The Government's 10 Year Plan for the NHS

Consultation response by the Health Devolution Commission, December 2nd 2024

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23 SHORT TERM AND 4 MEDIUM TERM RECOMMENDATIONS

Quick to do, that is in the next year or so

- ICBs should consider reviewing the balance of NHS and non-NHS partners in its membership who are best placed to deliver their goals going beyond Local Government and considering public health, civil society bodies, 'voice' organisations, and social care providers in its membership.

- There are a number of key questions to be addressed in developing a Neighbourhood National Health and Social Care Service organisational model and these need to be answered, in consultation with the sector and the public, as soon as possible.

- The NHS Ten-Year Plan should at the very least promote pilot ICSs that are allowed greater financial flexibility and increased so they have the opportunity to "double run" some services as occurred with the major change from large stay hospitals to community provisions following the NHS and Community Care Act 1990. A commitment to multi-year funding for capital and revenue is also required along with exception for social care commissioning from competitive tendering strictures.

- The child health equity framework developed to address the social determinants of children's ill-health offers a model of working that can be adopted at a variety of levels and should be incorporated into the government's NHS Ten-Year Plan and its public health improvement strategy within that.

- ICSs should develop their offer for children and young people through pro-actively including their voices, identifying what place means to them, and including education as a partner.

- Establish a Carers Commission to provide a permanent national forum for carers to formally engage with the government across all policy areas but with specific reference to the policies, performance and priorities of the NHS and the social care system.

- Explicitly supporting the value of respite care services that provide a crucial break for carers, (particularly those supporting people with dementia) in order to help them to carry on undertaking this vital role.

- The Commission believes that the NHS Ten-Year plan must clearly articulate the health needs of adults with learning disabilities and the importance that local areas should place on setting local targets for improving their health outcomes and access to health services including having an annual health needs assessment.

- The Commission believes that in order to achieve a shift in health care from hospitals to the community, mental health needs and services should be given parity of esteem with physical health in the NHS Ten-Year Plan, and that this should be reflected in a higher priority and increased resource allocations for mental health within the NHS.

- The NHS Ten-Year Plan should ensure that funding for mental health services continues to grow as a proportion of overall health spending, bringing the amount spent on mental health services more closely in line with the overall burden of disease cost. This would, for example, ensure delivery nationwide of community mental health hubs for 11-25 year olds, offering information, advice and counselling services under one roof.

- Five sets of actions can and should be taken now – in advance of any Royal Commission and/or cross-party talks - to stabilise the social care sector and ensure that the NHS can deliver its improvements:
    - a) Investment to solve the immediate funding crisis
    - b) Investment in a Social Care Workforce strategy including in care workers' pay
    - c) Investment in social care capital
    - d) Investment in care commissioning to stabilise the social care system
    - e) Investment in the care system infrastructure

- There is a strong case for the launch of a Ten-Year Social Care Plan consultation exercise to be launched in 2025 to look at the range of such social care issues above and beyond funding and the threshold for free social care which a Royal Commission/cross party inquiry would examine.

- There should be strong support for digital ways of in core aspects of the health and social care system including electronic care records, digitally-enabled care, system integration, health equity and access, patient engagement and empowerment, workforce training and development, operational efficiency, data-led service planning, and improved diagnostics and early intervention.

- The Government's Industrial Strategy should impact the health sector by accelerating adoption of digital health solutions including telemedicine, promoting artificial intelligence, improving data handling and delivering faster, and more accurate diagnostics and electronic health records to improve efficiency and patient care. The Commission believes that the health and social care system should be added as a sector in the government's Industrial Strategy to ensure these health benefits for patients, service users and the general public are realised.

- National Government should give clear and accountable leadership for reducing health inequalities, improving the public's health and maximising the role of health and social care as the engine room of inclusive economic growth. The Government should agree that England becoming a "Marmot" nation is a cross-government Mission.

- The centrality of poverty to public health outcomes should also be recognised by the Government and all of its policies across all Departments should aim to reduce not increase poverty. Economic growth on its own will not improve health unless that growth is shared across socio-economic classes and reduces overall inequality.

- A Cabinet-level Mission Delivery Board for health equity should be established to agree a timetable with milestones in order to deliver the Mission. This would be chaired by the Deputy Prime Minister, with the support of the Minister for Public Health, and be the cross-government mechanism to address the social determinants of ill health as well as delivering public health services.

- The Minister for Public Health should be, at least, a Minister of State, equal in status to the Minister for the NHS and the Minister for Care, and, given the cross-government nature of the task, should ideally attend Cabinet.

- Every Combined Authority and/or Metro Mayor should have a statutory public health improvement duty similar to those for London, Greater Manchester and the West Midlands to ensure that regional economic growth is inclusive and supports better health outcomes.

- Integrated Care Partnerships within ICSs should become the lead body in every area for improving the public's health, and Government should significantly strengthen the health equality and public/population health improvement powers, roles, resources and impact of these partnerships within every ICS.

- Metro-mayors and leaders of Combined Authorities should play a leadership role in their relevant Integrated Care Partnerships to ensure the health dimension of economic growth, and the economic growth of public health policy, are both an integral part of their work.

- The Government should create specific financial incentives for ICSs to focus on reducing health inequalities and improving population health; and to shift resources towards community-based health, social care and public health services. For example, a national Public Health Prevention Standard - similar to the national Mental Health Investment Standard - as a means of ensuring increased and sustainable funding each year.

- There should be a shift in the focus of regulation and oversight of NHSE and ICBs to ensure appropriate accountability for improving the population's health and reducing health inequalities alongside performance relating to financial balance and service access.

In the middle, that is in the next 2 to 5 years

- The Commission believes that once the government has established its vision for the future of the health of the nation and health services, the number of national targets for the NHS should be the fewest possible and the resources and power to deliver the vision locally should be devolved to the lowest level compatible with good governance, accountability, effectiveness and efficiency.

- In addition to reducing the number of national targets the Commission believes the Government should shift the nature of any national targets away from the way health services are delivered and towards the health outcomes that local systems should seek. The centre should then hold local systems to account for achieving these health outcomes.

- The Commission therefore suggests that the current consultation on a new NHS Ten-Year Plan leads to an opportunity for engagement with the public and stakeholders that could lead to the identification of a minimum number of national performance targets – plus a number of transitional targets - for which local systems should rightly be held to account.

- The Commission believes that in light of these developments at some point during the next ten years the boundaries of ICSs should be reviewed. The imperative is the need for geographic co-alignment of Combined Authority and ICS footprints with economic areas. There are currently only two 2 areas in the country where this is the case, despite the fact that one of the ICS's four aims is to support broader social and economic development.

Long term change, that will take more than 5 years

Many of the changes the Health Devolution Commission propose above can be begun in the short-medium term but their full implementation may continue into the longer term. However, the Commission believes that all of its proposals could - and should - start to be delivered within the lifetime of this Parliament.

With thanks to all the Commissioners and partner organisations that contributed to this submission

Q1. What does your organisation want to see included in the 10-Year Health Plan and why?

The Commission strongly endorses all three of the health shifts that the government have set out as their vision for the NHS, and which form the basis of the welcome and widespread consultation process about the future of the NHS that is now underway. It believes that the development of Integrated Care Systems (ICS) is not only the right structure for achieving the four broad aims they have already been set, but also makes them ideally placed to be the platform for delivering the three health shifts through strong local partnerships between the NHS and local government, and collaborative working with wider partners in the public and voluntary sectors.

