Cheshire East DRAFT Response

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

- Recognition that this needs to be a plan for health and wellbeing and health and social care services, not just the NHS. It needs to begin with an emphasis on individuals being empowered (and supported in being more health literate) allowing them to take responsibility for their own and their family's health and wellbeing and enabling families through a 'healthy household' approach and a 'healthy neighbourhoods' model (asset / strength-based utilising the community, voluntary, faith and social enterprise sector that will support Neighbourhood Health Services). The importance of prevention and early intervention must be emphasised and the recognition of the importance of addressing the wider determinants of health that impact upon individuals and communities as well as addressing all of the challenges facing the NHS **and** social care services. A systematic approach is required, rather than piecemeal improvement that fails to recognise the interdependencies within a very complex health and care system.

- Importantly, a 'neighbourhood health service' and 'shifting care into the community' must not mean shifting a medical model into communities. It requires a new proactive model of care that works more effectively with communities and wider partners.

- Underpinning the Plan should be a 'strength-based' practice approach across the health and care system, that recognises what positive steps are already being taken and advises/coaches about the next steps that need to be taken, rather than focusing on the deficits and providing paternalistic solutions that can generate further demand.

- We would like to see improved and extended (at least three years) financial settlements for local authorities (including the Public Health grant). These should take account of projected demand pressures and inflationary pressures, noting for Social Care services that, as opposed to RPI, the main driver of rising prices is in relation to increases in the national living wage. Most externally commissioned care costs are driven by this. Using the current financial year (2024-2025) as an example, the national living wage increased by close to 10% whereas councils were restricted to raising Council Tax by 5% - immediately creating a financial pressure and in turn, restricting the council's ability to respond in this area.

  The negative impacts of the wider determinants of health and health inequalities have increased as council budgets have reduced the services and resources available to support those in most need. This includes amongst other things housing, anti-social behaviour, provision of library and youth

services, employment support, benefits availability, community services, accessibility of green spaces etc.

If the NHS and Local Authorities have security of funding for at least a 3-year rolling base this will further enable them to commission services from the community, voluntary and social enterprise sector on a longer term basis rather than on a year-to-year basis, broadening the availability of services, strengthening the neighbourhood service provision and creating a more sustainable sector.

- A commitment to investment in Public Health to make up for the 25% reduction in the Public Health Grant since 2015. The reduction in the grant over the last 9 years and the internal financial pressures of local authorities have impacted upon the level of preventative work that Public Health teams have been able to commission or instigate. Similarly, there needs to be a move away from time limited grants (for example in relation to substance misuse) as these make it very difficult to plan in the long term.

- A recognition of and commitment to the 'Marmot principles' as set out in *Fair Society, Healthy Lives (The Marmot Review) (2010)* and *Health Equity in England: The Marmot Review 10 Years On (2020):*

  - giving every child the best start in life
  - enabling all people to maximise their capabilities and have control over their lives
  - ensuring a healthy standard of living for all
  - creating fair employment and good work for all
  - creating and developing healthy and sustainable places and communities.

  Inequalities should be considered in every decision and funding provided to areas that reflects inequality challenges (recognising that rural areas face particular challenges in relation to inequality and access to services).

- We recognise the immense challenges facing all parts of the NHS and social care providers in relation to the recruitment and retention of a skilled, qualified and experienced workforce. Addressing these issues will need to be a key part of the 10-year plan.

- Restore the grants to undergraduate health courses to reduce student debt as a measure to improve recruitment and retention. This could be linked to the individual agreeing a minimum period of service to the NHS or an accredited social care service, e.g. a hospice.

DRAFT

- A commitment to moving care closer to home and out of acute settings wherever possible, and that the care should be holistic, person centred (not condition focussed) that considers physical, psychological and social wellbeing and that engages the household whenever feasible, the patient and their relatives.

- A commitment to address funding and capacity issues in Primary Care. Many people are now turning to social care and secondary care (A&E departments) due to primary care limitations.

