THE KEY POINTS RAISED AT THE HEALTH DEVOLUTION COMMISSION MEETING

The Government's 10 Year Plan for the NHS

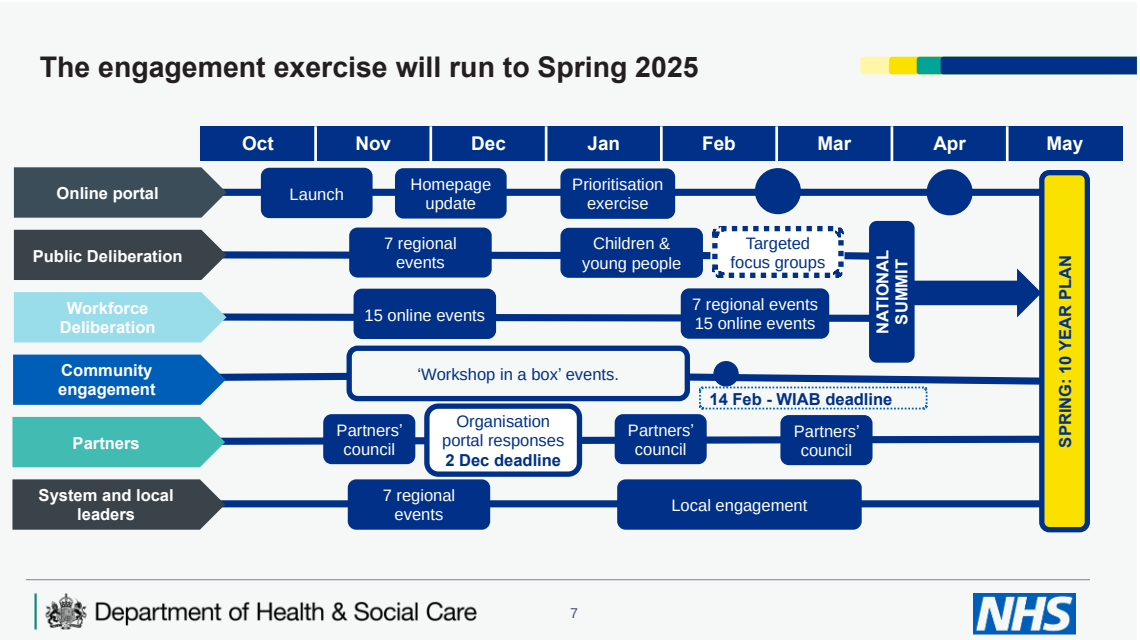
The case for a 4th shift: from national to local

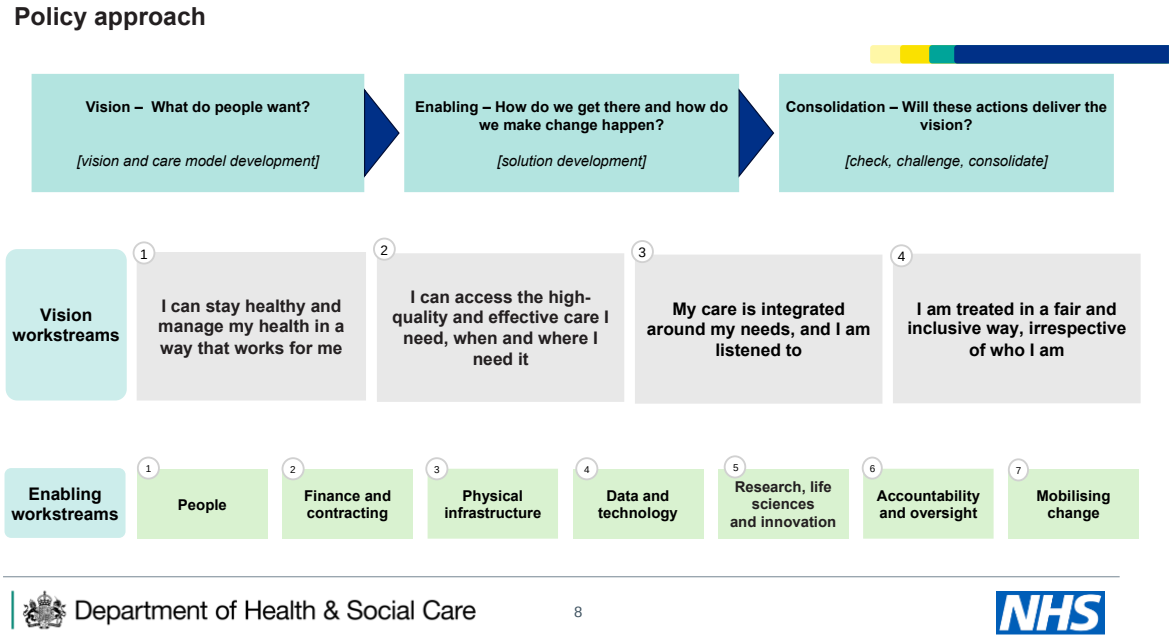
Held Online, Thursday 12th December

This is a short non-verbatim note of the key points made by contributors to the meeting of the Health Devolution Commission held online on 12th December 2024. A recording of the session is available here. Also appended is a summary of the welcome policy proposals in the English Devolution White Paper regarding health and devolution.

