REPORT OF THE HEALTH DEVOLUTION COMMISSION MEETING

Held in the House of Lords, Tuesday 10th September 2024

Contents

1. Introduction

This is a report of the keynote presentations and main points made during discussion by over 50 stakeholders (see appendix) attending the September 2024 meeting of the Health Devolution Commission held in the House of Lords. Speakers included:

- Andrew Gwynne MP, Minister for Public Health and Prevention
- Katherine Merrifield, Assistant Director, the Health Foundation
- Sarah Walter, Director, ICS Network, NHS Confederation
- Ciara Lawrence, Engagement Lead, and Jackie O'Sullivan, Executive Director for Engagement, Mencap
- Cllr Andreas Kirsch, Leader of Royal Borough of Kingston and ICB member for South West London, representing London Councils

This report is a full, comprehensive and detailed description of the contributions and discussion points made during the meeting in order to capture and reflect the rich insights and experiences of those attending.

Following this meeting, and as resources allow, the Commission will undertake a programme of work to develop contributions to the development of the Government's ten-year health mission for improving the public's health, transforming the NHS and building a National Care Service.

This will begin with a submission to the development of the NHS Ten-year Plan and the 2025 Spending Review - both due to be completed by spring 2025. An outline of this submission will be discussed at the next Commission meeting in December 2024, and then submitted to DHSC & HMT by the middle of January 2025.

2. Improving the Public's Health

Andrew Gwynne MP, Minister for Public Health and Prevention outlined the Labour Government's approach and priorities for improving the public's health. His wide-ranging speech included the following points:

- *The new Government 'gets' both the devolution and the integration agendas. It wants to see the transfer of power out to communities who can take back control*

- *The Government wants to see three transformational shifts: from hospital to community; from analogue to digital; and from treatment to prevention*

- *We know that healthcare accounts for only around 10 to 25 percent of a population's health and wellbeing, and much of the remainder is shaped by wider, fundamental socio-economic factors. I want to see the gap in life expectancy between poorest and richest populations halved.*

- *Becoming a "Marmot nation" is key. Prevention is therefore very much at the heart of the Department's bids for Treasury funding in the 2025 Spending Review.*

- *After the Darzi report we will develop a ten -year plan to fix our health services – our plan will set out not just what has to happen but how*

- *Lord Darzi's work will be built on through engagement with public and stakeholders and there will be a White Paper in the first half of next year. In other words, we don't just want this to be the Government's Plan. We want to build this Plan in partnership with the public, health care staff, and key leaders in health policy like yourselves.*

- *It would be a plan that also recognises that we want to ensure people can live independently as long as possible. That will require more seamless, more integrated care – the right care at the right time in the right place. Neighbourhood care centres will bring primary and community care together – and pooled or aligned budgets will help us go further*

- *The health mission is integral to the growth mission. When we reduce demand for health services and improve people's health, we will have a more inclusive and productive economy: the social determinants of ill health matter*

- *The Government will want to continue dialogue with key stakeholders and hopefully this meeting will be the start of a long relationship with the Commission as we share same vision – a better fairer more equal country with better health at its heart*

The discussion and response to questions from Commissioners and others was wide ranging with the following points emerging:

- Some actions to improve the public's health will apply throughout the UK so Ministers are working closely with their counterparts in Scotland, Wales and Northern Ireland to ensure there is a partnership approach to developing better policy and legislation.

- This partnership approach equally applies to working closely with local authorities, Mayors and Combined Authorities in England who have a central role to play (and will be asked a lot of) given their economies of scale in tackling the social determinants of ill health such as housing, low incomes, unemployment and poor air quality.

- There is a need to embrace those with lived experience as partners when we develop policy and we need to listen so that health services are more accessible for those with learning disabilities.

- The Autumn Budget 2024 and the 2025 Spending Review will determine the spending priorities for 2025/26 and successive financial years so is a key opportunity to implement the Government's three health mission 'shifts':

    - From hospital to community

    - From analogue to digital

    - From treatment to prevention

- Ministers are looking at proposals that will deliver the Health Mission, reflect the policies in the 2024 manifesto and support delivery of the aims and goals embedded in the NHS' constitutional standards.

- Hopefully out of the Spending Review there will be public health projects backed by funding. The calls by local government for multi-year settlements has also been heard by the Government.

