Northumberland, Tyne and Wear, and North Durham

Draft Sustainability and Transformation Plan (STP)

Report on engagement activity around the vision, principles and approach of the draft STP 23 November 2016 – 20 January 2017

1. Background

In November 2016 health and social care partners in Northumberland, Tyne and Wear, and North Durham published a draft sustainability and transformation plan (STP)

This was one of 44 plans developed across England to enable the implementation of NHS England's Five Year Forward View.

On 23 November 2016 the partners launched a period of engagement to raise awareness of the draft plan and address any concerns about the proposed vision, ambitions and approach to improving the health of 1.7m people living in Northumberland, Tyne and Wear, and North Durham, which was set out in the plan.

In line with best practice guidance this phase of engagement was specifically targeted at civic engagement, which aims to seek the views of community, charity and third sector groups and individuals with an influence on local civic life.

While not the primary focus of this phase of engagement, comments were also welcomed from of individual members of the public, patients and staff who choose to share their views on the draft plan.

The health and social care partners who led the development of the draft STP were clear that this phase of engagement would help to inform the development of the final STP.

2. Approach to Engagement

Each partner organisation took responsibility for engaging with their staff and key stakeholders around the detail of the draft plan. The full plan, a summary document and survey were posted on each organisation's website and publicised via:

- Engagement launch and reminder media releases that were used by the regional media
- information sent directly to community and voluntary/third sector organisations
- details circulated in partner organisations' communication tools for staff eg newsletters, e.bulletins
- information sent to people who had signed up to various patient and public engagement channels run by each clinical commissioning group in the area.

At the same time as this phase of engagement around the draft STP, a number of other engagement and consultation activities were being carried out in the region around other change programmes. This included the future of community hospitals in Northumberland and service change at City Hospitals Sunderland NHS Foundation Trust and South Tyneside NHS Foundation Trust. Engagement activities to support

these change programmes were also used to share information and seek views about the draft STP.

In those areas were other engagement activities were taking place five public meetings were held to give local people the opportunity to discuss the draft plan.

A total of 96 individuals and organisations responded to the survey, which asked the following questions:

- What do you think about the draft STP vision for our area? Is there anything missing or more we should aim for?

- What do you think about our ambitions for what health, well being and services should look like by 2021? Is there anything missing or more we should aim for?

- The Five Year Forward View identifies three main gaps – health and wellbeing, care and quality, funding – what do you think about the proposed actions to address those gaps locally? Is there anything missing or other actions we should take?

- What do you think about the scale of the challenge facing us in making significant improvements to health and well being, services and efficiencies? Are there any actions we could take to make these changes or speed up the rate of improvement?

- We will only achieve these ambitions for our area by engaging local populations, the people who use our services, and the staff that provide care. Have you any ideas of who we can effectively engage with the 1.7m people in Northumberland, Tyne and Wear, and North Durham?

A total of 165 people attended the five public meetings. Each started with a presentation about the draft STP by a senior manager or clinician from the health and social care partners that developed the draft plan. The presentation was followed by facilitated round table discussions that focused on the key questions asked in the survey. This format also gave attendees the opportunity to make any other comment on the draft STP. Detailed notes were made of all the questions, comments and responses given during the meetings.

A further 55 written responses were also received from individuals and the following organisations:

- North Durham Clinical Commissioning Group
- Alzheimer's Society
- British Medical Association
- South Tyneside Health and Wellbeing Board
- Great North Air Ambulance
- Newcastle's Elders Council
- Gateshead Health NHS Foundation Trust
- Durham County Carers Support
- Keep Our NHS Public North East
- Royal College of Physicians
- Newcastle Community and Voluntary Service
- Sunderland All Together Better Board
- Unison
- Royal College of Nurses
- Women's Voluntary and Community Service
- Clinical Council for Health Commissioning
- Local Medical Councils for Gateshead and South Tyneside, and Newcastle and North Tyneside
- North Durham Clinical Commissioning Group's Patient, Public and Carers Engagement Committee
- Tyne and Wear Fire and Rescue Service
- ACORN patient participation group.
- Gateshead Council
- Durham County Council

3. Key themes

This report aims to highlight the main themes that were raised during the engagement for consideration by the health and social care partners responsible for developing the final STP. Full details of all the comments received throughout this phase of engagement are contained in the appendix.

The Vision

The draft STP vision for the area was described as:

- Everyone who lives, works, learns in or visits the area will realise their full potential and equally enjoy positive health and well being
- Safe and sustainable health and social care services that are joined up, closer to home and economically viable

- Local people are empowered and supported to play a role in improving their health and well being.

The engagement phase emphasised that delivery of the draft STP would mean that by 2021:

- the health inequalities in our area will have reduced to be comparable to the rest of the country
- we will have thriving out of hospital services that attract and retain the staff they need to best support their patients
- there will be high quality hospital and specialist care across the whole area, seven days a week.

Few people, who contributed to the engagement, disagreed with the vision and a number commented that the vision was laudable. Some even suggested that the area should aim higher and strive for better health and wellbeing than other parts of the country rather than just working towards the comparable levels.

However there were many questions about how the area's health and social care partners would achieve the vision within the timescales of NHS England's Five Year Forward View (5YFV).

The Engagement Process

Many people seemed unclear about the purpose of the engagement process and a number expressed frustration that the draft STP did not include more detail about how the vision and aspirations for the regional would be achieved.

The majority of people who took part in this phase of engagement wanted to debate the detail of how implementing the vision would affect particular services, with concerns raised about potential changes or loss of current services that they value.

There were a number of negative comments about the format of the full STP with many commenting that it was written in jargon, much of which was not easily understood by people who did not work in health and social care.

There was a clear message from many respondents about the need for an open, transparent and inclusive consultation process that enabled people to be involved in shaping services for the future and able to contribute to an informed debate about the options for the future of the local health and social system.

There were also many offers of help - particularly from third sector and community organisations - to support any future consultation process.

Finance

The greatest level of feedback was around finance and the strongest view expressed by many who commented on the financial aspect of the draft STP, was that the

vision and aspirations were unachievable within the current resources available in the region.

There was scepticism from some responders evidenced by claims that the aim of the draft STP was simply to cut services to save money. Even those people who accepted that the area was facing particular challenges in terms of managing increasing demand for services, stated that more should be done at a national level to challenge the growing funding gap.

A number of responders who accepted that services needed to change suggested that double running costs would be needed to operate existing services while changes were made, particularly in relation to investment in health promotion and education.

There were also a number of questions about the detail of how the draft STP would make the required savings.

Tackling health inequalities

Mirroring the support for the draft STP's overall vision responders also acknowledged the need to tackle health inequalities in the region, with a particular focus on smoking, obesity and exercise.

However even those supportive of such initiatives stressed that such lifestyle changes were unlikely to positively impact on the health of the population and, in turn reduce demand on services, within the timescales of the Five Year Forward View (5YFV).

While there was clear support for the need for initiatives to improve the underlying health of the population, there were questions about the available funding for such initiatives, as well as calls for organisations to work more closely together to learn from successes elsewhere.

Workforce

Concern was expressed by some respondents about the impact of changes in the health and social care workforce impacting on the area's ability to achieve the draft STP's vision.

This included the end of nursing bursaries potentially resulting in fewer people training to be nurses, an ageing workforce, not enough GPs to meet demands, and a perceived lack of quality care staff to support an increasing elderly population.

People were particularly concerned about how the health and social care system could achieve the ambitions of care closer to home and seven day working with the many pressures facing the workforce.

A number expressed fears that if there were workforce gaps the system was unable to fill then greater demands would be put on carers and the voluntary sector, who were also under increasing pressure. These groups asked for the final STP to address those concerns

Geography and access to services

Not unsurprisingly those respondents who lived in rural parts of Northumberland and North Durham raised the ability to easily access services. They were particularly concerned about any service that may move or be centralised as a result of the draft STP, citing very real transport issues for people needing to travel from rural to urban areas and the potential demand on an already stretched ambulance service.

In North Durham respondents also commented on the perception of services in the county being split between two STPs areas – one for the north and other for the south of the county. They raised concerns about services on the borders of the two areas and some were unconvinced about the arguments put forward to justify the separation.

The role of local authorities

A number of respondents perceived the draft STP to be a document focused on health services and questioned the level of involvement of local authorities in its development.

They also raised concerns about the ability of the local health and social care system to be able to achieve the draft STP vision at a time when care budgets were also facing significant pressures.

What does it mean for me?

As described earlier many people who took part in the engagement activity appeared to expect the draft STP to be more detailed in describing changes to services and they wanted to know what it would mean for them and their individual health and social care needs.

