London Health and Social Care Partnership

Accelerating integration, building on the lessons of the pandemic

“If not now, when…?”

Findings and recommendations
April to November 2021

Public Health England

NHS

PPL

GREATERLONDONAUTHORITY

LONDON COUNCILS

Contents

Section 1

Executive Summary

“I refuse to believe that we do not already have the answer to the question. We cannot discuss something for 20 or 30 years and not know the answers. The challenge is to make something happen.”

Our approach

Report summary

The purpose of this report is to gather and synthesize experiences and analysis of partnership working in health and care across London, building on experiences both prior to and during the pandemic, as a basis for accelerating progress as we develop our Integrated Care Systems and partnerships. The intention was to identify practical next steps to support place-based and system working and, in doing so, to strengthen and improve the experience and outcomes of health and care for all Londoners, in line with the London Vision, London Recovery Programme, Recovery Missions, Health Inequalities Strategy, recent NHSE/I guidance (2020-21) and DHSC White Paper on "Working together to improve health and social care for all" (2021).

Critical literature review

There is a long history of integrated working in London. A key focus for this report was building on existing experiences and learning. This involved starting with a critical literature review covering the period immediately prior to the COVID-19 pandemic (2018 - 2020) as well as existing research looking at the challenges and changes that have occurred across the London region since (i.e. 2020 – 2021). The critical literature review covers national and regional publications and policy developments, as well as locally-produced documents produced at a sub-regional and borough level. A full list of the sources consulted and the key findings is included in Appendix B of this pack.

Stakeholder engagement

Primary research commenced in early May 2021. This included engagement with key health and care forums and groups across London, and 29 individual system leaders. Engagement has been supported by five meetings of a dedicated Task & Finish Group with representatives from across the London Health and Social Care Partners. In total, over 100 individuals at all levels of London's health and care system and from across London's diverse communities contributed to the findings of this report.

Core contributions have come from London ADASS, London's five CCG Chairs, Chief Executives of London's NHS Providers, London's Council Officers, Elected Members, the GLA, London's local Healthwatch organisations, Healthy London Partnership, London Councils, London Health & Wellbeing Board Chairs Network, London's five ICSs and Place-based leadership teams, London's Directors of Public Health, Public Health England, NHS England & Improvement Regional Team, VCSE leaders from across London and the London VCSE Network.

Critical Literature Review: "If not now, when?"

The literature review highlights how the first steps have already been taken. New ways of working, provider collaboratives, and borough-based partnerships in many areas of London provide a foundation to build on.

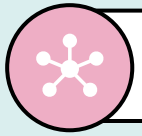
- National, regional and system stakeholders have all highlighted the role that collaboration has played in the successful elements of the COVID-19 response.
- The pandemic increased awareness of:
    - the need to **balance national accountability with local autonomy**,
    - the **benefits of integrated and cross-organisational working** across sub-regional, regional and national levels, and
    - the **importance of population health** approaches, with further reforms to public health expected.
- A network of leaders across the region from different organisations and sectors, down to the level of individual communities, experienced more regular contact and fostered **closer working relationships and improved understanding**.
- **Collaboration across providers** allowed for an increase in capacity over the pandemic period.
- The response to the challenges posed by the pandemic saw an **increase in local government involvement in London's ICSs** which had been seen previously as highly NHS-focused.
- **New committees and groups** were established to collaborate towards delivering improved quality of clinical care.
- **Effective utilisation of local knowledge of communities and their assets** provided a platform for local authorities and providers to expand neighborhood-based support, such as shielding hubs, and community hubs.
- **Changes to legislation** proposed in the recent DHSC White Paper, which are specifically intended to remove some of the barriers to partnership and collaboration and to make joint planning and delivery easier, have been broadly welcomed.

Lessons from the pandemic

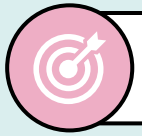
Responding to the COVID-19 pandemic was a 'generational challenge' for London's health and social care system:

- The experience brought into focus new challenges and challenges we have tried and failed to address in the past.
- It also showed us that we can build a better health and social care system post-crisis.
- In the words of one of our respondents, ***"In the future we will be asked, 'in knowing better, did we do better?'".***

Based on contributor feedback, ten key opportunities for learning were identified:



*When we have a clear **common purpose** and a **shared pool of funds** to achieve it, we can overcome cultural, financial and organisational barriers.*



*Focusing on **high-impact priorities** that we can only deliver together forces us to work faster and more collaboratively.*

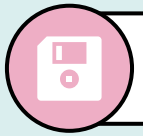
*We learnt more about the nuances and needs of the unique communities we serve and how best to **build trust** and engage with cultural competence.*

*Regularly getting the **right leaders in the same room** fosters stronger system relationships and more responsive decision-making.*

*Our system is more dependent on a **neglected social care sector**, especially care homes, than many of us had appreciated.*

***Larger bodies have a role in setting objectives** and supporting local teams, but the **best innovation happens close to the ground**.*

***Doing, rapidly iterating, and sharing** leads to better results, more quickly, than extended periods of planning and piloting.*



*We can greatly enhance each others' understandings of our populations with **simple data-sharing arrangements** and improved analytical capacity.*

*Despite over 10 years since the original Marmot Review, there remain **deep-rooted inequalities** across our communities.*

*Our communities trust and engage enthusiastically with integrated, co-located, and local **preventative initiatives**.*

“Integration should not be the focus. However, by putting people at the heart of what we do, greater integration may be a result.”

Framework for future integration: "Why can't we?"

Recovery from the COVID-19 pandemic presents us with complex challenges and a powerful choice.

We can continue to move forward, building on the very real, tangible experience of closer collaboration that defined London's pandemic response. This will include aligning health, social care and public health along with key regional and local partners such as the voluntary sector, volunteers, and the diverse communities of London. Or we can retrench to what might feel like the relative safety of where we were before, whilst acknowledging that for many that was a place where care was hard to access, fragmented, and delivering unequal outcomes.

Going forward and deepening integration is not without risk – it will require new ways of thinking, new identities, new expectations and behaviours. It will involve loss as well as gains. It will continue to be a moment of transition at the very moment where London's leaders and workforce are at their most exhausted. And it will require a joint commitment not to go backwards, if people are to invest the required time and resources to move forwards.

Against the risks of going forward lies the certain failure in going backward. The last 18 months have been the perfect case for change, in which we saw what might happen if we cannot work together effectively to support each other and ensure equitable access to primary, community, acute, social care and specialist services. We've also observed, sometimes first-hand, the incredible work we can achieve when we do successfully come together. This is a moment of opportunity, and one that requires courage and a shared acceptance of the challenges of thinking and doing differently.

"We are only as strong as our weakest part"
Sir David Sloman, NHSE/I Regional Director for London

What does this look like in practice?

5 Ps	Why can't we…	In practice this will mean…
Purpose 	**…make addressing inequalities the central purpose of London's five ICSs?**	1. **Addressing inequalities is at the heart of how we fund, plan, deliver and assure services** and reflected in how we measure the overall success of our ICSs and Borough-based partnerships. 2. **Our focus on inequalities is not seen as in conflict with other national and local priorities**, including reducing waiting lists and improving financial sustainability, but is instead viewed as our starting-point and endpoint for tackling these. 3. **We reflect the communities we serve** with visible community representation at all tiers of Regional, ICS and Borough-based decision-making.
Priorities 	**…agree in each borough-based partnership a small number of priority outcomes linked to this purpose which we will deliver in the next 12 months?**	1. **Priorities are set at a borough-level from a list of outcomes** that can only be achieved by partners working together based on the needs and priorities of all of our communities. Wherever possible, priority-setting builds on existing analysis, engagement and learning. 2. **Priorities are person-centred, measurable, and backed by local 12-month action plans** leveraging our collective assets with shared local accountability for delivery. 3. **In selecting priorities, we are explicit in what we are going to de-prioritise** for the next year in order to ensure these are deliverable.
Place 	**…recognise the many definitions of place, but agree that in London it is our 32 Boroughs that will be the heart of our local health and care systems?**	1. **Ongoing planning, commissioning and assurance functions are vested in joint borough-based teams wherever possible within legal and statutory boundaries,** hosted where appropriate within the local authority. 2. **Borough-based partnerships are enabled by a Region and ICSs who support them to have financial and decision-making autonomy**, whilst enabling collective efforts on shared priorities and best-practice. 3. **Health & Wellbeing Boards, Healthwatch, patient groups and voluntary and community sector partners are appropriately equipped** to support our communities, so their voices are both heard and acted upon.
Pounds 	**…commit to pooling all local health and care budgets by default, except where there is a compelling reason not to?**	1. **We openly share how money is budgeted and spent** across health, local government and voluntary and community sector partners in each borough, providing for the first time a single view of the 'local pound'. 2. **We can show how investment is growing in community-based prevention and early intervention**, improving outcomes and reducing long-term costs. 3. **Resources are demonstrably being distributed to where they are needed, using granular population health data and evidence** to focus our efforts on addressing long-standing and new inequalities.
Providers 	**…support provider collaboratives and primary care networks to deliver better outcomes both "At Scale" and within places?**	1. **Provider collaboratives are empowered to plan, deliver and assure the care they provide**, enabling "mutual-aid" across organisational and geographic boundaries, and supported by ICSs that help align their work together and with our place-based partnerships. 2. **The voice of primary care is reflected in decision-making at all levels**, with PCNs providing the "hub" for local care networks that focus on the holistic needs of individuals and communities. 3. **We invest jointly in the health, wellbeing and professional development of our workforces**, with specific and measurable goals around integrated training, professional development and resourcing across traditional specialisms and boundaries.
People 	**…think the best of each other?**	1. **We nurture and develop relationships between individuals at all levels** coming together regularly, as places and systems, to co-ordinate our efforts and resources with our local communities. 2. **We share openly with our partners the information they need in an honest, secure and timely way** in order to achieve the best possible health and care outcomes. 3. **We mean what we say and we hold ourselves accountable**, in willing better outcomes for Londoners, to ensuring the means are in place to deliver those outcomes.

Section 2

Engagement findings

Key lines of enquiry

Key Lines of Enquiry (KLOEs) were jointly developed with the London Health and Care Leaders' Group, which represents the senior London leadership teams of Public Health England, NHS England & Improvement, the Greater London Authority and London Councils. The KLOEs were applied to a critical literature review examining sources identified in the period of January 2018 through to April 2021, covering the last three years and developments prior to and during the COVID-19 pandemic. The literature review was then supplemented by a series of semi-structured interviews and broader group engagements across London.

a. What are the specific things that systems and boroughs will do to address the challenges of long-standing inequalities highlighted by the pandemic and new inequalities arising from it?

b. How are the experiences of social care in the pandemic, including residential and domiciliary care, best reflected and addressed in future plans, linking in with the work of London ADASS?

c. How will we manage the transition from pandemic response to a renewed focus on improving population health and wellbeing, including translating lessons learned into forward-facing and replicable strategies for improvement?

d. What can we learn from the experience of the pandemic, regional and local responses in relation to the priorities of the London Vision, including for the health and wellbeing of young Londoners, homeless people and those approaching the end of their lives?

e. What are the individual and shared enablers required to support and to sustain the continuation of progress and the restoration of services which are vital to Londoners' health and wellbeing, post-COVID?

f. What are the decision-making and participatory structures that are required at a system and place level to support the above?

g. In the context of ongoing funding challenges across all parts of London's public and voluntary and community sector, how do we optimise "allocative value", applying London's assets where they are needed most and will have the greatest impact?

Example questions

- *If all goes well over the next 10 years, what will be different about the way in which integrated health and care services are delivered in London?*
- *How have our responses to the pandemic at a regional and local level affected our progress in relation to the priorities outlined in the London Vision?*
- *Reflecting on your vision for the future, what obstacles will you have overcome / what will need to be in place to realise this?*
- *What are the specific things that integrated care systems (ICSs) and borough-based partnerships will need to do to address the challenges of long-standing inequalities highlighted by the pandemic and new inequalities arising from it?*
- *In the context of ongoing funding challenges across all parts of London's public and voluntary and community sector, how do we apply London's assets where they are needed most and will have the greatest impact?*
- *What are the immediate next steps you will need to take towards achieving the 10-year vision for integrated health and care?*

Developing this report

Over 100 individual contributors

29 individual semi-structured interviews

Five “Task & Finish” Group sessions

Contributions from London ADASS, London’s five CCG Chairs, Chief Executives of London’s NHS Providers, London’s Council Officers, Elected Members, the GLA, London’s local Healthwatch organisations, Healthy London Partnership, London Councils, London Health and Care Leaders’ Group, London Health & Wellbeing Board Chairs Network, London’s five ICSs and Place-based leadership teams, London’s Directors of Public Health, Public Health England, NHS England & Improvement Regional Team, VCSE leaders from across London and the London VCSE Network

The Task & Finish Group

A dedicated Task & Finish Group supported the development of this report by bringing together a breadth of experience, expertise and perspectives from across London, including representatives from key partners to provide direction and input into the engagement and development specific recommendations.

Members:

1. Anisa Goodwin, Director of the Office of London Partnerships
2. Clive Grimshaw, Strategic Lead for Health & Social Care at London Councils
3. Elena Bechberger, Director at the London STP Network
4. Geoff Alltimes CBE, Co-Chair of the London Estates Board
5. Halima Khan, Sarah Mulley, Executive Directors of Communities & Skills at the GLA
6. Henry Black, Accountable Officer for North East London Integrated Care System
7. Helen Coombes, SWL ICS NHS & London Boroughs Place Development Director
8. Maggie Mbanefo-Obi, Policy Lead, Health Protection (London) at Public Health England
9. Mark Kewley, Director at Imperial College Health Partners
10. Sarah McClinton, Director of Health & Adult Services at Royal Borough of Greenwich
11. Tom Shakespeare, Director of Integrated Care at Brent CCG & Council
12. Will Huxter, Director of Primary Care & Public Health Commissioning for the London Region

Meeting themes

1. **How will we ensure place-based integrated care becomes the "norm" for Londoners and not the exception?**
2. **What are we going to do differently from 2021 onwards to deliver on the promise of equality in health outcomes?**
3. **In the face of overwhelming waiting lists, how can we support each other to enable Londoners to receive timely elective and acute care?**
4. **What does this mean we need from the London health and care workforce and estate?**
5. **What does all this mean we need to do about money?**

Terms of Reference:

Provide advice and guidance

- Identify opportunities to improve integration in London's five systems and across all 32 boroughs.
- Prioritise local, sub-regional and regional actions to be taken to drive improvement.
- Advise on issues and barriers to overcome.
- Represent the views and needs of your sector(s) and area(s) of expertise.

Support conversations with stakeholders and facilitate consensus

- Support the project in navigating relationships with key stakeholders.
- Use influence to gain buy-in and support for the project and its aims.
- Provide direction to unlock existing issues and respond to new challenges as they arise.
- Promote the aims of the project and support the project within organisation(s).
- Lead on the development and delivery of discrete areas of the workplan.

Make recommendations

- Endorse the priorities for London and the proposals for change at a place, local, sub-regional and regional level.
- Agree practical next steps London can take to support the establishment of our five ICSs as statutory bodies.
- Agree the future direction of travel in London, whilst enabling remaining shared barriers to be overcome.
- Hold the project team to account.

Reflections on the pandemic

*”What the system did that made this work was **delegate locally, to trust locally, to be agile in providing support** to local authorities, PCNs etc. and then allowing them to get on with doing it.”*

*“There was **a really shared purpose, a goal that we all shared**… fundamentally no one demurred from the ultimate aim of vaccinating. The lack of hesitation and bureaucracy was amazing, people just did things.”*

*“On the vaccination programme, rather than saying ‘this is how we, the NHS, does things’, **we started with the population and the need and then we built approaches**.”*

*“We have **co-chairing arrangements** now, also meaningful, which can speak on behalf of the boroughs.”*

*“[During the pandemic], **senior decision makers met super-frequently**, daily calls with medical directors etc. - the agility this brings meant less ‘feeding the beast’.”*

***“[W]eekly meetings that describe performance at a place level**.”*

*“Now **we know if you want to mobilise large amounts of resource it is possible** to move homeless people into accommodation where it can be addressed… is it within our will to do it?”*

*“[A]t the core, there was **a group of people who met at 9am every morning**.”*

*"**Mindsets were shifted** around mental health, homelessness and young people as the pandemic forced intervention...and gave us space to rethink pathways and approaches."*

*"[The] pandemic has **brought the focus on care homes**, thinking on how do we take a joined-up approach to supporting both residents and staff."*

*“[We have learned] that **the social care market struggles** with a pipeline of workforce and pay."*

*“The lesson for me is **we need to appreciate domiciliary care staff more**.“*

*“In the COVID-19 instance **money was given collectively** so [there was] no argument over who was going to pay for what.”*

*“COVID-19 proved the principle that if **you remove the argument over whose budget is being used**, lots of the barriers disappear.”*

*“I think what we have learnt from COVID-19 is that **the more responsibility and authority you give to local areas, the better the outcomes**.”*

*“Take hospital discharge as an example, where it works well **systems are working together to make sure that the post-discharge support is there**.”*

*“We responded very well when we were left alone. If we can channel the same rigor and dispassionate approach to integration we will do it. **We might make some mistakes**, as we did with COVID-19, but the outcome will be greater than talking about it.”*

*“**We were prepared to ask for forgiveness** rather than permission e.g., on data sharing. It was all just a bit more permissible and risk-taking.”*

*“There was also **a sense on doing it and improving it**. We improvised multiple models and tested and learnt rather than trying to perfect it pre-implementation.”*

*“We have an integrated care executive to think about how are we creating the environment for change. **How do we create an authorising environment?**.”*

*“Were social care a voice round the table, **we would not have made this mistake** [discharging to care homes], and people are more aware of that.”*

*“**Local Authorities were able to mobilise** to make shielders in the community more visible.”*

*“**We developed new links with our communities**, and we have learnt about their needs and their relationships to public services… [W]e have learnt community solutions work better for many.”*

*“**COVID-19 has changed the communities** we have been involved with and has allowed us to access people that we wouldn’t have reached before”*

*“In COVID-19, there **was a disproportionate impact on certain communities**… it emerged that having discussions supported by community organisations which were representative and credible in those communities helped us shift the dial.”*

*“**COVID-19 has exposed an unavoidable correlation** between wealth and health.”*

*“Our faith leaders said it’s great to be spoken to in crisis, but **they want to be engaged all the time**.”*

*“We have been working on a citizens' assembly - **not patient or service user consultation, just a representative cross-section sample of citizens**.”*

