London Health and Care Partnership

NHS

A neighbourhood health service for London: **The Case for Change**

Developed in partnership between London's five integrated care boards, NHS England London Region, and the wider London Health and Care Partnership (London Councils, Greater London Authority, UK Health Security Agency, and the Office for Health Improvement and Disparities in London), with support from Londonwide Local Medical Committees.

May 2025

This London Case for Change should be read in conjunction with the **London Target Operating Model**.

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1. **London is experiencing a "perfect storm" in which deep-seated economic and health inequalities are driving ill-health, resulting in increasing pressures on the NHS, local authorities and local partners. In turn, these pressures exacerbate those same inequalities, and limit the ability of our boroughs, health and care providers and systems to respond effectively.** Whilst London's strength lies in its diversity, our communities are too often afflicted by poverty, economic inactivity, and social exclusion, all resulting in unwarranted variation in access to and outcomes of healthcare, growing disparities in health and wellbeing, and inequalities in overall life expectancy.

2. **Whilst no part of London's health and care system is immune to these developments, general practice in London is experiencing particularly severe challenges even compared to other parts of England.** This case for change considers the holistic impact of growing activity and financial pressures across the health and care system and the populations being served by each of London's five integrated care systems (ICSs) and 32 place partnerships. However, unapologetically, there is also a particular focus on primary care, and within primary care the opportunities and challenges facing general practice, in the context of the Fuller Stocktake and the Government's planned "three shifts", along with the move to a neighbourhood health service.

3. **London has already seen over a 20% reduction in GP practices in the last 10 years, with the most disadvantaged neighbourhoods and communities often the most disproportionately impacted.** Whilst some of this has been planned consolidation of smaller practices, these changes reflect the growing pressures across primary, community, mental health, and acute services; across adult, and children and young people's social care; and the voluntary and community sector in London. In turn, they contribute to, and are further affected by, increasing challenges in key areas such as access to high-quality care and the ability to attract and retain people into the workforce which provides it.

4. **In parallel, senior executives in London's hospital sector have highlighted that "we have no plan B" for acute care.** London, as elsewhere in England, has experienced continuing pressures across both emergency and planned care, starkly evidenced by the rise of "corridor care" and growing waits in A&E. The message from acute colleagues is that they have opened up all the wards and filled all the corridors they can fill, in response to an inexorable rise in demand in London, with facilities already stretched to breaking point in traditionally quieter summer months. If we cannot use this opportunity to create a genuine shift of activity away from hospitals into the community, and into more proactive and preventative care (including secondary prevention for those already identified as being at imminent risk, and a better model for managing outpatient care for those in receipt of treatment), then no amount of additional investment in the health service is likely to be sufficient to meet future needs.

5. **This document makes the case that our current structures, including acute, community, and mental health providers; ICSs; primary care networks (PCNs); GP federations; local authorities, and wider place-based partnerships in London, will not be able to respond to these challenges** without a clear, shared vision and the mechanisms to deliver this vision. This includes a consistent approach to developing Integrated Neighbourhood Teams (INTs) in London as part of the shift to neighbourhood working, encompassing the totality of population health priorities and needs; one which brings together partners across the public, private, and voluntary and community sectors; around health and wellbeing, public health, social care, and related areas such as housing, employment support, and criminal justice.

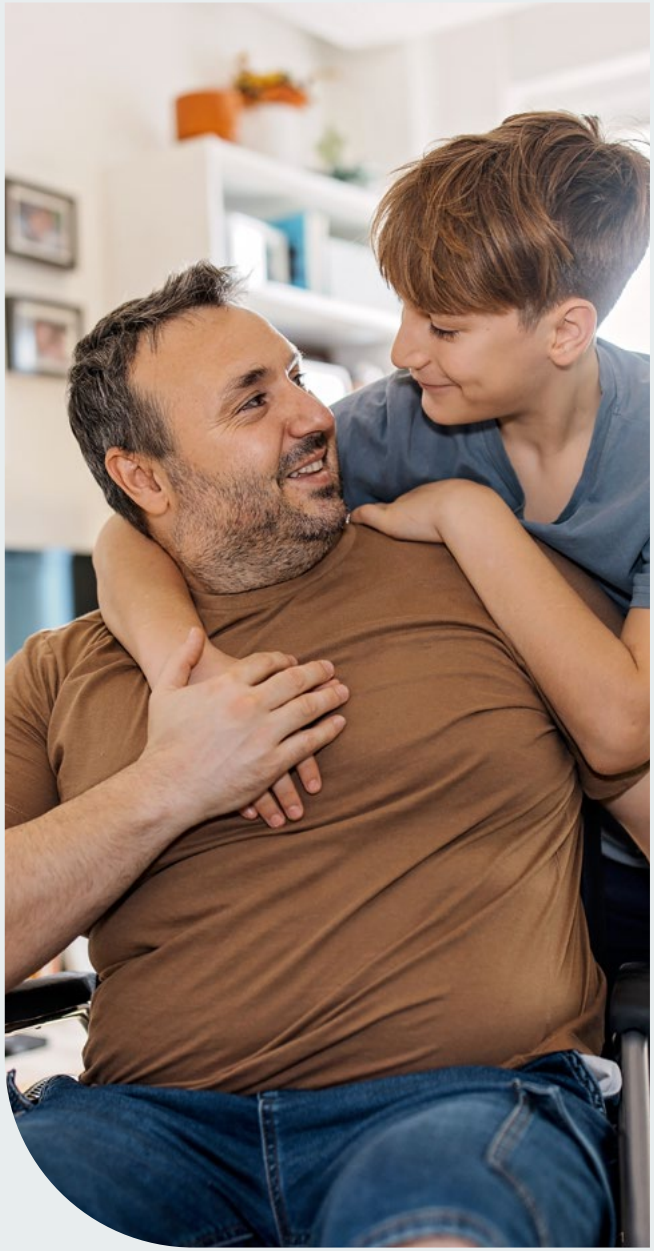
6. **The Government has set out ambitious plans to transform the NHS** into a neighbourhood health service which can respond better to individual needs, including through increasingly preventative and proactive care, building on three shifts – from hospital to community, analogue to digital, and treatment to prevention. These shifts will require change across all aspects of health and care in London, including how and where professionals work and interact, supported by systems and infrastructure designed to enable, and not inhibit, collaboration.