Some people highlighted that the draft STP was not specific about meeting the needs of certain groups in society, including people with mental health problems or learning disabilities, young people and carers.

They were explicit in wanting to see the draft STP's impact on those services explained in the next iteration of the plan.

4. Conclusion

This phase of engagement was relatively successful in reaching its core audience – those involved and influencing civic life.

Those that took part raised a number of common themes that should be carefully considered in the development of the final draft of the STP.

Any future consultation should embrace the offers of support made by community, charity and third sector organisations to ensure that a broad a reach of those people living in the area and working in the health and social care system have an opportunity to comment on the final STP.

It would also be helpful to consider the many questions raised by those who took part in this phase of engagement and look at ways of answering those concerns either before or during any planned formal consultation.

Northumberland, Tyne and Wear, and North Durham

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Written Responses from individuals and organisations

All organisations/individuals were contacted to confirm if they would like their submissions shared and given the following options

1. You are happy to have your full submission including your respondent details included and published

Or

2. You are happy for your submission to be published – but would prefer any details that identify you or your organisation to be redacted

Or

3. You would prefer not to have your submission published – but we can list you in the appendix as being a respondent

If no response received options 3 was automatically chosen.

No.	Name	Response Option 1/2/3	Page Number
1	Acorn	1	3-4
2	Alyson Learmouth	1	4-8
3	Alzheimer's Society	3	8
4	BMA	3	8
5	Carole Reeves	1	8
6	Carole Reeves	1	9
7	South Tyneside Council	1	9-11
8	Dave Bramley – Great North Air Ambulance	1	11-12
9	David Herbert	No response – Option 3	12
10	David Jenkins	1	12
11	Elders Council of Newcastle	1	12-14
12	Acorn	1	14
13	Emma-Lewell-Buck	No response – Option 3	14
14	Personal details redacted	2	14-17
15	Gateshead Health NHS Foundation Trust	1	18-22
16	Heather Glenn	No response – option 3	22
17	Heather Graham	No response – option 3	22
18	Iain Cameron	1	22
19	Ian Armstrong	No response – option 3	22
20	Julie Armstrong	1	22
21	Durham Carers	1	

22	Personal details redacted	2	
23	Janet Fraser	No response – option 3	
24	Jeanie Molyneux	No response - option 3	
25	Jeanne McDonald	No response – option 3	
26	Joan Hewitt	No response – option 3	
27	John Evans	No response – option 3	
28	Personal Details redacted	2	
29	Cllr John McCabe	1	
30	Sunderland Health and Wellbeing Board	1	
31	Lesley Hanson	1	
32	Carol Reeves – emailed from Healthwatch – County Durham	1	
33	Mark Husmann	No response – option 3	
34	Not published or named by request of the participant		
35	Royal College of Physicians	No response – option 3	
36	Save South Tyneside Hospital	1	
37	Newcastle CVS	1	
38	Steve Wood	No response – option 3	
39	Steven Ford	1	
40	Sunderland ATB Provider Board	1	
41	Sue Ward	1	
42	Not published or named by request of the participant		

43	Tyne Health	1	
44	Women's Commissioning Support Unit NE	1	
45	Personal Details redacted	2	
46	RNIB	No response – option 3	
47	Clinical Council for Eye Health Commissioning (CCEHC)	1	
48	Sunderland CCG	3	
49	Unison	1	
50	Gateshead & South Tyneside Local Medical Committee and Newcastle and North Tyneside Local Medical Committee – joint feedback	1	
51	Sunderland Local Medical Committee	1	
52	Not published or named by request of the participant		
53	Unite the Union	1	
54	Wes J Scaife	No response – option 3	
55	E Flett	1	
56	Working Links	1	
57	Healthwatch Newcastle	1	
58	Constituents of Newcastle upon Tyne Central	No response – option 3	
59	Nicholas Murrell-Dowson	No response – option 3	
60	Royal College of Paediatrics and Child Health	1	
61	Gateshead Council	1	
62	Durham County Council	1	

1	Acorn STP VISION In general support for the intentions which do aim at improvements to health, wellbeing, and healthcare More communication is needed, especially with patients (and their representative groups), and with the workforce Ensure the maintenance of quality of care, and the individual relationships in local GP practices AMBITION FOR SERVICES IN 2021 Health inequalities are also driven by national factors, such as poverty and relative deprivation, and will therefore impact on the local ambition Within the mental health forward view, lower level mental health issues need to be incorporated at GP practice level The capacity of the workforce to achieve the proposed outcomes must recognise the length of time required to train all medical professionals, the retirement rate of GP's, and the employment conditions of staff vis-a-vis agency workers The commitment to New Care Models of “outside hospital” services should involve patients in their development and monitoring New services should not destabilise existing outstanding GP practices and hospital trusts THE GAPS IN HEALTH AND WELLBEING, CARE QUALITY AND FUNDING Prevention and education for health is the key to all three gaps. Education can include eg Danish children being taught Resuscitation Better health also depends on national government responsibilities, especially taking evidence based action on alcohol (?pricing), sugar and fat reduction by the food industry, and a level of resources for social care able to support the STP There is clearly some scope for co-ordination/simplification in IT systems and other functions, and sharing best practice, to make savings, which could be realised in a non-competitive regulatory future SCALE OF THE CHALLENGE The challenge should be to national government on the scale of the resources needed. {The national funding gap over 5 years is met by a 1p increase in the

	rates of Income Tax} "Invest to Save" Move to ensure existing accountability legislation matches joined up thinking ENGAGING PEOPLE Continuing dialogue with patients and with staff, some still seem unaware of this process Patient representation at strategic, working group and delivery levels, (with support as discussed at "Lancastrian" meeting Wider use of media, e.g. Made in Tyne and Wear TV. Crisp advertising messages in GP practices, sports/swimming centres, libraries, schools, cinema, retail etc etc
2	Alyson Learmonth Sustainability and Transformation Plans (STPs) for Northumberland Tyne and Wear and North Durham (NTWND) and Darlington Teeside Hambleton Richmond and Whitby (DTHRW) I am writing to you in your role as Chair of the North Durham CCG. I understand that the above STPs operational plans and contracts are due to be signed off by 23rd December. I am writing to ask North Durham CCG to consider suspending negotiations leading to a contractual agreement binding them deliver the current Sustainability and Transformation Plans (STPs) for Northumberland, Tyne and Wear and North Durham (NTWND). I believe that the publicly available versions of this STP and that for DTHRW are insufficiently developed to be a robust platform for the next steps. There has been inadequate consultation time with both professionals and the public. There is also inadequate national finance to make the plans work. I will expand on this argument in the rest of this letter. First, I would like to introduce myself. I retired from my post as Gateshead Director of Public Health in 2012. Over the recent 12 months I and family members among us have had more personal contact with the NHS in various forms than at any other time in my life, and I feel immensely grateful to have experienced varied and generally excellent services offered by primary care, acute care, and maternity services. I fear that despite their stated aims of improvement, the pace of change and level of savings implied by these STPs will cause a deterioration in services, which I and other members of the public rely on. When in 2014 Simon Stevens set out his 5 Year Forward View (5YFV), he noted: 'Over the past five years - despite global recession and austerity - the NHS has generally been successful in responding to a growing population, an ageing population, and a sicker population, as well as new drugs and treatments and cuts in local councils' social care. Protected NHS funding has helped, as has the shared commitment and dedication of health service staff – on one measure the health service has become £20 billion more efficient. No health system anywhere in the world in recent times has managed five

years of little or no real growth without either increasing charges, cutting services or cutting staff.'

He goes on to discuss action to close the anticipated funding gap of £30 billion by 2020-21 on three fronts: demand, efficiency and funding. STPs have been developed to plan services on a larger geographic footprint than can be covered by the Clinical Commissioning Groups established by Andrew Lansley in 2012. I accept that this larger footprint is an inevitable consequence of the need to plan many major services for larger populations. At the same time, we need to ensure sensitivity to local populations, identities and needs. STPs should address all three fronts of the 5YFV: demand, efficiency and funding.

County Durham has a particularly difficult task because its population is affected by two different STPs: to the north Northumberland, Tyne and Wear and North Durham (NTWND); to the south Durham, Darlington, Teesside, Hambleton, Richmondshire and Whitby (DDTHRW). I will discuss first issues affecting both STPs, before giving further consideration to each in turn.