1 NHS TEN-YEAR PLAN

Sally Warren gave a slide presentation here on the process for undertaking a major consultation on the development of a new Ten-Year Plan for the NHS including the creation of a number of working groups to contribute to the plan. This is summarised in the two slides below:





Early findings from responses are that the public are very proud of the NHS but want to see the basic tasks (including use of technology) to be done well, more delivery of - and easier access to - services in the community, and more done to prevent ill-health.

NHS staff have similar views to the public, but in addition feel under a lot of pressure from staff shortages, technology issues, and underfunding; believe that shared digital health records are crucial; and strongly support prevention with an emphasis on early intervention and education from a young age.

2 PREVENTION: LIVE WELL

The Rt Hon Andy Burnham, Mayor of Greater Manchester emphasised that, whilst the NHS should remain a national service, the integration of services within the NHS and between the NHS and social care had to happen locally – echoing the Commission's call for a '4th shift' from national to local.

Andy focused on the shift to prevention saying that the task of preventing ill-health and tackling health inequalities should be led at the regional or sub-regional level through Combined Authorities because tackling the social determinants of health requires action at a larger scale than that of local authority boundaries. This would mean placing a joint responsibility on more powerful Integrated Care Partnerships of ICSs and Combined Authorities to prevent the ill-health of people in the places in which they live. He identified poor housing as one of the main drivers of ill-health, and that there should be a clear goal of ensuring every person has a good, safe and warm home.

The goal of preventing ill-health should be delivered through a new local system of practical support for individuals and families that he described as a 'Live Well' service to be run alongside local NHS services, and including core funding to support local Voluntary Community, Faith and Social Enterprise (VCFSE) organisations as delivery partners.

3 THE NHS AND SOCIAL CARE

Cllr David Fothergill welcomed the far-reaching consultation process for the new NHS Ten Year Plan and the three shifts in care to be achieved. He stressed that the NHS cannot be fixed without fixing social care and a similar process was needed for the development of a plan for social care. He also emphasised the key role of local government in tackling the wider of determinants of ill health, many of which lie outside of the NHS.

The full text of David's contribution is available here. The priorities for the NHS Ten Year Plan that he identified were tackling health inequalities, implementing integration, taking a preventive approach and supporting the contribution of the VCFSE sector. He highlighted the need to improve mental health services, improve the health and wellbeing of children and young people, and improve support for working age adults.

Speaking in advance of the publication of the Devolution White paper, David said that for ICSs to flourish, local government must be an equal partner, jointly driving forward the agenda. He emphasised the important role of local government as the democratically elected leaders of local places, uniquely positioned to bring agencies together around the needs of residents.

4. Q&A

During the following panel discussion, a number of key points were raised and answered:

ISSUES/QUESTIONS	RESPONSES
The voice of people with a learning disability: How will the government make sure that the views of people with a learning disability are being heard in development of the NHS Ten Year Plan?	In the consultation process for the NHS Ten Year Plan, the Department for health and Social Care very much want to reach communities and groups whose voices are seldom heard. For people with learning disabilities this includes having an easy read version of the consultation questions on the portal and the workshop-in-a-box; actively ensuring that people take part in the public deliberative events; and holding a focus group specifically for people with a learning disability in early 2025.
Workforce integration: What will greater integration between the NHS and social care workforce looks like in practice – the skills, roles, incentives moving between systems and so on?	The 'People' policy working group that will contribute to developing the plan will be looking at caring roles in community and in people's homes, career progression and the proper delegation of healthcare roles to people working in social care. GM are providing new career routes into health and social care for school leavers through apprenticeships and placements in the NHS that provide purposeful jobs for young people (some of whom might otherwise be at risk); and this will help meet the challenge of having a sufficient workforce to meet growing health and social care demand. There should be a bigger role in post 16 education for combined authorities and local government in a joint endeavour linking education to young people's holistic development.