*“Pandemic has highlighted the importance of public health… **public health has become so real** and a whole council responsibility.”*

*“I think the response has been phenomenal, **we have built stronger relationships at ICS and borough level**. [We have] positives to build on as well as negatives to correct. We have learnt the power of relationships and the power of common purpose.”*

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Source: Stakeholder interviews

Where we would like get to in the next 10 years

*"In ten-years time I think we need **32 thriving health and social care partnerships at borough/place level** that can demonstrate they have made people healthier and reduced the amount of hospital care. That means giving place a centre-stage in how we think about delivering health and social care."*

*"Firstly, you would start to see a **shift in what we call the life course**. Second thing is the primary interventions will be prevention. Third thing is when you go to see GP and you need help with benefits or housing, the GP can't just refer you to the council website, there will be an integrated joined-up service they can refer to."*

*"We would **not be having arguments over who is paying for what**, we would not be looking at personal or organisational positions and priorities only."*

*"If we have been successful much **fewer people will have to attend hospital**, [this is] one thing we have been talking about for many years. We know we need to take it seriously; [the] pathway needs to start even before presenting to [the] GP."*

*"I'd like to see services across health and local authority in **pathways that are not just linear**."*

*"I think the word 'system' is key. **Being part of a system** implies everyone, including the CVS, is present and that resources are allocated by and within the system."*

*"If in 10 years time things have gone well, I think firstly there will be a **real integrated care system** as opposed to a set of transactional relationship."*

*"We need to **think much more about population and individual needs**, both in terms of setting and how services are described and organised. You will be able to get anything you need from a **single point of access**."*

*"In 10 years' time, [I] would want this more joined up and I would want to see a national interdepartmental strategy where when there is a priority. [This should come] down as a very interdepartmental vision enabling us to work together local. No fighting over money. **This would include the third sector**."*

*"Strategically there would be a **realignment of commissioning and provision** such that the role of the commissioner is not superior to the role of provider, rather it is a collaborative experience. Tactically, there would be integrated partnerships sitting at borough level that bring together the provision of services. Operationally, we would have integrated teams sitting at ward level. Culturally, we need to actually work as a national health and social care system [where] everyone understands our responsibility is to the citizen. Stop the infighting [and] dispassionately look at the performance of our place."*

*"[That] **health outcomes would be better** is the primary point, and more importantly the **distribution of outcomes would be fairer**. I am primarily talking about community outcomes. We would have a different relationship with the public."*

*"The local vision is **'no wrong door'**, no more GPs and adult social care workers knocking people between each other. Locally-based teams with no organisational identities helping service providers understand their community in granular detail."*

*"Everything would be resident/patient focused. Only go to hospital for skills/equipment. [People] would have teams who can look after them in the community who are one team. They would have a lot of their own digital support so they can **manage their own long-term conditions** etc. social care problems etc."*

*"For me, the two key principles are: 1. What gets tackled is what matters to you, built on **needs of individuals rather than services**. 2. The person you see is the person who can help you solve all your issues, not just the one they specialise in."*

*"The main thing is that any individual living within a borough would receive a health and social care service that is **simply one service**."*

*"[We] wouldn't talk about separate teams, we would talk about **local care teams**. Would be tracking for these teams a combination of outcome and processes that relate to good outcomes."*

*"My starting point would be that there would be something in the region of **30-32 single health and social care budgets** that would cover at a borough footprint all locally delivered and decided health and social care services. That would be overlaid with a political governance system that genuinely makes **decisions about public resources at place level** [and] has clear and meaningful relationships with ICS governance professionally and politically."*

*"In ten years' time [what] I want to see in the NHS and social care is that we stop talking about 'hard to reach communities' which is a lazy term. Stop talking about inequalities, **start listening and talking about poverty and racism**."*

*"From a system perspective, I would like to see within a defined geography all organisations that care for people do so in a coordinated way. [I would like to see that] in London there is a common approach, and **a way is found to balance local issues with broader perspective**."*

*"Nothing I'd say is particularly new. **A complete dissolution of organisational boundaries**, an entirely seamless system whereby you would not be able to tell, and nor would you need to, which bit of the system you are dealing with."*

Source: Stakeholder interviews

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Why can't we… accelerate integration, building on the lessons of the pandemic?

The "why can't we…" approach to the challenges around accelerating integration, addressing health inequalities and improving outcomes for all Londoners is explored further in Section 3. Some of the key challenges and barriers which were cited by the over 100 contributors to this report included:

Perceptions that existing and emerging structures would stand in the way – "we would do this, but for…"

- *National*
- *The Region*
- *Our Integrated Care System*
- *Our Integrated Care Partnerships*
- *The Local Authority*
- *The Primary Care Networks*

Competing priorities and pressures will undermine the gains achieved during the pandemic as people return to "business-as-usual"

- *The need to tackle waiting lists and restore elective care*
- *Increased demand and a lack of funding for local authority and voluntary and community services*
- *The challenges of restoring financial controls and financial sustainability across the NHS, and acute deficits*
- *The competing pressures on GPs and broader primary care services*
- *Increased frailty and social isolation across all communities*
- *Lack of public funding for key services including mental health and for children and young people*
- *Addressing the ongoing impact of COVID on individuals and communities*
- *Agreeing on the need to tackle long-standing and new inequalities but failing to agree on how best to do this*

In the context of all the above, common challenges

- *Too many competing local, regional and national priorities*
- *A return to "command-and-control" and "top-down" performance management*
- *Competitive behaviours between different providers and parts of the system*
- *A lack of local ownership and engagement in the integrated care agenda*
- *Too much focus on "planning over doing", too many pilots and too little noticeable change at scale*
- *Workforce fatigue*
- *A lack of political engagement*
- *A lack of meaningful community engagement, including with seldom-heard groups*
- *Distrust of others' commitment to this agenda*
- *Governance, financial and decision-making structures which are siloed and not fit for purpose*
- *The scale of the challenge relative to the resources available to respond*

Section 3

Recommendations

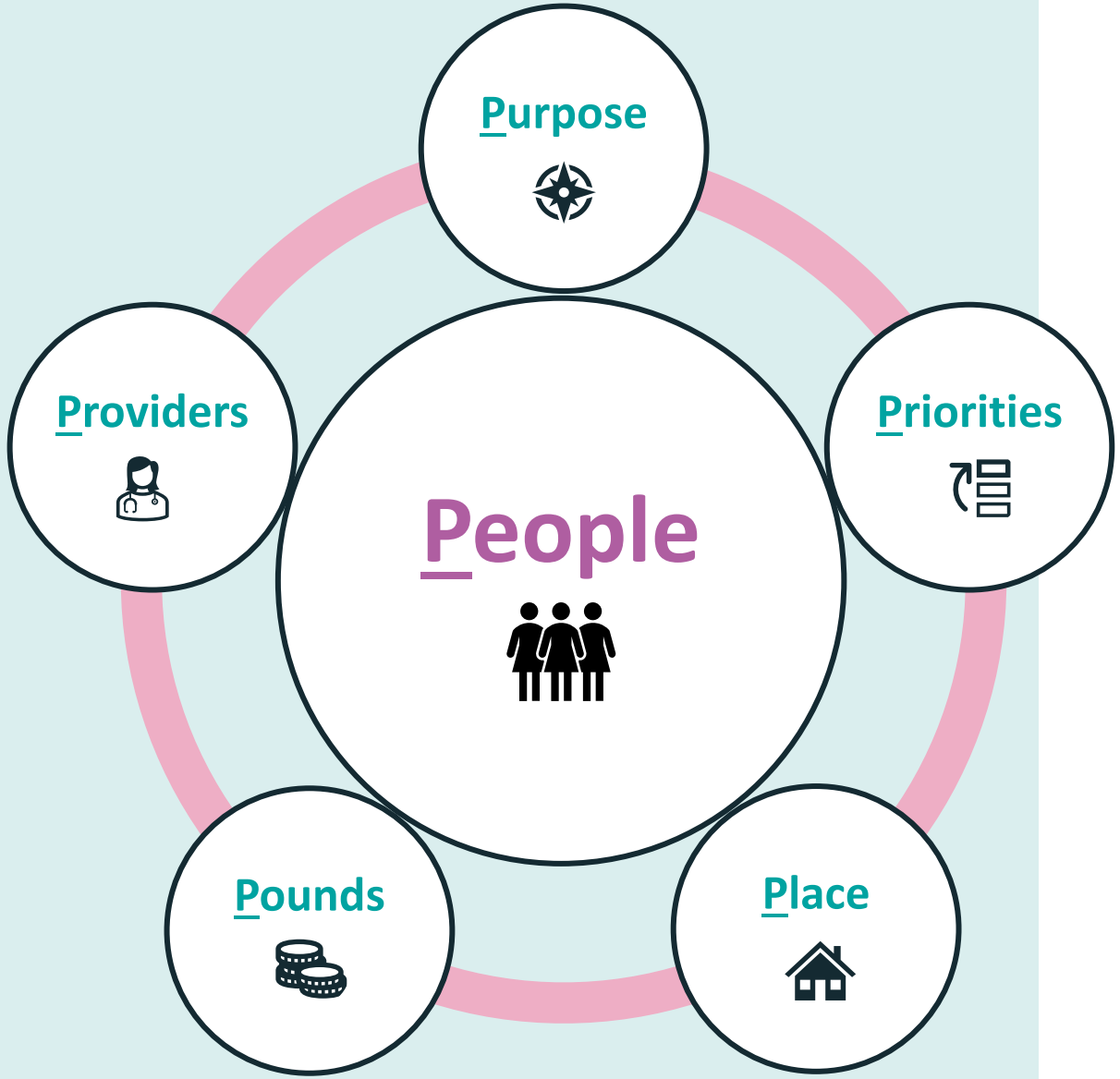
London's Five Ps

London's Five Ps (Purpose, Priorities, Place, Pounds and Providers) for Integration is a conceptual framework arising from discussions at the London Health & Social Care Partnership Integration Task & Finish Group, reflecting on the feedback from broader engagement and past experiences and lessons of integration in London and joint working during the pandemic.

The Five Ps provide organising principles that help us to articulate London's next steps to increasing integration in a meaningful way.

Intrinsic to all of these is the Sixth P of People.

Frontline professionals, patients and service users, families and carers, elected members, organisational and system leaders, and London's diverse communities are critical to the success of integration and core to each of the Five Ps.



“During COVID-19, for a time, we had a singular purpose. However, this is rapidly reverting to institutional purposes, and we are losing focus.”

Why can't we… make addressing inequalities the central purpose of London's five ICSs?

"There was a really shared purpose, a goal that we all shared."

The need to respond to the COVID-19 pandemic created a sense of urgency in London which allowed people, in the words of one contributor, to "think the best of each other" in the knowledge that all were working towards the same objective. A powerful shared purpose meant it was possible to overcome barriers to collaborative working which had previously been seen as insurmountable, including diverse organisational and professional identities, cultures, responsibilities, priorities, governance and funding arrangements.

"The vision itself needs to be one that everyone is signed up to and that feels truly compelling… inequalities could be that touchstone."

In the words of one contributor, "equalities is the right thing right now". Over the past 18 months, London's inequalities have been highlighted in a uniquely stark way that contributors agreed simply could not be ignored. The pandemic shone a light on and exacerbated existing inequalities, and created new inequalities in access, experiences and outcomes of health and care services. The challenge of providing "a good life for everyone" lends itself well to becoming the shared purpose for London's ICSs because ultimately it is a challenge that cannot be addressed by any one organisation alone. It speaks to people at all spatial levels in London and resonates with their values.

"This is not about creating a nice new narrative. It's about how we actually make the change."

Despite previous commitments, contributors were clear that these have not translated into adequate actions or changes. Over a decade on from the original Marmot report, it was highlighted how competing priorities and a failure to recognise and address the underlying root causes of inequality meant that life expectancy and quality of life in many of London's communities had got worse. As one contributor remarked, "working on the inequalities and social determinants agenda it always feels like two steps forward, one step back".

"The who miss out due to the lack of joined up services are those who are the poorest and most deprived."

There was strong support for "health inequalities in all policies" approach, but concerns remained that more operational changes were necessary to translate this into Londoners' everyday experiences. There was a need to avoid creating a "parallel agenda" around this area by embedding measures to address inequalities in how systems plan, deliver and assure all health and care services, and to "hold ourselves accountable" for the results.

"The solutions with the best results on disproportionate impact and inequalities have been all about engagement and co-production."

Ultimately, there was a strong sense that "if you will the ends, you will the means". Despite strong commitments to tackling inequalities by each of London's ICSs in all of the recent planning, this was not felt to be reflected in the day-to-day agendas, relative priorities and ways of working currently.

The following sections of the 5 Ps Framework reflect the steps respondents felt were required – in relation to Priorities, Place, Pounds and Providers – to ensure that by making inequalities our central purpose, we realise tangible changes in the co-ordination and outcomes being achieved through partnership working across London.

“If inequalities can’t just be tackled by health… well then our ICSs can’t just be about health!”

What would this look like in practice?

1. **Addressing inequalities is at the heart of how we fund, plan, deliver and assure services** and is reflected in how we measure the overall success of our ICSs and Borough-based partnerships.

   Enshrining "equity as an organising principle" for our health and social care system provides the common purpose needed to motivate effective collaborative working whilst also improving outcomes for, and building trust with, our most overlooked and disadvantaged communities. However, this needs to be "mainstreamed" in how our ICSs and borough-based partnerships operate, and not seen as a separate policy objective or set of responsibilities.

2. **Our focus on inequalities is not seen as in conflict with other national and local priorities**, including reducing waiting lists and improving financial sustainability, but as our starting-point and endpoint for tackling these.

   Contributors highlighted the risk of restoring services (such as in the area of elective care) based on pre-pandemic models risked "baking-in" past inequalities. Conversely, worsening inequalities are driving demand across our health and care systems and impacting on the quality, experience and sustainability of care. Only by applying an inequalities "lens" to the challenge facing systems can we "move beyond the current paradigm".

3. **We reflect the communities we serve with visible community representation at all tiers** of Regional, ICS and borough-based decision-making.

   Better representation means our system is better placed to understand and respond to the needs of all our communities, while community representatives visibly effecting real decisions is a starting point for rebuilding trust with minority groups who do not feel health and care serves them. A core message was that all systems need to get better at "you said, we did", whilst recognising that the best outcomes will be co-produced between professionals working across traditional boundaries and those they serve.

"If we set the right priorities, in stone, people can be more ambitious. The truth is this level of discipline is actually freeing."

Why can't we… agree in each borough-based partnership a small number of priority outcomes, linked to our purpose, which we will deliver in the next 12 months?

"Things we thought we could not do we did in record time. How to capture that energy, agility, and sense of focus developed in the pandemic to take forwards?"

The pandemic response demonstrated that in order to create change, in the words of one contributor, systems and partnerships need to "focus on one thing, at the detriment of others, to get things done". There was strong support for teams taking a "sprint" approach to achieving a select few priorities. An example was working iteratively to test and scale new models of care during the pandemic (such as discharge hubs) has produced rapid innovations that can be shared across the region to benefit patients for years to come.

"We have been too good at trying to focus on everything and failing to deliver anything at all."

Contributors described a system that has too often tried to "juggernaut change" and "boil the ocean", and as a result achieved very little. A failure regime that diverts attention and resources, coupled with organisations and individuals that have often been unwilling to deprioritise "pet projects", were given as reasons for London falling short of its vision to become the world's healthiest global city. Prolonged planning discussions and debates produce action plans that, in the words of one contributor, more closely resembled "shopping lists" and reduced the focus on "big ticket items" that might galvanise partnership working and innovation.

"We need to choose priorities, put resource behind them and stick at that for a while."

Looking ahead, London's health and social care system faces unprecedented challenges in terms of recovery and reorganisation. One contributor warned that "there will be no burning platform, no free funds for all or ignoring elective care". There was a strong sense of urgency around agreeing on those priorities we want to commit to as a system. Contributors also made it clear that this must come with clarity around resourcing and capacity. As one contributor noted, "systems can be great at producing plans but when matched with resources it doesn't square. We need clarity."

"Integration should not be the focus; however, by putting people at the heart of what we do greater integration may be a result in some places."

In addition to focusing on the areas of greatest need, contributors identified a fresh set of lenses through which to agree our shared priorities, focusing on (i) what we can only achieve together, (ii) where there is potential for practical, deliverable wins, and (iii) what will "galvanise people" to work in a different way. Contributors agreed that the "how" is more important than the "what". There was a desire for priorities that are "inter-departmental" and not purely clinical, to ensure as many individuals as possible are bought in to the first set of action plans. As one contributor noted, "it is not about trying to get the perfect set of projects".

"Don't do the pilot thing - make a change and then iterate it."

Contributors expressed a desire to "capture and embed" ways of working from the pandemic by limiting the number of concurrent workstreams, meeting frequently to operationalise our priorities, and trusting each other to work towards a common goal. Contributors are looking to form "collaboratives of the willing" and prove the value of an initiative (rather than "long trying to engage people whose hearts and minds are not in it") to bring the unconvinced into the fold. Finally, "clear articulation of what we are trying to do" and maintaining a "sense of urgency" on the part of leaders was highlighted as a means of recreating the conditions that allowed London to achieve so much over the past 18 months.

“We need to be specific that these are things we can only do together and that we are not set up to do currently but are within our gift to do.”

What would this look like in practice?

1. **Priorities are set at a borough-level from a list of outcomes that can only be achieved by partners working together**, based on the needs and priorities of all of our communities; wherever possible, building on existing analysis, engagement and learning.

