop local workforce plans in response to the national 'phase 3' letter (NHS England and NHS Improvement 2020c) but these will need to be reviewed and

refreshed to reflect the evolving course of the pandemic, its impact on demand for services and on staff, and to reflect the future financial settlement for health and social care when this becomes clearer.

Estates

The NHS estate – its buildings, land, equipment and other physical assets – is a critical issue in London that can act as both a facilitator of improvement and a major barrier to it. Since 2016, local systems have established strategic estates committees with representatives from commissioners, providers and key partners. Systems have also developed estates strategies that review how estate is used across partners and agree strategic priorities for investment and land sales. Objectives of working together at system level on estates include the following:

- agreeing a shared set of priorities for targeted investment
- ensuring buildings are used efficiently and that under-utilisation is minimised
- supporting new models of primary and community care by establishing community hubs for multidisciplinary working
- co-ordinating estate rationalisation to generate income to reinvest in local estate
- expanding estate capacity to meet growing demand for planned care
- securing funding from housing developers to help cover the costs of new health and care provision.

The 2019 plans set out the areas where the greatest needs exist in relation to estate. Primary and community care is a high priority in all five systems, particularly where GP practices are operating out of converted residential properties that are no longer fit for purpose. Addressing this will involve identifying opportunities for consolidation and co-location of primary care services.

There are also parts of the hospital estate that are in need of significant investment. For example, in North East London capital funds have been awarded for redevelopment of Whipps Cross Hospital and for a new health and wellbeing hub on the site of St George's Hospital.

System partners are increasingly taking a One Public Estate approach (Local Government Association 2020), collaborating across sectors and pooling resources where appropriate. For example, in Lewisham NHS providers (primary care, acute and mental health), the local authority and community partners are working together to develop four new sites offering integrated local services. Similarly, plans for a major housing development in Barking Riverside include a new health and wellbeing hub bringing together a range of services for the local community.

There are also examples of system partners working together to serve broader objectives through work on estates, including supporting efforts to regenerate high streets, tackle shortcomings in London's housing market and boost economic growth through the creation of new homes and jobs. For example, in South West London NHS organisations and local authorities are exploring opportunities to use vacant high street premises to deliver health care services.

Estates have not been a major focus for collaborative working during the pandemic, although there has been some creative repurposing of estates to serve specific needs, eg, enabling care home residents to access step-down beds on NHS estate so they can be discharged from hospital. The most significant longer-term implication of the pandemic in relation to estates will be the question of what the shift to digital means for estates in future. Systems will need to revisit estates plans once there is greater clarity about what a blended approach to digital and face-to-face delivery might look like.

Social care

Health care services are dependent on a well-functioning social care system, and the Mayor of London has previously stressed the importance of ensuring that any proposals for service change within the NHS take account of the potential impact on social care services (the impact on social care is one of the Mayor's six tests for health and care transformation in London).

This inter-dependency has been illustrated all too clearly during the pandemic, particularly in relation to care homes, whose staff and residents have been heavily affected by Covid-19. Some interviewees argued that as a result of the pandemic there is now a greater collective understanding of the importance of a well-functioning social care system.

Relationships between the NHS and social care providers were put under strain early in the pandemic, partly due to the rapid discharge of hospital patients to care homes. Since then, there has been a major focus on strengthening collaborative working to provide better support to care homes, including provision of training for care home staff in infection prevention and control, and improving skills in identification of acute illness.

More broadly, some interviewees (from both local government and the NHS) believed that the pandemic has driven forward health and social care integration and that there is now greater momentum behind this agenda. There is an appetite among system leaders to learn lessons from the experience of collaboration between health and social care during the pandemic, and to build on it. Existing objectives included in the 2019 plans – such as implementation of the national 'enhanced health in care homes' framework and the development of care home in-reach teams – are likely to be given higher priority as a result.

While this is encouraging, integration is far from the only issue of concern in relation to social care. As discussed in the following section, there remain fundamental weaknesses in the social care system that require a regional and national response.

6 Priorities for action

This section summarises the priorities for action for health and care leaders in London identified by our research. We focus on the five key areas covered in the previous section, with the addition of two further themes: embedding collaborative working and strengthening pan-London working arrangements.

Embedding collaboration for the longer term

Collaborative working at system level appears to have improved significantly since our previous research in 2018 and has been developed further through the response to Covid-19. However, while the experience of joint working during the pandemic has helped increase mutual understanding between local government and NHS leaders, it is important to recognise that the re-emergence of older barriers – such as funding and the risk of heavy top-down performance management in the NHS – may make these gains harder to hold onto.

