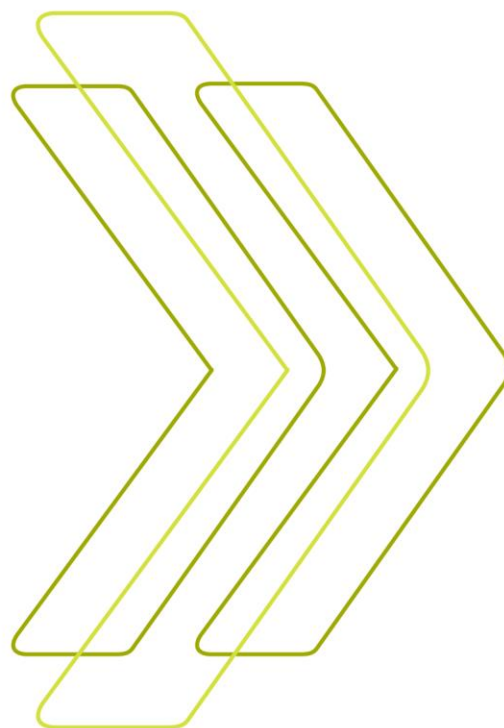


# **Sustainability and transformation partnerships in London**

**An independent review**

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This independent report was commissioned by the Mayor of London. The views in the report are those of the authors and all conclusions are the authors' own.

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# Contents

Key messages	4
1 Introduction	6
About this work	6
Our approach	7
Structure of this report	8
2 Background	9
The national policy context	9
The London context	12
3 What have STPs focused on?	23
Strengthening leadership and governance arrangements	23
Building collaborative relationships	24
Refreshing priorities	26
4 Other areas of progress in London's STPs	28
Strengthening public and clinical engagement	28
Delivering service change	30
Prevention	35
Developing integrated care partnerships and systems	36
Enablers	39
In summary	39
5 What challenges have STPs faced?	40
6 How do STPs fit into the wider London context?	45
Multiple levels of integration	45
London-wide leadership	46
In summary	49
7 Conclusions and recommendations	50
References	55

# Key messages

- The development of sustainability and transformation plans (STPs) is central to the NHS policy agenda, and it is expected that they will continue to play an increasingly prominent role in planning services and managing resources around places and populations.
- London's health and care system differs from systems in other parts of England because of its size, diverse population and the presence of major teaching hospitals with national and international roles.
- Place-based working in London needs to reflect these distinctive characteristics as well as the organisational complexity of the NHS and the contribution of local authorities.
- Many of the ambitions set out in London's STPs are being delivered at the level of neighbourhoods and boroughs and across boroughs, building on established and developing collaborations between the NHS, local authorities and others.
- STPs have a role in tackling issues that lend themselves to action across bigger geographical footprints, such as the configuration of acute and specialised services. Some issues will require collaboration between STPs and across the whole of London.
- London is experiencing rapid demographic growth, workforce shortages, and severely constrained NHS and local authority funding. This creates a challenging environment for STPs to operate within.
- STPs in London have spent much of the past year trying to overcome the challenging process by which they were introduced. Their leaders have focused mainly on the internal workings of the partnerships, building external relationships and addressing gaps in staff and public engagement.
- Local government involvement in STPs is variable and, in a small number of places, non-existent. This reflects the difficulties STPs experienced at their outset, the concerns of some local authorities that STPs are a vehicle for cuts and privatisation, and a perception that STPs are NHS-centric.

- The bed-modelling and financial positions that were set out in or inferred from the original plans no longer form the basis of the work being done in London, in recognition of the fact that some of these plans were unrealistic in the face of rising demand for care and anticipated population growth.
- There are many examples of service changes across London, often in individual boroughs or across boroughs. STPs have helped to facilitate some of these changes.
- The priority now is for STPs to build on this work and demonstrate how they can make a positive impact on issues that require action on a larger scale. They also need to communicate more effectively the contribution they are making to improving health and care.
- Teaching hospitals need to be engaged more effectively in the work of STPs, recognising their expertise in providing specialist care and in contributing to population health improvements and integrated care.
- The Mayor has a major role in working with the NHS, London councils and other bodies like Public Health England, building on the foundations that STPs have laid. This includes work on prevention and population health, which is underdeveloped at STP level, and where there are lessons from other global cities.
- A review is needed of how different bodies can best work together to improve health and care. The review should clarify how the London Health Board and Strategic Partnership Board can work with the new London region being established by NHS England and NHS Improvement and with STPs.
- As part of this, work is needed to establish how the resources of the Healthy London Partnership, Public Health England, Health Education England, academic health science networks (AHSNs) and other bodies can be more closely aligned with the work of STPs.
- The London-wide reviews led by Lord Darzi in 2007 and 2014 should be revisited and refreshed to address concerns we heard that there is a growing strategic vacuum in London resulting from the abolition of the strategic health authority in 2013 and fragmentation in London-wide leadership of the NHS. We understand that the Strategic Partnership Board has agreed that work needs to be done to fill this vacuum.

# 1 Introduction

## About this work

The Mayor of London commissioned The King's Fund to report on progress in the five sustainability and transformation partnerships (STPs) in London.

We were asked to:

- identify key developments in London's STPs since the publication of their initial plans
- explore progress made in priority areas identified in our previous report on London's STPs
- highlight examples of integrated working within London's STPs, as well as identifying key challenges and barriers to progress
- make practical suggestions for how these challenges can be addressed and how integration can be taken forward within STPs and across London.

This work follows a previous independent report published by The King's Fund and Nuffield Trust in September 2017 (also commissioned by the Mayor of London), which analysed the content of London's sustainability and transformation plans and the financial and activity assumptions underpinning them (Ham *et al* 2017b). It also builds on The King's Fund's wider work on STPs in England (Ham *et al* 2017a; Alderwick *et al* 2016) and the development of integrated care systems (ICSs) in some areas of the country (Charles *et al* 2018; Ham 2018).

Our 2017 analysis of London's STPs highlighted the following.

- STPs have the potential to improve health and care in London through collaboration between NHS organisations, local authorities and other partners.
- There were similarities between the plans in London and those produced in the rest of England, including ambitions to give greater priority to prevention and early intervention and to strengthen and

redesign primary care and community services, and plans to reconfigure hospital services.

- Some proposals to reduce the use of hospitals and cut bed numbers were not credible on the scale proposed, particularly in the context of predicted population growth.
- Proposals to close the expected financial gap in London were also questionable. Our analysis highlighted a lack of detail on how this would be achieved and unrealistic expectations regarding efficiency savings.
- As in the rest of England, much more needed to be done in London to engage with partners in local government and other sectors and to involve patients and staff in the work of STPs.
- The leadership and staffing of STPs needed to be strengthened to take them from planning to implementation.

The Mayor subsequently outlined six areas in which he needed assurance in order for him to support the plans' proposals: patient and public engagement, clinical support, impact on health inequalities, impact on social care, hospital capacity, and investment (Mayor of London 2017). These largely align with the assurances that were previously set out by NHS England (NHS England 2017a).

While we raised a number of concerns regarding the initial development of STPs in London and across England, we have strongly supported their development and continue to do so. The principles behind STPs and ICSs align with arguments we have put forward on place-based systems of care and population health. STPs and ICSs offer the best hope for the NHS and its partners to bring about improvements in health and care for their populations (Alderwick *et al* 2015; Ham and Alderwick 2015).

### **Our approach**

We carried out this work in two phases between February and August 2018.

Phase one involved a small number of interviews with leaders of the five STPs and from NHS England's and NHS Improvement's London regional teams. The purpose of this phase of the work was to understand the key areas of focus for London's STPs and to identify whether the plans and underlying bed

numbers and financial assumptions had changed. This was used to inform the scope and focus of the second phase of the work.

Phase two involved a series of 26 semi-structured interviews with senior NHS and local government leaders in each STP and with stakeholders working across the wider London system. We also held a roundtable discussion attended by 19 senior leaders from across the London health and care system and a group discussion with 17 representatives from London Healthwatch organisations. The purpose of this second phase was to capture the experiences and perspectives of a range of stakeholders from across the health and care system in London.

This report brings together our findings from both phases of the work – as well as drawing on wider literature and policy documents – to provide a progress report on STPs in London. It is based on the interviews undertaken, previous work by The King’s Fund, and our wider understanding of the issues across health and care and the London context. The main limitation of our work is the small number of people we were able to engage with in the time available. We recognise that the full range of perspectives on how STPs are evolving may not be represented in this report.

### **Structure of this report**

This report consists of four parts.

- The first part (section 2) describes the context of London STPs’ development, focusing on changes in national and regional policy since the publication of our last report.
- The second part provides a descriptive overview of the work reported as under way in London’s STPs, covering their main areas of focus (section 3) and progress in key areas (section 4).
- The third part (section 5) examines the challenges STPs have faced in making progress.
- The final part (sections 6 and 7) looks beyond the five STPs to explore how STPs fit into the wider London context and makes a number of recommendations for local and regional leaders.



## 2 Background

This section sets out the context that STPs in London are operating within. We begin by outlining the national policy context, describing the evolution of national policy around STPs, the development of integrated care systems, and the implications of the forthcoming NHS long-term plan. We then set out key features and complexities of the health and care system in London, as well as recent regional policy developments.

### **The national policy context**

#### ***Sustainability and transformation partnerships***

In December 2015, national planning guidance asked NHS organisations to come together with local authorities and other partners to produce 'sustainability and transformation plans' – local plans for the future of health and care services (NHS England *et al* 2015). Forty-four areas of England were identified as the 'footprints' for STPs.

Tasked with implementing the agenda of the *NHS five year forward view* (Forward View), plans were expected to outline how NHS services would work together with social care and other local authority services and how improvements would be made to the quality and efficiency of services and population health and wellbeing (NHS England *et al* 2014). STPs were also expected to demonstrate how their local system would achieve financial balance.

The King's Fund and others raised concerns around the process of developing the plans – which took place over a short timeframe and failed to appropriately engage local authorities, staff and the public. We also questioned some of the proposals contained in them, which often lacked detail and made unrealistic assumptions around financial savings and bed reductions (Boyle *et al* 2017; Ham *et al* 2017a; Quilter-Pinner 2017; Alderwick *et al* 2016; Edwards 2016).

The STP plans submitted in October 2016 have since been described as 'initial "Mark 1" proposals' (NHS England 2017b), and national leaders have made clear that they do not expect the proposals contained in them to be delivered in all cases (Stevens 2018). The narrative around STPs has shifted

significantly since their inception, with NHS England reframing them as 'sustainability and transformation partnerships' (NHS England 2017b). Most STPs have focused on further developing their partnerships rather than writing new planning documents.

National bodies have continued to prioritise the development of STPs, setting out expectations that they will 'take an increasingly prominent role in planning and managing system-wide efforts to improve services' (NHS England and NHS Improvement 2018, p 11).

