Heywood Foundation Public Policy Prize - "Health"

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Categories: Health

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ID: 2031-11 - Category: Health

The Role of Copper Alloys and Paints to Reduce the Spread of Pathogens

A solution to this problem is to use copper-based alloys and paints instead of aluminium or stainless steel which are currently used in hospitals, GP surgeries, dental practices as well schools and offices. The role of copper to eliminate disease has been known since at least ancient Egyptian times but the mechanism only began to be understood in the 19th century. The mechanism by which this works is called the oligodynamic effect in which the release of ions can kill bacteria and viruses in mere hours.

The cost of superbug infections including MRSA and E. Coli to the NHS is staggering. Other than the increased mortality for patients, E. Coli costs the NHS £14 million annually while MRSA cost nearly triple that at £45 million. A recent Imperial College study found that 1 superbug outbreak in a single hospital can cost almost £1 million. The NHS is not just facing a problem with COVID-19 but infection rates and disease transmission for decades has cost the public purse billions of pounds and with drug resistant strains becoming more common.

However, we have a chance to implement a solution that will not only benefit the public now but will for generations to come. By using copper-based alloys and copper-based paints on surfaces that are known to transmit pathogens we can eliminate a large percentage of transmission and reduce infections drastically. Studies have shown that 99% of E. coli was eliminated from copper and brass in 2 hours whereas it was able to live on steel for 30 days. With the H1N1 swine flu virus, the pathogen was reduced by 50% on steel after 6 hours whereas on a copper surface this was reduced by 99.99% in 6 hours. This is a virus which in 2010 cost NHS London £19 million. Another study found that MRSA was eliminated from brass surfaces in under 5 hours and on pure copper in less than 2. With COVID-19, a study by the US National Institute of Health found that on copper, COVID-19 was 99% eliminated in 4 hours whereas on steel it remained for 3 days. While drug resistant strains of pathogens are becoming ever more present, they have yet to find a way to be copper resistant over 3000 years which is something that cannot be underestimated.

While an initial retrofit is not the cheapest initial solution, a change to the Building Standards for new public buildings including hospitals and schools would minimise an initial increase in expenditure while reaping the reward of lower disease transmission. In time, when the infection rates in new hospitals with copper surfaces are significantly reduced and a cost benefit realised, a retrofit of all hospitals, GP surgeries, dentists and ultimately all public buildings would reduce the burden on the NHS in terms of both patient numbers and financially with each passing year.

While there will always be the need for cleaners in all public buildings, copper surfaces can clean itself consistently without any human interaction. With this strategy and use of metallic antimicrobial properties, the United Kingdom could be in a position where in our hospitals, our pathogen transmission hotspots are cleaning themselves 24 hours a day, every day. When a cleaner may have missed a door handle, the door handle cleans itself. Where a patient leaves E. Coli on a bannister, the bannister cleans itself. When MRSA is left on the railings of a bed, the surface kills it before the next patient arrives. Infections rate plummet, patient health improves, the burden on staff reduces and the expenditure fighting unnecessary pathogen transmissions is potentially cut by £Billions

ID: 872-11 - Category: Health

Eat for Britain

We will change our culture from “regardless of what I do the NHS is there to fix me” to “I am responsible for my own health, the government will support me in my choices and the NHS is there for emergencies.”

Whilst being fit is a good idea, you can’t exercise your way out of a bad diet, for thousands of years we took no exercise, we ate a traditional whole food diet, not too much and moved around throughout the day.

Actions to Fix and Capitalise

• Review and update our current “recommended healthy diet” taking into account the most up to date research into: whole foods, plant based eating, high welfare animal husbandry, eating less but better quality meat, gut health linked to mental wellbeing

• Change the tax system in order to make it cheaper to support everyone in eating our new recommended national diet

• Review what and how we farm and incentives farmers to produce what we need as well as protecting the environment

• Incentives supermarket chains to promote and make it easier / cheaper for customers to buy recommended diet ingredients

• Develop a TV and online training program using celebrity chefs and key influencers to train the nation. MAKE IT COOL

• Teach children to cook at school

• Protect and expand free school meals for KS1 as this set’s habits early

• Reinvigorate school food based on the quality of offer rather than choice

• Increase taxes on processed food in shops, in restaurants and take-aways call it a processed food tax

• Increase tax on low welfare food so that a mass-produced imported chicken is the same price as a free range organic British one. white bread / pasta has to be 50p more expensive that a whole grain alternatives

• Set minimum prices on some food so “big-business” can’t undercut small producers (they do this with bread in France €2 minimum for a baguette)

• Train GP’s in the effects of a healthy diet can have on patients (currently 6 hours in 5 years of training)

• Enable GP’s to prescribe training courses and whole foods not pills (could be a problem for pharmaceutical companies)

My thinking is not new, in many ways it's common sense but common sense is not common practice. Just because we expect people to know this does not mean they will do it, especially when they are marketed something completely different by the process food industry. Good farmers growing and producing the food we need don't have the marketing budget to compete,

We need to help and support our nation to eat well.

I'm in.....

How can I help? (I might have the £25K prize to invest for starters)

With love

Chris

ID: 2030-11 - Category: Health

Cost effective re-purposing of Test and Trace for management of long term conditions

Repurposing NHS Test and Trace for a cost-effective health service

As COVID-19 case numbers fall, we have a group of potentially redundant clinicians who have developed the skill set to manage health issues with members of the public over the phone. At the same time, it is estimated that 15 million people in England have one or more long-term conditions (LTCs). The WHO has already identified that treating such conditions in acute settings is not an effective treatment nor a cost-effective strategy. Now that telephone health management has become a part of the public consciousness, we should build on the IT systems in place and use the clinicians within Test and Trace to manage and improve LTC patient outcomes.

According to a Commons Select Committee, one of the biggest challenges to face the health service is the management of those with LTCs. However, the NHS has been built to tackle acute issues. The WHO recognises the inability and inefficiency of acute settings to manage chronic conditions. Their briefing paper on innovation in this area recommends that, for developed countries such as ours, innovation in healthcare models is needed, along with mass marketing to shift the thought paradigms within the population. The WHO also recommends a multi-sectorial health body to treat and manage long-term conditions, along with a range of staff utilising phone and digital platforms for the dissemination of information and patient access. Test and Trace, with the utilisation of multi-disciplinary clinicians to contact the public, has in essence become a pilot project to test the medium. Statistics suggest that 70% of the health and social care budget is spent on 30% of the population. The reality of this statistic is that patients with LTCs are visiting healthcare settings regularly and are desperately seeking help and advice to best manage their lives. A general search on the Internet demonstrates the

many and varied patient groups that have been set up for those seeking advice and guidance for their diagnosed chronic conditions, from fibromyalgia to arthritis to loneliness. There is a great need in these patient groups for reliable advice from experts to help them understand and manage their conditions. Research has shown that acute settings are not the best places to manage chronic conditions. Presently 111 and 119 offer the telephone as a way for patients to seek advice. However, with Test and Trace clinicians make the call. GPs and local authorities could refer to a rebranded Test and Trace, namely NHS Lifeforce. A mass marketing campaign could promote the service to ensure that the public knows that it is trusted clinicians on the phone line offering evidence-based advice. NHS Lifeforce would be a more appropriate way to treat chronic conditions, with opportunities for regular engagement and motivation. It would also be a more cost-effective way, using the phone, text messaging as well as emails and letters rather than 10-minute GP slots and long-awaited hospital appointments. Support and advice could be scripted and focused on issues such as mental health problems, obesity, diabetes and lifestyle choices. It would also be an opportunity to tackle the silent but deadly issue of loneliness that can so often lead to long-term conditions. NHS Lifeforce also offers a way to utilise the clinicians and the IT systems already created for Test and Trace, rather than discard them or have a reduced staff work to the narrow brief of infection control. For those frontline staff who have become burnt out and may be on the point of retiring, this would offer an ideal setting to use their experience and skills. NHS Lifeforce could work in the same way as Test and Trace with clinicians working a varied pattern of shifts from home and 7 day working 8am-8pm. A pilot project working with patients with “Long Covid” would be an appropriate place to start. There are estimated to be 300,000 to 400,000 patients diagnosed with this type of chronic fatigue condition. In summary, the system set up for Test and Trace should be adapted to offer the public a new, innovative, preventative and thereby cost-effective model for managing long-term conditions.

ID: 1200-11 - Category: Health

Response to Q1. Meals+: A New Take on An Old Classic – ‘Meals on Wheels’

What is Meals+? It’s concept that can be described as a new take on the long established ‘Meals on Wheels’ offer… defined by the DoH as: ‘Meals on wheels' are hot, nutritional meals delivered to people who are unable to, or find it difficult to, prepare a meal for themselves. A range of meals are produced, considering people's cultural and religious requirements, personal preferences and dietary needs.

This is an opportunity to reimagine the service in a way that aggregates many benefits to create

large scale social value: a preventative caring service, embedded within the community health and care economy. The idea is the design and implementation of a new national meals on wheels service. Meals+. Meals on Wheels have almost universally been withdrawn – leaving no comparable offer suitable for older people with social care needs. There are real tangible examples of negative health impact when services are withdrawn. Limited number of existing services remain but underachieve in terms of their potential social and economic value.

The service can act as eyes and ears alert to the usually hidden signs that people may be struggling or experiencing a decline in their wellbeing, shining a light on someone's circumstances, and proactively linking in the right support or intervention, avoiding a more detrimental outcome for that person. A summary of the achievable benefits include:

Addressing Loneliness and Social Isolation – a face to face service available 7 days a week at a pre-agreed time. Deliveries will be made by friendly, reliable people who form positive relationships and build rapport with their customers. Research has proven that the person-to-person interaction is the single most valued element of the service. Reduce demand and address capacity challenges in

Homecare services – consultation with homecare providers has revealed that between 20%-30% of the care visits they complete are for meal preparation and welfare checks, which neither activity requires a CQC regulated service provider to complete. The opportunity to replace these non-regulated care visits with a meal delivery and welfare check exists now. Linking the meals service with homecare providers will help to support their customers in a more integrated and holistic way.

Improve health outcomes and nutrition- Malnutrition (undernutrition) is characterised by low body weight or weight loss, which simply means that some older people are not eating well enough to maintain their health and well-being. It is estimated that around one in ten people over the age of 65 are malnourished or are at risk of malnutrition - over one million older people in the UK today. Malnutrition is both a cause and a consequence of ill health. It affects

health and wellbeing, increasing hospital admissions, and can lead to long-term health problems for otherwise healthy and independent older people. It can also mean more visits to the GP, increased chances of being admitted to hospital and longer recovery times from illness. A nutritionally balanced daily two-course hot meal can support healthy nutrition and avoid some of these risks to health and wellbeing.

Develop links with Primary Care – the service can provide additional intelligence to GP's and health professionals in the community, identifying red flags and making referrals to the appropriate service, enabling early intervention.

Create jobs, use Kickstart Scheme and Apprenticeships – the service will create a range of new jobs and well suited to take advantage of the governments Kickstart scheme, offering opportunities to young adults and a possible career pathway within social care. There is also the opportunity to develop apprenticeships, supporting the varied business functions.

Investment in electric vehicle fleet – the delivery of hot meals and face to face interactions with customers in their homes will require a fleet of suitable vehicles. Electric vehicles fit this bill well, because of the local nature of deliveries and opportunity to charge overnight between shifts.

Creation of new supply chains (in-country sourcing) – the setup of the service will inevitably require a supply chain. This is likely to include frozen meals, commercial catering equipment, premises, vehicles, and various support service contracts. The supply network that enables the optimisation of the service will inevitably require or provide the basis for a good degree of collaboration between public, private and non-profit sectors.

This service would also provide an opportunity to explore how support could be provided in the provision of free school meals to family homes.

Investment and financial model – with the current older population arguably being the most affluent of recent generations there is strong potential this could be a service charged to each customer e.g. £7 for a hot two course lunch meal. However, to achieve the maximum social value means testing may be a more appropriate model. There may also be an opportunity to free up some capital by making changes to the 'Winter Fuel' payment eligibility, for example offered only to those older people in receipt of means tested benefit. This would release some of the £2 billion currently spent annually on winter fuel payments as seed funding.

ID: 3031-11 - Category: Health

The NHS Requires Flexibility Staffing, Not Just More Staff

While it is obvious that the NHS needs significantly more staff, and indeed the government have pledged to train these, it is just as obvious that it is not practical to fund on a continuous basis all the additional staff that might be required during health emergencies such as we are currently experiencing.

The staffing requirement during the summer months, is under normal circumstances, lower than during the winter, particularly during a heavy flu season. During a localised incident it would be higher again, and during a pandemic obviously sky high. While it may be possible to have a small amount of movement between local hospitals, much more than that is not practical and during a pandemic as all hospitals require extra staff that just aren't available.

The inability of the Nightingale hospitals to be fully staffed highlighted the lack of additional capacity and just why this issue needs to be tackled to avoid similar issues occurring during future emergencies or pandemics.

The NHS Reserve - A Force For Good

To overcome the transient nature of the NHS staffing requirement, as outlined above requires an out of the box solution and I believe that forming an NHS Reserve is just such an idea.

Establishing an NHS Reserve similar to the reserve forces of the Army, Navy and Air Force, would allow the NHS to affectively increase its staffing to meet any demands placed upon it and in a cost effective manner. Whether these are large scale, national and long in duration, such as future pandemics, or short term and localised, such as large industrial incidents or terrorist attacks, an NHS Reserve could be mobilised at short notice to assist in whatever capacity was

required.

Having a supply of highly trained and motivated staff ready for service at short notice everywhere across the country would be of massive national benefit. Many care staff, nurses, hospital doctors and GPs have left the NHS in the last few years due to the excessive strain they found themselves under, however many of these might be willing to support the NHS again in an alternate role.

We know that once the pandemic is over the waiting lists for patients requiring treatment will be longer than ever and that the staff who will be trying to bring these lists down will already be exhausted. If such a reserve was already in place image how much easier it would be to simply call on the extra staffing to assist with the extra burden. The Reserve could not only be called upon to fill vacancies during difficult times, it could also relieve permanent staff having to work excessive hours due to exceptional circumstances.

The Reserve volunteers could regularly work within hospitals so remaining up-to-date with current practices by filling temporary vacant posts while full time staff undertook additional training, had sabbaticals or were away for any other reason, and all this could happen without leaving any Hospital short staffed. This would be a far less expensive option than the massive drain on the NHS that continuously hiring agency staff is.

This reserve could also place the UK in a unique position to assist poorer countries in times of need, and the knowledge that staff gained whilst undertaking this work might prove useful back to the UK.

Some members of this Reserve could also receive highly specialised training such as dealing with the effects of chemical weapons, gun shot wounds and many other non standard situations which would allow them to be deployed and therefore this expertise to be available within any hospital in the area or indeed the country, as and when needed. This Reserve could be used to staff the Nightingale Hospitals, and to free up regularly staff to continue with non COVID related health treatments.

Three quarters of a million people volunteered to assist the NHS yet only a small percentage were actually utilised. With the introduction of an ongoing training programme, a little imagination and some will power ‘The NHS Reserve’ could become a future force to be reckoned with.

ID: 846-11 - Category: Health

The Salvus initiative

Background: The official figure for the number of people sleeping rough on the streets of England is 4,266 of which 1,136 are in London. These figures have increased by 141% and 173% respectively since 2010. It is thought by many that these figures are a considerable underestimate but for the purposes of this proposal the official figure of 4,266 has been used. The majority of deaths among rough sleepers are drug related poisoning, suicide or alcohol related, and the main reason for someone finding themselves living on the streets is relationship breakdown.

Proposal: The problem of rough sleeping is a national one but it is seen locally all over the country. As such it will only be tackled by a determined and coordinated national approach - delivered locally. It is, therefore, proposed that a new project, the Salvus initiative, is launched. This initiative is designed to provide easily accessible homes for rough sleepers – the objective being to eliminate rough sleeping in England within 18 months.

Ethos and guiding principles: The ethos behind the charity and the Salvus initiative is simple. It is acknowledging that everyone needs a home. No one is born sleeping on the streets and no one chooses this as a way of life. Salvus will put the individual first and it will try to understand the needs of people who, for whatever reason, find themselves sleeping rough on the streets, and provide them a safe and secure home. Additionally, and when it is wanted, the Salvus initiative will provide rough sleepers with non-judgemental help and support. There are three guiding principles which form the foundations of the Salvus initiative. • Any person who is sleeping rough will be eligible for an Salvus initiative home. • No one will be turned away and no one will be denied accommodation because of their lifestyle. • Residents can remain in an Salvus home for as long as they need; they will be given every opportunity and assistance to move on but they will not be moved out against their will.

The Houses: The size of the Houses to be built in any one area will be determined by the scale of the rough sleeping problem in that area. In a location such as London where the number of rough sleepers is high, the number of individual units or homes in each House will be significantly higher than in places such as the South West of England. This proposal is based on

an average of 20 homes per House. The Houses built will provide the type of accommodation that people sleeping on the streets want and will use. Each home will be large enough to be comfortable (40 sqm) and will be in the form of a studio-apartment each complete with its own kitchen and bathroom. These are homes, not night-shelters or hostels and each resident will have unfettered and unrestricted access to their own particular home. Each House will also include a lounge / recreation area and a private room that can be used by the manager or for meetings.

Services provided: First and foremost, the Houses will provide homes for rough sleepers. Additionally, they will be designed to facilitate the provision of a host of services, all of which will be provided by existing agencies on an as-and-when-they-are-required basis. These include access to a GP and mental health services, drink and drug rehabilitation, employment search and career re-building, and access to move-on accommodation. It is proposed that when residents are ready to move on to other accommodation that they will a priority for social housing.

Management: A new national charity will be established and will be responsible for working with local and regional partners to deliver this initiative. The new charity will draw on the expertise of existing major national charities working in the areas of homelessness and rough sleeping, and it will be responsible for the strategic management of the Salvus initiative. The new charity will establish local alliances or partnerships with interested and involved organisations and these alliances will be responsible for the operational management of the Houses within their area and for implementing national policies. On a day-to-day basis each House will be overseen by a peripatetic manager with the overriding principle being that each House will be managed in a way that is sympathetic to the needs of its residents.

Finance: The capital and revenue costs are based on the creation and ongoing management of 250 Houses of 20 units each. Capital costs: Estimated at £2 million per House or £500 million overall. Revenue costs: Estimated at £200,000 p.a. per House or £50 million p.a. overall.

Funding: Capital: It is proposed that the £2 million average cost of each House is raised through individual and corporate philanthropic sponsorship. This would be the largest such exercise ever carried out. It would also be hugely ambitious but the visionary and innovative concept behind this project coupled to an inventive approach is designed to capture the imagination of the country's richest people and organisations, such that it can be achieved. Revenue: From the very outset it is proposed that existing charitable organisations working in the area of homelessness and rough sleeping, together with local authorities, will be partners in this project. It is proposed that partner organisations will commit to contributing towards the project's revenue costs. A significant contribution will come from residents of the homes in the form of housing benefit. It is also proposed that any shortfall is made up from central government funding.

ID: 990-11 - Category: Health

Creating a 'health reserve' to meet surge demand on the NHS

Summary:

The years to come will be very challenging for the NHS – even after the worst of the pandemic recedes, the burden of the disease will continue to be felt for a long time. The virus is likely to become endemic and it's predicted that pharmaceutical companies will have to play a game of cat-and-mouse to ensure vaccines catch up with mutations. Consequently, it's more vital than ever that the NHS be able to flex its capacity to meet surging demand in the face of new strains of coronavirus and flu that the population lacks immunity against.

Creating a 'health reserve' is a solution to that challenge. It would:

1. Make the NHS more resilient in winter and in the face of new waves or pandemics, without bringing on full-time staff who might not be needed the rest of the year.

2. Help the NHS get through the huge backlog of non-urgent screenings, treatments and operations that accumulates when the NHS is under strain.

3. Create opportunities for people to serve their country and take pride in their contribution to the community, with the power to appeal and be accessible to a wider range of people than

alternatives such as the armed forces.

4. Provide a source of income and rewarding activity for the unemployed, and a potential route into employment through the skills and experience gained, at a time of high unemployment caused by the economic costs of fighting the pandemic.

If it makes sense to keep a military reserve in the unlikely event of large-scale war, doesn't it make sense to keep a health reserve to fight the likely annual burden of new and existing diseases?

Detail:

Creating a health reserve will help the NHS cope with future surges in demand that the usual winter pressures plus new variants of COVID-19 are likely to cause. COVID-19 has shown that the real constraint on NHS capacity is not buildings, equipment or beds (all of which have been shown to be expandable remarkably quickly) – but people. This proposal argues that we should develop a health reserve, akin to the army reserve. Health reservists could be trained to perform a number of relatively simple but essential tasks, such as first aid, vaccination, 'proning' (turning a patient with respiratory distress onto their front) and basic patient monitoring. They could be called upon to relieve pressure when the NHS is under severe strain. By reducing the risk that the health service is overwhelmed, this proposal also reduces the likelihood that governments are forced into more lockdowns, with their attendant societal damage.

A well-organised, structured approach is needed because, without it, the NHS is simply unable to scale up with the speed and to the extent required. There has been much coverage in recent weeks of the bureaucracy that prevents retired healthcare workers from helping administer the COVID-19 vaccine. Next time round, those retired and prospective health workers could be pre-registered with the reserve and ready to go.

Even more crucially, the pool of retired health workers and medical students is simply not big

enough to enable to the NHS to cope with peak pressure. More people need to be trained in a number of basic but essential skills ahead of a bad winter and/or new wave, in addition to the pool of people with existing health experience. The lack of suitably trained staff is the reason that the 'Nightingale' hospitals have remained largely empty throughout the pandemic. In addition to managing peak demand, such a reserve could also help the NHS clear the backlog of cancelled operations faster, when surges recede (the number of patients waiting for more than a year to access treatment has skyrocketed from 1,600 in February 2020 to 192,000 in November 2020).

This proposal also brings important non-NHS related benefits. First, there is huge untapped appetite among people to serve their community and country. At the moment, however, the meaning of the phrase and practical opportunities to put it into action are mostly limited to the armed forces – a set of institutions whose reach, appeal and accessibility across ages, gender, ethnic, cultural and socio-economic background is far more limited than the NHS. The desire to serve by helping the NHS was apparent as soon as the COVID-19 crisis hit the country: by mid-April, over a million people had volunteered to help the NHS fight COVID-19. The health reserve would contribute to a renewed sense of community, which polls find is one of a few key positives from the crisis that people hope will outlast the pandemic.

Second, the health reserve could create work opportunities that people can take pride in, at a time of high unemployment caused by the economic costs of fighting the pandemic. The reserve would provide income as well as transferable skills and a route back into economic activity. For many, it may be a much more rewarding alternative than the bureaucratic requirements and minimum-wage offers that working-age welfare claimants must comply with and accept.

For those who might argue that this proposal is too costly, a brief response is that the cost of the reserve would be a fraction of the health and economic costs of delayed diagnoses and referrals, cancelled operations and new lockdowns. The reserve is also by design a very efficient model for rapidly scaling capacity up and down. If it makes sense to keep a military reserve in the unlikely event of large-scale war, doesn't it make sense to keep a health reserve to fight the likely annual burden of new and existing diseases?

By way of comparison, the army reserve, which could be used as a model, is rewarded as follows:

'As a Reservist you get paid for the time you spend training, and a bonus payment for completing a certain amount of training days each year. […] If you've left Regular service in the last six years, you could rejoin as a Reservist and get incentive payments of up to £10,000.'

ID: 685-11 - Category: Health

Empowering patients with health conditions to confidently self-care via remote means

Summary

A range of self-care health condition-related digital materials can be collated & presented so that people can choose a match for their specific health needs ie type of health & wellbeing need; accessibility and connectivity to digital aid(s); skills and confidence.

The plan

The main resource will be a variety of webinars (minimum 4) that can be pre-recorded by practising clinicians (eg doctor, nurse from different frontline settings) and intelligent patients with a live Q&A panel. This will help patients to use kit correctly to measure key valid biometric values such as oxygen saturation via a pulse oximeter for asthma or chronic obstructive pulmonary disease (COPD); or take their blood pressure - by watching a 'how to do it' video; or take their medication correctly eg watch how to use an inhaler for asthma - matched to a self-management plan eg for asthma, blood pressure control. In addition it will simple explain how to do a video consultation, use trusted health apps, use social media eg WhatsApp group managed by clinician- to enhance healthcare experience.

Capitalising on the situation: This empowerment of self-care will mean improved remote engagement between patient and responsible clinician; and enhanced responsibility for own care eg taking medication regularly...leading to improved clinical outcomes...thus less avoidable

NHS usage such as avoided hospital admission due to better asthma, COPD or raised blood pressure control - saving the NHS £000s per patient and making it more sustainable and reversing the spiralling health inequalities caused by COVID-19 pandemic. For example avoiding a stroke by controlling blood pressure can save the NHS/social care etc £30,000 allowing for the cost of hospital admission, social care, subsequent inability to work etc.

Thus it can be expected that communications teams from the NHS, social care, voluntary sector and media will freely advertise the webinars and associated resources, where the content is funded by this Charity or others and there is no commercial element that might influence recommendations.

ID: 484-11 - Category: Health

Making good the most serious shortage of all.

NHS staff shortages during a protracted national medical emergency can be solved by establishing, and constantly maintaining, a national database of Volunteer Medical Professionals (VMP) who would be recalled and deployed as, and if, required. ('Medical professional' for these purposes is one who needs to register in order to practice.) The database will comprise VMPs upon retirement or when they leave their medical occupation before retirement. VMPs would remain on the database for five years, extendable by request. This would be a purely voluntary scheme - akin to a medical TAVR.

Below is a schema (which is not exhaustive) for the above.

1. The database and governance:

a. The database to be overseen by a Minister of State, who is to ensure bureaucracy is minimised;

b. Administration, as directed by the Minister, to be undertaken at Regional NHS level with a named individual as 'Registrar' who will report to the Minister.

2. The Volunteer Medical Professional:

a. Is to register personally as a VMP to their Regional NHS unit;

b. Is to furnish fully all details required by the Registrar, and to report any changes immediately;

c. Is to ensure their Disclosure and Barring Service certificate is current at all times;

d. Where applicable the VMP must inform their employer of their VMP status.

3. The employer (if applicable):

a. Should allow such time off as VMP duties demand;

b. Should continue to pay the employee whilst they are on VMP duties.

4. VMP subsistence:

a. It is assumed the VMP will be deployed within their NHS Region. Motor mileage will be paid as per NHS staff with car parking free on site;

b. If the VMP is recalled to a place in excess of fifty miles from their home, the NHS hospital or organisation in which they are employed is to arrange accommodation and subsistence, if required.

5. Honorarium:

For each FULL year after registration the VMP to receive £500 tax free, or £750 if the VMP chooses to have the award paid to a nominated charity.

ID: 2125-11 - Category: Health

Pandemic response that will also future proof against further pandemics

Due to new variants, repeated vaccinations will not eradicate Covid. We know long Covid is

common and will be costly to manage long term. Mild cases in younger people are leading to long Covid hence more drastic measures needed. The ONLY way for us to live our lives free from the constant fear of Covid, illness, hospitalisation, death or long-term disability is to eradicate it. Billions have been spent on track and trace (reportedly ineffective) which is 'reactive' not 'proactive' and means we are chasing the virus constantly. The only option is for everyone to self test daily if they plan to mix with others that day, brush your teeth and Covid self test. This is already happening in other countries, the test is via saliva, takes seconds, is linked to your phone via QR with results in 15 minutes. We should invest heavily in self tests. Most have a mobile, those that don't relatives / community carers could assist. QR tracking is essential in a pandemic. Each person having a QR code is no different to having a normal passport. It could be temporary / trial basis. Anyone who has a positive home test would have a confirmatory PCR test administered by a nurse (in full PPE) and self isolate. QR codes mean they can be tracked to ensure self isolation and not putting others at risk. The above would lead to zero spread in the community or workplace. This will also catch the one in three who have no symptoms plus super spreaders eradicating super spreading events. Everything can re-open with no masks / social distancing and everyone will feel secure that everyone who is mixing is COVID FREE. You will scan your QR code on your phone to enter pubs, bars, restaurants, sporting events, cinemas, theatres etc. This technology is already in place. Tracking via QR will mean 100% compliance with large fines / arrests needed for non-compliance, risking many thousands of lives due to the knock-on effect. To start we could have a National Self Test Day – a Bank Holiday when we all test on that day. Very careful instructions would be shown on TV and advertised plus posted to all. It would be a national cohesive effort. This will show exactly who has the virus at one specific period in time which is priceless data for scientists and the Government. All tests should be means tested, free to those who cannot afford. Given the current low numbers achieved by lockdown we could do this ASAP and see where the current hot spots are. It will also mean that variants can be checked and any South African / Brazilian / evolving strains stopped in their tracks. This would be a huge exercise BUT worth it. Vaccine passports serve no purpose as they DO NOT mean you are virus free and DO NOT mean that you cannot spread the virus. Only a negative test can do this. If we all self test before we interact with others then we know we are keeping everyone we come into contact with safe. The ONLY reason we have the virus here is travellers from other countries. The only way to prevent travellers bringing the virus / new variants here is by having COVID FREE airports. These 15 minute saliva tests can be done at the entrance to the airport – a specific testing hall at which ALL members of staff and travellers HAVE to be tested and pass through to enter. This extra testing security means airports can be confidently COVID FREE - once in you know you are safe and can relax, knowing that no-one has the virus hence no masks or social distancing necessary. Once you reach your destination airport you show your test results on your phone to exit. Before your return flight you will do your morning test plus a further test at the airport. All airports should have their

own entry testing in place and be COVID FREE. This is cost effective for airports who can pay for tests as their planes can then be full again and airports can become relaxed for eating and shopping as all fear removed. This system would future proof / prevent future pandemics and the resulting economic catastrophe. We all spend two hours at an airport, are security scanned and a 15 minute test is no hardship. Our health service can get back to normal without endless virus precautions and the huge cost of treating Covid and PPE. In China all foreign visitors have to undertake a Covid test at the airport prior to entry and due to their QR tracking system are virtually Covid free. QR is not against human rights it is to protect us and in a pandemic it is common sense, although the knock-on effect would be more personal accountability / responsible behaviour and less crime. If you are a law-abiding citizen who cares about the welfare of others you would do this willingly. Anyone who is here illegally should be offered a QR code, made legal and allowed to stay providing not a danger. Vagrants would have a QR code and be kept safe and off the streets, which morally we should be doing anyway. We should have designated Covid hospitals (the Nightingale hospitals) that are for Covid patients ONLY eradicating the fear of catching Covid in hospital. At least 40% of initial cases of Covid were caught IN hospital. By having specialist Covid hospitals all staff would become highly skilled as treating Covid day in day out. With a new disease learning fast is critical. The staff at Covid hospitals would work NOWHERE else. After a positive test if hospital care needed patients can be taken to one of these hospitals nationally via specific Covid ambulance, after recovery they do not leave until they have tested twice as Covid free. All other hospitals would then be safe an Covid. This system can be used for any future viral threats and pandemics.

ID: 838-11 - Category: Health

Listeners

I'm not a medic and my exposure to stress has been limited to working in a classroom for 40 years. My only experience of grief is limited to bereavements. I took advantage of counselling and discovered that counselling is all about listening. You unburden- someone listens. Counsellors don't have solutions or give advice, they listen and with careful prompting lead you through your thoughts and over time, help you to come to terms with your angst.

Who is going to listen to the doctors, nurses, porters, healthcare assistants, amulance men and women to name a few? Not their families, they've lived through the back to back shifts and seen their nearest and dearest pushed to their physical and mental limits. Mental health services will be streched to capacity for those who recognise that they need support. CAHMS also for our children who are also suffering as a result of this insidious disease. Too often proud professionals are the last to admit or accept that they need support. Before it is too late a "listening army" of people needs to be recruited and trained.

Either fund the Samaritans (a charitable service who already provide NHS suppport) and increase the hours (24/7 supermarkets do it) that they are available for. Set up an independent phone line or online talking room. Advertise the service so it promotes the fact that it is not a sign of failure to ask for help.

Act now, or be prepared for people leaving the professions through exhaustion, early retirement, or a realisation that clapping does not compensate for low pay.

Professionals naturally counsel one another with leaders providing support for junior staff. Who will supervise those leaders? Other leaders?

ID: 709-11 - Category: Health

To provide mental/physical wellbeing sessions for all school age pupils as part of curriculum

It has become clearer than ever through Covid, that children and young people's mental and physical health are inextricably linked. As things stand one of the biggest burgeoning crises in our society is the catastrophic level of obesity and overweight pupils of school age, due to unhealthy and sedentary lifestyles, and lack of meaningful provision of any way to tackle this. It is a ticking time bomb in terms of life expectancy, life quality (mental and physical), life potential and health - from diabetes to heart problems, eating disorders, mental health problems, and problems with learning, and long-term increased dependency on services and the NHS through life. Covid has demonstrated that the overweight and obese are particularly vulnerable to such viruses with catastrophic outcomes.

With the majority of pupils living in families where their parents work full time, there is a need to provide mental and physical wellbeing within the education system, as the foundation for their development to fulfil their potential as happy, healthy individuals, from whatever their social background; it gives pupils confidence, improves cognitive ability, and helps them to learn the importance of respecting themselves and others, and taking care of themselves, and in turn their own children, and giving them sound building blocks for their lives.

Proposal is to provide all school-age pupils, whether within cities, towns or rural villages, with

the opportunity to boost their mental and physical wellbeing with a programme of a variety of daily exercise such as yoga, strength & conditioning, running, dance, swimming (through leisure centres) based around the facilities available at their schools and in the local community. It can be rotated for different age groups through the week (eg. in groups of 2 years), eg. so that all pupils can take part at one time eg. in the school sports hall) or for larger schools, in either morning or afternoon (8.30 or 3.30). Each school from the age of primary school upwards, to have the school day extended by 90 minutes. Eg. an age-group session can be held at 8.30am for 90 minutes, or 3.30pm for 90 minutes, or during a timetabled double-period during the day, so that there is time for changing, and a full hour's participation.

Rather than being part of the overall education budget (which risks it being appropriated for other uses), this should be Government-funded (separately from all other costs), with full accountability to specialist Minister for Mental and Physical Wellbeing for Schools, accountable to the Depts of Education/Health/Sport. The provision will be compulsory and inspected by Ofsted (who must also be trained on this). Within each school, it must be centrally coordinated member of staff trained/appointed and given responsibility for coordinating this as part of the curriculum. Depending on the School headcount/age range, a school may need more than one appointment. Also to provide funds necessary to train staff already employed at the school, to contribute (potentially with invcentives separate to their basic salaries).

It can be developed to help older pupils develop their interest in outside sports, through coordination with clubs and other schools in their areas. Also can be further developed to help pupils learn about health and nutrition and the interdependence of both on their mental and physical wellbeing.

The scheme to provide eg. exercise/yoga mats and PE/training kit for each pupil on an annual basis (schools can run a recycling second-hand outlet for outgrown clothing). Each pupil over 11 to b responsible for their kit/laundry (leggings/shorts and t-shirt or they can use their own kit). Up until this age, school will be responsible for providing and laundering all kit on a weekly basis, and kit to be stored at school.

GCSE PE (or the half-GCSE) which incorporates health and nutrition, to become part of every pupil's core curriculum so that all pupils continue to benefit from PE (which incorporates health/nutrition) until 16; and all pupils of 6th form age to have access to core PE through their place of education.