7. **These shifts cannot be achieved by the NHS alone.** It will require joint effort across London's public sector providers and voluntary and community sector partners, if London is genuinely to improve population health outcomes and reduce "failure demand" across our systems. Whether that is building capacity and local leadership within communities, developing digital and data infrastructure to enable earlier and better support and care, or helping people to stay healthy and well at all stages of their lives. This effort will need to start now, and to be sustained over time.

8. **Improving the quality and sustainability of social care for all will be critical to securing the future of both the NHS and local government in London.** The relationship with social care is two-way – it is a core part of supporting people and communities, and is at risk if we cannot do that in a sustainable way. Just as for those Londoners who, due to a failure to provide access to health and care services at an earlier stage, find themselves in the urgent and emergency care system, experiencing prolonged hospital stays, and living with otherwise avoidable and life-limiting long-term conditions; so too many Londoners will find themselves needing long-term domiciliary and residential social care for want of effective community rehabilitative, mental health services, and wider support to stay healthy, independent and well.

9. **The voluntary and community sector and communities themselves are already at the forefront of the neighbourhood agenda** but their capacity to respond to the challenges being faced is equally affected by the pressures on statutory services, including around a lack of long-term sustainable funding. As recent work with the NHS Confederation and Local Trust has highlighted, often those communities which are the most in need are the ones which have seen the greatest degradation and disinvestment in community assets in recent years. There is a risk that without sustained support and investment in the voluntary and community sector, London's public services will be unable to reach the people most in need, and will fail to harness wider community knowledge, relationships, and assets (sometimes described as "social capital"), which the experience of the pandemic and existing community-led work show are vital to address the inequalities driving growing demand.

10. **The benefits of successfully and consistently navigating the shift to neighbourhood and community-based approaches go beyond health and wellbeing.** Alongside benefits for the many children and young people, working-age adults and older people all living with complex needs, there is a requirement and an opportunity for teams to support those Londoners at risk of losing jobs due to unsupported physical and mental health conditions; and to enable people already classed as economically inactive back into meaningful employment. There are significant economic as well as health and wider social benefits to getting this right.



11. **Most importantly, this change is what Londoners themselves tell us they want.** Through a process of deliberative engagement led by Imperial College Health Partners (ICHP) and Ipsos-Mori, Londoners have expressed the desire for accessible, technology-enabled services which provide a consistent approach to care everywhere in London, whilst also being able to respond to the local population and individual health needs. Whilst this need for both consistency and adaptability often appears currently as a tension and potential barrier to change, if we cannot navigate this complexity, the neighbourhood health service will not be able to fulfil the aspirations of both better care for people and improved population health for all.

12. **Practically, if we are to meet the needs of all Londoners in the most efficient and effective way possible, we need to work in a way which recognises the importance of providers who are already engaged in delivering services across regional, system and borough boundaries.** Ensuring a balance between a health and care system which provides a core offer of high-quality, comprehensible, coordinated support wherever people live, whilst at the same time enabling frontline staff and local place partnerships to tailor that offer to meet individual requirements, is challenging – but is also fundamental to the success of the neighbourhood health service in London. Some of this may require national changes, including to NHS contracts and health and social care funding, but that does not mean it is not the right thing to do nor does it preclude making progress in the meantime.

13. **This document argues that in London, as elsewhere, we need to both learn from the lessons of the last decade and build on the successes.** No system or place is starting from scratch, but whether we are describing integration and the benefits of integration at a neighbourhood and community level or just better collaboration between professionals and communities, this will not materialise, scale or spread without specific support. This support will need to include the time and resources to develop the required relationships at a neighbourhood level; the ability to link progress and resources at place, our five ICSs and the London region; to develop clear strategies around key enablers including digital, data and estates.

14. **We believe that having nominated public sector organisations able to support the operation of the neighbourhood health service in each place will be critical to realising the vision and achieving the Government's three shifts.** The accompanying Target Operating Model articulates how, within each place, an "Integrator" will need to coordinate and enable delivery of associated functions around geography; workforce; relationships and interfaces; participation and working with communities, population health management and addressing inequalities; information sharing; access and technology; governance (clinical, professional and managerial); metrics and evidencing success; ensuring resources can flow to where they are needed; and supporting people through the change. This integrator could come from a range of existing place-based organisations, but it is critical that whichever organisation takes on this role, it is able and committed to working in partnership with other local organisations and as the enabler, not the leader or owner, of the neighbourhood working agenda locally.

15. **In the context of ongoing financial pressures across all sectors, and applying the principle of "building from where we are", this is explicitly not about creating new structures and organisational forms** but better harnessing what exists already. Specifically, this is not about asking organisations to take over, or in isolation take on the challenges of delivering a neighbourhood health service, but ensuring we are using the capacity and capabilities which exist in our larger community-based bodies to support explicitly the delivery by place partnerships as a whole of jointly agreed local priorities and plans.

16. **There is no "do nothing" option, but we will need to address remaining "wicked issues" which threaten to act as barriers to change.** These include how to resolve the patchwork of current services and offers across London, understand the role of existing structures such as PCNs in new models of neighbourhood health and care, and manage the transition without access to significant new resources. Currently, in London we spend billions each year on healthcare provision, and that cost continues to grow, even as health inequalities and public dissatisfaction increase. To succeed in this environment, change will need to be appropriately phased and prioritised, but cannot be avoided.