- Delegation of powers and resources from the centralised Cheshire and Merseyside Integrated Care Board to Place-based ICB teams and the neighbourhood partnerships that are delivering on-the-ground transformation (but are hampered by lack of capacity and access to finance).

- Standardisation of community services offers to address variance across the Place, to provide good access and equity for all Residents.

- A recognition of the need to stop major re-organisations of the NHS and enable the service to focus on service improvement. This would include reducing the bureaucracy of NHS England, Integrated Care Boards and the Department of Health and Social Care, including freezing recruitment in the civil service whilst similar restrictions are placed on NHS Trusts.

- Mitigate the pressures placed on NHS providers by reviewing the requirements of CQC inspections. Enable Trust Non-Executive Directors to have a greater role in improving services within their Trusts.

- Reduce the regulations on NHS trusts and their use of financial resources to enable them to invest in their local services and play their full role as anchor institutions. This would enable the NHS and Local Authorities to invest in the neighbourhood hubs favoured by the government.

- A commitment to making every health and care contact count (MECC) in terms of lifestyle and social support to enable every contact between a health and care professional and a patient/service user to have benefits in relation to the ‘whole person’s’ health and wellbeing, not just the condition being treated.

- Recognition of and a plan to address the crisis in SEND, both in terms of local authority funding and capacity to meet the increasing demands. In particular there needs to be more weight given to education’s role in preparing for adulthood and holistic wellbeing (in childhood and adulthood). This should be driven by the department for Education who should recognise the importance of more balance between these outcomes and those relating to education.

DRAFT

- Children and Young People with SEND should be provided with more information at a much earlier stage regarding opportunities in adulthood. This should include provision of adult role models and celebration of successes, rather than system and national focus on crisis. In addition, newly diagnosed young people should be adequately supported with appropriate information about their condition, support available locally, how to thrive with their condition and opportunities to connect with others with similar diagnosis. There also needs to be more recognition of the psychological adjustments and support required for both children and families when diagnosed with a neuro-divergent condition and/or disability.

- Recognition of and a plan to address the crisis in mental health services, in particular the lack of specialist acute mental health service provision for people with serious mental ill health who find themselves in unsuitable settings in hospital A&E or Police cells.

- Crisis support for acute mental health problems and the impact on A&E due to the lack of beds in mental health hospitals, as well as the difficulty of discharging in-patients into the community due to lack of supportive living accommodation.

- Access to different forms of supported living for people with physical and/or mental health problems. Colleagues in the social housing sector are considering stepping away from some forms of housing because of the challenges of providing it.

- A review of the thresholds into secondary mental health care and a clear pathway for those with dual diagnosis - i.e. substance misuse and mental disorders

- Recognition of and a plan to address the issue of Deprivation of Liberty Safeguards. Too many people are waiting too long for a Deprivation of Liberty Safeguards (DoLS) authorisation, despite multiple examples of local authorities trying their best to reduce backlogs and ensure sustainable improvement.

- A population health system that measures wellbeing rather than only illness and considers impact of professional interactions on overall levels of wellbeing (for example, the ONS4).

- A new approach to tackling stigma - raise awareness of the prevalence of issues and that people are not alone. Key areas of stigma are: disability, death, poverty, mental health and obesity.

- The use of all national policy levers and all Government Departments to maximise public health (for example across planning, housing, transport,

DRAFT

environment etc). For example, we are supportive of introducing highway infrastructure that promotes active travel, but whilst it is accepted that the Department for Transport may wish to make proportionately more of the capital funding from government reliant on demonstrably encouraging active travel, there needs to be an acceptance that there are significant practical limits to the extent to which additional infrastructure can be introduced within the course of routine capital maintenance. Without providing revenue funding to support capital measures introduced, financial prudence and common sense would suggest that councils can't commit to accepting capital funding to create assets they cannot afford to maintain.