This investment in the health and wellbeing of all pupils, will pay dividends, in giving all pupils, regardless of where they live or their background, the best chance to live fulfilling and healthy lives, having learned to take responsibility for their mental and physical wellbeing as far as they are able, and be able to contribute to society, and in time raise their own families with the benefit of this education (which will likely need to be provided on a long term basis since the cost of living/housing relative to earnings, means that most families have two full time working parents). The societal and individual benefits are priceless and impossible to put a value on - they are colossal. In practical financial terms there will be increasing short, medium and long term savings to the Treasury, through a decreased dependency on the NHS and wider services.

ID: 2261-11 - Category: Health

From BAME to 'Ethnic Minority in Britain' - a changing approach to ethnic disparities

No single policy intervention will ‘fix’ the structural inequalities that lie behind this ethnic and racial disparity. However, one place to start could be in agreeing on a more effective framing of this whole theme. As the summer of protests demonstrated in 2020, the language we currently possess when it comes to talking about race and racism is emotive. Understandably so, this matters to many Britons as it speaks to the fundamental fairness of British society.

In that effort, my suggestion would be to discard the confused acronym BAME and instead use the formulation ‘Ethnic Minority in Britain’, EMB for short. Beyond this linguistic shift, the aim would be to better align how public bodies and government talk about race and ethnicity with how it is lived in Britain.

The substance of this approach would differ from the current one in three main ways. Firstly, it would signal a shift away from thinking about ‘communities.’ Life is not experienced in the

aggregate, so talk of BAME communities (or for example 'the Asian Community') can only go so far. The language used to talk about ethnic disparities in Britain should reflect the individual and their immediate environment. Failure to do so can encourage the impression that these are essentialised traits of these apparent communities.

Instead of thinking of these communities of identity, I would suggest the focus should be on physical communities. Parts of major cities, that have seen particularly high incidence of COVID-19 related deaths, also happen to be home to many ethnic minorities in Britain. These geographic communities perhaps tell us more about the types of inequalities that led to the disproportionate deaths seen amongst ethnic minorities in Britain during the COVID-19 pandemic.

Secondly the use of EMB would allow the notion of 'whiteness' to be separate from that of being an ethnic minority. By decoupling black and Asian from the term, it would be an important signal that visible difference is not the sole determinant of being an EMB. It would be hoped that this sort of decoupling would encourage a move away from a concept such as white privilege. This has gained increased prominence recently in mainstream discourse, even though it is a contested term. While many people in Britain may find this term explains their situation, it privileges visible, racial, difference above all else. Ethnicity in modern Britain is a more complicated construct, and reducing in such a way does not serve those who most need attention. Ethnic minorities in Britain do not map neatly onto simplistic ideas about whiteness and non-whiteness, as BAME can be interpreted as suggesting. Moreover, the language that the government and public bodies use matters as these issues have proved to be of acute public importance and interest.

Thirdly, by focusing on this new conceptualisation, it is hoped that a plethora of policies could accompany this innovation. These would be aimed at fixing the perceived 'fairness deficit' in British society. One example could be mandated name blind CVs for job applications of certain grades. Studies have shown how people with names which appear to be from an ethnic minority are less likely to be offered an interview for a job. Extending this to hiding the names of universities and higher education establishments on CVs for these applications could be an effective way of enshrining fairness at the heart of the post-COVID-19 recovery, regardless of

ethnic background. By foregrounding fairness, some of the confrontational nature of these types of conversations could be defused. Employers could be encouraged to follow these types of practices via a scheme that certified companies and bodies according to their recruitment processes.

The overall aim of moving away from BAME, would be to stop othering parts of British society as somehow constitutionally different. Instead, using this EMB approach, the focus would be on individual experiences and obstacles with a stress on achieving a fair British society.

ID: 1957-11 - Category: Health

Creating a London Food Lab to support local and disadvantaged individuals

London Food Lab could be a hub of innovation bringing food entrepreneurs together to build better businesses and learn from one another. This concept offers a solution to a double sided issue of creating a sustainable food system and supporting individuals from disadvantaged backgrounds.

Presently, the government has provided funding and aid through grant and Bounce Back Loan schemes, but there remains a dearth of services for the thousands of businesses unable to apply due to time constraints or an inability to access them.

The London Food Lab is an incubator that is rooted in Localism, an ideology that many Britons would like to continue post-Covid-19. Now more than ever, as COVID-19 continues and Brexit begins, it is important to invest our time and energy into creating a more sustainable holistic foodcape for the UK. The London Food Lab is a for-purpose food business incubator, designed to help existing and inspiring food businesses thrive. Our aim is to equip people with the skills, tools, networks, and resources needed to become a thriving food enterprise in London and to collectively make London a more vibrant, diverse, and sustainable place to live and eat. We want to empower individuals with the capabilities they need to participate in a thriving local food system, giving them the tools and efficacy to become leaders in their communities, while providing better access to healthy, affordable and culturally appropriate food.

At its centre, it is a 3 month program that covers ideation, market research, prototyping, scaling, building a team, food business literacy and gives access to mentors, guest speakers and a range of tools and resources. And also offers research, event, and consulting services. We believe this will foster innovation through the open exchange of ideas and will build resiliency into the post covid food system but creating a community web of support.

The social determinants of health highlight the disparity of access for many BAME communities from the top down - unequal resource distribution, diminished access to health services, nutritious food, and economic resources. The London Food Lab would be specifically dedicated to supporting people from disadvantaged communities in London, such as BAME and low income individuals.

The London Food Lab is modelled after the Detroit and Sydney Food Labs, both of which have helped hundreds of entrepreneurs create businesses that improve sustainable food systems and diets. The Detroit Food Lab has been pivotal in helping the city recover after the abrupt collapse of the automobile manufacturing industry in the 1970s and 1980s. The Sydney FoodLab is connected to Sydney University and they partner on research projects. Also connected to the Food Tafe, so businesses have access to commercial kitchens and cookery training. This joining of business and research has yielded a range of interdisciplinary benefits and will go on to pave the way for many future projects and collaborations.

Investing into business accelerator programs like this are likely to result in compounding benefits. Under this model, it would be possible to invest in the success of dozens of start-up businesses, for the same funding level as one. This exponential value generation makes limited budgets stretch further while providing benefits for a wider range of participants as well as the UK in general.

ID: 1777-11 - Category: Health

A New Approach to Psychological Distress

1. Recognise that psychological wellbeing can be improved with concrete, intentional action, both on an individual and at a policy level.

Psychological distress is often viewed as predetermined and unchangeable. Many people live with extremely unpleasant symptoms of anxiety or depression for many years without realising that it is not an inevitability. Although not widely known or understood, there are plenty of concrete, effective, evidence-based strategies for improving mental health, that favour intentional changes to decision making processes and strategies for managing difficult thoughts and feeling, over the use of psychotropic medication. At the moment, these strategies are typically only available via resource intensive, one-to-one therapists, currently accessed either privately at significant expense, or after several years on a waiting list. As a result of this, people often live their whole lives without accessing knowledge that could potentially have an immensely positive impact on their wellbeing.

2. Remove the influence of entrenched interests in the perpetuation of the status quo.

Mental health treatment in the UK today relies heavily on the prescription of antidepressant and antipsychotic medication. While pharmacological interventions do have their uses, their role as the primary treatment currently used by the medical establishment is based in several factors that have nothing to do with treatment efficacy (indeed, the majority of these drugs barely outperform placebo in clinical trials), and which impede the adoption of more meaningful strategies. One of these reasons is the lobbying influence of drug companies, who profit enormously from the widespread prescription of antidepressant drugs, and which constitute a large amount of money and influence that has the potential to lose out as a result of a disruption to the status quo.

The other is the attitude of the Royal Society of Psychiatrists (the body in the UK that is primarily responsible for treating mental health problems), which is a group of professionals for whom being viewed as medical doctors is important. While they recognise the role of social and psychological factors in the development of psychological distress, and the role of

psychotherapy in its management, they often recommend this as an adjunct to the widely favoured pharmacological interventions.

The suggestion that perhaps the issues that they are tasked with treating are not well addressed with the drugs that they have made a central part of their strategy threatens both their identity as professionals and their role as the ultimate authority on the treatment of mental health problems. Indeed, if drugs are relegated to the side-lines in addressing mental health problems, then the psychiatrists surrender their authority in this area to the clinical psychologists, something that is clearly not in their interest.

3. Challenge the idea that mental health concerns are binary.

The current model treats mental health concerns as something that either exists in pathological form or does not exist at all. In order to qualify for a diagnosis, and therefore professional assistance in the management of psychological distress, it is necessary for the symptoms to be so severe as to cause significant disruption to one's life. This completely arbitrary line must be crossed for the professional bodies that are responsible for managing mental health concerns to recognise that there is a problem.

The reality is that these official diagnoses represent the culmination of years' worth of maladaptive behaviours, socioeconomic stressors and unwittingly unhealthy psychological habits, all of which could be addressed much earlier on in the process, saving a significant amount of distress, time, money and effort. The impact of allowing these things to fester cannot be overstated, as the effects of severe, un-addressed mental health struggles reverberate through families and communities, and across generations. Indeed, the personality disorders - which represent some of most severe and intractable of mental health disorders – typically result from abuse and trauma in childhood, something that is often not the result of parents being "bad people", but simply parents who are not coping with struggles of their own.

4. Invest resources in programs designed to prevent psychological issues from developing in the first place.

In order to make concrete progress in addressing this issue, it is important for there to be a shift in the attitude towards mental health problems. Crucial to this is the recognition that out of the many factors that impact on an individual person's mental health, there are some things that they cannot control, for which the government is responsible; and some things that they can control, for which the government should provide support and education.

The things that are not under an individual's control are the practical factors that impact on any one person's likelihood to find themselves on an upward path of education, growth and self-sufficiency. These are the things that some people take for granted, but which for many people feel impossibly out of reach. Examples are quality, affordable education; opportunities for fairly paid work; and a robust safety net to catch people from falling too far when things go wrong.

The things that are under a person's control are the small choices that they make, which over time can have a huge impact on a life's trajectory. As a rule, if one's model for decision making is to be swept up by emotion and impulse, then this will result in unproductive and even self-destructive choices; however, if the model for decision making constitutes managing and accepting difficult emotions and making choices in alignment with a predetermined set of values, then growth and progress are much more likely to result. While very easily said, the latter is not easy, and is a skill that most people do not even know that they should have.

The government should introduce classes at school, designed with the same evidence-based principles used in therapy, to help us all manage our unavoidable humanness, with the goal of preventing the spiralling destructiveness of mental health problems before they arise.

ID: 1749-11 - Category: Health

Following the Science? ' Keeping faith in science-driven policy making

The Problem – ensuring, restoring and maintaining public trust in Government policy making

Although initially greeted with broad public approval, over the course of the pandemic public trust in the political and policy mantra of 'follow the science' has wavered. Which science ? Whose science ? Have become increasingly relevant questions, that threaten to destabilise the development of evidence-based public health policies.

Polar opposites : exemplars of divergent science advice from 2020 pandemic

'Run riot' or 'Lockdown'.

Over summer 2020 opposing scientific camps either promoted fast severe lockdown or opposed such measures proposing instead that the virus should run free in less at-risk populations. Arguably this led to a delay in decision-making on lockdown policy prior to the second wave and importantly exacerbated distrust in governments and public policy. There was a perception of delay and indecision, inevitably disrupting confidence in government policy and worse still risking non-compliance with future policy rollouts.

The 'Little ships' or 'Mega labs'

Early in the epidemic when a novel virus meant de novo development of specific and sensitive diagnostics test for SARS COVID19 , there was a fierce debate in the public arena, as to the merits of the 'little ships' model of many small labs in research institutes and hospitals developing and running tests, or, the perhaps slower but ultimately larger capability and capacity of developing mega Lighthouse labs. There was a heated debate featuring eminent scientists and bioscience leaders, played out across the media. This wrangle engendered public sentiments of distrust and even anger towards government. The debate in and of itself threatened the successful development and implementation of a testing system.

Disadvantages of current scientific advice set up:

- In non pandemic times scientific debate between experts, professional rivalries, factional groupings and so on are part of the general lively development of scientific principles and procedures. In pandemic times, this adversarial 'normal' way of generating consensus works against the Government getting the best scientific advice which is trusted by the public.

- SAGE and its subcommittees are comprised of a small number of scientific experts in comparison to the large scale of national and global expertise available. A number of eminent scientists inevitably feel overlooked and seek to find an input, which can be disruptive, a distraction and can be to the detriment of making good policy.

- A relatively small number of scientific 'Talking Heads' on media airing their perspectives through a range of communications channels over-emphasises individual and singular views.

- The public feels excluded

Tackling the problem

Let's create a new path for capturing the breadth and depth of scientific opinion: crowd-generated scientific advice as a primary step to policy-making. Clearly development of policy cannot be made 'en masse' but the primary feed in needs to capture shades of expert opinion, bring in the breadth and depth of scientific opinion, and engage the wider public in the process and its culmination. The aim being to engender a sense of ownership by the public critical to future compliance with government policy.

HOW : ‘Open Mic Research Days’ on specific research topics

- An Open Mic Research Day is independent, inclusive, exploratory, open, original, inventive.

- An Open Mic Research Day could be used for any type of science.

What an Open Mic Research Day would look like: An on-line event hosted in turn by independent research-focused organisations eg Wellcome Trust, Health Foundation, CASE, Nuffield, appropriate to the science area of the day. In post pandemic times, an in-person conference meeting would work .

Examples of research topics that could have been used for Open Mic Research Days to develop consensus relevant to COVID:

‘Developing the best diagnostic tests’

‘Problems and solutions in vaccine development’

‘Treatment frontiers’

‘Managing severe respiratory illness’

‘Modelling pandemics- lessons to be learned’

Making an Open Mic Research Day happen:

1.Select participants - Invitation to all scientists with significant research funding in the area (criteria for inclusion such as: holding a 5 year programme grant fund currently or within 10 years, or holder of a senior fellowship) - the ‘Expert Group’ add in Policy experts - Funders -

Comms experts - Media

2. Develop questionnaire to members of Expert Group prior to Open Mic Day to elicit :

- Key research questions in the field directly relevant to the selected topics: now, next 5 years, next 20 years - Most important recent developments, searching out about the latest ideas

- Pit falls in the field- where not to go

- What are the barriers to progress?

- Where should science developments feed into policy?

Analyse responses and pre-circulate as a discussion document.

3. Structure day around presentations and discussion on these topics informed by survey For the topic areas, aim to produce options for the way forward, scenarios dependent on adopting different strategies, and evaluations of how the evidence could inform or develop policy

4. Members of public can sign up to listen to discussions and send in their questions and suggestions online for Q&A

5. Synthesise outcomes - Identify where the science can shape and inform policy - Put confidence limits about what is known / not known/ will never be known - Share where there are divergences of opinion and why, and the consequence of choosing different paths

6. Share the thinking. The key target audiences for the thinking developed from Open Mic Days are the Departmental Government Science Advisory teams, Government Office for Science, the

Cabinet Office and parliamentarians and funders. Dissemination of the thinking, options, strengths and weaknesses of the science should also be shared widely in the public arena. Ensure proceedings available for all online, use comms experts and creative innovators to share outcomes with scientific community, the public and media.

Summary

There should be a new way to generate scientific opinion: inclusive, integrated and relatable – at a stage before government-selected advisory committees shape ideas to form policy. The concept of crowd sourcing scientific advice through 'Open Mic Research Days' is proposed as a way to do this.

ID: 1349-11 - Category: Health

Direct soft sea power aid projection while maintaining levels of readiness for desaster relief

Currently the UK has some naval assets that are not fit for front line combat duties. The UK also has excellent military and naval engineers that are kept in a highly trained state to be able to deal with crises if they occur. It could be possible to marry these together with UK based engineering facilities to create a kind of mobile aid flotilla with a stock of ready to assemble systems for the quick assembly of infrastructure and buildings. There is sufficient expertise to deploy several flotillas that could sail on a type of goodwill tour near areas known to experience seasonal natural events that may require immediate aid and infrastructure support which could be rendered directly from the supplies carried by these flotillas. If no such events occur during the good will portion of the tour then other defined projects could be undertaken with the prefabricated elements carried within the flotillas directly helping communities (coastal) around the world and leaving a lasting legacy from green power plants to bridges to ports etc. Such activities would be in line with the UK's stated desired to help developing countries and be funded from the foreign aid budget while using UK produced prefabricated parts and maintaining the training of UK forces as the required deployment could draw staff from all branches of UK uniformed services.

Such an approach to projecting british values and engineering would have to be supported where necessary through diplomatic activities and operational endowments and local training

to operate and use the resultant legacy constructions. This would clearly allow for direct aid bypassing several issues currently garnering negative publicity such as corruption and missuse of funds and allow the UK population as a whole to see local value to the overseas aid (through local fabrication and provision of the necessary supplies for the constructions) and worldwide value from these gifts from the British people in line with our value system.

ID: 1236-11 - Category: Health

Student Service scheme for care homes.

One clear issue highlighted by the Covid-19 pandemic is the inadequacies in the care sector. At present, there are over 110,000 vacant roles, with a staff turnover rate of 30.7%. During the pandemic, staff shortages undoubtedly put greater pressure on the care sector, especially considering the high concentration of vulnerable individuals.

However, the pandemic has also highlighted longer-term issues within the care sector. Currently, one fifth of all care workers are over 55, meaning that in the next decade approximately 300,000 carers will be needed to fill the gap left by retirees. By 2041, people aged 65+ will represent 26% of the population, with 7% of the population being above the age of 85 years (according to the Office of National Statistics). This is compared to the population aged between 16 – 64 years, which will only rise by 2%. Furthermore, Brexit provides new barriers to the migrant care workers that this country has desperately relied on.

Another long-term problem exacerbated by the pandemic is the unsatisfactory University experience for students. Many feel very frustrated with the current Universities system, with sub-par Education costing high amounts, a growing mental health crisis and expensive rents for accommodation they are not allowed to stay in. Students feel as if University run as a business.

Surprisingly, I think these two problems can be married together with one solution. To encourage young people to work in the care sector, a new quasi “National service” could be created, with young people choosing to work in the care sector in exchange for a small salary and either free university tuition or subsidised university tuition (depending on the time spent working in the care sector).

The Government's role would be to co-ordinate the scheme by finding vacancies, advertising the scheme to young people and providing training, as well as subsidising University education. The benefits of this idea are numerous. Firstly, students will no longer be burdened later in life by crippling debt as they attempt to climb the housing ladder. Furthermore, this would give young people greater respect and compassion towards elderly people, as there is arguably a negative perception and a stigma towards care homes. A staggering 96% of care professionals feel their work makes a difference in people's lives, so it would a be positive experience for young people. This scheme could arguably shape attitudes in society and make Britain a more compassionate nation.

Secondly, this would help fill the staff shortages within care homes, improving the quality of care and easing strain on services. With 1.9 million UK born students, if only 10% of students took up the scheme, it would go a long to way to filling staff shortages.

As a young person aged 17 myself, I really believe the scheme would cater to both young people's futures and elderly people's needs, whilst potentially moving Britain into becoming a more compassionate nation.

ID: 929-11 - Category: Health

A system to filter out potential Covid 19 virus burdens in free air

I am a retired engineer. I have seen no mention of attempts to mitigate the effects of Covid19 by filtering free-air in public places/transport. I have no experience of virological research and offer this electro-mechanical solution from an engineer's point of view. Also, I have no evidence that the device would be efficient enough to neutralise Covid19 aerosols. The device would have a small, low speed fan at one end of a cylinder (dimensions should be concomitant with expected aerosol burden) between the fan and the other - open end - of the cylinder; there would be interposed, a magnetron (self-excited microwave oscillator i.e. microwave generator) irradiating the incoming air. The cylinder would probably need a right-angle bend between the input and the magnetron to stop any stray uhf diffraction. Having a fine grill to stop accidental ingress by persons and random access by rodents/insects etc. I haven't the necessary

resources/construction and testing equipment, to test the viability of this device but I feel it could be possible to build and use the device to good effect. Further: I believe such a device could be cheaply manufactured in large quantities. Initially the magnetrons might be taken from the thousands of micro-wave ovens that are disposed of yearly.

ID: 333-11 - Category: Health

Senior national service

As above.

ID: 324-11 - Category: Health

Loneliness and the divided society - let's tackle it together.

The problem I would like to fix is one of abject loneliness felt among certain groups in society. There has been a loneliness pandemic in the UK long before COVID-19. This is a hidden disease which is debilitating in itself but can also give rise to physical health problems and shorten lives. Among some people and cultures, it is a taboo subject, and some do not even realise that they live in its grip. The self-isolation necessary because of lockdowns, plus our politically divided society only exacerbate the situation. Two groups in society who I witness battling with loneliness are the elderly and younger adults who are newly arrived in the UK. Fixing this problem will not only lead these individuals to a better place of mental health but will lead to better cohesion and tolerance in our communities.

I work as a public service interpreter (English-French) and I teach public service interpreting to interpreters representing a huge variety of world language communities in the UK. Our clientele may be non- or limited English speakers and they include refugees, asylum seekers and economic migrants. There might be a Congolese young woman who was a victim of torture in her war-torn homeland, or a young Lithuanian man trying to carve out a new life by working in this new country.

These new arrivals feel lost, vulnerable, and silenced. They have the right to live in this country, yet they often do not feel part of it. The laws, customs, and language are quite alien. They need to learn how to navigate our public services: transport, health, education, housing, immigration, employment. They bring with them their other ways of doing things – from the food they eat, to the time they eat and the programmes they watch on TV. These differences can lead to mistrust and intolerance on both sides. Back home, they may be pharmacists, civil engineers, teachers, but their qualifications are not recognised here, and their lack of English holds them back. They want to set down roots, create a family and contribute to the wider society.

At the other end of society are millions of retired and old people who crave friendship, a purpose in their lives and who still have much to offer society. Many of these elderly people feel isolated and cast aside. They too might have held a respected job, but they no longer have that identity.

These two groups have one thing in common: loneliness. The COVID-19 pandemic means they can spend days without interaction with another human being. Activities which were once face to face are now done remotely, sometimes typed online: a consultation with a GP; a query with the bank; a discussion with a teacher. The opportunities to converse with another human being become fewer. In turn we become less practised and start to withdraw.

There is now surely an opportunity here to link these two groups. There is already much evidence of successful partnering schemes which link retired people who volunteer to read to young children in schools. Others have successfully been partnered with university students as part of befriending schemes to combat loneliness. A scheme which partners an elderly person with someone who wants to improve their English would be mutually beneficial. I encounter many limited English-speaking immigrants who are taking English classes but do not have any opportunity to practise the language with an English-speaker outside of their weekly lessons. They lack the confidence to try, 'my accent is too strong…I'm so slow and people are always in a rush…my grammar is terrible…people won't like that I sound foreign…'

During the first lockdown when much of the country stood still and we came to our doorsteps to clap the heroes, there was a welcome feeling of togetherness. Our country was united in a common cause, when for a long time it has felt very divided. Brexit and the ensuing topics of immigration and sovereignty, Northern Ireland borders and Scottish independence all threaten to destabilise and pit us against each other. We must seize this moment to remember that 8pm closeness and eagerness to help our neighbour to create something lasting and wide-reaching. Many older people do have the time and the patience to help someone else to improve.

The gains of such a scheme would reach far beyond combating loneliness. The opportunity to get to know someone from a different background to you is priceless. It leads to a mutual understanding of different cultures. It encourages tolerance and helps integration, whilst at the same time, allowing both sides to be heard. These new arrivals have so much to learn from our longer established members of society. I have witnessed the confidence, happiness and self-worth that comes from feeling settled in your new home. A sense of belonging and having the equal opportunity to access all that is available to those born here can only come from speaking the language.

This scheme could learn from befriending programmes mentioned above. In lockdown there would have to be remote meetings via a virtual platform: one hour per week of chatting in English. I suggest providing ideas and templates for structured conversations. There would be some initial costs involved: basic computer skills would need to be offered in order to access these platforms. Participants would sign up to a register so that safeguarding protocols can be observed, such as obtaining a DBS certificate. Once we are liberated by the vaccines, perhaps these meetings could take place face to face at community clubs.

As a teacher of multicultural adults, I am certain that the outcome of such partnerships leads to a realisation that we all have more in common than what separates us. As an interpreter I know that it is only through language that we can give a voice to each UK citizen. If we can achieve this while tapping into the experience of the older generation, then we can help new citizens integrate and fix loneliness along the way.

ID: 113-11 - Category: Health

NHS retired doctors and nurses 'Regular Reservists'

Would it be possible to put retired NHS staff on a list of 'Regular Reservists' similar to Military personnel who after active service were on 'reservist lists' for up to 2 years to be recalled in the event of war?

ID: 3008-11 - Category: Health

Summary - now is the time for the UK population to become “pharmacy-literate”!

The experience of the pandemic provides an unprecedented opportunity for engaging the public in a concerted education and information campaign to explain the role of medicines and vaccines: how they are developed, used, regulated and monitored for safety.

The aim would be to create a “pharmacy-literate” public. A parallel could be drawn with efforts to improve “financial literacy”.

The Problem:-

The pandemic has exposed the UK population’s lack of a solid base-level education about medicines and vaccines, compounded by disparate and inconsistent sources of information. During the past year we have witnessed the resulting knowledge gap being filled with conspiracy theories and misinformation, spread primarily via social media. The MMR

controversy of the late 1990s is another example of how easily false assertions can gain traction and cause fear amongst a public that is lacking in basic knowledge of the subject.

The Benefits:-

Greater public understanding of medicines and vaccines will assist the UK Government, its devolved administrations and health systems to:

• Debunk misinformation and myths around vaccines in particular – aiding efforts to overcome "vaccine hesitancy" and boost public confidence in the regulation of medicines.

• Encourage patients and carers to engage with regulators and the wider health system to report issues of safety and other concerns – strengthening the public's input to the data collected to monitor the safety of medicines and vaccines and building trust in the role of the regulators.

• Support citizens to take responsibility for their own health management by empowering them to make informed choices and decisions – contributing to a healthier population and relieving pressure on the NHS.

• A better informed and educated public would, arguably, be more willing to participate in health research and clinical trials – supporting efforts to position 'UK PLC' as a prime location to develop innovative medicines and treatments.

The Challenges:-

There will be challenges in how to create an education and information programme that is:

• Trusted (by the public).
• Accessible (to all UK citizens).
• Comprehensive (in terms of its content).

Meeting those Challenges:-

a) Involvement

Involving the right stakeholders to co-create the programme and to collaborate in its dissemination will help to ensure comprehensive content and, crucially, to build public trust in

relation to both the information delivered and the overall aims.

Key stakeholders to involve include:

- Patient groups - from across the UK
- Black and Minority Ethnic (BAME) community groups
- UK Regulators - primarily the Medicines and Healthcare products Regulatory Agency (MHRA), the Health Research Authority and NICE
- NHS and public health bodies (e.g. the National Institute for Health Protection)
- Community Pharmacists - the networks/representative bodies for community pharmacists across the UK
- Other healthcare professional networks and Royal Colleges – those with direct relevance, such as the Royal College of General Practitioners
- Department for Education

Representatives from UK patient and BAME groups should be at the heart of the development and delivery of the programme. From the outset they should be involved in defining and steering the work. The inclusion of BAME community and patient group representatives will help to engender public trust.

Those stakeholders who represent the health and education systems, healthcare professionals and the regulators would be able to contribute technical content for the programme and the creation of dedicated information resources.

There could be a limited role for the pharmaceutical industry, primarily in relation to content development and perhaps a contribution to funding. However, caution would have to be exercised regarding the extent of industry participation in order to avoid public perception of the programme being used as a “vehicle” to market pharmaceutical products.

b) Delivery

Making the programme accessible to the wider UK public will require a combination of the most appropriate delivery methods and support from the stakeholders – the latter can provide channels for dissemination through their own networks and communications; directly reaching out to patients and BAME communities.

A blend of different access points should be considered:

• Interactive electronic information terminals in every pharmacy and waiting room (GP surgeries, health centres and hospitals) – enabling patients and carers to access information, in a healthcare setting, about the medicines they are being prescribed and how to report side effects and other concerns.

• The National Curriculum would benefit from including the subject of medicines and vaccines (basic coverage of how they are developed, regulated and deployed) in the citizenship programme for key stage 4.

• A single trusted online source of information on medicines and vaccines that is independent of existing NHS and Government websites. A dedicated website could provide the public with very basic top level information on medicines and vaccines, whilst also allowing visitors to drill down into as much further detail as they wish:

o The top level should be composed of engaging content: simple in structure and delivered primarily in graphical format.
o Layers below can provide relevant health, technical and regulatory information and data, for those who wish to delve deeper.

• Regular blogs and podcasts from high-profile contributors could deliver “Pharma Facts” – myth-busting and fact-checking similar to those articles produced by the BBC health correspondents during the pandemic.

• A schedule of open public webinars that will deliver topical information on medicines and vaccines and will enable the audience to ask questions and explore topics with experts from the programme’s key stakeholders. The ‘ZOE Covid Symptom Study’ project has regularly run this type of webinar.

Co-ordination and Delivery:-

The MHRA, as the UK regulator for medicines and vaccines, could be ideally placed to lead and co-ordinate the overall programme and be given the additional resource this will require. The MHRA has an existing patient group forum which could be used to obtain initial input from patient representatives. It also has experience of bringing together stakeholders from across the wider health system, healthcare professions and patient groups, in order to address medicines’ safety issues. This could provide the basis for establishing a steering committee to define and oversee development of a concerted programme that enables the UK public to become “pharmacy-literate”.

ID: 3063-11 - Category: Health

Improving the way that GPs operate and building up a comprehensive health database.

GPs have extended the use of triage and phone and video consultations during the pandemic. I assume that, in the same way as different drugs were trialled to see which worked best to counteract the disease, these different practices are being evaluated to see what woks best for which patients and which diagnoses. There has also a large expansion in the use of home tests such as lateral flow tests and oxygen monitors. This could be considerably extended.

The NHS could develop a standard kit and range of diagnostic tests for use at home, based on the existing diagnostic steps that GPs follow. For example, it is already possible to get temperature, blood pressure, heart rhythm and oxygen levels as well as weight and height, and to take photographs of the affected part of the body. Lateral flow tests could be developed for diseases other than Covid. A range of blood testing tools could be developed using just a few drops of blood (as is currently done for INR). I realise that some considerable work would need to be done, but the development of the existing lateral flow tests, the development of the vaccines and the development of new ventilators show that these things are possible.

In parallel with this effort on the equipment and measurement procedures, an Internet diagnostician could be developed. It will check take the patient step by step through a diagnostic procedure, with the patient being able to provide the results from the various tests. In some cases, the diagnostic software will advise that the patient visit either their GP or A&E; and the system will enable the results of the tests to be forwarded accordingly before the patient arrives. In other cases, it may conclude that there is no need for medical intervention.

Of course, there is the risk of misdiagnosis, However, there is nothing to prevent the patient seeing either their GP or A&E if not satisfied. There is also the challenge of the patient carrying out the tests correctly. This last could be ameliorated by asking that the procedures be followed monthly, so as to familiarise the patient with them and to provide an additional diagnostic tool in that unusual results would be easier to spot.

GPs would have access to all these data and should review them from time to time to look for such peculiarities. It should be possible in some cases to take preventative action to avoid some conditions from developing.

In addition, the availability of all those data should help in analysing public health risk factors

within the population and assist in the test and trace process for new diseases. An analysis of the data will also enable the Internet diagnostician to be improved and additional testing requirements identified. It could also be used in training new medical staff and as an aide memoire for current staff.

As with any data collection exercise, there is the impact on privacy, and the risks of misuse and unauthorised access. Security protocols will need to be established and monitored.

The development of such a system will take a little time but is eminently possible. In addition to those indicated above, there is the opportunity for the NHS to patent some of the developed equipment and, more importantly, to provide a world leading process in diagnosis, preventative medicine and public health analysis.

ID: 2198-11 - Category: Health

Support bubbles transformed into Social Assets: for enhanced post-COVID recovery and effective response to emergency

1. Challenges

The COVID-19 brought us the following challenges. First, in the psychological aspect, social isolation and loneliness lead to increased rates of mental illness overall, and especially among youngsters and women [1]. Second, in the social aspect, the UK suffered from a devastating loss of charity funds with many organizations having to close down when help is the most needed, leading to a mismatch of demand and supply in this realm [2, 3]. Third, with the negative shock in the economy, especially the small and medium-sized enterprises and local family businesses were hit severely [4, 5].

2. Proposal in brief

Thus, I would like to propose a policy that can transform support bubbles into social assets, by joining digital currency on the existing support bubbles in order to build a strong sense of community, promote positive, voluntary actions, and help the local economy.

Within a given community cluster, a sophisticated incentive mechanism can be introduced, such that a voluntary good deed by a member can be rewarded in form of digital currency, which then the member can choose to either donate or spend in local shops. A strong web of

connections that spans from the individual, the community, to the local economy will help provide synergy and flexibility in UK's recovery from COVID and in national preparedness for any kinds of future emergency situations.

3. Theoretical backgrounds

Previous studies on Game Theory and Behavioural Economics have suggested the role of public policy in nudging people towards making more socially desirable choices, especially when the individual incentives can be aligned with the goals of a larger system [6, 7]. Also known as the Incentive-Centered Design, examples have been found both in the private sector regarding the user-generated contents and in the public sector where public policies can help set default options for instance in organ donations [8, 9].

4. Concrete implementation aspects

(1) Make community clusters

Support bubble was introduced in June 2020, and by August 44% of adults in Great Britain had formed a support bubble [10]. While the eligibility and coverage continued to evolve (i.e., childcare bubble or Christmas bubble), by 2021 most of the public has some familiarity with this policy. Based on the government's experience of developing and deploying the NHS COVID application, the government can form a digital platform to keep a record of these spontaneously formed social connections and link them to form "community clusters."

For the initial formation of these clusters, all types of local organizations such as the local council, public interest foundation, or healthcare group can jointly participate. For each community cluster, a project manager-type member can be selected based on the specific context of the emergency situation. For example, under the COVID pandemic, a person with experience of working in the pharmaceutical industry, healthcare, or psychological services may be suitable.

(2) Promote voluntary contributions through incentive and active feedback

Within each community cluster, people can use the platform (preferably, in form of a smartphone application) provided by the central government to help one another through actions such as delivery, teaching, or counseling, which will be especially useful in times of crisis. Such activities can further be appraised by the members similar to the recognition schemes in social media platforms. Based on the number of contributions and feedback from the members, the central government can provide digital currencies that can be used locally.

In essence, the proposed policy will manifest itself through an integrated digital platform that keeps a record of good deeds performed for the community, facilitate joint appraisal by the community, and manage digital currencies to be distributed to the members.

(3) Return to society by spending

Recipients of the digital currency will have an option of either donating to charity or spending in local stores. The increased expenditure will help the small and medium enterprises and local family businesses that depend on the local economy. With digital currency, it is easy to introduce caps to the maximum amount or set an expiration date to reduce fraud and increase spending within a specified time-period.

5. Expected outcomes

The UK has experiences with the support bubble, the NHS COVID applications, and the usage of local currencies in some cities. Supported by increased use of technology and data coverage, the policy can be implemented to (1) promote members to perform good deeds, (2) reduce a sense of social isolation and instead create a sense of community, and (3) increase dynamism in the local economy. In other words, the support bubble is no longer a “Bubble” that forms and disappears spontaneously, but a concrete “Social Asset” that can be utilized especially in a crisis.