17. **Effecting the required shift in existing resources, be those people, money or supporting infrastructure, will be complex** (even with specific organisational support). We do not have an obvious alternative in any part of our health and care systems in the absence of significant increases in public sector funding and in the face of ongoing unsustainable growth in pressures across health, local government and the voluntary and community sector in London. Whatever solutions we come up with, we will need to ensure these also provide options for sustaining neighbourhood providers including those GP practices which are already in or at risk of falling into distress.

18. **We have found an existing broad consensus on the need for change – the key question now is how that change will be enabled and delivered.** This report concludes that this is about spread, as much as it is about scaling. We already have good examples across London of the impact of working differently, but these are inconsistent and often very dependent on local circumstances, leadership, local goodwill, and short term/non-recurrent funding. The opportunity is to spread good practice within and between all 32 boroughs and the City of London, enabled by effective support at place, system and regional levels; and to make best use of our existing resources, with regional partners including the Greater London Authority (GLA), at a system, place and neighbourhood level.

19. **To achieve this will require clarity around what Londoners can expect, wherever they live in London;** the role of clinicians, professionals, volunteers, and all those who support them at place and system level; what we could do once for London, in making the most effective use of available time and resources; and how we can both draw down to and build up from neighbourhood level, in creating better outcomes for all.

20. **It will require shared leadership commitment – to take the opportunity of the Government's commitment** to a neighbourhood health service, and to the associated shifts, as a "green light" to convert existing ambitions and best practice into better outcomes for all Londoners.

    This means moving from working with small cohorts of complex patients, and delivering targeted, time-limited action to support individuals and communities, to embedding these approaches as "the way we deliver health, care and wider improvements in outcomes" across London.

Introduction and context

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The major challenges of poor health and wellbeing, persistent inequalities and dissatisfaction amongst staff and patients, require urgent action and a change in the way that different parts of the health and care system work with each other and the wider community.

Representatives of London's five ICSs and place based partnerships; NHS and non-NHS providers; the NHS England Regional team; London Councils; the Greater London Authority; the Office for Health Improvement and Disparities; the UK Health Security Agency; together with partners such as the Londonwide Local Medical Committees, have been convening since the summer of 2024 in the context of national developments including:

- **The Fuller Stocktake** Report (2022) and subsequent work on the future of primary care, sets out a vision of streamlined access to care and advice, with more choice and availability in the communities where people live; more proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs, including but not limited to those with multiple long-term conditions; and a joined-up approach to prevention, helping people to stay well for longer. These developments were encapsulated in the Stocktake within the concept of an "Integrated Neighbourhood Team" (INT), building on existing successful models of person and community-centred care across England.
- The **Independent Investigation of the NHS in England** by Lord Darzi (2024) sets out the growing challenges for the health service in England, including the impact of wider determinants of health in driving rising demand for healthcare services; the prevalence of long-term health conditions across age groups, and of mental health needs particularly affecting children and young people; and the erosion of public trust resulting from rising waits for access to GPs, community and mental health services, urgent and emergency and elective care.
- The **Manifesto Commitments** of the new Government (2024) to "Build an NHS fit for the future" is exemplified by a move to a neighbourhood health service with reinvigorated primary and community services at its heart, enabled by a shift of resources and focus from hospital to community, from analogue to digital, and from treatment to prevention.

The purpose of this document is not to repeat the national case for change, but to establish a shared understanding of what this means in the context of the health and wellbeing of nine million Londoners.

Where relevant, we reference broader developments and context, but specifically, this document is about identifying priorities locally, and understanding how London can help support and shape national developments across health and care, in the interest of the population as a whole.

Over recent years, including since the establishment of statutory ICSs in London, and the publication of the Fuller Stocktake in 2022, there has been much work at place, system and regional level in London to develop better integrated, person and community centred care, supporting improved health and wellbeing, and more sustainable health and care systems.

There is still much to do in working out how neighbourhood health and care services will operate in practice, informed by the problems they will need to address, and the opportunities to deliver better health and wellbeing. This includes through improved access, better support for vulnerable people and those living with complex health and care needs, enhanced investment, engagement and uptake across all stages of prevention, tackling health and wider socio-economic inequalities, and contributing to economic growth. Where better outcomes can be achieved, many of the changes that are needed are only achievable through a multidisciplinary and multiagency approach across a wider range of health, local government and broader services.

However, as this case for change highlights, the experience of implementing multidisciplinary working nationally and in London, is that simply bringing together professionals around a shared care plan and specific cohorts of patients is not going to be enough.

In setting out this case, we describe both the drivers which led us in London to a position where the status quo is not sustainable, and the opportunities that arise from the development of INTs across London, in a consistent way, building on existing resources, assets and best-practice, as a key part of building a better future.

The people we serve

Improving individual experience

Londoners have been clear and consistent around their expectations and aspirations for improving health and care in London. Through a series of recent **deliberative engagement** events supported by Ipsos Mori and Imperial College Health Partners, Londoners have told us that they are looking for:

1. **A consistent approach to how we respond to people and manage their needs across London**, applying the same systems, technology and rules so people know what to expect and how to access help when they need it (including via digital channels such as the NHS App), and which take account of social as well as clinical factors.
2. **A clear understanding of the choices available to them and the benefits of each**, including options around self-care and support from charities and other community organisations as an alternative to statutory services where appropriate.
3. **Integrated neighbourhood-based teams which deliver the same basic care across London,** with continuity of care and clarity around support for specific local needs, all enabled by secure data sharing and the types of digital technologies that people experience helping them to manage other key parts of their lives.
4. **Proactive care that is delivered in partnerships with communities**, is regular and consistent, but is also respectful of people's choices.

The findings reflect not just people's aspirations for themselves and their loved ones for the future, but their experiences of trying to access health and care when they need it today.

Today, the experience of people accessing health and care services is highly variable, particularly when they need support to come from a range of different health and care professionals and providers – even if those services are theoretically operating as multidisciplinary teams.

The findings reflect not just people's aspirations for themselves and their loved ones for the future, but their experiences of trying to access health and care when they need it today.