There will need to be a concerted effort from NHS and local authority leaders in London to 'lock in' the collaborative approaches developed over the last year and ensure the benefits are sustained in the longer term. This is likely to require three things.

- NHS, local authority and voluntary sector partners will need to continue the practical focus seen during the pandemic – delivering joint initiatives and implementing tangible improvements to services, as it is this pursuit of common purpose with real energy that has changed ways of working for the better.

- Continuing to build trust and to strengthen relationships between partner organisations is paramount. This may require leadership and organisational development support to help embed new ways of working and overcome the remaining hurdles.

- Ongoing evolution of structures and governance arrangements will be needed to underpin these changes, but this should not become the sole or primary focus of conversations between partners (a clear risk as

systems respond to the proposed legislative changes which may see ICSs become statutory organisations).

Where this collaboration is rooted in delivering real change it should also help ensure that it has the necessary breadth and depth across the system rather than being limited to strategic co-operation between a relatively small number of leaders. In turn this greater co-operation between a larger group of organisations and leaders should help increase sustainability and reduce the dependence on a limited number of individuals.

The experience of better system working during the pandemic has not been felt evenly by all – for example, primary care leaders have not always been closely involved in collaborative work at ICS level. By keeping the focus on delivery of pragmatic change, system leaders can expand the group of people involved and break down remaining barriers.

Moving from aspiration to action on reducing health inequalities

Reducing health inequalities was already a key objective prior to Covid-19 yet the experience through the pandemic has given this far greater priority and it's clear there is now high commitment among system leaders to work on inequalities with greater vigour.

System partners across London need to seize this moment to strengthen collective action on health inequalities. The partnerships developed in recent years between the NHS, local authorities and voluntary sector organisations provide a platform for taking broad-based action on the wider determinants of health. This collaboration is needed at three levels.

- Borough-based partnerships should be used to co-ordinate local action on health inequalities, with Directors of Public Health playing a key leadership role.
- ICSs will need to be clear how partnership working at this level can support and add value to borough-based work on health inequalities, linking with London-wide initiatives where appropriate. Public health expertise will also be critical at this level.

- At London level, partners will need to revisit which issues will benefit most from a more co-ordinated response across London, starting from the priorities identified in the London Vision and the Mayor's Health Inequalities Strategy and where necessary updating these in light of the pandemic.

NHS organisations can play an important part in efforts to reduce health inequalities by acting as 'anchor institutions', using their economic clout as major employers and purchasers to counter the economic and social damage inflicted by the pandemic on communities across London. This role also extends to academic institutions and other major employers, including social care, which can potentially act as an 'anchor sector' when taken as a whole.

Efforts to tackle health inequalities will need to include a focus on mental health inequalities, which are likely to widen as a result of the pandemic (Centre for Mental Health 2020). There are anticipated to be significant increases in mental health needs over the coming years as a result of the pandemic (particularly due to the impact of social restrictions and lockdown measures), with one analysis commissioned by NHS England finding that demand for adult mental health services and child and adolescent mental health services could rise by as much as 40 per cent and 60 per cent respectively (Discombe 2020).

Taking a joined-up approach to workforce

Prior to Covid-19, workforce shortages represented the biggest challenge facing health and care services in London and elsewhere. Since then, the response to the pandemic has relied on exceptional effort from staff and this will need to continue over the coming months as the vaccination programme gathers pace. National efforts to tackle workforce shortages have been hampered by the lack of a longer-term financial settlement, and the UK's exit from the EU has created additional challenges, including particular risks for securing the social care workforce needed in the capital.

All this points to the need for a more radical and comprehensive approach to tackling the workforce issues across health and care. This will require strategic action at all levels, with greater clarity about how these add up to a comprehensive strategy for the London workforce. Bold, co-ordinated leadership at London-level will need to be an important part of this, which could include building on initiatives such as the capital nurse scheme (Health

Education England 2020) for example by extending it to allied health professionals and social care workers.

In the medium and longer term, as many workforce responsibilities will be passed to ICSs, systems must have access to the resources and expertise they will need to lead on this issue. There will continue to be a need for London-wide coordination on workforce so it will be important that the five ICSs have the capability to work together on this issue, and that they take a joined-up approach spanning the whole health and social care workforce.

Building on digital transformation

The widespread adoption of digital delivery models during the pandemic has given new momentum to this agenda. The challenge for London's ICSs now is to sustain and build on this, embedding the progress made in a way that delivers the best outcomes and experience for local communities.