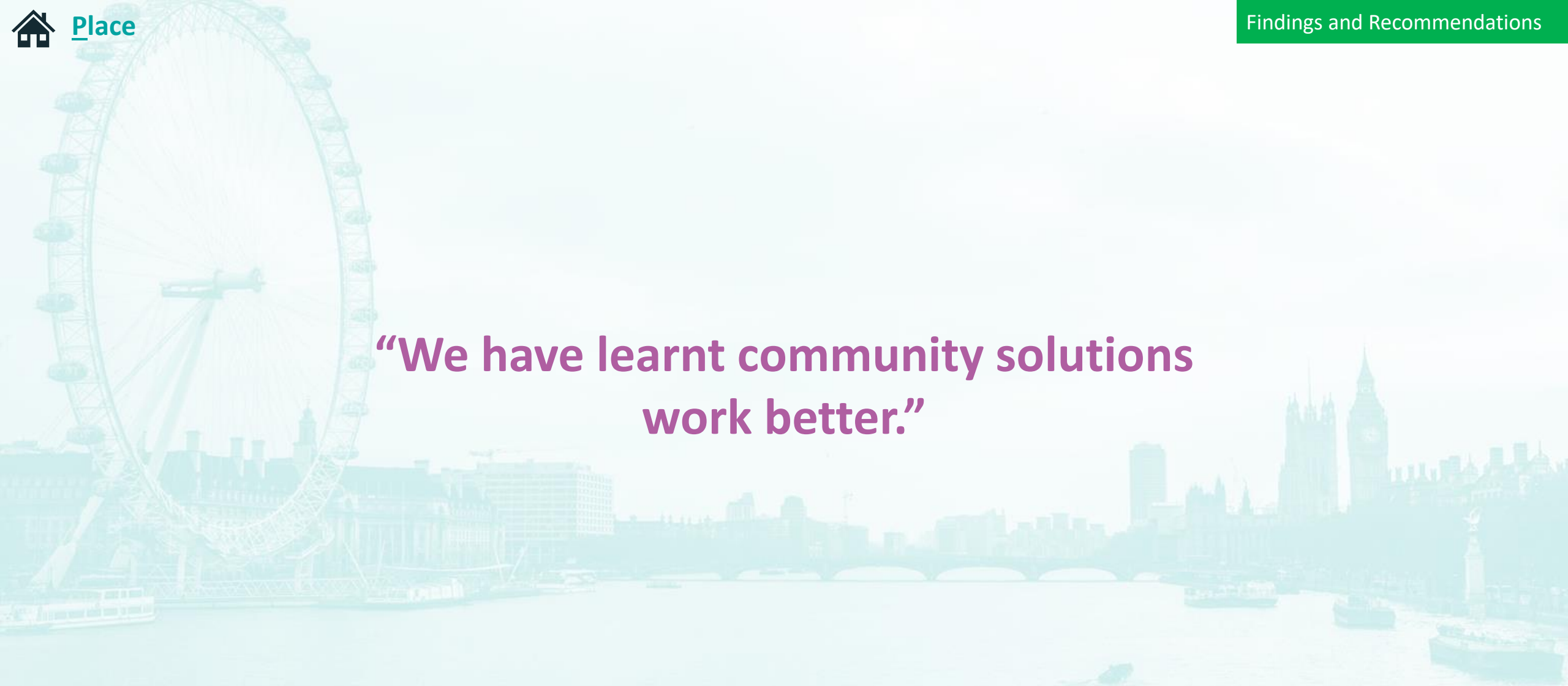
   The priorities need to link to the overall purpose, in this case, addressing inequalities. Directing focus to a small number of priorities was seen as key to providing clarity across our systems and permission and support to local teams to overcome barriers to better care. Building on existing engagement does not exclude the need to re-engage with communities and previously seldom-heard groups, but ensures we start from what people have told us already and do not ask them to repeat their stories again.

2. **Priorities are person-centred, measurable, and backed by local 12-month action plans** leveraging our collective assets with shared local accountability for delivery.

   There was a recognised need for priorities to be based around things that matter to local people and the "intrinsic motivations" of staff, with clear local accountability for delivery based on specific and time-bound commitments that engage all local teams and assets in achieving them. Integration in this context was seen as the natural end-point not the starting-point for delivery, and therefore more likely to be achieved and sustained.

3. **In selecting priorities, we are explicit in what we are going to de-prioritise** for the next year in order to ensure these are deliverable.

   "Prioritising everything means prioritising nothing". There is a need to be explicit about what will be de-prioritised, even if this involves difficult conversations. The alternative was seen to be agreeing to a long list jointly, and then not changing the way we individually work, eroding trust in the system and risking a return to prior siloed working. De-prioritisation in the short-term does not mean ignoring those areas but recognising this is a long journey and will need to be approached in phases based on different needs of local communities and populations.



“We have learnt community solutions work better.”

Why can't we… recognise the many definitions of place but that in London it is our 32 boroughs that will be the heart of our local health and care systems?

"COVID-19 taught us that the more responsibility and authority you give to local areas, the better the outcomes".

The pandemic response saw local authorities, health and the voluntary and community sector services provide unparalleled support and care to their communities, leveraging local assets, relationships and knowledge to identify those most at risk and provide support where and when they needed it. As one contributor put it, "We responded very well when we were left alone" This represented a significant change from what contributors described as the "command and control" approach of the past and provided a powerful business case for an objective most contributors shared – "we need to make Place important."

"It has to be integration on the basis of a genuinely equal partnership."

The idea that there can be integration without equal partnership was repeatedly rejected by contributors, including one who said simply, "I do not see this system working as one without working together." Contributors appreciated the need to "need to blend wider determinants into our vision" in order to improve health outcomes, and that this would be easier for local authorities, who "have a much stronger network within the community" than the NHS. Contributors were clear that this will need to be a new kind of partnership, one built on the basis of equality where all partners are empowered to say "no" when it counts and where NHS and local authorities hold each other to account for improving the health and wellbeing of the population within their area.

"Delegate locally, trust locally, be agile in providing support and then allow them to get on with doing it."

Contributors expressed a strong desire for joint place-based leadership with real "decision-making power". In this context, there was seen to be a need for pan-London support, where "region comes in as a way of setting common objectives"; but then, in the words of another contributor, "gets out of the way". There was a desire for regional and system leadership to set out a "strong London vision" without prescribing the means of delivery. As one contributor noted: "delivering care is not like building a car" and some local variation is warranted.

"Need to plan together in a way that is strengths-based."

As one contributor noted "maturity is recognising 'you are better placed to have this conversation'". The agile response of local teams to the pandemic demonstrated that "diversity is a strength". There was a sense that "people got through the pandemic because of the community and voluntary sector", and that the sector is well-placed to address what one contributor called "one of the major lessons of COVID-19" – the reality that "a lot of minorities do not trust the NHS". Contributors described VCS organisations as "representative and credible" and when engaged to mediate or support communications with communities disproportionally impacted by the pandemic, they can help "shift the dial". As one contributor said, "we need an open discussion about appropriately funding the community and voluntary sector."

"Places should commission the ICS as much as the ICS commissions place."

The next 12 months will see ICS development accelerate, and respondents described "local place-based system leadership with the authority to make decisions" as a "key enabler" for successful systems. As one contributor noted pragmatically, "we might make some mistakes, as we did with COVID-19, but the outcome will be greater than talking about it".

“The debate and discussion is at sub-regional regional or national level, which is not where lived experience actually happens.”

What would this look like in practice?

1. **Ongoing planning, commissioning and assurance functions are vested in joint borough-based teams** wherever possible within legal and statutory boundaries, hosted where appropriate within the local authority.

Whilst the future architecture of London will be determined in part by national policy and legislation, contributors highlighted the significant amount of local autonomy envisaged within current proposals; and examples of where local borough-based partnerships in London are already taking a lead role in planning, delivering and self-assuring care. There was seen to be a "window of opportunity" to make this "the norm" in London, with common and shared expectations across all sectors and providers enabling more effective joint-working at scale and place.

2. **Borough-based partnerships are enabled by a Region and ICSs who support them** to have financial and decision-making autonomy, whilst enabling collective efforts on shared priorities and best-practice.

Contributors consistently highlighted the link between recognizing that place-based partnerships are the "building block" of our future success as London, and ensuring that they have the ability to deliver on local priorities, through both clarity around where decisions are made (providing a reason for local partners to come together) and to use pooled funding to invest in identified priorities. Regional and ICS support was seen as essential in enabling a consistent standard of care across borough boundaries and to sharing best-practice within and between systems.

3. **Health & Wellbeing Boards, Healthwatch, patient groups and voluntary and community sector partners are appropriately equipped** to support our communities, so their voices are both heard and acted upon.

A lack of clarity around the role of organisations like Healthwatch in regions such as London needs to be addressed as a priority and not "an afterthought" in the development of our ICSs. Co-design was seen as critical to delivering better outcomes and a lack of resources as the major barrier to sustaining the necessary input from community groups and other non-statutory partners.

“The pandemic shows that if you throw a little money and effort in a focused way, you can make a long-term difference. There was a perception that it was unsolvable, until it was not.”

Why can't we… commit to pooling all local health and care budgets by default, except where there is a compelling reason not to?

"System leadership in the pandemic was committed to getting on with things and worrying about the money later."

Contributors described the "arguments" and "fights over money" which were characteristic of experiences before the pandemic, and how most of this "disappeared" as funding to deliver the pandemic response "poured in". Contributors put this down to a less siloed approach to allocating funds; one described how "money was given collectively so there were no arguments over who was going to pay for what. This set the mindset for collaboration".

"COVID-19 proved the principle - if you remove the argument over whose budget is being used, lots of the barriers disappear."

Moving forwards, contributors were clear that funding should be given collectively, accompanied by a "joined-up", clear interdepartmental vision communicated by the Region and ICS "from the health secretary downwards". Once landed, this "joint investment" would form a "genuinely pooled budget" with shared accountability, transparency, and flexibility to move funds where they are most needed.

"Fundamentally we need to bite on the prevention self-care improvement agenda, and to do this we need to move the money."

Contributors repeatedly raised the issue of financial strategy, with one noting that "it is really short-sighted in terms of cost… to ignore upstream issues." Despite what one called the "many good concrete examples we have in ICSs where they've invested in community services and demand on hospital services is less", only a fraction of total spend is currently directed towards preventative, upstream interventions. This led another contributor to assert that "money flows in a way that bears no relation to need." Gaining a commitment to spend differently has been a challenge in the past, and one contributor suggested framing the requirement as "moving resources to meet the needs of people" to bring the conversation back around to focus on the "needs of the individual not the system" and how we can "help the community help themselves".

"Moving a patient from health to social care carries no benefit for social care and vice versa."

Contributors described a "failure regime" that encourages counter-productive behaviours with systems prioritising their baseline and hitting targets before population needs. Many contributors were keen to give the example of how hospitals "make more money off blood tests and other minor interventions, which is completely the wrong incentive" and also spoke about the "cost-shunting" that occurs between sectors. Contributors expressed fear of returning to the status quo and a sense of urgency in developing "incentives that actually align with what patients want".

"One thing we learned is we need to get on and do it. Invest the money in the risk. We might not always get the money back."

There was agreement that, despite the risks involved, a failure to start thinking in terms of the local 'health and care pound' as a basis for investing in community-based prevention work will leave local leadership at place devoid of any real decision-making power, and allow pressure on acute services to become increasingly unsustainable. If the pandemic has taught us one thing, it is that "any investment in the NHS is only as good as the social care investment that goes with it." Another contributor put it more bluntly; "if we do not accept the cost of success, we will continue to pay the cost of failure."

"The more we can think in terms of a place-based budget and how that is prioritised and spent at place, the better."

What would this look like in practice?

1. **We openly share how money is budgeted and spent** across health, local government and voluntary and community sector partners in each borough - providing for the first time a single view of the 'local pound'.

The first condition for allocating resources to where they will have the most impact is understanding where each pound is currently being spent. Contributors consistently highlighted the lack of transparency within and between existing organisations and budgets, with as much variation within ICSs as between them. Added clarity will support better efficiency and overall use of funds and help re-direct limited resources to where they can help most.

2. **We can show how investment is growing in community-based prevention and early intervention**, improving outcomes and reducing long-term costs.

Holding systems to account for reflecting the commitment to prevention and earlier intervention in how resources are being utilised was seen as being critical to ensuring that this agenda is translated into effective action locally, as a key enabler of future financial sustainability across London.

3. **Resources are demonstrably being distributed to where they are needed** using granular population health data and evidence to focus our efforts on addressing long-standing and new inequalities.

Ensuring resources flow proportionally to reflect holistic population needs was seen as essential to address inequalities within the health and social care system and begin to repair relations and build trust with neglected communities. There was a strong feeling that the data exists to support this, but that it is not being used effectively yet in the allocation of resources, and that this would need to be an integral part of broader conversations around purpose, priorities and place.

“There is a tension between self-interest, population health and the needs of the individual.”

Why can't we… support provider collaboratives and primary care networks to deliver better outcomes both "at scale" and within each place?

"This is about systems working together and having a collective impact."

Contributors highlighted a range of provider learning and best practice that resulted from the pandemic response. One contributor added that "the idea that everyone has a stake in community health is another key bit of learning, rather than everyone feeling they are only responsible for their patients".

"[Previously] when our neighbours stumbled, we hired their workforce. This time, when our neighbours stumbled, we helped them up."

Contributors repeatedly criticised the current state of commissioning. One criticised "binary commissioner-provider conversations" and another said it was "crazy that right now the people who spend the money are not those who deliver the service". There was strong support for a "local-by-default" approach to commissioning, where only low volume, complex services are planned and delivered "at scale", was also clear.

"We still have organisational mindsets. We need to take off the skins of our organisations and come part of collaborative team."

On being asked to describe their vision for integrated health and social care services in London, contributors across London agreed that "the person you see should also be the person who can help you solve all of your issues". They wanted to see a system with "no wrong door" and a seamless, wrap-around service. There is a shared ambition to create "a real integrated care system, as opposed to a set of transactional relationships." However, contributors also recognised that "different languages and worlds we inhabit and work in" constituted an obstacle to this vision. Solutions included establishing "common points of references on how the system works" or by actively bridging the gap with "flexible reciprocal arrangements" where staff work 1-2 days a week for each other's organisations.

"Parity of esteem point is a principle we need to work towards."

There was a strong sense that social care, the voluntary and community sector and public health need to be seen as critical components of the system and not "externalities" to the NHS. As one contributor put it: "we need to appreciate [domiciliary] care people more." Another suggested that "we are underestimating how traumatised they feel, how exhausted they are", predicting that without better support and career progression, staff, especially in social care, will continue to leave.

"Primary care have not felt like an integral part of provider collaboratives and this needs to be made more explicit."

Contributors agreed on the crucial role primary care must play in improving outcomes for patients, with a key question being "how do we empower and engage PCNs but also ensure they are coming to the table?". One suggestion was that "boroughs need to step up and support PCNs to modernise with managerial support", whilst others including PCN Clinical Directors stressed a broader point about the role of primary care in bringing disciplines together at a local level: "it is not just about primary care but local care partnerships in neighborhoods".

"People have to give something up to gain something."

Contributors noted that delivering better services at scale will not be easy and will require people to "relinquish [some of] the control" they are used to, over budgets, staff and "their" patients. As one predicted, "we could revert if we don't change structurally".

“I think the word system is key. Being part of a system implies everyone, including the voluntary and community sector, is present and that resources are allocated by and within the system.”

What would this look like in practice?

1. **Provider collaboratives are empowered to plan, deliver and assure the care they provide**, enabling "mutual-aid" across organisational and geographic boundaries, and supported by ICSs that help align their work together and with our place-based partnerships.

Empowering provider collaboratives will reduce competition while providing greater opportunities to leverage knowledge, skills and expertise, building on the mutual-aid arrangements which have developed during the pandemic. There was strong support for self-assurance, with providers working to hold each other to account and support each other in service improvement. In London, effective collaboration not just amongst acute trusts but in mental health and community services were highlighted as models for future development.

2. **The voice of primary care is reflected in decision-making at all levels**, with PCNs providing the "hub" for local care networks that focus on the holistic needs of individuals and communities.

There was strong recognition of the role PCNs have played in the pandemic and support at all levels (including from primary care networks themselves) for a vision for PCNs that includes bringing together multi-disciplinary teams and perspectives to support more co-ordinated, effective care for individuals and communities. However, there was also concern that many PCNs are not currently effectively represented in decision-making at either an ICS or borough level, and addressing this is a priority in order to achieve further progress.

3. **We invest jointly in the health, wellbeing and professional development of our workforces**, with specific and measurable goals around integrated training, professional development and resourcing across traditional specialisms and boundaries.

Parity of esteem, integrated training and professional development opportunities across traditional boundaries, and long-term investment in the health and wellbeing of frontline staff and volunteers across the health and care system, were all seen as critical to the post-Covid period, to retaining existing professionals and developing the future workforce.

“Partners came together thinking the best of each other to deal with the biggest health emergency to face the world for over one hundred years.”

Why can't we… think the best of each other?

"An integrated approach means being honest and open and transparent."

There was a sense from all that, in building on learning from the pandemic, "we have a big opportunity on trust." Contributors called for careful thinking about how to hold-on to the "spirit of cooperation rather than suspicion" that was perceived to have had prevailed over the past eighteen months.

Many contributors noted that, during the pandemic, there was "less commentary and criticism of the performance of others" and that instead colleagues grew more respectful of each others' responsibilities. There was also a sense that the way colleagues communicated with each other had improved, with one contributor describing "having honest conversations on what is difficult for different stakeholder organisations and recognising what people can and cannot do." Another described how "one learning from COVID-19 is that you have to be respectful of the roles of other people in the lives of Londoners… when we become respectful of each others' responsibilities and are clear on what we are trying to do, we help each other meet those aims."

"You need to know people to work with them."

"The emergency response has compelled people who would not be in a room together to be in a room together". This was a sentiment echoed by multiple contributors. They also recognised the transformative power of simply "having the right people in one room together". Where before achieving a quorum in meetings had proven a struggle, the pandemic saw leaders meeting regularly, even daily, and making rapid decisions. There was a strong desire to capture and maintain what one contributor described as "the agile way of working" where "senior decision-makers met regularly" and solutions were "rapidly operationalised".

"For the first-time people understood where they were in terms of performance."

Contributors described how "hospitals that have been working together for years…for the first time saw their waiting lists and understood the huge variation in patient experience across neighbouring trusts". Data-sharing was brought up repeatedly, with one contributor remarking that "people have their eyes opened with respect to the population when they see the data", and another explaining that data-sharing was beneficial because it "starts people thinking 'how do we share the burden?'". The value of data in revealing "a lot of people in our communities whose vulnerabilities we did not know about" was also stressed.

"In London we have come through this as a community of leadership."

Contributors emphasised repeatedly the importance of strong leadership, but also leadership "based on values", leadership "with a vision", leadership where "people can challenge and enquire", and leaders who "break down barriers", who recognise "that this is important" and get people to "buy into it [the vision], espousing it in a way that builds support". Some contributors also praised the "inspirational work by some of our leaders to bring people together" and the "fantastic honesty" shown by leaders not "pretending they know it all". Others argued that we need a "very different type of person at the helm[s] of partnerships". One asserted that leadership in our places should be "collective", potentially with co-chairing arrangements, and include a balance of "clinical leadership and community leadership". Most importantly, all contributors expected leaders to ensure that "we don't go backward", to translate this to their staff and "constantly remind people" of our shared purpose.

“We are only as strong as our weakest member.”

What would this look like in practice?

1. **We nurture and develop relationships between individuals at all levels,** coming together regularly as places and systems to co-ordinate our efforts and resources with our local communities.