	A national social care workforce plan prepared by Skills for Care already exists and should be adopted and implemented by government now.
Preventing ill health and the role of the NHS: For children and families the work to prevent ill-health and the services of the NHS are inextricably linked. Children and families often present to the NHS with needs that are more about their social care.	The Plan will include the role of the NHS as anchor institutions in their communities, how services can be designed to reflect local community views and circumstances using examples such as 'poverty proofing' access to services, and being a better partner to the VCFSE sector and local government engaged, worked with, and treated, as equals.
Family support to live well: Should a Live Well service that addresses the social determinants of ill-health include integrated support for families and family hubs? Improving children's health outcomes prevents future ill-health and can deliver financial savings to the NHS as a result.	The 2010 Marmot report on the social determinants of ill health has already established that the biggest change can be achieved from interventions in the early years of life including those that improve 'school readiness'. GM have also developed a system that makes visible to all local services the results of the local health visitor survey of the health of every 2-year old, and identifies those who need additional support at an early age. Children have too often been overlooked and the huge reduction in the Public Health Grant over the last decade has had an impact on their health and wellbeing
Future of Social Care: What is the future of social care?	The excellent engagement process for the NHS Ten Year Plan should be a blueprint for the process of developing a ten-year plan for social care. The DHSC Select Committee is having a welcome inquiry into the cost of inaction in adult social care. It should hold a similar inquiry into the cost of inaction in reform and investment in children's social care.

5 MOVING FROM NATIONAL TO LOCAL

Rob Webster, CEO of the West Yorkshire Health and Care Partnership and a co-chair of the NHS Ten Year Plan working group on assurance and oversight reminded the meeting of the purpose and ambition of integrated care systems as new constructs with statutory duties and powers, and new ambitions to drive change and improve health outcomes in their area.

Place matters: He emphasised the importance of thinking about the health needs of people in the context of their place – that where people live has a major impact on how long they live and how well they will be. The local reports by directors of public health spell this out in terms of different life expectancies in different places. For example, life expectancy in West Yorkshire varies between places by 23 years, and even more for people with a learning disability. So health, social care and public interventions have to reflect these differences and be planned and delivered as close as possible to those people in those places.

Local needs not national averages: National perspectives applied to local circumstances can be very wide of the mark. For example, the 100,000 people who work in the health and care system in West Yorkshire are 1% sicker than the rest of the country which means we have 1,000 people a day not at work which is not taken into account in Whitehall or by national planning.

The Core 20 inequalities strategy that focuses on the 20% of the population living in the poorest parts of the country, and what needs to be done to improve their health, is one of the most successful focused approaches to health improvement by the DHSC and NHSE. However, the proportion of people living in those bottom two deciles in West Yorkshire is 34% not 20%. 22% of people live in the bottom decile, if you're a child its 28% and if you're non-white its 42%. So, a figure from Whitehall saying there is a population of 20% needing targeted support is redundant. The life expectancy for some populations groups such as travellers in our area is 50 years old. And the level of economic inactivity is much higher than the English national average. National averages as a planning tool are irrelevant to meeting local needs.

Local action works: This all points to putting solutions as close to people because when you do, 'magic can happen' and you can tap into local resources. For example, 22% of UK med. Tech. jobs are to be found in West Yorkshire, and working together across all councils a strategy for inclusive economic growth has been developed Our housing and health programmes are making a big difference to people with mental health problems.

For people living in the lowest decile we can identify interventions that will make the biggest difference on the biggest health issues such as cancer, respiratory and cardio-vascular disease including primary prevention (housing, education, environment), secondary prevention (case finding) and tertiary prevention (support for people living with multiple morbidities).

To make most difference on elective care pathways, you should work with people in the lowest decile at the outpatient stage - not at the GP/referral stage or the treatment stage because we do not communicate with people appropriately, particularly those whose first language is not English, those with a learning disability, and those with a lower educational attainment. And for people doing 2-3 jobs to survive and support their family being given one date and place for an appointment doesn't work. So, fundamentally, you have to put as much responsibility as possible in the hands of the person themselves, then the neighbourhood, then the place, then the region and then nationally.

Cultural shift: The proposed three shifts in care are cultural signifiers of change. The health mission is about improving the health of the population, improving the NHS and reforming social care but we always default to fixing the NHS. We must make all three goals equally important. The impact of the budget's increase in ENICs on the third sector, GPs and social care suggest that the importance of all three to improving health and improving the NHS is still not recognised or understood.

System change: The current system has the right functionality to deliver the changes needed – the right partners, statutory powers, and management structures to do the right things. ICBs and ICPs are the building blocks to shift power downwards to people and localities. Effective subsidiarity means clearly describing what should take place at each level in the system that will speed delivery, reduce bureaucracy and put power in the hands of people who can make a difference.