The Commission includes in its answers to questions 2, 3 and 4 recommendations for action that contribute directly to delivering the three health shifts, but believes that a fourth shift is also essential to enable these three shifts to happen, namely a shift from the national to the local:

- **A fourth shift: from the national to the local** - greater devolution of NHS power and resources to localities, and strong partnership working with Mayoral combined authorities and local government ensuring social care, public health and other public and VCSE services are better joined up and delivered as well as improved local democratic accountability

This shift is implicitly recognised by the Government's intention to bring forward development of a Neighbourhood National Health Service (NNHS) as an operating model for local community health and care services. However, given the very direct and real interdependencies of the health system, the social care system and the public health system the Commission believes it is essential that collaboration and joint working in decision-making and budgeting is made explicit by 'national to local' being declared the fourth shift.

This shift will also need to become deeper and wider than it has been to date. In government we have a Department of Health and Social Care and this should be reflected locally by NHSE talking of a Neighbourhood Health and Social Care Service to ensure the shift of care from hospital to community is fully embedded at a local level.

Integrated care systems and place-based ways of working are fundamental to achieving all four of the shifts that are required. Currently NHSE is massively missing the criticality of the contribution of local government, wider public services and communities/community led organisations.

A continuation of silo ways of working can only result in each of the systems failing to achieve success to the detriment of patients and service users, and leading to financially unsustainable services. The proposal for a national Integrated Care Partnership Forum, chaired by a government Minister, is a welcome development and this support for a devolved partnership approach must also run through every Integrated Care Board.

Other policy ideas needed to make the shift from national to local real, meaningful and permanent are included in the Commission's answer to question 5.

Q2. What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

Integrated care systems

Integrated care systems provide the best platform for achieving a shift in care from hospitals to communities by understanding and acting upon what needs to change in the way services are configured locally to make this happen. By developing and implementing joint strategies and integrated services within the different parts of the NHS, and between the NHS and other partners in local government and civil society, ICSs can make this shift happen in their boards and partnerships by working in ways that reflect the diversity of the health needs and experiences of different segments of their local populations (location, age, income level, ethnicity, gender and so on).

Crucially, the Commission believes that the NHS alone cannot achieve a shift in care from hospital to community. The social care system is of vital importance in its own right for people who draw on and rely upon its support. But action is required that involves greater integration and co-ordination between different parts of the NHS (e.g. between primary and secondary care) through effective care pathways and services for targeted groups of people at most risk of a hospital admission; and action between the NHS and other services (e.g. between the NHS and social care commissioners and providers as well as the VCSE sector and non-clinical support in communities, schools etc) to provide better care in the community and prevent unnecessary hospital admissions and improve patient discharge from hospital into community-based care.

In particular, the shift from hospital health care to health care in the community cannot be achieved, without improving key elements of the social care system upon which the NHS relies. To that end, the Commission believes that ICBs should consider reviewing the balance of NHS and non-NHS partners in its membership who are best placed to deliver that goal. This should go beyond Local Government, and involve directly public health, civil society bodies, 'voice' organisations, and social care and housing providers in its decision-making. Whilst care will be needed to ensure that IC boards do not become too unwieldly, the current balance of power and membership needs to change to reflect the goal of shifting care from hospital to community.

Funding of NHS and social care services will also need to be addressed during the period of the ten-year plan. If the plan is going to lead to real change, then ICSs are going to have to be given the funding as well as space and powers to do it. A lot of energy at the moment is going into the ICS and the providers delivering a balanced budget and there is little headroom for change.

The plan should at the very least promote pilot ICSs that are allowed greater flexibility including the opportunity to double run some services as occurred with the major change from large stay hospitals to community provisions following the NHS and Community Care Act 1990. A commitment to multi-year funding for capital and revenue is also required. The current system is wasteful as well as bewildering.

Neighbourhood health services

The Commission believes that neighbourhood health services will play a critical role in delivering community-based health care in the widest sense to improve health care for patients and reduce demand on hospital-based services. There are many approaches to developing neighbourhood national health services already in place varying from being a generic way of collaborative working by existing health organisations, through integrated neighbourhood staff teams and multi-sector health hubs (previously known as polyclinics) to a new local organisational tier that leads the NHS in every locality and in some cases hold budgets for both NHS and social care services.

One example of how this might look in practice can be seen in North West London where the ICS is developing Integrated Neighbourhood Teams to provide seamless community-based care; and are accountable for their local population and the individual needs within it. Whilst many aspects of how an Integrated Neighbourhood Team (INT) functions are to be defined in line with local population need, they will share some common qualities:

- They will all be geographically aligned to a population of c.50,000 - 100,000 residents.

- They will all contain the core services of General Practice, VCSE, Public Health intelligence, Adult Social Care, Domiciliary Care, Children's Services (including antenatal and post-natal care), Health Visiting, Social Prescribing, Care Navigation, Community Mental Health, Community Nursing, Community Therapies, Community Pharmacy, Dentistry and Optometry. In addition, they will have a dedicated integrator function, coordinated at Place level through General Practice, Community Providers or Local Authorities.
- Within these organisations, staff will take a "no wrong front door" approach for all services, which can be accessed digitally, by telephony or in person. People will get the help and service they need.
- Areas will work towards hub arrangements wherever possible in which core services will be housed behind a single reception.
- There will be transparency of resources within each INT, coordinated through the Place-based Partnership and interdependent to the North West London core offer developments
- People will access connecting services for all population groups, which operate at Borough or wider footprint, in an agile and responsive way.
- The core teams will pull down on more specialist, services at scale for specific population groups through their acute trusts and other specialist service provision.

Rolling this type of approach out nationwide, it will be important to determine which organisational models are most effective and efficient at providing integrated health and social care services at a neighbourhood level. It will also be important that systems and places are given flexibility in the application of neighbourhood health services, recognising that the professionals and services involved must vary to meet specific population needs.

Whilst a degree of consistency in model will help, significant focus on the key components that enable partners to integrate and work together in neighbourhoods is crucial. The current barriers are not only the absence of a model and organisational forms.

The starting point is that there are 175 place-based partnerships based on local government boundaries within Integrated Care System and around 1,250 Primary Care Networks of GP practices. It is estimated that there are around 100 million contacts made with community health services each year. A key question therefore is which approach to developing a neighbourhood health and social care service will work best given this context and how will the system need to change to accommodate them. In particular, to what extent will a neighbourhood health and social care service be in addition to or replace the existing networks of place-based partnerships and PCNs?

In principle the Commission supports the development of a model of neighbourhood health and social care service that devolves NHS power, resources and services to a place-based collaborative organisational structure that has responsibility for leading and delivering all health, social care and public health services in that neighbourhood area as well as involving other actors that contribute to living a good life such as housing, employment, schools, and the VCFSE sector.

The decision on the geography of the NHCS should be made by local systems, building on and reflecting the maturity and performance of the existing structures in different local areas. The primary care services in a locally defined neighbourhood (including GPs, dentists, pharmacy and optometry) will need to be supportive and work collaboratively with the NHCS, and in delivering their core services.