The first point to make is that this split deserves major attention. The population of County Durham will, if this goes through, be on the fringes of two urban-centred STPs. There will not be a single provider addressing the majority of population's needs. The NTWND STP states that this decision follows careful analysis of patient flow. The consequence is that integration will be more complicated for services such as social care, education, leisure, planning (including housing), environmental health, and economic regeneration. These services will be responding to two different sets of commissioning requirements, and in some cases working directly with many providers. Is this avoidable? If not, can extra time/resources be allocated to mitigate the potential difficulties this could raise?

There are also severe risks of a discontinuity between the two STP plans. For example if Darlington loses its A and E function, there may be a knock-on effect for Durham, although the intention is for the demand to be absorbed by North Tees. We see no evidence of comparison across the two STPs presented in either.

A second point regarding both STPs is that while they address demand (through enhanced prevention, both primary and secondary) and efficiency, the aspect of funding or investment for change is lacking. Historically it has proved the case that during a transformative change more resources are required. One service cannot ethically be withdrawn during the lead in period while preventive interventions to take effect. The issue of accurate timelines for the turn-round period of savings from prevention to be realised needs to be more rigorously and realistically addressed, especially in the NTWND STP. Since 2014 the requirement for 7 day services has been introduced with additional costs not identified in the STPs, apart from indirectly in some of the tables about hospital configuration for DDTHRW where consultant cover is mentioned in the small print.

The STPs focus entirely on closing the funding gap by 2021: the DDTHRW plan identifies a gap of £281m, or 12.4% of the NHS allocation across the footprint if remedial action is not taken; the NTWND plan identifies a gap of £641m by 2021, which may be as high as £904m from early joint work with local authorities related to health and social care. The 5YFV states that:

The NHS' long run performance has been efficiency of 0.8% annually, but nearer to 1.5%-2% in recent years. For the NHS repeatedly to achieve an extra

	2% net efficiency/demand saving across its whole funding base each year for the rest of the decade would represent a strong performance compared with the NHS' own past, compared with the wider UK economy, and with other countries' health systems. We believe it is possible – perhaps rising to as high as 3% by the end of the period - provided we take action on prevention, invest in new care models, sustain social care services, and over time see a bigger share of the efficiency coming from wider system improvements. The percentage changes required in both STPs is far higher than that indicated as possible in the 5YFV. A third point affecting both STPs is that they have not been able to adequately take into account the effects of austerity on local authority services, and make no mention of the impact of reduced welfare benefits affecting vulnerable groups such as elderly people or those with disabilities. Since public health transferred to the local authorities in 2012, austerity programmes have reduced the leadership and commissioning of many preventive services (stop smoking, obesity, alcohol, sexual health). Austerity also affects many of the services required for a whole system approach to prevention, identified above (social care, education, leisure, planning (including housing), environmental health, economic regeneration). Both STPs include the caveat 'the figures require risk assessment and validation as the plan evolves'. The NTWND STP covers 7 hospitals, 6 clinical commissioning groups, and 7 local authorities. With the caveat that investment funding is not addressed, I support the goals of: improving the quality of care, improving health and wellbeing and ensuring local services are efficient. This STP has the advantage of being supported by a report from the 'Health and Wealth - Closing the Gap in the North East' report of the North East Commission for Health and Social Care Integration (Oct 2016). This report expands of some of the underlying arguments, and begins to identify ways some of the changes may be achieved. For example, it proposes that The Commission recommends that increased preventive spend should be assigned to a dedicated preventive investment fund managed on a cross-system basis and bringing together contributions from all partners who stand to benefit from the expected savings, including central government. The NECA report also identifies examples of the way integration of services may be achieved, focussing on people with Long Term Conditions who as identified in the 5YFV, account for 70% of NHS resources, almost all adult social care services, and a significant and growing element of children's social care. However in picking up on this issue, the STP as noted above, does not give attention to the impact of austerity programmes on local authorities services, nor on the effect of reduced welfare benefits among vulnerable groups in the population. The STP in the Foreword states: 'While our financial sustainability is based upon modelling of the NHS budgetary gaps, it should be noted that work continues with our local authority colleagues to understand and reflect the continuing expected impact of austerity and the specific impacts on the NHS'. This recognition of the gap seems inadequate at the point of signing up to the STP. It is also alarming that on p16 of the STP the 'waterfall diagram' includes £158m unidentified efficiencies for the Providers, and £105m CCG efficiencies,

	in an effort to reduce the estimated £641m funding 'gap'. The DDTHRW plan covers 6 hospitals, 2 ambulance services, 5 Clinical Commissioning Groups (managing other primary care providers, including GP practices), 1 mental health provider and 7 local authorities. This STP is more explicit in making a core proposal to reduce the number of 'specialist hospitals' from 3 to 2, with either Darlington Memorial or North Tees being downgraded to 'local hospital' status. James Cook will be the only full-range specialist hospital: as now, it will have the only Major Trauma Centre, but it will also now have the only inpatient paediatrics (other than short stay). Darlington or North Tees will retain consultant-led obstetrics, but otherwise all the local hospitals "could offer" a wide range of general elective care, surgery, A&E, etc. – but with no firm commitment to maintain that range in the future. The STP predicts massive falls in three of the four hospital activity categories by 2019-20: "consultant-led first outpatient" down 20%, "non-elective" down 23%, and A&E down 22.5% (p.47). However on p48 of the STP the projected savings can be seen to come mainly from these hospital reconfigurations. The STP assumes its governance arrangements are adequate to take forward this plan and states that the next stage is to apply the decision-making evaluation to determine the preferred option for: a.The second specialist emergency hospital (in addition to James Cook) b.The preferred scenario for inpatient paediatrics and local short stay paediatric assessment. c.The preferred scenario for consultant lead obstetric care. Centralising specialist and acute provision in fewer hospitals as indicated on page 14 of the STP, means longer journeys and travel times – not only for patients and visitors, but also for ambulance crews. This applies especially to the rural CCGs covering Durham Dales, Easington & Sedgefield, Hambleton, Richmondshire and Whitby. In addition, when calculating cost savings, the STP takes no account of the increased costs incurred by patients, non-NHS providers, or indeed NHS elements outside the realm of the NHS Trusts and CCGs. By far the most radical change – and one essential if hospital activity levels are to fall - will come from devolving many healthcare services to primary care providers. These would be coordinated through Community Hubs, each serving a population of 30 – 50,000. I support the philosophy behind this, which is to radically reduce demand for hospital care by (a) expanding preventative healthcare to improve general levels of health and wellbeing, and (b) shifting diagnosis and treatment as far as possible to the primary care level. While the STP gives some projected cost savings from this, there is no systematic costing of the investments required to recruit and train staff, and to build new facilities. There are also no clear plans for the development and delivery of these much larger primary care services, nor for the integration of provision by local authorities, charities and non-profits, and private sector bodies such as GP practices. This will be especially problematic in rural areas such as Richmondshire, and Teesdale, both rural areas with sparse populations, poor roads and acute shortages of public transport. Given the additional acute problem of bed-blocking, it is alarming that no detail is offered of exactly how community provision will be coordinated more

	efficiently with hospital provision in the future, although on page 13 we see an expectation of: 'a resilient interface with the community and neighbourhood services to provide: •Urgent care services •Frail elderly assessment •Short stay paediatric assessment •Ambulatory care services •Fast access to diagnostic services •Signposting and transfer to the specialist hospitals, where appropriate' In summary I consider that these plans are not robust enough to 'sign off'. The NTWND STP requires further detail about how its proposed savings will be achieved, and what will happen with the residual funding gap. The DDTHRW plan has not consulted adequately on the implications of its major cost-saving proposals. Neither plan addresses the issue of integration with local authorities, which is essential if the move to community based services is to be successful. Both plans require further national funding if they are to work. Please ensure that the CCG Governing Body are able to address these and other issues to their satisfaction in a timely way, before contractually agreeing to deliver the STP.
3	Alzheimer's Society
4	BMA
5	Carol Reeves I identify the main problem with our NHS as being: UNDERFUNDING The idea that the quality and accessibility of health services will improve while major cutbacks in funding and services are happening is clearly unsustainable and unacceptable. The NDCCG should feed back the widespread dissatisfaction with the STP proposals. There has been zero public consultation or indeed consultation with front-line NHS staff. Meanwhile contracts are being signed on 23/12/16 with a start date of 1/4/17. Any consultation worthy of the name should surely happen before implementation. So-called 'engagement' events staged by the CCG have given virtually no information about the huge changes about to happen. The NTWND's process is particularly opaque, whereas with the 'southern footprint' news of closures of A&E depts and of consultant-led maternity and paediatric services has leaked out. Nobody disagrees with the idea of self-help but we are already pushing the boundaries of timely access to medical staff. I should be grateful to receive a response to my grave concerns about the STP and its implementation.