### ***Integrated care systems and partnerships***

In March 2017, NHS England described an ambition for some STPs to evolve into 'accountable care systems' (later rebranded as integrated care systems). These were defined as 'evolved' versions of STPs in which 'NHS organisations (both commissioners and providers), often in partnership with local authorities, choose to take on clear collective responsibility for resources and population health' (NHS England 2017b).

Ten areas were chosen to lead the development of ICSs, based on an assessment of their ability to work collectively to deliver the ambitions of the Forward View. These systems have been putting in place leadership and governance arrangements to support them to take collective responsibility for funding and performance and have begun work to develop new service models. It is very early days and the ICSs are still evolving, with varying levels of progress so far (Charles *et al* 2018).

The 2018/19 NHS planning guidance made clear that ICSs will become increasingly important in planning services and managing resources in future (NHS England and NHS Improvement 2018). Four 'second wave' ICSs were selected in May 2018, and preparations are under way to support further systems. Many local health and care systems have described ambitions to develop an ICS, which would include STPs, in London.

Groups of providers are coming together in some areas to join up the delivery of care, and STPs and ICSs often have several of these smaller 'integrated care partnerships' within them (Ham 2018a). NHS England is currently consulting on a contract that could be used to formalise these partnerships (initially known as the 'accountable care organisation contract' and later renamed the 'integrated care provider contract') (NHS England 2018b). Concerns have been raised that this could lead to a greater role for the private sector in the provision of care and that the language of 'accountable

care' indicates a move to an 'American-style' health system (Ham 2018a). Two judicial reviews were brought against NHS England in relation to the contract, but both were dismissed.

Other recent changes include an increasing trend for clinical commissioning groups (CCGs) to come together over larger geographical footprints across England. Some have chosen to merge, while others have appointed shared accountable officers or created joint committees. Providers have also been coming together in some areas using a variety of arrangements, including group models and mergers.

These developments represent a significant departure from the approach to health policy taken in recent decades. Working in this way is not easy in the context of the Health and Social Care Act 2012 and more than two decades of the contractually based purchaser–provider split. The King's Fund has argued that changes in legislation will be needed to align these developments with the statutory framework (Ham 2018b).

### ***NHS funding and the long-term plan***

The government has committed to increase NHS funding by an average of 3.4 per cent a year over the next five years. This settlement provides some welcome relief to the NHS but falls short of the 4 per cent a year that The King's Fund and others estimate is needed to keep pace with growing demand and transform services (Murray 2018). The NHS has been tasked with producing a long-term plan setting out how the extra funding will be used to deliver improvements. This is expected to be published in November.

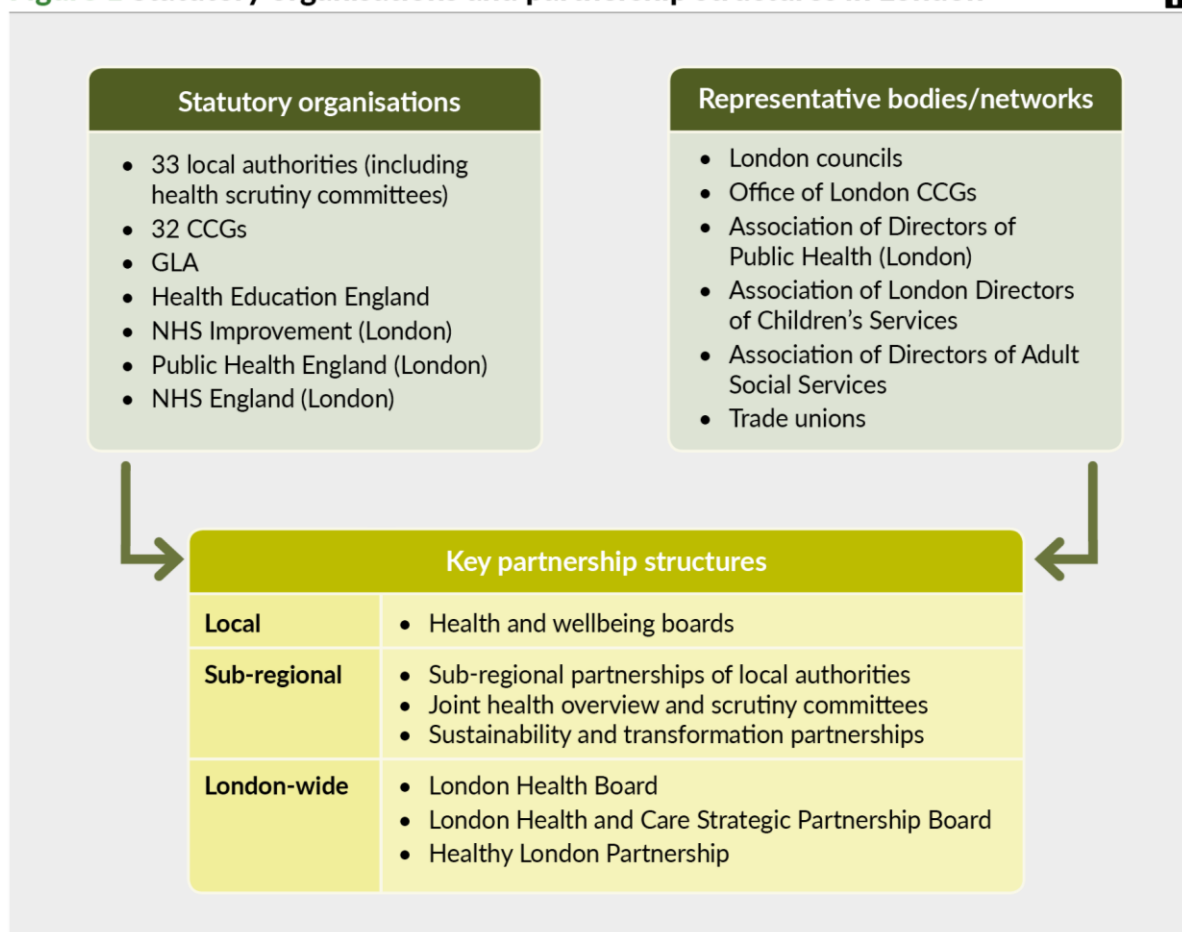
The Prime Minister has set out several priorities for the plan and priorities have also been outlined by the chief executives of NHS England and NHS Improvement and the former and current secretaries of state for health and social care (NHS Providers 2018b). Integration has been a common theme among these priorities, with clear indications that STPs and ICSs will continue as the principal means of delivering improvements in health and care.

The settlement does not cover funding for social care and public health services provided by local government. Public health funding has been cut in recent years, while a long-awaited Green Paper on social care and a new workforce strategy have been delayed until the autumn. Without investment in these areas, it will not be possible to deliver the ambitions attached to the long-term plan (Ham and Murray 2018), and STPs in London and elsewhere will not be able to meet their objectives.

## The London context

The considerable number of organisations involved in commissioning and providing care in the capital, the complex patient flows between them, and the concentration of centres of excellence for teaching, research and specialist service provision (including AHSCs), which undertake large volumes of clinical work for patients outside London – create a highly complex environment for London’s STPs to navigate (Ham *et al* 2013; Appleby *et al* 2011).

**Figure 1 Statutory organisations and partnership structures in London**

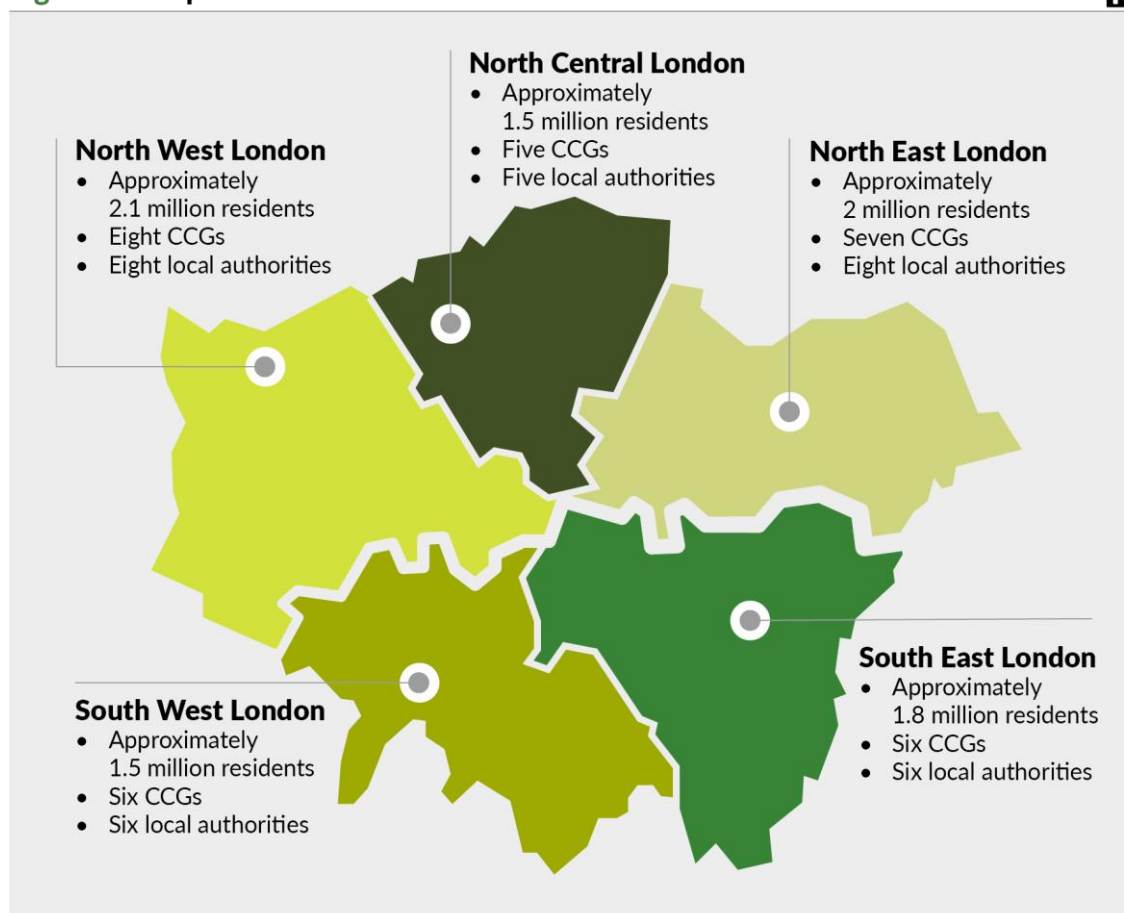


Source: Adapted from Naylor and Buck 2018

There are five STPs in London, based on areas that have been used for NHS planning purposes in the past. These areas vary in terms of their population size and the number of NHS and local authorities involved (Figure 2). A large number of NHS trusts and other providers, including 36 NHS trusts and foundation trusts, deliver care in London. These providers often deliver care

across multiple STPs, and those delivering specialist services receive complex flows that reach beyond the capital.