One possibility is to conduct pilot projects in regions that have experience with local currencies. Although the policy implementation will require support from the government, the policy introduces social contributions - which have been largely exempt from social valuation until now

- to the center of public attention. In this aspect, the policy can be considered a market-generating governmental intervention.

As experience with the policy accumulates, the government can also increase the intensity of the incentive as a form of giving universal credit. Through the cluster-specific scheme, the government can also take into consideration the gap in socioeconomic status to fine-tune the incentive scheme. In the long run, the government's experience of working with digital currency will serve as a groundbreaking approach.

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ID: 2018-11 - Category: Health

Motivating the overweight to want to lose weight

Summary

The UK has a weight problem, and it is no coincidence that we top the tables on deaths per million for Covid. Add to this the overall cost of obesity to wider society at £27 billion, it is a problem that needs fixing. The root of the issue is motivation. Unless an overweight person has a strong desire to lose weight, they won't. The proposal is to establish the medical equivalent of speed awareness courses - in private hospitals - with volunteer inspirational role models to 'hand hold' thereafter.

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The figures from Gov.Uk are quite shocking. 64% of adults are overweight, 28% obese, this is the fourth highest in the world. In children (aged 10-11), 21% are obese and 14.1% overweight. The policy paper of July 2020 'Tackling obesity: empowering adults and children to live healthier lives' is a great tool, but realistically it will only benefit those with a strong desire to lose weight. The real problem, is reaching out to the majority of overweight individuals who know it is a good idea to slim down (and encourage their children to eat healthier), but for various reasons don't. These are the individuals that weren't hospitalised through Covid and hence haven't received their wake-up call to action. Motivating the overweight - to want to lose weight - and hence be serious about going about it is the issue.

The answer lies in drawing a parallel with speed awareness courses - but with a medical

context. These would be ‘prescribed’ by the GP as appropriate for the individual. They would follow a similar format in that they are for a significant length of time (half a day), are part educational and part strong ‘wake-up’ call, but dissimilar in that they don’t take place in what can be demoralising venues. They would be run by specially trained medical staff (none of whom would be overweight). A programme could be put together based on the consequences of having a high BMI e.g. for every ten-point increase above normal, people’s livers become 2.7 years older than their chronological age. A big focus would also be on the damage to the life chances of children. Educationalists could be involved to ensure a varied, interesting, but suitably hard hitting presentation that isn’t all ‘screen time’. The aim would be high engagement and not too dumbed down or highbrow. The attendees need to come out changed.

To keep costs down and to continue - thinking outside the box – the proposed venues would be private hospitals (particularly those that are/were registered as charities and benefitted from generous business rates relief). It is an opportunity for them to share their good fortune with wider society. If newspaper reports are to be believed, many private hospitals did well out of the Covid crisis. Headlines were full of the ‘win win’ scenario for the private hospital sector. At the end of May 2020 for example, about £1.75billion was shared unequally between 26 private hospital corporations, each of which picked up payments ranging from £0.9m to £346.6m to Britain’s largest private hospital group, which is now Circle Health Holdings. (Source: The Lowdownnnhs.info. Analysis November 8th 2020). Most private hospitals tend to be small in scale (averaging just 43 beds) and are primarily staffed with nurses, most of whom work in them on a part-time sessional basis, while employed by the NHS. Making more use of private hospitals for schemes such as this (on a fair and honest price basis in recognition of their ‘duty’ i.e. shamed somewhat if they are unwilling to contribute to helping the nation become slimmer) makes practical and financial sense. Having the weight awareness courses in such swish, clean, and fresh venues would be a further motivational force for the attendees. We all need to be inspired.

Which brings me to the volunteer ‘hand holding’ inspirational role models – and for this I am going to become personal. When I took my elderly mother for a hospital appointment at The North Middlesex recently, we had the most wonderful experience. On entry there were three smiling women who were volunteers on Covid duty. One took our temperatures, one delivered our sanitiser and the other helped us to find our way. They were beacons of hope. So kind, helpful, and reassuring. They lifted our spirits, and we still talk about them. Similarly, when I

visited the Olympic stadium with my sister when they were in London, it was the volunteers we remember mostly.

The UK has the most amazing volunteer army. All ages, nationalities, socioeconomic status etc. and all happy to help. What works for them (invariably) is short-term involvement (particularly if they are retired or have a family) as 'mentoring' means a big time commitment. So my proposal is that following a course each attendee is allocated an inspirational volunteer for a short period to help keep them on track. Someone to go food shopping with, someone to relay weight loss successes with, and someone to help download relevant apps/ establish good jogging routes etc. Each volunteer will be allocated about 3 or 4 people to 'hand hold' and then when they are ready to let them go, they put them in contact with one other so that they continue to have support but with those on the same journey. These could become 'Better Life Buddies' providing ongoing mutual support and who knows…long lasting friendships thereafter.

The consequence of success of motivating the overweight to want to lose weight is a happier and healthier nation - not to mention a fortune saved for the NHS.

ID: 1788-11 - Category: Health

Artificial Intelligence in the NHS Mental Health Service

Summary

The government must meet the increased demand for mental health services sustainably and long-term. The gap between supply and demand in mental healthcare services is not solvable through human resource capabilities. Therefore, a digital transformation included in the reformation of the Mental Health Care Act 1983 combined with the implementation of computerized Artificial Intelligence (AI) based therapy in mental health services may ensure widespread access and availability of emergency psychosocial support, with a focus on sustainability.

Opportunities and Recommendations

First, the government should include mission-led innovation policies into the potential reformation of the Mental Health Act, expressed by the commitment of the Department of

Health and Social Care to prioritize the use of technologies with the mission of making mental healthcare accessible and available for the majority of citizens. The necessity of this digital transformation is emphasized exemplarily by the COVID-19 crisis its secondary consequences. Government action through legislative power can facilitate a reassessment of the standards for healthcare services. As a reformation of the Mental Health Act is already proposed, implementing innovation-oriented policies can further the government's development to be digital by default and aim for sustainable growth. This development would be in accordance with the government's aim to be a leader in the European AI environment, which is why we recommend actively fostering innovation in mental healthcare through high-risk investments.

Second, the NHS mental health services should efficiently adopt Artificial Intelligence to screen, diagnose, and treat patients. Particularly, a computerized cognitive behavioral therapy (CBT) software powered by AI to function as a human-like therapist may be a concrete solution. The system could be available as a mobile application to imitate the interpersonal interaction of texting. It would provide the first contact for patient assessment followed by a computerized talk-therapy. In contrary to other existing platforms such as Ieso Digital Health, the primary objective of the therapy software is not to act as a clinical decision tool by pairing patients with therapists. Moreover, the AI assists therapists by treating patients, either as the main form of therapy or temporarily until allocating a human therapist through an e-referral. This type of digital therapy might be already sufficient for patients with less severe cases. Users may register with minimal personal contact details to lower the cognitive barrier for mental health utilization unless needed for an e-referral. The development will require the formation of a policy collectivity as innovational challenges need the collaboration of public as well as private sectors. Similar to the successful NHS COVID-19 application, the development of the software can be achieved by creating public-private partnerships and following a multi-stakeholder approach. The collectivity could include private sector firms such as Zuhlke Engineering, VMware Pivotal Lab and Accenture, not-for-profit charities such as the Alan Turing Institute, Research Institutions such as Oxford University, units of the Department of Health and Social Care such as NHSx and NHS Digital, and the Health & Care Professions Council.

The state of the art of emerging technologies as well as the technologically advanced environment in the United Kingdom, promises feasibility. Comparatively, the UK is ahead of 28 European countries for the ability to capture the full potential of AI (McKinsey & Company, 2019). Further, the UK is a founding member of the Digital Nations and aims to be a leader in AI

and data revolution (HM Government, 2017). With Big Tech such as IBM Research or Microsoft Research inventing new solutions, the use of AI in mental healthcare is already considered a stepping stone towards the reinvention of services through government action.

The government underlined the aim of further digitalization with an AI Sector Deal worth £950 million (McKinsey & Company, 2019; HM Government, 2017). Additionally, the NHS increased their spending on mental health services by creating a fund worth approximately £2.3 billion a year by 2023/24 (NHS, 2019). Therefore, funding for development and implementation should be realizable. Moreover, the use of AI enables the early detection of illnesses, hence preventing costs for the healthcare system caused by the late intervention.

Research has shown the effectiveness of AI in mental health services. On account of its programming, AI can identify depression-associated markers in the text language of users and changes of behavior even earlier than human therapists. AI can analyze “data of volume or complexity that is beyond the analytical capability of individual humans” (Hall & Pesenti, 2017, p.9). In contrary to humans, the computerized therapist is constantly available.

An interdisciplinary stakeholder collaboration of software developers, product managers and designers, security experts, clinical professionals, and policy-makers can produce a stable product. Further, representatives from Understanding Patient Data can provide public discourse feedback about usability and readiness, hence including patients in the process. The Ada Lovelace Institute and the Centre for Data Ethics and Innovation could be involved as ethical advisors. Equally important, the application has to comply with the General Data Protection Regulation and the Data Protection Act 2018. We recommend involving legal advisors as well as the National Cyber Security Centre. Overall, the use of emerging technologies has the promise to be an adequate solution to the increased demand for mental health services. The implementation of a “digital therapist” tackles the problem of insufficient human resource capabilities and thus eases the burden on the system. De-stressing professionals could arguably lead to an overall improvement in therapy sessions, with further benefits for patients and staff. Considering the trend towards the use of AI in healthcare and the government's objectives, a digital transformation of the mental health care system included in the reformation of the Mental Health Act 1983 is a reasonable and necessary step to be taken.

ID: 173-11 - Category: Health

A unified governmnent strategy to get the nation counting calories, and reduce Obesity

Current food labelling is not fit for purpose, and the 'traffic light scheme' labelling (which is currently voluntary) is so often abused as to try and hide the actual level of calories inside a package of food. So often they will show the calories/fat/salt for 1/4th of a pack of a food you would never dream of sharing with anyone. Sweets are the worst offenders, with some traffic light labelling showing the calories for 5 sweets. Who reading this has ever eating 5 jelly babies out of a packet? It's not how people eat.

My suggestion is for there to be a complete overhaul of the food labelling system, a unified government strategy to go along with it including classes in schools, a commitment to a perpetual national advertising campaign, and a government app to help with the counting of calories.

Food labelling:

The current system is a total mess, and it is near impossible for anyone to easily remember how much energy they have consumed. Calories, Kilocalories, and arbitrary portion sizes are confusing and irrelevant. I propose a new unit of measurement called a 'Foodie'. A 'Foodie' would represent 100 kcal, and would only ever be whole numbers. In the event that there needs to be some rounding done, it would always round up to put people in a slight deficit. But actually in practise, it tends to work out almost exactly anyway. This would mean:

300kcal = 3 foodies

340kcal = 4 foodies

665kcal = 7 foodies

1220kcal = 13 foodies

And so on, and so on.

The logic behind this is that it is much easier to remember and do addition with smaller numbers. Remembering you have consumed 11 foodies so far is easier than remembering you've consumed 1020kcal.

And adding 3 foodies to 11 foodies is easier than adding 272kcal to 1020kcal.

We need to make counting calories so easy that an 8 year old could do it with minimal effort. We need to make it so simple that the average adult will do it subconsciously when looking at the front of a packet of food.

The second part of the initiative in regards to food labelling would be to put the foodie amount for the entire product on the front, and big font. People can divide 8 by 2 easily, if they decide to share the food. It shouldn't be up to the manufacture to be making that decision, and showing the amount of calories based on how many people you might share with.

The third part would be a QR code on the front. This would have more detailed information encoded in it. Salt content, macronutrient content, and kcals. As well as the name of the food.

All fast food outlets would also be required to show the amount of foodies their meals are worth, along with an easy to scan QR code.

The labelling would be compulsory for all packaged food.

Fresh produce would be exempt from these laws.

The app:

The next part of the unified strategy would be to develop an application for android and iOS that people can download. In this app they can set their height, current weight, and age. The app will then tell them how many 'Foodies' they require. For men this will be about 22 foodies, and for women about 20. It will differ a bit.

From inside the app people can scan the QR codes and keep track of what they're eating. They could also set goals, such as losing weight. This data would be anonymised and sent to the government so it can keep track on what the diets of Brits actually looks like, and this could help guide policy in the future.

These apps exist already (like myfitnesspal) but are overly complicated, and not well known enough to make a big difference on the scale needed. The data can also sometimes be wrong, so creating a government QR code standard for food data would improve the accuracy a lot.

The Education:

Now the public would need to be educated on this new system. A large TV and internet advertising campaign would be run, forever, promoting the app and telling people that men need 22 foodies and women need 20 foodies.

In schools, half an hour of PSHE would be dedicated each year to teaching children the system and getting them to download the app.

I believe that if we do all this, and make the process of counting calories almost so easy it can be done without any thought, people will do it and realise just how much more they're eating than is necessary. And with a multi generational approach to teaching the system, I believe it would pay dividends over a few decades as children transition to adult life with the knowledge of how to correctly track the level of energy they're putting into their body.

ID: 1358-11 - Category: Health

Maintaining the use of medical gadgets

It would be nice if the development and use if these medical electronic gadgets become a lifestyle for all. Imagine being able to assess one's health and take necessary precautions without having to queue up in a hospital just to be checked.

Creating apps or online platforms that might enable people to seek professional help when need be. These apps could contain basic health/medical information and measures to take during certain health/medical situations.

ID: 575-11 - Category: Health

A Territorial Army for the NHS

The policy proposal for the NHS Capacity challenge identified in Q1b above is to create an NHS Reserve or Territorial Army akin o the military’s TA.

Objective:

To build a trained and experienced reserve team, able to to support the NHS in times of crisis or seasonal work overload.

Principles:

The NHS would identify specific roles or functions which (a) are most likely to suffer from staff and skill shortages either seasonally or in times of crisis such as pandemic, epidemic, natural or transport disasters, terrorist attacks etc. ; and which (b) lend themselves to discrete or specialist training as described below .

The difference between this Reserve programme and a normal volunteer programme is that reservists will be selected and trained with a specific function or role in mind , which they can perform with a minimum of supervision as and when the need arises. The Covid Pandemic suggests a number of possible areas for Reservist training including : intensive care treatment, operation of ventilators and administering of vaccinations. Other examples might include basic nursing; first aid and trauma treatment, operation of specialist intensive care equipment , ambulance driving or simply general porter/auxiliary services.

A recruitment campaign would be aimed mainly at young people regardless of their level of education but a rigorous assessment process would identify which role was most suited to each candidate . Background and psychological checks would also be undertaken to ensure general ability and suitability of the candidate concerned.

Each successful candidate, a Reservist, would enter into a contract with the NHS through which he/she would commit to an initial and annual refresher training programme and to be available for a service call up for a minimum period each year on an -as needed basis. Employers would be encouraged, incentivised or even required to offer terms to new recruits which would allow Reservists to give the necessary commitment of time. Training would consist of a two part programme covering (a) general NHS standards and principles such as ethics, data protection, hygene etc and (b) the specialist skills needed to fulfil the requirements of relevant function. The specialist training would include some practical, on the job, experience which would be refreshed annually.

Each Reservist would be paid an annual sum in respect of his/her minimum annual commitment plus a per diem amount to reflect any additional time spent in NHS service. Other incentives could be considered such as tax breaks on Reservist payments, free rail /bus passes and an exemption from jury service.

Advantages. The Advantages of the NHS Reservist scheme would include:

- 1. Capacity Building : The creation of a flexible and auxiliary work force which could complement permanent NHS staff with the skills and knowledge that are most needed in times of seasonal stress or unexpected crisis;

2. Financial : Resources that are scalable will allow the NHS to avoid some full career training costs which are likely to increase as the supply of trained overseas staff becomes more scarce after Brexit. It could also reduce the amount paid to Medical/ Nursing supply agencies to cover temporary shortages; 3. Career Opportunities : The Plan could be a convenient entry point for young people who are not ready to commit, full time, to the NHS – but whose Reservist experience convinces them that they do indeed have the necessary vocation to care for others.

4. Utilisation of resources: The Plan is suited to the current employment climate of 'gig economy' workers and zero hour contracts and would provide an anchor of continuity for those who have no long term career prospects or commitment

5. Citizenship Enhancement: A Reservist Plan provides an opportunity for people to contribute to, and thereby earn a stake in society. It would help to 'round off ' those who pursue their main careers in professions such as law, finance or IT and would provide some real life experience and people skills for those who are otherwise cloistered in an office or 'virtual' environment .

ID: 558-11 - Category: Health

Mental Health for all: Responding to the urgent need for systems designed for equality

The coronavirus pandemic is a physical health emergency on a global scale, such as we have never seen in our lifetimes. But it is also a mental health emergency. Both the coronavirus illness itself and the measures governments have had to take to contain it are placing enormous stress on people's emotional health and wellbeing.

We have estimated that ten million people in the UK will require mental health support as a direct consequence of the pandemic. But the mental health impacts will not be felt evenly across society. We know that our chances of having good or bad mental health are unequal. Social and economic inequalities – poverty, racism, discrimination, and exclusion – create and perpetuate mental health inequalities. And just as some groups of people are more at risk from

the virus, many of the same people will also feel the worst effects on their mental health.

In November 2020, Centre for Mental Health published the final report of the Commission for Equality in Mental Health, Mental health for all? The report concluded two years' work exploring what causes mental health inequalities, why they have become so entrenched and what can be done to reverse them. Our report showed that mental health is made in communities, and so action to reduce inequality needs to begin at the local level, within communities, supported by local systems, services, and civil society. This is what we want to stimulate: to move from words to actions.

To build a system designed for equality. Across the country, groups of people are working to change this picture: to find new and innovative ways to meet people's mental health needs and to create wellbeing in their own communities. But many of these approaches are isolated, often small scale and short term. As we recover from the significant impact of a pandemic on society, we have an opportunity to make mental health equality a real focus for 'building back better'. But it will not happen unless we act now to change the systems that hold people and communities back.

We have developed an approach that will start the ball rolling in a small number of local areas where people are willing to work alongside us on a pilot programme to begin their journey to achieving mental health equality. We want to create a 'proof of concept' pilot, to find out whether the approach we have designed can take root in a community and spark the system change we know is needed. We have discussed this with community and system leaders in a number of local areas that are interested in being involved in fixing this problem. We want to build local coalitions to join together to establish the building blocks of a system designed for mental health equality.

We would work alongside each of the pilot areas to identify early actions they can take towards mental health equality and to agree some specific ambitions and goals for their local system. We would do this through a series of workshops and one-to-one discussions with stakeholders

in each local area, supported by our research and evaluation team who will provide evidence about good practice, economic analysis, and critical appraisal of proposed actions. We would work to support each of the local areas to draw up a shared 'mental health equality action plan'.

We would encourage the pilot areas to build a broad coalition including community organisations, experts by experience, civil society, business, and public services. We would also want to ensure that insights and learning from the pilot sites are shared widely and freely. To embed this, we would build alongside this targeted pilot our existing network of elected member champions for mental health and a new network of local mental health equality leaders, with whom we will share the results of the pilots as they emerge. We would publish a series of blogs, videos, and briefings during the pilot phase. We would plan to conclude the pilot programme with a brief report describing progress and exploring the potential for wider uptake. And with these we will make the case nationally for a system designed for equality, advocating for policies that support and enable local action and that reverse the inequalities that drive so much poor mental health. In the wake of a pandemic, the time has come to achieve 'mental health for all' by redesigning services that embed equality.

ID: 434-11 - Category: Health

OBESITY-THE SOLUTION

Tackling obesity and its causes requires coordinated interventions on three fronts, educational, health and commercial/regulatory, bringing together different participants like health professionals (including GP's), schools, supermarkets and food producers.

On the educational front, encompassing both the education sector itself and wider public messaging , there are a number of interventions. Young people from a very early age should be taught the importance of food and nutrition and how it relates to them and how it is produced. This needs to continue into Primary School and Secondary School and supplemented with food preparation and cookery classes. Exercise and fun sports and activities would become part of the school timetable and given much more emphasis than is currently the case. PE teachers would be recruited in inner city schools where is it more challenging for kids to exercise and children would be encouraged to walk to school wherever possible.

A major public information campaign highlighting the dangers of obesity would be mounted and maintained over a prolonged period, similar to those that have shifted public attitudes over time to drink driving and smoking. Support would be given to families who need extra support

and encouragement to maintain a healthy lifestyle.

The challenge is to deliver change and engage public support in those disadvantaged areas where obesity poses a particular threat. The community and voluntary sectors will have networks and ideas about how to get buy-in from communities. Role models/champions are able to reach audiences that conventional means don't (look at Marcus Rashford and Captain Tom).

In the health sector much is already being done to deal with the consequences of obesity, but strengthening the prevention/early intervention focus and building multi-disciplinary teams of medical, mental health and social care specialists specifically to support the wider strategy will provide additional momentum.

In the commercial sector both voluntary partnerships with business and a regulatory framework that incentivises change will be needed. Supermarkets will be encouraged to promote fresh fruit and vegetables instead of unhealthy options and junk foods. The subsidy support structure for the agriculture sector would encourage the production of the necessary products. Taxes targeted on less healthy foods would be used to subsidise some of the additional services being recommended. Advertising guidelines would change to incorporate this new way of thinking and all junk food adverts would be banned.

In terms of delivery and oversight, a cross-cutting government group, headed by a Minister but with a high -profile advisory group to advise and support, would be established to drive through the necessary changes and report progress on a regular basis.

ID: 2032-11 - Category: Health

Saving the NHS through innovative funding and structural changes

Additional funding and structural changes to NHS service provision are required to save the NHS.

In summary:

The phased introduction of a Health Insurance Supplement, in later life, in conjunction with the implementation of simpler more cost-effective NHS care pathways would address some of the inequalities in society and help fund the shortfall in NHS provision.

What are the issues?

Older people use disproportionately more of the NHS resources than the general population, especially in their last year of life. The over 65s may represent just 20% of the population but they consume about 40% of the NHS budget. This imbalance can be rectified by my proposal.

The Covid-19 pandemic has exposed inequalities between those relying on earned and unearned income. Those living on unearned income have generally been spared financial hardship during the pandemic, with many able to make additional cash savings. Although unearned income has declined due to both the pandemic and Brexit, those affected are generally retired and without the financial burden of raising a family.

However, where the retired population is suffering is being unable to readily access medical diagnostics and treatment under the NHS and hence fulfil their lives. Although statistics are produced on patient numbers waiting for treatment and surgery, these data fail to reflect the true situation. Patients can find they are not even registered on the lists from where the statistics are drawn.

How can these issues be addressed?

An effective solution would be to introduce a Health Insurance Supplement (HIS) at 50 years of age, when one's children are reaching an age when they can earn and hence require less parental financial support.

How would this work?

It could:

- Operate like employee National Insurance (NI) contributions and be linked to income - i.e. payable above an earnings threshold and then reduced for example to 1% of income above a higher limit (i.e. akin to the upper £50,000 p.a. threshold for NI in 2020/21).

- Start at for example 1% of income at age 50, increasing to 2% from 55, 3% from 60, 3.5% from 65 rising to 4% of income from age 70.

- Unlike NI contributions that stop at retirement, HIS would continue for life and based, like NI, on the ability to pay. This would reflect the reality that older people consume more of the NHS.

To determine the optimum contribution levels, modelling is required to quantify the money generated and its impact on enabling improved NHS service provision.

It is hoped that this new Health Insurance Supplement would come from disposable income, so the impact elsewhere in the economy needs to be assessed. Likely effects include a reduction in spending by older people on travel, holidays, helping younger members of the family and on resorting to paying for private healthcare.

The income from the proposed HIS will still fall well short of the additional funding required by the NHS to deliver sufficient essential health services for the ageing population. The additional funding therefore needs to be combined with the much-needed improvements, in the efficiency and effectiveness of NHS provision, through fundamental structural changes to the NHS.

Currently, older people are faced with funding certain basic healthcare themselves. GPs are often faced with the embarrassment of telling patients that if they want to secure a positive health outcome before it is too late, the only solution is to pay privately. This is to avoid irreversible damage to their body, retain mobility and enable an active life. After lengthy waits, for example to treat troublesome hernias, arthritic joints, painful limbs, vascular problems causing excruciating ulcers and to diagnose cancers, many older people are driven to fund procedures themselves. Costs for private diagnoses in NHS facilities can be exorbitant and far in excess of the actual cost.

In tandem with the new proposed HIS contributions, essential healthcare services need to become more readily available. Care pathways in the NHS must be simplified and shortened, with many of the intermediaries (often private companies), which are hindering rapid service delivery and recycling problems, being removed. These circuitous routes to care currently add financial cost, create excessive delays in healthcare and cause unnecessary morbidity and mortality.

Clear referral criteria need to be approved such that GPs and other referrers can use their judgement and refer straight to the treatment provider. A simple audit process can be implemented to check that the agreed criteria are being met.

If older people are investing their disposable income in the HIS, then the NHS services they urgently require and expect in their later years need to be assured. It is far more cost effective to pay more into the NHS for good NHS provision. Resorting to depleting personal savings to self-fund urgent and essential elements of private health care i.e. that the NHS has been unable to provide is an inefficient use of scarce funds. However, if this money is now invested in NHS provision then there needs to be a mechanism by which standard healthcare is guaranteed.

ID: 2028-11 - Category: Health

A Green Army

Summary:

The MOD is a major source of the UK government's carbon emissions. However, it could also be a major driver of the fight against climate change, using the same principles of military innovation and procurement that led to developments in medical treatment and the creation of GPS.

Policy:

General Nugee is soon to release his report on the MOD and climate change, and he has already created the Defence Green Network to seek sustainability ideas from personnel. Several projects have been launched, such as reducing plastics and disposable coffee cups, but there is a risk that the MOD simply seeks to replicate common actions from other organisations rather than taking the lead itself.

This is the wrong way for the military to address the problem.

Instead, they should view carbon emissions as a weapon system and respond accordingly, analysing the threat, developing a strategy to combat that threat, and then implementing it with maximum energy and aggression.

Such a response should focus on developing new technologies to address the threat, much like the MOD has always done in wartime; those new technologies can then be passed over into civilian life and expanded, much like military technology has done for centuries.

While an obvious area of development is electric tanks and planes, some other ideas for what the MOD could do are below:

1) Develop small-scale nuclear power for electricity generation. Large scale nuclear power stations face massive building costs and huge challenges disposing of nuclear waste. However, smaller nuclear power plants could provide vital baseload power, alongside battery technology, to overcome the limitations of intermittent renewable energy. The MOD's decades of nuclear experience place them in a strong position to develop and pilot small scale nuclear power, while also providing the security needed through their military infrastructure.

2) Develop carbon capture and conversion technology to create zero-emission fuels. Jet aircraft are likely to run on fossil fuels for decades, so they need clean fuel. A Canadian company has already developed a machine that converts the carbon in air into aviation fuel. The MOD should invest in, and deploy, that technology, innovating to reduce costs and enabling it to be scaled up. If combined with small-scale nuclear power, such machines could provide the MOD with zero-emission fuel for its entire vehicle fleet, enabling the achievement of net zero without undermining equipment capability. In the short-term it is likely to lead to higher fuel costs, but the long-term benefit of the technology justifies such investment, possibly including from the UK's new green bank to reduce pressure on an already tight MOD budget.

3) Develop geothermal deep-drilling technology to enable the use of geothermal power almost anywhere in the world. By developing deep-drilling capabilities, the earth's internal heat could be used to provide hot-water heating to MOD bases and also to generate steam to drive electric turbine generators. Civilian research in this area is already under way, but it is another area the MOD should seek to invest into to drive the technology forward and enhance its own capability.

4) Develop deployable 'steam-solar' power. Morocco has developed a large 'steam-solar' power plant, using mirrors to concentrate the sun's rays onto water to create steam to drive turbines. The MOD should seek to develop smaller, deployable systems to be used in bases around the

world, particularly in theatres of war, to provide free power to support operations. It would reduce dependency on diesel generators and the logistical supply chain required for them, and also drive battery development to be able to store power when the sun does not shine. Furthermore, since the system is super-heating water, it should also be designed to provide potable water, to reduce dependency on bottled water. Such a system would not only help the MOD, but also has widespread application for remote grids in hot countries, and reduces the need for the rare-earth minerals used in solar panels, which is a limitation on the widespread deployment of those panels.

5) Change how MOD buildings are constructed. The MOD should adopt new building techniques and materials on all their bases, using and testing the latest innovations to drive their widespread adoption. For example, when constructing new mess accommodation, instead of the standard 'university-style' concrete accommodation buildings, they could be constructed from wood, using the techniques Norway has adopted to build wooden skyscrapers, for example. This would reduce emissions from concrete, improve energy efficiency, and contribute to net-zero by locking in emissions from the timber used. All toilets should use rainwater for flushing to reduce water usage as well. The MOD should also be testing the ballistic capabilities of such new materials; if they are effective, they could provide an alternative to concrete barriers, providing eco-friendly defence without sacrificing effectiveness.

6) Instead of selling-off MOD real estate where bases are closed, a commercial team should be created to monetise MOD land, all maximising sustainability and usability. For example, a former Army base could be converted into a hotel and spa, with the grounds rewilded to provide a tourist attraction. The hotel would generate revenue, justifying keeping the land, rewilding would help offset some of the MOD's emissions and offer opportunities for scientific study, and the land would still be owned by the MOD, so could be reconverted in future if the need arose. Similarly, a former RAF base could be converted into an office and warehouse facility, designed to be low-energy and eco-friendly, which would be rented out to businesses. It generates revenue and provides a space for innovation in design, but could also be converted back into a military installation quickly if needed.

These are just a few ideas for what the MOD could do. The key is the principle - that the MOD

should lead, not follow. The military has for centuries led innovation, including medical advances and GPS; they should do the same on climate change, helping to develop and deliver game-changing technologies to defeat the global threat of climate change.

ID: 1918-11 - Category: Health

Seas the Opportunity

Summary

Rejuvenate and reopen the UK's disused sea baths and lidos.

Prescribe sea swimming and water-based physical therapy instead of prescription drugs to combat the UK's mental health crisis in the aftermath of the coronavirus pandemic.

Target 30-50 year-olds, who are increasingly stretched - and socially isolated - due to caring commitments with dependent children and ageing parents.

The challenge

There has been an uptick in the prevalence of mental health conditions as a result of coronavirus and related pressures.

This is set to worsen as the lockdown ends, and its economic impact filters through to widespread company closures and job losses.

There will be a spike in relationship breakdowns and familial problems as society readjusts to another new normal.

Too often, patients presenting at GPs are offered antidepressants, upon which they become dependent, resulting in a sedentary lifestyle which can contribute to other health issues and pile pressure on an already stretched health service.

Social prescriptions

Medicine until now has not seen social activity as part of clinical care. Social connectedness has a bigger impact on health than giving up smoking, cutting back on excessive drinking and reducing obesity.

The Compassionate Communities project in Frome reduced emergency admissions (which account for a fifth of the healthcare budget) in the area by 15% - at a time when emergency submissions in wider Somerset rose by 30%.

It combined community development with routine medical care by tapping into patients' own networks and connecting them with the extensive community activity available – whether that's a choir or a walking group.

The project improved patient outcomes and reduced emergency admissions to hospital.

Seas the opportunity

As an island nation, proximity and access to water have long been central to our way of life. Many of the UK's largest cities – London, Cardiff, Glasgow, Manchester, Belfast, Southampton - are situated by water and urban coastal populations are growing.

There was a surge in public swimming in the late 19th and early 20th Centuries, prompting development of 150 open-air baths, lidos and sea pools. But many have been forced to shut by council cuts, dwindling numbers and fierce competition from high-spec gyms.

The health hazards and risks associated with such blue spaces – from pollution, drowning and flooding - are well known and have deterred local authorities from maximising their potential. There is significant evidence showing the benefits of green spaces such as urban parks, woodlands and street trees in health protection and disease prevention.

By contrast, the impact of blue spaces on public health has only recently been scientifically investigated. There is growing evidence that exposure to blue space has benefits for both mental and physical well-being.

Medical studies show the numerous benefits of cold water immersion, from increased vitamin D and boosted endorphins to improving fitness levels and reducing stress.

The pandemic has coincided with a resurgence of sea swimming, and many people turned to blue spaces when gyms, clubs and sports centres were forced to close. Epidemiological evidence suggests people living near the coast are generally healthier, suffer less mental distress and are more satisfied with their lives than those living inland.

The positive effects of living near the coast seem particularly pronounced for those with the highest levels of socioeconomic deprivation, suggesting less health inequalities in such locations.

Blue spaces could be exploited to help tackle key public health challenges such as reducing the incidence of non-communicable diseases associated with sedentary lifestyles and stress.

Changing working patterns mean more people are working remotely, and not tied to urban centres such as London. There is a drive to get out of cities and live in the UK's beautiful countryside, close to nature. Coastal towns which suffered the brain drain effect of young workers seeking well-paid work in major cities are now enjoying a resurgence, as families look to improve their quality of life.

We could capitalise on that by funding infrastructure improvements in these coastal areas, and give new life to the run-down sea baths around the UK coastline. Refurbish them and provide access and changing facilities so they are attractive spaces to congregate and enjoy swimming/yoga/walking/SUP/kayaking.

These baths would become a hub for activity-based companies who would sign up to the healthy living scheme with GP surgeries and health authorities.

Once vetted, these companies would become providers of physical therapy to patients diagnosed with depression, insomnia, arthritis, fibromyalgia, ME and related symptoms.

The money saved on medicine, doctors' time and future treatment would be spent on the providers, ensuring they had the best equipment, facilities and incentives to work with the scheme all year round, providing a healthy shot in the arm to the local economy.

Parkrun for the sea, concierge for the community?

As they develop, the local hubs would become community focal points, where groups can meet

and exercise together. This in itself is therapy. The explosive success of parkrun was not just getting participants to strive for a 5k PB, but people turning out each week and making new friends with like-minded runners in the queue beside them.

As the Frome project showed, compassionate communities help reduce isolation and bring a sense of belonging into a society that is increasingly plugging into virtual networks rather than physical ones. Add a coffee/cake stand and a notice board to cultivate a vibrant community space like Facebook with fewer algorithms and more face-to-face interactions.

Target the carers

Promote the scheme among 30-55 year-olds, encouraging a change in physical and mental health coping strategies. These are often parents, often caring for older relatives, disconnected from social groups and increasingly isolated by technology which has been compounded by the coronavirus pandemic.

Give these people a space to relieve stress, reboot and make a connection that is grounded in them, rather than their parents or children – and is focused on a healthy activity rather than the pub.

Dr Kirsty McArthur GP

Dr Danielle McCarthy

Dr Patrina Parker GP

Caroline Hirst

Michael Hirst

Iain McCarthy

Ross Parker

ID: 1572-11 - Category: Health

Using direct payments to transform the quality of social care

We have been discussing the social care problem for decades. Understandably, the focus has been on how to pay for it but that misses an essential point, how to make social care better, how to make it a service that people want to pay for.

The provision of social services has remained largely untouched by the modernisation which has improved other services. Technology which could transform lives is only used at the margins. The quality of care is often low and takes no account of individual needs and preferences. The very vulnerability of the people receiving the services has made providers and funders highly risk averse. As Atul Gawande, the surgeon and writer, points out in his book Being Mortal, care home residents suffer the three plagues of “boredom, loneliness and helplessness,” unable to make choices about what they eat, how they spend their days, unable to live life on their own terms.