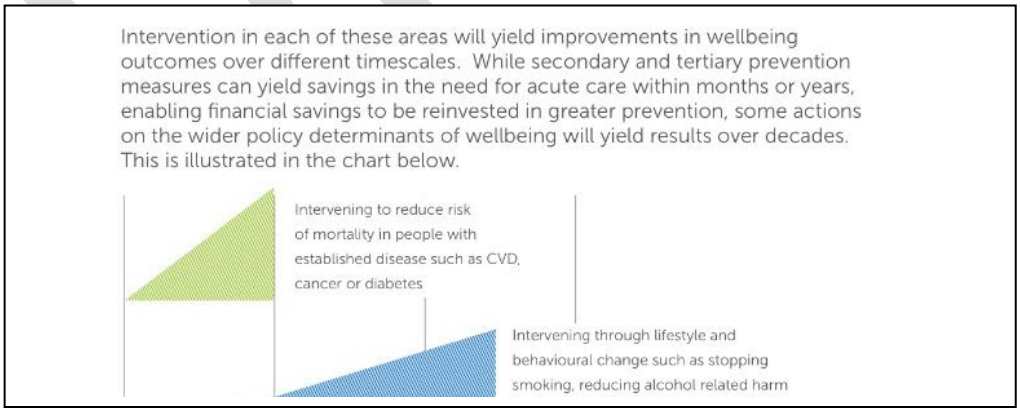
6	Carol Reeves Why is there no apparent role for Durham CC in the oversight of the Northern Footprint.? Why is Sunderland City Council given as the 'local authority'? What sort of consultation will there be with patients in N Durham? Thanks in advance,
7	South Tyneside Council Thank you for your letter of 29 December 2016 in relation to the above. I would also like to reiterate my thanks to you for attending South Tyneside's Health and Wellbeing Board on 8 November to outline the STP plan. Board members appreciated the opportunity to learn more about the plan. It was clear at the Health and Wellbeing Board meeting that the scale of the financial challenge facing the NHS is unprecedented with a £641 million gap if nothing changes between now and 2021. This is obviously compounded by significant financial austerity facing Local Authorities which is impacting on Adult Social Care resulting in a potential additional gap of £263 million and overall gap of £904 million. As a Council we recognise that we have some excellent health and care services across our area. In my own Borough this includes Haven Court a new dementia care facility embedded within the local community. We have also seen some real progress in prevention. This includes an increase in life expectancy and a decline in smoking levels. However, we know that other areas are also seeing these changes and that we need to go further and faster to close the health and wellbeing gap. Significant workforce challenges are highlighted within the STP which is affecting the quality of services leading to the need for change within our health and care services. This includes senior clinical roles such as Stroke Consultants which is having an impact locally but also challenges within Primary Care. Maintaining excellent health and care services as well as accelerating prevention activities cannot be achieved against such a stark financial background. It is recognised within the plan that the majority of what is written is based on existing plans from Local Health Economies. However, it must be recognised that these changes are as a result of reduction in investment which is leaving our health and care services in major deficit. While the plans identify a means to close this huge gap we remain unconvinced that the actions identified will be enough to meet the deficit. Both the NHS and Local Authorities are being asked to do more with less against a backdrop of an ageing population and an increasing number of working age adults with multiple health conditions limiting their life and impacting on their day to day activities.

	It is still a concern of the Local Authority that the STP is a nationally NHS driven planning process rather than an inclusive place based approach. This has left Local Authorities with no meaningful opportunity to engage or influence fully. While the plans make some reference to Health and Wellbeing Boards and Joint Health and Wellbeing Strategies the process has not afforded a truly collaborative approach to the work. The 'footprint' and indeed changing footprint which now sees North Durham as part of the Northumberland and Tyne and Wear plan is a nationally imposed footprint, not one developed from a real need to work together to improve the outcomes for local residents. In addition for our staff within social care, and residents with social care needs, the STP as it currently stands does not address in full the pressure on the system and the need for a drive to improve quality. Health and social care integration is highlighted but the plan does not provide a level of detail to be able to really understand what action is taking place. There is a clear commitment to scaling up prevention and closing the health and wellbeing gap within the NTWND plan with a significant level of detail focussed on priorities and areas of investment. However, there are concerns that due to the major existing deficit within the NHS, that prevention will be overlooked for investment or the re-alignment of resources across the system. The Five Year Forward View and the Mental Health Five Year Forward View makes a clear commitment to prevention. However this must be driven and funded by the NHS with joint leadership with Local Authorities. The care and quality gap identified within the plan also highlights the challenge in relation to variation of care, the pressure for the system in terms of capacity to move to seven day services and the gaps in the workforce. It also sets out a vision for care closer to home, proactive care planning and health and social care and a workforce with increased capacity. Improving care and quality cannot be done without investment and a shift of resources round the system. The NECA NHS Health and Social Care Commission Report developed a financial balance sheet for the NECA working with CIPFA. This identified that £5.2 billion is spent annual on the health and care system in NECA. Over 61% of this is currently on hospital care, 20% on primary care, 16% on social care and 3% on prevention. The ability to invest in primary and social care as well as prevention is very difficult when our hospital sector is under so much pressure and any funding released via changes is required to meet the deficit. We are not breaking the cycle of ill health but unless there is a significant shift in Government funding for health and social care this will remain a real challenge locally. You acknowledge in your letter that South Tyneside and Sunderland have

	their own engagement processes underway for changes to the local health system. A Joint Scrutiny Committee has been established and NHS colleagues are informing both the Scrutiny Committee and the Health and Wellbeing Board of local plans including engagement and formal consultation on any proposed changes. These changes will be extremely challenging at a local level. The STP has brought together system leaders to think about different solutions to the three gaps identified in the plans. Very strong leadership will be required to make the changes required. However even with proactive leadership the challenge, against the health, care and financial backdrop highlighted, will remain unachievable if the NHS and Local Government remain underfunded. What is still unclear in relation to the STPs is what formal sign off process will be required. As a Local Authority we would have real difficulty in signing off the final plan unless the full detail of the plan is made more explicit. Thank you once again for the work you have carried out to date and we trust you will find this feedback useful and continue to work with us to improve health outcomes for our residents.
8	Dave Bramley I am writing as a Consultant in Emergency Medicine and the Chief Medical Officer for the Great North Air Ambulance. I have read with interest the STP, and would like to highlight a potential risk and suggest a way to mitigate this. There are a small number of medical/ paediatric and trauma emergencies where time-critical interventions are essential: even with the 2012 introduction of Major Trauma Centres it was acknowledged that certain cases would not survive the extended journey directly to the MTC, and the Trauma Bypass Pathway stipulates that these cases should be taken to the nearest Trauma Unit. Typically these conditions include acute airway obstruction or ventilatory failure requiring rapid sequence induction of anaesthesia; life-threatening major lung or heart injury requiring resuscitative surgical chest procedures (open chest drainage or thoracotomy); cardiac arrest in pregnancy requiring immediate Caesarean Section; or major haemorrhage requiring immediate resuscitation with blood and blood products. The difficult decision to potentially remove this capacity from smaller hospitals will inevitably result in poorer outcomes and perhaps death for the small numbers of patients who have very high-acuity conditions which can only traditionally be managed by immediate hospital intervention. As you may be aware, the Great North Air Ambulance Service has been providing a consultant-led service capable of delivering all of the interventions mentioned above, at the point of need, for many years, which until recently has been limited to daylight

	hours but entirely funded by charity. Since 2015, a new initiative from the North East Ambulance Service has seen GNAAS providing an overnight on-call service for declared major incidents, and also staffing a "HEMS Car" on Friday and Saturday nights, capable of delivering these advanced interventions through the night. By extending this provision to 7 nights per week, there would then be a consultant-led resource capable of providing the initial time-critical resuscitative procedures at the roadside which would otherwise not be possible. I strongly feel that discussion with NEAS to explore the option of expanding this service would allow significant mitigation of some of the risk associated with reconfiguration of acute services, and would be delighted to discuss this option further and share our clinical outcomes data and governance infrastructure if this would be helpful.
9	David Herbert
10	David Jenkins I am writing to add my support as an emeritus professor of pathology and former medical consultant and manager in the NHS to the request not to proceed with supporting the presently proposed plans for the NHS. I have seen the draft STP for this region and it is clearly totally unrealistic in terms of matching ambition to finance. Any development of the NHS requires a substantial injection of cash liked to a realistic plan addressing all the complex issues the NHS is facing as it still represents a very efficient way of delivering health care, much more so than any further attempt at doctrinaire profit-based privatisation is likely to achieve. The reckless damage has to stop.
11	Elders Council of Newcastle These comments are from members of the Elders Council of Newcastle who are experienced users of health and social care services and have many contacts with older people. We have been involved extensively in commenting on plans and changes in these services. Some of us have attended recent STP presentations and events, and had the benefit of a discussion with Dr. Dan Cowie at our last Working Group meeting. We look forward to further involvement as the Plan is put into action, but would like to comment now on the first draft. In general, we support the STP vision for high quality services, with more action on prevention, and improving wellbeing, but are concerned that these aims can be achieved while at the same time reducing the funding gap. Our response to the key questions posed in your statement is as follows: 1. <u>STP Vision:</u> The vision is laudable and we in the voluntary sector will continue to support activities to promote health and wellbeing in our areas. We must point out, however, that in localities older people are active in promoting sustainable communities, but resources are needed to underpin community action. There's a role for peer to peer information and support, but this always depends on having clear access points to statutory services and clear pathways to joined up services. We would suggest that what is missing here is an understanding of how communities work. If we are to develop strong supportive communities then it is necessary to