- Maps show that poor outcomes for different health issues are often clustered in the same areas, where pressure on the NHS and social care systems is greatest. The data on health inequalities show there is around a 10-year gap in overall life expectancy between the richest and poorest areas of the country, and individuals in the poorest areas not only live less long, they also spend around 10 more years in poor health than those in the least deprived areas. Taking 'levels of deprivation' out of the funding formulae for local government was a mistake.

- The mission-led approach of the Government is outcome-driven. The five Mission Delivery Boards based on achieving better outcomes are a game-changer that will underpin and secure a ten-year programme of renewal.

- The top five public health priorities, collectively supported across government, are: reducing smoking, tackling obesity, reducing alcohol intake, reducing inactivity, and cleaner air. These are the five areas the health mission delivery board is looking at first, with the intention that the focus will then broaden to the wider determinants.

- Tackling the wider determinants of ill health, working towards the 'Marmot England' goal and having a better quality of life generally are also important. This includes Government action to ensure better housing, access to green spaces, better leisure opportunities, creating good jobs, reducing social isolation, better 'social' services, and participation in sport and cultural activities in the broadest sense.

- Seeing patients as an untapped resource in improving their own health care – improving patient agency - is key. This was highlighted in the 2022 Hewitt review and a specific focus is the Health App that not only gives people much greater access to their own health records but can help people make better decisions towards living a healthier life.

- Local Directors of Public Health will play a vital role in helping local councils to in deliver the cross-government public health mission. They are at the centre of the local system and should be to influence decision making across a range of departments and policies that affect the public's health.

3 Delivering the Labour Government's Health Mission and Manifesto Commitments

3.1 Keynote speakers

Katherine Merrifield, Assistant Director, the Health Foundation

The Challenge: The scale of the health inequalities challenge is huge:

- Life expectancy in the UK ranks 25th in the OECD and is now stalling
- Health Foundation analysis projects that an additional 2.5 million people will be living with major illness by 2040
- There are deep health inequalities between areas, for example, there is a 15-year difference in healthy life expectancy between Blackpool and Kensington and Chelsea.
- 7.5 million people report being either out of the workforce on health grounds, or in work with a work-limiting condition.

National action: Improving health and reducing inequalities will require fresh policies and new ways of working for Government. The Health Foundation July 2024 briefing 'Health at the Heart of Government' made a number of recommendations including:

- Learning from the Climate Change Committee by setting up **a new independent non-departmental public body** to provide advice and monitoring across government.
- To build accountability we also suggest requiring **annual reporting on progress to parliament** and mandating the use of health impact assessments on policies likely to have the greatest health impact
- **To strengthen spending on prevention,** recognising that all too often resources are directed towards crisis management including:
    i. Reviewing local government funding formulae to ensure allocations reflect need.
    ii. Shifting towards joint spending pots between different government departments, built on existing models like the Shared Outcomes Fund and supporting these joint pots to focus on longer term planning and prevention
    iii. And more radically, we're suggesting fundamental changes to increase and protect preventative spending – we've been doing work with Demos looking at developing a new category of government spending – Prevention Departmental Expenditure to enable prevention spending to be classified and ringfenced
- **To use targets to drive progress**. Clearly this is a big part of the focus in setting up the Mission Delivery Boards and we've been having positive conversations with the Cabinet Office and DHSC about this
- **To embed health as a shared goal across all missions**, not just leaving it to the health mission board. We think there are particularly important links to be made with the growth and opportunity missions

Regional action: Devolution also provides an opportunity to improve health but action is needed to maximise the role Combined Authorities can play. Health Foundation is funding a big programme, led by the West Midlands Combined Authority to explore the potential of that tier of government to improve health and we're also working with the Centre for Local Economic Strategies and the Kings Fund to build the evidence around health and devolution. Some early learning that's coming through about how to maximise the role that Combined Authorities can play in improving health are:

- Firstly, there are risks in framing devolution around fairly blunt measures of local economic growth and this makes it harder for areas to mainstream tackling health inequalities into delivery of the growth objectives.