   There has been strong feedback from across London that integration will only be successful in delivering better outcomes if we can retain the relationships and trust developed during the COVID-19 response. This will take investment of effort and time to retain the honest, open and transparent channels of communication necessary during the crisis, as systems and organisations seek to recover from the pandemic.

2. **We share openly with our partners the information they need** in an honest, secure and timely way in order to achieve the best possible health and care outcomes.

   Shared data was seen as critical to enabling places and providers to share understanding and develop joint plans for addressing local needs, however, it was recognised that past commissioner / provider splits performance management regimes, and competitive behaviours had made this difficult and a new commitment was needed to ensure that areas could genuinely move forward together.

3. **We mean what we say and we hold ourselves accountable**, in willing better outcomes for Londoners, to ensuring the means are in place to deliver those outcomes.

   Key to developing and maintaining trust in our future systems was seen to be the ability to follow-through on individual and shared commitments, including at a system leadership level, within our ICSs, or within individual boroughs. This encompasses each of the areas of Purpose, Priorities, Place, Pounds and Providers as articulated in this report; with the need for visible commitment to the agenda and to making ourselves accountable to the local populations being served, including around making tangible progress on addressing inequalities.

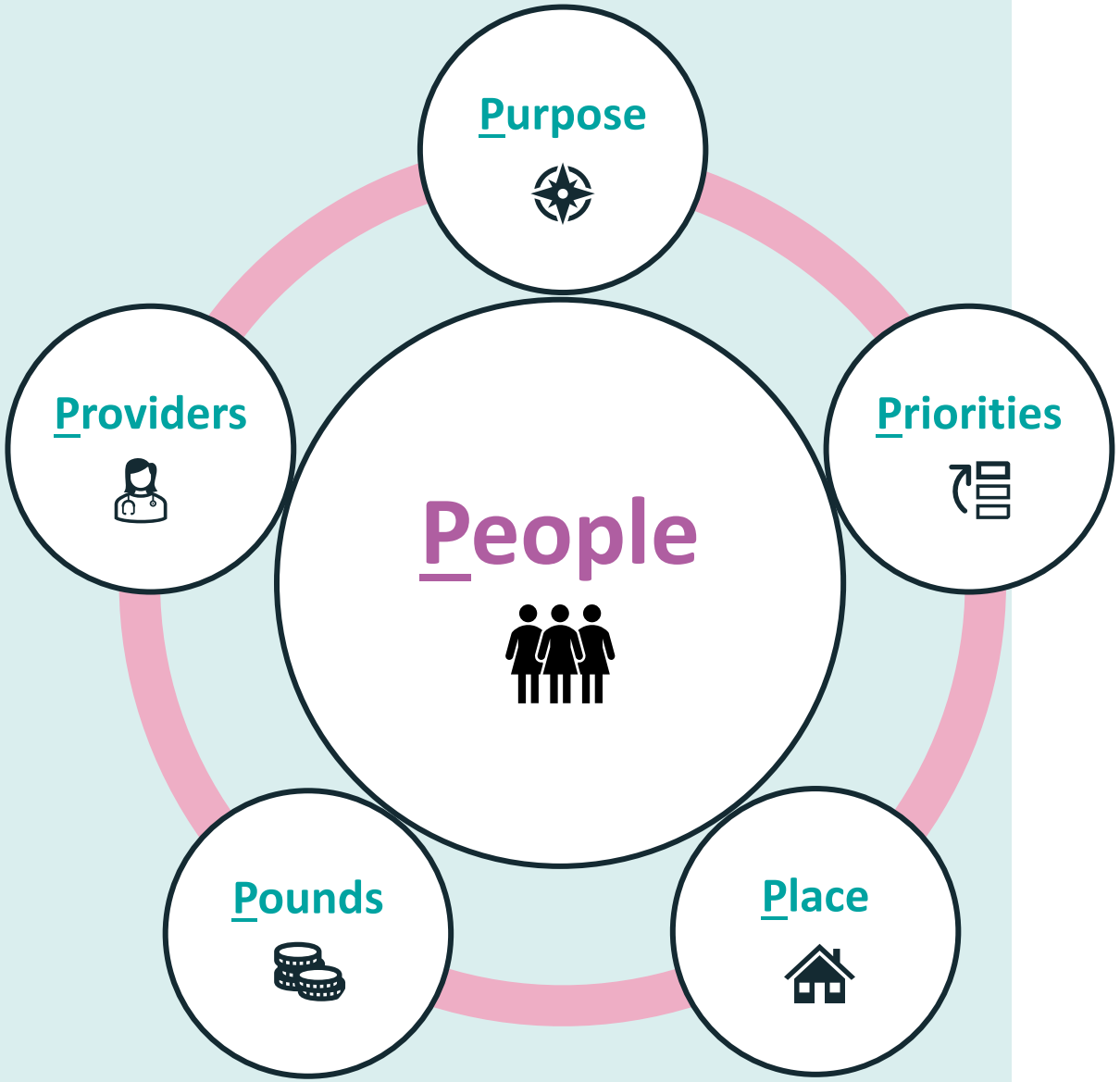
Next steps

We have an opportunity to incorporate what we have heard from colleagues from across our systems and London as a whole into the future of health and care in London.

The next steps in the journey to integrated, person and community-centered care will be shaped at a national level as well as locally but we know there is much we can do now to improve the experience and outcomes of Londoners.

At the heart of our next step is ensuring that the question "why can't we…" is being asked in all of our conversations - recognising that maintaining the "status quo" in London is not an option.

Our intention is to take this work forward jointly, as a partnership of NHS, local authority, voluntary & community sector and patient and public representatives to ensure that we recognise and embrace diversity, but also that we create the conditions for success across London: regionally, in our five ICSs, 32 borough-based partnerships, our Primary Care Networks and all our neighbourhoods.



Appendix A

Case Studies

What does this look like in practice?

“The future is already here – it's just not evenly distributed.”

William Gibson

As part of this report a number of examples have been identified from across London’s health and care systems, including how people have come together to join-up services and support around the needs of local individuals and communities:

Ref	Case Studies	Purpose	Priorities	Place	Pounds	Providers	People	ICSs
C1	Working together on the London vaccination programme to address inequalities and improve uptake.	●	●	●	●	●	●	NWL, NCL, NEL, SEL, SWL
C2	Using prioritised “sprints” to accelerate the pace of local transformation: BHR Integrated Care Partnership.	●	●	●	○	●	●	NEL
C3	Supporting each other through the pandemic and building back better: Harrow Health & Care Executive.	●	●	●	○	●	●	NWL
C4	Jointly developing and delivering the “Right Place to Live”: Royal Borough of Kingston.	●	●	●	●	●	●	SWL
C5	Camden Citizen Assemblies: setting expectations, not just recommendations.	●	●	●	●	●	●	NCL
C6	Top-slicing health budgets to fund partnership working and address inequalities: North Central London.	●	●	●	●	●	●	NCL
C7	South London Mental Health and Community Partnership (SLP) Nursing Development Programme.	●	●	○	○	●	●	SEL

In practice: Working together on the London vaccination programme to address inequalities and improve uptake

C1

Context

2020 saw the start of the largest inoculation programme in English history. However, whilst at time of writing more than 45 million individuals have received at least one dose of a coronavirus vaccine, uptake in the first few months varied, and was considerably lower among minority ethnic groups and individuals living in deprived areas. By late February 2021, across England just 60% of black people aged 70 or over had been vaccinated, compared to 75% of South Asians and 90% of the White population *(OpenSAFELY)*. It was clear that a different approach was needed in these communities.

Principles

- **Close collaboration** across councils and local partners, supported by local multi-agency vaccination strategies, with **inequalities and equity as cross-cutting priorities**, and close cooperation with national and regional partners.
- Weekly **data deep-dives** to identify areas of inequality around infections, vaccine uptake, hospitalisations and deaths.
- **Evidence-driven approaches** utilising behavioural science and local engagement with anthropologists to understand underlying causes of hesitancy.
- Funding to each ICS to support **community engagement** with a specific focus on communities at risk of being "left behind" in vaccine cohorts 1-4.
- **Multi-agency universal and targeted interventions** (communication, engagement, geographic allocation of testing and vaccination sites, support around shielding and self-isolation) informed by data and intelligence.
- Use of **integrated impact assessments** at borough level to inform longer-term and wider system recommendations.

Impact

Data and intelligence informed identification of vaccination sites, including faith settings and community venues – wherever people felt most comfortable.

There was a reduction in the proportion of Londoners who reported vaccine hesitancy from 13% in February 2021 to 7% in June 2021 *(ONS)*.

The proportion of eligible people vaccinated in England improved between 13th January and 8th July across key groups, including from 20.5% to 77.0% in Black people, 29.5% to 88.4% in South Asian people, and from 37.9% to 93.7% in individuals residing in the most deprived quintile (IMD) *(OpenSAFELY)*.

Tackling vaccine hesitancy and inequalities: An overarching London approach

Aspect	Data and evidence	Addressing hesitancy	Practical aspects of vaccinatio	Monitoring, evaluation and system leadership
Issues to consider	• **Data**: Best use of available data to understand where the inequalities are, to support local and pan London action and interventions • **Evidence:** work is rooted in the evidence including behavioural science and from other vaccination programmes. • **Lessons learnt:** identifying and sharing good practice from other countries, regions, boroughs	• **Hesitancy higher in:** Under 25 year olds, BAME groups (partic black ethnic groups) & less affluent Londoners • **Health and care professionals:** Current rates are lower comparatively • **Culturally competent community engagement:** essential, locally led, regionally enabled • **Behavioural insights**: understanding models of vaccination behaviours, including role of stigma	**Other aspects affecting vaccination uptake of minority groups** • Accessibility/familiarity of the setting • Invitation & appointment booking process • Vaccine site location • Opening hours/time off work • 58% of those in the UK answered no to the question *'is it easy to get a vaccine'* (Global Institute of Innovation)	• **Evaluation:** systematic, academically rigorous service evaluation that is agile, answers the essential q's and feeds learning back into the system • **Measures of success**: clearly defined • **System Leadership**: join up and oversight across the system, across the *test-trace-isolate –vaccinate* journey and tackling inequalities from COVID more generally • **Potential for drop off for second vaccine:** as seen in other vaccines
Next steps	• **Data:** Track and share data on vaccine hesitancy/acceptance, and vaccine uptake (rolling equity audit) • **Integrate**: Integrate vaccination data with surveillance and T&T data, to inform outbreak control /response • **Insights**: Facilitate the collection and sharing of insights from across London • **Evidence:** Synthesise the evidence on barriers, enablers and what works • **Quality assure:** provide PH input/ advice to ensure communications/ interventions are grounded in evidence • **Agile system:** Ongoing gathering of evidence / learning from the system	• **Coordinated and targeted programmes:** reaching specific communities. Current focus on BAME, health and care professionals and inclusion health • **Sharing resources and assets:** maintain an easy access repository of local, regional and national resources that are sensitive to local communities • **Network and support London partners**: across organisations to make connections, support workstreams • **Develop a bureau of professional speakers** • **Consider other models:** MECC	• **Adapting programme delivery:** understand barriers to access for minority and vulnerable populations, and feed into and refine NHS programme delivery • **Training:** emphasise and support healthcare staff in their role as a trusted source of health information for key population groups • **Impact of vaccination on behaviours**: monitor impact of vaccination rollout on social distancing and adherence to other NPIs; develop clear communications and other strategies	• **Evaluation:** evaluation of local/STP interventions/approaches, with academic support • **Listen and learn**: Use range of fora and networks to engage, listen and share good practice and understand partners' support needs • **Horizon scan/plan ahead:** for groups likely to have low uptake, thinking also of messaging for second vaccine • **Celebrate success:** keep momentum & promote further action • **Extending success**: use these opportunities/relationships for wider programmes to reduce inequalities more generally

Sources: Ealing COVID-19 outbreak prevention and control plan

In practice: Using prioritised "sprints" to accelerate the pace of local transformation: BHR Integrated Care Partnership

C2

Context

BHR Integrated Care Partnership is a partnership spanning the three boroughs of Redbridge, Barking & Dagenham and Havering working to a common set of values and principles. During the pandemic, BHR, like many others, saw a rapid acceleration in the pace of transformation work, including the development of discharge pathways in a fortnight following four years of previous discussions. There is strong desire to cement multi-disciplinary team (MDT) working by default, building on the experiences of the pandemic to maintain commitment to and the pace of transformation and improvement.

Impacts

- Tangible and rapid progress in priority areas on account of teams and individuals investing their time and resources in a focused way.
- Credibility of transformation work enhanced through practical demonstration of how successful integrated and focused working can be.
- Fewer and more efficient governance conversations, and a greater emphasis on testing and scaling innovations.

Principles

- **A smaller range of activity delivered over shorter periods of time.** A limited number of workstreams, each no longer than two months, creates a sense of focus and clarity of direction and was seen as key to preventing "drift".
- **Working with "the willing" to 'test by doing'** rather than getting held up at the stage of trying to achieve uniformity from the outset.
- **Priorities developed based on how teams will need to work differently to deliver** with a focus on encouraging people to work together.
- **A limited number of priorities** that are clear, simple and not purely clinical to ensure they are relevant to all health and care partners.
- Driving home the **impact for citizens**, in order to establish a shared sense of purpose and a focus on outcomes.

Three priorities which are galvanising teams to work together differently

1. Children's health
2. Mental health
3. Addressing overcrowded housing

MDT working

Sources: Contributor; BHR Integrated Care Partnership update (Sep 2019)

In practice: Supporting each other through the pandemic and building back better: Harrow Health & Care Executive

C3

Context

The Harrow Health & Care Executive (HHACE) was formed in February 2020, just before the start of the pandemic, after a review of the Harrow ICP and the decision of the Joint Management Board in Harrow to institute a weekly meeting of system leaders to oversee the next 100 days of partnership development. HHACE swiftly became instrumental to Harrow's response to the pandemic, including around shielding, managing capacity and flow, and latterly the vaccination programme. More recently, HHACE has returned to looking at key areas of system transformation, ranging from improving support for children & young people, care homes, and the frail elderly, to targeting key enablers such as integrated education, training, and digital development.

Principles

Virtual meetings on MS Teams enabling broader and more regular attendance across system leadership, allowing trust and relationships to build over time.

Meetings are opened by the **Chair reminding all participants of the purpose** of the meeting; to bring together system leaders to make decisions in the interests of all the people of Harrow.

Actions are reviewed and closed weekly, and standing items are agreed to ensure key messages are communicated clearly outside the virtual room.

Continuous learning and reflection. Meetings conclude with a brief reflection on the meeting itself, what has gone well and what might need to change in the coming weeks. Meetings continuously evolve and draw strength from the ability to adapt to local priorities and to survive membership changes.

Impact

- Issues are resolved more quickly, often through joint solutions.
- Increased trust between partners and the development of strong, productive relationships within a framework of genuinely equal partnership.
- Rapid mobilisation and sharing of support where it is most needed.
- In the formal one-year "reflect and review" process, 100% of respondents from across the system responded to "I believe the Harrow Health & Care Executive has been effective in improving joint-working over the last 12 months…" with either 'Agree' or 'Strongly Agree'.

The Health & Care Executive's membership has been critical to its success

1. Co-chairing arrangements and strong council attendance mean the meeting feels like a joint enterprise grounded in Harrow as a place.
2. VCSE-led and focused items are a regular part of the Friday agenda and a strong VCSE voice forms a core part of the decision-making process.
3. Major NHS Trust are all represented in the room at a very senior level, even though the leaders in question have roles which span multiple boroughs.
4. PCN clinical directors co-lead major workstreams that sit underneath the ICP and (as well as the GP Federation) regularly attend and contribute to meetings.

Sources: Contributor

In practice: Jointly developing and delivering the 'right place to live': Royal Borough of Kingston

C4

Context

The Royal Borough of Kingston (RBK) is a relatively affluent part of Greater London but the impact of COVID-19 has brought into focus local disparities and those struggling to survive in an area with high living costs and a limited supply of affordable housing. In response, the local authority has initiated a programme spanning housing, regeneration, social care, property and development, and NHS partners. The programme aims to use council-owned assets to develop and deliver a housing transformation programme, "Right Place to Live". The provision of good quality, supported and specialist housing is about ensuring all of Kingston's residents can live well, whilst addressing determinants of health and wellbeing and inequality.

Principles

- **Making the best use of existing accommodation**, both supported and sheltered, and, as far as possible, making existing mainstream housing suited to the requirements of older and disabled people.
- **Harnessing RBK assets and key partners including the NHS and other local "anchor" institutions to tackle inequalities**.
- Development of a range of new-build supported and specialist housing over the next 10 years **that reflects and addresses identified needs**.
- Ensuring that support and care services, both within supported housing and for people living in mainstream housing, are effective in **promoting people's wellbeing and independence**.
- Taking a **holistic, evidence-based approach to a housing programme** which encapsulates the housing needs of a wide range of vulnerable households and citizens who have been particularly negatively affected by COVID-19.

Impact

- Development of over 1,000 homes aimed at meeting the housing and wider support needs of low income families and people at risk of homelessness.
- Change to the Council's approach to housing for older people and those adults and children with care/support needs.
- Innovative designs becoming mainstream, including housing that enables multi-generational living, housing that offers care-ready living environments, and housing that uses technology and spaces to encourage community-led development of places.
- Council assisted directly to build the right mix of housing products and types to better meet local housing need highlighted by COVID-19.

In the long-term RBK seeks to develop homes and places which…

- Are high quality, sustainable and carbon-neutral, encouraging increased biodiversity
- Make the best use of council and/or other public sector sites/assets
- Are care ready and digitally enabled homes/places
- Include tenures that reflect identified need and market requirements
- Incorporate health and wellbeing principles into housing design
- Contribute to economic and health wealth creation

Right Place to Live is part of a long-term Council-wide transformation programme and so the project will be incorporated and 'mainstreamed' into the Council's overall approach to modernising service delivery workstreams. The programme will also provide a replicable template for the Council when it comes to develop future housing strategies and delivery programmes in response to changing local needs.

Sources: Contributor

In practice: Camden Citizen Assemblies: setting expectations, not just recommendations

C5

Context

In the context of the NHS Long Term Plan, and "Camden 2025", a vision for the future where everyone contributes to achieving a safe, fair, creative and active community, local health and care partners have committed to putting the voice of residents at the heart of transformation across the borough. In 2020, the Health and Wellbeing Board sponsored a Health and Care Citizens' Assembly made up of a representative cross-section of local residents. The objective was to build on the priorities of the vision and themes raised in a previous Neighbourhood Assembly; to give residents the power to help shape the local Integrated Care Partnership's common purpose; and to inform Camden's new Joint Health and Wellbeing Strategy.