	involve people at neighbourhood level, but support is needed. 2. Ambitions for the future: High quality services, both within and out of hospital require more multi-disciplinary working. Our experience is that teams working is the way forward, e.g. as in the reablement service - the six week programme of rehabilitation available to some - but not all - patients following a hospital stay. There are other examples of what works well - so it is important to learn from them. Reducing health inequalities is an ambitious aim - what seems to be missing is a need to work closely with any public health initiatives e.g. on issues like smoking and obesity areas where a health authority needs to work closely with the Local Authority, and the voluntary sector. We are concerned about the workload for GPs and other staff in the community, hence the reference above to team working which may help to spread the load and retain staff as well as offering a good service to patients. 3. Five Year Forward View and Gaps: As well as increasing collaboration between organisations, making best use of services etc., we would point out the crucial role of carers, especially informal or family carers. They are sometimes not fully recognised as being the most important element in a care team and can help to coordinate services between different agencies. As far as we know the ageing population will continue to increase. And we also know that as we age we are more likely to suffer from more than one health condition. Coordinating treatment between specialities - and between services - is an important issue, so having a named key worker is useful especially at times of transition between services. For the future we understand that there is likely to be a 'family care' gap as there will be more people ageing without children, so having a key worker will be more important than ever. Living independently at home for as long as possible is an objective for most of us to maintain our quality of life, and at the same time keeping out of expensive hospital care. To this end we should like to see more recognition of the importance of well designed homes and well designed neighbourhoods to enable people to flourish in their communities. It seems likely there will be some more sheltered housing built - but the majority of us will go on living in the existing housing stock and chosen neighbourhoods, so an area for development may be cooperative housing and cohousing schemes to cater for an ageing population, recognising the strong links between housing, health and care. 4. Improvements and efficiencies: At present, it seems an impossible task to make improvements and at the same time reduce the funding gaps. From an older persons perspective we have made some modest suggestions about the importance of links with other services e.g. public health and housing and the voluntary and community sector, including older peoples organisations - but they will not produce significant savings in the short term. In the meantime we will continue to be engaged in discussions, and in action in our own communities to promote wellbeing.
12	Acorn Prevention and eduction are key. While there is clearly some joined up thinking here, this isn't just a NHS/social care problem. Healthy diets, for instance, could involve ensuring that LHA school dinners are actually healthy and that health education for children and young people is not only specific but can be introduced into other subjects too: in geography, for instance, by exploring who eats what where and the effects of different diets on health and longevity as in the Mediterranean diet or in social history. Some lateral thinking is needed to join up key players outside the NHS box. Getting the press/media on board is important too and on an ongoing basis as is seeking to expand the ways in which patients can be involved in developing and

	delivering the STP - possibly one route being via Newsletters.
13	Emma Lewell-Buck
14	**Personal Details redacted** **RE: Northumberland Tyne & Wear and North Durham Draft Sustainability & Transformation Plan.** **My family and I relocated to the xxxx from the xxxx. The contrast between the two areas in terms of health & wellbeing, wealth and life expectancy is truly shocking. So whilst I welcome the overall aim of the plan (to improve the Health & Wellbeing of the population, improve the quality of acute Hospital care, shorten stays in hospital and to better integrate Health and Social Care) I am not at all convinced that the proposals within the STP will improve matters. In fact I worry that they could make the situation far worse.** **1) Overall the aim of the STP is unrealistic.** It is difficult to imagine how an NHS funding gap of £641million (£904 million including social care) can be achieved by 2021, whilst at the same time scaling up prevention and increasing the availability of services closer to home. Such a major transformation of services would require a significant financial investment and this simply isn't available because Local Authorities have had their budgets slashed. For example Durham County Council had the Public health Grant cut buy £4.3 million in 2016/17 alone and the Drug and alcohol Budget will need to contribute £1.3 million to the reduction programme for 2017/18. (see links below) **Durham C.C Public health Grant cut**. https://democracy.durham.gov.uk/documents/s67882/Item%209%20-%20County%20Durham%20Drug%20Strategy%20Action%20Plan%202014-2017.pdf **Drug and alcohol Budget reduction** https://democracy.durham.gov.uk/documents/s67882/Item%209%20-%20County%20Durham%20Drug%20Strategy%20Action%20Plan%202014-2017.pdf It is particularly puzzling that the STP would aim to save £89m on out of hospital care and £18m in prevention if they are serious about improving these services. However, even if by some miracle this extra money were available, some interventions would simply not reduce the need for acute care in the short or medium term (see chart below). And it would be risky and dangerous to reduce beds, A&E's and Consultant led Maternity Units if the current demand for acute services continued to rise.  **2) Not all of the proposed prevention Stategies are proven to work** Therefore it shouldn't be assumed that there will be a reduction in demand for acute services by implementing such schemes. Take for example the proposal to help people with mental health problems back into work.

Whilst it sounds good in principle, at this stage the North East Mental health and Employment Trailblazer is only a random control study, one of 4 pilot schemes nationally. Only recently started, this will run for two years and test the effectiveness of placing employment coaches with IAPT teams on improving better job entry and sustainability, improved clinical recovery rates.

Whilst I genuinely hope the scheme is successful, there are no guarantees and little evidence to suggest it will at this stage. An earlier 6 month pilot of this scheme only resulted in only 15 paid jobs. 240 people participated in the scheme out of 413 referrals. Data on Mental Health outcomes was only available for

10. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/415177/IPS_in_IAPT_Report.pdf

The budget for the Mental health & employment Trailblazer is 12 million nationally and £2.2 million in the NECA area. Jointly funded by the European Social Fund and Dept of Communities and Local Government, it is anticipated that 1500 people will participate. However in the NECA area alone there are over 46,000 ESA Claimants with a mental health or behavioral condition (of these 9630 are required to seek work), many others who have a mental health condition secondary to another health condition or disability and an estimated 25% of JSA claimants could have some degree of mental health condition. This scheme is rather small considering the numbers of people who require help and if successful the scheme would need to be increased significantly to offer help to have any real impact. See below for more information.

NE Mental Health & Employment Trailblazer – Sunderland Health and Wellbeing Board -July 2016

http://www.sunderland.gov.uk/Committees/CMIS5/Document.ashx?czJKcaeAi5tUFL1DTL2UE4zNRBcoShgo=zQ6tUVEfha7dE0LcxwHkA78DM6sSyV20L8TwwyrPNpoCx8Zl9LtKDg%3D%3D&rUzwRPf%2BZ3zd4E7Ikn8Lyw%3D%3D=pwRE6AGJFLDNlh225F5QMaQWCtPHwdhUfCZ%2FLUQzgA2uL5jNRG4jdQ%3D%3D&mCTIbCubSFfXsDGW9IXnlg%3D%3D=hFflUdN3100%3D&kCx1AnS9%2FpWZQ40DXFvdEw%3D%3D=hFflUdN3100%3D&uJovDxwdjMPoYv%2BAJvYtyA%3D%3D=ctNJFf55vVA%3D&FgPlIEJYlotS%2BYGoBi5olA%3D%3D=NHdURQburHA%3D&d9Qjj0ag1Pd993jsyOJqFvmyB7X0CSQK=ctNJFf55vVA%3D&WGewmoAfeNR9xqBux0r1Q8Za60lavYmz=ctNJFf55vVA%3D&WGewmoAfeNQ16B2MHuCpMRKZMwaG1PaO=ctNJFf55vVA%3D

Q Where would the funding come from to continue this scheme when the scheme is finished?