In a series of parallel engagement sessions across London, we have heard many good examples of improved neighbourhood and community-centred care, much led by individual clinicians, professionals and communities themselves.

However, whilst there has been considerable focus in recent years on developing person and community-centred care across England, including through the development of multi-disciplinary teams around key population groups such as frailty in older people, recent research published by **National Voices** found patients reporting that too often they:

- Have to repeat themselves in dealing with multidisciplinary teams.
- Do not feel involved in the decision-making around their care.
- Experience a loss of continuity of care as a result of shifts to multidisciplinary teams.
- Do not always know who the right person was to speak to, or understand what the role of the person they are speaking to is in their care.
- Are unsure what to expect from appointments.
- And are concerned that, paradoxically, the increased complexity of being supported by a multidisciplinary team means they have to invest more time and energy in navigating the care system and in advocating for themselves.

Feedback from GPs and others working in the community, highlights that these frustrations are equally part of the daily experience of professionals trying to support their patients in a more joined up way.

Bringing together key clinicians and professionals into teams which can take a holistic view of a patient's assets, needs and outcomes will be critical to improving health and care in London, and many of our multidisciplinary teams are already leading the way.

However, the issues highlighted show not only the importance of addressing siloed-working and better integrating our teams, but of doing it in the right way, including the need for effective communication and engagement with patients and carers and between professionals at each stage of the process. Insights which apply at the level of individual patients are equally applicable in engaging with wider communities in London.

Whilst people understandably want and need high-quality local health and care services, the help that patients and carers need can in many cases be better provided by using non-medical services, including through London's voluntary and community sector and resources within communities themselves. Yet, just as growing pressure on statutory services has created in too many areas a "vicious circle" of growing demand and decreasing ability to respond to that demand, so NHS providers and other statutory partners now need to find more effective and sustainable ways of working with communities at a hyper local level, over the short, medium and long term.

Growing public dissatisfaction with the availability of GP appointments (despite the real growth in appointments in recent years), has been highlighted both at a national level in the Darzi report and in local system and place work within London. Whilst there are issues in the current imbalance between capacity and demand, including as a result of practice closures, workforce challenges, the impact of the pandemic across our communities and services, as well as pre-existing disconnects between primary and secondary care, there are also opportunities to improve the systems and approaches to managing this work. In reality, the number of primary care contacts, if anything, have increased significantly in London, but not in a way which has kept pace with wider demands.

Building on the principles of "Modern General Practice" and the Primary Care Access Recovery Plan, many practices are already operating in a way that improves the management of administrative requests and can appropriately support patients to work with the right members of the practice team providing a timelier response and to create capacity to better support more complex needs. Others are working in partnership with other providers, including the London Ambulance Service, in addressing demand; or with community health and wellbeing workers to transform the approach to primary care within communities.

It is difficult to defend very different levels and systems for accessing appointments in London in the absence of clarity as to why these differences exist. Issues of capacity and the implementation of effective systems will require action across whole areas, potential redistribution of resources and standardisation of basic processes. Equally, developing better ways of supporting the needs of more complex patients, including through improved technology and data sharing to enable better proactive and preventative care, would, if implemented successfully, help free up capacity and time to support the wider population as a whole, (including those at risk of future ill-health, in the absence of effective and accessible primary and community-based support). However, the time period to realise these benefits has often acted as an inhibitor to change.

Continuity of care remains critical for both clinicians and patients. Previous **Nuffield Trust** research has highlighted that:

"Relational continuity of care in general practice is associated with a significant number of benefits to individuals and wider health systems, including: better clinical outcomes for an array of conditions; reduced mortality; better uptake of preventative services; better adherence to medication; reduced avoidable hospital admissions; and better overall experience of care amongst patients who prefer continuity and are able to obtain it".

In recent years, professionals and patients across London have highlighted how much of this relational continuity has been lost.

To an extent, this has been replaced by informational and management continuity, however, it will be important to ensure that as services develop in the future, for those patients who benefit most from relational continuity, we are able to provide it. Although much current literature on continuity focuses on continuity of GP care, discussions across London in the development of this case for change have highlighted the important role that continuity of care provided by other health and care professionals and the voluntary and community sector plays in driving improved individual and population health outcomes.

Improving population health

The outlook for the health of the population without significant changes in lifestyle, economic opportunities, and more successful primary prevention is not positive.

The estimated prevalence of people with moderate to severe frailty in London is **12% to 26% in people aged 65 and above**. The **population in London** in this age group is projected to grow from 1.2m in 2024 to 1.6m in 2034, with the very elderly (those aged 85+) growing at an even faster rate. This represents a challenge to healthcare but even more to the fragmented and economically challenged social care provider system that will need to change dramatically if these growing needs are to be met.

Modelling by the **Health Foundation** found that the number of people living with major illness is projected to increase by 37% – over a third – by 2040. This is nine times the rate at which the working-age population (20 to 69 year olds) is expected to grow (4%).

Much of this relates to conditions such as anxiety and depression, chronic pain, and diabetes which are generally managed in primary care and the community. This reinforces the need for investment in general practice and community-based services, focusing on prevention and early intervention to reduce the impact of illness and improve the quality of people's lives. This is even more the case as **frequent attenders** use primary care at five times the rate of other patients, and their rate of use has been steadily increasing over time.

Sadly, many of these problems result in economic inactivity which in turn worsens health and wider inequalities.

The recent White Paper **Get Britain Working** reports that long-term sickness-related economic inactivity is at a near-record high. Disability prevalence is also increasing, with 2.6 million (38%) more people in the working-age population classed as disabled compared to a decade ago. Recent research as part of the **Pathways to Work Commission** led by Alan Milburn has highlighted how up to 7 in 10 of those engaged who were classed as economically inactive wanted to work. The Office for Budget Responsibility (OBR) calculate that an additional half a million people participating in the workforce would save £18.7 billion. This represents an important opportunity for the health sector to contribute to this wider goal, but at present, there is limited ability for the system to focus on dealing with these needs.