- Transport has an important role to play in the Ten-Year Health Plan to improve health and wellbeing and as a tool to support prevention and early intervention. Transport provides access to amenities, services and employment, and it promotes socialisation. Mobility is an essential part of a place. The way we move affects our health as individuals and as a community, depending on the mode of transport we use.

  There are three key areas which link transport and health and wellbeing:
  - Transport and access: Transport plays a key role in improving access to services (i.e. health, education, employment), particularly for vulnerable groups like older people.
  - Mode of transport: Mode of transport affects physical and mental health, including physical activity and commuting time.
  - Wider effects of transport and infrastructure: Transport can facilitate social interactions and promote social inclusion.

- The health benefits of active travel are clearly established with a wealth of evidence to demonstrate the benefits. There are opportunities for health workers to be supported to prescribe walking and cycling for health, wellbeing and to promote active travel for everyday journeys.

- It is important that the plan recognises the role of local bus services in providing accessibility and therefore supporting health and wellbeing. There were 2.8 million bus passenger journeys made between 2022 and 2023 and a significant proportion are older and more vulnerable people. Provision of bus services support people to remain independent in their own home for longer. In addition, young people rely on bus services to access school and further education, training, apprenticeships and opportunities which would not otherwise be possible – all of which relate to wider health outcomes.

- Community transport has significant benefits to local communities by providing access to health care, shopping and opportunities for social interaction. Many good neighbour schemes and community car schemes are provided specifically for access to hospital. Recognising and valuing the role of these services as part of the Ten-Year Health Plan will be important.

DRAFT

- Recognition that for some local authorities that border other Integrated Care systems, that there is a need for connectivity with those neighbouring systems that our residents may access services within and a mechanism to ensure inclusive conversations with the ICB that we are a part of (so for Cheshire East a part of Cheshire and Merseyside, that includes Greater Manchester, Derbyshire and Staffordshire ICBs)

Useful links

The state of health care and adult social care in England 2023/24 - Care Quality Commission

The case for neighbourhood health and care | NHS Confederation

https://www.nhsconfed.org/publications/working-better-together-neighbourhoods

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

Challenges

- Critically, the neighbourhood health services need to be co-produced in partnership with commissioners, providers, the local authority, the local voluntary, community and social enterprise sector, residents etc involved in the design. An imposed 'top-down' solution will not create the local buy-in and ownership that is required.

- The double running costs of the transition phase have prevented this happening for the last 15 years. Investment (capital and revenue) is needed in community and primary care services to create the infrastructure and staffing to take on these services, whilst at the same time continuing to run them in the hospitals until the community provision is ready to receive patients. At that point the costs will transfer from the hospital to the community. The recent cost of living / inflation crisis has exacerbated the issue as resources have become even tighter.

- Many GP surgeries lack capacity and infrastructure to provide additional services and struggle to provide the services they currently do. Revenue and capital investment will be required to facilitate Neighbourhood Health Services.

- The concept of 'integrated care' has not yet delivered what it was supposed to deliver (based on the concept of 'Accountable Care organisations'. Acute Trusts are not responsible for their catchment area's population health, only their own service provision. They continue to deliver the care they have always delivered and to be financed and performance measured in the same

way. This prevents any shift of capacity into communities. The performance and inspection regime will need to change to consider overall population health, not just organisational performance measuring, to facilitate a significant shift to a neighbourhood health service.

- The reluctance of clinicians and other professionals to use new technology at scale and as effectively as we could e.g. virtual consultations for people at care homes allowing ambulance personnel to undertake see and treat initiatives (also for people with chronic illness who are at home). The Prison Service is making better use of tele-consultation than the NHS, so learning can be taken from there.

- Hospitals too often bring back patients for review at out-patient clinics when other alternatives are available e.g. teleconsultations. Particularly in rural areas this places great pressure of patients and their families to travel often by public transport.

- The lack of 7-day services and infrastructure.

Enablers

- Virtual wards and the use of different technology will allow us to do more in communities.