- Secondly, there are serious issues around accountability with lots of players and lots of action across councils, ICSs, Combined Authorities and others but it's not coordinated. Further directions for different parts of the system to work together may help but it is important to recognise the different contexts and geographies mean that one size won't fit all
- The third issue is in many ways the most obvious one – the chronic underfunding of councils and the impact this has on their ability to fully participate in joint working to narrow health inequalities.

Integrated Care System action: ICSs need more national support and focus to ensure broader goals to reduce inequalities, improve health and take stronger action on prevention are not crowded out by more immediate, high-profile objectives.

- A survey of ICS leaders by NHS Confederation suggests there is strong commitment to tackling health inequalities but 1 in 5 said they had very low or low confidence in their ability to fulfil their role in doing so
- Research carried out by The Health Foundation showed that local interpretations of policy objectives on health inequalities vary, and local leaders hold contrasting – sometimes conflicting – perceptions of the boundaries of ICS action particularly around the extent to which ICSs should extend their focus beyond reducing healthcare inequalities
- This research also showed that there are concerns among local leaders that objectives on reducing health inequalities are being crowded out by other policy priorities, such as pressures on NHS hospitals.
- National policy is vague about what ICSs should be doing in this area. A degree of flexibility makes sense but the lack of clarity creates a number of potential risks. There needs to be more clarity to guide ICS action. There are also issues around national oversight which needs to reflect the broad range of objectives for ICSs rather than remaining narrowly focused on NHS performance

Sarah Walter, Director, ICS Network, NHS Confederation

Sarah outlined the context within which ICSs are currently working:

- The NHS Confederation's ICS Network has all 42 ICSs in membership.
- ICS leaders every day are committed to the Government's three transformational shifts as outlined by the Minister and which we expect to form the basis of the 10 Year Health Plan. These are core to the purpose of ICSs and why many ICB and ICP leaders have taken on their job.
- We expect the Darzi Review will highlight the pressure systems and staff are under. Some of its expected analysis has been reported in the press. While the overall diagnosis is likely to be bleak (reflecting staff and patient experience), it's essential now to give staff and patients hope as the first step to turning things around.
- In a difficult financial environment, the new Government's manifesto commitment to "over time shift resources to primary care and community services" is the right one to address the structural drivers of today's pressures.
- By bringing together system partners to consider how to make best use of collective resources, integrated care systems are the best way to integrate services and achieve this shift care closer to home to improve tomorrow. However, they need to do this while managing performance, quality and access today
- We welcome the chance to work with government to develop 10 Year Plan to turn things around. However, there's a risk that, while we for the plan to be developed and implemented, in the meantime things could get worse before they get better.

Sarah went on to describe the state of ICSs and the financial pressures:

- Development of the 10 Year Health Plan and delivering the manifesto commitments needs to take stock of where we are now. The NHS Confederation will be publishing its annual 'State of ICSs' report later this month. We have already released a couple of key findings.
- ICS leaders are struggling to marry their collaborative ambition with today's fiscal realities. Delivering against short- and longer-term priorities is a careful balancing act, and performance-management conversations focused almost entirely on finances are crowding out the longer-term transformation ICSs were established to deliver. Nearly three-quarters of ICBs have submitted deficit plans to NHS England with a total overspend of £2.2bn.
- To balance budgets today, they are being forced to cut back, delay or defer the very preventative programmes that will lead to tomorrow's financial sustainability as well as improved outcomes.
- While ICSs leaders fully support the need to shift more resources into primary and community care closer to home, resources are going in the opposite direction. NHS Planning Guidance has asked system to maintain acute care bed capacity and balance budgets. As a result, ICSs are being forced to cut preventative care to maintain acute capacity for winter – money is still going in the wrong direction.
- Changing governance through statutory ICSs was only one piece of the puzzle - financial flows, culture, workforce, etc. all need to be aligned to enable systems to deliver change and improvement for patients.
- Financial incentives need to support shift towards preventative and primary/community care – we are about to begin working with several ICSs to develop and deliver a new approach to outcomes-based contracting, that rewards systems for keeping people health and preventing worsening ill health.
- The shift to primary and community and digitisation will require capital funding – we believe there's a £6.4bn capital funding gap. Given the pressure on public finances, we need to be prepared to look at radical options to open up additional sources of capital funding.
- As the government's manifesto identified, place and neighboured will be key to integrating care closest to patients. Yet, while progress is being made, ICSs still feel behind where they'd like to be in delegating to the most appropriate local level.