Children are perhaps even more of a concern. In England, over one in five children are overweight or obese by age five and a quarter have tooth decay. The demand for child and adolescent mental health services has grown enormously, with the number of under 18s referred to **Child and Adolescent Mental Health Services (CAMHS)** rising by 53% to over 1.2 million between 2019 and 2022.

Children are waiting an unacceptable time for **support** – with nearly 40,000 children experiencing waits of at least two years. A third (28%) of children referred to mental health services (270,300) were still waiting for support, whilst almost 40% (372,800) had their referral closed before accessing support.

Improved approaches to population health, better integrated teams and a more responsive approach to local needs combined with closer working between health and social care provide significant benefits to the social care system.

Recent research by the **County Councils Network** (November 2024), indicates that the costs of providing care and support for working-age adults and those with a lifelong disability is now the largest area of adult social care expenditure in England – (in 2023/24, 63% of all adult social care commissioned support, such as residential and home-based care, was found to relate to working-age adults) – with an increase from 2019 to 2024 of 32% or £2.6 billion pounds.

The research indicates that this is being driven by the complexity and type of care individuals are receiving, rather than increased numbers of people requiring support; whilst in children's social care, figures from the **Department for Levelling Up, Housing and Communities** (DLUHC) show a second consecutive rise of 11% in real terms planned expenditure for 2024/25 to £14.2 billion.

In London, London Councils representing the 32 boroughs and the City of London has highlighted in recent research how spending on adult social care, children's social care and homelessness has increased from 60% of net revenue expenditure 10 years ago to 84% today. Almost one quarter of London's local authorities will need Exceptional Financial Support (totalling £430m) to balance budgets in 2025/26, and over £500m of savings will be required just to stand still.

In 2025, planned increases in employer national insurance contributions and the national living wage will impact the sustainability of care providers across London. There is no single, simple solution to the problems of growing social care funding pressures; but there are a number of exacerbating factors. These include a lack of access to timely, coordinated support for children and young people with complex needs; support for working adults who are at risk of becoming or currently classed as "economically inactive" for treatable health conditions; and older people, particularly those who are coming out of hospital and being directed into long-term nursing and residential homes due to a lack of community rehabilitation capacity.

Conversely, increasing access to, and the efficacy of, neighbourhood-based health and wellbeing services, and integrating bio-medical and social support, provides one of the few opportunities to start to address the ongoing and currently inexorable rise of social care expenditure and the concurrent pressures on local government finances across England.

Addressing persistent inequalities

The prevalence of the issues described in the preceding paragraphs is not experienced uniformly across the population.

Trust for London's Poverty Profile highlights that once housing costs are considered, up to 24% of Londoners are living in poverty, rising to 34% of those of a non-white ethnic background and 47% of single parents.

The persistence and worsening of intractable health inequalities is driven by a range of factors that are outside the scope of traditional healthcare.

Healthcare providers will need to work with other agencies and professionals to support them in dealing with the underlying determinants of poor health and wellbeing. This requires a focus on place, an organised response, and the deployment of a wide range of skills and expertise. This will in turn lead to a more person-centred approach that will rebuild trust with those we are trying to help. The often atomised nature of provision in many places is an obstacle to this, and ways to create more coordinated approaches, aligned objectives, and joint working will support bringing the different strands of work in this area together more effectively.

Poverty, poor housing, and social isolation are significant risk factors for ill-health. NHS services have often not had strong links to local authority housing teams and housing providers, nor to organisations which can support with access to benefits, as well as to education and employment. To be really effective, London's neighbourhood health service as elsewhere in England will need to work much more closely with these bodies to understand, plan for, and take action around wider socio-economic determinants of health and wellbeing, however difficult this may be.

There is a similar issue in the way that inequalities in access to healthcare are often driven by inequalities in access to transport. Therefore, links to transport planners and to organisations which may offer volunteer transport are also important.

Meeting the needs of the population and addressing inequalities will require a much better understanding of the different types of need in the population. To realise the ambition for prevention it will be important to be able to identify who is most likely to benefit from proactive approaches. This requires the use of methods for segmenting the population, predicting risks within the segments and linking this to elements of clinical work, so that patients who are at risk, or could benefit from an early intervention, can be identified.

Using a population size larger than the average practice for this analysis reduces duplication of effort and the call on scarce analytical expertise, but it can also identify opportunities to use the resources of the extended primary care team or other appropriate staff.

Working across a neighbourhood offers the opportunity to use place-based approaches and large group consultations or support groups for people with high levels of risk factors. This is critical to expanding the scope of primary care without placing additional burdens on practice staff, although it will be important not to undercut the role of GPs and practice staff in doing this.

The following section explores the implications for services of responding to these challenges and opportunities, as neighbourhoods, places, systems, and the London region as a whole.

Improving services

The development of integrated neighbourhood services will support improved health and wellbeing, managing the demand for care, and delivery of better preventative services and outcomes. In doing so, we should also improve productivity and reduce some of the cost pressures facing health and social care by providing more timely and optimal care. The economic case for change is strong, but there is also an argument that the model can help to meet other important challenges facing primary care, hospitals, and the wider system.

Supporting and developing general practice and primary care

Flourishing and effective primary care is vital to the success of the NHS and there are reasons for concern about its current condition and its ability to deliver what is required in future. Whilst this is an issue in all regions, there are specific concerns around the situation in London. High levels of workload and demand, staff shortages, economic challenges for GP practices, and a range of other pressures including an increasingly complex set of population needs and pressures on other parts of London's health and care system have led to:

- London seeing a 20% reduction in GP practices over the last 10 years.
- London having the lowest rate of GP full time equivalents (FTEs) per capita of any region (and falling).
- London having the highest rate of GP appointments per GP FTE.
- London having the highest proportion of GPs over 60 (double of all other regions combined).
- London having the highest rate of leavers and the lowest rate of joiners to general practice.
- London's most deprived populations having a lower number of GP FTE per capita in all five integrated care boards (ICBs).
- 40% of practice premises in London dating from before pre-1948.