Q. I would like the STP to make clear that this is just a pilot scheme and to specify that the aim is to help ESA claimants find 'good quality work', because there is evidence to suggest that a transition to poor quality employment can actually be more harmful to patients with mental health problems than remaining unemployed. It would be a counterproductive to lose sight of this. References to the effects of poor and good quality work were also made in the 'Health & Wealth Closing the Gap in the NE' report. Below is further reading.

'The Psychosocial quality of work determines whether employment has benefits for mental health: a longitudinal national household panel survey' Butterworth et al 2011.

This report is Referenced by the NECA document - in a nutshell moving into a poor quality job was more detrimental to mental health than remaining unemployed. (-5.6 vs -1.0)
http://oem.bmj.com/content/early/2011/02/26/oem.2010.059030.abstract

3) Lack of detail on the NTWND leadership and Governance structure.

It is unclear from the STP whether the Leadership Board is fully developed or not. (see image

1). For the purposes of transparency and accountability, it would be useful if the current situation could be clarified. Ideally the chart would include the names of the officials & elected members contributing to the partnership, what organizations' they represent their positions within their respective organisations and position within the Leadership Structure.

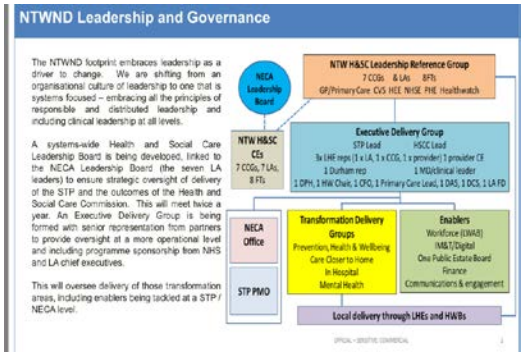


Image 1.

4) It is unclear how much involvement Durham C.C & Tees Esk & Wear Valley Foundation Trust have had in developing these plans.

NHS guidance states that Sustainability & Transformation plans should be jointly developed by Health & Social Care Agencies, yet in an email I received from Durham C.C it states "The Chief Executive has written to the leads for the STPs covering County Durham to clarify that the Council had not had the opportunity to consider the draft plans". It also states "that they do not contain sufficient reference to social care" which I find particularly worrying.

Also the **'NTWND STP Q&A Document'** (see image 2) does not include either Durham County Council or Tees Esk & Wear Valley Foundation Trust on the chart listing the Organisations which form the Partnership.

Q. Please could you confirm whether these two very important organisations have been part of the Strategic Partnership Board that has developed this plan and if so, in what capacity?

3. What is happening in Northumberland, Tyne and Wear and North Durham

The Northumberland, Tyne and Wear, and North Durham footprint covers the boundaries of six clinical commissioning groups and six local authorities

A draft STP has been developed by a partnership of a number of organisations, as detailed below. The work is led by a strategic partnership board made up of senior representatives from many of the organisations working in our local health and social care system.

NHS commissioning organisations	Healthcare provider organisations	Local authorities
Sunderland Clinical Commissioning Group (CCG)	Northumbria Healthcare NHS Foundation Trust	Northumberland County Council
South Tyneside CCG	Northumberland, Tyne & Wear NHS Foundation Trust	Newcastle City Council
Northumberland CCG	The Newcastle-upon-Tyne Hospitals NHS Foundation Trust	Gateshead Council
North Tyneside CCG	Gateshead Health NHS Foundation Trust	North Tyneside Council
Newcastle & Gateshead CCG	South Tyneside NHS Foundation Trust	South Tyneside Council
North Durham CCG	City Hospitals Sunderland NHS Foundation Trust	Sunderland City Council
	County Durham & Darlington NHS Foundation Trust	

Image 2 - 'NTWND STP Q&A Document'

http://www.northdurhamccg.nhs.uk/wp-content/uploads/2016/11/NTWND-Q-and-As-updated-10-11-2016-v3.pdf

5) Insufficient oversight & Scrutiny by Elected Council Members.

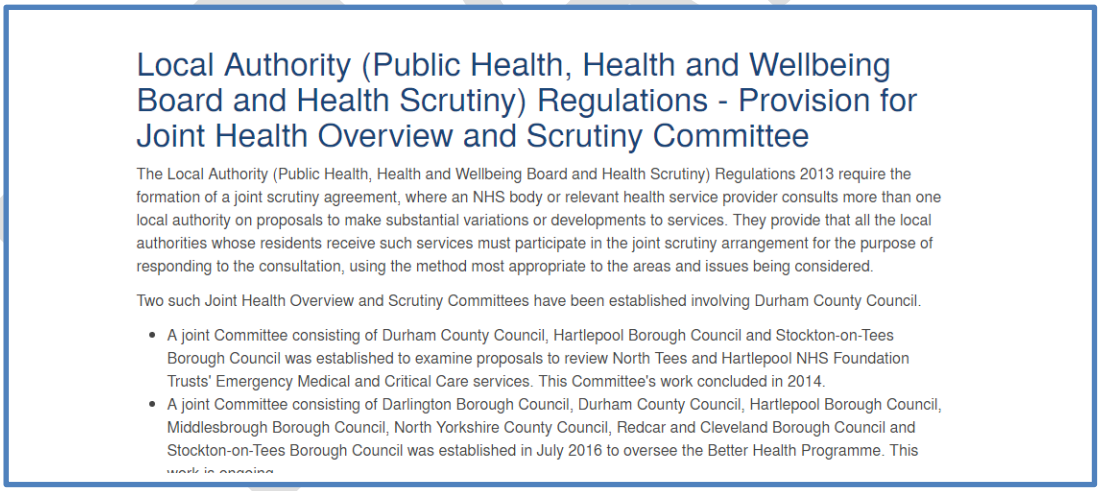
Durham County Council is covered by two NHS Sustainability & Transformation Plans **(STPs)**. Although both will be overseen by the NE Joint Health Scrutiny Committee **(NEJHSC)**, the STP covering South Durham **(DDTHRW STP)** also benefits from having oversight from the 'Better Health Programme Joint Health Scrutiny Committee'. This is clearly unfair as both STP's should be subject to the same degree of scrutiny and residents in both 'Footprints' should benefit from the same level of elected representation.
Each of these Committees is quite different in terms of Protocol & Terms of Reference. The BHP Committee structure is far better suited to the role as it has 3 representatives from each constituent Authority and was specifically set up to look at and respond to the 'DDTHRW STP'. By contrast the 'NE JHSC' has only has 1 member from each Constituent Authority, has a broad remit and is only obliged to hold a full member meeting twice a year. Besides this obvious unfairness, there is also a Statutory duty to establish a joint scrutiny agreement (see image below).
Please refer to the Protocols for each Committee for comparison.

- **Protocol & Terms of Reference for the Better Health Programme Joint Health Scrutiny Committee.**

https://democracy.durham.gov.uk/documents/s70755/Better%20Health%20-%20Agreed%20ToR%20and%20Protocol.pdf

- **Protocol & Terms of Reference for the NE Joint Health Overview and Scrutiny Committee - (see part 4 of the minutes).**

https://www.hartlepool.gov.uk/download/meetings/id/5623/download_the_agenda_and_reports



Local Authority (Public Health, Health and Wellbeing Board and Health Scrutiny) Regulations - Provision for Joint Health Overview and Scrutiny Committee

The Local Authority (Public Health, Health and Wellbeing Board and Health Scrutiny) Regulations 2013 require the formation of a joint scrutiny agreement, where an NHS body or relevant health service provider consults more than one local authority on proposals to make substantial variations or developments to services. They provide that all the local authorities whose residents receive such services must participate in the joint scrutiny arrangement for the purpose of responding to the consultation, using the method most appropriate to the areas and issues being considered.

Two such Joint Health Overview and Scrutiny Committees have been established involving Durham County Council.

- A joint Committee consisting of Durham County Council, Hartlepool Borough Council and Stockton-on-Tees Borough Council was established to examine proposals to review North Tees and Hartlepool NHS Foundation Trusts' Emergency Medical and Critical Care services. This Committee's work concluded in 2014.
- A joint Committee consisting of Darlington Borough Council, Durham County Council, Hartlepool Borough Council, Middlesbrough Borough Council, North Yorkshire County Council, Redcar and Cleveland Borough Council and Stockton-on-Tees Borough Council was established in July 2016 to oversee the Better Health Programme. This work is ongoing

6. Inadequate Public Engagement

I have been very disappointed by the number of the public engagement events that were held, especially as they happened at such a busy time in the run up to Christmas. Only one event was held outside office hours and the venue wasn't even accessible to wheelchair users.
The event I attended in Consett was very poorly attended, with only a handful of people present.