Sarah described the opportunities for improvement from better regulation:

- Changing the approach to oversight and regulation right will be crucial to enabling the government in achieving its ambitions to devolve, shift to prevention and move care closer to home.
- The NHS operating model and future regulation needs to better balance short-term operational and longer-term transformational objectives. Currently, it's too focused on the short term and doesn't take into account deliver of local integrated care strategy.
- NHSE had asked ICBs to take on a greater performance management role, but without rebalancing their national and regional oversight – thus adding a new layer, rather than delegating existing oversight. This "middle layer" of oversight has become too crowded and too burdensome.
- Only 40 per cent of ICS leaders feel that system accountabilities with NHSE's national team are clear. However, there are areas where it is working:
    - North East and Yorkshire – the NHSE regional team works with the ICBs on the basis of improvement support, trust and mutual respect through a "4+1 model", rather than top-down performance management.
    - Norfolk and Waveney's has made impressive improvement on ambulance waiting times, enabled in part by the supportive dynamic between the ICB, providers and NHS England regional colleagues to develop a cross-organisational approach to risk.

Sarah emphasised the importance of having a 'whole of government' approach to health, and boosting the labour market:

- As the Secretary of State has said, health can be a driver of economic growth. The Government's Growth and Health missions both provide a golden opportunity to address this.
- The NHS Confederation has today (10th September) published a new report with Boston Consulting Group looking at how the UK can learn from other countries to take whole of government approach can tackle the causes of long-term sickness and economic activity. The current state of play:
    - Since 2020, economic inactivity in the UK has risen by 900,000 people, with 85 per cent of this increase due to those who are long-term sick. The UK has been an outlier among its peers over this period – on average EU countries have seen economic inactivity fall by 2.3 percentage points, while the UK's has risen by 1.1 percentage point.
    - Around 375 million workdays were lost in this period due to people being out of the workforce due to long-term sickness.
    - Reintegrating between half and three-quarters of those who have dropped out of the workforce for reasons of ill health since 2020 could deliver a £109-177 billion boost to the UK's GDP (2-3 per cent in 2029) and unlock £35-57 billion in fiscal revenue over the next five years. Investing in health can drive economic growth.

- Our new quantitative analysis of the wider social and environmental determinants of health shows that:
    - Social and environmental determinants are often more important to health outcomes than clinical or behavioural factors, such as diet and exercise. For example, economic and working conditions explain more of the variance in health outcomes across England than behavioural choices.
    - For some counties – depending on their performance compared to the rest of England – investing in tackling wider determinants could have more impact on health outcomes than investment in behavioural factors.
    - Over the past seven years, changes in living conditions and crime are the factors that have driven most significant changes in health outcomes.

- There are three key barriers which often prevent or hamper such cross-government working and which any whole of government approach to health must address:
    - A common purpose: Drive buy-in across all levels of the system for action on major complex challenges such as long-term sickness driving inactivity.
    - Collaboration and place-based decision-making: with accountability structures that incentive collaboration and local-based decision-making.
    - Joined-up funding and resources: that facilitates longer-term funding horizons where government has a shared view on how to maximise economic and social benefits from health investment and health is a cross-cutting Treasury priority.

In her closing remarks Sarah highlighted that:

- The financial position is very difficult for many ICSs and risks putting ICSs into reverse on prevention
- Changes to financial incentives, oversight and regulation can help to change course
- Capital funding is key and we must be prepared to consider bold solutions given the state of public finances, enabling us to do more with existing revenue funding
- Cross-government working to improve health can help people back to work, boosting the labour market and economic growth

Ciara Lawrence, Engagement Lead and Jackie O'Sullivan, Executive Director for Engagement Mencap

Ciara has a learning disability and began by answering the question 'what is a learning disability?'.

"For me, it is a condition that starts around birth, it is lifelong and affects the way you learn, communicate and understand, but with the right support people can live a brilliant life every day of their lives. And everyone is different.

"So what do we want and need?