This will require rapid evaluation of new delivery models to understand who and for what these work best for, with a particular focus on ensuring that they don't exacerbate or create new inequalities.

As the system recovers from the pandemic, ICS leaders and others will need to support a long-term shift to a 'blended' model of delivery that combines the best of digital approaches with the benefits of face-to-face contact when that is most appropriate. This is likely to be something that ICSs and other partners in London will need to support over a number of years. The wider implications of this shift, including on future workforce and estates requirements, will require careful consideration and will necessitate changes to existing planning assumptions.

Collaboration on estates and facilities

The state of London's health and care estate remains a long-standing strategic issue. This will need to be a major focus for collaborative working going forward, building on the closer partnerships forged over recent months. Modernising estates could contribute to economic recovery and regeneration in some parts of London and it will therefore be important to think broadly about the opportunities this presents for local communities.

Estates is an area where ongoing leadership at London level will be needed. The work conducted by the London Estates Board to develop a London health and care estates strategy should be returned to, with the aim of ensuring there is a co-ordinated approach to capital investment and prioritisation across the city.

Investment and reform for social care

Social care in London (as elsewhere in England) was struggling going into the pandemic, with a fragile provider market, workforce shortages and a range of concerns about quality of care. The pandemic may have helped to shine a light on some of these issues, but overall its impact has been to exacerbate the challenges that already existed (Bottery 2020).

The neglect of social care is a national issue, which needs, first and foremost, a national solution – in the form of immediate financial support from government to alleviate short-term funding pressures combined with longer-term investment and reform (Charles and Ewbank 2020).

Nonetheless, system leaders in London can also help by continuing to prioritise the development of integrated approaches across health and social care. ICSs and borough-based partnerships should be used as platforms to bring this about. Our finding of increased local authority involvement in ICSs is encouraging in this regard, and ICS leaders should make concerted efforts to strengthen this further. They will also need to work directly with social care providers, just as they do with NHS providers.

Strengthening arrangements for pan-London working

We have previously highlighted the challenges arising from the highly complex set of arrangements for health and care in London, and the need for greater coherence at London-level to support co-ordinated action across the large number of organisations involved (Kershaw *et al* 2018; Naylor and Buck 2018).

Our latest research indicated there has been some improvement over the past two years. Several interviewees mentioned that the appointment of a single regional director for NHS England and NHS Improvement in early 2019 and the merger of what had been two separate regional teams meant that there

was now clearer and more consistent leadership of the NHS in London. The valuable leadership role played by the regional office of Public Health England during the pandemic was also mentioned by some.

London partners – including the NHS, London councils (and individual boroughs) and the GLA – will need to continue to work together to evolve and improve the functioning of the pan-London bodies that exist to support collective action. As ICSs take on a more prominent role (and potentially move to a statutory footing) this will need to include clarifying how ICSs and pan-London partnerships can work together in a mutually reinforcing way. The abolition of Public Health England means that the future arrangements for public health leadership in London will also need careful thought, particularly in relation to health improvement functions outside of the remit of the new National Institute for Health Protection.

Just as it will be important for London's five ICSs to be able to work together to tackle workforce challenges (*see* above), this will also be needed in relation to commissioning specialised health services. London contains a high proportion of tertiary and specialist centres within a relatively small geography. As NHS England intends to delegate the majority of the current specialised commissioning budget to ICSs, it will be important to identify where ICSs may need to co-operate to ensure a coherent approach to these services as well as understanding the implications for providers and patients.

7 Conclusion: looking to the future

The Covid-19 pandemic has greatly increased the challenges facing health and care leaders in London. The wider context of a deep economic recession and damaged public finances (particularly in local government) would be difficult at any time. In addition, Covid-19 has increased health inequalities, exhausted the workforce, led to a surge in the backlog of patients waiting for treatment and is driving increased demand in areas such as mental health. More change is still likely as London faces continued high infection rates and the roll out of the largest ever mass vaccination programme.

Yet, perhaps because of these challenges, there has been progress and acceleration in many aspects of system working in London. While this progress may not yet have been 'locked in' and relies in many cases on individual relationships, it is nonetheless important even if we are largely drawing on experiences at one level of the system (our research being based on interviews with senior leaders rather than the views of middle management or frontline staff).

Since the research was undertaken for this report, NHS England and NHS Improvement has published its new statement on the future of ICSs and a new set of proposals for legislation (see Murray 2020 and Murray and McKenna 2020) and the government has published a White Paper setting out its proposals for a Health and Care Bill (Department of Health and Social Care 2021). In some respects, the direction of travel these outline is well-aligned with the ways of working that have been developing in London.