This will lead into wider public service reform and open up the development of a re-named neighbourhood health service that is more like the Live Well model that meets people's physical, mental and social needs; and that recognises and builds upon the assets and contributions of people in the places in which they live.

6. Q&A AND CONTRIBUTIONS

Key points raised in the subsequent discussion included:

Optimism: There is now a new landscape of policy and priorities with a welcome emphasis on localism and integration but there remains the need to avoid the urgent today getting in the way of the important tomorrow. The right measures of change and mutual accountability for their delivery is crucial. Need to systemise pockets of excellence to ensure they become the norm.

Unpaid carers: Need to fully and explicitly recognise the contribution of unpaid carers to the effective functioning of the health and social care system and their needs. This should be included by viewing carers as partners in the People and Accountability/Oversight policy working groups of the NHS Ten Year Plan.

Children: The government's mission milestones for children embrace health and education and this must be a cross-government task (nationally and locally) that includes school readiness and primary health prevention. There must be a 'children's health in all government departments' approach.

Mental health workforce: The innovation in removing barriers to joining the mental health workforce in places like GM should be implemented around the country to prevent creating barriers for the mental health workforce being able to move between different parts of the country. The regulatory framework for the mental health workforce will be important to achieving this.

Postcode lottery: There is a difference between a policy that seeks to avoid a postcode lottery in people's access to services that by having a uniform or flat offer of services in every area; and a policy of improving access to services that varies from place to place because it recognises local inequalities and differences in people's needs and circumstances. Local flexibility to deploy resources well will enable this variation in services to take place without resulting in a perceived 'postcode lottery' of access to services or health outcomes.

Patient list-base in general practice: This will be a key tool in improving co-ordination of services at a local level, and where GPs play a critical role in neighbourhood health and care services.

How local is local? To achieve the impact desired requires action at the level of the functional economy – the sub-regional or Combined Authority level - where all players can be engaged, relationships with government departments built, and in which local authorities work to a common agenda and local delivery takes place.

Prepared by Phil Hope and Steve Barwick, Secretariat of the Health Devolution Commission

APPENDIX – EXTRACTS FROM THE ENGLISH DEVOLUTION WHITE PAPER

- We will introduce a new bespoke duty for Strategic Authorities in relation to health improvement and health inequalities.
- We will introduce an expectation that Mayors are appointed to Integrated Care Partnerships and are considered for the role of Chair or Co-Chair. The Mayor should also be engaged in appointing Chairs of Integrated Care Boards.
- Over the long term, the government is announcing an ambition to align public service boundaries, including job centres, police, probation, fire, health services and Strategic and Local Authorities.

Strategic Authorities have a key role to play in taking action, particularly on the social determinants of health, through the exercise of their functions, in areas such as transport, housing, and planning, and through working with other local leaders to move away from traditional forms of service delivery to a holistic approach, organised around service users.

To support Strategic Authorities to be active leaders in this space and drive a "health in all policies" approach in line with our Mission government approach, the government is introducing a new bespoke duty in relation to health improvement and health inequalities. This will ensure Strategic Authorities have regard to the need to improve health, and the need to reduce health inequalities, in the exercise of their functions, and give them a clear stake in improving local health outcomes. This will complement the existing health improvement duty held by upper-tier Local Authorities. We will engage Strategic Authorities, Local Authorities and the NHS as we take this forward.

The government recognises the benefits that aligned geographical boundaries can have for improving coordination between public services. In South Yorkshire, the aligned boundaries between the Integrated Care System and the Combined Authority have facilitated joint working, including the Mayor chairing the Integrated Care Partnership. The government will therefore work with stakeholders to identify areas where alignment and closer working can be facilitated where there is a clear rationale for doing so, and where the benefits in aligning geographical boundaries significantly exceed any costs and risks incurred.

To support better join-up between Strategic Authorities and Integrated Care Systems, the government expects that Mayors (or a delegate) will be appointed to one or more relevant Integrated Care Partnerships in their local area. We will also establish an expectation that the Mayor or a delegate is considered for the position of Chair or co-Chair of the Integrated Care Partnership, alongside Local Authority, Integrated Care Board and independent chair options.

We will further set an expectation that Integrated Care Boards will engage with mayors during the Integrated Care Board Chair appointment process and will involve them in setting their priorities and developing their plans.

The government recognises that Strategic Authorities will need appropriate powers and levers to maximise their impact on public health and the government's health and growth missions. The government will keep under consideration the powers and levers that should be made available to Strategic Authorities to support delivery of improvements in health outcomes and maximise impact on the health and growth missions.