- **Prevention**. We need accessible information, the right support, people treating me life a human being and not patronising me. We need tailored health prevention programmes, not just easy read versions of leaflets. We need support networks, groups designed for people with a learning disability, gyms that welcome people with a learning disability with trained instructors. I want to be able to go to my doctor and say 'I think there's something wrong with me, please could you listen to me and help me work out what?
- **Treatment.** If you are treating me, tell me what I need to do, make it clear. Take time to listen to me – not everyone with a learning disability is the same. Some people can't express pain – and some people have even died because of that.
- **Social care**. People with a learning disability need person centred care, based on the social model NOT the medical model. Everyone thinks about social care being about older people in care homes with registered nurses or blocking NHS beds, but that isn't true and we need a different model of care to older people.

Ciara went on to describe her experience of the system:

"Transition to adulthood was a nightmare. Everything was ok while I was at school, but afterwards I was assessed by loads of people who awarded me points to see if I met criteria. Whenever I applied for anything, I keep being told I don't meet the criteria because I can walk and talk.

"I applied to go on the learning disability register at my local GP for years and years and was told it wasn't on my notes or on the system so they wouldn't let me on. Talk about computer says no! It took until I was on TV being interviewed by Jon Snow, before I actually got a call asking if I would like to go on it, and since then I have had three annual health checks, blood tests, smear tests – I am like Mrs Health Guru now – and encouraging other people with a learning disability to do the same."

Jackie described some basic facts about the health of people with a learning disability:

- There are 1.5m people with a learning disability in UK
- People with a learning disability die over 20 years earlier than general population – the higher rate of avoidable deaths could be prevented by better healthcare. For women it is 23 years earlier!
- ICSs are required by law to have an annual LeDeR action plan and a nominated lead on each ICB – but we haven't seen evidence of this.
- Only 25% of eligible people are on the learning disability register in England. No automatic roll on from transition to adulthood. The computer systems don't speak to each other (a GDPR issue previously discussed by the Commission).
- 150,000 get care so there is a high level of unmet need; CSA data analysis shows 2.6M over the age of 50 who should be getting care but aren't. Highest volume of calls on to our helpline.

Jackie went on to describe some key issues to be addressed by the health and social care system:

- A few hours or day services can make all the difference to someone's ability to live and independent and healthy life.
- We talk about social care in terms of older people in 'old folks homes', but most of 62% of the budget goes on people with a learning disability.
- Almost all social care for people with a learning disability is funded by Local Authorities – very little private provision because people don't have the money to pay for it.
- And it requires a more specialist workforce – behavioural support, some nursing duties, coaching – continuity of care very important – and we need a proper workforce plan including better pay.
- As Amanda Pritchard, CEO of NHSE said – "if we make our services better for people with a learning disability, we make it better for everyone"

Cllr Andreas Kirsch, Leader of Royal Borough of Kingston and ICB member for South West London, representing London Councils

- Local government has an explicit role in delivering social care and public health services that would be easily recognised as being important to this agenda – but that is the tip of the iceberg of what local government brings to the agenda of health.
- It is imperative that the Government's mission thinking recognises the wider determinants of health, and therefore the key role of local government, because these wider (alternatively called social) determinants are estimated to account for up to 80% of people's health outcomes, with healthcare services contributing around 20%.
- "Health inequalities and the social determinants of health are not a footnote to the determinants of health. They are the main issue." Michael Marmot
- Much of that 80% is affected by the services, facilities, infrastructure and policies of government, and the majority of that is determined at a local level. Some example policies that contribute are:
  - Planning policies that prevent fast food outlets near schools
  - Providing parks and open spaces for recreation
  - Trading standards that stop illegal tobacco products
  - Housing – as providers of social housing and ensuring the quality of stock
  - Ending homelessness
  - Early years and health visiting provision for children – to make sure they have a healthy start in life
  - Good education and a good environment – as well as good housing - are the building blocks of good health.
- The Royal Borough of Kingston has done some excellent work with promoting active travel, especially cycling, and embarking on estate renewal that will encompass open space and health related infrastructure.
- South West London ICB recognises the role that local government plays in reducing inequalities – and supporting the big listening exercise which supported the strategy development to make sure smaller community groups have their voice heard.
- In London – through the London Health Board – we are committed to making London the healthiest global city, and the best global city in which to receive health and care services. Which can only be done with bold strategic leadership underpinned by local delivery.
- A brilliant example of this is the 'one million hearts and minds campaign' being developed for London. Utilising the best data to target communities that suffer the greatest inequalities in outcomes from cardio vascular disease.
- This will build on other pan-London campaigns like the London HIV Prevention Programme, collectively funded by the Boroughs – which help prevent ill health by providing targeted outreach, community engagement and ultimately changing behaviours, through encouraging testing and maintaining medication.