**Figure 2 Footprint of STPs in London**



Source: Adapted from NHS England (nd)

NHS England, NHS Improvement, Public Health England and Health Education England (and its local education and training boards) all play important roles in London. A small supporting team, the Healthy London Partnership, was set up in 2015 to enable implementation of the city-wide aspirations set out in the report of the London Health Commission (see box below) and to support delivery of the Forward View. Healthy London Partnership is funded by London's CCGs, the London office of NHS England and the Greater London Authority (GLA) and works in partnership with others, including local authorities.

The organisation of local government is also complex with 33 borough councils (including the City of London Corporation) as well as the GLA and the Mayor of London. The responsibilities of councils include adult social care,

children's services and public health, and boroughs collaborate with the NHS through health and wellbeing boards and other mechanisms. Collaboration is developed further in some places than others. Overview and scrutiny committees play an important role in providing local democratic oversight of NHS services.

Political priorities vary between boroughs and there is a natural dynamic to operate on a single-borough basis by default. Mechanisms exist for collaboration between boroughs, with London councils playing a role across the capital. There is increasing collaboration around four 'sub-regions' each represented by an informal partnership (Central London Forward, South London Partnership, West London Alliance and Local London). These partnerships have emerged organically and do not map onto NHS geographies such as STPs (Naylor and Buck 2018).

The Mayor of London is responsible for strategic planning and has formal powers in relation to economic development, transport, policing, fire and emergency planning. The Mayor and GLA also play a leadership role in the city-wide devolution arrangements. In relation to health care, the Mayor and GLA work mainly through influence and persuasion rather than direct control.

The Mayor has a statutory responsibility to publish a health inequalities strategy, and a new strategy was published in September 2018 (Mayor of London 2018). The strategy focuses on five key themes: children; mental health; places (including air quality and housing); communities (with a particular emphasis on social prescribing); living (including food, tobacco and alcohol). London's boroughs have a key role in its implementation and in commissioning and providing public health services since their transfer from the NHS in 2013 (Naylor and Buck 2018).

### ***Recent policy developments in London***

London's health and care system has been the subject of numerous reviews over the past century and more. The most recent pan-London strategic visions were set by the work of Lord (Ara) Darzi in the form of two reviews (see the box below).

### Recent reviews of health care in London

In 2007, *Healthcare for London: a framework for action* was published under the auspices of the London Strategic Health Authority (NHS London 2007). Alongside a focus on some public health issues, it outlined a number of changes to the delivery of health care services.

- More care should be provided at home, including rehabilitation, management of long-term conditions and end-of-life care.
- Polyclinics should be rolled out to provide more convenient access to a range of services in a single setting such as general practice, community services, outpatient services, minor procedures and diagnostics.
- Major acute hospitals should provide more specialised health services, reducing variation in outcomes through ensuring that volumes are sufficient to optimise quality (entailing the consolidation of stroke and trauma services onto fewer sites).
- Elective care centres should focus on high-throughput surgery with greater separation of emergency work to enable better outcomes.

For more detail on the history of London's health system and a discussion of progress implementing these recommendations, see Appleby *et al* 2011.

In 2014, the London Health Commission, initiated by the then Mayor and chaired again by Lord Darzi, published its final report, *Better health for London* (London Health Commission 2014). In the intervening period, the Lansley reforms had dismantled strategic health authorities and established 32 CCGs in London. Organised around the goal of making London the world's healthiest city, the commission identified a number of priorities.

- Combat childhood obesity, including through use of planning powers to regulate the prevalence of shops selling unhealthy food and promoting access to healthy alternatives.
- Accelerate initiatives to improve air quality in London – for instance, extending the planned ultra-low emission zone.

- Make further progress on tobacco use through making London's parks smoke-free and cracking down on the illegal tobacco trade.
- CCGs to be empowered to work together with multiple local authorities in sensible footprints to improve planning and service delivery.
- CCGs to move to commissioning integrated physical, mental and social care services for population groups with similar needs.
- Extended access to general practice (8am to 8pm) to be rolled out supported by substantial investment in the primary care estate and encouraging GPs to work in networks.
- Outcomes for specialist care to be further improved through promoting centres of excellence in cancer and cardiovascular services.

One year on, a progress report highlighted the refocusing of the London Health Board, measures to improve urgent care services such as NHS 111 and investment in general practice facilities (Mayor of London *et al* 2015). While there were no further publicly available updates on delivery, progress in some areas continued. For example, London led the country in the rollout of extended access to general practice.

In November 2017, a set of agreements was reached concerning health and care devolution in London, confirming that some control over health and care would be delegated to the capital. A memorandum of understanding was signed by bodies in the London health and care system (CCGs, local authorities and the GLA) and by government departments and national NHS bodies (including HM Treasury, the Department of Health and Social Care, NHS England, NHS Improvement and Public Health England) (London Partners 2017). While this did not create any significant new regulatory or fiscal powers for London, it outlined a number of important agreements.

- Money raised through NHS land and property sales within London will be kept within the city, with the London Estates Board identifying re-investment opportunities to support city-wide priorities.



- Regulatory processes are to be aligned and a place-based framework for system regulation to be piloted to make it easier for the London health and care system to function in a joined-up way.
- A new London Workforce Board to be established, which could facilitate integrated working and may act as a locus for pooled funding from Health Education England, Skills for Care and others.
- Responsibility for transformation funding to be delegated to the London Health and Care Strategic Partnership Board from April 2018.
- A commitment to 'explore options' for further restrictions on advertising unhealthy food and drinks, and the prospect of collaborative, city-wide action on some public health issues (Naylor 2017).

To support delivery, a number of partnership arrangements have been established. The Strategic Partnership Board was created in 2017 with a remit to promote integration, whole-system planning and implementation of the devolution agenda. It reports to the pre-existing London Health Board (chaired by the Mayor), which provides political oversight. The Strategic Partnership Board is supported by Healthy London Partnership.

New boards were created to lead work on areas such as estates and workforce, and the London Prevention Partnership Board is to be strengthened to support collaborative initiatives across the city – for example, on illegal tobacco and counterfeit alcohol enforcement. A Digital and Informatics Partnership Board has been established to co-ordinate initiatives such as a London data strategy and oversee capital investments in digital infrastructure (see figure 3).

**Figure 3** Simplified diagram of structures for strategic oversight of pan-London work on health and social care



Source: Tuckley (2018)

### ***Demographic pressures in London***

With a population of around 8.8 million, London is by far the largest city in Western Europe. Population density is markedly higher than in other areas of the country and the population is significantly more diverse, with more than 300 languages spoken by its residents (Table 1).

Despite the economic power of the capital, there are high levels of deprivation among its residents, with seven of the ten most deprived areas of England located within London (Department for Communities and Local Government 2015). There are also severe and enduring inequalities in health outcomes, with healthy life expectancy between boroughs varying by as much as 15 years for men and 19 years for women (Greater London Authority 2017).

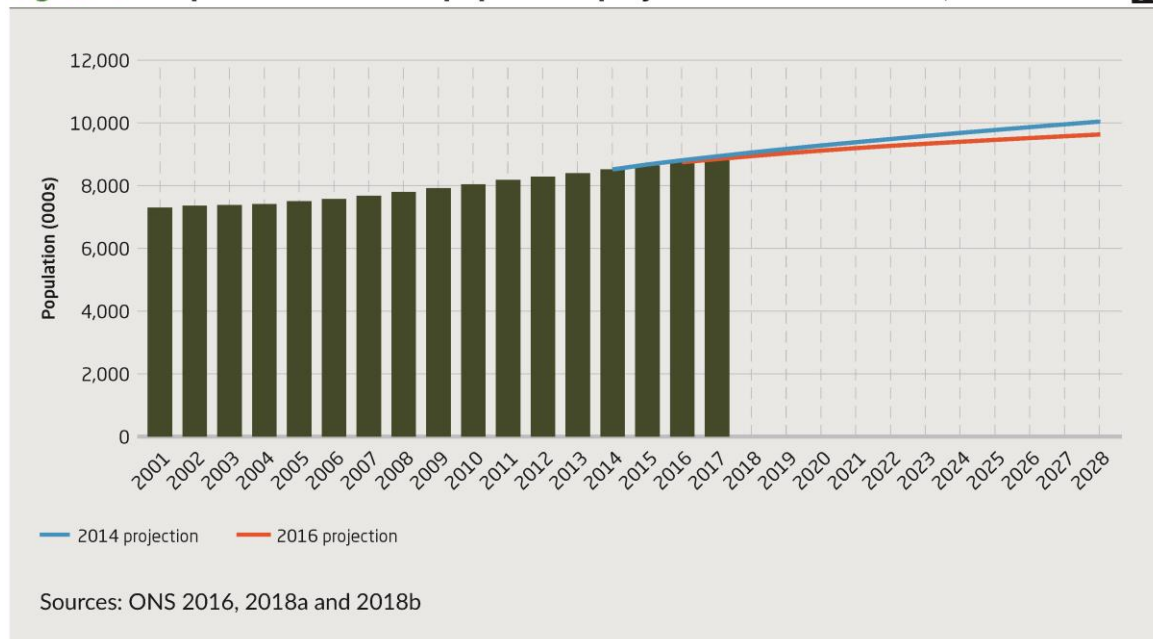
London has seen sustained growth in its population over recent years, with an increase of 14.7 per cent between 2007 and 2017 (compared to an 8.2 per cent increase in the total population of England over the same period) (Office for National Statistics (ONS) 2018b). This growth is projected to continue, with current forecasts estimating a 7.7 per cent rise over the coming decade. The projected population growth differs across the STPs, with North East London facing the biggest increase (Table 1). These projections are lower than those at the time STP plans were written (Figure 4) owing to several factors, including reduced levels of international migration (ONS 2017).

**Table 1 Projected population change by STP footprint, 2023 and 2028**

		2018	2023	2028
North Central London	Estimated/projected population (thousands)	1,509.9	1,584.9	1,640.2
	% change from 2018		5.0	8.6
North East London	Estimated/projected population (thousands)	2,023.7	2,146.3	2,240.6
	% change from 2018		6.1	10.7
North West London	Estimated/projected population (thousands)	2,095.9	2,146.4	2,181.1
	% change from 2018		2.4	4.1
South East London	Estimated/projected population (thousands)	1,827.2	1,916.2	1,986.8
	% change from 2018		4.9	8.7
South West London	Estimated/projected population (thousands)	1,508.9	1,566.2	1,608.5
	% change from 2018		3.8	6.6

Source: ONS 2018b

**Figure 4 Comparison of London population projections 2014 vs 2016, 2001–2028** 



Population growth will place significant demand on the capacity of the health and care system, particularly on acute hospital beds and the available workforce. Increasing bed and staff numbers in line with population projections is unlikely to be affordable. The number of Londoners aged 85 and over is expected to increase by a quarter between 2018 and 2028. As in the rest of England, responding effectively to the ageing population will require greater integration of care and support to people in their own homes.