Principles

A shared endeavour. Local health providers and Camden Council worked with a range of NHS and VCS partners to prepare for and deliver the assembly. Buy-in from partners was secured by investing time to understand what partners and stakeholders hoped to get out of the assembly process.

Citizen members of the assembly were engaged as **Citizen Scientists** to investigate the experiences of their family, friends and neighbours. **Empowering members to reflect and explore beyond their own personal experiences** has been an important part of participating in the assembly.

A **clear shared purpose is essential**, and investing the time in understanding and generating this is critical.

The assembly **allows the journey to shape the output:** a citizens' assembly is a process and needs to shape what the final product is.

Impact

Assembly members identified **three priorities** and a **final set of expectations** to guide the health and care system towards achieving them. These were used to inform the Health and Wellbeing Board's Joint Health and Wellbeing Strategy.

Assembly members also considered the unique roles of the Council, NHS, VCS groups, and individuals themselves, and articulated specific expectations of all the major partners.

Events were well-received by assembly members and described as "collaborative and "interesting". More than 95% of assembly members who provided feedback stated they would recommend the events. Several assembly members intended to remain involved and to play a role in holding the Council to account.

"What are residents' expectations of health and care in Camden?"

1. **Reduce health inequalities** in the borough. Ensure that local services can tackle the impact of the pandemic on the most affected groups.
2. **Ensure my family, friends, neighbours and I can stay healthy, safe, and well** in Camden, particularly our mental health and emotional wellbeing.
3. **Ensure local services work together** to meet the needs of residents and communicate effectively with residents.

Sources: Contributor; Camden Health and Care Citizens' Assembly - Final Report (Nov 2020)

In practice: "Top-slicing" health budgets to fund partnership working and address inequalities: North Central London

C6

Context

North Central London (NCL) is home to a wide variation in Deprivation Scores, with a 50% difference between the most and least deprived boroughs. This drives poor outcomes for populations across the footprint. In response to the latest NHS Planning Guidance, and to improve outcomes and achieve financial sustainability, NCL have created an Inequalities Investment Fund by top-slicing COVID-19 funding to provide greater and more targeted support to those deprived areas: to narrow health inequalities, and to fund approaches that deliver greater equity in resourcing across its five boroughs.

Principles

An initial £2.5m Inequalities Investment Fund was generated by **top-slicing COVID-19 funding**.

80% will be allocated to ward, borough or NCL-wide projects that can be shown to have a **direct impact on the 20% Most Deprived Wards**. ICPs, provider alliances and provider partnerships may apply.

IMD scores were used to identify the 20% Most Deprived Wards and to give a **weighted investment for each ward** to address planning guidance priorities.

10% will be made available for borough ICPs, multiple ICPs or all ICPs to tackle local, multi-borough or NCL-wide inequalities.

Funding criteria designed to identify high impact actions that will yield the greatest benefit for NCL' communities and the system, drawing on it's response to COVID-19, rich data, and evidence of interventions that can be scaled.

Not a short term 'quick fix', but a fund that will grow. The intention is to create a recurrent fund of £5m from 22/23 by top-slicing system growth.

Impact

- Improved outcomes for citizens living in NCL, especially those resident in the 20% Most Deprived Wards.
- Expanded evidence base for how effective, measurable, high impact interventions can make a direct difference to systems, citizens and the financial position, to support the release of more funding.
- Increased opportunities to test new and innovative models of care aimed at addressing issues that directly impact the lives of communities and creating new opportunities for residents.
- Funding of solutions that break down barriers between organisations and both develop new relationships and extend existing ones.
- Funding of interventions that target the most deprived communities and that reach out proactively to NCL's resident black and minority ethnic populations.
- Support the formation of borough, multi-borough and NCL-wide partnerships that engage our populations, the VCS and other partners across health and care to improve the lives of residents.

Planning Guidance Five Priority Areas related to Inequalities (80% of funding)

1. **Restore NHS services inclusively**
2. **Mitigate against digital exclusion**
3. **Ensure datasets are complete and timely**
4. **Accelerate preventative programmes that proactively engage those at greatest risk**
5. **Strengthen leadership and accountability**

Sources: Contributor; NCL Inequalities System Investment Fund 21/22 Overview & Approach (Nov 21)

In practice: South London Mental Health and Community Partnership (SLP) Nursing Development Programme

C7

Context

The NHS Long Term Plan emphasises that the performance of any healthcare system depends ultimately on people. As the world's largest employer of highly skilled and compassionate professionals, the NHS is no exception. However, workforce growth has not kept pace with demand, and the way staff are supported to work does not always reflect the changing needs of patients. Nursing leads at South London Partnership, a collaboration between Oxleas NHS FT, South London & Maudsley NHS FT, and South West London & St George's Mental Health NHS Trust, recognised these challenges. They observed unwarranted variation in staff retention rates, agency use and staff turnover levels across the three Trusts and formed the Nursing Development Programme to address them.

Principles

- Nursing Development Programme **jointly led** by the Directors of Nursing and with Development Nurses appointed on full-time secondments.
- 'What to change' **informed by staff views** and experiences, collated at trust level, including what would improve nurses' working lives.
- **Regular cross-Trust workshops and other staff engagements** to obtain their input, share experiences and challenges and build consensus at every level.
- Rapport and trust built by **recognising different leadership styles** and supporting one another. Development Nurses given **time to 'settle in'.**
- **Shared and aligned goals** of improved patient care, staff satisfaction and retention in the partnership.
- Time invested in building **trust and relationships at all levels**, and in understanding and respecting differences.

Impact

Improved staff experience, career development and recruitment resulting in better patient outcomes and use of resources.

Reduced unwarranted variation in recruitment and performance frameworks across South London.

Improved engagement, knowledge and best practice-sharing across the Trusts supporting staff to deliver high quality care.

Improved retention rates (including increased retention of newly qualified nurses) and a 1.5% reduction in staff sickness rates, contributing to less use of agency staff and subsequently cost-savings.

The programme has been well received by staff at the Trusts. By increasing skill mix into mental health ward teams there is potential to increase time with patients which improves experience for all.

The Nursing Development Programme has won the Nursing Times Workforce Award for Best Workplace for Learning and Development (over 1500 staff) in 2018 and was shortlisted for the Health Service Journal (HSJ) Awards – Workforce category in 2018.

New standards and competencies co-designed with staff

- career development frameworks
- common job descriptions and competencies
- new Nursing Associate roles to provide a career development path for existing staff
- employee passport enabling quick and easy movement between the Trusts
- joint recruitment campaigns
- funded post-graduate training opportunities

Sources: This case study was originally prepared by the Leading Change, Adding Value Team in 2019

Appendix B

Literature Review

Critical literature review

“If not now, when?”

Integration in a post-pandemic London

“Turn the COVID-19 pandemic experience in to a ‘transformative shock’ by integrating what we learn from the experience into future ways of working; and by building resilience for the future. This will be underpinned by important changes to our governance and leadership, which will include an enhanced and dedicated focus on inequalities and equity.”

Source: Our Healthier South East London Recovery Plan

Introduction

This document provides a summary of documentation developed over the period 2017 – 2021 relating to the London Region and ambitions, achievements and experiences in the area of integration of health and social care.

The paper brings together national and regional publications as well as locally-produced documents that describe integration at a system (sub-regional) and place (borough) level.

The document is designed to enable, at a glance, identification of areas where there has been shared direction of travel, ambitions and experiences. It is also designed to summarise some of the key challenges and barriers that have been identified and threaten to impede further progress towards better co-ordinated, person and community-centred care, and care delivered in a way which addresses both new and pre-existing health inequalities.

This review forms part of a wider programme to support those across the London region identify how best to develop and build practically upon the positive experiences of integration, both prior to and as part of the COVID-19 pandemic response.

Key lines of enquiry

a. What are the specific things that systems and boroughs will do to address the challenges of long-standing inequalities highlighted by the pandemic and new inequalities arising from it?

b. How are the experiences of social care in the pandemic, including residential and domiciliary care, best reflected and addressed in future plans; linking in with the work of London ADASS?

c. How will we manage the transition from pandemic response to a renewed focus on improving population health and wellbeing, including translating lessons-learnt into forward-facing and replicable strategies for improvement?

d. What can we learn from the experience of the pandemic, regional and local responses in relation to the priorities of the London Vision, including for the health and wellbeing of young Londoners, homeless people and those approaching the end of their lives?

e. What are the individual and shared enablers required to support and to sustain the continuation of progress and the restoration of services which are vital to Londoners' health and wellbeing, post-Covid?

f. What are the decision-making and participatory structures that are required at a system and place level to support the above?

g. In the context of ongoing funding challenges across all parts of London's public and voluntary and community sector, how do we optimise "allocative value", applying London's assets where they are needed most and will have the greatest impact?

Sources (1/4)

#	Document title	Author(s)	Publication year	Geography	Purpose
1	*London Health Devolution Agreement*	*London Partners*	*[Signed] November 2017*	*Regional*	*Memorandum of understanding setting out how government and national bodies will support the development and testing of health and care devolution across London.*
2	*London Health Inequalities Strategy*	*GLA*	*September 2018*	*Regional*	*This strategy tackles the determinants of health which lead to differences - or health inequalities - by focusing on five key areas: Healthy Children, Healthy Minds; Healthy Places; Healthy Communities and Healthy Living.*
3	*London Vision 2019*	*GLA, London Councils, NHSE/I London, PHE London*	*September 2019*	*Regional*	*The London Vision sets out the shared priorities of the partnership which is made up of the Greater London Authority, Public Health England, London Councils and the NHS in London. It was prepared to guide the partnership to design London-wide and local action together with Londoners.*
4	*The NHS Long Term Plan*	*NHSE/I*	*October 2019*	*National*	*The NHS Long Term Plan was published setting out key ambitions for the service over the next 10 years. Following the 70th anniversary of the NHS and the long-term funding settlement, the NHS Long Term Plan was developed in partnership with frontline health and care staff, patients and their families and other experts to lay out the roadmap for improvement of services and outcomes, building on the previous Five Year Forward View.*
5	*London Councils Health Collaboration Report*	*London Councils*	*February 2020*	*Regional*	*This report was developed to support London Councils, elected members and officers of the 32 London boroughs and the City of London in conversations with the NHS around the future of collaborative working across the capital. It relates to two Pledges to Londoners within the London Councils' Health theme: 1) a step change in integrated health and care, and 2) an agreement on funding and devolved powers. It also supported the London Council's objective to "Act with partners to transform both access and quality of health and care services for Londoners".*
6	*North East London Integrated Care System Recovery Plan Summary*	*North East London Integrated Care System*	*May 2020*	*Sub-regional*	*North East London COVID-19 recovery plan.*
7	*The Experience of Managing COVID-19 in Social care in London*	*ADASS*	*June 2020*	*Regional*	*This report describes the experience of social care teams across London through the initial phase of the COVID-19 pandemic from March 2020 – June 2020. It summarises the context for social care, the experience of both staff and clients through this period and sets out recommendations that build on the learning and experience gained throughout.*
8	*COVID-19: current position and our recovery plan*	*North West London Health and Care Partnership*	*June 2020*	*Sub-regional*	*North West London COVID-19 recovery plan.*

Sources (2/4)

#	Document title	Author(s)	Publication year	Geography	Purpose
9	*London Recovery Programme Overview paper*	*GLA, London Councils*	*October 2020*	*Regional*	*A short summary of their programme of work and a framework for 'London's recovery and how partner organisations and community groups can contribute to the programme'.*
10	*Our Healthier South East London Recovery Plan*	*Our Healthier South East London*	*November 2020*	*Sub-regional*	*South East London COVID-19 recovery plan.*
11	*Desktop review of London ICP plans to identify local and regional priorities to further integration*	*Kings Fund*	*November 2020*	*Sub-regional/ Local*	*The King's Fund thematic analysis of borough-based Integrated Care Partnership (ICP) plans-on-a-page, complemented by insights from Greater Manchester to identify options and implications for London.*
12	*Integrating care: Next steps to building strong and effective integrated care systems across England*	*NHSE/I*	*November 2020 (Updated January 2021)*	*National*	*This document details how systems and their constituent organisations will accelerate collaborative ways of working in future, considering the key components of an effective integrated care system (ICS) and reflecting what a range of local leaders have told us about their experiences during the past two years, including the immediate and long-term challenges presented by the COVID-19 pandemic.*
13	*North Central London Recovery - system plan*	*North London Partners in Health and Care*	*2020*	*Sub-regional*	*North Central London COVID-19 recovery plan.*
14	*Support to London ICS's from the HEST (Health Equity and Strategy Team)*	*Public Health England*	*2020*	*Regional*	*After PHE report highlighting how COVID-19 was creating new inequalities and exacerbating existing ones, public health, local government, GLA and NHS partners across London have come together to identify priorities to address health inequalities and to implement actions to address these health inequalities.*
15	*[Letter from the partnership] Integrating care: Next steps to building strong and effective integrated care systems across England*	*London's Health and Care Partnership*	*January 2021*	*Regional*	*The written response of London's Health and Care Partnership to the consultation document 'Integrating care: Next steps to building strong and effective integrated care systems across England'.*
16	*NHS Operational Planning and Contracting Guidance*	*NHSE/I*	*January 2021*	*National*	*The 2021/22 priorities and operational planning guidance sets the priorities for the year ahead, against a backdrop of the challenge to restore services, meet new care demands and reduce the care back logs that are a direct consequence of the pandemic, whilst supporting staff recovery and taking further steps to address inequalities in access, experience and outcomes.*

Sources (3/4)

#	Document title	Author(s)	Publication year	Geography	Purpose
17	*Integration and innovation: working together to improve health and social care for all*	*DHSC*	*February 2021*	*National*	*The proposals outlined in the White Paper build on the NHS Long Term Plan and the subsequent NHS's recommendations to Government and Parliament for an NHS bill. The proposals cover three key areas; working together and supporting integration; reducing bureaucracy; and enhancing public confidence and accountability. The White Paper also contains additional proposals around social care, public health and quality and safety.* *The legislative are also designed to accelerate the positive changes in the health and care system that have come about through the pandemic.*
18	*ICS Development - Design and Implementation Programme: Programme Overview in London*	*NHSE/I*	*February 2021*	*Regional*	*A short presentation pack summarising the ICS Design and Implementation Programme in London in February 2021.*
19	*Integrated care systems in London: challenges and opportunities ahead*	*Kings Fund*	*February 2021*	*Regional*	*Commissioned by the Greater London Authority, this report looks at how the five ICSs in London were developing before COVID-19 and how this has changed as a result of the response to the pandemic. The authors consider the key strategic priorities for London's ICSs focusing particularly on how they are addressing health inequalities, the use of digital technologies, workforce challenges, estates and social care. The authors conclude by highlighting key risks and opportunities for London's health and care system.*
20	*2021-22 ICS Implementation Programme and STT Strategic Plan: overarching stakeholder co-production, engagement and communications*	*NHSE/I*	*March 2021*	*National*	*'ICS policy engagement work' paper prepared by the System Transformation Team for the discussion at the SMT meeting on Tuesday 23rd March 2021. The paper includes four sections: 1) Overarching ICS engagement strategy; 2) How we involve stakeholders in policy development; 3) Engagement architecture and calendar; and 4) Policy product pipeline and associated engagement work.*
21	*Wave 2 Learning: reflections from NHS England and NHS Improvement (London) and the NHS in London*	*NHSE/I*	*April 2021*	*Regional/ Sub-regional*	*A short report that shares learning from NHS London, the ICSs and system in London from the response to the second wave of COVID-19 in London. This period has been defined as running from mid-Nov 2020 to end-Feb 2021, encompassing the second wave of* *COVID-19 activity, winter 2020/21 and the end of the EU Exit transition period. The report incorporates feedback from the Gold team, ICS COVID Leads and the EPRR managers in providers and CCGs across London.*

Sources (4/4)

#	Document title	Author(s)	Publication year	Geography	Purpose
22	*Supporting place-based partnerships: what role should national leaders play?*	*Kings Fund*	*April 2021*	*National*	*A short blog post published by the Kings Fund on their latest report 'Developing place-based partnerships: the foundation of effective integrated care systems'.*
23	*Clinical leadership to improve population health & reduce health inequalities*	*NWL Clinical Quality Leadership Group (CQLG)*	*May 2021*	*Sub-regional*	*Short presentation pack from NWL CQLG how clinical leaders can play a part in learning from the pandemic response in order to address the inequalities it (re-)exposed.*
24	*The role of primary care in integrated care systems*	*NHS Confederation PCN Network & Primary Care Federation Network*	*May 2021*	*National*	*Short report setting out the views of members of the PCN and Primary Care Federation Networks on the underpinning principles needed for strong primary care involvement at system and place.*

Part one: Integration in London 2019

“Where we were”

London has a long history of developing integrated care and a shared ambition to build on progress already made (1/2)

Greater integration has been supported by NHS and local government stakeholders at a national, regional and place level (1/2):

- Prior to the pandemic, collaboration was increasingly seen as the "norm" in London; however, the extent to which boroughs and the NHS engaged in integrated planning, commissioning and delivery was varied.
- The 2017 London health devolution agreement included commitments to action from the GLA, all of London's CCGs and local authorities, and national bodies. The agreement placed subsidiarity – the principle that decisions should be taken or influenced locally wherever possible – at the heart of its commitments.
- The devolution agreement recognised that, in areas like managing NHS estates, implementing new models of care or applying for funding, having multiple decision points and processes within London made whole-system planning more difficult.
- Through regional-level organisations such as the London Estates Board and London Workforce Board, the agreement sought to use devolution as an opportunity to encourage city-level action where appropriate to the scale of a given challenge.
- Parties to the devolution agreement committed to reaching a shared understanding of the systemic issues that pose a challenge to integrated working and working with national bodies as a region to jointly identify opportunities, pilot novel initiatives and models of care, and to share expertise across London.
- The NHS Long Term Plan (LTP) set out an ambition for ICSs to have a key role in working with Local Authorities at 'place' level. In 2019, local authorities were represented at STP / ICS partnership boards in London; however, interviewees for the London Councils Health Collaboration Interim Report had expressed concerns about how representative these Boards were of different borough interests, and it was suggested that a set of London "principles" to define how local government should be engaged could be beneficial.

The road to better coordination of health and care:

2014: NHS and local government's national leaders set out a vision of more collaboration in the NHS Five Year Forward View.