- But there is always more we can do – and we are willing and able to play our role, our key role as leaders of place, because:
  - Councils are recognisable and relatable to residents and the many diverse communities within them
  - Local authorities have valuable relationships with communities and can reach a wide spectrum of community leaders to help spread information
  - Local authorities unlock ideas and resources, recognising communities as contributors
  - We act as brokers to mobilise the breadth of expertise and knowledge of voluntary, community, faith and social enterprise sector (VCFSE)
  - We have a close relationship with unpaid carers
  - We deliver services for and with the most vulnerable including housing, parks and open spaces and trading standards to keep residents safe
  - Councils are in control of many of the social and physical enablers that can drive down demand
  - Local government is integral to impacting and improving many of the wider determinants of health including education – the best way to improve resident's health is to help them to help themselves.

- But we can't hide away from the challenges we face as local government, especially the difficult choices that have to be made as funding is limited and demand is growing. However, it is a very resourceful sector and is ready to work as a trusted partner.

3.2 Key Discussion Points

- The Government's Health Mission is also a Growth Mission. The linkage is two-way – better health leads to economic growth; and better jobs leads to better health. There is also a direct two-way relationship between health and deprivation. Poor health leads to less income and low incomes lead to poorer health.

- It will be important to ensure that the improving the public's health is a part of all five of the government's five missions (and not restricted to just the Health Mission): The five missions are:

  1) Kickstart economic growth - to secure the highest sustained growth in the G7 – with good jobs and productivity growth in every part of the country making everyone, not just a few, better off.
  2) Make Britain a clean energy superpower- to cut bills, create jobs and deliver security with cheaper, zero-carbon electricity by 2030, accelerating to net zero.
  3) Take back our streets- by halving serious violent crime and raising confidence in the police and criminal justice system to its highest levels.
  4) Break down barriers to opportunity - by reforming our childcare and education systems, to make sure there is no class ceiling on the ambitions of young people in Britain.
  5) Build an NHS fit for the future - that is there when people need it; with fewer lives lost to the biggest killers; in a fairer Britain, where everyone lives well for longer.

- There needs to be a focus on improving social care as well as the NHS. This has not been highlighted in the first 8 weeks of the government but is central to achieving improvements within the NHS because of the interdependency of the two systems, and the value it brings to the quality of life of people with social care needs. The system is in crisis and needs urgent investment and reform now.

- There has been insufficient attention given to the health and care of children in the first 8 weeks of the government. Experience of children's organisations is a strong risk that health devolution will result in a reduction in funding and support of children's health and care services. 57% of ICS forward plans did not identify a lead person for children's health. There needs to be much clearer accountability for children's health in ICBs, place-based partnerships and Primary Care Networks.

- The experience of Hyde in Greater Manchester is integrated neighbourhood health and care services do work and that effective mechanisms can be put in place to ensure that the needs of groups such as children and those who experience health inequalities are not overlooked or ignored. A key to success is to improve the leadership and authority of those integrated neighbourhood services so they have real power and resources at their disposal to focus on those in most need.

- Making change happen in services at the same time as running those services is hard – trying to change the engine of the car whilst its speeding down the motorway. This points to the need to provide 'double running costs' to allow new services to be established before running down the old-fashioned services they will replace.

4 The Commission's 2025 Programme of work

4.1 The Labour Government's Health Mission, NHS Ten Year Plan and Spending Review 2025

The Government is creating a Ten-Year Plan to deliver the Government's Health Mission and its manifesto comments on health and social care. There are three broad strands:

I **Primary Prevention**: A cross government approach to preventing ill-health, covering issues such as reducing smoking, reducing alcohol intake, improving diet, the role of local councils and statutory funding through the Public Health Grant.