London faces a distinctive collection of health needs. For example, rates of sexually transmitted infections and HIV are both well above the national average (Baylis *et al* 2017; Smith 2016). The same applies to infectious diseases such as malaria and tuberculosis, which are rarer in other parts of the country.

### ***Financial and operational pressures in London***

Since the turn of the decade the NHS has undergone an unprecedented slowdown in funding growth (The King's Fund *et al* 2017). In the face of rising demand for care and workforce pressures, this has led to a marked deterioration in financial performance and a reduction in operational performance, with key standards being missed routinely (Anandaciva *et al* 2018).

London has not escaped these pressures, with 13 of London's 36 trusts ending 2017/18 in deficit (NHS Improvement 2018b) and four in special measures for finances, quality or both at the time of writing (NHS Improvement 2017a).<sup>1</sup> Financial deficits were most significant in the acute sector, both nationally and in London; London's acute trusts reported an aggregate deficit of £245 million in 2017/18, while providers of ambulance, community and mental health services were £124 million in surplus.

London trusts account for the two largest deficits in the country, with King's College Hospital NHS Foundation Trust and Barts Health NHS Trust both ending 2017/18 with deficits in excess of £100 million (NHS Improvement 2018b). At the other end of the spectrum, University College London Hospitals (UCLH) NHS Foundation Trust and the Royal Brompton & Harefield NHS

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<sup>1</sup> Barking, Havering and Redbridge University Hospitals NHS Trust (finances); Barts Health NHS Trust (finance and quality); King's College Hospital NHS Foundation Trust (finances); and St George's University Hospitals NHS Foundation Trust (finances and quality).

Foundation Trust recorded two of the highest surpluses (approximately £75 million each), in part due to one-off measures such as selling surplus land and receiving sustainability and transformation funding. These figures should be interpreted in the context of these organisations' large financial turnovers.<sup>2</sup>

As is the case across the country, performance against waiting time standards has fallen short of national standards in recent months. In 2017/18, four-hour performance among providers of London's A&E services fell from 89.6 per cent in the first quarter to 85.7 per cent in the fourth quarter compared with national performance in quarter four of 85 per cent (NHS Improvement 2018a, 2018b, 2017b, 2017c). Although the available data for performance in community and primary care services is limited, there is evidence nationally that access to and quality of care is suffering as they struggle to meet rising demand within the resources available (Baird *et al* 2016; Maybin *et al* 2016).

Similarly, operational pressures are exacerbating longstanding concerns about access to mental health care (NHS Providers 2017; Gilbert 2015). One manifestation of this is the ongoing use of out-of-area placements for people needing acute inpatient care, both across England and in London. In London, almost all out-of-area placements active at the end of June 2018 (95.8 per cent) were due to there not being a bed available locally (NHS Digital 2018).

Local authorities have experienced significant cuts to their budgets over the past decade. Consequently, national gross spending on adult social care services by councils fell by 7 per cent between 2009/10 and 2016/17 (The King's Fund *et al* 2017).<sup>3</sup> Demand for adult social care continues to grow, and local authorities – including London's boroughs – are therefore grappling with delivering services in very challenging circumstances.

### **Workforce pressures in London**

Workforce shortages in NHS and social care services are a problem across England, and London faces particular challenges. Vacancy rates for acute nursing posts averaged 15 per cent among NHS providers in London in 2017/18, compared to 10.1 per cent across the rest of the country (NHS Improvement 2018b). Vacancy rates for medical posts in London were closer

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<sup>2</sup> King's and Barts Health had operating incomes in excess of £1 billion in 2016/17. At the time of writing, 2017/18 financial accounts for these trusts were not publicly available.

<sup>3</sup> Measured on a gross expenditure basis, which accounts for spending by social care departments and includes client contributions.

to the average in other regions for 2017/18; however, the medical vacancy rate in community provision was substantially above average. There are similar shortages in social care, with a vacancy rate for direct care roles in adult social care of around 8.7 per cent in London compared to 7.3 per cent across England and there is a high turnover of staff in social care roles (26.1 per cent in London in 2016/17 compared to 31.2 per cent across England) (Skills for Care 2017).

The UK's vote to leave the European Union (EU) raises questions about the future supply of health and care staff across England, and London is particularly reliant on EU nationals. In March 2017, EU nationals made up 11.2 per cent of London's NHS workforce compared to 5.2 per cent of the total NHS workforce (NHS Digital 2017b).<sup>4</sup> The referendum result appears to be having an impact nationally; the number of nurses from European Economic Area (EEA) countries joining the Nursing and Midwifery Council (NMC) register fell by around 87.4 per cent between 2016/17 and 2017/18 (Nursing and Midwifery Council 2018).

In social care, 13 per cent of staff in direct care roles in London are from EEA (EEA) countries,<sup>5</sup> compared to 7 per cent nationally (Skills for Care 2017). While the long-term impact of leaving the EU remains to be seen, London's health and care system is unusually exposed to the consequences of an exit which sees migration fall sharply.

### ***What does this mean for London's STPs?***

The combination of these pressures creates a highly complex and challenging environment for STPs to operate within but also underlines the critical need for mechanisms through which health and care organisations can come together to plan services and manage resources. In the following section, we consider how London's STPs have approached this so far.

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<sup>4</sup> Headcount. Among staff working in trusts and CCGs with a recorded nationality and based on self-reported nationality.

<sup>5</sup> The EEA includes all EU member states plus Iceland, Lichtenstein and Norway.

## 3 What have STPs focused on?

Over the past year, STPs in London have focused their efforts on strengthening leadership and governance arrangements, building collaborative relationships and refreshing priorities. In this section, we provide an overview of the work undertaken.

### **Strengthening leadership and governance arrangements**

Putting in place the arrangements to support the implementation of STPs has been a key focus for London's STPs. This has involved work on developing STP leadership and management capability, internal governance and joint commissioning arrangements.

All five STPs have appointed single accountable officers across the CCGs in their footprints. The process of negotiating and implementing this change across constituent CCGs has been a key area of activity. There are some variations around the arrangements – for example, Croydon CCG (in South West London) and Lambeth CCG (in South East London) share an accountable officer despite being in different STPs.

Four of the five STPs have appointed the joint CCG accountable officer as the lead for their STP. North West London plans to create a separate post of STP lead. Some STPs have put in place a management infrastructure to support delivery, which includes a mixture of roles focused on STP-wide work, and roles focused on individual CCGs. For example, in North Central London, STP-wide directors of finance, strategy and acute commissioning have been appointed and work alongside chief operating officers for each of the constituent CCGs.

There have also been changes to commissioning arrangements to support collaborative working within STPs. The precise arrangements differ in each STP, with varying combinations of responsibilities aggregated to STP level.

- In North Central London a joint commissioning committee has been established, which has responsibility for commissioning acute services, learning disabilities contracting associated with the transforming care programme, urgent care services and specialised services not commissioned by NHS England.
- North East London has recently established a joint commissioning committee to plan some services at an STP level, including specialised and ambulance services and acute mental health beds
- South West London has a committee for collaborative decision-making with a remit covering service changes or commissioning plans that will affect the population of more than one CCG.
- In South East London a central team has assumed responsibility for acute contracting across the six CCGs.
- North West London plans to commission acute services, the bulk of mental health provision and NHS 111 services at STP level.

### **Building collaborative relationships**

Collaborative relationships are a prerequisite for delivering change, given that STPs lack any formal powers. Consequently, building these relationships across a wider range of organisations has been another key area of focus for London's STPs.

Given the leadership arrangements of London's STPs and the joint commissioning arrangements that are now in place, the level of CCG engagement is already high. STPs have therefore sought to facilitate greater collaboration with other partners, including providers and local authorities, some of whom have also encouraged collaborative working. This has included creating regular opportunities for these partners to come together and work to identify common priorities requiring collective action.

STPs have worked hard to involve acute providers, including adapting governance models to ensure that provider leaders are full participants (for example, in North Central London, where the central leadership team includes a provider chief executive) and appointing provider representatives to lead individual workstreams (including, for example, planned care, productivity, and digital). Similarly, in South East London, the STP 'leadership quartet'



includes a provider chief executive and some workstreams (for example, on urgent and emergency care) are being led by provider representatives. In North West London, the STP builds on provider–commissioner collaboration established through the Shaping a Healthier Future programme, a plan to reshape services across the footprint.

One of London’s distinctive characteristics is the presence of a number of major teaching hospitals and specialist services with national and international roles. These hospitals have unrivalled expertise and experienced leaders and staff who could make a substantial contribution to the work of STPs. The challenge has been how to engage them fully in the work that is taking place when their focus is often beyond their physical location, despite continuing efforts to do so.

STPs have undertaken a number of actions to strengthen relationships with local authorities, building on existing borough-based collaborations through health and wellbeing boards and other mechanisms. For example, we heard of local authorities being involved in priority-setting exercises and, in some cases, having formal roles in STP governance structures. In North Central London, some STP staff are located within local authority offices, helping to create a stronger connection with local government.

While some of the work to build collaborative relationships has taken place across whole STP areas, there has also been considerable work to build partnerships at a ‘sub-STP’ level. For example, in Merton (which sits within the South West London STP), NHS provider representatives (including acute, community and mental health) and CCGs have come together as a forum with the local authority and the GP federation to develop joint working across the borough. In most cases, relationships between NHS and local authorities were described as stronger at the level of individual CCGs and boroughs than across the STP as a whole.

We heard mixed views regarding the extent to which these efforts have borne fruit. For example, interviewees in North East London described a ‘positive shift’ in relationships between providers and commissioners, while in North Central London we heard that the STP was ‘moving from a plan to a proper partnership’ and that relationships between providers were ‘getting much better’. On the other hand, in South East London we were told that ‘there is not sufficient buy-in’ from all the partners involved, particularly among providers and local authorities.

Local authority involvement in STPs remains a key challenge in many areas, with significant barriers to progress (explored in the next section of this report). Much more work is needed to build mutual understanding between NHS and local authority colleagues, with one interviewee describing how 'there is still a lot of learning to be done. It's getting better but it's fundamentally about the different cultures' (director of public health, local authority). The perception that STPs are NHS-centric and in the early stages were focused on cuts in budgets and hospital beds has coloured the views of some councils and their willingness to get involved.

### Refreshing priorities

STPs have undertaken work to review their priorities and develop the next layer of operational detail about how these will be implemented (although at present, much of this is still at the planning stage). In aggregate, this has not led to major changes and many of their core aspirations remain consistent with those articulated in the original plans -- for example, around strengthening primary care and community services and doing more work on prevention. In a few cases, the partnerships have sharpened their focus around a small number of goals and have identified new priorities.