The key questions to be addressed in developing a Neighbourhood Health and Social Care Service organisational model (which should simplify rather than create yet more complexity and bureaucracy) include:

- **Design principles**: What principles should inform the model of a Neighbourhood Health Service? What degree of flexibility should there be to develop different approaches based on any agreed design principles? How can we ensure that the design and implementation is led by places themselves based on their understanding of their local populations? Who needs to be consulted such as patient groups, advocates, and direct community engagement.
- **Functions**: What purpose, functions and priorities would the Neighbourhood Health Service have? Would they reflect many elements of the model described in the Fuller Stocktake of primary and community care?
- **Services for key groups**: What would neighbourhood teams be expected to do with key population groups? For example, would they work proactively with frail people with escalating risks, provide holistic support for those with long-term conditions, give community support to children and families, and ensure holistic support is provided to adults with learning disabilities to reduce health inequalities?
- **Footprints:** Should the footprints of a local network of Neighbourhood Health Service bodies be geographically co-terminus? Can existing organisational boundaries (Local Government or PCNs) be adopted/amended for this purpose?
- **Population**: Should they each serve a roughly similar size of population (the existing approach in Primary Care Networks of GPs is 30-50k and around 1,250 PCNs in England) or vary according to local circumstances??
- **Leadership**: Who would lead a Neighbourhood Health Service For example, if GPs wish to focus on their frontline role of serving patients, then others would be appointed to lead and manage the new local organisation.

- **Staffing**: What staff would participate in the model – district nurses, physios, specialist staff currently employed in GP practices under the ARRS funding, others? Should services be delivered as they are now? Are there co-location opportunities or innovative approaches to really embed services within existing effective community spaces? Should time be spent on building trusting relationships between the different workforces in each area, and creating patient-centred care pathways for those with complex needs?
- **Scope**: What are other primary care services might be in scope but, like GPs, be involved but not lead or be employed by the Neighbourhood Health Service, such as dentists and pharmacists?
- **Social Care**: How would social care commissioners and providers be included in the Neighbourhood Health Service organisation? Could it become, in effect, a Neighbourhood Health and Social Care organisation under joint leadership of the NHS and Local Government? And could social care staff be the 'oil of integration' using their networking skills, training and capacity to identify people's needs in a holistic way.
- **Voluntary sector:** How would the neighbourhood model embed non-statutory organisations as key partners in delivering care and supporting local populations to remain well and enable sustainable and meaningful involvement of the sector?
- **Funding**: How much would funding for the services and functions it provides be devolved to the Neighbourhood Health Service to manage and configure? How will funding flows and accountability work in practice? How would capital funding be deployed/delegated to support investment in local neighbourhood services/infrastructure?
- **Population health management**: What population data and tools should the ICS provide to enable a neighbourhood health and social care service to identify people in their footprint with potential risks, escalation and non-compliance, and take pro-active action?
- **People engagement:** How should the community's insights be gathered from local people and community groups through questions such as 'what matters most to you in improving your health and wellbeing?'. How can existing ways for engaging with people and community groups be built upon alongside other methods such as focus groups, feedback surveys and using conventional 'market research' methods?

Children

Children are not the same as adults. The Commission has previously drawn attention to the need for Integrated Care Systems to develop a comprehensive approach towards improving the health and care of children and young people. There are crucial differences between the health (physical and mental), social care and public health needs and services for adults, and those of children and young people.

This includes recognising that babies, children and young people have different needs, and require services to support their different stages of development. It also means serving children in the context of their family, and incorporating the vital role that education (from birth to adulthood) plays as a partner in addressing the health and social care needs of children and young people and how good health contributes to success in education. Partnership working across schools, colleges, health, social care etc will be strengthened with the introduction of a single consistent 'child identifier' that all organisations use.

The Commission believes these differences should be reflected in the approach taken to delivering the three 'health shifts' for children and young people so that these reflect 'their world'. This could be summed as another core health shift for children: **from individuals to families**. And this could be reflected in practice by adopting innovative approaches such as the role of 'parent carers' who provide holistic support to families; and by targeting resources on children and their families in geographical areas and communities in greatest need or living in poverty.

National Framework: The core20plus5 for children and young people is a national framework that should underpin and ensure that children are a mainstream feature of the new NHS Ten-Year Plan. Some local systems such as the North East and North Cumbria Health and Care Partnership have adopted and developed this framework to reflect the needs and circumstances of their particular region.

Schools: The Commission believes that schools and colleges are key community anchor institutions for children and families; and teachers are an essential part of any multi-disciplinary approach to addressing children's health and care needs. Many schools are already providing a whole school approach to mental health with services to promote and support CYP health and wellbeing - for example through Mental Health Support Teams. However, this is not yet reflected in the policies, priorities and membership of Integrated Boards and Integrated Care Partnerships within Integrated Care Systems.

In planning a strategy for improving the health and wellbeing of children, new mechanisms for engagement with local schools and colleges may be needed and in ways that clearly articulate the benefits to achieving the goals of those institutions of being an active partner with the ICB.

Place-based working: The Commission supports the place-based approach to commissioning and delivering health and care services that is now underway through ICBs, place-based partnerships and Primary Care Networks but believes it is an approach that may need to look different to reflect the world of children and young people and that recognises their changing needs as they grow and develop. Should the concept of Neighbourhood National Health Services and health hubs look different for children and families – why and in what way? How will schools fit within the NHSCS? Does the model need to be adapted to reflect the lives of children, young people and their families as it develops over time?

Improving children's health: The Commission believes that the child health equity framework developed to address the social determinants of children's ill-health offers a model of working that can be adopted at a variety of levels and which should be incorporated into the government's NHS Ten-Year Plan and its public health improvement strategy within that.

Voice: The Commission has long championed the voice of people who draw upon health and care services and this applies to children and young people. Having children's organisations 'in the room' when systems and service commissioners are making decisions about policies, priorities and resources is key to ensuring that the needs of children and young people and their families' are met. Making ICSs accountable for their actions regarding children and young people should be a common theme and thread in the NHS Ten-Year Plan.

Unpaid Carers

The Commission welcomes the measures in the autumn Budget 2024 to support unpaid carers but this should be only the start of a new approach that recognises the huge value that unpaid carers bring to the lives of people in need of care and support, and to the NHS and social care system that simply could not work or be financially sustainable without them. To that end the Commission believes that the NHS Ten-Year Plan should include three measures for carers:

- Improving identification of unpaid carers in order to offer improved support
- Establishing a Carers Commission to provide a permanent national forum for carers, including young carers, to formally engage with the government across all policy areas but with specific reference to the policies, performance and priorities of the NHS and the social care system.
- Explicitly supporting the value of respite care services that provide a crucial break for carers of all ages, (particularly those supporting people with dementia) in order to help them to carry on undertaking this vital role.

Adults with Learning Disabilities and/or autism

The Commission has long championed the health needs of adults with learning disabilities and highlighted the shocking difference in their health outcomes – as well as in many other areas of life including homelessness, skills, deprivation and employment - compared to others with similar health conditions.

Average life expectancy for someone with a learning disability is 65 years – 23 years earlier than the general population. Black and Asian people with a learning disability have even worse health outcomes – life expectancy for an Asian boy with profound and multiple learning disabilities is 9 years old. Furthermore, many of these deaths are avoidable and are related to healthcare.