II **NHS Transformation**: Focus on the NHS in England (a Ten-Year NHS Plan) but will include social care where there is a close dependency between social care and NHS e.g., avoidable admissions and delayed discharges from hospital to home. An independent baseline analysis of the state of the NHS by Lord Aa Darzi to inform the development of the plan will be published on 12th September.

III **Building a National Care Service**: There is likely to be a government commissioned process to produce a plan for this work and this will be announced in due course. A key element is the creation of a Fair Pay Agreement for the care sector to address issues of low pay of care workers that leads directly to low quality and poor productivity from high staff turnover, poor retention, high training costs, high use of agency staff and high vacancy rates.

In early December 2024 the Commission will meet with Sally Warren, DHSC to discuss the content of the NHS Ten Year Plan and priorities in the Spending Review 2025. This will include consideration of the findings of the Independent Investigation of the NHS by Lord Darzi published on September 12th 2024 that provides a crucial baseline analysis of the state of the NHS to inform the development of the plan and future spending priorities.

4.2 The Commission's unique contribution

The Commission is uniquely placed to contribute insights, experience and best practice regarding:

- How to **balance the national with the local** – the vertical (top-down command and control; with the horizontal – (local accountability, local priorities, and partnership working with local government). And how ministers can meet the public's (political) expectation that having a national health service means having a uniform health service everywhere.

- How to **shift the performance metrics** from inputs (funding) and outputs (waiting times) to outcomes (people being and feeling physically/mentally well) whilst ensuring clear accountability for service and system performance; and how to navigate this change with stakeholders and the public.

- Ensuring the Plan addresses the **health and care of those who have been previously overlooked** that the Commission has championed in the past – e.g., people with learning disabilities, children, and unpaid carers

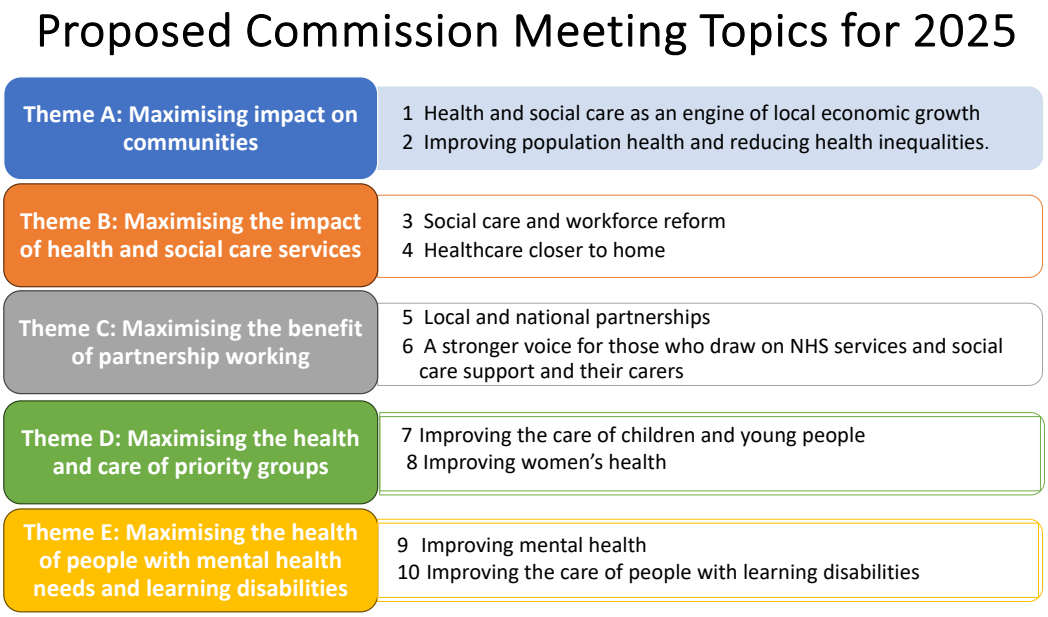
The Spending Review 2025 will be central to establishing the sequencing of the priorities for action that the Government will take in pursuing its Health Mission.

The Commission will seek to develop a single submission to the development of the ten-year NHS plan, and the priorities for action in the 2025 spending review.

4.3 Future Key topics

The Commission will continue to have a key and unique role to play in convening politicians, policymakers, practitioners and people in thought leadership and innovation, policy advocacy and best practice in the new political landscape over the coming period.