For example, North East London STP has identified outpatient transformation and primary care development as service priorities, as well as broadening its focus with a view to positively influencing a wider range of factors that affect residents' health, such as housing, green spaces and clean air. South West London has made efforts to improve ownership of proposals by undertaking a 'refresh' of their plan. As part of this, it published a discussion document in November 2017 with a view to then working with partners, including local authorities and NHS organisations, to produce 'Local health and care plans' in 2019, and an STP-wide clinical strategy. One interviewee described this as an attempt to 'effectively rewrite the transformation plan' (local authority representative).

In some areas the work of STPs has involved contributing to pan-London initiatives. For example, partnerships have fed into a programme of work focused on a common commissioning framework for general practice. Led by London-wide local medical committees (a representative group for GPs), NHS England and the Clinical Commissioning Council, the programme aims to support GPs in London to develop networks, work at scale and support the development of integrated care systems.

One area where the partnerships have departed from their original plans is in relation to the proposed changes to hospital bed numbers. During the first phase of this research we asked representatives of each STP about this aim and all were clear that, while they had not refreshed their plans, they were no longer working to the bed number and financial assumptions laid out in the published plans. STPs said they now plan to manage demand within current bed capacity by transforming services to 'do more with the same, rather than make absolute reductions' (STP representative).

All five STPs have spent considerable time and effort trying to reshape how they are perceived in response to criticism and concerns surrounding their initial development and the content of their plans. All have 'rebranded' their partnerships in an attempt to move on from this, and the partnerships now refer to themselves as:

- North London Partners in Health and Care (North Central London)
- East London Health and Care Partnership (North East London)
- North West London Health and Care Partnership
- Our Healthier South East London
- South West London Health and Care Partnership.

For clarity, we refer to all five as 'STPs' or 'partnerships' throughout this report.

Alongside setting local priorities, the partnerships have also responded to national priorities set out by NHS England – for example, around maternity services, mental health, primary care, cancer, urgent and emergency care – and we heard that NHS England had come to see STPs as a 'unit of delivery' for these priorities. Consequently, STPs' own priorities and organisation had evolved to reflect national agendas and establish mechanisms to oversee their delivery. As some providers' financial and performance positions have deteriorated, these have risen up STPs' agendas, and interviewees described an expectation from the regulators that STPs take ownership of these issues.

## 4 Other areas of progress in London's STPs

Having set out the main areas of focus for London's STPs over the past year, we now consider the extent to which they have made progress in several core areas. Drawing on the insights of those interviewed for this work, we report on progress in relation to: strengthening clinical and public engagement; delivering service change; developing more advanced models of integrated working. We also reflect on factors enabling progress among the STPs.

### **Strengthening public and clinical engagement**

Due to tight timelines, STPs around the country struggled to ensure meaningful wider engagement – with both the public and frontline staff – in the process of drafting their plans (Ham *et al* 2017a; Alderwick *et al* 2016). In recent months, London's STP have worked to overcome this.

#### ***Public engagement***

All STPs described work to strengthen public engagement over the past 12 months. For example, the South West London STP has placed a particular emphasis on improving patient and public engagement in response to concerns about the earlier stages of the process:

*The initial planning of the STP was woefully ignorant of the people they wanted to do these plans to, the community they wanted to serve... It was a gaping hole... Since then there is a lot more acknowledgement that we have to be bold.*

(Director of Public Health)

South West London STP has established an engagement and communication function, led by a Director of Communications and Engagement, which now co-ordinates NHS and local authority communications across the STP. As part of its 'refresh' process, the STP published a discussion document in November 2017, which was then used as the basis of a public discussion that lasted from November 2017 to February 2018. It has focused its engagement on specific priority areas such as children's mental health, recognising that conversations tend to be of a higher quality when they are 'specific' and 'about something that's real'. They have also taken a more local approach to involvement

through borough-level work, attending established patient engagement forums and working with local Healthwatch to convene events to facilitate dialogue with the public. This was described as a 'grassroots' approach to engagement. They have also published a report outlining the actions taken as a result of stakeholders' comments (South West London Health and Care Partnership 2017).

Other STPs have also focused their public engagement work at the sub-STP level. For example, South East London STP consulted on proposals to transform renal and cardiac services through a series of engagement events in each of the boroughs, leading to local tailoring of some of the plans. The general view among those we spoke to was that STPs still need to do more to develop a clear narrative about their 'offer' and the impact this will have on people receiving care.

Looking across the five areas, interviewees told us that public awareness of STPs is low. We also heard a view that this is inevitable and that engagement should focus on the specific service changes that are relevant and meaningful to members of the public, rather than STPs themselves: 'patients need to know what and how they are working on to change how care is delivered and what it means to them – it is not important to know it is part of the STP' (provider representative).

### ***Clinical engagement***

We heard mixed views in relation to the level and quality of clinical involvement in STPs. While CCGs are constituted to involve their member practices, most people we spoke to highlighted this as an area that requires further attention.

Clinical engagement was felt to be particularly important in relation to designing and implementing service changes. We heard several examples of STPs developing formal mechanisms for improving engagement among local clinicians, including an extended 'clinical senate' involving a range of professional groups in South West London and a 'health and care clinical cabinet' in North Central London. While progress has generally been made on engaging senior clinicians, there is more to do in engaging the wider clinical workforce, although we heard that an initiative to address this had recently been launched, led by the regional medical directors and regional chief nurse.

A common concern raised by those interviewed was that primary care staff had not been sufficiently involved in the work to date. Some interviewees

described the challenge of engaging GPs as they are a dispersed group spread across many settings; however, one interviewee described that the challenges this presented were being used 'an excuse for not engaging with the difficult conversations' (local authority representative) with this group and another reported that STPs 'don't understand primary care' (primary care representative).

Some STPs have developed mechanisms to involve GPs on a more formal basis – for example, by including GP federations (which are increasingly common across London) in STP governance arrangements and identifying 'lead GPs' for smaller areas within an STP who are tasked with disseminating information among colleagues.

### **Delivering service change**

Compared to the progress that has been made in developing the partnerships and on strengthening collaboration and relationships within them, there is much less evidence of STPs delivering on planned service changes.

Opinions among interviewees varied on the extent to which this was avoidable. Some felt it was to be expected given the stage of STPs' development and their focus on developing the internal workings of the partnerships and managing day-to-day financial and performance issues in NHS organisations. Others expressed disappointment at the lack of progress, with one interviewee describing change as being made 'in baby steps'.

Notwithstanding this, all STPs were able to point to evidence of some specific service changes over the past year which focused on strengthening primary care. For example, the South East London STP has done work to redesign primary care, with all general practices in the footprint now working at scale through federations and networks. Interviewees in South West London described developments in primary care in Merton and innovative work being done by the GP federation.

North East London STP described improvements in maternity services and changes to primary care services, including implementing integrated community teams and initiatives to tackle workforce shortages by employing pharmacists in GP practices. Interviewees in North Central London described having made progress in redesigning urgent and emergency care pathways across the STP. North West London STP has rolled out a 'discharge to assess' process for patients leaving hospital.

A number of STPs are focusing on delivering service change through reconfigurations of acute services – for example, North Central London is working to centralise elective orthopaedic services. Significant reconfigurations are planned in some areas, often building on plans that predate the STP, including developments relating to Imperial in North West London and Epsom and St Helier in South West London. Work to take forward the reconfiguration plans in South West London includes an equality impact assessment of the planned reconfiguration. Given the contentious nature of reconfiguring acute services, several STPs described progress as being slower than planned.

Service changes are most often taking place below the level of STPs – for example, in individual boroughs or neighbourhoods, although in many cases these are supported by STPs. Some STPs reported progress in spreading good practice – for example, the changes to primary care in the North East London STP built on models developed in Tower Hamlets and Hackney. Illustrative examples of service changes in each of the five STPs are provided in the box which follows.

### **Case study 1: working at a borough level**

#### *Spreading the Sutton red bag across the South West London STP*

Sutton introduced the 'red bag' (or hospital transfer pathway) innovation, working with more than 80 care homes as well as the ambulance service, social services and hospitals to provide more joined-up care to people living in care homes in the borough. When a resident becomes unwell and is assessed as needing hospital care, care home staff pack a dedicated red bag that includes the resident's standardised paperwork, their medication, clothes for discharge and other personal items. Part of the standardised paperwork includes a 'This is Me' leaflet, which contains personal information unique to that resident – including likes and dislikes – which can be particularly important for those care home residents with dementia. The bag is then handed to ambulance staff, who pass it to hospital staff on arrival. When patients are ready to go home, a copy of their discharge summary is placed in the red bag so that care home staff have access to this information when their residents arrive back home.

This simple initiative has also helped improve the discharge process and has been reported as reducing residents' average length of stay in hospital by four days (South West London STP 2016), saving £167,000 a year. Increased multidisciplinary working and training has led to a significant reduction in

unnecessary ambulance call-outs and hospital admissions. The initiative is now being introduced into Merton nursing and residential homes for older residents and the plan is to roll it out to other boroughs across the STP as well as nationally.

### **Case study 2: an STP-wide initiative**

#### *Integrated urgent care in North East London STP*

Since 1 August 2018, people in North East London have had access to free clinical support and assessment at any time of day or night under the new NHS 111 Clinical Assessment Service. Commissioned by the North East London Commissioning Alliance (the seven CCGs in North East London) and provided by the London Ambulance Service, the service provides a single point of access to local urgent care services, enabling people to receive urgent advice over the phone from GPs, nurses, paramedics and pharmacists 24 hours a day.

The service provides:

- urgent care advice or treatment outside of normal GP practice opening hours
- assessments over the phone – along with advice or treatment recommendations from a range of health professionals if required
- direct booking appointments
- the ability to prescribe medicines over the phone if necessary
- transfer to mental health crisis services if necessary
- easy access to patients' records and care plans.

It is hoped that the service will improve patient care and experience as well as better manage demand across the system. The benefits of bringing the seven CCGs together to commission this service include the ability to procure on a 'critical mass' level and the seven CCGs being able to pool their clinical, technical and commissioning expertise.

### **Case study 3: an STP-wide initiative**

#### *Treating mental and physical health equally in South East London*

One of South East London STP's priorities is to treat mental and physical health equally. Currently, access to certain evidence-based treatments needs to be significantly improved and needs to be available across all boroughs. To tackle this, organisations across the area are collaborating to develop a



consistent approach to recognising and supporting people with mental health needs. Specific aims include ensuring that all health and care services in the STP target those most at risk of developing a mental health problem, provide preventive care, identify issues early, and give timely access to specialist assessment and advice when needed.

A particular area of focus has been out-of-area placements. In 2017/18, the STP committed to reduce these to zero by June 2019, which it is currently on track to deliver. To help deliver this, in February 2018 the STP facilitated a South East London-wide workshop for provider and commissioning leads to address system challenges and agree how best to use expertise across the system. This focus on out-of-area placements has been supported by work to improve crisis management in the community and wraparound services for patients, including crisis recovery home treatment teams, crisis cafés and telephone helplines for patients and carers.