- Create more flexible opportunities for work. For example, staff may be willing to provide brief hours of work that fit in with carer responsibilities, e.g. provide 3-4 hours of work a week to enable nursing staff can have meal breaks. Too many nurses report not being able to take proper breaks due to pressures on wards. This would also help to reduce the employment of agency staff.

- Provide care whenever feasible in the home to avoid having to transport people by ambulance to clinics and then back home again.

- A training and development academy for social care providers to enable them to undertake delegated health and care tasks to ensure a competent and skilled workforce and offer.

- Diagnostic services in communities.

- Re-purposing funding away from acute to care communities to fund local service e.g. therapy, GP and DN.

- Enhanced community reablement, mental health reablement and dementia reablement.

DRAFT

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

Challenges

- The scale and complexity of the NHS and wider care system and the costs associated with significant investment in technology. There is also a challenge in achieving consensus in relation to the nature of the technological improvements made and we know from experience that clinicians and other professionals will not use technical/digital solutions that they don't feel they own or add value to their role. The Cheshire Connected Care Record went live in 2017 to share summary patient data across GPs, Acute, Mental Health and Social Care Services. However, for various reasons usage is minimal.

- Digital transformation risks exacerbating inequalities through digital exclusion. More effort and resource will be required to support those with greater digital need for example those with literacy challenges, disability, low incomes, rural broadband challenges, or in older age.

- Cybersecurity and mitigating against the risks of significant ransomware related shutdowns.

- Medical training does not adequately train staff in the use of technology to the extent that we should. It needs to be a part of undergraduate training and post graduate syllabi (eg. virtual consultations, digital data sharing, AI etc).

- Suppliers are not employing open standards to facilitate data sharing and interoperability across systems. Data standards that facilitate easy sharing between different supplier's systems need to be enforced.

- The single biggest failure is the fact that there are multiple standalone systems that don't integrate with one another within the same hospitals/ ICB areas let alone across the country – until a common approach is adopted there is no chance of progress – also a national approach to Caldicott principles is required.

- There also need to recognise we still have a whole generation for whom digital isn't the default.

Enablers

- A commitment to reducing digital exclusion by providing funding and/or initiatives to upskill residents and staff in the use of digital resources.

- The use of creative technology e.g. the Happiness Programme which is evidenced based in terms of falls prevention, social stimulation and improved dexterity for those people with Dementia or similar cognitive conditions

DRAFT

- Population health and segmentation and proactive risk stratification planning e.g. high intensity users, frailty and dementia.

- Data scientists and BI performance analysis.

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

Spotting Illness

Challenges

- Waiting lists, lack of staff and resources across all parts of the system, GPs, Mental Health, Acute Trusts and Community Services.

- A reluctance to share patient data, nervousness re. data protection.

- Over reliance on what is offered e.g. screening – identifies people who have disease but also those for whom it may never cause harm. This can lead to unnecessary demand.

- Information regarding a family history of a condition is not necessarily used as effectively as it should be to screen/advise the next generation. There is potential to do more.

- Individuals unable to access any provision to even start the discussions, voice concerns etc. Many can't use the digital appointments etc so end up ignoring early warning signs.

Enablers

- AI facilitated screening

Tackling the causes of ill health

Challenges

- Societal norms that accept and promote food and drinks high in fat, salt and sugar, over-eating, drinking to excess, drug-taking and vaping. A failure by successive governments to address the wider determinants of health in more deprived communities including, poverty, educational attainment, raising and supporting young people's aspirations, the quality and affordability of housing, reasonably paid and secure employment, neighbourhoods and environments that deter or prevent people from walking or cycling; poor air quality, reduced or removed funding for key public services that focus on prevention and early intervention, including NHS dental services, maternity services, mental health services, career advice and youth services; over-complexity in the system that causes confusion for people seeking help and advice at an early stage (they give up and don't bother)

DRAFT

- As the demand for affordable housing increases, we will see more residents living in inappropriate housing including poor housing conditions which can impact on their health and wellbeing.