There are no easy answers. Confronting the truth that you can no longer look after yourself is uncomfortable and unpleasant. However, there is a way to make the provision a bit better. That is by giving the recipient of the service the cash to buy their own care. There is a lot of money potentially available, with spending in England by local authorities on personal social services amounting to more than £17 billion a year.

Handing that over to individuals would empower them in a dramatic way, giving them the kind of choice and control that could make a difference to the services they receive. It would not even need major legislative change to achieve this. Direct payments for social care have been an option since 1997 and in 2007, the government introduced the broader concept of a ‘personal budget,’ followed by the 2014 Care Act which put a further emphasis on the personalisation of care.

However, direct payments are only chosen by about 130,000 of the two million people who

receive publicly funded care. As long as the cash option is only taken up by a few then a full transformation of the way social care is delivered will not be achieved. Giving everyone a direct payment could drive innovation and encourage new providers.

There are examples from other countries around the world, where more imaginative approaches are helping to improve the quality of life of the people in care homes. These include the Eden alternative in the US which provides small scale care homes for up to ten residents which offer a much wider range of activities that can be tailored to individual needs. Other examples are found in the Netherlands where the Buurtzoorg model, focuses on providing individualised care, an approach which has brought improvements in satisfaction and cost reductions.

A system which puts the spending power in the hands of individuals will make it more likely that these kinds of new approaches and new providers will emerge. There is similar scope for real improvements in service in the provision of home care. This is the support provided to people in their own home to help them with activities like washing, dressing and meals. Even if this care is of high quality, it is likely to be unsatisfactory because it will not meet the person's individual needs but those of the provider.

In the UK 873,000 people receive home care, amounting to 318 million hours, and a total market of £4.6 billion a year, of which £3.9 billion is spent by the public sector. Again this adds up to a significant amount of money potentially available to individuals to employ carers directly and so make their own choices about what hours they want them to come and what tasks they want them to carry out.

While there has been little recent research on the effect of direct payments on the quality of life of the recipients that which has been carried out shows significant benefits. Research by the charity, In Control, in 2006 found that 98% of people said they were quite or really happy with services once they had individualised budgets, compared with 48% receiving local authority provided care.

Those sceptical about direct payments tend to suggest that the reason they have not taken off is that they place unmanageable burdens on the person or their carers but systems of support could be put in place relatively easily. That could range from voluntary sector advice or comparison websites to the provision of agents or brokers. These agents could be in the private sector or voluntary organisations perhaps working on similar lines to independent financial advisers.

While more research needs to be done there is some evidence that because the individual is spending their own money they spend it more effectively and so reduce overall costs. Those using services will know the costs of what they are buying or want to buy and so are more likely to be willing to make trade-offs in a way that council employees never can. The limited analysis to date shows that average costs for local authorities are 12% lower with direct payments than traditional funding approaches.

There are also lessons from abroad. In Germany, which has a private care insurance system, social services clients are offered the choice between cash and benefits in kind, where care is provided by an agency. Only about two thirds choose to take the benefits, even though the cash option is worth only 50% of the costs of providing the benefits. To make this happen all that would be needed is a simple adjustment of regulations to require councils make a direct payment the default option offered to those entitled to social care.

By giving people real choice and control over the kind of service they receive they will get better care and it will become easier to persuade them to make provision for that care and open up a way through the problem of social care funding.

ID: 997-11 - Category: Health

Requirement for a Reserve of former officials to support the Civil Service in a crisis.

Summary

Requirement for a Civil Service Reserve.

Although the Covid 19 pandemic put immense pressure on the NHS, it has also put great strain on the wider Civil Service which has had to react to new challenges, spilling over from Covid, while keeping the country running with all its normal needs. The Civil service needs to establish and formalise a Civil Service Reserve of former officials, which it can call on to support, supplement and reinforce existing officials when a similar crisis strikes. These are an increasing likely to occur given environmental and global challenges. Cost for the Exchequer should be low or negligible. Such a system would also mitigate the costs of calling-in civilian consultants, or volunteers, which may nevertheless be needed at some stage.

Proposal

The UK Civil Service should institute a programme among its staff, similiar to that adopted by UK armed forces, so that the Civil Service can in the future call back to its ranks those essential and experienced staff which could be deployed in a crisis to support the existing, full-time staff over an extended period.

Ministers, with advice from senior officials, would decide when the threshold to call on the reserve had been reached.

This would have to be run on a voluntary basis for staff presently coming up to retirement or leaving the Civil Service for other occupations. But in time, the requirement to be deployed in a crisis after leaving the Civil Service could be a condition of service.

Departments would be in a position, by accessing records of service, to identify just which former officials were well-placed to fill gaps that surfaced during the crisis, best to fit requirements.

To ensure former officials were as up-to-speed as practical with new developments, policy and procedures in the department, as well as maintaining necessary clearances to a standard necessary for supporting day to day work, they would attend the department for, for example, five working days a year. During this time they would support the department’s daily operation,

but also aim to refresh a working knowledge and familiarity of the Department sufficient to fulfil as best as possible a supporting role in a crisis.

Like the UK's military reservist programme, the employers of former civil servants would be asked to maintain the salary of those attending their former Department for the annual refresher update of five days, or longer as needed during the crisis up to an agreed time limit, perhaps two months. Former civil servants drawing a pension who had retired could be entitled to travel expenses.

To mitigate travel cost to the exchequer for the annual refresher period, former Civil Servants in the Reserve who lived a distance further than 50 miles from the place of work could be asked either to work from home, or to attend a nearby Civil Service department office from where they could operate. In a major crisis, the Civil Service would retain the right to deploy former staff where necessary, but every effort would be made to minimise disruption and distance from home. If required for longer than the two month period suggested, then HMG would need to consider covering the salary of the Reservists. Not to do so could disincentivise employer firms from agreeing to support the programme and freeing up their staff.

ID: 2284-11 - Category: Health

Universal Basic Income

The precarity associated with this unprecedented global health crisis, Covid-19, has irrevocably damaged lives and livelihoods. Our economy is suffering, as is our mental health. People have been allowed to fall through the cracks in Covid-19 support. Even those who have been supported are confronted with an uncertain future. The pandemic has shed new light on the need to better fulfil Article 25 of the UN Declaration of Human Rights that states:

"Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."

In the UK we are lucky enough to have the incredible National Health Service (NHS) ensuring everyone has access to good and free universal health care. The amazing staff have bravely

carried us through this crisis and deserve all the applause awarded to them on the doorstep in lockdown.

Other aspects of our welfare state, however, are could be improved. As with furlough and associated Covid-19 support schemes, many of those in need are missed completely. The selective, means-tested measures are exclusionary and overly-bureaucratic; costing the tax payers extra money for an inefficient and ineffective system. Those who do receive benefits are often stigmatised or face mental health difficulties associated with low self-worth or feelings of hopelessness. Others are ensnared in 'unemployment traps' where the risks associated with taking up an insecure job and losing access to the benefits they rely on for survival are too high.

Even now, as we seek to return to normality following a third lockdown, unemployment is uncharacteristically high. Jobs have been lost and businesses have failed. Isolation has been hard and mental health has floundered. We have endured a year of uncertainty and fear and it is a testament to British fortitude that we have soldiered on. However, the end isn't necessarily in sight with a third wave in Europe threatening to wash up on our shores and an increasing number of people, through no fault of their own, are reliant on support from the Government. We need a reliable and universal way to ensure that everyone has the means to an adequate standard of living in accordance with Article 25 of the UNDHR.

Following the first lockdown many people called for a temporary 'Unconditional Basic Income' (UBI) to plug the gaps left by furlough and other Covid-19 support schemes. A UBI is commonly understood as a guaranteed, periodic cash payments made to everyone without means-test or requirement. This policy idea, previously perhaps confined to fringe academic circles, is now a common conversation topic in households across Britain. Its universal nature would mean that everyone would have been supported through this crisis and it would have gone a long way to alleviating the stress and strain of uncertainty in these precarious times. It would have significantly reduced the number of people who slipped through the gaps and would undoubtedly have saved lives.

There are also lessons for our welfare state in general, however. Many now label UBI as “our generation’s NHS” and it has the potential, if implemented effectively, to solve many issues associated with our current benefits system. As mentioned before, its universal nature stops people falling through the gaps whilst it also reduces the bureaucracy arising from means-testing and removes the stigma associated with selective schemes. It has the potential to improve both mental and physical well-being, as evidenced by trials in Europe and North America. It is also affordable and attainable and will help protect against future pandemics or crises of a different nature. There is a lot of uncertainty going forward, with the climate crisis and the alarming increase in automated jobs. A UBI would go a long way to reducing this uncertainty and ensuring everyone has the means to maintain a minimum standard of living for themselves and their families.

ID: 2177-11 - Category: Health

Online Safe Spaces: an expert online domestic abuse assistance portal (available for free).

1. Domestic abuse, including domestic violence, has risen dramatically as a direct result of Covid lockdown restrictions. The UN has described this phenomenon as a “shadow pandemic”. Multiple data points unequivocally confirm this: the BBC estimates that globally domestic abuse has increased by 20% during Covid lockdown; according to the ONS, the police recorded 206,492 violence against the person offences flagged as domestic abuse-related between March and June 2020, a 9% increase compared with the same period in 2019; and according to the Guardian calls to the National Domestic Abuse Helpline rose by 80% in June of 2020.

2. It is difficult to imagine a more horrendous scenario than being in effect imprisoned in one’s own home with a perpetrator who inflicts domestic abuse (very likely including domestic violence) on you, and possibly your children. There have been 3 lockdowns all of which lasted over a month (at least), and we are in the midst of the 3rd lockdown.

3. Compounding the severity of the situation, due to lockdown restrictions, the usual pathways to domestic abuse assistance have become unavailable e.g. schools; interaction with friends, colleagues and relatives; interaction with social services; space away from the perpetrator whilst at work and online – all of which ordinarily offer an opportunity to contact specialist services without being monitored.

4. Therefore, we are witnessing the simultaneous trends of a dramatic rise in domestic abuse alongside a dramatic recession of the pathways to access support for domestic abuse.

5. As well as being an odious crime which inflicts terrible damage on individual victims at the time of abuse, domestic abuse is well understood to be the origin of many subsequent societal problems such as: immediate and lasting psychological trauma, loss of homes for those who flee, children of victims performing poorly at school, the risk that victims of domestic abuse may repeat the cycle on their own family, and so on. Therefore, it is certain that this dramatic rise in domestic abuse will generate a proportionately dramatic rise in such societal problems for many years into the future

6. In direct response to this situation, in May 2020, Royal Mail and Hawkrose, created Online Safe Spaces (OSS) together with leading UK domestic abuse experts from: the University of Bristol, Hestia charity and Sussex Police.

7. OSS is a discreet, safe, no-internet history portal that sits at the bottom of a webpage and opens up a window on any website. The service provides support, advice and helpful contact numbers for those who are experiencing, or are at risk of, domestic abuse.

8. OSS was launched on Royal Mail's and Parcelforce Worldwide's websites 4 months later in September 2020. Please see paragraph 9iii below for details of other organisations who have also installed OSS on to their websites.

9. OSS has 4 objectives:

i. To offer expert support to persons suffering or at risk of domestic abuse. We believe we accomplished this thanks to the leading domestic abuse experts who supported us.

ii. To be 100% safe for users. This has been achieved thanks to Royal Mail IT experts: the software leaves no internet history and cannot be used to trace users. Furthermore, a key premise of OSS was for the software to be installed on websites which are not associated with domestic abuse. As such, should a user interact with OSS on e.g. www.royalmail.com, and then subsequently that user's perpetrator examines the internet history, only the Royal Mail website would be listed – and this should not raise any suspicions on the part of the perpetrator.

iii. To be ubiquitous. Royal Mail offers OSS for free to any organisation who wants to install on to their websites; the onboard process is very simple. At the time of submission (March 2021), OSS is installed on 23 websites, for example: Royal Mail, Parcelforce, Ministry of Defence (intranet), 4 global law firms, Thames Water, Anglia Water, Southeastern Railways, Post Office. Over 18 additional organisations have confirmed they will install OSS on to their website, for example: eBay, a high street bank and a major UK telecoms company. Since launch, Royal Mail has continually strongly promoted OSS both with its customers and more generally through its social media. We expect many more participants.

iv. To raise the public profile of the issue of domestic abuse by virtue of OSS being on as many websites as possible. It is unquestionable that stigma and taboo surround domestic abuse and that this acts as a material hinderance to persons asking for help. It is only by raising this issue in the public conscience that we will rid the stigma and taboo and so begin to start to tackle this issue on a fundamental basis.

10. At the time of submission and 7 months after launch, we have recorded just under one million clicks across the OSS portals which are available online. We estimate that each user clicks 4 times, on that assumption, we estimate that just under 250,000 persons have used OSS. For the last 3 months, we have recorded an estimated 1,330 users per day. In order to maintain the 100% anonymity of the service, OSS does not record IP addresses – this would have

provided much more accurate usage data.

11. OSS has received multiple endorsements at launch including: UN Women UK, 2 UK Government Ministers, the Domestic Abuse Commissioner and Sussex Police.

12. The initiative was called “Online Safe Spaces” so as to align with the Home Office and Hestia’s “Safe Spaces” campaign under which certain pharmacies offer shelter within their premises to those suffering from domestic abuse. Both initiatives benefit from and are mutually strengthened by this alignment.

13. We look forward to expanding the number of organisations who install OSS and so provide direct expert help to even more domestic abuse victims as well raising the profile of this issue in the UK.

ID: 1215-11 - Category: Health

To learn how to cook , healthy affordable food, help unemployed hospitality cooks and chefs

What has come to light in different ways is that people do not know about food and how to cook it . We now have several generations that have no idea, so they rely on takeaways and junk food. My suggestion is that the effect that the pandemic has had on hospitality, that we use the unemployed cooks/chefs to teach people how to cook basic healthy food .This would have a knock on effect that people would eat better and not rely on takeaways and junk food, so also addressing the problem of obesity

So my idea is to set up places where people can go to learn to cook. Have a course for either one full week or one day a week for 6-8 weeks so people can be taught the basics. The staff from hospitality could be paid extra on top of unemployment benefit to use their skills and knowledge to teach cookery. The extra money would make up a little for what they lost in the last year, plus something to add to their CV,s. The people attending would be given time off work with pay so they can attend. Low income people cannot afford to do something if the lose out financially, and any extra payments would be on the understanding that the course in

completed and verified.

The course would be were they would learn how how to prepare and cook so able to feed themselves (and family) for a week. The class should include how to shop for healthy and and budget friendly ingredients. The class must be simple and not lecturing, maybe show how similar ingredients could be used e.g. Cottage pie one day, spaghetti bolognaise another. Vegetarian options possible, not vegan, some people cannot afford or have knowledge to be vegan, if all they know is takeaways and junk food. Classes would also need to cater for different ethnicities, e.g. Indian /Caribbean. Portion control would also need to be addressed as a lot of people as well as supermarkets have lost the idea of what is normal/sufficient portion. A small addition to this would be a piece from a nutritionist to get away from silly ideas on diets and how to eat sensibly (proteins carbohydrates fats vitamins etc) but well.

As regards the food, here is where the supermarkets come in, as they seem to have done ok out of the pandemic. If they could put a package together of ingredients that could be supplied for the classes. I think at the moment on of the major ones is putting one together for people to buy food for a week, but again this is a big supermarket that not everyone has access to one. The need for better health and to help out out fishing industry, part of the cooking could be for fish , not the old fish and chips, but some people have never tried fish unlike people on the continent.

The class would need to supply a simple recipe book and if needed an online link so a person can watch again how something is prepared. Although online classes are available, nothing beats hands on teaching and extra little tips for instance, how to hold a preparation knife and the right way to stir something. In addition there would need to be as part of the classes on how to do an easy packed lunch for school children and how to cover school holidays(Get Marcus Rashford on this).

So where could these classes be? They need to be in the community, not at some far away destination, as people do not have money for extra travel costs, so why not use some of the empty small shops near where people live to set up the classes. Some places have just betting shops and a whole load of takeaways covering a street .Give preference in these areas to small food shops (lower or free council tax/business rates) as some places do not have any food shops .Adjust planning laws accordingly. Make kitchen equipment available, again supermarkets for chopping boards, saucepans etc, they will love the publicity, some homes do not have even basic equipment to prepare food.

In addition schools need to be teaching cookery again, not the silly stuff my daughters were taught , luckily I taught them properly. I have always thought schooling misses out on life skills. Every child should be able to read, write, work a bank account and feed themselves.These are skills that everyone should have whether a graduate, plumber or gardener.

So what is not needed, no great expensive advertising on television. No costly government cartoon adverts or anything endorsed by celebrities, chefs etc. No online bloggers who know nothing about cooking, just interested in getting their faces online. Facebook and Twitter? I am not sure, always seems to me people arguing or any having a fixed opinion, but then I could be biased.

Talk to local area councils as they are more in the know of which of their residents /areas would benefit. Social services are on the front line where they can see that proper diet would be a great help. In addition schools who also on the front line of seeing what children are in need and put information out via them to the parents. Although this seems aimed at people with families this should not exclude older people 20,30 and above. At the other end are the fit elderly who have now found themselves without their life partner who always did the shopping /cooking.

Finally check local job centres for unemployed cooks/chefs from hospitality in desperate need of work.

This pandemic has shown the wide gap between the haves (financially stable) and the have nots just clinging on and the state of our health.

ID: 40-11 - Category: Health

Pat A Pet

Pets provide an important benefit by offering companionship, reducing stress, boredom and depression. They can also be a worry in terms of peoples concerns about being able to look after one on a long-term basis in terms of the ability to provide veterinary care and exercise, and what would happen to a pet if they became ill. Previous pet owners are also reluctant to enter into a permanent bond with a pet as the grief of losing a pet is painful.

I feel there is an opportunity to marry pet owners, and their pets, with the elderly on a short-term basis each week. This is distinct from longer term commercial arrangements. It is about a pet, mostly a dog but potentially other pets as well, being borrowed by another individual for a couple of hours each week to provide contact and companionship, free of charge. There would be no expectation other than the pet providing comfort and companionship to the person concerned by sitting with them. I have two dogs who are both extremely loving. My small dachshund would happily sit with another person for a couple of hours on their knee.

There is also the potential for solo visits to take place during times like the pandemic, and in other times, for the pet to be accompanied with its owner. This could bring about a sense of community caring which has become lacking in recent times.

There could be a certification arrangements through veterinary practices to green light a pet as one which would be suitable for pet sharing and a correlating registration service for people to request the service. The service would be open to elderly people living on their own. The pet owners would sign up as volunteers through a recognised service such as Age UK where there would be a correlating vetting process for the individuals involved to ensure that the vulnerable were protected from potentially unscrupulous individuals. GP practices could also use this service for social prescribing. The cost of the pet and individuals certification would be met by the government, and passported through to the Voluntary, Community and Faith sectors working in partnership with local government. This project would accord with many of the aims of the VCF sector and funding of the project would provide support for this unsung sector within our communities. The idea could be piloted in a Beacon Authority arrangement initially.

Whilst at times like this we cannot reach out and touch other people, we can find comfort in pets. Pets can alleviate the stress caused by social distancing, and 'shielding', and offer many benefits which can help longer term mental health issues encountered through prolonged isolation. This programme would offer the ability to provide some of this comfort, and establish a routine for lonely people, without the worry that more longer-term pet ownership can create.

ID: 2275-11 - Category: Health

How to improve UK financial literacy levels

(In reference to 'A lack of financial literacy skills exacerbates the economic impact of COVID-19')

Summary:

Thanks to a general lack of financial education, much of the UK population was ill-prepared to withstand the economic shock of COVID-19. One in three of us had savings of less than £600; one in ten hadn't any savings at all (creditfix.co.uk). Poverty and unemployment are among the most intractable issues for a government to tackle, but a relatively straightforward and impactful resolution would be to make financial literacy a standalone subject on the national curriculum. This would ensure students have a dedicated opportunity to learn, and by including it within Ofsted's education inspection framework, teachers would have access to necessary resources, training, and advice. That way, the next generation will be better prepared for the next economic downturn.

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This initiative would be a tangible way of delivering against the government's Levelling Up agenda, as a knowledge of compound interest benefits a young person's wealth whether they are from Redcar or Basingstoke. Moreover, there is no shortage of informed and well-placed partners to assist with implementing a dedicated curriculum, from Martin Lewis, the Money Saving Expert, personally funded the roll-out of 340,000 financial textbooks to state schools; to the Financial Times, who have just launched their own financial literacy foundation, aimed at tackling this very issue in adults.

Any proposed curriculum could address three key areas: first, the key concepts of personal finance. Savings and interest, debt, inflation, and a discussion about what constitutes value for money and how that might differ from person to person. It should also approach security and fraud, as there is no shortage of scams and get-rich-quick schemes that young people are exposed to online.

Second, an explanation of the most common financial products: debit and credit cards,

mortgages, pensions, and safe investing vehicles such as an ISA. Discussions might focus on how a young person can get on the housing ladder, or how student loans work. After all, it has been shown that a lack of understanding in this area makes it less likely for a pupil to apply for university at all (Callender, C. and Mason, G., Does Student Loan Debt Deter Higher Education Participation? UCL, 2017).

Finally, there is a fantastic opportunity to tie personal finance to the big picture topics. We know young people are more engaged than ever with the world they'll inherit. Alongside the traditional understanding of how they might be affected by the Chancellor's budget, students could learn how money and investment can meaningfully impact the ESG (environmental, social, governance) agenda: affecting corporate change through shareholder activism rather than obstructive street protests.

COVID-19 has underlined the need for financial skills: many of us will be unable to budget for the lean times or risk falling into unsustainable debt. Beyond that direct need, this is a straightforward opportunity to build back better after the pandemic. By providing a basic financial education, we are not only giving young people the tools to improve their own fortunes during the good times, but giving them a shield to prepare for the next inevitable downturn.

ID: 2229-11 - Category: Health

A re-usable COVID-19 testing system, which is sustainable and accessible.

Re-usable COVID-19 tests need to be reliable, sterile and easily accessible to everyone. Due to the re-usable nature, they can be supplied more widely and have less of a carbon footprint. Many single-use plastic products which until recently have been used on mass, e.g. women's sanitary products have now had new, more sustainable alternatives put to market e.g. the menstrual cup. This same principal can be applied to COVID-19 testing, as similarly to the menstrual cup, the testing equipment would need to be easily sanitised at home after each use and like the menstrual cup, this could be done either in boiling water or in the microwave.

The swab used in the test could be made from a material such as silicone (due to its heat resistance characteristics), similarly to menstrual cups, and sanitised directly after use. Instructions for this home sanitation process would need to be included in the testing pack, but

it could entail either submerging in boiling water or being placed in the microwave.

Similarly to the swab, the extraction tube could easily be sanitised and re-used after testing.

The buffer solution used in the testing process is divided into small plastic capsules which are then double packaged. Could this not be produced in small bottles with an airtight pipette top, and directions included for how many drops should be used per test? This alternative would substantially lower plastic usage, as the bottle wouldn't need to be plastic-wrapped.

The plastic waste bags are not necessary to use at all, unless the test comes back as positive in which case, the safe disposal of the test would be important. However these would not be needed at all, if most parts of the test were re-used.

The test strip would be the hardest part of the testing kit to make sustainable and re-usable. The most similar product available on the market would be the digital pregnancy test, however producing these for nationwide distribution would be a long, and expensive process which is unlikely to be government funded. Due to this, there would need to be a charge for this part of the testing kit. However the market for this could be bigger than we realise, as many people who strive to live as sustainably as possible are likely not content with the current weekly disposal of COVID-19 testing equipment, so would happily make a one-off payment for a test strip which could be used unlimited times.

This may not a realistic fix to the sustainability issue of disposable COVID-19 testing, however I do think this issue is something that needs to be further considered and even making one product within the testing kit re-usable could make a significant difference.

ID: 1990-11 - Category: Health

Creating a patient audit trail

Health care systems are highly heterogeneous and numerous. My fix is how to store in one place, the health care data held in disparate systems, without an impossible integration task (cost, time, security, data cleansing etc).

Existing healthcare systems are central server based systems focussed on a health care professional as the user. A users data will be stored in a varying number of systems depending upon where they have had interaction with NHS services. Ultimately, the data is owned by a

member of the public (MOP) who as no direct access.

If we look at the high level NHS business process. A MOP will interact with the NHS via their GP and will receive written notification of appointments and outcomes. Such paperwork is generated by a myriad of sources and each document tends to contain a mixture of static patient data and data about the transaction or event. The documents vary from the mundane (e.g. prescriptions) to summary of a treatment (e.g. a cancer patient no longer needs treatment). Apart from a MOP keeping a file of all of this paperwork, it is not normally available for a subsequent diagnosis. The various codes and formats used simply make it impossible to collate into a single form. Fundamentally, NHS systems are designed to manage a single medical case, not to keep a life time summary of everyone in the country.

A very common solution used in business is to employ a document management system to store customer correspondence so a call centre would have a view of a company's interactions with a customer. E.g. rather than interrogate a billing system it is easier to have a copy of the last bill to hand. If we apply this logic to the NHS, we would intercept correspondence from the NHS to a MOP and load it into a document management system which would then forward it to the MOP along their preferred channel. The document management system would then have an audit trail available for subsequent diagnosis during the next medical case.

Creating a single document management system for the NHS may be impossible so we should focus on the ownership of the data to help a MOP store and retrieve their transactional data history. Such data could be stored in the NHS App and managed via the App. To avoid a never ending data modelling exercise, we would store the data in human readable form e.g. each letter is a locked pdf. The MOP could then choose to share his history when being consulted by an NHS professional who would be able to read and understand the documents audit trail.

To make a successful business case the App could allow its owner to select a preferred correspondence channel thus saving postal costs when the App is the selected channel. It is suggested that local document management instances are used in NHS premises. They could be

either integrated with existing local systems or used stand alone to manually scan documents.

It is possible to extend the concept to include other events than correspondence. The user of an NHS app could be given the ability to record events using the technology available on a modern mobile device.

• QR codes which could be provided by the NHS at every point of service delivery for the MOP to scan as a record.

• Bar codes of medicine could recorded

• Blue tooth could record interactions with NHS personnel

• Blood pressure and temperature readings could be photographed

In summary, the suggestion has two components

1. Manage an audit trail of NHS interactions in the NHS app

2. Use document management systems to replace existing printed paper correspondence to input to the audit trail. It is a largely a process solution rather than system design. It would require the reader of the audit trail be able to understand what they are reading.

ID: 1925-11 - Category: Health

Covid-19 and Social Mobility

1. Introduction.

Social mobility strives to ensure everyone, regardless of socio-economic privilege, receives equal opportunities throughout their education and careers. In short, where we start in life shouldn't dictate where we finish. The benefits of having improved social mobility are clear. For example, if British businesses attained average levels of social mobility, the economy could be

boosted by £170 billion (Oxera and The Sutton Trust, 2017).

Tragically, Covid-19 has disproportionately affected those from lower socio-economic backgrounds (LSEBs), specifically in terms of education and employment. The Social Mobility Commission reports that 600,000 more children now live in relative poverty, compared to 2012. The commission warns this figure could increase significantly as a result of the pandemic.

Additionally, The Centre of Economic Performance (CEP) has cautioned that Covid-19 will drive young people into a "dark age of declining social mobility". Prior to the pandemic, those aged 25 and under had already been subjected to wage reductions, poorer living standards and fewer employment opportunities (Blanden et al 2020; Major and Machin, 2018). It's very likely these issues will worsen during the coronavirus fallout.

2. Education, Education, Education.

Coronavirus has had a profound impact on education and the consequences of the disruption will have a serious, long-lasting effect on students from LSEBs.

Research has shown that children from wealthier backgrounds have spent 30% more time on home learning than children from LSEBs (The Institute of Fiscal Studies [IFS], 2020). Additionally, poorer students are less likely to have had access to study space, online resources and are more at risk to stresses that negatively impact on their learning (The Sutton Trust, 2020). Let's remind ourselves that at the age of 16, only 24.7% of disadvantaged students achieve a good pass in their English and Maths GCSEs compared with 49.9% of other pupils. This demonstrates the inhibitive effect of an LSEB on someone's education. It's frightening to consider how the pandemic will exacerbate these figures.

Furthermore, it's argued that school and college closures will have a 'scarring' effect on poorer students (CEP, 2020). The long term consequences of this scarring make for grim reading: disrupted learning will cost £350 billion in reduced lifetime earnings for current pupils, those from the most disadvantaged backgrounds being hit the hardest (IFS, 2020). Clearly, the impact of school closures on disadvantaged students is a national crisis.

3. Employment and Welfare Inequality Exposed.

Major and Manchin (2021) argue that those who are experiencing the greatest difficulties during the pandemic are more likely to live in cramped conditions and suffer from underlying health issues, increasing their vulnerability to the virus. Additionally, workers from LSEBs are likelier to have key roles, putting them at greater exposure to Covid-19. This has been corroborated by data from the Office of National Statistics that shows coronavirus mortality rates have been twice as high in deprived areas than in wealthier regions.

Moreover, the pandemic has shut down entire sectors of the economy and, undoubtedly, the sectors affected the most include the hospitality and services industries. It's widely documented that these areas of the economy disproportionately employ younger, lower-paid workers, meaning the high numbers of people from LSEBs in these sectors have been at far greater risk of losing income throughout lockdowns.

To surmise, many people from LSEBs have had their incomes reduced, face job uncertainty and are statistically at greater risk of dying from coronavirus. These tragic summations are an embarrassing reflection of the UK's levels of socio-economic inequality.

4. Moving Forwards.

Immediate action is required to reverse the inequality caused by the pandemic. Below are a number of potential resolutions aimed to help alleviate the educational and employment crises faced by some of the poorest in our society.

- National mentoring programme: The UK has an enormous pool of diverse, world-leading, expertly-trained academics and professionals who could support students from LSEBs make up for lost lesson time. A national mentoring programme may also encourage public and private sector organisations to develop their own social mobility outreach and recruitment practices.

- Summer schools, extending the school day and student welfare: Boosting the amount of time students spend in the classroom will go some way in supporting those whose education has been derailed. However, increasing the time students spend at school must be handled sensitively to ensure the stresses of missing education are not worsened by being overwhelmed with mountains of catch-up work. Therefore, student welfare and mental health funding will be critical when schools reopen.

- Adult education, job guarantees and protected characteristics: Greater emphasis on adult training is crucial in creating a mobile society and more efficient economy. Extending the current apprenticeship levy would continue to provide an effective platform for training, learning and development. Furthermore, we should ‘re-brand’ what it means to be an apprentice and encourage people of all ages, and at any stage of their careers, to be open to the idea of training for a different career path. This could help those who have lost jobs from the pandemic find work again. Businesses should also be asked to introduce job guarantees for workers who are facing unemployment during the aftermath of the pandemic. Additionally, protected characteristics need to be updated to include LSEBs, thus creating a level-playing field during recruitment.

- Social mobility in central government: The absence of a dedicated minister and effective

governing body for social mobility downplays the seriousness of the issues referenced during this discussion. This must be addressed to demonstrate that social mobility is at the heart of the government's agenda.

These proposals will require significant financial backing and it's imperative the Chancellor specifically targets social mobility in the next budget.

Social mobility is a problem that's growing exponentially. This pandemic presents us with a unique opportunity to implement radical, long-term policy changes to combat the socio-economic inequality in our country and thus, make our society fairer, healthier and more prosperous. The best time to make these changes was decades ago: the next best time is now.

ID: 1891-11 - Category: Health

Summary of a paper outlining a scheme to prevent catastrophic climate change.

Introduction And Aim

There is impending ecological disaster from climate change due to carbon emissions; humanity is not taking the sufficient and effective policies and actions needed to reverse carbon emissions. Countries will not achieve their internationally agreed emissions targets and the absence of such policies will also result in economically damaging and politically divisive emergency action as environmental damage leads to demands for emergency precipitate responses.

This paper outlines a scheme for nations significantly to reduce carbon emissions. The scheme is practical and consists of a single set of tools that will cause rapid and substantial shifts in consumer behaviour through creating a market that seriously incentivises "green" behaviour throughout every part of the economy. The advantages of this scheme over any others are:-

• Politically popular • Minimal state regulation required • Government funding needed is

essentially nil • Economically stimulating • Wealth redistribution

The Problem And The Need – Sustainable Global Consumption

Rapid and substantial reductions in carbon emissions require global industry to adopt complex, interrelated, vast, wholesale changes in sourcing, supplier management, raw material usage, fuel usage, transportation and production/manufacturing. Such changes will only happen when global consumers demand them through their buying behaviour. Buying behaviour is not changing because of a number of seemingly intractable barriers:-

• Lack of alternatives (or they are perceived as inadequate or too expensive) • Lack of incentive • Lack of precise knowledge • Perceived unfairness (to individual sacrifice when others do not do the same)

Only overcoming these barriers will lead to the required massive change in attitudes of consumers so they consciously make pro-environmental decisions every time they purchase any good or service. This needs a paradigm shift for billions of people.

Elements Of Shifting Consumer Behaviour – Changing Attitudes

Any mechanism to overcome the barriers must recognise all the following:-

• Self-interest guides behaviour; relying on altruism is insufficient • The self-interest basis is determined by each individual, not the state. • Sacrifice is insufficient as an incentive to change behaviour • People want a real choice if they are to be able to choose greener options • Information is needed so people can make considered decisions in their own interest • People may make different choices – and not be vilified or penalised for doing so

Any mechanism that acknowledges these realities will have the following 4 features:-

• “Environmental Price Tag” (EP) for every product/good/service – providing succinct yet precise knowledge about their environmental impact

• Incentives to not make the purchase OR to buy a greener alternative (ie lower EP).

• An Effective Choice of alternative(s) for every purchase.

• No Perceived Unfairness if someone else makes a different choice.

A Unified Market Mechanism To Reward Consumers For Making The Green Choice And Lowering Carbon Emissions

Concept:- Based on national CO2 emissions targets, every citizen has the right to cause a certain amount (and no more) of CO2 emissions (their “allowance”). If they wish, they could cause fewer emissions and trade/sell part of their allowance to someone who wanted to emit more. Every year, an individual’s allowance decreases in line with the national target; even allowing for trading, overall emissions must decrease. If markets responded to this concept, then businesses would strive to produce low emissions goods and services in order to gain/retain market share and consumers would find ways to reduce emissions in order to trade their allowance for something they find more valuable.

The Market Mechanism is based on making entire economies totally responsive to this concept of allowing individuals to only buy that which their emissions allowance permits unless they buy more emissions allowance from those who choose to pollute significantly less.

• Governments create a unique “crypto-currency” denominated in grams CO2 (“CCreds”). Use current blockchain and payments technology to establish “banking”, accounts and related transactions.

• Governments calculate a “Personal Environmental Allowance” (PEA) for every eligible citizen based on the total annual target for national carbon emissions divided by the number of eligible citizens.

o PEA denominated in CCreds or g CO2

o Government will credit individual CCred accounts with their PEA once per year

o Every individual’s PEA will reduce year on year.

• Governments collect CCreds from all primary producers and importers of fossil fuels; the value collected to equal the carbon emissions (in g CO2) of the fuel/oils.

o In order for them to collect the CCreds they must surrender to the state, the businesses will be forced to dual price all their sales with both Environmental Price (CCreds) and cash price.

• All subsequent sales by all businesses in the onward supply chain will be dual priced as each business in the chain collects the CCreds it needs to pay its own suppliers. This “pull” effect will drag the new currency through the economy

o Government feeds the crypto-currency into the economy at one end (consumers) and requires primary producers to surrender them back at the other end.