2015: the London Health and Care Collaboration agreement was published and the Healthy London Partnership was established. 'Vanguards' in 50 areas began to develop and test new models of care.

2016: NHS and local councils formed Sustainability and Transformation Partnerships covering all of England, to consider local health and care priorities and to plan services together.

2017: Areas refined initial proposals, drawing on conversations with frontline staff, local residents and others in the community. London partners sign Health and Care Devolution Memorandum of Understanding (MoU).

2018: Some partnerships began to take on more responsibility by becoming 'integrated care systems'.

2019: NHS Long Term Plan confirmed that every area will be served by an integrated care system by 2021, with primary and community services funded to do more.

2020: Building on previous publications for legislative reform, NHS England set out details for how systems will accelerate collaborative ways of working in the future, considering the key components of an effective integrated care system (ICS) and reflecting what a range of local leaders have said about their experiences during the last 2 years, including the immediate and long-term challenges presented by the COVID-19 pandemic.

2021: NHS England response to the ICS consultation document and the government brings forward legislative proposals to support integration.

Sources: The NHS Long Term Plan (2019); London Councils Health Collaboration Interim Report (2020); London health devolution agreement (2017)

London has a long history of developing integrated care and a shared ambition to build on progress already made (2/2)

Greater integration was supported by NHS and local government stakeholders at a national, regional and place level (2/2):

- In the LTP, NHS England had described how ICSs should bring together local organisations to redesign care and improve population health, creating shared leadership and action. It was noted that ICS system-wide objectives should reflect national and local priorities.
- In the LTP, NHS England positioned PCNs as the main vehicle for the collaborative delivery of out-of-hospital, personalised and population-focused care.
- Contributors to the London Councils Health Collaboration Interim Report identified the role of the independent chair of each ICS as being key, working with the borough-based Integrated Care Partnerships to ensure their views are fully reflected, and to help neighboring areas share best practice and learning. According to the report, which was developed to support London Councils, elected members and officers of the 32 London boroughs and the City of London in conversations with the NHS around the future of collaborative working, London's councils were able to bring to the Local Care Networks significant existing understanding of and relationships with their local communities.
- The London Vision, which articulates the shared ambition of the Greater London Authority, Public Health England, London Councils and the NHS in London, placed a strong emphasis on population health improvement. NHS England retained a strong clinical focus in the Long Term Plan but there was an expectation that local NHS organisations (through ICSs) would increasingly focus on population health and local partnerships with local government-funded services. Meanwhile, the London focus, as articulated in the London Vision, included commitments to local asset-based local approaches, integration of community-based services, and the maintenance of high-quality specialist services.
- According to the Long Term Plan, the London ambition for the next five years was for every borough to have developed place-based leadership arrangements with shared accountability and pooled budgets for specific groups of patients or people with similar needs.
- NHS England had recommended that only statutory NHS providers should be permitted to hold NHS Integrated Care Provider contracts.

Sources: The NHS Long Term Plan (2019); The London Vision (2019)

The London vision for integrated care included a renewed focus on population health and community care, and greater collaboration at all population levels

The vision for integration in London as outlined through successive strategies and plans included:

- Increased focus on population health. Stakeholders agreed on the need to focus on opportunities for broader population health management, and how to jointly make London a great place to live and work. A shift in emphasis and resources towards understanding and preventing the root causes of ill-health and tackling health inequalities is needed.
- A single CCG per ICS by 2021, while protecting existing local joint-working arrangements. CCGs mergers and new system-wide governance arrangements put beneficial local arrangements at risk.
- Greater collaboration at all at all population levels to make better coordinated care "the norm" across London.
- Common principles to guide local approaches. Regional and local government stakeholders agree that a "one-size-fits-all" solution is not appropriate, but a common set of "approaches" or "principles" could be agreed to ensure all areas progress in an aligned direction.
- Greater involvement of local government and shared leadership of ICPs. Local government should be involved in co-creating future health and care landscape and their commissioning expertise sought to ensure a broad range of providers are engaged.

And changes to the established models of care:

- Commitment to a series of community service redesigns everywhere to introduce fully integrated community-based health care.
- Dissolving the historic divide between primary and community health services by delivering a boost to 'out-of-hospital' care.
- Embracing social prescribing and neighborhood teams comprising a broad range of professionals.
- Supporting patients to access support and care in the way which is most appropriate to them including creation of multi-channel approaches and Single Point of Access.

The argument for greater engagement with local government:

- Local authorities have significant expertise and infrastructure for engaging with local communities.
- Local government possesses key assets and skills including their relationships with local people, communities and VCSE partners, and a reputation for delivering change and managing demand within tight budgets.
- Local authorities are well-placed to lead on developing population health management in partnership with local Primary Care Networks and Integrated Care Partnerships.
- Local authorities have existing infrastructure which is potentially critical to the success of PCNs including in their experience and relationships of working with the voluntary and community sector on service delivery.
- Combined NHS and local authorities' approaches are one way of potentially addressing pressures on both, through both more efficient and effective use of resources to support patients and service users.

Sources: London Health Inequalities Strategy (2018); The NHS Long Term Plan (2019); The London Vision (2019); London Councils Health Collaboration Interim Report (2020).

In 2019, London had significant barriers to overcome

Increasing integration in London was seen and experienced as a complex task, and stakeholders at every level highlighted challenges. These included:

1. **Key workforce shortages** impacting overall capacity to take forward the integration agenda and availability of key skills and expertise in the right place and at the right time.
2. **Local government and NHS budgetary pressures.** In 2019, London Councils estimated that London boroughs had experienced a reduction in core funding of over £4 billion in real terms since 2010.
3. **Historic divide between health and care**, reinforced by legislation.
4. **Differences in stakeholder priorities and vision** (strategic vs operational; acute vs community; NHS vs local government; National vs Regional vs Local). For example:
    a. NHS: need to reduce pressure on acute and emergency services, through improved population health, developing alternative treatment pathways, improving discharge.
    b. Local authorities: need to see a "return on investment" with every borough having its own elected members, local priorities and legal duties.
    c. London Region: responsible for overall performance and assurance across the region.
5. **Stakeholder intercommunication and understanding.** Elected members are believed by London Councils to be under-utilised and engaged, perhaps because system colleagues are not fully aware of their role. Perceived lack of involvement of this key group in NHS planning or key NHS decision making.
6. **Complicated funding arrangements.** While the Better Care Fund (BCF) has provided an opportunity for councils and the NHS to work together to reduce delays, the National Audit Office reported that the funding mechanism is overly complex, and there is a lack of clarity on the return on investment. The LTP notes BCF funding has sometimes been used to replace core council funding.
7. **Resistance to change** including concerns around overall levels of commitment to joint plans in the context of individual organizational pressures and the realism of some of the ambitions. "Change fatigue" and a lack of clarity around how ICSs, ICPs, PCNs and other system partners will work together or how existing services and ways of working will transition.
8. **Potentially conflicting national, regional and local priorities.** Difficulty in agreeing approaches that achieve overall performance targets and reduce unwarranted variation across the capital, whilst being flexible to local priorities and needs.
9. **Alignment with democratic structures and a complex political environment* in London.** Consolidation of CCGs and development of cross-borough ICSs creating potential new challenges to working with local government.
10. **Different geographic footprints.** Differing sizes, geographic footprints and borders at each spatial level, including alignment of PCNs to Wards, Provider footprints to boroughs and ICSs.

Sources: London Health Inequalities Strategy (2018); The NHS Long Term Plan (2019); The London Vision (2019); London Councils Health Collaboration Interim Report (2020).
*Added following feedback from the London Health and Care Partnership Integration Task and Finish Group (14th May 2021)

The 2019 London Vision outlined 10 areas of focus

1 Reduce childhood obesity

- Sets out an ambition to support every young Londoner maintain a healthy weight.
- Commits to achieving a 10% reduction in the proportion of children in reception (age four or five) who are overweight by 2023/24, targeting those most at risk.

2 Improve the emotional wellbeing of children and young Londoners

- Sets out an ambition to ensure that adolescent mental health services available to all young people whenever they need them.
- Commits to MH support teams, Healthy Schools London, and digital innovation.

3 Improve mental health and progress towards zero suicides

- Sets out an ambition for London to be a city where everyone's mental health and wellbeing us supported; working towards becoming a Zero Suicide city.
- Commits to equal access to mental health care, support and treatment.

4 Improve air quality

- Ambition is that every Londoner breathes safe air.
- Commits to partnership working to reach legal concentration limits of nitrogen dioxide and working towards WHO limits for particulate matter concentrations by 2030.

5 Improve tobacco control and reduce smoking

- Ambition is for London to be a smoke-free city.
- Sets out a commitment to working towards a reduction in smoking prevalence in London, especially among groups with the greatest health inequalities.

6 Reduce the prevalence and impact of violence

- Sets out an ambition to make Londoners feel safe by reducing violence in communities.
- Commits to partnership working, including with the London Violence Reduction Unit, to develop and implement violence reduction policy, including addressing its root causes.

7 Improve the health of homeless people

- Ambition is no rough sleeper deaths and no discharges from hospitals onto the streets.
- Commits to developing services that improve the health of rough sleepers by building on best practice, piloting new models of care, and improving data collection.

8 Improve services and prevention for HIV and other STIs

- Ambition is to reach 0 new HIV infections, no deaths and no stigma by 2030.
- Sets out commitment to broaden partnership working to focus further on tackling health inequality and a wider range of sexually transmitted diseases.

9 Support Londoners with dementia to live well

- Sets out an ambition for London to become the first dementia-friendly capital by 2022.
- Commits to ensuring that Londoners receive a timely diagnosis, ongoing support and are able to live well in their community.

10 Improve care and support at the end of life

- Ambition is for every Londoner to be able to die at home or in a place of their choice, comfortably, surrounded by people who care for them.
- Commits to ensuring personalised care planning for Londoners in their last year of life.

Sources: The London Vision (2019)

Four enablers appear frequently around improving integration and delivering better outcomes for patients

Similar to those identified by the London Vision, four enablers were identified across multiple sources as key to improving integration and delivering better outcomes for patients. These often span local geographic boundaries and have been identified as benefitting from and being a pre-requisite of a more coordinated system-wide approach.

Finance & Commissioning

Included: Finance and commissioning structures and mechanisms (including pooled budgets and joint funding arrangements); financial planning.

Relevance: provide the means for joint-working, sustainability of services, local investment and effective management of financial risks and rewards.

Governance

Included: Leadership arrangements; participatory structures; mechanisms for oversight and support.

Relevance: Enabling and accelerating joint working, shared planning delivery and assurance.

Workforce

Included: Factors impacting the workforce and strategies to attract, train, develop and retain the health and care workforce.

Relevance: Integration can enable more effective use of resources and co-ordination of care and outcomes.

Digital & Data

Included: Digital infrastructure, systems and tools, and the use of data to support decision-making.

Relevance: Better information management is a key enabler of coordinated decision-making, prevention and proactive planning and intervention.

While pooling budgets and establishing joint-working arrangements were supported, these structures were not fully defined

Governance

- In the Long Term Plan, NHS England called for the establishment of ICSs everywhere from 2021, underpinned by clear accountabilities. According to NHS England, each ICS should have a partnership board, drawn from and representing commissioners, trusts, primary care networks, local authorities, and the voluntary and community sector.
- Each ICS would need to align with existing statutory governance forums, including Health and Wellbeing Boards. In 2019, it was not clear how this would operate in London where there are multiple Health and Wellbeing Boards for each ICS.
- ICS Partnership Boards are expected to be supported by governance including regular meetings of provider and commissioner executives to monitor and oversee NHS transformation, operational and financial performance. However, in 2019, these governance relationships were not well defined.
- In the London Councils Health Collaboration Interim Report, it is reported that some areas have suggested that Health and Wellbeing Boards and ICS Partnership Boards serve the same function, but the report notes that they have different statutory responsibilities. The report lists developing a London framework for the role of Health and Wellbeing Boards as a priority, as well as the proposal that borough-based ICP boards be chaired by a council officer or joint local authority – NHS appointee.
- In the Long Term Plan, NHS England suggests statutory NHS providers would hold NHS Integrated Care Provider contracts.

Finance & Commissioning

- Prior to the pandemic, the rules and processes for procurement, pricing and mergers could sometimes hinder integration between providers, but legislative changes were expected that would support more rapid progress. These proposals are now articulated in recent Department of Health and Social Care's White Paper (see part three).
- In the Long Term Plan, NHS England set out an expectation for every ICS to introduce streamlined commissioning arrangements to enable a single set of commissioning decisions at system level, most likely involving a single CCG for each ICS.
- Pooled budgets were recognised as a long-term objective by most organisations. In the London Councils Health Collaboration Interim Report, it is reported that in London, pooling and prioritising resources and establishing joint governance arrangements under the direction of Health & Wellbeing Boards was a priority intended to reduce health inequalities and improve care.
- Addressing provider deficits was a key priority for NHSE/I but also a concern for other stakeholders both in relation to the impact of changes and the risk of becoming responsible for these.
- The London Vision was generally supportive of aligning or blending health and social care budgets but only where councils and CCGs agree it "made sense".
- It was unclear whether there was sufficient investment to support the level of change required to address long term health inequalities and reduce acute demand.
- In the Long Term Plan there was an expectation that Mutual Aid would be a key part of the role of ICS leaders, managers and clinicians, as part of a 'duty to collaborate'.

Sources: The NHS Long Term Plan (2019); The London Vision (2019); London Councils Health Collaboration Interim Report (2020); Integration and Innovation: working together to improve health and social care for all (2021)

London stakeholders had already identified workforce, diversity and inclusion and improved data sharing as being key for the future

Workforce

- Stakeholders recognised the damage high vacancy levels were causing and agreed that improving recruitment and retention was an answer; the London Vision focussed on the high cost of living as a reason for poor retention in London, and diversity and inclusion in both recruitment and the workplace culture as being key priorities in London.
- There are some specific workplace culture / practice policies where all stakeholders are in alignment. These include; increasing flexible working, increased international recruitment as a short-term fix, expanded university/training places for GPs and nurses as a long-term solution, more collaborative ways of working to improve staff experience and quality of care, increased opportunities for developing skills.
- Development of the PCN workforce was seen as key to supporting more collaborative working at a local level.
- Stakeholders were generally supportive of improving joint-working between VCSE and statutory workforce as a means of alleviating pressure on statutory services and facilitating care closer to home and in the community.
- There were different perspectives on what it meant to have an integrated workforce, between more collaborative / 'bottom-up' approaches vs. more structural / centrally-led change.
- International recruitment was a focus of both national (Long term Plan) and local (London Vision) strategies to address workforce shortages.

Digital & Data

- There was a shared vision (articulated in the London Vision and NHS Long Term Plan) to increase the use digital tools (including innovative use of wearable devices) that would enable patients to manage their own health, free up health and care providers' time for more personalised care, reduce hospital admissions and integrate services.
- Shared patient records and care plans were recognised as essential tools to drive integrated care and joint working to manage long term or complex conditions.
- There were also plans to use data to monitor performance and inform service redesign.
- From an ICS perspective, they intended to introduce digital systems to enable joint working and information sharing.

Sources: London Health Inequalities Strategy (2018); The NHS Long Term Plan (2019); The London Vision (2019); London Councils Health Collaboration Interim Report (2020).

Part two: Integration in London through the COVID-19 Pandemic

“What we did”

Collaborative working improved significantly during the pandemic, but there remains a need to develop improved relationships into long-term change

Significant improvement in collaborative working was observed during the pandemic:

- There was increased awareness reported of the benefits of integrated working across sub-regional, regional and national levels.
- This included increased joint-working and multi-agency approaches at neighbourhood, place and system level in responses to the challenges of the pandemic.
- The pandemic provided an opportunity to reduce bureaucracy through suspension of routine governance and controls, enabling quicker, more flexible responses.
- Regulatory interventions during the pandemic response were more enabling than limiting, providing 'air cover' and practical support.
- Community hubs were set up by local authorities to coordinate the support provided by the council, NHS and voluntary and community organisations.
- Local knowledge of the requirements of specific communities and local assets were utilised in bringing together and proactively targeting those at greatest risk or need.
- Other forms of neighbourhood-based support, such as shielding hubs, were set up by local authorities with support from primary care, community and mental health providers.
- Joint working was also seen between social care teams and local councils to respond to issues such as rough sleeping.
- Health Equities and Strategy Group (HEST), established a community engagement lead network to facilitate collaborative working across all 32 London Boroughs.
- New committees and groups were established to collaborate towards delivering improved quality of clinical care e.g. in NEL, a steering group was set up with members from the five provider trusts and the CCG.
- Collaboration across providers allowed for an increase in capacity over the pandemic period, the establishment of a Critical Care Hub in SEL being an example of this.
- Prior to the pandemic, ICSs were perceived as highly NHS-focused, however, in order to respond to the challenges brought on by the pandemic, local government involvement was seen to have increased.
- At a regional level, there was more regular contact between leaders from different organisations and sectors, which helped to build relationship and foster an environment for collaboration.

Further considerations

- Although the majority of systems are keen to ensure that progress made on joint working is preserved following the pandemic, there is a need to ensure that there is appropriate scrutiny of these changes, given they were implemented quickly and without much public consultation.
- Regardless of these steps towards collaborative working and formation of new relationships, there is still a lack of structure to support these new ways of working. There is a shared understanding of the need to turn these individual relationships into structures that preserve collaboration beyond individual leaders.

Sources: COVID-19: current position and our recovery plan (2020); Our Healthier South East London Recovery Plan (2020); NCL Recovery – system plan (2020); North East London Integrated Care System Recovery Plan Summary (2020); Desktop review of London ICP plans to identify local and regional priorities to further integration (2020); The Experience of Managing COVID-19 in Social care in London (2020); Integrated care systems in London Challenges and opportunities ahead (2021), Clinical leadership to improve population health & reduce health inequalities (2021)

The pandemic was a "transformative shock" which rapidly accelerated innovation and delivered potentially permanent change across the key enablers in commissioning, workforce and digital health

Finance & Commissioning

- During the pandemic joint financial frameworks were established at pace to facilitate joint working across and within systems, for example to support rapid discharge and maximise care capacity.
- Additional funding was made available to support staff wellbeing and address the unequal impact of pandemic on staff.

Workforce

- Many providers collaborated to take advantage of potential benefits of e-rostering and e-job planning, giving staff better control and visibility of their working patterns, and getting staff to where they are needed.
- Many systems introduced workforce initiatives that included remote working plans, technology-enhanced learning and the option of staff digital passports intended to ease cross-system movement of staff.
- BAME staff in London received tailored support to help them through a pandemic that affected them disproportionately.
- Many systems introduced mental health support packages for all staff.
- Staff were rapidly upskilled in key areas including remote working and MDT working.
- Standardised approaches to staff testing and risk assessment were developed rapidly.