Achievements to date include improved access to specialist perinatal provision in Lambeth, Lewisham and Southwark and implementation of the Early Intervention Psychosis two-week access standard across all six of the STPs' CCGs.

### **Case study 4: an example of multi-borough level work**

*'Street triage': local integration in North West London*

Working with boroughs across the footprint, Central and North West London NHS Foundation Trust and West London Mental Health Trust have introduced a 24-hour inter-agency triage scheme to support people experiencing mental health crises that require the support of both police and mental health professionals.

Since the scheme was introduced in January 2018, police officers can call a single point of access (SPA) team for advice from a mental health professional when they are concerned about the mental health of a person they are attending. Support from the single point of access team may include making a referral to the mental health crisis resolution team or rapid response team, who are then able to attend the scene if necessary to provide further support, assessment and advice. This ensures that people get the health care they need as quickly as possible, as well as reducing the need for police to use the section 136 Mental Health Act to remove vulnerable people to a place of safety while they await assessment by a mental health professional.

The goals of the service are to enhance professional assurance and support, improve clinical outcomes and patient experience, and use resources more efficiently and effectively.

**Case study 5: working below the level of STP**

*Improving care for people with diabetes in Haringey and Islington (part of North Central London STP)*

As part of North Central London STP's proposals, the Haringey and Islington Wellbeing Partnership (consisting of Haringey and Islington local authorities, Islington and Haringey CCGs, Whittington Health NHS Trust and Camden and Islington NHS Foundation Trust, and Barnet, Enfield and Haringey Mental Health NHS Trust) has prioritised improving care for the 25,000 adults living with diabetes in the two boroughs with the aim of:

- reducing variation in the quality of care
- improving patient experience and co-ordination of care
- increasing investment in community and primary care for diabetes
- increasing the uptake of structured education to support people with type 2 diabetes to self-manage
- increasing the proportion of people with diabetes who are meeting their three key treatment targets (controlled blood pressure, controlled blood sugars and controlled cholesterol).

The partnership has already delivered some successes. For example, GP practices are now financially supported to undertake annual reviews for patients with diabetes in the two boroughs. A new diabetes prevention programme has also been rolled out, providing lifestyle support for people with pre-diabetes. The programme has already received more than 3,000 referrals.

Future actions include forming quality improvement teams in primary care (to be supported by transformation funds from NHS England). The partnership is also piloting new pathways to support improved mental wellbeing in people with diabetes.

The service changes described above reflect some of the priorities that we identified in our initial review of London's STP plans (Ham *et al* 2017b),

particularly in relation to strengthening and redesigning primary and community services and reconfiguring acute and specialised services.

STP plans also highlighted improvements to social care services as a priority area; however, we found little evidence of specific progress in this area. We heard that STPs have been 'NHS-focused' and that where there has been an emphasis on social care, this has often been limited to addressing delayed transfers of care in line with national NHS priorities. Some STPs felt that there were fundamental reasons for their lack of progress in this area, principally the impact of cuts to local authority budgets.

### Prevention

Our previous review of STPs identified a range of ambitions to prioritise prevention and reduce inequalities. We heard from interviewees that directors of public health have contributed substantially to STPs' prevention agendas. Notwithstanding the fact that some people felt this was positive, we also heard that, for different reasons, more work is required.

One example of progress is the refresh of priorities in North East London, which included the STP broadening its emphasis with a view to positively influencing a wider range of factors that affect residents' health, such as housing, green spaces and clean air. South West London has also made this a central objective of its refresh, and all partners in the STP have committed to a shared health promotion priority – children and young people's mental health – as it was felt that this is a specific area of need where all partners can work together to have the greatest impact.

Most people we spoke to felt that more work was needed on prevention and health inequalities. Some interviewees suggested that STPs are not the best level for this work, with more scope for progress in individual boroughs, in some cases, building on the work of health and wellbeing boards, and some initiatives being led across London as a whole. Others recognised the opportunity associated with STPs but felt that rather than prevention informing their agenda, it had been somewhat siloed to date.

As one interviewee from a national body put it, 'My concern... is that it [prevention] is still not in the DNA of the STP as a whole'. One of the reasons may be that responsibility for public health was transferred from the NHS to local authorities in 2013 and in London is now led by 33 boroughs (including the City of London Corporation). While there is much expertise across the

capital, including in Public Health England, it can be difficult to make best use of this expertise in partnerships like STPs that are still relatively new and have focused much of their work to date on the NHS.

We were also told that work on prevention has tended to be crowded out by a focus on short-term operational issues and that the financial position of local authorities and the NHS has impacted on STPs' ability to invest in prevention despite their best intentions to do so.

### **Developing integrated care partnerships and systems**

STPs have identified a number of levels of activity at which work on integration and service change will take place, reflecting the development of integrated care partnerships within STPs and ICSs elsewhere in England.

For example, in North East London, three sub-systems have been identified that will form the basis of efforts to develop integrated care partnerships. In South East London, 'local care partnerships' will operate on borough geographies and in South West London, four local health and care transformation boards have been formed. There are also many examples of well-established integrated working arrangements in boroughs and neighbourhoods across London – for example, in Tower Hamlets, Hillingdon and Croydon (see box below).

#### **Initiatives to integrate care**

##### *Hillingdon Health and Care Partners, North West London*

In Hillingdon, an integrated care partnership (previously referred to as an accountable care partnership) is bringing together the local acute provider, Hillingdon Hospitals NHS Foundation Trust, the community and mental health provider, Central and North West London NHS Foundation Trust, the borough's GP federation, a community interest company comprising voluntary sector organisations, and the local CCG. The partnership's priority is to provide more co-ordinated care for people aged 65 plus that relies less on hospital care and improves patients' experiences and outcomes. An example of service change includes the rollout, following a pilot, of care connection teams – multidisciplinary teams, informed by integrated care providers in other countries, which plan health and social care for older people who are at risk of needing hospital care.

While the partnership's governance model is still being refined, initially it is being managed through alliance agreements. The intention had been to move to a capitated budget in 2018/19, but that is yet to happen due to ongoing discussion about financial arrangements.

### *Tower Hamlets, North East London*

Building on a number of previous integration programmes in the area, the Tower Hamlets Together multispecialty community provider vanguard has introduced a number of initiatives to join up health and care services, with a particular focus on residents with complex health and social care needs, public health initiatives and children's services. The partnership includes an alliance between the CCG, the local NHS trusts and the GP Care Group (a community interest company of all 36 practices in Tower Hamlets) that jointly holds the contract for community health services.

Initiatives led by the partnership include a community geriatrician post, a pilot of a new model of community nursing (based on the Buurtzorg model from the Netherlands), and a new consultant-led virtual community renal service, which gives GPs direct access to specialist advice. It has been reported that this service has helped to reduce the average wait for a clinic appointment from 64 to 5 days.

### *One Croydon Alliance, South West London*

The One Croydon Alliance is a partnership between local NHS providers, Croydon Council and Age UK Croydon, established to integrate services to improve how they work for patients and the community. All six organisations in the borough are working together: Croydon Clinical Commissioning Group (CCG), Croydon Council, Croydon GP Collaborative, Croydon Health Services NHS Trust, South London and Maudsley NHS Foundation Trust, and Age UK Croydon. Initially this focused on improving the health and wellbeing of older people in the borough with the aim being to break the cycle of hospital admissions for people over 65 with long-term conditions by providing personalised care closer to home and support to live more independently.

By shifting expenditure from delivering acute care towards prevention work and support in the community, initial successes have included fewer patients needing care packages for longer than six weeks after leaving hospital and a 20 per cent reduction in the length of hospital stays. In the project's initial three months, more than 450 residents either had a reduced length of stay in

hospital or avoided admission altogether. This helped to reduce costs for adult social care, which were reinvested in other services locally.

The alliance is now expanding to work on all ages. It is also exploring formalising the integration of the health bodies to further develop the opportunities of integrating health and care.

Some STPs are beginning to describe themselves as 'integrated care systems', reflecting the national move towards this terminology. And some are exploring how financial arrangements could incentivise both providers and commissioners to take steps that are sensible from a system perspective.

However, while it is clear that STPs have ambitions to develop their capabilities and responsibilities in this way, there appears to be some way to go before they will be in a position to take on the additional freedoms and responsibilities of an ICS (including taking on a system control total, for example). One interviewee described their system as being 'quite a long way from a health economy that would voluntarily move towards an ICS'. Another described London's STPs as being 'behind the curve compared to other parts of the country' in implementing ambitions to create ICSs, but the desire to do so and planning for that to happen remains strong.

Based on the insights of those we interviewed, South East London and North East London appear to be the furthest ahead in their thinking around how integrated care systems could operate locally. For example, South East London has set out ambitions for an ICS based around multiple levels of integration: borough-based integration of primary care, community and social care services; horizontal provider collaboration of acute services across the footprint; and joint working among providers of specialised services (including mental health) covering South East London and beyond.

Questions were raised by interviewees over whether the current STP geographies are suitable for developing an ICS, with some suggesting that smaller areas within STPs would be a more suitable footprint. A common view among those we spoke to was that integrated systems in London will need to operate as 'systems within systems' given the size and complexities of these health and care economies. There is some evidence of this work starting, in particular in South East London.

We heard that although there was generally ambition across London to develop ICSs, there was a lack of clarity about how to 'translate it into

reality', with some suggesting it would be helpful to get more assistance from the national bodies with this.

### Enablers

Looking across the progress that STPs have made in the past year or so, a few key enablers stand out as making change possible.

- Local leaders (particularly clinical leaders) who are committed to improving local services, and effective working relationships (among providers, between providers and commissioners and between NHS and local government organisations) underpinned by a sense of shared purpose across different organisations all help.
- The presence of pre-existing integrated working arrangements – for example, through health and wellbeing boards – was described as important in providing a foundation for STPs to build on. These arrangements were often described as being more established within individual boroughs and neighbourhoods than at the level of STPs.
- Where progress had been made at STP level, we heard that this had been supported by having a clear rationale for undertaking work at this scale – for example, in relation to developing estates strategies.
- Capacity and capability within STPs were also identified as important in driving progress – for example, putting in place a management team at STP level in North Central London was described as leading to 'a real step change in focus and delivery'.

### In summary

While STPs have worked hard to strengthen public and clinical engagement over the past 12 months there is much more to do. There are many examples of improved service models being developed, usually in boroughs and neighbourhoods. The challenge for STPs is to build on this progress to bring about large-scale improvements in service delivery.

## 5 What challenges have STPs faced?

London's STPs have faced a number of barriers to progress.