The Commission believes that the NHS Ten-Year Plan must clearly articulate the health needs of adults with learning disabilities, and the importance that local areas should place on setting local targets for improving their health outcomes and access to health services including having an annual health needs assessment.

It must also recognise the critical financial pressure facing councils over the next five years that comes from pressure in the learning disability/autism sector. Delivering on these issues is crucial for integrated working - these start with SEND and CAMHS services and continue through to continuing health care and after care services to people who been detained under the Mental Health Act.

Most councils report that the NHS is not adequately funding these key services with disparity of investment and sustained pressure on councils putting them at risk. Over time – over the next ten years – the shift from hospital to community will have implications for the balance of where funding is spent. The focus should shift from one primarily looking at flows out from the hospital to one that is properly supporting community-based care.

Mental health

A variety of research reports have shown that mental illness significantly contributes to avoidable or unnecessary hospital admissions in England, as well as being a major contributor to numbers of people out of the workforce with long term ill health, including that:

- Individuals with mental health conditions are more likely to experience emergency hospital admissions due to inadequate access to timely community-based mental health services or inadequate support from outpatient services, crisis intervention teams, or early community mental health care.
- People with severe mental illness often face physical health conditions (like cardiovascular and endocrine diseases such as diabetes) at higher rates than the general population which when not managed well, can lead to hospital admissions.
- Patients with mental health conditions are less likely to receive appropriate primary care, which may lead to conditions worsening and requiring hospital admission.
- The strain on England's mental health crisis support services, with some regions lacking accessible or sufficient crisis services, can lead to patients being taken to emergency departments (or to out of area hospital placements creating another set of problems) resulting in admissions that might have been avoidable with better preventive care.
- Limited support in the community can also lead to relapse or exacerbation of symptoms, and there is a gap in crisis prevention for people with mental illnesses, including increasing rates of mental ill health among children and young people, leading to increased visits to emergency departments and/or hospital admissions.
- Individuals with mental health conditions represent a notable proportion of high-use patients in emergency departments, partly due to lack of support outside the hospital.
- It should also be acknowledged that inequalities in access, including barriers to support, and experience of mental health care creates inequality in outcomes for some communities such as minority ethnic communities and low-income areas
- Socioeconomic factors, including homelessness and poverty, disproportionately affect people with mental illness, contributing to higher rates of hospital admissions.
- Individuals who lack stable housing or social support may be admitted to the hospital as there are few alternatives for addressing their mental and physical health needs in a holistic way.

Given this evidence, the Commission believes that in order to achieve a shift in health care from hospitals to the community, mental health needs and services should be given parity of esteem with physical health in the NHS Ten-Year Plan, and that this should be reflected in a higher priority and increased resource allocations for mental health within the NHS.

Furthermore funding for mental health care, across the spectrum of complexity, should continue to grow as a proportion of overall health spending, bringing the amount spent on mental health services more closely in line with the overall burden of disease cost.

Community mental health hubs for 11-25 year olds, offering information, advice and counselling services under one roof should be rolled out nationwide to reduce pressures on CAMHS through earlier intervention in line with the shift of care from treatment to prevention.

Having choice of intervention and co-creation of care plans in mental health services is vital to achieving the best possible outcomes. There should be a move away from thinking about a 'single best intervention' in mental health and greater recognition of the evidence that consistently shows the benefits of a range of equally effective interventions, with the ultimate deciding factor in effectiveness being service user preference. Meaningful and informed choice should become the reality for every service user across the country.

The NHS Ten-Year Plan must also ensure that the long-term workforce plan, currently being reviewed, makes mental health workforce and the psychological professions a core part of that plan. Increases in demand for mental health services has outstripped increases in capacity routinely and that has a number of consequences, including people's mental health potentially worsening whilst they wait for access to services.

Social care reform

The Commission believes that 'fixing the NHS' requires also fixing the broken social care system as the two systems are so interdependent. This is not just about the specific points of active interaction between particular health and social care providers such as discharging people from hospital. It is about a shift in the NHS and government mindset about the central importance and value of social care services in local communities in keeping people healthy and safe, and able to live full and independent lives.

The government must create the circumstances for 'repairing' both services and achieving greater integration between the two systems at a local level so as to provide seamless services for those needing health and social care support, help prevent ill-health and reduce the unnecessary costs created by silo working.

The Commission believes that the NHS Ten-Year Plan is an ideal opportunity for the government to spell out and begin to implement its plans for the future development of the social care system. These plans can and should be separate from the process to develop a cross-party consensus on a major reform of how the system is funded. Five sets of action can and should be taken now to improve the delivery of social care whilst that wider strategic question is addressed and a consensus solution established:

a) Investment to solve the immediate funding crisis

The Commission very much welcomes the announcements in the Autumn Budget 2024 of a 6.7% increase in the NLW as this will rightly reward hundreds of thousands of frontline care workers whose role is equivalent to much higher paid equivalent band 3 staff in the NHS; and welcomes the additional investment in public services that will give a 3.2% increase (£3.7bn) in the spending power of local government that funds the publicly funded elements of the social care system.

However, the Commission is deeply concerned at the impact that the Autumn Budget 2024 will have on increasing the costs to social care providers of delivering social care services without providing the funding to meet those costs. It is estimated by the Nuffield Trust that the total cost of the increased employers National Insurance (NI) and the increased National Living wage (NLW) will be some £2.8 billion whilst the amount of ring-fenced support for social care (adults and children) to local government is only £600m (which is included in a calculation of their increased spending power)

This means there is now a serious risk that many private and charitable sector providers of publicly funded social care services (residential and home care) will have to hand back care contracts to local councils and, even more worryingly, consider their future existence, if this imminent funding crisis is not resolved – and quickly. A survey of 1,180 social care providers by the Care Provider Alliance showed that without immediate government intervention:

- 73% will have to refuse new care packages from local authorities or the NHS;
- 57% will hand back existing contracts to local authorities or the NHS;
- 77% will have to draw on reserves;
- 92% who serve self-funders will be forced to increase their rates
- 22% are planning to close their businesses entirely

The impact will not only be on cutting the availability of support for the users of social care, it will also undermine the financial sustainability of local government which will have to pick up the costs of delivering the services, create a 'race to the bottom' in the quality of care provided as contracts are awarded to the cheapest providers, and impose additional costs on the NHS which relies on social care services to reduce key cost drivers such as delayed transfers of care from hospitals.

The Commission recommends in the strongest possible way that that the Government undertakes an immediate review of the impact of the budget on social care services with a view to finding solutions to the crisis – this could be either awarding additional ring-fenced resources to local councils to enable them to pay higher fees in their care contracts, transferring a small proportion of the additional resources given to the NHS to social care perhaps through an increase and reform of the Better Care Fund, or exempting care providers from the increased employers NICs.

b) Investment in a Social Care Workforce strategy including investment in care workers' pay

Skills for Care have published a comprehensive workforce strategy for social care that mirror the areas of focus in the NHS Long Term Workforce Plan namely: attract and retain; train; transform. The Commission believes this strategy should be adopted by the government as the basis for producing a government-led strategy with clear milestones for its implementation and funding. Pilot programmes regarding the upskilling and improved pay for domiciliary care workers are welcomed.