All of this is contributing to burn out and poor morale – with research by the Royal College of General Practitioners (RCGP) indicating that 42% of GPs are unlikely to be working in general practice in five years' time, and a quarter of GPs saying it is very unlikely.

Without significant change, London will experience a further acceleration of these trends over the next 10 years. Without sustainable and accessible primary care, including general practice but also community pharmacy, dentistry and optometry, the neighbourhood health service in London will fail.

Increasingly patients have needs for support that go beyond what would normally be offered in primary care, (or are bringing issues such as housing problems as they do not know where else to take them), but which are related to known determinants of physical and mental ill-health, for example in the relationship between poorly heated and ventilated homes, increasing prevalence of respiratory conditions, and exacerbation of feelings of anxiety and depression.

It is dispiriting for professionals not to be able to deal with these issues, either because they are outside the scope of the care they can personally provide, or because they will take more time than is available in a short consultation. This applies equally to issues where a brief or motivational intervention to support prevention is of greater value and impact than a bio-medical response. Bringing front line professionals together from a range of services, working collaboratively with patients, service users and carers, will enable clinical and professional teams to provide the help people need, when and where they need it, rather than just constantly having to refer onwards with little hope or expectation of a resolution. This is needed both to improve access for patients and service users to the support they need, and to maximise the impact of that support in the short, medium and longer term.

Creating capacity for GPs to provide continuity of care to those who need it, is critical to improving our system responses to the growing numbers of people in London living with complex needs. Better managed systems for rapid access, approaches to provide continuity to those that need it across sectoral boundaries, and empowering other professionals and services to act where appropriate, will in turn help to provide GPs with more time and more satisfying work. There is a risk of creating new supervisory and oversight challenges and pressures; but if we can achieve this effectively, it will not just improve the lives of patients and service users but also of the professionals, including GPs, who are providing this support.

One of the most serious obstacles to developing integration and new models of delivery is the availability of time to develop the relationships, new systems, and other important aspects of change management. Smaller organisations have more difficulty in doing this. Even for larger teams and organisations, it is difficult to plan major changes in short meetings squeezed into a busy schedule, but they have more opportunities to do this.

Across London, our PCN clinical directors and wider stakeholders have indicated how the development of PCNs has often not delivered on some of the promises, beyond the narrow objective of providing a vehicle for the employment of additional roles. It is important to note that although some have incorporated, PCNs were designed to be networks, not organisations. However, there are opportunities to get the benefits of increased scale in primary care without damaging the local focus which has made it so effective. This would allow for more joint working to improve back office support, extended hours, the (re)development of GPs with a special interest, and other aspects of the type of extended, community-oriented primary care that is the goal in many health systems across England and around the globe.

Improving interfaces and relationships with wider partners

The policy focus on access and changes in patterns of work has meant that continuity of care, which is very important for patients with more complex needs, has suffered. The increase in the number of people with complex problems means that changes in how care is organised and delivered will be needed.

These patients will need continuity of care and, in many cases, the support of the wider team including community, mental health, and social care as well as voluntary and community sector partners, through a "whole family" based approach.

Relational continuity is important but increasingly difficult to deliver with high levels of demand and an increasingly part-time workforce. Micro teams and the development of informational continuity can help to support this. Very small practices have often been able to provide this well but it is becoming increasingly challenging to do so as demand increases, and the GP and wider primary care workforce becomes more part time.

The acute sector is facing continuing increases in demand and rising costs driven by new technologies, population size and age structure. The Health Foundation estimate that this could require between 21,000 and 37,000 additional beds by 2030/31. This would not be a cost-effective investment and runs against the (so far unsuccessful) attempt to shift work and resources from secondary care. Improved primary and community care, and a social care system that is properly funded, provide part of the answer to this problem. Better prevention, improved management of long term conditions, investment in rehabilitation and end of life care, all offer a prospect of reducing the rate of increase in hospital activity and in some cases making absolute reductions, but will require a new model of secondary care as part of this shift. It will require significant increases in the capability and capacity within local services and a more navigable health and care system in which the emergency department is not the first port of call when patients or referrers can't get what they need.

Addressing waits for treatment, outpatients, and diagnostics is a major priority. Across many specialties, a change in the outpatient model, closer working between specialists and primary care, and the development of new pathways with primary care will provide one of the few ways in which we will successfully increase capacity and provide different and more appropriate ways of meeting demand, in the short and longer term.

A lot of unhelpful bureaucracy has developed to manage referrals between different parts of the system. In some cases, this is because of the proliferation of specialist teams whose remit is not always clear and which may overlap. Whilst there have been some positive developments, for example from existing advice and guidance models, wider triage and referral management often introduces a layer of additional administration where the value and benefits are unclear. Attempts to manage demand may actually increase overall work, as time is spent dealing with the complexity and overcoming barriers to providing the care that patients are identified as needing from the start.

Additionally, and as highlighted in recent engagement work by NHS England and the RCGP, including the Red Tape Challenge Early Findings, a high proportion of primary care contacts currently are patients who are on a secondary care waiting list, and are related to the issue they are on the waiting list for. There is a need for simplification and standardisation and in some cases the complete removal of duplicative services. This will be helped by the development of more locally coordinated and less fragmented services. Teams based on relationships and clear understanding of each other's roles, do not need to rely so much on bureaucratic methods of coordination[1].