### **Financial, performance and workforce issues are crowding out work on transformation**

STPs in London as well as across the country are finding it difficult to balance the short-to medium-term focus on clinical and financial sustainability with their intended role as delivery agents for long-term, strategic change. In the face of growing and sometimes severe pressures, NHS organisations have understandably focused on their own performance and this has made it difficult to give priority to partnership working.

Substantial time has been spent trying to manage financial problems among providers, and the scale of deficits in some providers has overwhelmed the STP agenda at times. Growing workforce shortages are also a major challenge. We heard that operational pressures absorbed substantial time and energy over winter, with a particular focus on performance against the four-hour emergency care standard.

It is not only NHS organisations that are struggling to balance day-to-day pressures with strategic change. Substantial cuts to local authority budgets and local elections (which took place in May 2018) have impacted on their capacity to engage with their STP even where there is enthusiasm to do so.

### **STPs are struggling to find sufficient resources to support transformation**

We were told that the pressures services are currently under make it difficult for STPs to invest now to make changes in the future. Limitations on capital funding were identified as a particular issue in relation to developing the premises and infrastructure needed to support new models of primary care and integrated community services.



Some interviewees told us that there are several investment streams available to support transformation, For example, through the Healthy London Partnership, AHSNs, and Collaborations for Leadership in Applied Health Research and Care. However, there is a lack of alignment between them and these different funding sources could deliver better value if they were more closely connected.

Some STPs – including North West and South West London – were working to bring together a pot of transformation funding through sourcing contributions from organisations across their patches. Others had made successful bids for targeted resources – for example, North East London received funding in support of its digital transformation and workforce programmes. The absence of ICSs in London means that the capital has not benefited from the additional support provided to some of these systems.

### **The nature of STPs has made it difficult for local authorities to engage**

A strong message from many of our interviews was that STPs have historically been a ‘toxic brand’ among some stakeholders both in the NHS and local government in London. This was closely linked to the shortcomings in the early stages of the STP process described previously.

The scale of financial and demographic pressures in London meant that assumptions around financial savings and bed numbers in the initial plans were more unpalatable than they were in some other areas of the country. Even though STPs had now moved away from these proposals, there is still a perception from some that they are vehicles for cuts. These concerns are particularly prominent among some local authority partners.

Local authority involvement has also been held back by a perception that STPs are NHS-centric. We heard from local authority representatives that they are still seen as ‘NHS beasts’ that are ‘top-down whereas local authority work is bottom-up’. Another interviewee (regional health body representative) told us that ‘the NHS launched this stuff and local authorities had to join... That has always been the fracture point’.

### **STPs lack a clear vision that is shared by partners across the system**

Based on the interviews conducted for this work, there does not appear to be a clear shared view on the future direction of travel in each area with

collective ownership across different organisations. There are some areas of agreement – for example, around the need to join up fragmented services and improve services based in the community. However, there was not a consistent sense of an agreed understanding of how different partners would work together to get there.

We heard that there is not a clear enough narrative around how STPs are expected to benefit local residents or staff. One reason is that STPs started by responding to national NHS priorities rather than involving local people in conversations about what matters to them. This contrasts with some of the borough-level improvement work, which has focused on the needs of the local community and has been more conducive to creating common purpose across organisations.

While there was consensus around the value of partnership working at the level of individual boroughs as well as collaboration across London as a whole, there was less agreement around the functions and value of an intermediate tier. One interviewee went so far as to raise concerns that STPs ‘risk taking away from the more important units of planning and delivery’ (primary care representative). Some interviewees see STPs as artificial constructs that have been centrally imposed: ‘it’s very much an artificial administrative unit, there’s no love attached to the STP – it’s not like a county or a borough – it doesn’t have much glue within it’ (provider representative).

There is not only a lack of clarity around the agreed direction of travel but in some cases fundamental disagreement between partners about what it should be. This is particularly true where contentious acute reconfigurations are planned. For example, in North West London, two councils (Ealing and Hammersmith and Fulham) are opposed to the Shaping a Healthier Future programme, which concerns the future of Charing Cross and Ealing Hospitals. As a result, these councils have not been able to sign up to the STP, and we were told that they have ‘no shared agenda’ with the CCGs.

We heard that ‘heavyweight political issues’ had been an obstacle to local government engagement in some cases, including examples of local politicians who are fundamentally opposed to the STP agenda. There has been some political opposition in relation to concerns about the potential for privatisation of services, driven by debates around the potential introduction of an ‘accountable care organisation’ contract. All STPs have a mixed political complexion among their constituent local authorities, presenting challenges of working collectively when councils may not always see eye to eye.

## Translating current national policy initiatives into London is not straightforward

As described earlier, the health and care system in London is more complex than others across the country due to the size and diversity of its population and the number and range of health and care organisations involved. Complex patient flows and interdependencies across providers, and the presence of centres of excellence for teaching and research and specialist service provision add to the complexity. The number of organisations, overlapping boundaries and 'different cultures of care' make relationships complex and multilateral, making it difficult to provide system leadership at the level of an STP.

The complexity of the London system means that it is challenging to identify a geography for the STPs that makes sense to all the different partners involved, an issue that dates back to well before the inception of STPs. Some interviewees contrasted this with integrated systems that have developed around a 'natural' geography where many of the organisations are coterminous and the patient flows are relatively contained. We heard differing opinions in relation to the current STP footprints and whether they are appropriate. Despite these concerns, some warned against attempting to redraw the boundaries as 'they will never be right for everything'.

A common view held by those interviewed for this work was that insufficient attention has been paid to this by national and regional leaders. One interviewee expressed the view that 'national policy on integrated care has found London inconvenient,' that it 'just pretends London doesn't exist,' and that 'no one has managed to get to grip with that complexity and what that means for integrated care' (provider representative). This underlines the challenge of making place-based working effective in a global city where some providers serve patients from many areas.

Teaching hospitals have a potentially important part to play in STPs, but their national and sometimes international orientation does not make this easy. These hospitals and their staff are major assets and their engagement in STPs in the next phase of development needs to receive much more attention than hitherto. The experience of the Montefiore Health System in New York demonstrates how an academic medical centre in a quite different context has been able to reach beyond the walls of its hospitals and play a leadership role in integrating care and improving population health (Collins 2018).

## **The current system architecture does not support collaborative working**

London's STPs face the same challenges as systems elsewhere in the country, namely the difficulty of collaborating in the context of a legislative framework and system architecture that was designed around autonomous organisations competing with one another. The statutory accountabilities of individual organisations can conflict with system objectives, and STPs have no formal authority to bring about change.

The current approach to NHS regulation focuses on organisational performance rather than looking across pathways or systems, and the behaviours and priorities modelled by the regulators often run counter to broader system interests (Care Quality Commission 2018). These tensions are particularly evident in London due to the financial and operational issues in some of London's providers.

We heard that the regulators were using STPs as one of the mechanisms through which they can manage these issues and that STPs are seen by some as being 'London outposts' of the regulators. Regulatory behaviours can act as a barrier to individual organisations' engagement in their STP, particularly for providers in special measures: '[Our relationship with NHS Improvement] is national not regional and it's about the organisation not the system. That's the principal dynamic between us and NHSI and any system conversation you try to have is second order to that' (provider representative).

We also heard that many of the relationships between London providers continue to be competitive, while those between providers and commissioners are often still transactional in nature: 'it's quite difficult to go from an adversarial position where you're arguing constantly over contracts to one where we're all on the same side – it's not going to happen quickly' (provider representative).

## 6 How do STPs fit into the wider London context?

As The King's Fund has outlined elsewhere (see Naylor and Buck 2018), cities are becoming increasingly important in promoting their residents' health and wellbeing. Crucial to maximising their impact is co-ordinated action at multiple levels.

A key question for STPs is how they relate to the structures that exist to co-ordinate health and care across London. This includes organisations and partnerships that operate at a more local level than STPs, as well as those that operate at a London-wide level. This section sets out findings regarding how STPs fit into this landscape and how the existing architecture is functioning.

### **Multiple levels of integration**

There was widespread recognition among our interviewees that STPs represent just one level of collaborative working. Much of the work that is taking place to improve and join up service delivery is happening at the level of local partnerships in single boroughs or between boroughs (with health and wellbeing boards and health overview and scrutiny committees playing a valuable role in some cases).

There was a common view that boroughs provide natural geographies or populations around which to plan and organise service delivery and that most of the 'activity and energy' around service transformation sits at this level. There are many examples of innovative service models being developed within these 'sub-STP'-level partnerships, including the examples set out earlier in this report.

There is widespread agreement that STPs should seek to build on and support this work, acting as 'co-ordinators of borough-based improvement'. STPs were also seen as having a role in undertaking work that requires action across bigger footprints than individual boroughs or collaborations between boroughs. Examples include managing estates, workforce and some specialist service reconfigurations.

These findings echo those of our work into the development of STPs and ICSs elsewhere in the country, where large integrated systems usually contain several smaller sub-systems within them (often based around well-established geographical groupings) and where much of the activity to transform and improve services takes place (see Charles *et al* 2018 and Alderwick *et al* 2016 for examples).

Some of those interviewed for this work suggested that these sub-systems should play an even greater role in London's STPs than elsewhere due to the scale and complexity of the London system. This was summarised by one local authority representative who explained that, 'the actual number of players is far larger than you tend to see in an out-of-London context. Getting things done therefore requires you working at a lower level than the STP.'

In addition to 'place-based' integration, there are examples of provider collaborations across the capital. Examples include Royal Free London NHS Foundation Trust's group model in North Central London, the Guy's and St Thomas' Healthcare Alliance with Dartford and Gravesham NHS Trust in South East London, and a newly formed provider collaboration in South West London. Innovations in services are to be found in these provider collaborations as well as in borough-based collaborations.

### **London-wide leadership**

Although our work was focused on STPs, the state of London-wide leadership, both vis-à-vis the NHS and local government, was raised by interviewees. A number of themes emerged from these reflections.

First, stakeholders were unanimous in recognising the need for some functions to take place at a London-wide level (indeed, some saw London as a more meaningful footprint than STPs). For example, one CCG accountable officer reported that 'there is a recognition that lots of things need to happen on a London level', and an STP representative reflected that 'on the right things the added clout of the Mayor, the health system and the local authorities working together is great'.

The precise combination of responsibilities that should sit at the London level was subject to some debate, but they include estates, workforce, public health and prevention and support for digital initiatives too. While interviewees recognised that the input of Health Education England and Public Health England will be important to at least two of these areas, there were

mixed views on how well these organisations were currently influencing and supporting the London agenda.

The health and care devolution arrangements in London are still evolving, having been introduced only relatively recently (as one senior commissioner said, 'I think it will take time to get that into the right place'). Notwithstanding this, interviewees' recognition of the need for effective London-wide leadership for health and care often went hand in hand with a perception that the existing collection of pan-London bodies was not providing this.