However, the proposed approach will inevitably bring some disruption. Under the legislative proposals, CCGs will be abolished and their staff will be folded into ICSs. A statutory ICS could mean a greater degree of standardisation, transparency and clearer governance. However, it may also disrupt existing relationships both between NHS organisations and also between the NHS and local government. It will be important to ensure that ICSs do look to support and foster strong relationships at borough level (including delegation of

funding) as it is here that the real strength of joint working across the NHS, local government and voluntary and community sector sits.

The national vision for the future also gives a prominent role to provider collaboratives – groups of (NHS) providers working together at ICS level. These are at a relatively early stage in London, as elsewhere, but are likely to play a very significant role in the capital's health and care system in the near future. NHS England and NHS Improvement intends to provide more guidance on the different models for these collaboratives later in 2021.

The current intention for the proposed legislation is to leave a lot of flexibility for local determination. This includes how the balance of responsibilities are split between ICSs and their constituent boroughs. This permissive approach reflects the current wide variation across the country in terms of context, geography and history. However, it is questionable whether having five ICSs evolving in very different ways across London would be sustainable, not least in terms of the complexity it would generate for providers that span ICS boundaries. There may therefore be value in developing some consistency of approach across London in terms of the relationships between ICSs, borough-based partnerships and provider collaboratives.

Finally, the research for this report was undertaken at a point when the first wave of Covid-19 receded from London. Further waves have since arrived and the mass vaccination programme has begun. Both will create continued uncertainty and opportunities for learning. As the exceptional level of uncertainty begins to decline later in 2021, leaders will need to refresh their longer-term plans, acknowledging both the build-up of significant backlogs in the health service and the major financial challenges in local government. In developing these plans it will be important to ensure the better system working that took place through Covid-19 remains front and centre.

References

Alderwick H, Dunn P, McKenna H, Walsh N, Ham C (2016). *Sustainability and transformation plans in the NHS: how are they being developed in practice?* London: The King's Fund. Available at: www.kingsfund.org.uk/publications/stps-in-the-nhs (accessed 13 November 2020).

Augst C, Dickson N, Francis R, Gerada C, Gorton S, Ham C, Murray R (2019). 'Letter to the Secretary of State with recommendations for an NHS Bill'. Letter. Available at: www.nhsconfed.org/resources/2019/09/recommendations-for-an-nhs-bill (accessed 9 December 2020).

Berube A, Trujillo J, Ran T, Parilla J (2015). 'Global city GDP 2014'. The Brookings Institution website. Available at: www.brookings.edu/research/global-metro-monitor (accessed 9 January 2021).

Bottery S (2020). 'How Covid-19 has magnified some of social care's key problems'. The King's Fund website. Available at: www.kingsfund.org.uk/publications/covid-19-magnified-social-care-problems (accessed 8 January 2021).

Bottery S, Babalola G (2020). 'Social care 360'. The King's Fund website. Available at: www.kingsfund.org.uk/publications/social-care-360 (accessed 5 January 2021).

Carding N (2019). 'NHS "needs more acute beds" after decade of reduction'. Health Service Journal website. Available at: www.hsj.co.uk/policy-and-regulation/nhs-needs-more-acute-beds-after-decade-of-reduction/7025365.article (accessed 11 November 2020).

Centre for Mental Health (2020). *Mental health for all? The final report of the Commission for Equality in Mental Health*. London: Centre for Mental Health.

Available at: www.centreformentalhealth.org.uk/publications/mental-health-for-all (accessed 9 January 2021).

Charles A (2020). 'Integrated care systems explained: making sense of systems, places and neighbourhoods'. The King's Fund website. Available at: www.kingsfund.org.uk/publications/integrated-care-systems-explained (accessed 8 December 2020).

Charles A, Ewbank L (2020). 'The road to renewal: five priorities for health and care'. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/covid-19-road-renewal-health-and-care (accessed 14 December 2020).

Charles A, Ewbank L, MvKenna H, Wenzel L (2019). 'The NHS long-term plan explained'. The King's Fund website. Available at: www.kingsfund.org.uk/publications/nhs-long-term-plan-explained (accessed 8 December 2020).

Charles A, Wenzel L, Kershaw M, Ham C, Walsh N (2018). *A year of integrated care systems: reviewing the journey so far*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/year-integrated-care-systems (Accessed 13 November 2020).