• Consumers may trade unused CCreds for cash money in an open market place, increasing the incentive to “go green” whilst allowing those, who need/wish to emit more, to do so

• The Mechanism will bear down on carbon emissions by:-

o enabling consumers to make informed choices (the dual price – the Environmental Price Tag)
o providing more low carbon choice as business seek to minimise the EP of their products in order to remain attractive

o reducing the available PEA every year

o incentives – making it very attractive to forgo some carbon intensive activities and selling the saved PEA; thus reducing perceived unfairness

• Requires minimal state expenditure or regulation and control because the EP behaves like "real-world currency", making it almost impossible for business to evade the system. Allows natural human/consumer behaviour to flourish whilst pervading every economic interaction between organisations and individuals.

o If implemented in full and without caveat will possibly incentivise consumer behavioural change, with minimal resistance, quickly enough to prevent catastrophic climate change.

ID: 1854-11 - Category: Health

Changing the Face of Suicide Support

The alarming increase in suicide and suicidal feelings is an opportunity to look at the issue differently. Rather than, what will get people through the system the quickest? Or what will result in the lowest cost? How about our starting point is what will best meet the needs of someone who is feeling suicidal?

1) It would be sustained and long-term. The approach of most mental health services by necessity is to offer a limited number of sessions. This immediately sets the intervention up to fail. Why? Because it indicates to the suicidal person, that they will be cut off from support. It effectively sets a timer on recovery. Healthcare doesn't do this with broken legs or heart disease. Yet, in mental health, despite its seriousness, we say you get six sessions and by that time you need to be better. It is one-size fits all approach that dehumanises people when they are most in need of being treated as an individual with specific needs.

2) It would be confidential. Suicidal people often have major concerns about the implications of speaking about their distress. They often worry about its impact upon their career, family and even their freedom. In spite of this, NHS mental health services are not confidential. If you cannot guarantee the confidentiality of people's stories, they will not be able to speak openly about what's causing their distress. If we accept that talking about mental health is important and effective, then we should guarantee 100% confidentiality otherwise we cannot reasonably expect them to recover.

3) It would be face-to-face. Medication and digital services are both excellent at treating a wide number of people quickly at a low cost – however they are not human-centred. Medication only works for some people and you cannot treat someone who is suicidal without giving them the opportunity to talk. Research has repeatedly shown that medication on its own, will not resolve people's suicidal feelings. Equally, there is no evidence as of yet to suggest that increasingly popular text and web services are effective in supporting the suicidal and there is even evidence to suggest that the use of technology can increase isolation. Maybe it's time to accept that the best approach is the one that most resembles treating someone as a human, speaking with them face-to-face. Not only is face-to-face interaction the best way to facilitate trust, it immediately signals to the individual that you care much more than a text or an email.

4) Volunteer input It is widely accepted that there is a declining mental health workforce with 1/11 Psychiatrist posts unoccupied and 1/7 Mental health Nurse posts. It is also widely accepted that there is a huge amount of pressure on the NHS. The best possible service would harness the power of volunteers to deliver longer-term suicide support. As we saw during the Coronavirus, there are plenty of people willing to help and contribute to our healthcare system – if we can harness that goodwill into a programme of support that does not necessitate professional qualifications, then we might be able massively increase the workforce available to support suicidal individuals while keeping the cost low. Furthermore there is academic evidence that volunteer -led support can be effective in supporting those with mental health issues (Turkington, Spencer, Lebert, & Dudley, 2018).

5) It would be compassionate and would not use CBT Due to pressure on services, many NHS mental health interventions now operate in ways which maximise efficiency (in terms of getting people through the system) and reduce the compassionate element which would actually make it an effective service. For example, most services operate a three strikes and you're out rule. If you do not attend a session, there will be a warning letter or email. They offer the appointments available regardless of the needs of the visitor. They use long waiting lists to manage demand which communicates both that the individual is further stretching the service and that they are not important enough to be seen urgently.

A more compassionate service would respect the severity of the situation and see people

quickly – there would be no waiting list. The best possible service would be more compassionate – it would check in with visitors when they didn't attend appointments to try and understand why – no angry emails. Lastly from the moment they stepped on site, they would be made to feel valued as a human being. They would be greeted in a comfortable and welcoming space. Instead of CBT, it would allow the person to tell their own story rather than using blanket strategies to 'fix' them. It would focus on listening over advising.

6) It would be with the same person The ideal service would be with the same person. Many charities use digital services which mean that suicidal individuals are supported by a different person each time they call/text. This forces them to retell the same painful story each time they engage with the service. This retelling is for the benefit of the service rather than the benefit of the individual. It should be the opposite, the service should know their story. By seeing the same person who knows their story, you can begin to build up trust which will enable the visitor to open up and share their pain.

This might sound ambitious and starting from an idealist viewpoint but if we accept that suicide is a matter of life and death, then surely it makes sense to create the best possible service rather than just muddle one together? This is an uncomfortable issue but it is not a niche concern. Suicide remains the biggest killer of all adults under the age of 35 and the biggest killer of men under the age of 50. If healthcare is about saving lives, then this is a good a place as any to start. It's time to actively invest in alternative approaches to suicide support that make use of the human skills of ordinary people.

ID: 1823-11 - Category: Health

Loneliness

During the pandemic the issue of loneliness has become more prevalent. Loneliness does not discriminate against age, race or gender, it does not care where you are and what you have done. Loneliness impacts people's mental health and the only cure are people.

How do we fix it? For me there are five ways that we can look to address the problem.

1. Community Contacts

Community contacts work with individuals to match their interests with groups and organisations in the area. At the first meeting, interests, challenges and opportunities are discussed. The community contact takes this away to then research and identify opportunities for the individual to present. At the follow up meeting ideas are presented and can cover many topics from gardening to cinema, music to exercise, book clubs and walking clubs. The idea would be to present five different options so that the individual can then try tasters and decide what they want to do. For each of the options where they are group activities a buddy will be assigned to the individual so they do not feel alone when going for the visit time to an event.

2. Technology Champions

One of the greatest ways to reduce loneliness is to bring the world to the individual and this is especially important when the individual is not mobile. Technology champions would visit and work with the individual to initially identify their technology needs. Once this is done they then devise a programme to demonstrate and assist the individual with their technology needs this can be from zoom meetings, to face time as well as how to text/ WhatsApp.

3. Buddy Groups

For some people, they simply want to meet and talk and the set up of buddy groups that change on a six monthly basis will assist with this. These can meet in local coffee shops, libraries or in a park and the idea is that it is a chance for people to meet in the area. Topics are texted to get the conversation started and time limit set so that people do not feel that they have to stay, although they can if they wish to! The six monthly time frame means that the groups are kept fresh although people will obviously be able to keep in touch. There will be an element of commitment to ensure that people come and try to meet.

4. Mentoring

Mentoring is a great way for 1-2-1 support and growth. This can be done older to younger or reverse mentoring where a younger person mentors an older person with an opportunity for ideas and experiences to be exchanged. There would be two ways for mentors and mentees to meet. Firstly, the mentors and mentees complete forms setting out interests and what they are looking for. They then can meet with the understanding that both must be comfortable with the set up. The second way would be through a speed meeting set up, where people meet, ask questions and choose mentors.

5. Community Programmes

These would support all of the above ways and could also be opportunities for people to reskill as well. Using local facilities, the programmes could be focused on interests as well as providing educational opportunities as well. There could be sponsored training programmes allowing individuals to learn about different opportunities so that they can be employed as necessary.

There would also be virtual events, such as film nights, concerts as well as online discussion groups for this who are less mobile.

Financing

This would be raised through local community sponsorship and business support with opportunities to sponsor specific programmes. Grants from the lottery as well as charities would assist with the provision.

This programme would be community led to give people then sense of belonging, so they know they are not alone.

ID: 1630-11 - Category: Health

Long-term pandemic prevention and preparedness measures

There are two opportunities for the UK to use the COVID-19 crisis to be more resilient to future

disasters. Firstly to improve domestic emergency preparedness by incentivising emergency-relevant industries to operate in the UK and by sustaining COVID-19 response capacity developed during this crisis; and secondly to invest in pandemic disease prevention abroad, capitalising on our world-leading international development and tertiary education sectors.

Britain was largely unprepared for the COVID-19 pandemic. The government was not able to source adequate supplies early on in the pandemic including ventilators and personal protective equipment (PPE). The public health system was unable to keep track of the disease as it spread through communities, and as a result the UK has some of the worst COVID-19 mortality figures in the world. However, we did do some things well. The national capacity for genome sequencing allowed rapid identification of mutant strains, whilst the pharmaceutical industry and academic centres of excellence were able to develop vaccines, and bring them to market, in record time.

This teaches us that where there is existing technical or industrial capacity, it can be leveraged for disaster response. Furthermore this ability to leverage existing capacity is incredibly valuable, saving thousands of lives and millions of pounds of economic damage. With this in mind I think this is an ideal time for the government to incentivise building national capacity in emergency-relevant industries. For example, factories for manufacturing medical equipment or PPE might usually be located in Asia because of the lower cost of business, but it is in the nation's interests to move these industries back to the UK, with financial incentives, because of the value of these industries in a time of crisis. This is preferable to simply stockpiling emergency supplies because the industries are more likely to remain for the long-term, and provide economic benefits in their own right such as employment for British people, whereas stockpiles can easily be left to rot without continued investment (which does not provide any ancillary benefits). It is less likely that continued investment in emergency stockpiles will persist across multiple government regimes, as the threat of pandemics fade in the public memory, but the economic incentives granted to emergency-relevant manufacturing industries are more likely to be maintained, so we can respond to the next emergency.

During the course of the pandemic more capacity has been generated in valuable areas such as

rapid testing for disease, and information sharing between government bodies and local councils. This capacity should be maintained and could also be used in other productive ways. For example the networks that have been set up between councils, the NHS and the emergency services could be used to respond to other public health problems, but also environmental disasters or terrorist attacks. It would be a shame for the experience gained and money invested during this crisis to go to waste once the pandemic is over.

Preparedness is only one half of pandemic defence – the other half is prevention. There is an inevitability to pandemics. Wild animals host a great variety of viruses, most of which are harmless, but these viruses are constantly mutating and mixing. The boundless diversity and mutating nature of viruses in the wild make the emergence of pandemics inevitable. The trick is to be ready when they first transfer to humans so that they can be contained, and to monitor them in animals so that we can see them coming.

Livestock are often the intermediate hosts of pandemic diseases, for example domestic poultry for bird 'flu and domestic pigs for swine 'flu. Sanitary livestock agriculture practices can reduce the risk of pandemic diseases spreading through livestock to humans, and animal disease testing allows for the early detection of pandemic threats. In the UK we have a well-managed livestock sector and top-notch veterinary practice and testing facilities, which makes it very unlikely that the next pandemic virus will emerge here. But as we have seen, pandemic diseases are not constrained by national borders. It is in the UK's interest to help improve the quality of livestock agriculture, the animal-source foods supply chain, and veterinary services in other countries for our own national security.

The UK has one of the world's preeminent international development organisations. We should use this expertise to effectively, and sustainably, invest money to improve developing countries in ways that will prevent pandemic disease emergence. Many of these investments will have multiple benefits. For example, not only will animal disease testing centres alert us to potential pandemic threats, they will also help prevent outbreaks of animal diseases that can have severe impacts on agricultural productivity. Primary health facilities will detect and prevent the spread of pandemic disease, but will also reduce maternal mortality and preventable diseases, and improve productivity.

The UK is also a world leader in education. Laboratories are useless without adequately trained staff, and veterinary services can only improve if there are well-trained veterinarians to do the work. We should embrace this opportunity to train up a new generation of virologists, veterinary epidemiologists, nurses, doctors, human epidemiologists, health administrators and veterinarians from particularly at-risk nations. Investment in this human capital, as well as the physical facilities mentioned above, will help keep the world safe from the next pandemic threat.

In conclusion, we are presented with an opportunity to improve the UK's preparedness for pandemic threats by ensuring that the investments we have made in the COVID-19 response can transition to sustainable and long term states that will leave us better prepared for the next crisis, while also providing benefits in other spheres. COVID-19 has also identified weaknesses in the UK's ability to deal with certain threats. These weaknesses should be addressed by increasing the national capacity, through incentives that bring emergency-relevant industries back to the UK. Alongside preparedness we should help prevent the emergence of the next global pandemic by investing in human capital and physical facilities in healthcare, agriculture and veterinary services in at-risk countries, using our world-leading education and international development capabilities.

ID: 1526-11 - Category: Health

AI Vision powered Drones

OBJECTIVE:

This project aims to eliminate the spread of SARS-CoV-2 virus completely. It also aims to eliminate any Coronavirus particles present in the environment.

PRINCIPLE:

Understanding the nature of Covid-19 is the key to understand the importance of this project. Covid-19 is a very dynamic problem. That means, people are getting infected at an exponential

rate. If we compare the speed of virus spread with the speed at which tests are being performed, we can conclude that no matter how fast we go with the testing process, even 1 infected person can still infect hundreds or thousands in a single day. This brings us to the ultimate conclusion, that is, to stop the spread of Covid-19, we must stop it at the same time and for all.

DETAILS OF IMPLEMENTATION:

Here's the plan to implement the above mentioned conclusion. We need a vision that can detect the presence of Coronavirus particles in a living being (Humans, Animals, Pets) and in its surroundings. This vision should be attached in the interior of a drone that has the functionality to fly. This drone should also have a high intensity Red light source attached to it. We need a large number of drones with this vision attached. We will also need sufficient number of police officers for ensuring the effectiveness and hassle-free implementation of this project. We will also need multiple IT teams which will manage the locomotion of drones from one place to the other. We will need tanks containing sanitizers in them. Further, a sufficient number of hospitals need to be established to deal with the growing number of detected positive cases.

The police officers of each city/village will be divided into sufficient number of groups. These groups will travel to each and every locality of their respective city/village and stand ready. They will be signaled by the government at a specific pre-decided time to move further with the plan. Before this specific time, these groups must be ready. On signal, these groups will go in their respective localities, and people should come out of their homes and stand at their home entrances, meanwhile maintaining social distancing. IT team will control the drones as the drones fly in to each locality at around the same time in every city and use their vision to scan the population present in that locality as well as its surrounding air for the presence of Coronavirus.

If a person is infected, the drone will throw red light on that person. If a certain region of air is infected, the drone will torch the infected air region using red light and it will be torched/thrown light at until that region is completely free of Coronavirus particles. This region will then be sanitized using hose pipe connected to sanitizer tank. This process will be carried for each person as well as each locality in every city and hence the entire country at the same time. All people who will be detected with Covid-19 will be sent immediately to ambulance where they will wait for the process to get finished in their locality. Then they will be moved to hospitals where they will be given proper treatment.

ID: 1318-11 - Category: Health

Fixing the NHS

The underfunding of the NHS is a very clear problem, which has been highlighted during the COVID-19 pandemic. The lack of resources, equipment and staff has surprised many people who assume the NHS will always be there for us when we need it.

The love and support for this national institution could not be higher at the moment. British people are proud of the NHS and all it stands for and want it to continue and thrive as it should.

I suggest we harness the good will and concern the nation has for the NHS and introduce an annual £10 payment that every tax paying adult makes in the knowledge that the money will be used only for the NHS, transparency is key. £10 a year isn't that much individually but it would create a fund of millions each year that can be used to much improve the NHS and make us all really proud, I'm sure most people would gladly give £10 out of their annual salary to ensure the success of the NHS.

ID: 1222-11 - Category: Health

Re-thinking housing for the elderly as an alternative to care homes and to reduce loneliness

The Covid-19 epidemic has highlighted the social isolation of the elderly in particular and while the epidemic has certainly exacerbated the issue, it was an issue long before Covid-19 challenges emerged. During the pandemic, however, the elderly have lost confidence in the care home sector and whilst care homes will always needed for those with nursing needs, now is perhaps an opportunity to take stock and re-think how older people live and interact in the community. There may be alternatives to care home places and warden assisted flats which would encourage the older generation to ‘downsize’ leaving larger properties available for families, whilst improving their social interaction resulting in well-known health benefits Most elderly people live in households of just one or two. They frequently live in larger properties as there is little incentive to downsize at present and this presents issues of underutilised housing and also loneliness. A single elderly person in a large home with families all around may well be lonely, without peers or those with similar interests to interact with them. In addition, the burden of maintaining large homes is challenging, but the alternatives of warden assisted flats or care homes are not always attractive, and there are few alternatives. I would like to see government taking a new look at housing and how it can better serve our elderly population. I have often seen large plots of land and new build developments in our area that take little or no

account of potential single occupancy needs or the elderly population. Many are flats or large houses, not suitable for the elderly, and bungalows are rarely built. I have often remarked on seeing a smallish plot of land that then has one large house placed on it, that it could have been better developed in an alternative way to support the elderly in the community. I would like to see more development of groups of ground level small 1-bedroom properties around a central quad. The idea is that you could accommodate 5-6 single (or couple) accommodations with a central garden square; each having an open plan kitchen, diner, lounge and one bedroom, with an upstairs bedroom suite for use by visiting friends/relatives. The older person would have the independent living often wanted, together with the social interaction of others in similar circumstances, and being in the local community allows interaction with other age groups. Thus, the small plot that would have accommodated one 5-bedroom house, now accommodates 5-6 couples, or 5-6 singles. It could even be expanded to include a multi-occupancy house in the small group, in the same way as those in their 20s often share houses with others. It is curious as to why older people do not tend to live in multi-occupancy houses. For the older person without significant care needs, this seems like a good solution to housing challenges and would also provide company. Perhaps we need to encourage people to think more about this sort of option and to include houses designed with this in mind in developments. Each room would need an en-suite bathroom and the kitchen would need sufficient space to allow everyone to cook. In parallel, I would like to see the government re-consider the development of dementia villages. Working successfully in other countries, there have been rumours of such villages in the UK, but I have not heard of any in practice. The communities are closed, so cause little concern to neighbouring villages but can provide such huge benefits. We should be pushing ahead with alternatives to care homes which have lost a lot of trust during the pandemic, but also should be looked at with new eyes for alternative ways to live which maximises housing availability but also enhances the lives of the elderly.

ID: 1212-11 - Category: Health

Creation of a volunteer National Health Reserve (2nd submission attempt)

SUMMARY

Hundreds of thousands of citizens have volunteered to help the NHS during the pandemic, but it has been difficult to mobilise them effectively. To be ready next time, we need a National Health Reserve of volunteers; trained, vetted and ready at short notice to take on roles which would free up NHS staff for “frontline” duties.

PROTECT THE NHS More than any other single factor, the UK government's response to the pandemic has been driven by the need to stop the NHS being overwhelmed. Out of a total of about 125,000 NHS acute and general overnight beds, first wave Covid occupancy peaked at over 21,000 and second wave at nearly 40,000. Even the creation of 10,000 Nightingale beds did not fulfil its promise because of the lack of health professionals to staff them. So, where does this leave us if or when there is a next time?

CAPACITY

NHS bed and staff numbers are below average in international comparisons and there may be good arguments for spending more to increase capacity, but this would mainly address the NHS's regular day-to-day needs, not an exceptional event like Covid-19. Mothballing Nightingale-style beds might be possible and relatively affordable, but keeping medical professionals on standby to staff them would be another matter. For example, an additional 10% of hospital staff (around an extra 90,000 support staff, nurses and doctors) would cost at least £2bn a year. In a few years' time, wouldn't it simply be too tempting for a government to trim this? Instead we need something which could rapidly increase emergency NHS capacity but cheap enough to survive austerity cuts: I've called it the National Health Reserve (NHR).

VOLUNTEERING

Volunteering is popular. Before the pandemic there were already some 100,000 regular volunteers in NHS hospitals. When Covid hit, in just three days, 750,000 people expressed interest in becoming NHS Volunteer Responders. The British Red Cross has 80,000 Community Service Volunteers. The goodwill is there, but mobilisation of such large numbers from scratch has been challenging and in many cases inconsistent, haphazardly coordinated and often weighed down by red tape. We now need to draw on this experience and create a permanent, fully-vetted volunteer force trained in a wide range of ancillary medical skills, who could be quickly mobilised in an NHS emergency. This would be modelled on other volunteer networks such as Army Reserve, St John Ambulance, British Red Cross, Community First Responders, special constables and Royal Voluntary Service.

ROLE OF THE NHR

The NHR's role when mobilised would be to enable NHS professionals to concentrate on the most demanding jobs, while the NHR takes on the less skilled tasks. These could cover many of the sorts of services provided by healthcare assistants in the NHS, test and trace, and administering a vaccine, etc.

WHO WOULD JOIN?

Some NHR volunteers might be former health professionals, but the majority would be people without previous formal medical experience who would need to be trained in a range of medical skills. Volunteers could include 16-18 year olds (NHR cadets) and there could be other specific schemes for students and apprentices.

TRAINING

This would take place at local centres based in hospitals. Volunteers would need to be offered a flexible training menu, including hands-on skills, classroom teaching and online modules, which would need to reflect how much time the volunteer could commit and any prior relevant training they had completed. Formal accreditation would be given as different skills are acquired.

TIME COMMITMENT

This would also have to be flexible, but a minimum might be six hours a month during non-deployment/training periods, though much higher during actual emergencies. Employers would be required to allow NHR volunteers time off work for emergency duties – on the lines of jury service – but during other times volunteering would usually take place in the volunteer's own time, although employers would be encouraged to facilitate days or weeks away from work for specific training.

PAYMENT

Apart from reimbursement of reasonable expenses, volunteers would not normally be paid for providing their services, but where volunteers had specific and valuable skills, retainer fees may need to be considered, as would compensation for the self-employed for time away from work.

COST AND SIZE

St John's Ambulance has over 15,000 volunteers and an operating cost in a normal year of about £100m. Their pilot project (jointly with the NHS) aimed at creating 10,000 NHS Cadets has a budget of £6m. This gives a range of average costs per volunteer from £600 to over £6,500. I do not have the information or specialist knowledge to provide more accurate costings, but would suggest that an annual average cost of £2,500 to train and support each NHR volunteer would be a reasonable starting point. I suggest an initial target size of 100,000, at an annual cost of £250m.

NOT REINVENTING THE WHEEL

It is essential that existing health sector volunteer organisations are partners in the establishment, training and deployment of the NHR. As well as British Red Cross, St John Ambulance and RVS, there are many other national and local health volunteering organisations, including Helpforce, which "partners with health and care organisations to increase volunteering opportunities and accelerate their impact" and the Voluntary and Community Sector Emergencies Partnership – "Bringing together local and national organisations, to deliver a more coordinated response to emergencies". They have all made a vital contribution during Covid, but their work tends to be either supporting the NHS on a continuing day-to-day basis, or is more broadly focused than supporting the NHS alone. In contrast, the NHR's aim would be specifically to support the NHS during a "disaster". Other than as part of their training, volunteers would not be expected to support NHS staff except during emergencies, nor would they be expected to play a role in non-NHS activities.

ID: 1044-11 - Category: Health

Improving access to treatment for children and young people with critical mental health problems

The mental health of our nation's children was highlighted as a priority in the NHS ten year plan. Before the pandemic, the availability of children and young people's mental health services were sadly inadequate. Many areas have tried and failed to increase provision of mental health services for children and young people. Devastatingly, the pandemic has dramatically exacerbated this issue and we are now at a crisis point where many children and young people with serious mental health issues do not have access to the treatment they so desperately need.

When a child or young person is critically unwell and becomes a significant risk to themselves, they may require admission to an inpatient unit that specialises in treatment of mental health issues. The number of children and young people currently requiring these inpatient beds vastly exceeds the number of beds available. So what happens to these children? They get admitted to the local acute paediatric hospital which does their best but is far from ideal. Imagine you are a suicidal 15 year old who has lost all hope. You've been admitted to a ward where there are crying babies most nights, you are told not to leave the tiny dingy room due to covid-19 ward restrictions and none of your friends are allowed to visit you. There's nobody with specialist training in mental health issues to treat you and it's four weeks until they think there might be a bed for you in a unit that can treat you. How will you get through the next four weeks? Sadly, this is the stark reality for many many children across the country.

This crisis has been accelerated by the pandemic and that in turn has forced many of us who work in acute paediatrics to accept that we must be part of the solution. Given these children are now stuck on acute paediatric wards for weeks on end, acute hospital wards must stop being a holding place and start being treatment facilities. The government need to financially incentivise acute hospital Trusts to build purpose designed wards for children and young people with mental health problems. They need to provide funds to staff these wards. There is an insufficient number of child and adolescent psychiatrists nationally so the government must provide incentives and train acute paediatric doctors to treat and care for children and young people with mental health problems. Whilst this solution requires an initial outlay of financial support, it would not take long before this intervention started saving the NHS and country money. We cannot stand by any longer, for the sake of the generations to come, we must take these steps now.

ID: 757-11 - Category: Health

A solution to 'bed blocking' in our geriatric wards

Build an NHS nursing home which is run by the hospital, on the site of every hospital with a geriatric ward. Enabling elderly people who are ready to leave hospital but have no one to care for them and cannot go to their own home without care, can be moved to release beds for new patients.

The homes would be a halfway house for these people. There would be Coordinators whose job is to find permanent homes for them, who liaise with GPs, families, care givers, councils and private care homes to carry out financial, ability and needs assessments to ensure that the elderly people are rehomed in the correct type of home to suit their needs or have the correct care package in place.

The places in the NHS nursing homes can be paid for in the same way as other nursing homes are paid for now. So if a person has enough capital they'd pay for their care and accommodation, etc and if they do not have capital then it would come out of the social care budget in the same way that it would for any home having the person.

The length of stay would be a maximum of 4 weeks during which time it is the job of the Coordinator to carry out the assessments and find alternative care and/or homing for the person.

ID: 653-11 - Category: Health

A National Employment Service - available to all at the point of need

Great things can grow out of traumatic events. In 1948, following the Second World War, our National Health Service was established (thanks to the vision and courage of its pioneers) I believe the Covid-19 pandemic has demonstrated the need, and provided the stimulus, for establishing now a ‘National Employment Service’ (NES).

As with our brilliant NHS, the NES would be available to all at the point of need. It would exist alongside the public and private employment sectors, but it would provide a 'safety net' to ensure that the means exist for all to participate in the creation of our national wealth and to share in the benefits of our mutual efforts.

At present, unemployed people receive 'benefits', funds given to them, so that they can live. During the pandemic, with millions more becoming unemployed, more demands have been placed on the benefit system. These funds, with those aimed at facilitating job retention (the furlough system), are irrecoverable.

In re-thinking this, we now have the opportunity to design a better system of employment and, more importantly, one that recognises that human nature and dignity require people to be able to earn their income, feel valued, respected by all, and become contributors to the 'Common Good'.

The NES would provide the means of ensuring full employment and a dynamic system that can respond to changing needs or emergencies. It would provide the means whereby all those who wish to be employed have that opportunity. They would earn a living wage (at least), discover and develop their talents, and as a consequence of secure, stable and continuous employment, be confident about forward planning and commitments, living a life without the anxiety resulting from the fear of unemployment and loss of livelihood.

Membership of the NES

Those unemployed for twelve months or more would automatically be invited to join the NES and informed that instead of receiving benefits, they would henceforth be employed by the NES.

Others could choose to join the NES, e.g. on leaving full time education, when seeking a change in direction, or when making a geographical change in the location of their employment, at any stage of their working life. This should ensure a good skill and experience mix within the NES and potentially enhance the scope and quality of the services it could provide.

With the NES as their employer, members would earn an index-linked living wage (at least), plus N.I. contribution and access to a pension scheme, in return for continued participation as employees. Level of remuneration would take account of qualifications, experience, and level of job responsibility.

Entry into Employment

Those newly registering with the NES would have an in-depth interview at their local Job-Centre Plus. Following a welcome, it would be explained to them that the NES aims to achieve high standards of knowledge, skill, and behaviour, and a work force the Nation can be proud of.

Interviews carried out by JCP staff would discover the areas of knowledge, skill, and vocational preferences, of each individual and then allocate them to the appropriate category (or categories) of work under which they would be listed. Induction programmes (including in-service training) and supportive specialist help would be arranged where needed. JCP staff would also be responsible for checking qualifications, DBS checks, etc. which would be archived for any future reference.

At last, JCP staff would revert to their original role of helping people to be employed – a welcome end to their current task of checking on each individual's job-seeking activities, and issuing of punitive sanctions (withholding of benefits), a source of much distress to many vulnerable people.

Funding the NES and its Launch

The NES would recoup much of the cost of the wages/salaries it pays to its registered members (plus administrative and other expenses), by hiring their services to the wider world of work. The existence of the newly established 'National Employment Service' and its workforce would be made known by a widely based National programme of advertising and information provision. An invitation to hire members of the NES, would be sent to all potential employers and firms, in the public and private sectors, strongly promoting recognition of the benefits of engaging them:

• ready availability of appropriately trained & qualified, reliable, vetted, and insured workers;

• attractive and competitive rates of hire they will be contracted to pay to the NES;

• rates/conditions of service set by the NES in agreement with professional bodies & Unions;

• freedom from documentation/administering of wages, NI, pensions, sick-leave payments, redundancy & tenure issues, maternity/paternity leave, etc., as the NES is the employer ;

• a free specialist advice and support service, offered by the NES for hiring its workers;

To be known as the ‘Hirers’, these firms would cover the whole range of industry and commerce, without exception, including health, education, caring services, financial services, manufacturing, construction and demolition, waste disposal, recycling, transport (passenger and commercial), warehousing, distribution (wholesale & retail), agriculture, tourism, and the leisure industry.

Benefits to our Economy, Recovery from the Pandemic and our International role.

A National Employment Service would benefit the UK Economy whilst yielding vitally important human and social benefits, boosting national confidence, enabling us to ‘pull together’ after the pandemic and Brexit, cementing the bonds that hold Society together.

Initial costings show the NES to be viable. Instead of being a cost, previously unemployed people would now become a benefit, contributing to their cost of living, making fewer calls on medical/social services.

As with our NHS, a successful NES would be a World first! Whilst demonstrating our respect for human rights, it could be promoted as a system the World could emulate.

The right to work, Article 23(1) of the ‘Universal Declaration of Human Rights’ proclaimed by the United Nations in 1948, which we in the UK signed, states:

“Everyone has the right to work, to free choice of employment, to just

and favourable conditions of work and to protection against unemployment”

Establishing our National Employment Service would demonstrate compliance

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ID: 633-11 - Category: Health

My National Health Service - Rethinking the funding of 'My NHS'

No system or structure is fool-proof but some are better than others. The point is that for too long the NHS has been used as a political football and there has been a lack of transparency, or honesty about the real cost of providing such a comprehensive and universal public service. There is an urgent need for a rethink about how the NHS is funded. The British people have a shared interest for a health and social care service that is well funded and properly managed. I

believe the Covid-19 pandemic has provided us with the opportunity to revisit the funding of the NHS and also, to some extent, social care. There is a need to consider a new funding structure that takes account of the growing population and anticipates dynamic trends. My premise is not to ignore the vision of an NHS that is funded by general taxation, as set out in the 1944 White Paper, however a rereading of the National Insurance Act 1911 would show that a dedicated taxation structure was envisaged and indeed it already exist in the form of the National Insurance Contribution, NI. The premise of NI was to provide social security, child benefit and health care support. My suggestion is that the National Insurance contribution should now revert to its original purpose. As is the case now, the idea is that everyone of working age, (including those who are retired and on benefits), would continue to make contributions towards the health and social care pot. This New NHS NI contribution funding structure would be ring fenced and all underspend or profit generated would be ploughed back into front-line services. To ensure that the money raised is administered in a transparent and apolitical way and with a view to long term planning a new body called NHS Governing Board, should be set up to manage, administer and distribute the funds. The NHS Governing Board would consist of Medical and Nursing professionals, Social Care professionals, health and social care researchers and Lay members. The structure and organisation of the NHS Governing Board would be similar to the BBC board of Governors, The Bank of England Monitory Committee and the Welcome Trust Board of Governors. While there would still be Ministerial oversight the role of the Health Secretary would be more nuanced. Primarily it would be more administrative and longer term strategic consideration rather than the micro-management of the service. The role of the NHS Governing Board Specifically; a) the NHS NI contribution would go to a New NHS Governing Board be would be completely ring fenced from other central government taxes and spending b) funding allocations, decisions about priorities, planning and future developments would be under the stewardship of the NHS Governing Board c) there would be subsidiarity with devolved powers to local hospitals/trusts d) the whole structure would still be under the Health Secretary control (but quality would be overseen by a Ministerial appointed QCQ department) but e) no Health Secretary can change or interfere with the structure, operation or workings of the Board without public endorsement Long-term planning f) one of the key remit of the NHS Governing Board would be to plan and budget for TEN year cycles, with light touch review very 3years g) financial plans must be in place to provide funding support in case of emergencies and other unforeseen possibilities h) an NHS sovereign wealth sub-committee (chaired by a respected international industrialist) would be set up to manage an investment portfolio (10% of the yearly budget is top sliced to create an investment fund similar to the Welcome Trust). A percentage of the profit from investments would be distributed, yearly, to hospital as unconditional additional funding i) no hospital would be penalised for underspending, saving money or creating a substantial contingency funds for itself. It may be that policy wonks have already consider such an idea and perhaps rejected it for whatever

reason. However, I still think it is worth reconsidering in its totality. As you know the love and affection that the British people have for the NHS is unparalleled. There is a heartfelt warmth and a kind of mystical, doe-eyed quality in the way people think about the NHS and as a result there is an unrealistic expectation in the range and type of services they expect from it. People want a universal service that is free at the point of delivery and accessible to all, irrespective of their geographic location. However, in my view and as proven by the state of the NHS at present, the difficulty is that the current NHS funding and administration model is unsuitable in the long-term. There is interference, problem of overcapacity (increased population); chronic health and social care needs (ageing population) and an increasing range of new health and social care concerns. In otherwords the NHS is expected to maintain existing services as well as anticipate and respond to new health related trends. If we continue with the current funding structure then I believe that at some point there will be a devastating collapse of the whole system at worst or a ramshackle health service that would no longer be supported by the British people. I would encourage you to test out the idea presented to see whether people are willing to support such a comprehensive proposition.

ID: 276-11 - Category: Health

Housing First as the answer to roughsleeping

Rough sleepers usually have a myriad of problems. Sleeping outdoors is the result of other problems, not the problem itself. The real problems stem from child abuse, poor mental health, addiction, and so on. And many who are not addicted to drink or drugs become so having been on the streets.

It is hard to conquer an addiction to drink or drugs. Harder still if you are on the streets, or have no stable home, or relationships. Yet despite that, we persist in believing that rough sleepers should solve their problems before they get a permanent home. They should staircase through hostels etc.

All the evidence is that this does not work very often. And it is very expensive. A Westminster rough sleeper casework manager told me once that he had more staff than there were rough sleepers, but that they could not offer the rough sleepers what they wanted or needed – a stable place of their own, from which to rebuild their lives.

They do it differently in Finland, where they follow the “Housing First” principles. They give people a (tiny) place of their own, conditional only on them treating it with basic respect. That gives them space to tackle the demons in their lives, be that mental illness or addiction. With help, of course. It doesn’t work for all, but it does work for some. The evidence base is well-known, and can be found here: https://hfe.homeless.org.uk/principles-housing-first (I have no connection to this organisation).