Digital & Data

- Effective data collection and sharing mechanisms were introduced during the pandemic to enable the collection and sharing of data that would benefit the population.
- Throughout the pandemic, surveillance and early warning data was used to monitor outbreaks, allowing a more proactive and joined up response.
- Remote consultations became mainstream and patients were able to be seen more quickly.
- The "Talk Before you Walk" approach was adopted to reduce face-to-face emergency department attendance, using alternative digital solutions such as the 111 for effective triage.
- Remote monitoring was introduced for certain patient groups with long term conditions.

Governance

- Throughout the pandemic there were signs of increased cross-provider collaboration in London. Examples included the establishment of clinical networks and provider collaboratives underpinned by mutual aid.
- Prior to the pandemic, systems were 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.
- ICSs have provided feedback to Regional stakeholders that good partnership working must be underpinned by mutually-agreed governance arrangements, clear collective decision-making processes and transparent information-sharing.

Sources: COVID-19: current position and our recovery plan (2020); Our Healthier South East London Recovery Plan (2020); NCL Recovery – system plan (2020); North East London Integrated Care System Recovery Plan Summary (2020); Desktop review of London ICP plans to identify local and regional priorities to further integration (2020); Integrated care systems in London Challenges and opportunities ahead (2021) NHS Operational Planning and Contracting Guidance (2021).

Part three: Proposed legislative changes

"What next?"

The recent DHSC White Paper aims to remove barriers that have historically hindered or prevented effective collaboration

Introduction

- In September 2019, the NHS published a response and recommendations on Long Term Plan legislative proposals. In February 2021, the Department of Health and Social care published 'Integration and Innovation: working together to improve health and social care for all' outlining the Department's legislative proposals for a Health and Care Bill. The proposed new arrangements would begin to be implemented in 2022.

Key points

- A statutory ICS will be formed in each ICS area. These will be made up of an ICS NHS body ICS Health and Care Partnership, bringing together the NHS, local Government and partners – for example, community health providers.
- The powers to remove commissioning of NHS and public health services from the scope of Public Contracts Regulations 2015, including repealing Section 75 of the Health & Social Care Act 2012 and Procurement, Patient Choice & Competition Regulations 2013.
- The NHS should be free to make decisions on how it organises itself without the involvement of the Competition and Markets Authority (CMA).
- Removes NHS Improvement's specific competition functions and its general duty to prevent anti-competitive behaviour.
- Where procurement processes can add value they will continue but that will be a decision that the NHS will be able to make for itself.
- For social care, a new legal power to make payments directly to social care providers to remove barriers in making future payments to the sector.
- A new standalone legal basis for the Better Care Fund and a legal framework for a 'Discharge to Assess' model.
- Place level commissioning will 'frequently' align geographically to a local authority boundary.
- The ICS will have to work closely with local Health and Wellbeing Boards (HWB) as 'place-based' planners. The ICS NHS Body will be required to have regard to the Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies that are being produced at HWB level and vice-versa.
- More effective data sharing across the health and care system, which is critical to effective integration, and will enable the digital transformation of care pathways.
- The ICS NHS Body will be allowed to delegate significantly to place level and to provider collaboratives and NHS providers will be able to form their own joint committees.
- NHS Trusts and Foundation Trusts (FTs) will remain separate statutory bodies with their functions and duties broadly as they are in the current legislation. NHS providers within the ICS will retain their current organisational financial statutory duties.

Sources: Integration and innovation: working together to improve health and social care for all (2021).

Two forms of integration will be underpinned by the legislation: integration within the NHS, and greater collaboration between the NHS and local government, as well as wider delivery partners

Sources: Integration and innovation: working together to

Integrated Care Systems (ICSs) will become statutory bodies.

Integrated Care System		Integrated Care Partnership
ICS NHS Body responsible for the day to day running of the ICS.	**ICS Health & Care Partnership** with health, social care, public health and other partners.	**Place-based joint working** between the NHS, local government, community health services, and other partners such as the voluntary and community sector.
Merging of functions of STPs/ICSs with functions of a CCG to bring together strategic planning and allocation of resources.	**Supporting integration and developing a plan to address a system's health, public health and social care needs.**	**Joining up of services to support people to live well, arranging care around people, prevention and supporting people with multiple health & care needs.**
• **Developing a plan to meet the health needs of the population** within their defined geography. • **Developing a capital plan for the NHS providers** within their health geography. • **Securing the provision of health services** to meet the needs of the system population.	• **Improving population health.** • **Tackling inequalities.** • **Potential forum for NHS and Local Authority partners** to agree co-ordinated action and alignment of funding on key issues.	• **Frequently, place level commissioning within an integrated care system will align geographically** to a local authority boundary. • **The Better Care Fund (BCF) plan will provide a tool** for agreeing priorities.
• **A statutory duty to meet the system financial objectives which require financial balance to be delivered.**	• **The NHS and local authorities will be given a duty to collaborate with each other.**	• **ICS legislation will complement and reinvigorate place-based structures for integration** such as Health & Wellbeing Boards, the Better Care Fund and pooled budget arrangements.
• **The ICS NHS body will have a unitary board directly accountable for NHS spend and performance**. • **The Chief Executive will be the Accounting Officer for NHS money** allocated to the NHS ICS Body. • **The board will include a chair, the CEO, and representatives from NHS trusts, general practice, and local authorities** and others determined locally e.g. community health services (CHS) trusts and Mental Health Trusts, and non-executives. • **ICSs will also need to ensure they have appropriate clinical advice** when making decisions. • **NHSE will publish further guidance on how Boards should be constituted**, including how chairs and representatives should be appointed.	• **Members of the ICS Health and Care Partnership could be drawn from a number of sources including Health and Wellbeing Boards within the system, partner organisations with an interest in health and care** (including Healthwatch, voluntary and independent sector partners and social care providers), and organisations with a wider interest in local priorities (such as housing providers). • **The intention is to specify that an ICS should set up a Partnership and invite participants, but the intent is not to specify membership or detail functions for the ICS Health and Care Partnership** – local areas can appoint members and delegate functions to it as they think appropriate.	• **Place-based arrangements between local authorities, the NHS and between providers of health and care services should be left to local organisations to arrange.** 'We expect local areas to develop models to best meet their local circumstances.' • **NHS England and other bodies expected to provide support and guidance**, building on the insights already gained from the early wave ICSs. • **The statutory ICS will also work to support places** within its boundaries to integrate services and improve outcomes. • **NHSE to work with ICS NHS bodies on different models** for place-based arrangements.

The 'triple aim': better health and wellbeing for everyone; better quality of health services for all individuals; sustainable use of NHS resources.

New statutory duties

Membership

- **Defined ICS NHS Body** optional additional members.
- **Health & Care Partnership** determined by each system.
- **Place-based working** defined locally.
- **Clinical advice** to be incorporated in decision-making.

'Together referred to as the ICS'

'Place'

Part four: Building a resilient, integrated future across London

“What does this mean?”

Post-COVID 19 there has been even greater emphasis on tackling inequalities, improving population health, and managing future pandemics

In documents published from 2020 onwards, calls for action emerged that broadly fell into three categories: 1) short-term actions required to recover from COVID-19, including actions to manage the ongoing pandemic and enable the restoration of elective services; 2) actions required to make London's health and care system more resilient; and 3) actions building on what has been learnt. In parallel, new legislative proposals are designed to help to embed rapid improvements made to the system as it has adapted to challenges arising from COVID-19.

Overall, the focus of these sources appear slightly different when compared with those published prior to the pandemic:

- Following the pandemic there is an even greater emphasis on tackling inequalities, prevention and improving population health. These themes are not new, but their prominence has increased. Ensuring patient and staff safety through effective infection prevention, restoring elective services and increasing patient engagement were also key priorities shared by National NHS and ICS stakeholders across London.
- "Local first" place-based service delivery is perceived as being more widely supported by stakeholders at all levels.
- London ICSs were noted for placing a greater emphasis on the value of the 'patient experience' and the need to improve care for those with complex needs.
- Reducing unwarranted variation was not a strong theme across the ICS recovery plans.

Recovering from the pandemic: actions for ongoing pandemic management

- In addition to the National COVID-19 vaccination programme, the plans and perspectives published by National, Regional and ICS stakeholders have identified many other mechanisms for the short-term management of the ongoing COVID-19 pandemic. These could include: effective use of estates and community pathways to separate covid and non-covid patients, requirements for patients to isolate prior to admission, establishment of borough-level COVID-19 response units, pre-admission testing, continued use of remote consultations and digital health to minimse contact, remote monitoring of people with long term conditions to promote self management, reducing outpatient attendances of low clinical value, rollout of community health response teams to reduce durations of long stays, increased diagnostic capacity, equipping social care and care homes with effective infection-control equipment and training, new COVID-19 escalation pathways, jointly-planned local lockdowns, short-term surge capacity and home-visiting services.
- ICSs are looking to develop single system-wide co-designed plans to deliver, jointly with local authorities, effective system-wide, multi-sector and place-based responses to COVID-19. These plans would likely feature colleagues in health, the voluntary and community sector working together with local communities at borough level to manage COVID-19 on an ongoing basis.
- To effectively manage capacity, and to reduce the risk of infection spreading, ICSs need a single view of demand and capacity for health and social care services.

Specific challenges

- Patient safety and preventing further spread by separating covid and non-covid is a priority that will negatively impact capacity and productivity. One ICS mentioned using the independent sector to alleviate capacity restrictions. Prior to the pandemic there was also broad support for integrating VCSE and statutory workforce as a means of alleviating pressure on NHS services.

Sources: ICS recovery plans for NW, SE, NE and NC London (2020); Desktop review of London ICP plans to identify local and regional priorities to further integration (2020); The Experience of Managing COVID-19 in Social care in London (2020); Integrating care: Next steps to building strong and effective integrated care systems across England (2020); Integrated care systems in London Challenges and opportunities ahead (2021); NHS Operational Planning and Contracting Guidance (2021);

A priority for London's recovery from the pandemic is the restoration of elective services and the reduction of waiting lists

Recovering from the pandemic: actions for restoring elective services

- National NHS stakeholders have made a series of suggestions for restarting elective services:
  - Incorporate clinically led, patient focused reviews and validation of the waiting list on an ongoing basis, to ensure effective prioritisation and manage clinical risk.
  - Develop support tools for elective care recovery at a system level e.g., common tracking of waiting lists; dynamic planning of elective capacity and shared capacity, demand and monitoring data.
  - Implement dedicated elective care, high impact service models at system level to tackle the back-log, such as dedicated fast track hubs, dedicated elective service pathways, and elective activity coordination hubs for booking and scheduling across sites.
  - Apply cross-system learning to respond to high-impact changes, including adapting the ward environment to enhance flow and physical segregation of patients.
  - Continue to work with VCSEs to help clear elective care backlog.
- ICSs reinstating elective services with significant waiting lists recognise a need to:
  - Enable greater flexibility in where patients are treated to clear the backlog.
  - Increase the pace and scale of elective transformation work.
  - Adopt system-approaches to managing available capacity and associated waiting lists, providing each other with mutual-aid wherever possible.
  - Develop "Elective Care Recovery Plans" – prioritizing patients in order of clinical need.
  - Significantly reduce urgent and emergency activity to create capacity to manage planned care.
  - Strengthen partnerships to support "community by default" clinical pathways.

Sources: ICS recovery plans for NW, SE, NE and NC London (2020); Desktop review of London ICP plans to identify local and regional priorities to further integration (2020); The Experience of Managing COVID-19 in Social care in London (2020); Integrating care: Next steps to building strong and effective integrated care systems across England (2020); The Experience of Managing COVID-19 in Social care in London (2020); Integrated care systems in London Challenges and opportunities ahead (2021); NHS Operational Planning and Contracting Guidance (2021).

The London Recovery Board, formed in June 2020, has developed a mission-oriented recovery plan for post-pandemic London

Building on closer partnership working between the Mayor's office and London's 32 boroughs, City Hall and London Councils formed the London Recovery Board with 'leaders of London's anchor institutions' to plan and oversee the capital's wider long-term social and economic recovery, developing 9 missions aimed at reshaping London into a fairer, more equal, greener and more resilient city than it was before the pandemic. The board first met on 4th June 2020.

1 A Green New Deal

- Tackle climate and ecological emergencies by doubling the size of London's green economy by 2030.
- Modernise public transport, get building emissions to net 0 and grow London's burgeoning £40bn 'low carbon goods and services' sector to create more green jobs.

2 A Robust Safety Net

- By 2025, every Londoner is able to access the support they need to prevent financial hardship.
- One point of access for advice services and crisis support.
- Improve access by embedding council-run, charitable and other relevant services in community settings.

3 High Streets for All

- Deliver enhanced public spaces and exciting new uses for underused high street buildings in every Borough by 2025, working with London's diverse communities.
- Develop the capacity of local authorities and town centre partnerships, and pilot high street Innovation Zones.

4 A New Deal for Young People

- By 2024 all young people in need are entitled to a personal mentor and all young Londoners have access to quality local youth activities.
- Develop mentoring schemes, endorse professional youth work, fund place-based youth provision.

5 Helping Londoners into Good Work

- Support Londoners into good jobs with a focus on sectors key to London's recovery.
- Support those hardest hit by the pandemic (young people, carers, those with complex needs).
- No wrong door for skills and careers support.

6 Mental Health & Wellbeing

- By 2025 London will have a quarter of a million wellbeing ambassadors, supporting Londoners where they live, work and play.
- Co-design wellbeing ambassador positions with communities, ensure all support is culturally appropriate.

7 Digital Access for All

- Every Londoner to have access to good connectivity, basic digital skills and the device or support they need to be online by 2025.
- Understand how digital exclusion affected Londoners during the pandemic, train all adults in basic digital skills.

8 Healthy Food, Healthy Weight

- By 2025 every Londoner lives in a healthy food neighbourhood whose characteristics will be designed with partners and citizens (e.g., water fountains, green space, places for breastfeeding, healthy food options).
- Expand the School Superzones programme.

9 Building Strong Communities

- By 2025, all Londoners will have access to a community hub ensuring they can volunteer, get support and build strong community networks.
- Support Londoners to lead the recovery in their own communities, amplify unheard Londoners' voices.

Sources: London Recovery Programme Overview (2020)

Ensuring London's systems are resilient in future outbreaks will require greater investment in London's staff, estates, system collaboration and places

Key to London successfully recovering from the pandemic is being seen to be 'building back' a health and care system that is more resilient to future pandemics, including new variants of COVID-19.

Actions mentioned as those required to make London's health and care system more resilient:

- Enhancing prevention and infection control measures, in line with National Guidance.
- Increasing capacity to prepare for future surges by expanding critical care, the 111-service and models for mobilising additional capacity (e.g., volunteers, social prescribers and care navigator link workers).
- Upskilling staff to work in different areas (including new and virtual multidisciplinary teams working across organisational boundaries) and specialties.
- Ensuring ICS estates are resilient and adaptable and therefore better able to meet the needs of local people, the workforce and infection prevention measures (e.g., segregation).
- Developing effective partnerships between different services and providers.
- Developing testing services to meet the needs of the whole population and adapting and retaining best working practices.
- In addition to expanding services and increasing capacity, NHS England and the DHSC share the view that systems need to work at 'place' level to tackle the wider determinants of health and connect socio-economic recovery with London's workforce challenge. Several ICSs reference in their recovery related plans for investing in prevention.

Increased emphasis on patient engagement

- Both NHS England and ICSs prioritise patient engagement and an appreciation of the 'patient experience' in future planned. As one ICS notes, London needs to take the opportunity to really engage patients and build a new social contract with its communities.
- While NHS England advise that systems maintain communication with patients and proactively "reach out to those who are clinically vulnerable" the ICS recovery plans also recognise that understanding the patient experience of the pandemic is important for the design of new models of care. This includes commitments to "continue to inform, engage, and involve patients" by developing new best practice approaches to working with local people and local Healthwatch organisations.
- ICSs describe plans to "build engagement activities through partnerships", utilise digital platforms to "understand the patient perspective of using services differently", and to use the "inequalities exposed by the pandemic" to engage with communities.

Sources: ICS recovery plans for NW, SE, NE and NC London (2020); Desktop review of London ICP plans to identify local and regional priorities to further integration (2020); The Experience of Managing COVID-19 in Social care in London (2020);); Integrating care: Next steps to building strong and effective integrated care systems across England (2020); The Experience of Managing COVID-19 in Social care in London (2020); Integrated care systems in London Challenges and opportunities ahead (2021); NHS Operational Planning and Contracting Guidance (2021).

The pandemic created new challenges but also helped London to achieve greater integration. How can progress be protected from future financial pressures?

While the challenge of responding to the pandemic has provided a stimulus for innovation and change, it has also introduced new challenges and barriers that will need to be overcome to make systematic improvements.

Specific challenges referenced included:

- Disproportionate impact to some patients who may not have received vital care on account of changes in the service (including patients with learning disabilities and/or mental health issues). These patients will need to be prioritised.
- New or increased numbers of patients with mental health conditions, including post-intensive care COVID-19 patients with PTSD, and anxiety and agoraphobia in those who were required to shield and who will need mental health support to re-integrate into normal life. A new "walk and talk" service is being implemented for those experiencing anxiety leaving their homes.
- Money management support required to help prepare members of the community for when the national support stops.
- Displaced resources as a consequence of 'virtual by default' service consolidations may require redeployment.
- Significant waiting lists for elective care services.
- Workforce fatigue: London's workforce are tired, many have experienced loss of patients, colleagues, friends and family.

While stakeholders recognise the impact of the pandemic on the mental and physical health of the population, and the financial impact on Londoners, there was less discussion on the long-term financial effects of the pandemic. With temporary funding packages expected to expire, questions are raised:

1. Prior to the pandemic, budgetary pressures, different priorities and workforce shortages were all regarded as barriers to improved integration – will these obstacles reassert themselves?
2. Without additional funds, and recognising the national debt incurred during COVID-19, how can London maintain its momentum towards better integration?