The Commission also welcomes the measures in the Employment Rights Bill to improve the pay and conditions of the care workforce. A Fair Pay Agreement (FPA) for the social care sector is essential and the Commission looks forward to the delivery of that agreement as the core solution to addressing the long-standing problems of low pay, high vacancy rates, and high staff turnover that have dogged the social care sector for too long.

However, as the care sector FPA may not be implemented until 2027/28 because of the legislative and administrative processes that have to be undertaken, the Commission recommends that the government fund a temporary uplift in care workers pay – above the NLW – to help care providers attract and retain staff, reduce their reliance on costly agency staff and unnecessary training costs, and improve the quality of care that care workers provide. Such an investment would have also social and economic value, creating talent pipelines and career progression as well as local economic uplift.

c) Investment in social care capital

The Commission believes that additional government investment in care capital is required to fill the gaps in care in some parts of the country – often called 'care deserts'. This is investment that would both improve the availability and quality of care, and lead to economic growth in places where it is needed most. Specific proposals the Commission believes are worth exploring further include:

1. Creating a £2bn Social Care Investment Affordable Loan Fund to support the creation of care places in areas where the gap between supply and demand for care is greatest. This includes investment in digital ways of working for services such as domiciliary care to improve efficiency and quality.
2. Enhancing the Fund through capital contributions by social investors who receive a balanced mix of financial and social returns
3. Establishing ***national standards*** including greater transparency on financial returns for private investors in social care services. This would be consistent with Department for Education proposals for private child social care services.

d) Investment in care commissioning to stabilise the social care system

The Commission believes that the skills and capacity of local government to commission social care services have been severely eroded in recent years but that a relatively small investment in the spending review to improve social care commissioning will make a big impact on the quality and availability of social care services. The current model of social care commissioning based on price and volume has to change as it drives down quality to reward those providing care at the lowest rate, and providers can grow in size only if they reduce the price to win contracts, leading to a downward spiral in service quality.

Specific proposals the Commission believes are worth exploring further include:

1. Develop ***national standards*** to regulate the commissioning criteria and processes for awarding and supporting care contracts using quality criteria as well as price and volume
2. Support social care commissioners to adopt the goal of creating a local market of high-quality care providers. This requires the government, as well as local government, to take a market shaping role if it wants to see social care providers deliver services that also give benefit to the NHS
3. Exempt local government social care commissioning from the requirement for competitive tendering. This would bring social care into line with the NHS which has been freed from the internal market and competitive tendering that wastes a huge amount of time, talent and resources as providers fight to win or retain contracts often creating a 'race to the bottom'.
4. Improve the commissioning capacity within local government to ensure a 'mature' contracting relationship with private care providers
5. Provide training and support for local government commissioners

e) Investment in the care system infrastructures

The Commission believes that to ensure change in social care is 'hardwired' there needs to be a significant enhancement in the national infrastructure that supports the social care system. The Commission welcomes the new Adult Social Care Negotiating Body being formed through the Employment Rights Bill as an important new part of that infrastructure.

Specific proposals the Commission believes are worth exploring further include:

1. Converting Skills for Care into a national statutory Arms-Length Body (ALB) accountable for developing, monitoring and supporting delivery of a new national care workforce strategy
2. Ensuring social care has full representation on the Board of Skills England
3. Creating a National Care Commissioning body – an NCC to mirror NHSE - to:
   I. Support and improve the care commissioning capacity within local government
   II. Provide training and support for local government care commissioners
   III. Ensure care commissioning standards are being adhered too.
4. Investing in and reforming the Care Quality Commission to better monitor and report on the standards of care and support delivered by care providers; and the effective working of the social care system as a whole. Options for co-regulation - as in the housing sector – should also be explored as building up a local assurance system will have value rather than solely relying on a remote national regulator.
5. Moving towards social care providers as well as local government commissioners of social care being members of Integrated Care Boards (and not just the Integrated Care Partnerships).
6. Ensure social care providers are full members of the Neighbourhood National Health Service structures as they develop.
7. Ensure that the findings of the Dash Review of patient safety and quality are fully reflected in the reform of the services and operating model of the Care Quality Commission

There is a strong case for the launch of a Ten-Year Social Care Plan consultation exercise to be launched in 2025 to look at the range of such social care issues above and beyond funding and the threshold for free social care which a Royal Commission/cross party inquiry would examine.

Q3. What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

The Commission supports the goal of delivering a shift in health, social care and public health services from analogue to digital. There are multiple examples of the effectiveness of this shift for patient health outcomes, the wellbeing of recipients of social care, and the public's health. Digital tools benefit healthcare staff by reducing administrative burdens, enhancing care coordination, and improving decision-making. For health and social care commissioners, these tools help optimise resource allocation, reduce costs, and improve patient outcomes.

As digital solutions continue to evolve, including the growing importance of Artificial Intelligence (AI) within these new ways of working, the Commission believes that the potential for further efficiencies and improved care delivery will expand, contributing to the overall sustainability of the health and social care systems. The areas in which a shift from analogue to digital ways of working could bring about improvements across health and social include:

- Integrated personalised electronic health and care records
- Digitally-enabled person-centred health and care including personal monitoring, support in the home, and combatting loneliness
- Integrated health and social care systems in joint working, multi-disciplinary teams and integrated care pathways

- Health equity and access including data-led service planning and delivery, and language translation
- Patient engagement and empowerment including patient portals and self-service platforms
- Workforce training and development including continuous learning improvement
- Operational efficiency including streamlining administrative tasks, service planning, and resource allocation
- Improved diagnostics, predictive analytics and early intervention

The NHS and social care systems need to ensure that, as new technologies are deployed into the health system, staff are given the time and training to deploy them to best effect. And to ensure that for those service users unable or uncomfortable using new technology in accessing health service, there is also support in a way that works for them. Technological evolution should not be allowed to create health inequalities for those unable to interact with the system in new ways.

To that end a two-pronged approach should be taken to the development of customer facing systems. First, effort must be made to make them as easy to navigate as possible through user testing and co-production with groups most likely to struggle. This would ultimately benefit all users. And secondly, there must be recourse to an alternative system for people unable to use technology.

Regulation of new technology needs to, in as far as is feasible, keep pace with the rate of technological change. The goal must be a regulatory system that isn't a barrier to the roll out of safe and effective technologies but one that provides public reassurance that there are sufficient protections built in to safeguard against harm.

Economic growth

The Commission supports the Government's view that the NHS and social care system is a major engine of inclusive economic growth, and believes it was an opportunity missed to not explicitly include them in the list of sectors covered by the Government's Industry Strategy. However, the Commission believes some sectors such as the Life Sciences that are included in the strategy will have a direct positive impact upon the goal to shift from analogue to digital in the NHS, social care and public health.

Other sectors in the industry strategy will also have a health benefit such as improving the skills and income of the local workforce and building economic growth in low-income areas that experience highest levels of ill-health.

Examples of how the Industrial Strategy could have an impact on health include accelerated adoption of digital health solutions including telemedicine, artificial intelligence, improved data handling and faster, and more accurate diagnostics and electronic health records to improve efficiency and patient care. A focus on Research and Development could also position the NHS at the forefront of medical innovation by encouraging collaboration between the NHS, universities, and private industry to advance medical technologies, drug development, and public health initiatives.