14	**1. What do you think about the STP vision for our area? Is there anything missing or more we should aim for?** The GHNT board of directors is supportive of the overall direction of travel. As an NHS FT the board is committed to working with all stakeholders to deliver this vision. Our objectives as a trust reflect the desire for seamless and integrated care. Working in partnership with colleagues through the Gateshead Care Partnership, to deliver community services in addition to our acute and mental health care provision, we believe we have put in place sound foundations. In delivering the full portfolio of acute, community and mental health services we believe we are well placed to support the empowering of local people and will work with other agencies to achieve this. Our People Strategy reflects our recognition of the importance of our workforce and the need to support their health and well-being. We also take seriously our responsibilities as a major employer in Gateshead acknowledging that the decisions we make impact not only on our staff but their families as well. While the vision is applicable across the STP footprint we believe that there is a need to strengthen and recognise the local elements with the vision clearly defined at each relevant level. To apply the analogy of family our board considers our immediate family to be Gateshead, its residents and other stakeholders; our close family is Gateshead:Newcastle and we look to build and maintain strong relationships across the health and social care economy. Our extended family is the STP footprint and we come together with common interests and issues when appropriate. We feel the plan should be strengthened in its vision and detailed planning to demonstrate how these different components are aligned. In setting the vision it would also be beneficial to be more explicit about what success in each of the three areas described will look like in 5 years time. **2. What do you think about our ambitions for what health, well-being and services should look like by 2020? Is there anything missing or anything more we should aim for?** As with the vision the GHNFT board is supportive of the general direction of travel. **Health inequalities** – the board recognises the need for ambition and supports the intention. However, at the same time, we would suggest that there should also be a sense of realism. Is it truly achievable that health inequality will reduce by the level indicated within the timescales proposed? If so, the plan needs to be very much more specific about how this will be delivered and the resources that will be deployed to support this. We would suggest that a more realistic and honest assessment of the timetable to achieve this should be applied. Aligned to this we are concerned that the Health and Social Care Commission identified a need for a significant investment in prevention for the tangible benefits to health to be delivered. We have seen no evidence of where or how this investment will be made. The financial profile for the STP suggest savings can be taken within the next five years as a result of measures taken nder the broad heading of 'prevention'. At the same time we understand that Local Authorities are reducing their budgets during the period of his plan, including those for Public Health. Consequently, we have reservations regarding the logic

that underpins the assumptions included in this plan regarding both the delivery of improved health and reduced costs to healthcare.

Out of hospital services – the board supports this approach and will work with other stakeholders to achieve it. At the same time we feel there should be more detail on the model to be applied and recognition that this may require significant investment across health and social care – the source of such funding is not yet identified with any confidence. Nor are we convinced that there is any national or international evidence that, by improving out of hospital services and given the NTWD demographic profile, the financial savings envisaged from the acute sector are realistic.

We would like to see more detail regarding the approach to Local Authority services including the risk of reduced services as a result of council budget reductions and how the STP arrangements will minimise these risks. We recognize the benefits of a more integrated approach with social care and are committed to developing this.

In developing out of hospital services we would also like to see more specificity on how the voluntary sector will be used going forward recognising that this will also need investment in management and governance if it is to be as effective as is needed.

The board notes the reference to a PACS or MCP being developed in accordance with national directions of travel and would expect GHNFT to be fully involved in the development of any local proposal in advance of the final STP plan being submitted.

High quality acute care 7 days a week – the board supports this approach and is committed to working with colleagues across the STP footprint in the delivery of this objective.

However, we feel that this aspiration requires considerably more work before the STP presents a detailed proposal of how this can be achieved. Our view is that there is a need for greater clarity about the steps that will be needed to achieve this including recognition of the reality of the workforce challenge (insufficient staff in training to meet all national clinical guidelines), the need to reconfigure existing acute hospital programmes if the 7 day objective is to be delivered, honesty in the STP about the costs of delivering a 7 day service and a clear willingness to engage with all stakeholders about the potential changes that will be required.

3. **The Five Year Forward View identifies three main gaps – what do you think about the proposed actions to address those gaps locally? Is there anything missing or other actions we should take?**

Ill health prevention/improving wellbeing – the GHNFT board is supportive of the approach but as described above feels that there is more detail required to demonstrate how this can be delivered in the proposed timescale with the resources being made available.

Improving the quality and experience of care – at GHNFT we put the delivery of high quality care and patient experience at the heart of all that we do. We believe that with the addition of community services to our portfolio we are uniquely placed to continue to develop and refine an effective integrated care programme in Gateshead.

We are concerned that the level of ongoing cost improvement expected in the current financial hypotheses has the potential to detract from our ability to maintain our levels of

care, experience and access to service.

We are also concerned (as described above) that the availability of a suitably qualified workforce in a number of areas (e.g. A&E and maternity) will require new models of service delivery to be developed if the 7 day challenge is to be achieved.

At present there is insufficient detail in the plan to allow the board to make a judgment on whether the approach is deliverable however laudable the sentiment.

Closing the financial gap – the board fully appreciates the scale and importance of addressing this challenge but is concerned about the reality of the figures included in the financial waterfall chart.

In particular the board is concerned, as described above, that the level of internal efficiency that is required of all providers has not been fully tested and has the potential to have a negative impact on the ability of all provider organisations to deliver the current proposed quality and quantity of service. This concern is included in the Trust's operational plan for 2017-18.

As a provider of Pathology services GHNFT looks forward to developing its state of the art centre to support others across the STP but has not yet fully tested the financial assumptions that are being made regarding system savings.

The financial assumptions regarding the development of out of hospital services, the level of assumed investment and the financial impact on the acute healthcare system have not yet been worked up in detail. As a result the GHNFT board is unable to comment on the validity of the financial hypothesis to close the identified gap presented in the STP submission.

In addition the board would prefer to see the full implications of the Local Authority financial positions built into the analysis – both gap and planned solutions – to allow for a genuine whole system approach to health and social care to be taken.

4. **What do you think about the scale of the challenge facing us making significant improvements to health and well-being, services and efficiencies? Are there any other actions we could take to make these changes or speed up the rate of improvement?**

Overall the GHNFT board recognises the scale of the challenge and supports the general approach of building on existing programmes of work and the vision that is described. However, the board is of the view that more detailed plans are required before comments can be made on whether the actions planned will be sufficient to meet the challenge and the risks that these in turn may present.

The board feels that insufficient attention has been given to the question of risk assessment – both identifying the impact of the do nothing position and the impact of the planned approach (e.g. impact on acute services if funding diverted to out of hospital).

GHNFT is fully committed to working as part of the local health and social care system and to the development of more detailed STP plans. Our view remains that there is insufficient detail in the document at present; it represents a series of aspirations as currently written and for it to be developed into a detailed project plan that can then be assessed and

	commented on should be the priority for the next phase.
16	Heather Glenn
17	Heather Graham
18	Iain Cameron I am a resident of East Boldon and have worked as a doctor in the NHS since 1969 . This STP is badly written , vague and difficult to understand . I believe its bland meaninglessness is intentional and tries to pull the wool over our eyes as regards continuous salami cuts . We spend less on our health than any developed country so when are you going to stand up this right wing government . You must have a difficult job but cooperating with softening up for privatisation should be a step too far for anybody with a conscience . Someone has to stand up to these people ; like Martin Luther you need to say , " here I stand , I can no other so help me God "
19	Ian Armstrong
20	Julie Armstrong Re http://www.sunderlandccg.nhs.uk/wp-content/uploads/2016/11/NTWND-Q-and-As-updated-10-11-2016-v3.pdf 3. CCG's Providers and Councils - is this a mistake? They seem all mixed up.
21	Durham Carers Carers – Nationally and Locally • 1 in 8 adults – 6.5 million people in the UK are Carers - set to increase to 9 million by 2037. ***The NHS has 1.3 employees – Therefore Carers are the biggest Care Provider!*** • Currently over 1 million Carers care for more than one person • Carers save the economy £132 billion per year in Health and Social Care costs (Source - Carers UK) • 2011 Census showed that there are over 60,000 Carers across County Durham **Response to the Draft STP - Durham County Carers Support:-** • Difficult for anyone other than a health professional to respond to the document in its current format as it requires a level of understanding that is out of most people's everyday existence. To quote the Kings Fund. • The NHS 5YFV is a huge document and there is little to attract or invite comment from Carers as there is no separate chapter that recognises their contribution or their situation, or how they will be identified and supported. • Carers are only mentioned **12 times** in the whole report – this is a huge omission as Carers are the largest care provider in the country and save the nation £££££'s • The contribution made to the reduction of health inequalities across the

County by Voluntary, Non-Statutory/Third Sector organisations is not recognised. It appears that they are on the periphery of the draft STP - they will continue to be hampered in providing a constant sustainable service as they are constantly battling for funding - more security is needed.