Interviewees representing different parts of the system articulated a sense that rather than being mutually reinforcing, the concurrent work of multiple organisations is leading to a lack of clarity and co-ordination regarding their different roles and priorities and, in some cases, duplication.

*I think as far as the greater London context, I think it's a complete vacuum; I don't see any context.*

(Provider representative)

*I think there is a lot going on in London at the moment, but there is a real issue for us pulling together as a city in the way that, for example, Manchester or Liverpool or Newcastle is able to do.*

(Director of public health)

*I think there's been a bit of a disconnect sometimes between what's been happening at a London level versus what is happening at a [STP footprint] level and a borough level.*

(CCG representative)

The Healthy London Partnership was cited as an example of a team working across London where more could be done to clarify its contribution working with STPs and pan-London bodies. A CCG representative commented:

*We did a big review of [the Healthy London Partnership] last year, and it probably needs to be further reviewed. But we probably still need a place where we come together to do one for London-type things... But it probably has slightly drifted and hence our ability to articulate a strategy for better health for London has slightly got lost in the mists of time.*

Another interviewee observed that the Healthy London Partnership was established at a time when the 32 CCGs of London operated relatively autonomously, whereas today joint leadership arrangements in most CCGs call for an adapted form of pan-London co-ordination.

Some interviewees commented that leadership of the NHS in London has been less directive but more fragmented than previously. Current arrangements, including the division of responsibilities between NHS England and NHS Improvement, were contrasted with NHS London, the strategic health authority (abolished in 2013), which was felt to have had a greater opportunity to provide strategic leadership across the city.

One provider representative commented that, 'I think the lack of a strategy for London since the SHA went whenever it was... has left nothing in its place.' Views such as this contributed to a sense of a growing strategic vacuum in the NHS in London. We understand that the Strategic Partnership Board has discussed this and agreed that work needs to be done to fill this vacuum and provide greater clarity on the vision for the future.

Stakeholders were generally positive about the recent announcement that the responsibilities of NHS England and NHS Improvement will be brought together under a single London regional director, with aligned regulatory functions (NHS England 2018a). Interviewees felt that this presents an opportunity to bring greater coherence to the London agenda and help to build on the work that both regulators have done while working within the constraints of the current statutory environment.

Despite having limited direct powers in relation to health care, interviewees recognised that the Mayor occupies an influential position with potential to provide leadership in contributing to setting a health and care agenda for the whole city. Prevention and inequalities were identified as areas where the Mayor's influence is already having a positive impact. Some interviewees expressed a desire for the Mayor to do more.

As one director of public health commented, 'the things I've seen coming from the Mayor's Office are not as you would in other major cities [for example] Los Angeles, New York, etc. London is relatively quiet from the Mayor's Office.' In relation to this comment, it is worth noting that mayors in global cities often have responsibility for a larger portfolio of policy areas than the Mayor of London and some revenue-raising powers.



Many interviewees wanted to see closer partnership between the health system, the Mayor and the GLA. A senior commissioner, for instance, commented, 'I personally believe closer working with the GLA around health issues is absolutely critical'. Interviewees also expressed a desire for greater coherence between the work of the Mayor and the GLA, boroughs and the NHS organisations. Others were clear that the Strategic Partnership Board, which will be co-chaired in future by the new regional director for London of NHS England and NHS Improvement (rather than the regional director of NHS England) and local authority leadership, would be their preferred approach to co-ordinating this joint work.

### **In summary**

Interviewees were in agreement that London needs mechanisms to bring key stakeholders together to provide leadership across the capital on key issues. However, London's existing arrangements have resulted in a complex and cluttered environment with the sense of a growing strategic vacuum around the future direction for health and care, which has been recognised by the Strategic Partnership Board.

The imminent appointment of a London regional director for NHS England and NHS Improvement is widely viewed as an opportunity to address this. Closer alignment between the new NHS London region and existing structures such as the London Health Board and the Strategic Partnership Board will be important in supporting London's health and care system to meet future needs.

## 7 Conclusions and recommendations

Our work shows that London's STPs have spent much of the past year trying to overcome the challenging process by which they were introduced. This has required their leaders to focus mainly on the internal workings of the partnerships, strengthening relationships with organisations within the footprints, and addressing gaps in staff and public engagement. The original plans to reduce the number of hospital beds in some STPs are no longer being pursued as it is recognised that they were unrealistic in the face of growing demand on services and population growth.

STPs have continued to evolve in a challenging environment for both the NHS and local government. As in the rest of the country, financial and service pressures have increased, and some NHS organisations have understandably focused on their own performance rather than giving priority to partnership working. The uncertainty associated with Brexit appears to be having an impact on the recruitment and retention of nurses from the EU (Nursing and Midwifery Council 2018). This may be a particular challenge for London because of its greater reliance on staff from the EU.

Despite these challenges, there are many examples of service changes taking place across London. These are often occurring in individual boroughs or across boroughs through partnerships between NHS providers, commissioners and local authorities, supported by STPs. Many of these changes are seeking to integrate health and care services to improve the outcomes and experiences of patients and service users. The establishment of hospital groups around some of London's teaching hospitals has been another source of innovation.

London has many assets in the public and private sectors and the recommendations that follow should be read with this in mind. The challenge is to harness the commitment of leaders across all sectors and of staff delivering services to improve the outcomes and experiences of Londoners. This means drawing on the contribution of people and communities themselves as well as finding more effective ways of using the resources controlled by the NHS and local government.

STPs have an important part to play in making this happen and they need to work closely with others to realise the potential that exists. The recommendations that follow have been framed with this in mind, recognising the contribution of local authorities, the Mayor, NHS bodies and other stakeholders in working with STPs to make the best use of all the resources that exist.

### Recommendations

*STPs must build on the work they are doing to improve services and communicate this effectively*

There is widespread recognition that London's STPs need to more clearly demonstrate that they are contributing to improving health and care. The challenge they face is how to do so when they are seen by some stakeholders as artificial constructs and are viewed in parts of local government as a toxic brand as a result of the process by which they were introduced. There is also a perception that STPs are NHS-centric and that local authorities and third sector organisations have not yet been involved as equal partners. Where STPs are making a positive impact, they need to communicate this more effectively.

*STPs must continue to build capabilities to bring about improvements*

The King's Fund's progress report on integrated care systems in England has outlined what needs to happen across the country to build on the foundations that have been laid to deliver improvements in health and care (Charles *et al* 2018). The recommendations in that report should be adapted to London's distinctive characteristics to support STPs to make further progress. They include:

- continuing to strengthen relationships both within the NHS and with key stakeholders
- engaging fully with staff and the public with a particular emphasis on the engagement of frontline clinical teams
- developing collective and distributed leadership and ensuring that STP leaders have dedicated time to fulfil their roles

- strengthening the governance of STPs and ensuring that their work does not conflict with the accountabilities of NHS organisations and local authorities
- recognising the importance of working through neighbourhoods and places as well as systems to make an impact
- focusing the work of STPs on those issues that are best dealt with at the level of systems such as estates, workforce, digital and IT, and specialised services (which sometimes will require collaboration between STPs).

### *Teaching hospitals need to be fully engaged in the work of STPs*

The presence of several major teaching hospitals in London presents a challenge and an opportunity to place-based working. Leaders of these hospitals have contributed to the work of STPs, but much more needs to be done to draw on their expertise. The challenge is how to do so when teaching hospitals serve patients from both the communities where they are located and areas across London and the rest of England. The experience of the Montefiore Health System in New York demonstrates how an academic medical centre can play a role in integrating care and improving population health, and the lessons from this example need to be studied and acted on.

### *Local authority engagement is key to the success of STPs*

While London's STPs have sought to strengthen relationships with local authorities, their involvement remains a challenge in some parts of the capital. Although there are often barriers to greater participation by local authorities, these must be overcome if STPs are to deliver meaningful improvements to health and care for patients. Local authority engagement is essential in achieving closer integration of health and social care, improving population health and strengthening links with people and communities, learning from places like Greater Manchester where local authorities are fully engaged in this work.

### *Population health needs more attention in the work of STPs*

STPs and ICSs across England need to give greater priority to action on the wider determinants of health and health inequalities. In the case of London, the Mayor has a leadership role on population health and this is being pursued through work on the health inequalities strategy and embedding health objectives in other policies. This work must be adequately resourced – if necessary through a strengthened public health function across London

(Naylor and Buck 2018). Closer collaboration between the Mayor, STPs, Public Health England (London) and boroughs is needed and there are important lessons from areas outside London, like Wigan, which are leading the way (Ham and Murray 2018).

### *Resources and expertise of other bodies must be aligned with STPs*

STPs are developing in the context of complex organisational arrangements within both the NHS and local government. A wide variety of bodies are involved in supporting improvements in health and care, including academic health science centres and networks, the Healthy London Partnership, the London Clinical Commissioning Council, commissioning support units, Public Health England (London) and local education and training boards. The time is right to review how these bodies work and how their resources and expertise can be better aligned with STPs and work on population health. Making better use of resources and expertise in public health should be a high priority.

### *London-wide governance arrangements should be reviewed to ensure they are working effectively*

Now is also the time to ensure that London-wide governance arrangements are working effectively. This means reviewing the role of the London Health Board, the Strategic Partnership Board, the new joint NHS England/Improvement regional office, and boards that have been established to lead on the workforce, estates, digital and prevention. These boards have a potentially important role in co-ordinating work across STPs and bringing together NHS and local government leaders on issues that would benefit from a London-wide approach. It is essential that they have a clear focus and that their membership reflects the work they are doing (Naylor and Buck 2018).

### *A clear and compelling vision for the future of health and care in London is needed*

The reviews led by Lord Darzi in 2007 (NHS London 2007) and 2014 (London Health Commission 2014) need to be revisited and refreshed to ensure that there is a clear and compelling vision for the future of health and care, which is widely shared and effectively communicated. The imminent appointment of a London regional director across NHS England and NHS Improvement and recognition by the Strategic Partnership Board of the need to articulate a vision are steps in the right direction. A good starting point for this is the recently published health inequalities strategy and the vision should take

account of this as well as current and future national plans, including the forthcoming NHS long-term plan, and London's distinctive characteristics. It should also articulate the role of STPs and set out a route map for their migration towards integrated care systems. The Mayor and GLA are working in partnership with the NHS in developing the vision.

*The law will need to be changed to create alignment with what STPs are being asked to do*

As a final comment, we would reiterate a point we emphasised in our previous report (Ham *et al* 2017a), namely that STPs are a conscious workaround by national NHS leaders and they have no legal status. Their success hinges on the willingness of partner organisations to lend their support to what STPs are seeking to achieve and the skills of STP leaders in working in a complex and often confusing organisational and regulatory landscape. Ultimately, legislative changes will be needed to align the statutory framework with the work that NHS providers, commissioners and local authorities have been asked to do. For now, coalitions of the willing from across the public sector and beyond offer the best hope of making progress.

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