In conclusion the Commission believes that the health and social care system should be added as a sector in the government's industry strategy to ensure these health benefits for patients, service users and the general public are realised.

Q4. What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

Public and population health improvement services

The Commission's work begun in 2020 is rooted in the belief that the government should not just support better health and social care services but act positively to address both people's health needs and the causes of those health needs – "tough on ill-health and tough on the causes of ill-health".

The Commission strongly endorses the aim of shifting the NHS away from being a sickness services towards actively preventing people becoming ill or deteriorating further in their health and wellbeing. In this respect it is important to acknowledge the inequality in prevalence of ill-health and the importance of early identification of disease, as well as the importance of measuring and addressing this as part of the shift from treatment to prevention.

The £3.9 billion Public Health Grant to local authorities has had major cuts in recent years leaving it 28% lower on a real-terms per person basis than in 2015/16, with more deprived areas experiencing the greatest cuts. The Commission believes that public health services have a critical role to play in delivering the shift from sickness to prevention and there should be a step-change increase in the Grant, particularly in the most deprived areas where the public's ill-health is worst, and that it should remain a ring-fenced budget to ensure it is focused on measures to prevent ill-health and not used to fund other services.

The £5 billion Better Care Fund was originally intended to promote greater integration across the NHS and local government including health, housing and social care. The Commission believes that the BCF should be reformed to move its resources 'leftwards' or 'upstream' to demonstrably support a shift from sickness to prevention, and ensure the services it funds are deployed directly to help prevent people's health deteriorating and reduce the demand for acute care (hospital) services.

Social prescribing is an approach that connects people to activities, groups, and services in their community to meet the practical, social and emotional needs that affect their health and wellbeing. Although relatively small in size (around £5m per year) the Commission believes this approach should be expanded as part of the wider strategy to shift the NHS from sickness to prevention and be an essential service within Neighbourhood Health Services.

Tackling the social and economic determinants of ill-health

Whilst moving from treatment to prevention requires changes within NHS and local government public health services, the challenge goes much wider to address the wider social and economic determinants of ill-health. The Commission has long called for a twin approach of both a 'health in all policies' approach to inform the impact of wider public policies and services such as housing and transport; and an 'economic growth in all health policies' approach to inform NHS policies and processes such as local employment, procurement, supply chain development and partnership working.

The centrality of poverty to public health should also be recognised by the government, and all of its policies across all Departments should aim to reduce not increase poverty. Economic growth on its own will not improve health unless that growth is shared across socio-economic classes and there is determined complementary action, for example on child poverty reduction, improving affordable and healthy housing and delivering an inclusive as well as sustainable industrial strategy. Overall government policy should be aiming to reduce inequality and thereby increase healthy living.

The NHS and social care system currently lies outside the scope of the economic focus of the government's devolution strategy. However, there are many developments happening on the ground that clearly show the direct two-way connection between economic success and healthy communities, the two-way benefits of addressing both in tandem, and the potential roles that Mayoral Combined Authorities and Combined Authorities can play in leading local health and care systems at a regional scale and to addressing the wider determinants of ill-health. For example:

- The Rt Hon Andy Burnham, Mayor of Greater Manchester has recently taken on the role of co-chair of the GM Integrated Care Partnership which is also taking forward a Working Well system approach to health and unemployment in GM.
- Oliver Coppard, Mayor of South Yorkshire is now chair of the South Yorkshire Integrated Care Partnership
- Dr Nik Johnson, Mayor of Cambridgeshire and Peterborough is the health lead for the M12 group of Metro Mayors and is co-chair of the Health Devolution Commission.
- The Health Foundation Mayoral Regions Programme that is investigating how Mayoral Regions can improve health and reduce inequalities by taking action across regions.
- The Labour Together report 'Public Service Reform and Devolution' that describes the lessons to be learnt from the experience of Greater Manchester, South Yorkshire and other areas which have secured increased powers over wider public services such as health, policing and probation.
- In West Yorkshire, collaboration and joint employment between the ICB and WYCA focused on inclusion, tackling inequalities and the determinants of health. This has driven, for example, significant focus on work and health including establishing a Partnership Agreement that sets out a shared commitment to working together on the factors that affect population health: fair economic growth, climate, tackling inequality and the determinants of health.

The Commission believes that in light of these developments at some point during the next ten years the boundaries of ICSs should be reviewed. The imperative is the need for geographic co-alignment of Combined Authority and ICS footprints with economic areas. There are currently only two 2 areas in the country where this is the case, despite the fact that one of ICS's four aims is to support broader social and economic development. Reducing ill health and supporting the workforce through the delivery of, for example, Specialist Employment Support for people with health conditions and disabilities is a very important ICS role and one that will be far better facilitated through aligned footprints (including with Job Centre Districts).

The Commission has previously examined this wider societal challenge and following its July 2024 meeting the Commission recommended wide-ranging reforms including that:

- National Government should give clear and accountable leadership for reducing health inequalities, improving the public's health and maximising the role of health and social care

as the engine room of inclusive economic growth. The Government should agree that England becoming a "Marmot" nation is a cross-government Mission.

- A Cabinet-level Mission Delivery Board for health equity should be established to agree a timetable with milestones in order to deliver the Mission. This would be chaired by the Deputy Prime Minister, with the support of the Minister for Public Health, and be the cross-government mechanism to address the social determinants of ill health as well as delivering public health services.

- The Minister for Public Health should be, at least, a Minister of State, equal in status to the Minister for the NHS and the Minister for Care, and given the cross-government nature of the task should ideally attend Cabinet.

- Every Combined Authority and/or Metro Mayor should have a statutory public health improvement duty similar to those for London, Greater Manchester and the West Midlands to ensure that regional economic growth is inclusive and supports better health outcomes.

- Integrated Care Partnerships within ICSs should become the lead body in every area for improving the public's health, and Government should significantly strengthen the health equality and public/population health improvement powers, roles, resources and impact of these partnerships within every ICS. Metro-mayors and leaders of Combined Authorities should play a leadership role in their relevant Integrated Care Partnerships to ensure the health dimension of economic growth, and the economic growth of public health policy, are both an integral part of their work.

- The Government should create specific financial incentives for ICSs to focus on reducing health inequalities and improving population health; and to shift resources towards community-based health, social care and public health services. For example, a national Public Health Prevention Standard - similar to the national Mental Health Investment Standard - or a payment mechanism for Population Health Management as a means of ensuring increased and sustainable funding each year.

- There should be a shift in the focus of regulation and oversight of NHSE and ICBs to ensure appropriate accountability for improving the population's health and reducing health inequalities alongside performance relating to financial balance and service access.

Q5. Please use this box to share specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivered.

A New Shift - Four: from National to Local

The Commission welcomes the Government's strong commitment to devolution as a core enabler of economic growth, and believes this should also be a feature of its approach to reform of the NHS. The Commission, like the government, believes that achieving a health shift from hospital to community will not come about as a result of directives issued from a desk in Whitehall.

Given that is the case, a key challenge for ensuring that the three health shifts happen in practice is arriving at the best balance between the number and nature of targets for change that are set nationally (with 'vertical' accountability upwards to Westminster), and the devolution of power, government resources to local partners, stakeholders and communities to decide local priorities and ways of meeting them (with 'horizontal' accountability sideways to local partners and communities).