Department for Communities and Local Government (2019). 'English indices of deprivation 2019'. GOV.UK website. Available at: www.gov.uk/government/statistics/english-indices-of-deprivation-2019 (accessed 9 January 2021).

Department of Health and Social Care (2021). *Integration and innovation: working together to improve health and social care for all*. GOV.UK website. Available at: www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all (accessed 11 February 2021).

Discombe M (2020). 'Mental health demand could rise by 40pc warns NHSE research'. Health Service Journal website. Available at: www.hsj.co.uk/mental-health/mental-health-demand-could-almost-double-warns-nhse-research/7029085.article (accessed 11 December 2020).

Ewbank L, Thompson J, McKenna H, Anandaciva S (2020). 'NHS hospital bed numbers: past, present, future'. The King's Fund website. Available at: www.kingsfund.org.uk/publications/nhs-hospital-bed-numbers (accessed 11 December 2020).

Greater London Authority (2017). *Better health for all Londoners: consultation on the London health inequalities strategy*. London: Greater London Authority. Available at: www.london.gov.uk/talk-london/healthstrategy (accessed 9 January 2021).

Ham C, Alderwick H, Edwards N, Gainsbury S (2017a). *Sustainability and transformation plans in London: an independent analysis of the October 2016 STPs (completed in March 2017)*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/sustainability-and-transformation-planslondon (accessed 17 November 2020).

Ham C, Alderwick H, Dunn P, McKenna H (2017b). *Delivering sustainability and transformation plans: from ambitious proposals to credible plans*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/delivering-sustainability-and-transformation-plans (accessed 9 December 2020).

Health Education England (2020). 'CapitalNurse'. Health Education England website. Available at: www.hee.nhs.uk/our-work/capitalnurse (accessed 5 December 2020).

Healthy London Partnership (2019). *Our vision for London. The next steps on our journey to becoming the healthiest global city*. London: Healthy London Partnership. Available at: www.healthylondon.org/vision (accessed 11 December 2020).

Holmes J (2021). 'Brexit: the implications for health and social care'. The King's Fund website. Available at: www.kingsfund.org.uk/publications/articles/brexit-implications-health-social-care (accessed 8 January 2021)

Kershaw M, McKenna H, Charles A, Ewbank K, Ham C (2018). *Sustainability and transformation partnerships in London: an independent review*. London: The King's Fund. Available at:

www.kingsfund.org.uk/publications/sustainability-transformation-partnerships-london (accessed 13 November 2020).

Local Government Association (2020). 'About one public estate'. Local Government Association website. Available at: www.local.gov.uk/topics/housing-and-planning/one-public-estate/about-one-public-estate (accessed 15 December 2020).

Mayor of London (2017). 'The Mayor's six tests'. Mayor of London website. Available at: www.london.gov.uk/what-we-do/health/champion-and-challenge/mayors-six-tests (accessed 6 January 2021).

Mayor of London (2018). *The London health inequalities strategy*. London: Greater London Authority. Available at: www.london.gov.uk/what-we-do/health/london-health-inequalities-strategy (accessed 9 January 2021).

Murray R (2020). 'A recipe for baking in collaboration? NHS England and NHS Improvement's proposals for new legislation'. Blog. The King's Fund website. Available at: www.kingsfund.org.uk/blog/2020/12/nhs-england-and-nhs-improvements-proposals-new-legislation (accessed 11 December 2020).

Murray R, McKenna H (2020). 'The next steps towards integrated care'. The King's Fund website. Available at: www.kingsfund.org.uk/publications/next-steps-towards-integrated-care (accessed 11 December 2020).

Naylor C, Buck D (2018). *The role of cities in improving population health: international insights*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/cities-population-health (accessed 11 December 2020).

NHS England (2014). *Five Year Forward View*. London: NHS England. Available at: www.england.nhs.uk/ourwork/futurenhs (accessed 23 November 2020).

NHS England (2015). *Delivering the Forward View: NHS planning guidance 2016/17–2020/21*. London: NHS England Available at: www.england.nhs.uk/publication/delivering-the-forward-view-nhs-planning-guidance-201617-202021 (accessed 13 November 2020).

NHS England (2017). *Next steps on the NHS Five Year Forward View*. London: NHS England. Available at: www.england.nhs.uk/publication/next-steps-on-the-nhs-five-year-forward-view/ (accessed 13 November 2019).

NHS England and NHS Improvement (2019a). *The NHS Long Term Plan*. London: NHS England and NHS Improvement. Available at: www.longtermplan.nhs.uk/publication/nhs-long-term-plan (accessed 8 December 2020).