We tried that, inadvertently, this spring. Anecdotally it worked, as this Times Article by Christina Lamb shows.
https://www.thetimes.co.uk/article/at-the-prince-rupert-they-treat-the-homeless-as-guests-except-they-give-them-a-hug-0z26c9z0v

I hope that HCLG are doing long term follow up work, but I think we know enough to at least launch a full-stale randomised control trial of housing first in the UK. We could improve lives and save money. Not often you can do both.

ID: 260-11 - Category: Health

Whilst the NHS has been applauded for its response to the Covid-19 crisis, it highlights the fragility of the system given the need to reduce support for other medical issues e.g. cancer detection and treatment. This brings into question the organisation and management of the NHS. It can be said that the NHS would have a superb organisation were it not for its patients.

The first significant attempt to re-organize the NHS was the Griffiths Report in 1983. Sir Roy Griffiths was the Director of Personnel for Sainsbury when seconded to conduct his review. The application of management techniques to process thousands of common items (tins of baked beans et.al) do not necessarily apply when having to process thousands of individual items (patients with unique characteristics). However, the current system seems to ignore this essential difference.

I have benefited from the services of both private medical support and the NHS (Two triple bypass operations, colon cancer and current kidney cancer) and, prior to retirement, been a Governor for Papworth Hospital. Throughout this period I have been able to observe the differences that apply between the private and public sectors.

The main difference I have noted in the public sector is the considerable number of staff with labels that indicate they are administrative rather than medical. I also find it difficult to justify the fact that many of the Senior Management in NHS Trusts are not medically qualified but influence medical outcomes and are paid salaries far in excess of what would apply to comparative posts in the private sector. Quis Custodiet Ipsos Custodes?

One other obvious difference relates to funding. In the private sector the money comes before the required action.

Another area of significant change has been the role of the General Practitioner. I used to have a 'Family Doctor' who brought me into the world, removed my tonsils and later my appendix, all done at the local 'Cottage Hospital'. He knew me and my medical history. At my current Surgery I have no idea what Doctor I will see due to the high turnover of medical staff, partly as a result of the generous retirement packages made available. This ensures that there is no continuity and at each visit to a new Doctor time is taken up reviewing my medical history. It is also noticeable that there is a prevalence to refer patients to a higher authority with consequential longer waiting times for attention.

The many significant advances resulting from medical research and consequential applications to patients' treatment has generated ever increasing demands for medical attention requiring more specialisation within the system with more expensive and complicated equipment. It would be morally indefensible and political suicide for any government to reverse this situation..

Given the foregoing, what are the challenges and opportunities facing the NHS.

First, Staffing. There needs to be a thorough job evaluation conducted throughout the NHS against a background which recognises the primacy of those medically qualified with front line operational responsibilities. Having been involved in such an exercise in industry, I have no doubt that the roles and responsibilities of nursing staff would place them at a much higher salary level than is currently recognised.

Second, There needs to be a strategic review of the processes for delivering medical services. The current set-up where hospitals are expected to cover the full range of medical procedures, from the simplest to the most complex, is not sustainable. The establishment of the Cambridge Medical Campus combining formerly separate institutions is the way ahead, but requires the provision of a second tier of facilities to deal with more basic procedures. This second tier could be achieved through the amalgamation of separate surgeries within defined areas., in effect the re-creation of 'Cottage Hospitals'. These would provide for continuity and a recruitment resource.

Third, Funding.,the most difficult problem that has to be faced. The present system bears no relation to the required outcomes, and will not be able to provide the funding that future pressures will demand. Whilst the provision of medical services free to all is commendable it removes any sense of responsibility from the recipients of those services. The only was to resolve this is to require those seeking attention to pay a proportion of the cost for access. There are a number of alternative systems to achieve this, what is now required is a commitment to move in this direction.

Fourth, Preventive Action. There needs to be as much attention paid to tackling issues which guarantee subsequent medical problems as has been paid, successfully, to reducing smoking.

Such campaigns need to be national, properly resourced and sustained.

As Dickens said...."It was the best of times, it was the worst of times"

There has never been. nor will there ever be again, a better opportunity to make the basic changes that we need to cope with an ever more complex and potentially dangerous future. Tinkering will not serve, we require significant actions. As Lloyd George once said...." Your cannot cross a chasm in two bounds".

ID: 245-11 - Category: Health

A renewal of social meeting: tangible places from intangible times

In seeking to re-establish trans-societal connections as a response to divisions in society, exacerbated by Covid-19 social distancing, one remedy, a potentially fast remedy, is to create and vastly improve places of social interaction and meeting. The places were human experience is publicly shared and from where good deeds, sharing, learning and social wellbeing mechanisms spring forth. Social cohesion is needed now more than at any time in our lifetimes. Tangible places where this can happen are one very good answer to this challenge. It is here where great community benefit, freely and organically created, can result. Whether this be friendship and general support, medical or psychological advice, personal fitness, learning, public meetings, exhibitions, workshops and community sales, events of all manner come forth. Where such places already exist, these are often a humble (all too humble) community hall or building of some age, poor condition and resources. Often uninsulated and expensive to heat (or more usually are just underheated and uninviting). But for many this is something that simply does not exist at all. A radical rethink is required. A renewal of what these places might be – amongst the best buildings in our community. Town centres or more likely the local places that make up towns and cities often have no gathering place, no hall or community centre. This is exactly the case at Westcliff-on-Sea, a persistently socially deprived place in the 2nd lowest decile of the ONS Indices of Deprivation. This means that the only places for local people to meet are the streets or private buildings such as shops or restaurants. Such meetings tend to be incidental, short lived and unlikely to lead to comprehensive or diverse outcomes. As valuable as incidental meetings are, locals are not connecting in extended, meaningful ways likely to help improve society. These places need to be amongst the best resourced buildings in our cities, towns and villages, not the worst. The attitude towards these buildings needs to be completely

turned on its head. No longer should they exist as poor excuses for community buildings, they should be amongst our best buildings, well resourced, warm, bright, clean and sustainable. Buildings of the best modern architectural intervention. Buildings that people eagerly wish to use and enjoy, supporting growing social interaction. Where these buildings do not exist they are desperately needed, in priority order. The suggestion is that local authorities acquire existing underused buildings or sites, if necessary on a compulsory purchase basis, and place ownership of these assets wholly in the hands of 'not for profit' community trusts for re-purposing or new build as places and spaces for local people to meet. The buildings must be community owned so that the sense of ownership, responsibility and delivery all sit together – whilst some might be very well run too often these are Council owned and run with the bureaucratic encumbrance and lack of imagination of the polity. Nor can they be privately owned or support private rents, acting in the specific interest of an individual or company. The cost basis for this is likely to be low given the present state of the market and the fit-out and set-up costs need to be covered. Yet the potential outcomes are rich in what they can deliver. Net sum gain should easily be demonstrable with well used resources. Where these buildings do exist and are anything other than already well resourced buildings of good condition, these buildings need help along similar lines, through re-building as necessary. There also needs to be permanent financial support from the local authority (i.e. from community finance), underpinning basic costs as a permanent social contract responsibility. So too there needs to be a responsibility on any trust for good management and fund raising, to help maintain and improve resources. In creating these places (with a suitable new, locally named identity) a new, tangible vision of community unity and support is created, a new view of what these community places can be. Available and accessible to all. Then interconnected virtually and through human exchange, across the country for all to share and learn. A deliberately devolved, small scale, local approach shares local responsibility widely. So too would personal and societal gain be shared widely.

ID: 66-11 - Category: Health

Freedom of choice and Centres of Clinical Excellence

All cancer patients now have to have their case presented to a Multidisciplinary Team (MDT) to sanction treatment pathways. In principle this is a brilliant idea and I was involved in setting up such oversight committees in the 1970's. The original idea was to support the clinician AND the patient and ensure the latest treatment was being provided. Sadly, these MDT sessions have now become a gateway to ensure that a population of cancer patients is treated and not an individual. There is no choice at all as far as the patient is concerned and they do not even attend the meeting. Their advocate, their oncologist, is also shackled and cannot deviate from the decision made at the meeting unless he calls a new one. This is a real problem when dealing with cancers that are not amenable to effective therapy and patients are desperate to take any

risk to survive. Whilst it is vital that maximal efficiency must prevail when resources are constrained, as in the NHS, this has filtered across to the private sector. At least, at one time a patient and a doctor could treat the individual and so long as there is oversight and a logical approach then that should be allowed - not the case in the NHS at all and now not the case in the private sector. We talk about personalised medicine and this is nowhere more important than in cancer where in fact every cancer is different. You cannot have personalised medicine and a"One Size fits All". To resolve this and for both NHS and private cases, we need to free the 16 or so Centres of Cancer Excellence that are already in existence and let them treat patients in innovative ways but in studies involving small numbers and individuals rather than huge Randomised Clinical Trials. Treat the patient and not the population because each cancer is different. These centres would still require oversight and must publish their data, good or bad, so that complete transparency exists and the patient is protected. In the private sector, this is even more important and private units should be set up to protect the patient from the charlatans. This process should be easy and cheap to set up and the restoration of choice would be popular. To me the MDT process has gone too far and rather than supporting the patient it is dictating therapy especially in cases of unmet clinical need. This is wrong and as a retired surgeon I always treated individuals and not populations. Let's extend that courtesy, indeed human right, to oncology. It is why I am glad we have left the stultifying bureaucracy of the European Medicines Agency but I dread the possibility that the MHRA (our regulator) will not free itself of the shackles. Let's help it.

ID: 3060-11 - Category: Health

Over the past year, coronavirus accommodations have led courts and law firms to make a number of temporary changes to the way legal cases are developed and heard. If made permanent, some of these changes could provide economic and legal opportunity across the UK. Similarly, moving some legal proceedings entirely online – once thought unimaginable – is an idea that looks substantially more reasonable in light of the last year. By creating a system for hearing small civil claims online, the Government could ease the pressure on legal aid resources while increasing equity in representation.

Essay:

During the coronavirus pandemic, technology has made everyday life – or, at least, a version of it – possible. The 'Great Move Online' has kept countless businesses open, offered essential services and allowed us to maintain ties with loved ones, despite months of separation. But while so much is now possible, technology has also revealed its own limits, highlighting the

importance of the ‘personal touch’ in business and government, as well as in our social lives.

This essay considers what opportunities might be presented to Britain’s legal system and legal services industry by the technological progress we have experienced over the past year. It argues that technology – and, in particular, the new appetite for digital solutions generated by the pandemic – has the potential not only to radically improve operational efficiency and the rule of law on a national level, but also to help to raise Britain’s profile as a global centre for legal innovation and excellence.

The Coronavirus Act 2020 introduced a range of changes to the legal landscape, allowing civil proceedings in magistrate’s courts to be conducted via telephone or video and expanding the use of audio and video live links in criminal proceedings. The Supreme Court building closed, but continued to hear cases online. In so doing, it implemented a range of measures that legal academics (most notably, Richard Susskind) had been advocating for some time. Yet, pandemic-related technology proved its value beyond simply keeping courts open. It demonstrated how technology could assemble geographically dispersed legal teams. It proved how file-sharing systems could minimise inevitable administrative delays. And it shows that real-time transcription or recording systems – often built into videoconferencing software – have the potential to improve record-keeping and transparency. It is vital that the government works to keep up this momentum in helping courts to run more efficiently.

Of course, virtual hearings are not going to be appropriate in all cases. As the course of the pandemic begins to slow, all of us are realising those aspects of human interaction that technology cannot replicate, whether that be human touch, eye contact and simply hearing another’s voice in person. In some areas of the law – in family or immigration law, for example, where cases involve complex personal and social issues– in-person hearings remain a vital service. However, acknowledging this balance helps to provide a path forward. The establishment of a robust, digital system for some, more straightforward areas of the law (for example, following the model of Abu Dhabi’s virtual small claims court) would introduce much-needed technological efficiency to the legal system, while also freeing up resources for the areas that need them most.

Indeed, this approach could offer a solution to one of the legal systems more pressing concerns: availability of legal aid. Since the introduction of the Legal Aid, Sentencing and Punishment of Offenders Act 2012, legal aid has been radically restructured in the UK, with public funding no longer available for the vast majority of civil, family and immigration cases. Some fourteen local authorities have been classed as ‘legal advice deserts’; areas where no applications for civil legal aid were granted. A targeted approach to online hearings could

improve efficiency to such an extent that resources could be reallocated, ensuring that everyone receives the legal advice they deserve, regardless of financial standing.

There is also space for online proceedings in commercial law, with international implications. Britain's legal system has long been one of its most successful exports. We are a centre for international arbitration for contracts the world over, and embracing technological innovation in this field is vital if we are to maintain this position. For commercial firms, the launch of virtual arbitral tribunals – which have just passed a year-long stress test – provides a model for moving certain commercial proceedings in public courts online. As other countries around the world, including China, race to establish international digital legal platforms, government support for similar initiatives in the UK should be seen as a core element of maintaining our national advantage.

Finally, a large part of Britain's standing on the international stage stems from its legal system, with the UK having long been the gold standard for the rule of law. These principles include such inalienable rights as equality before the law and the concept of a fair trial, as well as accessibility of legal systems and the power of reason over personal discretion. As the world embarks on a new digital age, the technological quick-fixes that proved invaluable in the pandemic have great potential to reinforce these principles further. The law can be more transparent, more consistent and more accessible with technology. This is undoubtedly true. But technology is not the answer to everything.

Moving forward, I would ask the government to follow a model such as that set out above. I would ask it to harnesses the power of technology, while recognising its limitations. Technology could transform some areas of the law with previously unimaginable efficiency and it could bolster Britain's place on the world stage, but it could also offer a real opportunity to recognise the role that the personal touch plays in all our lives, reallocating human resources where they are most essential.

ID: 1621-11 - Category: Health

Mental Wealth for All

A major problem in todays society is that people confuse mental health with mental illness. This is fuelled by a culture that promotes 'toxic positivity'. We are told all the time that we need to be positive and happy, however this is unrealistic and makes people feel worse because they think that there is something wrong with them because they're unhappy. Currently, in lock down, people are at home, feeling unmotivated and low, they're alone and they're looking at material online that they then compare themselves to. Which makes them feel worse and so

the cycle continues. They feel uncertain, lonely, un-motivation, less than and a whole range of other negative emotions.

In order to combat this, we need education. This could be targeted at all age groups, because all age groups need to know about mental health and when a negative mood, is just a bad day and when it's a mental illness that needs professional support.

- Mental health professionals promoted on social media, that share content on what anxiety it, what depression is and what are the warning signs of when a bad mental health day, turns into a mental illness

- Flyers/booklets sent to houses with easy read information about mental health

- A regular slot on the radio stations that people can send in question to about their mental health

- Zoom sessions for school age children with accessible materials on what anxiety and worry are and what to do if you feel X, Y, or Z

- create videos that teach people the basics of mental health

- provide people with information on what is mental health (low mood, mild anxiety, feeling a bit blue, having an off day, worries) and mental illness. They can then have a better understanding of when they need to engage in some self care to make themselves feel better or when they need to seek help from a professional. They will also be better able to spot these signs in their friends and family.

- get experts by experience to share their stories so that the different groups of people have someone they can relate to

- Education on coping strategies and how to engage in them, making sure that there are accessible options for all, not just those with the economic capital to buy things

In targeting these different areas, social media, schools, post, online videos, radio and perhaps even advertisements on TV, this will increase the accessibility of this information. Many people are struggling with internet poverty currently and so the post option would also be necessary.

We need to education people on what our body does when we are anxious, why our heart races, what are negative thoughts and why do we have them, how can we improve our mood, how can we increase our motivation, how do we set goals we can stick to and achieve, what is stress and how do we reduce it.

If we did this through accessible ways, like the ones listed above, we would reach large portions of the population. Being told that other people struggle with the same things that you do is a very validating experience and is sometimes all the person needs to help them get over their fear or period of low mood. The alternative is, the person feels alone, does not tell anyone, the problem gets worse and they sit on an every growing wait list for a mental health service that is already massively overstretched.

This could be an inexpensive support system for people are currently there is a mental health epidemic happening across the UK. If we can support the general population with these difficulties and empower them with accessible education to help themselves and others, then we can free up some of the wait times on the wait lists for mental health services so see people presenting with sever mental ill health, which will subsequently reduce risk of harm to themselves and others and reduce the risk for admission to hospital.

ID: 246-11 - Category: Health

We cannot afford not to care.

The COVID pandemic has provided us with a unique opportunity to correct the problems we have created with the division of the NHS and Social care, dating back to the creation of health authorities in 1974.

In 2005, the Sixth Health Report estimated the cost of joining up social care and the NHS to provide seamless free care at £1.5 billion a year, projecting forward that the cost of providing this care by 2050 would have risen to four times that cost (£6 billion a year).

When we review the cost of the pandemic as having been because we were protecting our most vulnerable, the projected cost of an entirely free of charge care system, as with the NHS, seems reasonable.

We have repeatedly been told how important the protection of the 'most vulnerable' is, to the extent that the cost of doing so was not even considered. It was deemed so important that we were prepared to shut down society, put people into enforced isolation, close schools and greatly damage the education of children and young adults, ignore long term health issues, and destroy businesses and jobs. Ironically the forseeable loss of life expectancy because of the cost of COVID policies may make free social care more affordable.

The largest cost of providing this service will be staffing, and a stumbling block seems to be that we have an inability to perceive that carers should be paid a living wage, many work for sub living wage and Councils' subcontracting to the cheapest providers will predetermine poor working conditions and derisory pay for this work force. The Office of National Statistics identified early on in the pandemic that there was no disproportional representation of NHS workers within COVID death numbers, but carers and other frontline key-workers were disproportionally represented in mortality figures. This again leads to disproportionate mortality figures in BAME communities who are overly represented in the care workforce.

A key problem seems to be perception: why is it that people are so invested in the NHS, people protest for our doctors and nurses, throughout the pandemic they have been provided with care packages, respite, vouchers for discounts, yet for people working in care there is nothing - In my own example my local cafe offers free drinks for NHS workers, yet nothing to other 'key' workers. Particularly with care workers, they seem to be viewed as an underclass - we do not

like to think about care, possibly because how we treat our most vulnerable reflects on us as people, and particularly with the level of care which we give to the most vulnerable in this country - we should be ashamed.

As a care worker, I have worked throughout the pandemic, when other services, NHS - GPs, physiotherapists, occupational health, etc etc; were 'unable' to attend to patients we carried on. Our - usually decent - PPE was taken away and given to the NHS, we used food preparation gloves, plastic aprons, and eventually paper facemasks - we were given one per 7-10 hour shift. On one shift I was administering CPR to a client who had suffered a seizure, my fellow carer and I were wearing plastic aprons, gloves and paper masks, then two ambulances with four paramedics arrived to take over, they were dressed in hazmat suits and wearing breathing equipment. One of the paramedics said it was amazing how we had carried on working through the pandemic and gave us the spare face masks he had on his ambulance. We carried on working throughout the pandemic, you can't stop washing people, changing their nappies, feeding them, but the other services could. So what is essential - what is most important?

Care is holistic, why do we perceive the care someone is given in hospital as more important than that given to them either at home or in care home? Both are equally important.

The opportunity: On a patient needing to return home from hospital they are assessed by a care team and carers are put in place, because it is all under one umbrella and there are no questions about funding, carers are employed by the NHS and an appropriate care package can be put in place. Carers do not have to be paid by hours of care performed, and are paid working wages with all benefits of other NHS employees; meaning they and the work they do is properly respected.

With no issues about the funding or sourcing of care packages the system of people going home or into care facilities becomes seamless, meaning that if a pandemic should occur again, the bed blocking issue will not exist.

Repeatedly government commissions have recommended that the two services are made seamless again, and government ministers have rejected the recommendations. If we insist that the reason for the Lockdowns and handling the pandemic in the way we have is because we are so insistent on protecting the vulnerable - at any cost- we need to make this an absolute imperative.

If it is so important to take care of our most vulnerable and not let them die from COVID 19, then we should not be prepared to allow them die from neglect.

ID: 93-11 - Category: Health

A nation of medics - part 2

There is a moment of opportunity post-COVID-19 to take the current healthcare professions and expand them into a leading employment and economic driver of the UK economy, and Britain's diplomatic approach in the wider world. • The current system of training is centred on too few institutions – so increase radically the number of medical schools. Put an end to élitest assumptions and the rejection of many highly-qualified applicants by establishing new medical schools throughout the UK regions, attached to hospital trusts who would welcome the teaching connection. • Young people's interest in medical careers is at an all-time high – so encourage an expectation that all young people with a relevant aptitude in science or social care should pursue a qualification through the expanded medical training routes, even if they subsequently choose to work outside the sector. Medical training takes longer than other higher education courses, with higher costs – so offer 'national medical service' bursaries dependent on students undertaking practical medical work during, or subsequent to, their training. • UK hospitals are grossly understaffed – so flood them with locally-qualified, plentiful qualified personnel. NHS staff feel unappreciated and unvalued – so show them the medical sector is one of the most prioritised UK economic sectors with global opportunities. The UK's NHS treatments and standards are already respected around the world – so build on existing international sharing of best practice, eg. COVID treatment protocols, and step up proudly as a global educator on healthcare. • UK-trained medical professionals are seen as world-class medics – so export them fearlessly, to countries where there is great need, to countries which seek to develop their medical sectors, to countries we would befriend. Cuba has shown how diplomacy

can be developed effectively through medical outreach and assistance; there can be no greater global aid contribution than growing doctors and nurses for the world's population. COVID-19 has shown that disease respects no nation's border in our modern, interconnected world. Here is an opportunity for the UK's medics to similarly work without borders, winning us a global reputation as a nation synonymous with medicine and science, caring for our own, and working for all.

ID: 1325-11 - Category: Health

Fixing the unemployment problem, and simultaneously capitalise on the opportunity to enhance the UK's well-being.

The Covid19 pandemic has brought about vast unemployment, generating a devastating effect on the economy, and job and financial losses have caused poor mental health. The introduction of a working week of four days paid by the employer and one day by the government, as a type of furlough scheme, provides a way to get the economy back on its feet by generating thousands of new jobs, while simultaneously, enhance the well-being of the whole country.

Good mental health is an essential national asset in its own right, yet, the UK already had a mental health problem before the pandemic; living under continued worry has compounded the problem. The Mental Health Foundation recently surveyed people in full-time work and found over a third were anxious about losing their job. A widespread negative impact on the unemployed found a quarter was not coping well with the pandemic's stress, almost half were concerned about not having enough food, and one in five had experienced suicidal thoughts - an alarming situation. Poor mental health is closely associated with worse physical health, further affecting the ability to lead fulfilling lives, which adds to the NHS's pressure.

Tens of thousands of jobs have been cut as the Covid-19 pandemic continues to hit the economy with unemployment at 5% for the period September-November 2020 (Office for National Statistics). A total of 591,000 young people aged 16-24 were unemployed in the same period, 10,000 more than the previous quarter and 109,000 than 2019 (House of Commons Library). Nearly 10 million people were furloughed via the Coronavirus Job Retention Scheme between its start and December 2020, and there is no doubt it has helped many businesses survive. Thankfully, the government extended it to the end of April 2021; however, the UK unemployment is likely to reach 2.6 million, equivalent to 7.5% of the working-age population

when it finishes (Office for Budget Responsibility). The Bank of England made a similar prediction of 7.7% but suggested it could raise as high as a staggering 10%.

The majority of people in full-time employment are working five days a week, an average of eight hours a day. Yet, longer hours do not necessarily equate to efficiency. Being tired, stressed, or depressed means performance suffers from low productivity. Crucially, working less, such as this idea suggests in a four day week, has many psychological benefits in a life-work balance that reduces stress and anxiety, which, in turn, improves physical and mental health overall. Workers are happier and less likely to take time off sick. Having more time to spend with our loved ones generates better relationships by giving them more energy. A free day could be spent in a meaningful way for the individual, such as within the community, supporting each other to create a positive environment for everyone involved (PensionBee, 2020). Or a parent working full-time could spend a day with their child without needing to find or pay for childcare.

A four-day working week may sound radical, but this idea could work in both the public and private sectors to get the economy back on its feet by generating thousands of new jobs. Introducing a working week consisting of four days paid by the employer, and one day by the government (possibly at 80% furloughed) would mean a new full-time position created for someone currently unemployed for every four people in full-time employment. Unemployment would be significantly reduced, and having a sense of purpose by working, would bring good mental health and well-being, which could ease pressure on the NHS. A new employee working the non-working day of the four existing employees would mean the employer pays five employees for 20 days worked in one week, and the government pays for the five days off (see attached diagram). However, more taxes would be brought into the treasury because all five employees would be paying tax and national insurance on both the four days worked paid by the employer, and the one day paid via the government. Additionally, the new employee would not be claiming any unemployment benefits and employers liability national insurance paid for every additional new employee.

Nobody wants to live through something like this pandemic ever again. Still, having one in four extra people in the workplace means extra employee sufficiency to cope in a similar situation. Indeed, NHS staff would be able to recuperate one day a week following the mental draining of

working throughout the pandemic. Additionally, all five employees could be called upon to help at times of pressure such as within the winter months to work the government paid day off for a short period when demand was high, which would be paid by the employer.

It's a win, win situation for the government, employers and employees, both new and old, while simultaneously enhancing the working population's well-being.

ID: 1227-11 - Category: Health

A British Disaster Response Agency

The COVID-19 pandemic has exposed severe problems in the British state's emergency response capabilities which have cost time and lives and rocked public confidence in the state's ability to protect them. Solving these problems must be underpinned by structural reform and a recognition that crisis response is best managed not through the plethora of disparate bodies and protocols which exist at present, but through a unified Disaster Response Agency.

At the outset of the COVID-19 pandemic, the British state was ill-prepared to deal with a crisis of its scale and nature. The UK Influenza Pandemic Preparedness Strategy 2011 - the most recent, publicly available paper on the UK response to such an emergency - states "It will not be possible to halt the spread of a new pandemic influenza virus, and it would be a waste of public health resources and capacity to attempt to do so" (p. 28). It is to the state's fortune that this policy has not been more widely publicised, contradicting with cool indifference both the actions of those states most successful at tackling COVID-19, and the present policy of the British government. Moreover, that the 2011 plans appear to have enjoyed no significant alteration since their original publication reveals a startling complacency, discordant with the 2017 National Risk Register (NRR) identification of pandemics as among the likeliest crises to seriously threaten public health over the coming years.

The pandemic has illustrated in grim colour the paramount importance of a more thorough approach to crisis management than that outlined above. Developing such an approach requires us to eschew scapegoating and recognise that individual failures have been symptomatic of deeper-rooted structural and cultural faults. The poor material preparation for

the handling of natural threats is at least partly the consequence of the regularity with which officials are expected to leap between briefs and departments, stymieing a buildup of specialist knowledge and experience stored within a single government body.

The creation of such a body with specific responsibility for the prevention and mitigation of future natural crises is the best framework through which national emergency response can be developed and implemented. The pandemic has inculcated a host of individuals across myriad fields with experience of managing emergencies. It is through harnessing talent in business, for instance, that the UK has become a world-leader in vaccine procurement and delivery, and the wealth of human capital such as this which the pandemic has cultivated ought to be tapped to form the backbone of a Disaster Response Agency.

The work and advice of individuals from diverse fields, experienced in crisis management and working in tandem, will provide emergency response plans superior to those made by officials viewing these problems in abstract. Likewise, a dedicated cadre of scientists employed by the Agency would be able to continuously monitor global developments, updating policy recommendations to Ministers on at least an annual basis and thereby keeping pace with threats which are inherently quick to evolve. This would further foster a culture of proactivity which could yield wider benefits were it to be allowed to cascade throughout other governmental bodies.

Furthermore, a Disaster Response Agency headed by an apolitical figure has the potential to cool political jealousies and circumvent the parochialism which has occasionally bedevilled departments in the midst of our pandemic response. The competing and sometimes conflicting objectives of, for example, the Department for Health and Social Care and HM Treasury, have squandered time and led to inconsistent communication from various sources. Insofar as this has been visible to the public, the pandemic has been a challenge not merely to our physical health but also to our civic health, dangerously eroding public confidence in state institutions and bringing into question their ability to fulfil their first duty in keeping us from harm.

A single corpus of policy and advice from a Disaster Response Agency would allow for the government to act with the consistency and speed which emergencies of the pandemic's intensity require, as opposed to the inter-departmental disagreement and delay which has been a regrettable hallmark of the past year: the sprinter will, after all, always outperform the man running a three-legged race. The drawing of talent from various fields both public and private would also ensure advice was balanced and sympathetic to the needs of various constituencies, allowing the Agency to serve as a representative forum in which a doctor and small business owner both experienced in crisis response would be able to work collaboratively, avoiding a repeat of the polarisation between such groups which appears to have grown apace during the pandemic's course. Similarly, public confidence will be most effectively buttressed by a communications strategy fronted by impartial experts, who have been most favourably perceived during the pandemic in contrast to the Ministers who, despite their best efforts, will inevitably be perceived as at least partly motivated by partisan interest.

A final, and perhaps most intriguing, benefit of a Disaster Response Agency would be the holistic view of crises it would be able to assume. Although COVID-19 has placed health emergencies at the centre of our attention, other natural disasters are likely to become more common this century. The UK wildfires of 2018 and the flooding which now regularly blights much of the country in wintertime stand as examples of the ecological disasters which the effects of climate change engender. While attempts at departmental reorganisation in the pandemic's wake, such as the the founding of the National Institute for Health Protection, are encouraging, it is not clear they will be able to take the wide-ranging view a Disaster Response Agency would in identifying common links between recent and future disruptions and, consequently, the common solutions they might share in areas such as logistics response. Ambitious though this goal is, with the right funding and political will marshalled behind it, a Disaster Response Agency would present an opportunity for the UK to become a world-leader in crisis prevention and management.

ID: 1219-11 - Category: Health

How to get better at socialising after lockdown

As an 11-year-old boy I am not very good at socialising (especially with mum's friends) and with COVID-19 it has definitely impacted with not only my socialising skills but with everyone's. Also, everyone connects in my friendship group online through games and calling each other which is not the same as meeting in person.

At the moment, we should self-isolate and wait a few months. If we do that then when the elderly and more vulnerable population are vaccinated then we can go see them and everyone will be able to go out.

After that, as a way to counter act the problem of not being able to socialise now, when children go back to school, they should take a week in school to do some socialising lessons as well as still doing the main and more crucial lessons. This will ease the pressure for the kids and get them better at talking with friends and classmates that they have not seen in months. If we do this then our generation might actually benefit socially from this pandemic because we will have learnt how to do things that are difficult, and we won't be so unsocial and addicted to our phones as people might think we are. Schools should do:

- Skills on how to teach us to start a conversation and give sentences that can be used as this is hard and can make you feel awkward

- Skills on what to do if you are stuck in a conversation and want to get out of it nicely

- Skills on how to know and show positive body language like eye contact, listening properly and facing and paying attention to the person, to encourage other people to speak who might also be feeling insecure

- Skills on how to politely show that you want to end a conversation without hurting their feelings

- Team building so kids do different activities and they don’t realise they are socialising or talking with each other because they are having fun. This will help them make friends again too.

When they have learnt skills in lessons, it is useful to practise these skills as this helps people feel more confident. Some lessons could be teenagers practising different situations with other teenagers. There are also apps that help people talk but to robots that mimic people. This means people don’t feel as self conscious as talking to a person and so might do it more. They could also do this during lockdown. Teachers could enforce this by setting these apps as

homework and also other people could do them in their spare time if they wanted to.

This is all not only for kids and teenagers but for all ages as the lockdown comes to end and we get back to normal because this will help everyone to get better at socialising and talking with other people.

ID: 2196-11 - Category: Health

Care in the community needs to be more joined up

Having cared for my husband with Lewy body dementia at home I found the care wanting. The GP is not in the NHS and runs a business so wants to cut costs. I requested to change his medication from tablets to liquid when my husband could no longer manage tablets and was told it was too expensive. I was warned by his consultant no medication, apart from what he gave, would help but others could have severe detrimental effect. I contacted his NHS consultant and he got the medication sorted. My husband had not been seen by a GP for over a year. I was concerned as he was sleeping more. I rang the Parkinson's nurse for advice. One night I had to call NHS 111, he was getting spasms. One of the practice GPs came to the house. He assured me he was not near the end and was fine. He was then in problems a month later at the weekend and I rang NHS 111. He was unable to get up and was getting severe spasms. A district nurse came. The next day I needed more assistance and rang the surgery. The GP said a district nurse would come that afternoon. The district nurse rang up and said she was too busy and would come the next day. She came the next morning but had to discuss the treatment with the GP as she could not sanction it so the medication would not be started till the following day. Here we are discussing end of life care. GPs need to be brought back into the NHS, they need to employ sufficient district nurses to give humane care and do on call again in their contracts so patients are cared for properly. They are doing out of hours for yet more pay. Nobody had an overall picture of my husband's care. I was doing my best and ringing up the social worker, occupational therapist (council one), Parkinson's nurses for help/advice. When that failed I turned to relatives who were doctors.

When I could no longer manage my husband alone I needed the help of carers. I contacted the social worker. The care package was asked for in August and I got it in February but the carers were not all trained. It took two people so I was working with the one carer I was allotted. The carers were starting to be clocked in and out. Carers need to have qualifications in moving and handling and basic care. They need to have some flexibility in the time at each place as sometimes things take longer than anticipated and other times it can be shorter. If carers were

part of the NHS then the requirements of an individual would be appreciated and hopefully suitable care would be given. The occupational therapist trained me on using a four way glide sheet and asked me to train the carers. She was so helpful. The district nurses now just administer drugs and are not involved with care. We need nursing back and this is what a carer should do for people who require it. The social worker had not appreciated my husband's poor mobility so only allocated one carer. She could not get two when asked to. When my husband's condition deteriorated I got my sister as he needed changed between 8am when a carer came and 5.30 pm when a carer came. She had looked after my mother at end of life and was a consultant anaesthetist. If I had not had her I would have had an even more challenging time. For the final 3 days of my husband's life we got exemplary end of life care.

The whole setup for care is fragmented. This results in an inadequate service and the relatives having to fill the gaps. If social care was not separate and not outsourced then a more joined up service would result and the professionals would all have access to the same notes and could build up a more holistic picture of a patient's condition. My contact with the Parkinson's nurses was invaluable but none of that was recorded. One came to the house before just Christmas and asked me about his incontinence. She actioned a practice district nurse to contact me. I got much better pads and no longer had to change the bed every day. I knew my husband's health was declining but nobody else, apart from the council occupational therapist who bothered to come and see him, would believe me. I kept him smart and as fit and content as I could. There should be a team of doctors, nurses, therapists and social workers looking after a patient so a holistic approach is nurtured. The doctors would then learn more about dementia and be able to be more supportive. My husband was more aware than they gave him credit for. They knew nothing about the spasms in very late stage dementia. These are distressing for both patient and carer. My sister who was a neurologist diagnosed them.

The best help came from the NHS providers, Parkinson's nurse, consultant and the council's occupational therapist not from the private sector. To reduce abuse of the NHS could a nominal fee be charged for a visit so people do not go just to get free drugs that are cheap like paracetamol etc? If the doctor requires a follow up appointment this should not be charged.

ID: 1410-11 - Category: Health

Free the Land. Save our Guts.

After WW2 Bomb factories produced petroleum chemicals for fertiliser and pesticides. Fertiliser use exploded. With petrol chemicals comes the increased risk of diabetes, obesity, heart disease, depression, autism, cancer, Alzheimer and autoimmune diseases amongst others. Also the chemical processes of mining phosphate rock for example, are far from 'tackling net zero'.