The Commission believes that the three health shifts are rightly goals that are set nationally for local areas to achieve. They are fundamental directions of travel that together will help to improve the public's health, deliver better health services, and create effective and efficient ways of working.

However, the Commission believes that how these shifts are achieved is best determined locally by the local partners who understand and are closest to the particular health needs, social and economic circumstances, and performance of service providers in their local areas. Four key questions about what a shift 'from national to local' as a central enabler of the change might mean in practice and which are explored in further detail below are:

- **National/Local**: How to achieve a better balance between national targets and priorities, and local targets and priorities that drive the work of Integrated Care Systems and place-based partnerships?
- **Outputs/Outcomes**: How to rebalance system performance metrics from those that focus on inputs (e.g., funding) and outputs (e.g., waiting times for operations) to metrics focussed on outcomes (e.g., people being and feeling physically/mentally well)?
- **Transitional/permanent**: How to set national targets intended to incentivise a shift in performance that once achieved are removed but monitored to be r-introduced if needed?
- **Public expectations**: How to navigate this change with stakeholders and the public; and in particular, how Ministers can meet the public's expectation that having a national health service means having a uniform health service despite major differences in local circumstances and needs as well as the overall ambition to rebalance the economy (previously known as levelling up) by which certain aspects such as performance and funding might need to differ dependent on geographic, demographic and economic differences.

The national/local balance

A key question to be addressed in the new NHS Ten-Year Plan is the balance between priorities and targets for the NHS that are set nationally and those that are set locally. On the one hand is the desire to use a top-down 'command-and-control' approach to deliver key objectives and ensure equity across the country on key NHS performance measures; and on the other is a desire to devolve decision making and resources to local health and care systems that are best placed to identify, plan and deliver services to meet local health, social care and public health needs.

Some key factors influencing where this balance between what is decided nationally and what is decided locally lands are summarised below:

National ‘push factors’	Local ‘pull factors’
Public expectations about uniformity, fairness and equity in the NHS across the country on service performance standards (e.g., waiting times for emergency care and elective surgery, access to a GP)	**Local public expectations** about the performance of health and social care services in their area
Clinical standards on service quality and safety in care and treatment of patients	**Local government/NHS priorities** for action on specific local health challenges based on population health needs (e.g., reducing diabetes in targeted population groups)
Government priorities for nationwide action on specific health challenges (e.g., child vaccination rates, cancer screening)	**Population variations** between areas in the nature of their populations’ health needs, their geography (urban/rural settings for service delivery),
Government responsibility for fair allocation and efficient use of public resources	**Market variations** in supply and demand of social care services (residential and domiciliary care), care staff, and ‘market making’ activities by local authorities
National levers for change on healthy behaviour (e.g., legislation or taxation relating to food quality or potentially harmful consumer products)	**Local levers** for change on healthy behaviour and the social determinants of ill health (e.g., expenditure of the Public Health Grant, patient experience of care and treatment, local partnership working arrangements)
National action on the social determinants of ill-health (e.g., action to reduce poverty, improve poor housing, and improve poor air quality)	**Local action** on the social determinants of ill-health (e.g., poverty, poor housing, poor air quality)
National funding decisions: NHS budget, Public Health Grant to local authorities, Local Government Grant settlement	**Local funding decisions** e.g., council tax levels, the social care council tax premium
National workforce pay and conditions: Pay awards for NHS staff, a Fair Pay Agreement for care workers, and national workforce strategies across both health and social care (including education, training, qualifications, detailed workforce needs analysis and plans)	

The Commission believes that once the government has established its vision for the future of the health of the nation and health services, the number of national targets for the NHS should be the fewest possible and the resources and power to deliver the vision locally should be devolved to the lowest level compatible with good governance, accountability, effectiveness and efficiency.

In that regard, the Commission strongly welcomed the Hewitt review of integrated care systems as a detailed and helpful analysis of the steps needed to take health devolution to the next stage of development. Within its 36 recommendations the Commission identified five of the ’must do’ changes proposed by the Hewitt Review to be acted upon by Government, namely to:

1. Adopt the Hewitt six principles of integrated care: collaboration; shared priorities; local leadership; support; accountability; and data.
2. Implement a new national architecture of a broad-based national Health, Wellbeing and Care Assembly and a cross-government National Health Improvement Strategy
3. Set no more than 10 national targets and give local ICS priorities equal weight to them
4. Support the development of Local ICS Outcome Frameworks within a National ICS Outcome Framework
5. Creating a national social care workforce strategy

The new NHS Ten-Year Plan should incorporate the ‘must-do’ actions above and in addition include action to:

1. Re-balance local mutual accountability and national accountability for health policy and expenditure including that of all NHS Trusts in an ICS area
2. Ensure that systems address the health and care needs of people of all ages with learning disabilities

3. Ensure that systems address the health and care needs of children and young people
4. Ensure a strong voice at every level in the system for patients, people with lived experience of care and local residents.

The outcomes/outputs balance

In addition to reducing the number of national targets the Commission believes the Government should shift the nature of any national targets away from the way health services are delivered and towards the health outcomes that local systems should seek. The centre should then hold local systems to account for achieving these health outcomes.

In this context, local systems should primarily be held to account nationally (as well as locally) for delivering the three health shifts and for developing the Neighbourhood Health Service model of care in their area. But local systems should be free to decide how they will achieve those shifts and develop this model to suit their local needs and circumstances.

The government should be clear on **what** it wants to achieve (the outcomes and vision) and then let local partners through integrated care systems determine **how** they can achieve it (the delivery of the vision and those outcomes). This would be consistent with a number of outcome frameworks already in place for MCAs and LAs.

The transitional/permanent balance:

One main concern that many single-issue or single-client group organisations have with a devolved approach that reduces national direction in favour of local decision-making is their previous experience of a down-grading of the health needs and services for key population groups such as children and young people, people with learning disabilities and people with mental health needs.

For them, strong national leadership, direction and targets for delivering better health services to these and other specific population groups are needed because it is their groups whose health needs are felt to be most often ignored, overlooked, downgraded or relegated in the list of local priorities. Their experience is that it is the health needs of these groups that tend to be neglected locally when national political priories (such as reducing long waiting lists) are used to hold local health leaders to account for the performance of their NHS organisation or system.

The Commission believes that one approach the government could consider to address this problem would be to create transitional targets for local systems for improving the health services and outcomes of the population groups most at risk of being downgraded. These could include transitional targets for improving the services and health outcomes of children and young people, people with learning disabilities and people with mental health needs.

Public expectations of the NHS

Surveys have shown that there remains a high level of support for the founding principles of the NHS, namely that that the NHS should provide a comprehensive service available to all remain free at the point of delivery and be funded primarily via taxation. There is also public support for

increasing the number of frontline staff in the NHS and for reducing the waiting times for key services. The public want the NHS to prioritise:

- increasing the number of staff working in the NHS (45%)
- reducing waiting times for core services (36%)
- reducing waiting times for A&E (35%)
- improving waiting times for routine hospital treatment and care (35%)
- improving access to face-to-face GP appointments (32%).

The public also want to see:

- increased capacity in social care settings so that people can leave hospital sooner,
- a workforce plan for the number and types of staff the NHS needs to deliver services in the future
- a seven-day work week for all parts of the NHS, meaning appointments are offered at a wider range of dates and times, including at the weekend.