The Fuller Stocktake highlights the need to align hospital specialists to INTs. A recent **report by National Association of Primary Care (NAPC)** supports this recommendation, demonstrating indicatively across a range of specialties how a population of 50,000 generates significant outpatient activity. The table below shows the weekly activity for a sample[2]:

Patients per week for a 50k population

Specialty	First appointment	Total
Paediatrics	19	50
Cardiology	28	62
Dermatology	22	58
Respiratory	12	36
Neurology	9	26
ENT	23	49

Geriatric medicine records fewer outpatient visits but consultants also provide a lot of support and advice as well as managing the acute and rehabilitation phase of patients' care. Areas such as endocrinology and diabetes, not included in the data shown left, are further examples of specialties where the main provision is often already being delivered in primary care. The question is whether traditional outpatient consultations are always the best use of associated specialist expertise across all of these areas, if there is an opportunity to put more resources into advice and guidance, email consultation and multidisciplinary discussion between specialists, GPs, and patients and carers. Although there has been a lot of effort to develop integrated care for a long time, the hospital specialists have not been widely involved. They have a lot to offer and engaging them in population health management and new ways of working with primary care can pay **dividends** in reduced hospital use. Again, to make the most of this requires a degree of standardisation of the approach and it is difficult to do this with one PCN or practice at a time.

Critical interfaces include substantial partnerships with social care and VCFSE sectors in London. Many people supported on an ongoing basis by integrated neighbourhood-based teams will have some degree of social care need and will be receiving domiciliary care or be in a care home. Here, the large domiciliary care sector has a potential to contribute more to supporting people at home through being linked more effectively to health and other services. Similarly, there is already experience of providing enhanced support to care homes which has had success in reducing unnecessary trips to hospital and improving end of life care. This is another area where the interfaces between different services create work and obstruct the delivery of effective care.

1 NHS England » Outpatient services: a clinical and operational improvement guide and rcp-modern-outpatient-care-using-resources-to-add-value-implementation-guide.pdf

2 Based on a 50 week year. 2023/24 Data NHS Digital Hospital Outpatient Activity 2023-24 - NHS England Digital

Currently, growing pressures on social care and wider local government funding, threaten the ability to engage in the construction of truly person and community-centred approaches to care which are fully inclusive of all the partners who need to be involved. Financial pressures affect not just local government but also the private providers, social enterprises, and charities which are the primary providers of social care in London. However, too often, increases in social care demands and pressures are themselves being driven by a failure to intervene proactively and preventatively – to stop patients getting to the point where they are dependent on packages of intensive social care support, often for the rest of their lives. This includes support for children and young people at risk of mental and physical ill-health, and working-age adults classed as economically inactive. It also includes the increasing prevalence of multiple long-term conditions at an earlier stage of life, which impact on people's ability to enjoy a healthy and independent old age.

The VCFSE sector plays a significant role in delivering services in response to both social and healthcare needs. VCFSE organisations can be particularly well placed to respond to needs which may be better met through 'social prescribing' rather than medical models of care. They are also often deeply embedded in local communities and play an important role in identifying inequities in access to health and care which can be addressed by the INT.

The complexity of the sector and the number of organisations can make joint working a challenge. The development of neighbourhood teams could help to find ways to make the interfaces and communication channels more effective without multiplying bureaucracy. This will not just help with specific areas such as social prescribing, but also in helping with wider goals of improving health and wellbeing and reducing inequalities. To do this it will be necessary to address a long standing issue that has held back the ability of the VCFSE to fully realise its potential - the short term and piecemeal nature of statutory funding for their work. This requires a fundamental change in commissioning philosophy and approach; and the ability to develop and constructively engage with communities and community leadership as a core part of enabling this change.

At the moment, London's services are a patchwork of historic commissioning decisions and competition between providers. At both a system and a regional level, providers struggle to integrate with multiple different configurations of local health and care provision; whilst at the frontline, services can feel inflexible and unable to respond to the specific needs of individuals and communities, including some suffering the worst health inequalities.

There is a need to work out the balance between standardisation and local decision-making, and there does not seem to be an agreed view of what needs to be determined at neighbourhood, place, ICB, regional or national level. The development of place and neighbourhood models could provide a way of addressing this issue.

Enabling this change

Developing our core infrastructure

The ambition to develop larger multidisciplinary teams in primary care and closer working with local government and the voluntary and community sector too often flounder on issues such as the availability of places to sit, information systems that can and do share information, and other basic infrastructure.

Whilst physical co-location is by no means a guarantee of better team work and integration, it helps, and generally makes things easier for local people and staff. Regardless of the physical location of staff, the ability to share information relating to individual service users within an updated framework of understanding and respect between all relevant professionals, is central to the better coordination of care.

London's primary care estate is currently inadequate, with a regional review of estates showing that a third of London GP practices were unable to comply with the Disability Discrimination Act – a third needing to be rebuilt and 44% needing repairs.

Digital infrastructure also plays a vital role in supporting care provision across the capital. Whilst there is still work to do to bring together disparate systems across providers and ICBs, there has been extensive work in London to create joint infrastructure such as the **London Care Record**, which has been used almost 40 million times by health and care staff. An economic analysis shows that this has corresponded to saving health and care professionals' time of up to a value of £44.4 million. Associated data being brought together by **One London** and, nationally, the **NHS Federated Data Platform** are critical to both individual healthcare and wider population health management. However, at a granular level, a recent RCGP survey showed that almost half (46%) of general practice staff responding reported that their PC or laptop software was not fit for purpose, with 38% saying their broadband connection was not of an acceptable standard.

The opportunity to take an approach to planning the estate and digital infrastructure that considers all the resources across a place, means that more imaginative and effective solutions can be developed than if each organisation plans this on their own.

Developing our workforce

The growing challenges in responding effectively to individual and population health needs within our current infrastructure arguably represents a "moral harm" to many of those working on the frontline of London's health and care services. That there is fierce competition for some staff groups and the costs of living in London adds to this challenge.

This is evidenced by growing problems in recruiting and retaining staff across health and social care, including in primary, community and mental health as well as residential and domiciliary care in London. There is a risk and a reality of market failure in care services in many areas.

A successful future neighbourhood health service would provide a platform for arrangements across London to support the development of the future workforce and ways of working that bridges the divide between the need for consistency in the core offer, with the power to work with individuals, neighbourhoods and communities differently.