- Bias in the data as it primarily comes from the white British population, but other minorities may be more at risk

- Being aware of mitigating against data in relation to certain communities having poorer life chances because of way society sees them. Discrimination e.g. screening that fails to take into account different skin colours/ clinical overshadowing for people with learning disabilities and life expectancy is therefore reduced (particularly for Gypsy, Roma and Traveller Communities). Similarly, language Barriers and information which is sent to patients is not in their own language, causing them to miss appointments and has led to fatalities.

- Time for clinicians and care professionals to ask those holistic questions. There is a lack of confidence / knowledge regarding solutions to improve social wellbeing being that are available and a lack of funding for solutions to be available.

- Lack of understanding of behaviour change theory - this is vital for everyone to understand, both in terms of their own personal behaviours and in terms of advising others. There are instances of poor implementation of the Mental Capacity Act when people are unable to make informed decisions about their treatment, and this can lead to patients being unable to receive appropriate health care pre-admission and pre-discharge.

- The ethical challenges of being able to react to crisis but also understanding the important role of avoiding crises.

- Stigma associated with disability, death, poverty, mental health and obesity. People (both patients and professionals) are afraid of these issues therefore don't raise them until crisis point rather than at the point of early intervention. We need a whole range of campaigns to tackle stigma in relation to these issues. We also need to ensure that health needs to be a key theme across all policies - for example, wellbeing and preparing for adulthood outcomes should be as important as educational attainment outcomes. Similarly, there needs to be better recognition of coercion and control by family members or Domestic Abuse, leading to patients being unable to attend appointments.

- There should be a whole systems approach to tackling overweight and obesity led by national measures such as extending the tax on sugary drinks to foods excessively high is saturated fat and salt. Policies on obesity should consider planning to promote physical activity, food provision and support

regarding digital device usage (avoiding sedentary behaviour) rather than focusing on weight loss injections as a panacea of long-term condition prevention.

- Universal primary prevention should not be lost amidst secondary prevention and targeted prevention initiatives: remembering Rose's prevention paradox- the greatest numbers will benefit through hybrid approaches, yet the NHS tends to promote targeted and secondary prevention as a priority.

- Lack of awareness that population health management requires the following:

  - Robust evidence-based interventions that can be applied to the populations identified
  - A systematic approach (such as use of the Joint Strategic Needs Assessment) to assess the most beneficial population/ health issue that population health management resource should be applied to
  - An understanding that population health management is moving into "screening" and as such careful consideration of screening criteria is relevant. Adverse impacts should be carefully evaluated in relation to population health management approaches.

Enablers

- Continuation and expansion of social prescribing models as part of the approach to prevention early intervention

- A more proactive, inclusive and holistic approach to SEND and mental health.

- Innovative approaches to homelessness such as the Macari Foundation in stoke on Trent offer one model of support: https://macari-foundation.co.uk/the-centre/

Q5. Please share any specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivered in, for example:

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

- Three-year funding settlements for local authorities (including the Public Health Grant)

- Ring-fencing prevention budgets within other budgets (NHS and other Government departments)

- Safe injection suites to reduce drug related deaths.

- Reinstatement of funding for hospice care (for hospice at home and in-hospice care). This is critical in relation to improved palliative and end of life care and in response to the Assisted Dying bill.

DRAFT

- Promote advance care planning in primary care

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

- Introduce a 'polluter pays' approach to taxation eg public health harms of gambling (costs borne by companies making profits. Additional social value contributions from companies that are producing products that are negatively impacting upon or facilitating negative impacts upon population health (eg. foods high in salt, fat and sugar, vapes, social media, mobile phones etc)

- The banning of vapes except as a smoking cessation tool.

- The introduction of minimum unit pricing for alcohol. Widening the tax advantages of lower alcohol drink options e.g. 2.5% for beer and making them more accessible within pubs and bars

• Long term change, that will take more than 5 years

Review in light of H&W Strategy / Blueprint

DRAFT