Finance & Commissioning

- According to NHS England, systems will have more say in specialist commissioning moving forwards, but some commissioning functions may be undertaken by provider collaboratives. Within the ICSs, commissioner leadership will decrease as providers assume more responsibility.
- NHS England have called for the finances of the NHS to be organised at an ICS level but for allocative decisions to be put in the hands of local leaders. ICS leaders would then, with collaboratives, distribute funds from a centralised 'pot', delegating significant budgets to 'place'.
- It was noted by one ICS that a speedy recovery and elimination of the backlog will necessitate greater investment.
- NHS England and ICS stakeholders recognise that progress made on shared financial frameworks must be built upon if truly pooled budgets are to become a reality in the long run.
- The role of financial arrangements in mitigating inequalities has received increased attention in system and national plans. ICSs are expected to target resources to prioritise disadvantaged communities.
- Also mentioned in ICS plans: moving away from PbR, blended payments models, prioritising services and re-reviewing investments, risk sharing, decreased productivity/inefficiencies and pooling budgets.

Further considerations

- Stakeholders reference different means of prioritisation, including calls to prioritise addressing inequalities, backlogs and to increase capacity.

Sources: ICS recovery plans for NW, SE, NE and NC London (2020); Desktop review of London ICP plans to identify local and regional priorities to further integration (2020); The Experience of Managing COVID-19 in Social care in London (2020); Integrating care: Next steps to building strong and effective integrated care systems across England (2020);; The Experience of Managing COVID-19 in Social care in London (2020); NHS Operational Planning and Contracting Guidance (2021); Integrated care systems in London Challenges and opportunities ahead (2021).

To “lock in" collaborative working London must continue the "practical approaches" co-developed in the pandemic, "build trust and strengthen relationships”

Post-pandemic expectations of Regions and ICSs across England include 1) Enable all NHS Led Provider Collaboratives to go live by 1 July 2021; 2) Facilitate delivery of place-based care; 3) Embed clinical leadership; and 4) Implement the NHS Comprehensive Model for Personalised Care. In addition to National expectations, significant learning and reflection has led to ICSs developing plans that build on London’s collective experience to inform their ongoing development and it is generally agreed that London must not revert unintentionally to the old ways.

ICSs and system colleagues are being encouraged to:

1) Strive for equal partnerships to co-design, co-produce and co-deliver

- During the pandemic, stakeholders developed a better collective understanding of their interdependencies and operated as more equal partnerships.
- To keep these advancements, ICSs are encouraged to: 1) preserve forums for regular contact; 2) ensure equal board representation and respect equal partnerships; 3) expand on camaraderie, build trust and strengthen relationships; 4) maintain a one-team, outcome focused mindset; 5) commit to providing mutual aid; and 6) support cross-council collaboration.
- System and ICSs must avoid reverting to “parent-child” behaviours or focusing disproportionality on NHS or acute care issues.

2) Facilitate place-based care (but also pan-system provider collaboratives)

- To continue with the pre-pandemic ambition for a “local first” care model, ICSs are encouraged to: 1) preserve and expand community hubs at a local level; 2) accelerate plans to offer a single set of community pathways; 3) maintain and build on multi-agency relationships; 4) leverage new relationships for non-COVID-19 activity; and 5) develop place-based leadership arrangements (including primary care, local authorities, public health, service providers and Healthwatch) to ensure each place has the appropriate resources, autonomy and decision-making capabilities.

3) Embrace new leadership styles

- During the pandemic, leaders were visible and adopted an “open, pragmatic, problem solving, compassionate and inspiring” leadership style which as well received by NHS stakeholders. Early ICSs have also attributed their successes in part to good leadership across the system, including at the frontline.
- Leaders are encouraged to embrace this open, shared leadership style long-term, and to ensure transparency across decision-making.

4) Foster a culture of compassion and learning

- During the pandemic, greater emphasis was placed on the workforce and individual welfare, mental health and resilience. Individuals felt like they were a part of something meaningful.
- Moving forwards, London should seek to retain a culture of continuous learning and maintain the emphasis on staff wellbeing. It is important also to recognise that London’s staff are people with families.

5) Give appropriate attention to social care – see slide 26 for further details on care homes.

- During the pandemic, stakeholders across developed a greater collective understanding of the importance of a well-functioning social care system, health and care integration and engaging social care providers.

6) Embed clinical leadership at every level (including at place, in provider collaboratives and at a system level) and 7) Maintain flexibility and agility

Sources: ICS recovery plans for NW, SE, NE and NC London (2020); Desktop review of London ICP plans to identify local and regional priorities to further integration (2020); Integrating care: Next steps to building strong and effective integrated care systems across England (2020); Integrated care systems in London Challenges and opportunities ahead (2021); NHS Operational Planning and Contracting Guidance (2021); Wave 2 Learning: reflections from NHS England and NHS Improvement (London) and the NHS in London (2021)

Workforce recruitment and retention challenges remain after the pandemic, but there is a new and welcome emphasis on staff wellbeing

Workforce

- The pandemic has highlighted the importance of a full staffing and as such post-pandemic there is an emphasis on addressing vacancies by improving recruitment and retention.
- The impact of the pandemic on staff wellbeing is generally recognised, and initiatives like rolling over unused annual leave are already common.
- Based on their recovery plans, London ICSs are aware of the increased role they are expected to take in workforce coordination, and it is recognised that this must be coordinated across London.
- There is increased recognition of the potential benefits of up-skilling, especially in digital skills and in collaborative working.
- Recognition of the singular effort of staff over the pandemic period is explicit in a few ICS plans, but some organisations (at all levels) do not explicitly recognise staff effort.
- There is National and system recognition of the need to address the staff wellbeing crisis in the short term, but less consensus between systems on how much effort should be put into developing longer-term support structures.
- National policy emphasises developing staff passporting to allow easier movement between systems, but this does not appear in all ICS plans despite a consensus on the importance of flexible working.
- It is not clear whether support packages for staff wellbeing will take on a more permanent form.

Further considerations

- How can staff be engaged to tailor support packages and new ways of working with them?
- How can the shared experience of the pandemic be channeled into creating a better workplace culture that improves retention and staff wellbeing?

Estates

- New solutions were developed during the pandemic to provide patients with covid-free care, such as surgical hubs designed to undertake high volumes of low complexity surgery in Covid free sites.
- Ongoing pandemic management will require the continued separation of covid and non-covid patients.
- Providers are increasingly taking a ''one public estate'' approach, collaborating across sectors and pooling resources.
- Estates can be used by system partners working in collaboration to serve a broader set of socio-economic objectives. This may become more prominent as systems move to adopt more population health-based approaches.
- Some believe that modernising estates could contribute to economic recovery and regeneration but that leadership at London level will be needed.

Sources: ICS recovery plans for NW, SE, NE and NC London (2020); Desktop review of London ICP plans to identify local and regional priorities to further integration (2020); The Experience of Managing COVID-19 in Social care in London (2020); The Experience of Managing COVID-19 in Social care in London (2020); Integrating care: Next steps to building strong and effective integrated care systems across England (2020); Integrated care systems in London Challenges and opportunities ahead (2021); NHS Operational Planning and Contracting Guidance (2021).

ICSs are encouraged to develop new digital solutions to support real-time provider data-sharing and decision-making at all levels

Digital & Data

- There is a shared vision for digital transformation, which has been further driven by the pandemic.
- New legislation will be introduced to ensure that effective data sharing, which was seen during the pandemic is maintained.
- Data collected during the pandemic will be incorporated into existing databases in order to help prioritise support.
- 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. Outpatient appointments will continue to be delivered virtually where possible. Some social care services will be adapted to ensure that they can continue delivering support online or over the phone.
- Use of digital technologies which improved patient experience should also be retained.
- Systems are also expected to roll out digital solutions to drive improvements in mental health.
- ICSs are encouraged to develop new digital solutions to support real-time provider data-sharing and decision-making at all levels. Emphasis is placed on continuing to support primary care.
- There are immediate plans and a mandated timeline for the development of shared care records.
- ICSs will also be required to develop population health management tools.

Further considerations

- Questions remain around how to ensure digital technology advancements do not widen existing inequalities, and there are significant concerns around digital exclusion. It is acknowledged that a "digital-first approach" will not be suitable for everyone or everything.
- New digital initiatives launched during the pandemic and those under development will require proper evaluation.

Governance

- There is an acknowledgment that ICSs will need to transition gradually those groups set up in the emergency back to being the Integrated Care Partnership Boards they were pre-Covid.
- Mergers of CCGs means some ICSs are putting borough-based arrangements in place to fill this gap.
- Infrastructure enabling a collective voice for primary care, such as "at scale" collaborations, is needed. These should form a 'golden thread' from primary care to place and system.
- NHS Operational Planning and Contracting Guidance requires ICSs to develop system-wide governance arrangements to enable a collective model of responsibility and decision-making between system partners.
- Strategic planning will be retained at the ICS level, and delivery will increasingly be through partners working together in each place in ICSs, built around PCNs in neighborhoods. Likewise, budgets will need to be delegated to support place-based delivery.
- Clinical, data-led leadership is paramount, with representation of both on ICS partnership boards.
- The pandemic response required leaders across London to meet regularly and develop strong personal relationships. These relationships and forums for regular contact must be preserved and converted to formal structures that will preserve collaboration.
- ICSs are moving to increase local government involvement in planning and decision-making. NHS England have called for ICSs to define their leadership arrangements for places, provider collaboratives and individual organisations.

Further considerations

- London's wellbeing space is crowded, and the roles and responsibilities of different parties need to be clarified and agreement reached for how partnerships can work in a mutually reinforcing way.
- NHS stakeholders used to "command and control" and "on-size-fits all" approaches will need to become comfortable with a greater variation in the models of governance and delivery.

Sources: ICS recovery plans for NW, SE, NE and NC London (2020); Desktop review of London ICP plans to identify local and regional priorities to further integration (2020); The Experience of Managing COVID-19 in Social care in London (2020); Integrating care: Next steps to building strong and effective integrated care systems across England (2020); NHS Operational Planning and Contracting Guidance (2021); Wave 2 Learning: reflections from NHS England and NHS Improvement (London) and the NHS in London (2021); Integration and innovation: working together to improve health and social care for all (2021); ICS Development - Design and Implementation Programme : Programme Overview in London (2021); Integrated care systems in London Challenges and opportunities ahead (2021), The role of primary care in integrated care systems (2021)

Tackling inequalities is a top priority for National, Regional, London ICSs and London borough leadership teams

Pre-pandemic

- LTP funding was contingent on local areas setting out specific measurable targets on tackling inequalities.
- The regional focus was centred on addressing inequities in the impact of social determinants of health through partnership working.
- Roll-out of social prescribing, link workers, community navigators and other such support roles, often VCSE-led, were already gaining traction at national and regional levels.
- It was generally recognised that inequalities could only be addressed in an integrated, cross-system way. Pooling resources through Health and Wellbeing boards was already yielding some success in London.
- Inequality issues often framed around specific groups e.g., the homeless, those with LD/A, BAME communities.

Pandemic innovations/changes

- COVID-19 exposed existing health inequalities experienced by ethnic minorities, especially those in London, and by the elderly and those with disabilities, and the failure of health and care to address these.
- COVID-19 generated new inequalities, including those experienced by 'shielders' and 'key-workers' working in front-line occupations, including the health and care system.
- Shielders and other disadvantaged groups have and are still suffering disproportionately from the mental health impact of lockdown.

Building a resilient, integrated future

- Recognition across health and care that COVID-19 has both exposed existing inequalities (ethnicity, age, geography) but also created new ones (shielders, essential workers) that must now be taken into consideration.
- Renewed focus in ICP, ICS and national post-pandemic planning on how organisations can use their positions as 'anchor institutions' in the community to tackle broader causes of inequalities.
- SEL highlight the importance of embedding changes to governance and leadership that ensure "a dedicated focus on inequalities", something other systems and national planning place less emphasis on.
- London ICS plans emphasise the importance of cross-system partnership working in tackling inequalities unique to London and common to its five ICSs in terms of data sharing and shared training sessions.
- National and system planning both highlight potential of data-led population health approaches in identifying and monitoring inequalities in access, experience and outcome. Stronger emphasis at a system level on data being used to prioritise tackling the most pressing inequalities first.
- Stronger focus on addressing social determinants of health through system partnership working is clear in ICS plans post pandemic.
- Renewed emphasis in ICS plans on the importance of ensuring interventions are 'culturally competent'.
- Recognition in ICS plans that mental health inequalities are likely to grow as a consequence of the pandemic, and that this issue needs to be addressed before it worsens.
- NEL highlight the need for Equalities Impact Assessments for new policies fast-tracked during the pandemic that may be exacerbating inequalities, and multiple ICSs note that the role of local engagement leads will be key and that their views must be considered.
- There is still recognition that VCSEs will play a crucial role, but more commitments to action from statutory organisations (as a result of the pandemic experience) mean VCSEs are one part of a multifaceted approach to tackling inequalities.

Further considerations:

- How can trust be rebuilt with communities, especially BAME communities in London, who suffered disproportionately during the pandemic? Is there agreement on what it means to be an 'anchor institution' and how this position can be used to tackle inequalities? How exactly can ICSs use their position in communities, role as employers and procurement power to influence social determinants of health?

Key findings:

- System and national plans look to work towards an integrated, data-led approach to identify inequalities and monitor progress.
- Renewed focus on the role of health and care organisations as 'anchor institutions' whose position in the local economy provides another means of tackling inequalities in the community.

Sources: London Health Inequalities Strategy (2018); London Vision 2019 (2019); NHS Long Term Plan (2019); ICS recovery plans for NW, SE, NE and NC London (2020); The Experience of Managing COVID-19 in Social care in London (2020); Desktop review of London ICP plans to identify local and regional priorities to further integration (2020); Integrating care: Next steps to building strong and effective integrated care systems across England (2020); Integrated care systems in London Challenges and opportunities ahead (2021); NHS Operational Planning and Contracting Guidance (2021); Wave 2 Learning: reflections from NHS England and NHS Improvement (London) and the NHS in London (2021); Integration and innovation: working together to improve health and social care for all (2021); ICS Development - Design and Implementation Programme: Programme Overview in London (2021), Clinical leadership to improve population health & reduce health inequalities (2021)

Consideration must be given to learn from the pandemic experience of care homes and to build back a more resilient social care system

Pre-pandemic

- The LTP called for the implementation of the EHCH model (Enhanced Health In Care Homes) in all care homes by 2023/24, intended to ensure good links between primary care and care homes, and provide holistic, wrap-around, MDT care for residents. There was already recognition that carers needed greater support.

Pandemic innovations/changes

- Initial strategic focus on preserving capacity in the clinical hospital setting led to tragic consequences. London care home deaths were proportionately higher than those outside London and the impact on social care staff has been particularly acute. The death rate in social care was approximately twice that of healthcare workers.
- The decision to protect provision in clinical hospital settings was modified as the pandemic progressed.
- GPs/PCNs and care homes working together was key, and joint working between London councils coordinated care home capacity.
- The London response was heavily data-led, timely local collection and aggregation of data was key to flagging concerns as they appeared.
- Locally-led arrangements and pan-London procurement solutions brought reliability and organisation into the system
- **The psychological impact of the pandemic on care home residents and staff cannot be underestimated.**

Building a resilient, integrated future

- ICP, ICS and national stakeholders agree on the need to progress vaccination and ensure infection prevention. London ADASS have called for the same principles of infection control and prevention (including PPE, training, zoning and testing) to be applied throughout the length of the care pathway and warn that adequately equipping care homes will only be possible with a new financial model. There are calls for immediate financial support from government to alleviate short-term funding pressures in social care.
- Further work is needed to mitigate the ongoing risk to the demographically distinct London social care workforce, and to provide adequate wellbeing support.
- Moving forwards, social care support must be proportionate to that provided to the NHS in each area. With local authority budgets under pressure, the BCF or similar mechanisms for additional funding support need to be explored.
- Implementing EHCH model has become a more immediate priority in ICS plans post-pandemic.
- ICS plans indicate an appetite among system leaders to build on pandemic collaboration between health and social care and all ICS plans appear to appreciate the importance of collaboration within systems. SEL take this further by proposing structures that preserve the relationships developed in the pandemic, for example, Strategic Care Home Groups at place level.
- NWL propose to develop a single view of demand and capacity for health and social care services, including capacity to cohort patients in line with infection prevention and control guidance.
- NEL propose bringing care homes into the Digital First Accelerator project to improve digital services for patients, staff and visiting clinicians.
- However, ADASS want to address the over-use of care and support as a means of increasing the speed of discharge and ensure a longer-term view of patient health is taken.
- Unlike local government plans, in NHS organisations' post-pandemic planning there is less of an acknowledgement of the true extent of staff and resident suffering in care homes.

Key findings:

- In the short term, infection control is the top priority and financial arrangements must facilitate, not obstruct, this.
- All conversations on improving integration in London must recognise the traumatic experience of social care sector staff and patients.
- Further work is needed to ensure decision-making around care for elderly patients, especially discharge from secondary care, is not happening in silos.

Sources: NHS Long Term Plan (2019); London Vision 2019 (2019); ICS recovery plans for NW, SE, NE and NC London (2020); Desktop review of London ICP plans to identify local and regional priorities to further integration (2020); The Experience of Managing COVID-19 in Social care in London (2020); Integrated care systems in London Challenges and opportunities ahead (2021); Integration and innovation: working together to improve health and social care for all (2021).

Conclusions

Is this the perfect moment for change?

- DHSC, NHS England / Improvement and London's five ICSs have all highlighted the key role that collaboration has played in the London's COVID-19 response.
- The pandemic has increased awareness of the need to balance national accountability with local autonomy.
- Changes to legislation proposed in the recent DHSC White Paper are intended to remove some of the barriers to partnership and collaboration and to make joint planning and delivery easier.
- There is increased awareness of the importance of population health approaches, and further reforms to public health are expected.
- A network of leaders across the region, down to the level of individual communities, have fostered closer working relationships and improved understanding through the pandemic.
- The first steps have already been taken, with new ways of working, provider collaboratives, and borough-based partnerships in many areas of London providing a foundation to build on.

The sources summarised in this literature review describe the experiences of integration in London. In this context, the pandemic has been seen as a "transformative shock", a "catalyst", and a "stimulant" which drove the health and care system to make changes that had "long been on the 'to-do' list" and to take steps that some did not think were previously possible. However, the pandemic has also been experienced as a traumatic, exhausting and expensive experience with long lasting, negative impacts on population heath and inequalities.

The literature review has attempted to bring together key perspectives, plans and calls to action: to identify the key areas of agreement, and those areas where there is not yet a shared consensus.

By looking at documents published in prior years, it is possible to observe the changing focus and London's journey to greater integration. Overall, the pandemic appears to have brought health and care systems in London into closer alignment, and there is a strong desire to learn from the experience and embed some of the positive changes that have been made.

Specific themes that were felt very strongly and expressed unanimously included the development of place-based delivery, population health approaches, improved partnership relationships and a shared desire to address health and broader inequalities.