• Industrial agriculture has significantly lower nutritional content than the same foods produced a century ago.

If the guts biosphere is the natural enemy of the virus, our over reliance on penicillin along with our diet has weakened its effectiveness. Especially when soil health has no quick turnaround from the decades of petrol chemicals and pesticides that have leached into the substrate and water courses. On my own farm I reduced the reliance on fertilisers by experimenting with a rich supply of glover to oxygenate the pasture naturally. It was a big hit with the Bees.

Buy organic you ask? Well, the static wage coupled with inflation, keeps most of us tethered to the supermarket. Yet another battle of price/profit versus best practice is quickly being settled - and not in our favour. Organic farming is labour intestive. Less than 3 per cent of UK farmland is organic.

Let me begin by stepping back for a moment in history and see how we got here - its a cautionary tale... Starting in 1604, the Enclosure Acts, petitioned by landowners to enclose their entitlements, brought subsistence farming for the masses to an end. Fenced-out from vast tracts of commonage, along with vital foraging rights, the fabric of society had truly become undone.

Given the unknown future and the proximity to one another, is there really any hope of a return to the countryside with our youth continuing to see their futures out-sourced and automated? Nearly half of the country is owned 0.06 per cent of the population and we the people live on less than ten percent of this green Isle.

But there is a solution! A new green exodus, if you will.

For the purpose of simplification, lets call it a Land Reform Act. An Act comprised of a mixture of MOD land, Crown estate, NATIONAL TRUST also land compulsory- purchased from the big landowners (with a one off- acreage tax to find fair value, and thus finding the most accessible land with pre-existing infrastructure). Perhaps an offer from our would-be King would be the perfect spearhead? To assess viability and get the ball rolling, let me briefly lay out a possible model, point by point:

• The able-bodied would-be applicant would receive a short organic farming course followed by a hands-on experience with perhaps an Agri-college and the outline of their responsibilities in order to maintain their placement.

• The resulting Green Cert would give them an option to farm a parcel of land (that they are not permitted to sell off or rent out).

• The suitability of crops and animals would be matched to the terrain, as well as to the applicants own preferences. This would then be coupled with the required targeted training.

• Along with an eco-cottage, the land would have an out-building offering renewable off-grid sustainability.

• The land would be allocated seasonal planting, and targeted date-lines of the harvesting to be accomplished.

• The monopoly of the supermarket might slowly be joined by a network of farm co-operatives, and an ecosystem of satellite distribution centers supplying a national chain of farm shops, offering low-cost organic food for all.

Think of it as a job opportunity that come with a house and access to co-operative machinery and seed banks. A helping hand proffered to the younger generation, those from minority groups and inner cities, who have no hope of getting on the property ladder. This mass cottage industry would not only heal 'soil health' and 'dietary change to restore biodiversity', but also to a certain extent heal some ailments of society, lower our carbon footprint, stem the toxification of our watercourses and provide a great push against the housing shortage.

Now being outside the EU trading block it would also guard against global supply-chain impacts and punitive trade tariffs. I would also suggest a new green courses to be introduced into the school curriculum. But moreover a long term approach will improve the nations health, injecting a much-needed vitality to other fringe service providers, along side manufacturing and National supply links, that would have a ripple effect in multiple directions, ultimately releasing the pressure on the NHS.

By Dominic St Clair

ID: 1347-11 - Category: Health

ScreenDoor (Holistic Covid19 Management)

The uniqueness and innovative points of our solution found in a well designed cell-phone based evidence generation system _a developed mobile application that works as a point of care

diagnostic tool (informed consent, symptom triaging, vital sign acquisition using visible light) and a voice calling system that similarly triages patients for a less resource rich deployment and enables phones to become a diagnostic kit. ScreenDoor is designed to have an inbuilt system for collecting health vitals such as heart rate, breathing rate and oxygen saturation using the camera - with options to use external medical devices. Visible light does not penetrate skin with the same efficiency as Infrared light; however, by ensuring the same sensor is used, we can base our calculations off a baseline and anomaly detection - self calibrating for every device in the field. The amalgamation of all of this data will be analyzed by statistical tools to determine the probability of infection by COVID-19, as well as the severity of infection. This means that only cases identified as severe will be logged on for testing and subsequent hospitalization, whereas mild cases are continuously monitored at home in isolation from unexposed individuals (disclaimer discussion pending but determination leans towards potential positives to minimize risk). Through longitudinal monitoring of health vitals, this tool has the potential to detect infections in the preclinical phase (asymptomatic infections - through cross validation among the metrics collected). The early detection reduces community spread of the pathogen (before any current test would be administered) and allows early intervention implementation; potentially saving lives. By using hyperlocal positioning in the form of Bluetooth proximity (signal strength from nearby devices running the application), we are able to enhance our probabilistic detection with contact tracing - stretch goal, geolocation through GPS more readily applicable. The various means for data collection means that we will be able to reach out to all various populations that either have complex smartphones, simple mobile phones or just access to the telephone. This will enable data collection from both privileged and under-privileged communities.

ID: 1188-11 - Category: Health

Problems, opportunities, capitalisation : an unutilised, educated workforce to provide nutrition/lifestyle classes to schools

As explained above, I believe nutrition/cooking and lifestyle should be a compulsory subject in the national curriculum of all schools in order to make a significant and quantifiable impact of reducing NHS demand in the longer term. The lifestyle element should include exercise and mindfulness to prevent mental health issues. Nutrition and cookery are self explanatory but should include innovative ways to make quick, tasty and healthy meals as economically as possible.

How can schools across the country find suitable staff to provide teaching in nutrition/cooking

and lifestyle ? The answer is easy... there is a mature, educated and capable workforce well equipped for this role. There are millions of ‘stay at home mums’ looking to get back into the job market; despite many having degrees and previous professional careers, it is exceptionally difficult for this sector of the population to find employment after a long career break. This idea could also help increase the numbers in teaching; teaching nutrition/lifestyle may encourage further teacher training in other subjects. The role could also be open to qualified nutritionalists. However, a clear curriculum plan with pre-prepared material would not require prior nutrition specialism.

Should there be another pandemic, the unutilised, educated workforce described above could be used to help fill all the new job roles needed. ‘Stay at home mums’ looking to get back into the workforce would see this as a great opportunity. Perhaps there should be a campaign to recruit this very capable sector of the population. Life begins around 50 for many women. There is a preconception I believe generally by employers that women of a certain age are ‘mumsy.’ This is a great pity and misconception. There are many advantages recruiting from this sector. I hope these 21st century highly capable ‘auxiliaries’ can be used for either teaching nutrition/lifestyle to help unburden the NHS in the future or to help support the pandemic.

ID: 985-11 - Category: Health

Take remote working to remote places.

As above, the logical extension of 100% online or a blended model of face to face and online is that this opens the opportunity for specialist, evidence based interventions such as Functional Family Therapy to be delivered to remote or sparsely populated areas which otherwise could not sustain the infrastructure costs of a specialist team. For example, an FFT team could work out of a centre in Edinburgh and service the Islands and Highlands. It could send a therapist for one week a month to a remote area to support the initial engagement of families and to ensure their comfort with online working through set up of the system for example. This could then move to online through the course of the intervention to the end point (usually 3-5 months of weekly sessions). Given that many young people travel to school for weekly boarding on the mainland, their engagement through online working could be secured to.

The challenge is partly one of technology but also a cultural one and a practice one. Therapists will want to return to face to face and their practice may well improve as they do, however being able to deliver services to the hardest to reach geographically is a noble aim and easily achieved if the service model can be successfully adapted to be good enough. The win is a

locally delivered service plus the potential for significant cost savings if young people are prevented from entering care.

ID: 388-11 - Category: Health

Giving citizens free access to an online mental health first aid course

The COVID-19 pandemic has worsened the mental health crisis and so this policy is a 'lockdown-compliant' measure that aims to counteract the negative impact that the pandemic has had on mental health. This policy involves providing a free online course to citizens on the basics of mental health first aid. This policy is designed to equip citizens with the basic tools to support their friends, family and colleagues with their mental health.

The policy itself is simple: all citizens will be able to access an online course which, once completed, will equip them with knowledge of the basics of mental health first aid. This knowledge can then be used by people to better support relations who are suffering from mental illness. Furthermore, such a scheme will likely generate more conversation surrounding mental health, thus reducing the stigma around mental illness which currently prevents many people from seeking treatment and professional help for their mental illness. The online course would be funded by the government but would be provided by an existing charity that specialises in running mental health first aid courses.

This policy seeks to counteract a significant problem posed by the COVID-19 pandemic: the negative impact on the public's mental health that the pandemic has had. The policy also capitalises on two behavioural changes that have been caused by the pandemic: an increased willingness to work from home, and an increased willingness by people to volunteer their time for social causes.

The mental health crisis has been compounded by the COVID-19 pandemic, but it is also a long-term issue that will need to be addressed well beyond the end of the pandemic. This policy of a free online mental health first aid course for citizens can be used to combat the mental health crisis in both the short-term (during the pandemic) and in the long-term (after the pandemic has ended). The online-nature of the mental health first aid course will mean that it is

a viable policy to be implemented during the pandemic because it does not require in-person contact between those who are participating in the course. This makes it a mental health policy that can be used whilst lockdowns and social distancing policies are in place. The online nature of this policy also means that the variable costs of the policy (the cost of allowing more people to access the course) are negligible, making it a sustainable long-term policy in combating the mental health effects of COVID-19 that will continue beyond the end of the pandemic.

Behavioural changes from the pandemic also suggest that there will be higher take up of this free online course relative to if the policy was introduced before the COVID-19 pandemic. This is because people are more willing to work from home and are more willing to give up their time for volunteering as a result of changing attitudes since March 2020. This suits the free online mental health first aid course because it can be taken from home (say during a lunch break when people are working from home), and it requires people to give up their time for an important social cause (improving public mental health).

ID: 2136-11 - Category: Health

Optimise the Nightingales

There is an increased NHS waiting list.

People are in pain or have no quality of life.

The Nightingales, although temporary, are bought and paid for. Extend the leases for 6 months and have super centres - each Nightingale becomes a Hip replacement centre or Cataract surgery centre.

One centre. One Operation.

Dedicated surgery teams working 7 days a week to “industrialise” the process.

Only choose waiting lists that can be more simply organised at a low risk for these super centres.

ID: 1568-11 - Category: Health

Incentive to commit

Medical students University fees could be reduced or paid fully providing they agree to practice in a shortage area for a minimum number of years, say 7 to 10. If they leave before that time the would have to pay the fees back, or at least a proportion of them. This would help ease the shortage in rural areas and also contribute to the levelling up agenda.

ID: 1272-11 - Category: Health

The need for, and creation of, The NHS Reserve

The fundamental challenge presented by the current pandemic is that, left unchecked, the healthcare resources required to treat all those affected are far in excess what is available even in a wealthy country with an adequate health service.

The only response available has been to reduce healthcare demands during the pandemic by imposing socially and economically damaging restrictions on all our lives. These restrictions have had, and will continue to have, severe negative consequences far beyond the period of the pandemic.

It is neither feasible nor desirable to maintain a healthcare system at the levels needed to cope with extreme events just in case another pandemic comes along. Therefore a solution is required where resources can be dramatically increased in times of dire need; a pool of resources (both physical and human) which is held in reserve until such time as they are needed.

This model for dealing with national and international crises which threaten to overwhelm public resources is not without precedent. In the global conflicts of the twentieth century, the mobilisation of large swathes of society was instrumental to our efforts and ultimately our successes.

Most directly, there was the use of conscription to temporarily swell the ranks of the armed forces. However, the Spitfires that defended our shores were not just flown by pilots who had

never flown before, but were constructed by workers who had never constructed aeroplanes before. Factories and people were temporarily repurposed to ensure Britain had the capacity to meet the immediate challenge.

More generally, the use of amateurs is interwoven with our professional public services:

The Territorial Army, now the Army Reserve, has been an integral part of our armed forces for over 100 years.

The close relationship between the Royal and Merchant Navies ensures we have non-military physical resources such as troop transporters and hospital ships in times of conflict.

School governors are essential to the running of our schools.

The criminal justice system relies on jurors taken from the general public to decide on cases both mundane and highly complex.

And now we face the challenge of vaccinating a nation, volunteers are again being called upon through the programme run by St John Ambulance.

During this pandemic, the main problem faced by the NHS has not been one of expertise or commitment but one of capacity. It is the same problem we faced at Dunkirk and in the fields and factories of wartime Britain. And we solved those problems by mobilising a new, temporary workforce assembled from a willing and resourceful nation.

It is the concept of the Army Reserve and possibly the echo of military conscription which I suggest could be used to prepare for future healthcare emergencies where again we are facing overwhelming issues of capacity.

The NHS Reserve would be an organisation working with (or within) the NHS, possibly with the

help from volunteering experts such as St John Ambulance.

The aim would be to dramatically increase the capacity for critically ill patients by 10's of thousands with as little as a few weeks' notice in times of national emergency.

The NHS Reserve would be staffed by volunteers who had trained alongside NHS staff in their free time just as Army Reservists do. They would have gained and maintained up-to-date skills and experience. And again, as with the Army Reservists, these would be people willing and able to work on the frontline, directed by and alongside professionals.

In terms of physical assets, "Nightingale" sites (conference centres, hotels etc.) would be identified in advance and set up with all the services required in case they were needed to act as fully functioning hospitals. Existing buildings would need to have extensive adaptations made to them. New buildings created as we regenerate our town and city centres would be designed with both their primary function and their healthcare reserve function catered for.

The idea would be to have a physical and human reserve which, with little notice, could drastically expand the frontline capacity of the NHS in a time of crisis.

Even if we are fortunate enough never to have another pandemic like this one, the education and involvement of a large number of us in our healthcare system will have other benefits. We would better understand our own healthcare needs, be able to care for our loved ones with greater skill and knowledge and it would undoubtedly create a feeling of involvement and cohesion which would benefit us all.

As we begin to emerge from the shadow of this pandemic, people are better informed and

more involved in the issues of care and health than ever before. The creation of The NHS Reserve would capitalise on these sentiments and allow us all to feel that we were helping reduce the risk to our society from the inevitable challenges of the future.

ID: 826-11 - Category: Health

Provide Cadet Training Schemes and Bursaries for NHS/Social Care roles.

1. Capitalise on the 750,000 people who volunteered to help the NHS during this time of crisis by constructing a reserve volunteer list who could be called upon again, reducing the need to recruit further should they be needed again. Encourage retiring staff to go on this list for 2 years.

2. Allow volunteers to undertake support roles to clinical staff where able.

3. Ensure that current staff get to take their holiday and have a holiday!

Government to work with a national hotel chain to provide an away from home holiday for up to 7 days for NHS/Social Services staff and families. Many have had to take a holiday in lockdown, (more than once) being forced to stay at home, often alone!

4. Reinstate the bursary scheme for Nurses and AHPs to attract entrants from across all strata of society, possibly with an entrance exam or other route in (See no.5). This is necessary as students are not able to sit GCSE's at present.

5. Reintroduce the NHS cadet scheme and extend to Social Services, this will allow 16 year olds to work on a 2 year programme designed to give them experience and knowledge of working within various departments: both clinical and non clinical across health and social care. This would need to be delivered locally but designed nationally with set goals to be achieved and a pathway into professional training at that end such as nursing, physiotherapy etc.

ID: 680-11 - Category: Health

Incentivizing people to good health

1. Affordable foods - Reduce or eliminate VAT on designated healthy foods.

2. Vegetable/Fruit Days - Create a national day, one a month for healthy foods. e.g.) October is broccoli month, this could be a platform to talk specifically about benefits of foods.

3. Exercise discounts - Provide tax right-offs for attended gym membership. Provide tax reductions for individuals that prove active attendance of wellness classes such as yoga/sports clubs.

4. Better education - Introduce a life sciences class in formal education that amongst other things, educates children what good health is and what it isn't/how to avoid it.

5. Tax credits for non attendance of hospitals - A little like credits with auto' insurers for 'no claims' individuals receive significant tax credits for 'non hospital attendance.' They would simultaneously be encouraged (as they have during the pandemic) to communicate as much as possible with their GP online.

ID: 293-11 - Category: Health

A vision to provide high-quality, accessible and sustainable healthcare for all

While the NHS has rightly been lauded as one of the best national health systems in the world, with font line healthcare workers who have shown extraordinary courage and resilience through the COVID-19 pandemic, the accelerating pace of technology and innovation in healthcare dictates that we must not rest on our laurels.

I recommend a new turbocharged digital health strategy for the UK with a vision to provide high-quality, accessible and sustainable care for all by establishing a new digital health ecosystem. Digital healthcare has many advantages in terms of accessibility, quality and affordability but to realise its full potential will require a carefully planned approach. This should encompass a vision, strategic objectives, priority focus areas and implementation principles. Moving ahead quickly, and getting it right, will give a real boost to the digital economy and help offset growing healthcare spend in the UK.

For a country with our level of GDP per capita, aspirations of technological leadership in areas such as AI, genomics and life sciences, the UK has an urgent need to increase its implementation of digital health. The Oct 2018 Dept of Health Paper on entitled Future of Healthcare - Our vision for digital, data and technology in Health and care - was a good blueprint for progress in this regard but we can and must go faster.

In my vision, all of the patient data generated by UK's hospitals and outpatient clinics (public and private) is digitized. Citizens can access their own medical records via a secure online portal and can choose who else can access their records. The system will improve the cost-effectiveness, sustainability and efficiency of the NHS. It will also facilitate the transition to preventive, rather than curative, medicine and is underpinned by blockchain technology, a crucial pillar in ensuring the integrity and security of all patient data.

Many health services will occur online from video consultations to e-prescriptions. We will reach a stage where over 75% of our entire public bureaucracy is digitised. The digital health ecosystem integrates with other government and private sector systems and automates many ordinarily complex operations. An example is registering a death and notifying all the relevant parties: in the future, once a death in the UK is registered online, notifications are automatically sent to that person's workplace, the tax office and the population registry.

Our new privacy and data security compliant UK healthcare digital platform can be used to exploit cost-effective and high value benefits not previously available without the access to its data. We will become a trailblazer in launching major clinical pilots in personalised medicine. These pilots combine genomic and other health data to better predict and prevent cardiovascular disease and breast cancer. The long-term goal of these pilots is to develop algorithms that can be fed into clinical decision support software, which would in turn be made available to general practitioners. This way doctors can be empowered to use genomic data to provide more targeted prevention and care to patients.

Underpinning all of this is a world class data and analytics capability, which our top UK universities already have. We just need to put it to work in a new public health strategy. The vision statement of this strategy is simply "Better information – better health!".

My final idea relates to passports. Leaving the EU means we will need a replacement British

passport. If we get it right, our new passports could have an electronic ID which allows UK citizens to access thousands of new digital services provided by the UK government (as opposed to just one – immigration). Estonia is a great model for digital government for us to learn from in this regard.

ID: 1766-11 - Category: Health

Improving disabled access to public footpaths

Lots of people with some physical impairment would love to access public footpaths. A person who is able to walk, may not be able to clamber over a stile, plus, Covid has made us mindful of the fact that disease can be easily transmitted by people touching objects. I suggest that where possible (and I think this would be in tens of thousands of instances) stiles should be replaced with foot operated gates, or by mini chicanes that would prevent livestock escaping but allow humans access without having to climb or touch surfaces with their hands.

In a linked initiative, I suggest all public bins (including dogs bins) should have lids on them, and be operated by foot. And that each finger post indicating a footpath should have a coded description of future "hazards" on the path eg S (stile) F (ford) etc.

ID: 250-11 - Category: Health

Reducing Red Tape to Save Lives

Current Recruitment of Retired Doctors and Nurses suggest unnecessary bureaucracy .

Extraordinary circumstances require an extraordinary response.

Never has there been a need to fast track a willing previously qualified workforce so swiftly that they are in a state of readiness to respond to this National Emergency, yet there is a suggestion that a business as usual response is hampering this initiative.

Doctors and Nurses (me being one retired this March) should have been fast tracked on a recruitment program and not put on the same program as a normal long term applicant.

Training requirements demonstrate the need for an update on Core knowledge of Vaccinations, storage, preparation, administration, anaphylaxis and resuscitation these are vital but this could have been covered in a half day session.

The other half day could have covered to administrate Photo ID and badge preparation the provision of scrub suits/ uniforms and the gathering of any other human resource crucial personal details.

Now with this group of trained clinical staff on vaccination that have returned from retirement bringing with them their careers expertise a hugely experienced workforce could have been swiftly mobilised.

With this workforce geared up a National Plea could have been made by Public Health England calling all those that want a vaccination.

With the collaboration of business and industry and the Red Cross, large venues or supermarkets could have been commandeered for administration of the vaccine (Ideally outside with Gazebos) .This call up would not be age restricted as in this way you vaccinate a cross section of society thus spreading the range of the heard immunity to preempt the known mutations of this virus.

Facilities would be socially spread with seating arrangements allowing the sufficient time lapse of possible anaphylaxis. The Public would be asked to come with photo ID / passport NHS number and fill a simple form of their GP practice details, for forward communication.

On completing of the vaccination the individual would be issued with a vaccination passport indicating their next booster date and for them to keep for the records.

The New Vaccination Workforce details could form a Register.

With all staffs agreement to stay on this register strategically this may prove to be a vital contingency for the future. If such a register is established it should be complied in such a way that it can be accessed by a search engine. In this way should the need arise in the future like a National Emergency or Major Incident the skills and qualifications and location of these staff can accessed and targeted to the location of need at ease. Too often I hear of Acute Trusts calling a Major Incident and know that this means calling on their off duty tired staff, when a fresh pair of hands could make all the difference.

This could be a very positive outcome from such a disastrous Corona Event.

ID: 1552-11 - Category: Health

the global uses of drone to fill glaring gaps in resources.

The use of drones are classified into two categories and each of the fields can be exploited to capitalize fully on its potential i.e.

1)Drone use in combating COVID 19 pandemic;

2)Drone use Supportive activities. The use and their details are provided in the following sections: 1.Drone use cases in combating COVID 19:

a.Spraying disinfectants

i.Drones designed to spray disinfectants have been remodeled with pesticides on agricultural lands. While the verdict is still out on the effectiveness of using drones to spray pesticides, nevertheless, it is an important use case of drones that are widely being deployed by countries.

ii. Drone companies in countries such as China have teamed with Agricultural research institutes to make effective use of drones for spraying disinfectants. China, South Korea, UAE, Israel, and India have deployed drones to spray these disinfectants in their respective urban and rural spaces. The primary recipients of drone based disinfectant operations have largely been Government offices, hospitals, public places.

b.Monitoring body temperature:

i.Drones mounted with thermal cameras have been deployed by state authorities across the world to detect body temperatures of people in public places. Some drones are fitted with AI-enabled cameras which enable to the identification of any abnormalities in body temperature.

ii.A team of researchers from the University of South Western Australia has reportedly made a breakthrough wherein the drones fitted with specialized cameras can detect coughing, sneezing, detect heart and respiratory rates of people and monitor their body temperatures. Countries such as China, Saudi Arabia, Jordan, Israel and Bulgaria have deployed drones to monitor people's body temperature.

c.Medical and food supplies delivery :

i. there are some essential human activities which necessitates people to venture out. For instance, for their daily needs, people move out of their homes to purchase food and medical supplies (for COVID and non-COVID patients).

ii.Advantage of deploying drones for food and medical supplies transport during COVID 19 becomes particularly important given the fact that there is a significant drop in air traffic congestion. Transportation of medical supplies, medical equipment and even blood samples could be pursued through drones.

iii.A company named Antwork has flown medical samples and quarantine supplies from People's Hospital, Xinchang county to Disease control center in Xinchang county. The company is also considering expanding its operations in Hangzhou and Wuhan provinces of China. Chinese e-commerce company JD has used drones to supply medical equipment to hospitals located in remote areas of Wuhan.

iv. In case of China, reports suggests that robotics have been extensively used inside hospitals to cater to these needs of COVID infected patients. Robotics have been deployed to deliver food to patients in COVID infected wards.

v.Zipline, a drone company has already proven and validated drone based medical supplies deliveries in Rwanda, Africa. The company is currently engaging in talks with US Government to seek permission to begin operations in Untied States. Similarly, a Canadian company Drone Delivery Canada has also begun negotiating with the Government of Canada for transportation of pharmaceutical products in suburban and rural areas of Canada.

2.Drones use Supportive activities:

a.Surveillance and ensuring lockdown:

i. police forces have deployed drones to expand the coverage of their surveillance with faster speed. Drones are uniquely positioned to not only pick up signs of lockdown violations on the streets but also to ensure that people are adhering to social distancing rules on rooftops.

ii.One of the unique advantages of deploying drones to ensure surveillance and lockdown is that it precludes police officers performing such duties from getting infected by COVID 19, particularly those operating in declared containment zones. iii.Countries such as Israel, China, USA, Malaysia, Kazakhstan, Italy, France, Jordan, Belgium, Greece, etc. have deployed drones to ensure lockdown in public places. In case of Israel, drones are regularly sent in places wherein people have been quarantined. Such quarantined people are required to come near their windows to provide visual confirmation that they are inside their houses. Drones have also been used to disperse crowd and ensure that people are practicing the social distancing norms. a sudden drop in crime statistics in Israel could be attributed to extensive deployment of drones by the state of Israel. China too has deployed its drones extensively to monitor congested areas and disperse crowd in its cities and other areas.

b.Public Broadcast :

i.While drones continue to be effectively deployed to surveillance and ensure lockdown, its effectiveness substantially increases when it is fitted with speakers. Drones with mounted speakers have frequently been used in countries such as China, Israel, France, Spain, India etc. to disperse crowd in public places.

ii. Drones deployed for public broadcast can be effectively used for not only dispersing crowd

but to also relay area specific messages pertaining to COVID 19 to educate and raise awareness among inhabitants. In scenarios wherein some people are found to be not wearing masks, drones with mounted speakers are able to relay messages encouraging people to wear masks. In case of countries such as Malaysia, Qatar, Kuwait, drones with fitted speakers have been used to relay messages in multiple languages.

c. Survey mapping :

i. Drones have also been found to play a critical role in activities like survey mapping. For instance, while planning construction of hospitals and critical care facilities drones could be used to play an important role in surveying areas. In case of China, the country has made use of satellite technology to survey areas.

ii.According to reports, several empty fields in countries such as China, US and Germany have been converted into makeshift hospitals. Drones have played a critical role in survey mapping of such areas to construct hospital efficiently and with minimal human involvement.

iii. Further drones fitted with lightings have been used to illuminate areas which have been designated for construction activities. Drones were used for one such hospital construction in Wuhan, wherein 6 drones hovering 50 meters above ground could illuminate an area of 6000 sq meters and remain illuminated for 10 hours with a single charge.

ID: 979-11 - Category: Health

Transform the nation's health to make the UK the world leader by 2040

We need a comprehensive, integrated framework to address the nation’s health, with a series of short, medium, and long-term initiatives to deliver the necessary transformation. Some examples of such initiatives are set out below.

1. Envision, evolve, experiment

Given projections of demographics and the incidences of major lifestyle diseases, together with the impact of issues such as antimicrobial resistance and emerging technologies, what would be best achievable health service in 5-, 10-, and 20-years’ time? A diverse multi-disciplinary group

of experts should be set up to define the purpose and vision of an integrated, cradle to grave health service having regard to affordability. What are the fundamental steps needed to get there? What are the risks?

Change will involve evolution and experimentation should be encouraged. For example, there could be pilot schemes to change the shape of GP surgeries to move from cure to prevention. Surgeries could have resident personal trainers, nutritionists, and counsellors to whom patients could be referred on-site. Doctors are higher cost and too busy to spend time on some of the fundamental lifestyle issues which require behavioural change. There is a huge potential to save drug costs and improve treatment by focusing the right level of expertise on prevention at the right time. (Also see encourage below)

Those responsible for change should establish more mutually beneficial partnerships and alliances across government, academia, and commerce. For example, it is disappointing to see on the National Obesity Forum website the quote “we would prefer to partner with Whitehall but that’s not an option: the Government thinks it’s doing too good a job to need time for partnerships”.

2. Educate

Make health a compulsory GCSE which could also act as a platform for more advanced studies. Going beyond PHSE/RSE it should cover subjects such as anatomy, physiology, psychology, and nutrition. The goal should be to help students understand how their minds and bodies work and the impact of the environment they are in. If we all understood how we are programmed to think and function as sophisticated relationship-driven animals, and the mismatches we face between our evolutionary design and the modern world, significant improvements in mental, physical, and social well-being could be achieved.

Great progress has been in providing better information on health matters (e.g. the “Better Health” initiative) and in embracing technology (e.g. “Couch to 5K”) but more could be done. All

present guidance should be critically reviewed and updated. For example, leading experts now question the “Healthy Eating” guidance and its validity. National guidance needs to cut through misleading and contradictory sources of information. Similarly, the information on physical activity should also be reviewed. There is some good content, but it isn’t necessarily complete or logically structured. In general, guidance on the 5 or so drivers of a healthy lifestyle, (avoidance of toxins, management of stress, nutrition, physical activity, and sleep) should be packaged on a new standalone website using the latest communication techniques. Leveraging partnerships and alliances with those with common interests would also be sensible as today’s efforts are hampered by GOV.UK’s infrastructure which appears outdated when it’s compared to production standards and technology of other, often less credible, sources.

3. Encourage

In many cases health issues arise from behavioural, not information, gaps. For example, smokers know the dangers of smoking but continue to smoke.

Recognising the impact of socio-economic factors, health services could be positioned differently. Again, by way of a pilot, centres could be created where people would want to go because it helps them, gives them hope and may even be sociable. Health may only part of the equation as numerous services could be brought together in a mutually beneficial way: part health treatment, classes and advice, part employment /benefits assistance, part Citizens Advice Bureau, part coffee shop, part community centre etc. These centres could be part of a repurposed high street where the services, especially in more deprived areas, are positively repositioned away from the taint and fears of social stigma. Depending on how they are set up it would be worth considering leveraging the operating models of say Citizens Advice or the grants approach of Sport England. Another possibility would be linking-in with a re-imagined high street in conjunction with other local authority initiatives.

Where climate change has David Attenborough as its figurehead, there is no such unifying voice or force in health. It may be good to find one. However, even in the absence of one such figure it would seem sensible to create a national impetus to focus on health. Enlist business leaders, well known personalities, and others as health ambassadors, implementing initiatives in their

business, delivering the messages, leading by example etc. As a condition of lottery funding why not require Olympians to devote time to health promoting activities?. It should also be possible to leverage the work undertaken by other organisations such as those of the Premier League clubs.

4. Enforce

Consideration should be given to setting up a group to co-ordinate different regulatory efforts to counter the most egregious manipulation through health claims and messaging by food manufacturers and retailers, technology companies, fitness and nutrition advisers, the media, and others. By way of example

• Why are there so many fitness devices and equipment which provide different (inaccurate?) readings for the same activity?

• Should there be stronger independent quality standards imposed on the providers of fitness and nutrition education? Today's qualifications and their practise are variable to say the least.

• If we want to reduce the vast consumption of ultra-processed food, should there be food packaging coding in line with the NOVA system of food classification? Should processed food be taxed differently rather focusing simply on sugar tax?

The group need not be large, in relative terms, as it should once again build relationships with, and leverage the work of, others in the public and private sectors with common goals (Government agencies, Which? British Advertising Standards etc). The public should also be encouraged to raise issues to be followed-up.

ID: 741-11 - Category: Health

Recognise pandemic readiness as a national defence requirement

Give responsibility for pandemic readiness to the national defence forces.

This approach would have these benefits:

- Readiness for national threats is part of the established culture

- Threat monitoring, workforce training, drills and equipment readiness and renewal

- National assets such as testing may be useable by NHS operations, but this capacity must always be held in reserve, not absorbed into the NHS general capacity

- Real estate that is currently surplus can be re-purposed as required

- Staffing availability for response

ID: 2277-11 - Category: Health

Response – Pandemic Organism Biochemistry & Therapeutics Database

Vaccines are highly specific to a given emerging pathogen, and as a result need to be developed from scratch once a pandemic organism is identified. Although vaccines have the benefit of preventing disease, they are of no value to an individual who is already ill. In this setting, supportive care and antimicrobial therapy are necessary. Although some pandemic candidates such as Anthrax are susceptible to currently available antimicrobials, others, like SARS-CoV-2, are not. At present, antimicrobials are developed piecemeal in profit-oriented programs mostly run by drug companies. We need a centralised, intelligent database of biochemistry that is focused on pandemic candidates, but is in the public domain, as was the Human Genome Project. An opportunity lies in the fact that, as a result of evolution, there is a remarkable homology of biochemical systems across different species. We are all familiar with the fact that all of life on earth is based on DNA. This similarity extends right down through life, to the structures and behaviour of proteins, fats and carbohydrates etc. Consequently, the search for therapeutic agents is not random. It is a quest for the “Periodic Table” of biochemistry, a matrix of chemical structures and functions. Modern information technology will enable laboratories

throughout the world to share data and inspiration in a way that no humans could. The central AI system could alert one laboratory the moment that another uploads a relevant piece of work, even if that link had not previously been expected. Thus, the bark of the Cinchona tree produces Quinine, which has been used to cure malaria for centuries. If specific antimicrobials cannot be found in nature, they can be designed using knowledge of the biochemistry of the pathogen, and the 3-D electrophysical structure of the molecules involved. Once potential drugs have been identified, they should be developed in a progressive fashion depending on calculated utility. Protected by such an armoury of drugs in readiness, we would be better equipped to face not only the next pandemic, but also emerging antibiotic resistance.

The Human Genome Project provides a model for how this can be achieved. A Founding Committee should be set up, drawn from people with expertise in the relevant branches of Science, Information Technology and Project Management. They would set up subcommittees covering identification of pathogens, biochemistry, pharmacology and information technology. Global partners including the WHO should be identified. In order to maintain worldwide cooperation, project members need to display sensitivity to diverse cultures, in relation to potential exposure to zoonoses as well as acceptability of therapies. Funding should be raised for the organisational infrastructure, the IT hardware and software, and research grants.

If humanity can map the entire human genome in thirteen years, surely thirty years later we can, indeed must, take on this challenge.

ID: 2109-11 - Category: Health

The combination of direct provision with policy level decision-making in one forum.

The Food Insecurity Network in Dundee, Scotland, was developed at the start of the Covid-19 pandemic in response to the immediate and urgent need to provide food to local people. It is a city-wide network of 24 community food projects, senior managers from Dundee City Council and the city's volunteer network. Since the start of the pandemic, the Network has met weekly to keep track of local issues and tailor local responses to ensure that local people's needs are identified and addressed. The inclusion of senior managers from the Council means that addressing need has not been limited to direct provision; necessary policy changes are also identified and discussed as local issues arise. The combination of direct provision with policy level decision-making in one forum is what makes this Network unique. In the worst week in April 2020, the Food Insecurity Network fed 4,700 people. The grounded nature of the response means that the Network soon identified that people needed more than the provision of food – it became clear that households were unaware of available financial support, and either unsure how or unable to access mental health support. The Network therefore extended its reach,

working with other organisations across the city to provide financial advice and mental health support. The Network is currently also exploring ways to work with community food gardens as both a means to address lack of fresh fruit and vegetables, and as a mechanism to support mental health. We propose that this model of practice provides a potential new model for local governance. It has had a baptism of fire – responding to a crisis that no-one knew was coming and that local governments across the country were wholly unprepared for – successfully building relationships and alliances to ensure a coordinated, effective response that ensured dignified access to food while supporting people's financial stability and mental health. It transformed traditional policy structures to ensure that both immediate and long-term needs were identified and addressed through respectful, dignified responses that centred people's lived experiences within the decision-making forum. Now is the time to capitalise on this experience, to capture the learning and understand how this participatory, coherent and sustainable model of practice can be implemented in other contexts and enable us to build a social support system that respects people's dignity while responding to real need.