This will also require new roles, with appropriate cross-skilling of professionals and increased permission for those working with individuals, families and within neighbourhoods to act. It will need different ways of working enabled by different ways of contracting staff to be able to work across different settings and access different systems, as determined by the needs of patients and service users.

Facilitating the shift

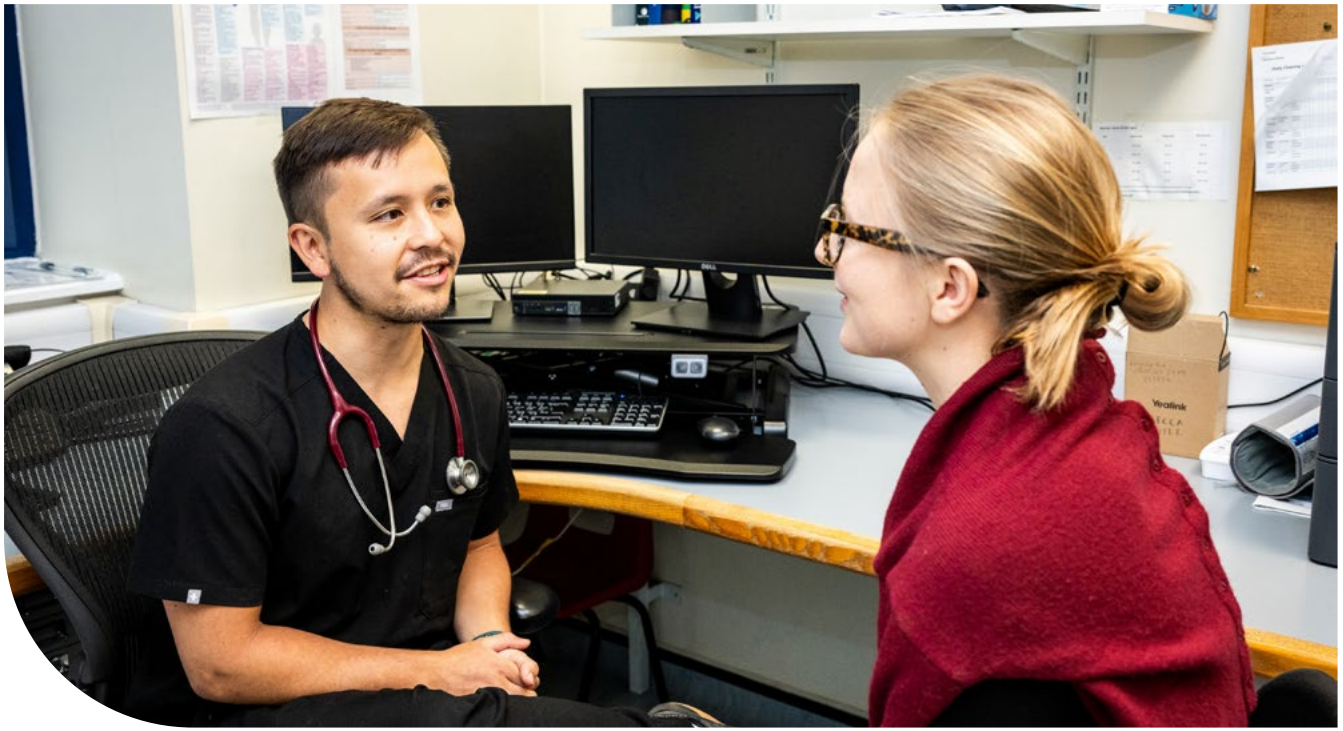
Many of the issues set out in this case for change can be aided by a more coordinated and less fragmented approach to organising the very complex web of different services from across health, local government, and the voluntary and community sector.

Experience from previous attempts of health and care integration in England and internationally, is that it requires the creation of new systems and processes, the growth of new and improved inter- and intra-organisational relationships, new patterns of commissioning, continuous quality improvement, and organisational development work to make progress.

This requires leadership and resources, and does not happen spontaneously.

Without clear and consistent organisational functions to enable this, there will not be adequate ways to resolve issues, make progress happen, coordinate resource allocation and investment in shared infrastructure, and create a momentum for change. And without this, the necessary focus and accountability that is a feature of successful approaches to integrated care and population health management will be difficult to create, and the development of a clear shared narrative, understanding and vision will be increasingly impossible.

Critically, given the resource pressures across our system at all levels (including recently announced reductions in resourcing of our ICBs), and the centrality of local knowledge and relationships to make this a success, the functions required to enable better coordinated, person and community-centred care, (including but not limited to related organisational development, infrastructure and operational support), are likely to need to be hosted within existing health and care organisations working at borough level in London, if we are to make the required progress.



Conclusion and next steps

Conclusion and next steps

The goals of:

- improving population health,
- improving the quality and experience of care,
- reducing cost and improving value,
- creating rewarding work for staff and,
- reducing inequalities

are central goals of most health systems in England and around the world.

Developing relational, neighbourhood-based approaches to delivery – with strong ties to the full range of physical and mental health services, local authority and wider public services, and support from the voluntary and community sector, creates the best possible environment in London for these aims to be achieved.

This will require new ways of working for a wide range of professionals, both including and extending beyond the traditional primary care team. And there will be implications for operating models, success measurement, contracting and funding flows, which will require commissioners and provider leaders to develop new ways of working in partnership within the statutory sector and also with the wider VCFSE and independent sector. Alongside this case for change we will present a proposed Target Operating Model which sets out the expectations at INT, place, ICS and national level.

It is also important to note that, notwithstanding the new ways of working required for INTs to succeed, many if not most interactions between health and care professionals and service users will, entirely appropriately, remain as now, as a contact with a single professional. They will need to do this in an environment that supports them to be effective and which can quickly mobilise other services where they need them.

This document is part of London's broader strategy to deliver integrated, person-centred care at neighbourhood level. It should be read alongside the London Target Operating Model.

Accessibility

If you would like this document in an alternative format, please email **communications@selondonics.nhs.uk**

www.england.nhs.uk/london

Published May 2025