Five central themes and top.ics were suggested as the focus for the Commission's work in 2025 and organisations were invited to work with the Secretariat on shaping this proposed programme:



Please contact stevebarwickPC@outlook.com if you would like to discuss supporting the Commission in 2025.

Appendix

REGISTERED TO ATTEND (IN ADDITION TO CO-CHAIRS AND ALL SPEAKERS)

Rt Hon Stephen	Dorrell	Commissioner and former Health Secretary
Dr Linda	Patterson	Commissioner and Bradford District Care NHS Trust
Nadra	Ahmed	Commissioner and National Care Association
Peter	Hay	Commissioner and former President ADASS
Cllr Izzi	Seccombe	Commissioner and Warwickshire County Council
Cedi	Frederick	Commissioner and Kent and Medway Integrated Care Board
Jennifer	Connolly	Commissioner and West Yorkshire Health & Care Partnership
Michael	Wood	Commissioner and NHS Confederation
Nicole	Smith	Commissioner and LGA
Lisa	Nicholson	Commissioner and London Councils
Thomas	Britton	Commissioner and GMCA
Rukshana	Kapasi	Commissioner and Barnardo's
Jeff	Smith	MP for Manchester Withington
Baroness Claire	Tyler	Lords Integration of Primary and Community Care Committee
Baroness Ilora	Finlay	Lords Integration of Primary and Community Care Committee
Cllr Wayne	Fitzgerald	Peterborough Council
Greg	Fell	Directors of Public Health
Katherine	Woolf	Parliamentary Academic Fellow
Becky	Rice	Barnardo's
Benedict	Lejac	Barnardo's
Natasha	Kennedy	Mencap
Mubasshir	Ajaz	WMCA
Evie	Wiseman	GMCA
Connie	Anker	Cambridgeshire and Peterborough Combined Authority
Nishanth	Babu Mathew	Mersey Care NHS Foundation Trust
William	Pope	NHS Suffolk and NE Essex ICB
Laura	Churchill	Central London Community Healthcare NHS Trust
Kate	Shields	NHS Cornwall and Isles of Scilly ICB
Rima	Makarem	Bedfordshire, Luton and Milton Keynes ICB
Clare	Watson	Cheshire and Merseyside ICS
Anisa	Goodwin	Office of the London Health and Care Partnership
Alexandra	Coulter	APPG for Arts, Health and Wellbeing
Geoff	Alltimes	London Borough of Hammersmith and Fulham
Annabel	Culley	Association of Directors of Public Health
Marie	Phelps	Royal College of Psychiatrists
Saskia	Jenkins	Royal College of Psychiatrists
Jess	Rackham	Royal College of Psychiatrists
Alexandra	Houston	Royal College of Psychiatrists
Ellen	Dunn	UK Council for Psychotherapy
Sharon	Brennan	National Voices
Steve	Mulligan	BACP
Beth	Ormrod	Macmillan

Holly	Fraser	Macmillan
Edward	Jones	NHS Confederation
Hashum	Mahmood	NHS Confederation
Jack	Sansum	NHS Confederation
Layla	McCay	NHS Confederation
Nileema	Patel	The Health Foundation
Mariah	Kelly	The Health Foundation
Dr Jane	Harvey	Healthy Hyde
Ed	Hammond	Centre for Governance and Scrutiny
Sam	Boyd	DHSC
Victoria	Bishop-Rowe	Auditory Visual UK
Andrew	Catto	Integrated Care 24
Sumayyah	Mian	National Medical Director's Clinical Fellow
Ashish	Dwivedi	Health Integration Partners
Claire	Kennedy	PPL consultancy
Joe	Smale	Cystic Fibrosis UK
Emily	Holzhausen	Carers UK
John	Perryman	Carers UK
Nishita	Choudhury	Macmillan
Patricia	Farrell	Great Ormond Street Hospital
Andy	McGowan	Carers Trust
Ramzi	Suleiman	Carers Trust
Mimi	Launder	HSJ
Ann	McGauran	Municipal Journal
Steve	Barwick	Health Devolution Commission Secretariat

The partners of the Health Devolution Commission are NHS Confederation, Local Government Association, London Councils, West Yorrkshire Helth and Care Partnership, Mencap and Barnardo's.