ID: 2013-11 - Category: Health

Bright Idea(s)! A Colourful Cure For The Nation's Blues...

We all know that our nation faces a looming mental health crisis.

My idea targets the huge extent of low-level mental health issues (the light blues) in our society, with the aim of preventing seriously dark blues.

My idea, life-enhancing and potentially life-saving, is...

1. Science- and people-based.

2. Simple and practical.

3. Powerful and effective.

4. Wide-ranging and long-term.

5. Easily and quickly implementable.

6. Tangible and relatable to.

7. Universally inclusive and politically neutral.

8. Relevant to individuals, organisations and business.

9. Socially motivating and uplifting.

10. Cost-efficient to government.

11. Economy-stimulating.

12. Open to creativity, innovation and development.

13. Self-perpetuating and unlimited.

My big idea is to launch a determined national campaign, championed by experts and the country's top leadership, for the personal investment of the entire population, all of us, in those two most powerful and life-enhancing elements of everyday life - Colour and Light!

We are all surrounded, everywhere and all the time, by some kind of colour and some form of light. They influence our brain function and can significantly impact our mood and mental state.

Happily, we can all contribute positively to our own mental well-being, and that of people around us, through our (science-based) choices of colour and light, on our person and in our environment. Maximising their potential for mental health benefit.

This really is something we do, as individuals and as a society, have control over. We should grab this particular moment of unity, this singular opportunity, to instigate a lasting

enhancement of everyday life, for the good of us all.

Colour and light...

Fantastic potential for happier people.

A happier nation.

The key is selling the big idea to the country.

Inspiring the innumerable spin-off ‘little’ ideas that will ensure its success.

So, how?

1. Launch it as a unifying national initiative in the style of the highly successful “Save the NHS” campaign.

2. Keep it simple.

3. Engage with people’s emotions, hopes and dreams for the future.

4. Explain the principal motivations - Mental well-being first and foremost.

5. Outline the scientific basis. (Employing physical, biological, medical, social and behavioural sciences.)

6. Highlight the full range of other benefits.

7. Provide clear information, guidance, ideas and resources.

Colour and light - Big-picture ideas...

1. WE ALL WEAR CLOTHES.

Let's encourage everybody to wear brighter, lighter, cheerier colours. Let us, as a nation, dispense with the prevailing dark, dull and boring in favour of uplifting brightness and lightness.

2. WE ALL HAVE/BUY STUFF.

Let's persuade the population to choose mood-lightening colours for every single item we use and buy from now on. Everything from computers to cars. Create the demand and business will create the supply. (Boosting the economy, with the myriad benefits that brings.)

3. WE ALL LIVE/WORK SOMEWHERE.

Let's motivate all individuals, businesses and organisations to brighten up their home/work environments. It doesn't take much to make a huge difference. (Again, generating economic activity.)

4. WE ALL INTERACT WITH PUBLIC BODIES.

Let's convince all government bodies and public institutions to go bright and light, wherever appropriate. The happier the interactions between people and authority, the better for society.

5. WE (MOST OF US) ENGAGE WITH TECHNOLOGY.

Let's promote the optimal use of colour and light for mental well-being on all devices, interfaces, software, web sites. Easily done.

The possibilities for uplifting colour and light in everyday life are limited only by our imagination.

For instance (a quick, random brainstorming here), people, businesses and organisations could be inspired to...

1. Display bright and cheerful flowers and plants, inside and outside.

2. Maximise exposure to natural daylight. Engage in mindful sky-watching, outside or through windows. Sunrises, sunsets, blue skies, interesting clouds, stars. Have breaks from work to do this.

3. Initiate schemes to trade in depressingly dull clothes for cheerier ones.

4. Reevaluate 'favourite' colours. Choose new ones scientifically shown to be better suited to mental health. Consider motivations for colour choice, and be open to change, according to what our brains like, as opposed to subjective preferences.

5. Light up the dark, appropriately. The skyline. Buildings. Statues. Architectural features. Pavements. Gardens. Trees. Fountains (creating rainbow spectrums).

With light projectors. Floodlights. Searchlights. Fairy lights. Neon signs. Glow-in-the-dark paint.

6. Incentivise business to transform and improve brand designs and colours.

7. Choose colours (clothes, device settings, environment) according to current activity. Select the best for alertness, concentration, exercise, relaxation, sleep.

8. Wear/display a unifying local/national colour of the day/week/month to forge community cohesion.

9. Eat a greater variety of more colourful food. Brighten healthy but boring foods (like porridge?) with safe natural colourants. Make eating fun for reluctant eaters. Physical and mental health benefits here aplenty.

10. Actively look for the extraordinary colour and beauty in nature, on a macro and micro scale. Providing grounding in the stress of modern life.

11. Optimise the use of colour and light in all building/infrastructure projects.

12. Promote colourful, spirits-raising art/photography/video displays in empty/closed shop

windows.

13. Bring colour to the concrete jungle with wall murals, frescos, authorised ‘graffiti’ areas.

14. Learn and teach colour theory in depth at school. College. Public information posters.

15. Choose brightly coloured animal companions, like tropical fish, or cheery pet clothes, if suitable.

16. Coordinate the colours of houses or buildings in a street. Communities coming together.

17. Redesign school uniforms. Work outfits.

18. Tint spectacles/sunglasses the best colour for mood, if safe and appropriate.

19. Opt for clean, bright white rather than dark hues where colour is inappropriate.

20. Create official post(s) of ‘Colour Champion(s)’ or suchlike to promote the campaign at all levels...

There it is...

A national campaign for colour and light.

A happier, brighter future.

I hope that it is seriously considered for implementation, and results in a significant, lasting, positive impact on our country and our people.

I had fun doing this.

Thank you.

ID: 1848-11 - Category: Health

how to fix healthcare in the US

The broken healthcare system is a common problem in society today. The debate about healthcare issues in the United States and how to fix a broken system has been going on for the past several decades now, with no effective solution to the problem in near sight. It is a significant critical issue that requires serious attention because people get sick every day and emergency situations confront medical facilities at alarming rates. The government has turned its sights on the people, hoping that the healthcare problem will solve itself with the 20th century bureaucracy. The policies the government has put in place have only enriched the political healthcare stakeholders such as the insurance and pharmaceutical companies who see healthcare as a means to enrich themselves. For the economy to get back on its feet, and to improve the standard of healthy living in the country, the healthcare mess must undergo radical surgery.

Healthcare costs in America are some of the highest globally. While other countries are providing free healthcare to their citizens, the United States still grapples with ineffective service provision where one has to pay for healthcare at a cost very high. In order to fix this problem, the government needs to implement such measures as establishing a Universal Healthcare System. This will guarantee universal coverage that provides equitable healthcare to all US citizens. The unified system would mean that more money goes into care, and less into administrative costs (Brown, 2018). The government should also hire more primary caregivers and doctors who focus on preventive ways of curbing health problems. It should also close most medical facilities and hospitals and reassign doctors to home-and-community-based healthcare tasks that help people get well and stay healthy. This is a cost-effective program that will ease the burden of healthcare and reduce costs.

Administrative complications and regulatory significance have also created a backward force in the effort to get quality and quick medical services due to the bureaucratic procedures involved. The government needs to simplify processes for prior authorization, for instance, as in the case of Covid-19 vaccine approval by the FDA, for quick response to emergency and delicate situations. Hospitals and other medical facilities should also regulate their schedules as well to free up some hours weekly in order to allow doctors and primary caregivers to focus on

patients, instead of attending to administrative functions only. This will enhance healthcare provision to all and not just some with the money.

The government should also allow professionals in the field of medical health, such as physicians, to be on the frontline to lead American healthcare and transform the delivery of care, instead of the traditional legal players who do not conform to; better care, better health, and lower costs. This will improve the care system as management by physicians will enhance the evaluation and enactment of policy changes that will improve the lives of their patients, as well as the well-being of the caregivers themselves. Such policy changes as, going where the patient is, will improve convenience and satisfaction, as well as, enhancing the flexibility of the doctors to attend to as many patients as possible. In retrospect, getting a doctor to the patient is a lot cheaper than having an ambulance come two days later, in cases of medical emergencies. Because the physicians are on the lead of the health sector management, they will acquire and use the necessary advanced technologies to improve service delivery.

Access to social determinants of health such as proper food and clean water is another area that needs to be looked into keenly. In order for the government to improve healthcare and to also reduce the per-patient medical costs, it is imperative, therefore, to provide nutritious foods, free of charge, for all Americans living with medical conditions like diabetes, that tends to Fix Healthcare 4 be diagnosed in older people. This will create a system where the health of the older generation is cared for and the prevention of such conditions is enhanced through better feeding. By putting American healthcare on a measurement diet, and hence depending on the performance metrics, the focus will be on how to better care for patients and improve healthcare over time. Every household should have access to clean water to ensure that people are prevented from water- deficiency related illnesses.

Medical principles and ethical codes of practice are another healthcare problem that needs attention. Practitioners in the medical field, including physicians and medical equipment companies, as well as nursing homes have engaged in practices that are against the moral code of conduct. Medical practitioners have fraudulently engaged in billing the government's healthcare program such as Medicare for services not rendered (Dyer, 2015). Medical equipment companies also overcharge for the same. These kinds of practices hinder the

government from providing quality healthcare for the patients due to limited resources and should stop. Physicians should also shun the idea of referring their patients for tests to a laboratory they own. This is because of the vested financial interest they have. Such practices hamper the government's efforts and promise to its citizens of healthcare provision.

The Healthcare problem in the United States is a direct result of a broken system of healthcare management and the failed policies of the federal government. Increasing the quality of care is no doubt the responsibility of the government. Physicians can lead in establishing measures that are necessary to improve the quality of care because essentially value or quality rendered is determined by how medicine is practiced. Other participants in the healthcare system, such as employers, workers, suppliers of medical resources, as well as patients have a role to play in transforming the healthcare sector.

ID: 1765-11 - Category: Health

Give everyone a carbon credits that they can sell for hard cash

There are many people who, like me, could never afford to take driving lessons, buy a car or keep a car. Or go on holiday, domestically or abroad. We are among the materially poorest people in the nation. I am disabled: I suffer from severe arthritis, Crohn's disease and I am on the autistic spectrum (Asperger's). Yet I go everywhere on a bicycle, it is like a wheelchair for me, I can't really get far without it, but even though I hold a Blue Badge, I do not have a car and I can live well without one. I go out on the bicycle in all weather conditions at all times of the year when I am not too ill. What I am trying to say is that if someone like me can manage without a car for leisure purposes then most other people can too. I could easily cycle 20 miles per day on my electric pedelec, and not think anything of it. I can also carry around 50kg of shopping.

On the visible horizon the era of the autonomous vehicle is driving towards us, so I cannot see what excuse people will have for leaving their rusting hulks of complicated metal outside their houses when they should be a able to summon a communally shared "room on wheels" to take them unquestioningly to their desired destination.

I think the government should consider offering to buy back people's driving licences, for life. So if you are willing to give up driving, you will be paid an appropriate sum and you will consent to washing your hands of driving for the rest if your life except in very exceptional circumstances (when you could buy the right to apply for a new driving licence and be retested, such as if you experience severe disablement).

But the main point I would like to make is that every citizen should be given an annual carbon budget made of credits which they can sell, for a good price to other citizens who may wish to carry on owning a car and driving around or flying. The budget should apply to everyone over the age 16, although disabled people should have a higher budget. It should not apply when people who have to drive vehicles for their work, or to pilots and air-cabin staff. This way, people who have no choice but to get around on foot, by bicycle or on public transport, who can rarely, if ever afford a holiday, who are usually the most financially poor in the UK, the most carbon virtuous among us, can sell most of their credits to the highest bidder, and they will profit from their virtue. Theymay even be able to afford a holiday, or to get a better bicycle.

I will not pretend that it is always easy cycling to hospital appointments in the pouring rain in the middle of winter with strong winds in your face, but I do not experience that as a hardship, more as a challenge that makes me glad to be alive, and it enables me to deeply appreciate the sunny days when there are charming zephyrs wafting the scent of meadow flowers as birds sing with joy.

Not being locked into a metal box, blasting out harmful particulates and other toxins which harm children, animals and everyone else, puts you in touch with the beauty of being alive. If you could also get paid for it, why wouldn't everyone want to live like that?

ID: 1687-11 - Category: Health

Integrate Alternative Treatments Into The NHS

The NHS has been struggling to cope with demand for years, and the recent Covid 19 pandemic has pushed it to its limit. Sadly, many frontline workers have been left traumatised, exhausted and wanting to leave.

At the same time, superbugs are predicted to become the number one cause of death by 2050. We can no longer rely on antibiotics, vaccines and other drugs alone to deal with this, and as a result we need to drastically reinvent the way we do healthcare. The combination of a failing NHS and the likelihood of further pandemics in the coming decades is a deadly one. This is why I would urge policy makers to consider integrating alternative treatments into the NHS.

Around 2/3 of the NHS budget is spent on treating chronic conditions. Type 2 Diabetes alone costs the NHS £1m an hour to treat, and yet it's a preventable and reversible condition. Qualified alternative practitioners such as Medical Herbalists, Naturopathic Nutritionists, Hypnotherapists, Osteopaths and Acupuncturists have exactly the right skills to treat these conditions, and are perfectly placed to do so. Virtually all of these practitioners have no choice but to work for themselves, and many lack the business skills needed to sustain their practice. Offering these practitioners an opportunity to work within the NHS benefits everyone. Patients have easier access to specialised treatments which are most likely to help them, Doctors spend less time with patients they can't help, and practitioners have a regular income.

In Asia this has always been common practice. In China, Traditional Chinese Medicine (TCM) and modern medicine work side by side. It's considered negligent to prescribe chemotherapy without herbs to support, and when Covid patients were treated with herbal medicine the mortality rate dropped from 2% to 0.6%. In the UK Medical Herbalists have successfully treated a number of patients with both Covid and Long Covid over the past year, undoubtedly saving NHS resource in the process. We specialise in treating chronic conditions which accounts for a significant amount of NHS spend. These include illnesses like Fibromyalgia, Chronic Fatigue Syndrome and Long Covid which are not easily treatable within the NHS.

In the mid 1990's a study by the Somerset Trust For Integrated Healthcare looked at how Osteopathy, Herbal Medicine, Homeopathy, Massage Therapy and Acupuncture might help patients with chronic conditions. It found that 85% of patients felt better for having used these therapies, and most did not need referral into secondary care. The cost was no more than that

of mainstream care, and patients paid a contribution themselves. Other projects around the country have had similar results, and my personal experience both as a patient and a practitioner supports this.

Other examples of where alternative medicine could support patients include:

- Hypnotherapy being used for pain management, minor mental health problems and addictions.

- Herbal medicine in the treatment of both minor acute conditions such as colds and flu, drug resistant infections, and chronic illnesses.

- Naturopathic Nutritionists to educate, motivate and support people with Type 2 Diabetes in healthy eating. Special diets can be implemented in early stage Dementia too.

- Personal trainers, fitness and dance instructors to help with weight management and mental health through exercise.

- Osteopathy and acupuncture in injury rehabilitation.

Supportive and preventative measures such as healthy eating classes, resilience training, and support groups would also have an important role to play. This would enable larger groups of the population to benefit at the same time.

Taking this pressure off the NHS would free up more resource for areas its best place to work with, such as surgery, emergency medicine, and treatment of more advanced pathologies. Likewise there would be more capacity for dealing with future pandemics. If enough practitioners were available on a daily basis within primary care settings, patients would have fast and easy access to the specialist care they need.

Integrating alternative treatments into the NHS would:

- Drastically reduce pressure on staff and improve their working conditions.

- Drastically reduce the drugs bill.

- Pass more responsibility to each individual for their own health outcomes.

- Offer new job opportunities for qualified alternative practitioners or Doctors/Nurses wanting to leave their profession.

- Improve accessibility of alternative treatments for those who'd like to use them.

- Offer an alternative to those who can't use mainstream treatments, eg, women who need HRT but can't take it for safety reasons.

This is how I would like to see the NHS working over the coming decades, and if herbal medicine could be integrated it would provide further opportunities for farmers and herbal medicine manufacturers as well.

ID: 1646-11 - Category: Health

Health Service is not a party issue but is managed as a cross party service

The Health Service has to stop being a political ball, bounced between the opposing parties but it needs to became a permanent cross party fixture that is managed as such. It also needs to stop being piecemeal and start 'joining up' public health, care homes and acute health. And where good practice is already happening and making a significant difference, ensure it is known elsewhere.

Once a health review of the Covid pandemic has been completed (and don't take years doing it!), it would be time to explore how to 'fix it'.

Use that information to contribute to the new ideas and shape of a revitalised Health Service. It would also include the need to recognise that there are some things that cannot be done on the health service and to make that clear. As stated above, ensure that public health, care homes and acute health remain constantly in the loop.

Instead of 'managers' and politicians making decisions about the long term plans, take time to involve a cohort of people, not always the expected ones (see Matthew Syed, "Rebel Ideas").

Take time. Think long and creatively. Use the resources within the community as there are many, including the patients. Find out what other areas are doing to address issues as there is a lot of good practice already going on. Make sure the computers and systems join up across the service as that's a big problem (Young people often have the skills at a fraction of the cost of consultants!) So many companies re-purposed to help produce equipment during Covid, showing we have the capabilities: involve them in the discussion. A lot of health issues are social issues: build those solutions in. Talk to those with social issues and where health problems are high. While re-thinking, plan for ecological solutions where appropriate.

Money is often the excuse and we're tempted to stop before we begin, but this is part of the creativity that is needed - and there will be ways to save money. Money is available when needed, as the pandemic has shown but longer term financial solutions will need to be developed as part of the project.

It's an exciting and potentially fantastic opportunity if only there was the desire to be creative, a willingness to take the time and rather than score a political point, go for the greater good. The long term result will be enormous.

ID: 1203-11 - Category: Health

How community cohesion can support mental health?

Mental Health presents us with a challenges, especially during the Covid crisis. However, it also provides us with an opportunity to address these long forgotten questions, which includes mental health across the generations and across cultures.

In response to this, communities need to come together to respond together and work together to beat this together. Bring mental health at the forefront and not hidden away in the shadows.

Mental health is weaved through every aspect of life, relationships, challenges and hopes. We all need to find a collective community response that enhances community cohesion and supports mental health.

In my local community, one of the charities called Hope for Sutton which is run by volunteers has provided community befriending services, food parcels, a friendly ear and someone to talk to if you are lonely. The most lonely and isolated people across the community have reached out and the charity has responded by wrapping its' arms around the community. This has created hope for the future. The diversity of volunteers and recipients shows how interconnected the community is and what can be done when we are all in this together. This is just one example of what can be done to enhance bonds and create links to support mental health.

This approach can be used anywhere and everywhere, any community, any location. Everyone can make a difference everyday. This intergenerational solution is based on compassion, hope, faith and charity and these values will be essential for the next five years.

'Everything that is done in this world is done by hope' - Martin Luther King

'Hope is being able to see the light, despite all of the darkness' - Desmond Tutu

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ID: 1009-11 - Category: Health

Harnessing the role of Long-Covid Centres

Approximately 10% of mild coronavirus cases who were not admitted to hospital have reported symptoms lasting more than 4 weeks. This is commonly known as ‘Long Covid’ following substantial research and development into the impact of Covid-19. As a result, it was announced in December that 69 sites would be established to support Long Covid patients access specialist help. There is a real opportunity to capitalise on this infrastructure, to provide

an upscaling of support for other chronic illnesses, particularly post-viral illnesses such as Chronic Fatigue Syndrome (CFS) which share clinical and symptomatic similarities.

Around 15 million people in England have a long-term condition, for which there is no cure and which can be managed with drugs and other treatment. Chronic illnesses have a significant adverse impact on the individual, families, friends, community and the wider economy. They also present difficulties in the availability of healthcare resources to provide adequate support. However, the establishment of Long-Covid centres ought to be capitalised on in a more strategic, long-term, and holistic way. Rather than a rehashing of an ineffective 'quick fix', or a sticking plaster, a primary aim of these centres should include to understand the chronicity of the longer-term problems posed by chronic illnesses. Although those with Long-Covid will require wraparound support and the provision of this service is much needed, without considering how similar chronic illnesses and post-viral illnesses, such as CFS, could be included in this wraparound support would be an opportunity missed. There is also an opportunity to shift and learn from pre-existing conceptions and barriers to services which sufferers of post-viral illnesses face on a daily basis, in accessing healthcare services and referral to community and outreach services.

To demonstrate how this could be achieved, I will focus in on CFS, which is a long-term illness with a wide range of symptoms including sleep problems, extreme tiredness, headaches, among others. There is an expanding amount of research, operating at pace, which suggests that there are similarities between CFS and Long Covid, in their sharing of similar symptoms such as extreme tiredness, brain fog, muscle pain and continuing headaches. For decades, many people with CFS have been dismissed by their doctors, employers and even families with accusations of exaggeration or these being psychosomatic ailments. A significant minority of those with CFS remain housebound or even bedbound, and this presents a significant social issue with consequences for the wider economy, society, and environment.

It is unfortunate, albeit thoroughly encouraging, that the acceptance and shift in public attitudes and clinical research into longer-term illnesses may arrive as a result of Long-Covid. Nevertheless, the social and built infrastructure that will be established as a result needs to account for the symptoms experienced by Long-Covid patients and include a wider cohort of

people who experience very similar day-to-day symptoms.

With viral pandemics potentially becoming a more common occurrence, to be managed across society, the Long-Covid Centres ought to be in place for the long-term, and facilitate the investment in research and development to provide the three following pro-active channels of response:

1. Wraparound care and support for those with Long-Covid AND other chronic illnesses, or those who present chronic symptoms, to invest in long-term solutions to tackle and manage their illness and/or symptoms;

2. To invest in biomedical and clinical solutions and understand the chronicity of the various symptoms to tackle the status quo, which provides a significant social challenge and the removal of a significant cohort of the community from society, and the economy;

3. Invest in research and development to fully understand the drain on healthcare resources and the economy of chronic illnesses, including the emerging Long-Covid, to understand how government action can respond and support those with chronic conditions and ensure that there is a 'open door' policy so that no one is turned away from services based on unhelpful beliefs, a lack of research and the theory of 'deconditioning'.

The experience of CFS has presented a number of weaknesses in behavioural and psychological interventions, which have often proven ineffective at best, and potentially destructive and counter intuitive. Highlighting CFS as a case study helps to learn from other chronic illnesses to avoid a similar path, provide an evidence base to support the effort against Long-Covid, and potentially future viral pandemics. Investment in biomedical and clinical research is essential to develop a robust information base, and which has arguably shone a light on a weakness in the approach of healthcare policy towards longer-term conditions.

To ensure that the healthcare system is robust and can withstand the potential for a substantial increase in more working-age people experiencing chronic illnesses, it must capitalise on the opportunity that Long-Covid Centres present in understanding the experiences of patients and significantly investing in a long-term response.

ID: 953-11 - Category: Health

Helping people reduce or come off medication with known addiction or withdrawal issues.

The pandemic has led to a decrease in mental health and an increase in the prescribing of medication for conditions such as stress, insomnia, anxiety and depression. When these drugs are withdrawn or even reduced the symptoms (“discontinuation syndrome”) can be horrendous. Furthermore, many people use opioids, benzodiazepines and other similar substances which can cause tolerance (requiring ever-increasing dosage) and addiction.

There is a simple solution to this problem. These medications could be licensed in 1mg (scored so that they could be cut in half) and 0.25mg quantities. This would allow GPs and pharmacists to a prescribe precise patient-led dosage and enable tailor-made tapering. It would be very easy to do. For example, my own prescription (escitalopram, an SSRI antidepressant) only comes in 20mg, 10mg and 5mg tablets. But the ideal tapering regime requires reductions of no more than 10% at time. And that is 10% of the current dose, not the starting one. So reducing or coming off these drugs is made harder than it needs to be. Homemade solutions (such as splitting pills or diluting in a titration) is messy and imprecise.

(I am aware that some -- not all -- of these drugs are available in liquid form and in theory that sounds ideal. However I’ve tried the liquid and had a nasty episode: I was on 10mg tablets and so switched to 9 drops (@1mg per drop) then 8, and so on. However, I discovered that taking them on an empty stomach was a very bad idea: I assume that not only was there no pill “filler" to slow the release of the medication but it was also in an alcohol (ethanol) solution making absorption even quicker. So small dose tablets are a much better option.)

A patient could take a combination of smaller denomination tablets to achieve a slow, smooth and steady taper in accurately quantifiable steps. This would also end up saving the NHS money on endless repeat prescriptions.

ID: 919-11 - Category: Health

Turning the NHS COVID-19 app into a wider public health tool

Summary:

The recent shift in attitudes to the role the state should play in preserving people's health is an opportunity that can be seized. We propose transforming the NHS COVID-19 app, with its 20m-strong user base, into a wider public health tool to make society healthier, as well as to reduce pressure on the NHS and the public finances. The pandemic-induced changes in attitude allows the app to be developed in ways that would otherwise have encountered strong resistance, or at least would have led to low uptake and engagement. The app could be developed to serve a number of related and mutually reinforcing objectives, including:

1. Nudging people towards healthier lifestyle choices based on their data;

2. Testing public health interventions;

3. Supporting detection and monitoring of infectious diseases;

4. Improving access to patient records and NHS services;

5. Providing personalised health advice and facilitating early identification and treatment of illnesses.

Detail:

When the intense pressure on health services recedes after the pandemic, the NHS – and the public finances – will continue to face sustained and growing pressure from an ageing

population and a rise in chronic illness.

One of the most important strategies to address this – and indeed, one of the best ways we can prepare against future waves of COVID-19 or new pandemics – is to improve the underlying health of the UK population. As part of that drive, the NHS COVID-19 app could be expanded to serve a broader range of health policy objectives. These include:

1. Encouraging healthier lifestyles, with a view to tackling preventable and costly conditions such as obesity and hypertension (a key objective of the NHS Long Term Plan). The app could inform people about their risk, based on the data they input (about, for instance, their age, lifestyle and exercise habits) and coax them towards healthier behaviour. There might also be scope for "gamifying" health activity, taking inspiration from the mobile gaming industry, which has perfected the art of sustaining people's attention through, for example, carefully designed "reward" systems.

2. Testing the effectiveness of public health interventions. The app could also be a perfect 'sandbox' to gain behavioural insights and improve the effectiveness of government messaging and nudges. For example, before launching a wider obesity campaign, the app might test different messages and notifications on different users to see which ones have the greatest impact on behaviour.

3. Supporting detection and surveillance of infectious diseases. During epidemics (including winter flu seasons), the app could ask users about symptoms they are experiencing, to generate intelligence on the prevalence and spread of infectious diseases. This would simply be a generalisation of the app's existing function to collect information on COVID-19 symptoms (though without the information being used to support Test and Trace).

4. Improving access to patient records and NHS services. To encourage the largest number of

people to retain and use the app, it might be wise to develop functionality that delivers clear and practical benefits to users, such as an effective booking system for NHS appointments. This could be done by combining it with another NHS app that is already set up to do that, but whose reach and take-up (both within the NHS and by patients) is far more limited. To make the app even more useful, users could be given a right to request access to their records on the app, with a concurrent obligation on NHS bodies to make those records available there if patients request it.

5. Providing personalised health advice and facilitating early identification and treatment of illnesses. Gradually, other existing NHS apps such as 'Ask NHS – Virtual assistant' (a symptom check app similar to 111) could also be rolled into the "master" app, since linking functionalities and data will improve all of the services offered by the app. For example:

• The symptom checking function could be made much more powerful and accurate by enabling it to pull data from your patient records.

• Improve the extent to which people act on advice received through the app: for example, if a user received advice to see a GP, they could be taken straight to a booking page for an appointment.

• The data could also enable predictive screening based on machine learning algorithms.

Crucially, the app would ensure patients retain control over what functionalities they want to use; the data they wish to share with the app; and the uses to which that data is put.

ID: 733-11 - Category: Health

Activity needs to be incorporated into day-to-day personal development

Activity should be part of all development plans including education, public and private sector work (PDRs), social and welfare support. A BTLE 9-axis accelerometer to measure steps and VeDBA (vector body acceleration) with battery costs <$1.50 USD and there is no reason why the adult population cannot all be accountable for activity, leveraging today's cheap technology.

GPs are now prescribing activity but, often this is too late. This is not is state control to force exercise. This is the state taking pro-active steps to safeguard the mental and physical wellbeing of the general population. Simple re-purposing of existing infrastructure, adding:

- A secure data vault to the Track and Trace app to monitor active check ins

- Encourage or mandatory wellbeing thresholds to public and private sector PDRs to ensure activity

- Activity as part of universal credit submission and qualification

- Create a govt approved accelerometer subsidised with financial incentives to use it

As we emerge from the pandemic home working will continue as companies have seen increases in efficiency and are saving on logistics overheads. However, the long-term effects of home working are very dangerous and will only manifest when it is too late. It is absolutely IMPERATIVE that we motivate the population as a whole to adopt a healthier and more responsible lifestyle.

The variety of proposals to improve diets, tax sugar, put up barriers to alcohol and tobacco consumption are all laudable but will have limited impact if we have a sedentary population. Introducing activity tracking to the workplace, education and other elements is critical to the nation's overall success, economically and socially.

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Activity tracker

- IP67 - waterproof

- CR2032 Li-Coin battery cell

- BT4LE data transfer

- 9-axis 3D accelerometer

~$1.50 (USD)

Track & Trace Website

- Using the current QR code model to develop incentivised activity programs

- Secure data vault to store and share movement of individuals for PDR/state aid qualification

- Develop big-data modelling to manage national activity, fitness and wellbeing

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ID: 726-11 - Category: Health

COVID Response App - Fighting Isolation, Promoting Education, Facilitating Collaboration

It is thus essential that a national App be created not just to support the government by collecting individuals data in the battle against COVID (such as the NHS track and trace app), but also includes services and support to users in the form of mental health and wellbeing support. This would include daily check-ins for individuals on how they are feeling right now, tips and advice for staying active and of sound body, meditation tips, as well as tackling additional issues as they emerge through the app (i.e. providing sources for healthy eating as obesity rates grew during lockdown). Which such support mechanisms are in existence, they are often focused on just one element, often charge subscription fees and are widely unknown to many citizens. What society needs desperately right now, is a one source solution provided free of charge to guide, advise and listen to citizens regarding matters of physical and mental wellbeing. Taking such an approach would achieve the difficult feat of building trust with users by offering them guidance and support, rather than simply asking them to provide their COVID status as existing apps do. Once this is accomplished, a more unified effort in tackling the virus can take place, alongside the distribution of information to users in an attempt to tackle miss-information on COVID that is widely prevalent right now. Beyond COVID, this app could be used for continuous support, including during winter months, national emergencies and times of social and economic strife in the country, leveraging the apps architecture to adjust the content to align

with the current circumstances. It would not be a one stop shop to solve all citizen needs (i.e finding a job or speaking to a mental health expert), but rather it would engage, inform and direct the user to the required services appropriately. It would also tailor messages to daily specific COVID related information, such as sending users warnings about having house parties on New Years Eve, information on the new COVID variant as its existence became apparent, or providing tips for support on mental health on the most depressing day of the year (Monday 18th January according to statistics). The app could be piloted and tested within a sample group, before being scaled out across councils and the wider nation. It would seek to address the basic question to citizens, what are my 10 biggest worries right now. These range from employment, to anxiety, to balancing child minding and working from home. An in-app survey could gather responses from citizens on how these worries develop and evolve, helping developers adjust the app content accordingly. This would help connect citizens with eachother, shifting the concept of community building from exclusive online communities that are often fee based, to an open and collaborative effort between the state and citizens alike. As countries across the world begin to look at public service delivery in terms of citizen wellbeing (e.g. Scotland and New Zealand introducing a wellbeing budget, focusing the provision of public services around the welfare of the citizen), this initiative would not only serve as a strong policy to counter the effects of COVID on the population, but would furthermore set the foundation for stronger integration of individual welfare into the policy making process across the whole of government.

ID: 661-11 - Category: Health

Provide effective support for the housebound elderly to maximise the use of video consultations

Frail elderly patients account for a significant proportion of GP workload but are the group least likely to cope with video consultations. They are also frequently at risk from avoidable health problems such as dehydration, hunger and failure to take medication properly.

If general practices (or groups of practices) were funded to employ mobile healthcare assistants (mHCAs) provided with iPads/tablets, these individuals could visit vulnerable patients regularly and not only help rectify self-neglect but also facilitate video conferencing.

For example, a GP home visit or hospital admission could be avoided by an HCA:

- checking patient's well-being by means of simple tests, eg temperature, confusional state;

- checking for food, preparing a drink and simple meal, and leaving a flask;

- checking medication status and dealing with problems;

- contacting relatives or Social Services for social needs eg no food, dirty laundry, uncollected rubbish;

- contacting the general practice if a perceived need for a consultation with nurse, doctor, pharmacist or other clinician.

In the early eighties, many of these needs were met by members of the district nursing team, including State Enrolled Nurses (SENs) who have been reinvented as HCAs, and also by Bath Nurses. Since then, initiatives have been introduced to monitor some patients' key health readings remotely but these have been piecemeal. Indeed, similar roles to that of the mHCA described above will be active already in some areas but there is a need a national initiative.

The mHCA role could be developed by apprentice style training as NVQs were used in the early stages of the role's development. No prior nursing experience is needed. Enhanced HCAs can be taught higher skills, such as giving injections, and it is a role with flexible boundaries. In the 1970s, only doctors could do cervical smears but by the 1990s these were universally done by nurses. Similarly, many tasks previously done only by nurses have passed on to non-nurses, such as taking blood samples. Visiting and assessing patients at home, with the benefit of a video link backup, should not require dauntingly high educational standards. A caring person with common sense, reasonable dexterity, adequate literacy and numeracy, and a driving licence (outside dense urban areas) would fit many of the requirements.

Given the costs of an avoidable GP/nurse home visit or hospital admission, the mHCA would, with the aid of pump-priming funding, reduce morbidity and costs and improve the quality of life for all concerned and ultimately prove cost effective - unless mired in bureaucracy!

ID: 591-11 - Category: Health

The media are full of the problem of obesity in this country. Diets are everywhere. This problem causes serious medical issues, mental as well as physical, but it also impacts on unemployment and other areas, consequently costing the country a fortune.

Junk food is blamed and, whilst I uphold that a diet of mars bars is not healthy, I do not think only junk food is to blame.

The following applies to all animal produce but let us take as an example a humble chicken. From the moment a chick hatches it is given food studied to make it gain as much weight as possible in the shortest possible time. This food contains all sorts of additives and hormones. The chicken does grow fast and fat. Then what happens is that we eat the chicken and thus we ingest all the additives and hormones that the chicken was fed. So we grow fat and fast too. It happens in ALL animal food and so in all our food.

Could this not be what is causing this mass obesity?

Now we are out of Brexit would be a good time to test this by banning all intensively reared animals.

It would mean that the price of meat would rise but that could be countered with a farming subsidy eventually financed by the saving to the National Health Service. EVERYONE in the land would benefit.