The Commission believes that many of these public expectations are not unreasonable or inappropriate, and recognises that to reduce the number of input targets to move towards an approach based more on outcomes would require considerable public consultation. The Commission suggests that the current consultation on a new NHS Ten-Year Plan leads to an opportunity for engagement with the public and stakeholders that could lead to the identification of a minimum number of national performance targets that reflect many of these expectations and for which local systems should rightly be held to account.

Recap and timeframe for delivery of 23 short term and 4 medium term recommendations from the Health Devolution Commission.

Quick to do, that is in the next year or so

- ICBs should consider reviewing the balance of NHS and non-NHS partners in its membership who are best placed to deliver their goals going beyond Local Government and considering public health, civil society bodies, 'voice' organisations, and social care providers in its membership.

- There are (at least) eight key questions to be addressed in developing a Neighbourhood National Health and Social Care Service organisational model and these need to be answered, in consultation with the sector and the public, as soon as possible.

- The NHS Ten-Year Plan should at the very least promote pilot ICSs that are allowed greater financial flexibility and increased so they have the opportunity to "double run" some services as occurred with the major change from large stay hospitals to community provisions following the NHS and Community Care Act 1990. A commitment to multi-year funding for capital and revenue is also required along with exception for social care commissioning from competitive tendering strictures.

- The child health equity framework developed to address the social determinants of children's ill-health offers a model of working that can be adopted at a variety of levels and should be incorporated into the government's NHS Ten-Year Plan and its public health improvement strategy within that.

- ICSs should develop their offer for children and young people through pro-actively including their voices, identifying what place means to them in their area, and including education as a partner.

- Establish a Carers Commission to provide a permanent national forum for carers to formally engage with the government across all policy areas but with specific reference to the policies, performance and priorities of the NHS and the social care system.

- Explicitly supporting the value of respite care services that provide a crucial break for carers, (particularly those supporting people with dementia) in order to help them to carry on undertaking this vital role.

- The Commission believes that the NHS Ten-Year plan must clearly articulate the health needs of adults with learning disabilities and the importance that local areas should place on setting local targets for improving their health outcomes and access to health services including having an annual health needs assessment.

- The Commission believes that in order to achieve a shift in health care from hospitals to the community, mental health needs and services should be given parity of esteem with physical health in the NHS Ten-Year Plan, and that this should be reflected in a higher priority and increased resource allocations for mental health within the NHS.

- The NHS Ten-Year Plan should ensure that funding for mental health services continues to grow as a proportion of overall health spending, bringing the amount spent on mental health services more closely in line with the overall burden of disease cost. This would, for example, ensure delivery nationwide of community mental health hubs for 11-25 year olds, offering information, advice and counselling services under one roof.

- Five sets of actions can and should be taken now – in advance of any Royal Commission and/or cross-party talks - to stabilise the social care sector and ensure that the NHS can deliver its improvements:
    a) Investment to solve the immediate funding crisis
    b) Investment in a Social Care Workforce strategy including investment in care workers' pay
    c) Investment in social care capital
    d) Investment in care commissioning to stabilise the social care system
    e) Investment in the care system infrastructure

- There is a strong case for the launch of a Ten-Year Social Care Plan consultation exercise to be launched in 2025 to look at the range of such social care issues above and beyond funding and threshold for free social care which a Royal Commission/cross party inquiry would examine.

- There should be strong support for digital ways of in core aspects of the health and social care system including electronic care records, digitally-enabled care, system integration, health equity and access, patient engagement and empowerment, workforce training and development, operational efficiency, data-led service planning, and improved diagnostics and early intervention.

- The Government's Industrial Strategy should impact the health sector by accelerating adoption of digital health solutions including telemedicine, promoting artificial intelligence, improving data handling and delivering faster, and more accurate diagnostics and electronic health records to improve efficiency and patient care. The Commission believes that the health and social care system should be added as a sector in the government's Industrial Strategy to ensure these health benefits for patients, service users and the general public are realised.

- National Government should give clear and accountable leadership for reducing health inequalities, improving the public's health and maximising the role of health and social care as the engine room of inclusive economic growth. The Government should agree that England becoming a "Marmot" nation is a cross-government Mission.

- The centrality of poverty to public health outcomes should also be recognised by the Government and all of its policies across all Departments should aim to reduce not increase poverty. Economic growth on its own will not improve health unless that growth is shared across socio-economic classes and reduces overall inequality.

- A Cabinet-level Mission Delivery Board for health equity should be established to agree a timetable with milestones in order to deliver the Mission. This would be chaired by the Deputy Prime Minister, with the support of the Minister for Public Health, and be the cross-government mechanism to address the social determinants of ill health as well as delivering public health services.

- The Minister for Public Health should be, at least, a Minister of State, equal in status to the Minister for the NHS and the Minister for Care, and given the cross-government nature of the task should ideally attend Cabinet.

- Every Combined Authority and/or Metro Mayor should have a statutory public health improvement duty similar to those for London, Greater Manchester and the West Midlands to ensure that regional economic growth is inclusive and supports better health outcomes.

- Integrated Care Partnerships within ICSs should become the lead body in every area for improving the public's health, and Government should significantly strengthen the health equality and public/population health improvement powers, roles, resources and impact of these partnerships within every ICS.

- Metro-mayors and leaders of Combined Authorities should play a leadership role in their relevant Integrated Care Partnerships to ensure the health dimension of economic growth, and the economic growth of public health policy, are both an integral part of their work.

- The Government should create specific financial incentives for ICSs to focus on reducing health inequalities and improving population health; and to shift resources towards community-based health, social care and public health services. For example, a national Public Health Prevention Standard - similar to the national Mental Health Investment Standard - as a means of ensuring increased and sustainable funding each year.

- There should be a shift in the focus of regulation and oversight of NHSE and ICBs to ensure appropriate accountability for improving the population's health and reducing health inequalities alongside performance relating to financial balance and service access.

In the middle, that is in the next 2 to 5 years

- The Commission believes that once the government has established its vision for the future of the health of the nation and health services, the number of national targets for the NHS should be the fewest possible and the resources and power to deliver the vision locally should be devolved to the lowest level compatible with good governance, accountability, effectiveness and efficiency.

- In addition to reducing the number of national targets the Commission believes the Government should shift the nature of any national targets away from the way health services are delivered and towards the health outcomes that local systems should seek. The centre should then hold local systems to account for achieving these health outcomes.

- The Commission therefore suggests that the current consultation on a new NHS Ten-Year Plan leads to an opportunity for engagement with the public and stakeholders that could lead to the identification of a minimum number of national performance targets – plus a number of transitional targets - for which local systems should rightly be held to account.

- The Commission believes that in light of these developments at some point during the next ten years the boundaries of ICSs should be reviewed. The imperative is the need for geographic co-alignment of Combined Authority and ICS footprints with economic areas. There are currently only two 2 areas in the country where this is the case, despite the fact that one of the ICS's four aims is to support broader social and economic development.

Long term change, that will take more than 5 years

Many of the changes the Health Devolution Commission propose above can be begun in the short-medium term but their full implementation may continue into the longer term. However, the Commission believes that all of its proposals could - and should - start to be delivered within the lifetime of this Parliament.