NHS England and NHS Improvement (2019b). *The NHS's recommendations to government and parliament for an NHS Bill* [online]. NHS England and NHS Improvement website. Available at: www.longtermplan.nhs.uk/nhs-publishes-response-and-recommendations-on-long-term-plan-legislative-proposals (accessed 8 December 2020).

NHS England and NHS Improvement (2019c). *NHS Long Term Plan implementation framework* [online]. NHS England and NHS Improvement website. Available at: www.longtermplan.nhs.uk/publication/implementation-framework (accessed 11 December 2020).

NHS England and NHS Improvement (2019d). 'South London Mental Health and Community Partnership (SLP) Nursing Development Programme'. NHS England and NHS Improvement website. Available at: www.england.nhs.uk/atlas_case_study/south-london-mental-health-and-community-partnership-slp-nursing-development-programme (accessed 20 November 2020).

NHS England and NHS Improvement (2020a). *Integrating care: Next steps to building strong and effective integrated care systems across England* [online]. NHS England and NHS Improvement website. Available at: www.england.nhs.uk/integratedcare/integrated-care-systems/ (accessed 8 December 2020).

NHS England and NHS Improvement (2020b). 'Journey to a new health and care system'. Presentation. East London Health and Care Partnership website. Available at: www.eastlondonhcp.nhs.uk/downloads/ourplans/Coronavirus/Journey%20to%20a%20New%20Health%20and%20Care%20System.pdf (accessed on 18 January 2021).

NHS England and NHS Improvement (2020c). 'Third phase of NHS response to COVID-19'. Letter. NHS England and NHS Improvement website. Available at: www.england.nhs.uk/coronavirus/publication/third-phase-response/ (accessed 5 January 2021).

NHS England and NHS Improvement and the National Collaborating Central for Mental Health (2019). *The Community Mental Health Framework for Adults and Older Adults* [online]. NHS England and NHS Improvement website. Available at: www.england.nhs.uk/publication/the-community-mental-health-framework-for-adults-and-older-adults (accessed 9 December 2020).

Office for National Statistics (2013). '2011 census: local characteristics on ethnicity, identity, language and religion for output areas in England and Wales'. Office for National Statistics website. Available at: www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/2011censuslocalcharacteristicsonethnicityidentitylanguageandreligionforoutputareasinenglandandwales (accessed 9 January 2021).

Office for National Statistics (2020). 'Population projections for clinical commissioning groups and NHS regions: Table 3'. Office for National Statistics website. Available at: www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/clinicalcommissioninggroupsinenglandtable3 (accessed 9 January 2021).

Ogden K, Phillips D, Spiliotis J (2020). 'Covie-19 and English council funding: what is the medium-term outlook?'. Institute for Fiscal Studies website. Available at: www.ifs.org.uk/publications/15041 (accessed 11 December 2020).

Serle J (2020). 'Region will have just five CCGs by April. Health service Journal'. Health Service Journal website. Available at: www.hsj.co.uk/nhs-west-london-ccg/region-will-have-just-five-ccgs-by-april/7028712.article (accessed 11 November 2020).

The King's Fund (2020a). 'Health inequalities: our position'. The King's Fund website. Available at: www.kingsfund.org.uk/projects/positions/health-inequalities (accessed 14 December 2020)The King's Fund (2020b). 'Public

health: our position'. The King's Fund website. Available at: www.kingsfund.org.uk/projects/positions/public-health(accessed 14 December 2020)

The King's Fund (2020c). 'Social care: our position'. The King's Fund website. Available at: www.kingsfund.org.uk/projects/positions/social-care (accessed 14 December 2020)

The King's Fund (2020d). 'NHS workforce: our position'. The King's Fund website. Available at: www.kingsfund.org.uk/projects/positions/nhs-workforce (accessed 14 December 2020)

The King's Fund (2021). *Response to NHS England and NHS Improvement on proposed changes to integrated care systems* [online]. The King's Fund website. Available at: www.kingsfund.org.uk/publications/response-nhs-england-improvement-integrated-care (accessed on 14 January 2021).

Timmins N (2019). *Leading for integrated care: 'If you think competition is hard, you should try collaboration'*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/leading-integrated-care (accessed 8 December 2020).

Wenzel L, Robertson R (2019). 'What is commissioning and how is it changing?'. The King's Fund website. Available at: www.kingsfund.org.uk/publications/what-commissioning-and-how-it-changing (accessed 14 December 2020).

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