- Too many acronyms in the report.

In terms of the Challenges that the report highlights:-

HEALTH AND WELLBEING

- Improving the health and wellbeing of the population – Carers have an important role to play in reducing smoking, obesity and alcohol related hospital admissions for the people they care for. In turn Carer Support organisations play an important role in supporting Carers to look after themselves and avoid, or reduce, behaviours that affect their own physical and mental health and thereby their ability to continue to care. Carers are often unsupported, over-stressed and living on very low incomes - many use alcohol and tobacco as coping mechanisms.

- "Getting serious about self-care and prevention" but we found no mention of carer's health and preventing carer breakdown.

- Ensuring every child has the best start in life

Carer Support organisations provide specialist support, advice and information for Parent Carers caring for children with additional needs – for example:-

- To have their child's needs assessed
- To have their own needs assessed
- To be given an EHC Plan
- To receive training to help understand their child's needs
- Specialist advice and support to maintain their caring role
- Support to maintain their own physical and mental wellbeing and that of their family
- Reduce the prevalence of smoking and obesity and reduce the impact of alcohol
- Enhance people's ability to self - care, increase their self-esteem and self-efficacy

- Carer Support organisations routinely signpost to opportunities to help with smoking cessation, obesity, healthy eating, physical activity, maintaining a healthy weight, improving mental health and maintaining wellbeing, alcohol consumption within recommended limits.

CARE SERVICES

- **Improving the quality of care that people receive** – No mention is made of the care that is, and can be, provided within the home by Carers. Confident, supported Carers can reduce the need for hospital admissions and allow people to recover at home or be supported to manage their long

	term conditions. If support for Carers and those they care for was more "joined up" and consistently funded then this would make good financial sense and help to achieve savings. • The report states that 25%-50% of hospital beds are used by people who do not need hospital care. If some of these people were able to be discharged home to confident, supported Carers this would create tremendous savings. **Evidence shows that 25% of readmissions to hospital is due to Carer breakdown and so we would like to see uncompromising actions in place to identify Carers and strongly embedded systems established to ensure Carers have the best support possible at every stage of their caring journey.** **EMPOWERED AND SUPPORTED** • Similarly 66% of people want to die at home but 55% are on an end of life pathway of care in hospital due to lack of resources to support them at home - a lack of Consultants able to administer pain relief medication could be a factor. We appreciate that Carers do not always want this level of responsibility however with joined up support this could become a reality for more Carers and those they care for. This would also be more cost effective than people ending their days in hospital when their wish is to do so in their own home. • One of the proposals in the STP is to discharge people from hospital and assess afterwards. Our experience would say that this will result in a higher number of re-admissions. Yes it would free up a much needed hospital bed but if this means that the bulk of care for that person is then transferred to a Carer who is unsupported and lacks confidence in their caring role a re-admission will result. Carers UK tells us that 25% of re-admissions is due to Carer Breakdown. • Very often it is the Carer that makes the crucial decisions on whether to call 111 or arrive at A&E not the patient. It is at this point that Carers feel vulnerable and unsupported. • Emphasising on getting people back to work with long term conditions appeared in the plan, but it made no reference on how Carers could remain in work should they wish to do so. Is the reason they provide free care! Does supporting the long term unemployed back into work, particularly targeting those with mental health and MSK problems belong in a NHS plan? **We would like to see a greater emphasis on the role of the Carer to enable them to feel better supported to care safely and taking into account their own needs**.
22	Personal Details redacted I have read the public summary document of the draft Sustainability and Transformation Plan and I am no clearer on the specific impact this will have on health and social care in my local area. However, it seems highly unlikely that without significant increases in funding (and certainly not

	with cuts of 64 million in the next 5 years!) the NHS in our area can improve the quality and efficiency of care whilst also launching an improved health promotion programme. Given the direct experiences of myself, my family and friends - poor ambulance response times, reduced inpatient maternity services, chaos at Cramlington Special Emergency Care Hospital, difficulties accessing GPs and non-existent support for those with mental health problems - the comforting words in which this document is couched are no more than 'management speak' which will reassure no one. I appreciate CCGs are in a cleft stick but I would prefer that those tasked with developing these plans joined their staff and an overwhelming majority of the public in calling on the Government to increase funding. These plans have not been based on a thorough and transparent consultation nor have they been debated in Parliament. Yet many of those who are aware of these plans are very fearful that they will further threaten a much loved service that is already in crisis.
23	Janet Fraser
24	Jeanie Molyneux
25	Jeanne McDonald
26	Joan Hewitt
27	John Evans
28	Personal details redacted Please find below my comments on the abovementioned plans: I first became aware of the existence of this plan following a meeting regarding the closure of the hospital beds at Rothbury Community Hospital in the Jubilee Hall, Rothbury in November. In order to respond to the plan, I have had to download a document of 100 pages and, in addition, two further documents of more than 30 pages in order to fully understand some of the terminology and acronyms thrown about in the report. I now note that only four public meetings are to be held to give members of the community an opportunity to discuss - all of them last week, in Hexham, Blyth, Ashington and Belford. And comments are required by 20th January. In my opinion, this is not demonstrating enough willingness to collect sufficient response. There is much to commend in the draft sustainability and transformation plans; particularly the focus on preventative strategies and working in partnership with other public bodies, although there is little detail on how effective partnering could be achieved without increases in staffing levels - would the increased co-operation activity be carried out with current manpower levels? Moving through the Summary Plan 21st October 2016, page 5 sets out a vision of a 'place-based system...' which is, to be frank, not a very good start. A place based system that is the best place...? The following three bullet points make much more coherent sense. However, the two tone blue box in the bottom right hand corner has some very facile and questionable statements. There is nowhere in the rest of the document which explains why, for example, 'hospitals at the centre' should or could be replaced by 'home as the hub', other than for a casual fatuous catchphrase. I'll gloss over the diagram on page 7. I just hope you didn't pay very much for it. Page 9, however, is an excellent summary chart. What it says to me, though, is that a £641m gap across health by 2021, means that you/(we) cannot afford a 7 day service and the current NHS crisis only amplifies that message. We have gone from a relatively healthy, service in 2010 to one, riven with crises where, for possibly the first time, spending per patient has fallen to 6.6% of GDP, much lower than the EU average. I shall refrain from further comments on the liars

	and failures in political leadership, but why don't you make sensible steps to fix the 5-day system before going further? Page 11 refers to savings from provider efficiencies of £241m. In the waterfall chart on page 16, this is split into 'identified' efficiency savings of £83 and 'unidentified' efficiency savings of £158m. That's a rather large guess for 'unidentified'. I can't find any explanation in the document of who these 'providers' are. There is a diagram on page 50 with some little blue circles, but no further detail and no explanation on how these little blue dots will cough up the dosh... Page 14 has a statement that 'hospital-based care has more pathways than closer to home care - poor choice'. This is unclear and confusing - are we talking hospital treatment or social care? In fact the whole page needs rewriting. Page 15; 60% of the savings are 'assumed' to be achieved from efficiencies. I think that most critical financial authorities would cast doubt on being able to reach these. Have a look at the National Audit Office report into the collapse of the UnitingCare Partnership: https://www.nao.org.uk/wp-content/uploads/2016/07/The-collapse-of-the-UnitingCare-Partnership-contract-in-Cambridgeshire-and-Peterborough.pdf Page 21 - 'Maximise the opportunities to integrate Health & Social Care' - I can only applaud, but, on its own it does sound a bit 'motherhood & apple pie'. I'm assuming this is linked somehow with the Northumbria PACS described in pp 47-52, but it's hard to tell as this does not mention Social Care. Perhaps this is deliberate... Page 22 - I can only applaud any efforts to achieve any of this. It would obviously have hugely significant impacts on the NHS. But, at the moment, my experience of the NHS is that we have highly dedicated staff doing their best to provide excellent care in a system which is hugely overstretched - where is the extra funding to achieve all of these aims? It's completely laudable, but I see no evidence that the politicians in charge of the purse strings will come up with anything other than platitudes. Whoops... there I go again... Well you did ask for feedback. Page 23 - This is completely jargon-packed and very difficult to understand by anyone ouside of those who put it together. Does it have the most acronyms on one page? Page 24 - Not easy to understand, but my take on this is that, in future, patients & staff will spend more time travelling. (Although it does say on page 33 that 'a radical hospital reconfiguration will not deliver the financial outcomes we require for a safe and sustainable system'). Page 27 - introduction of Northumberland ACO which, on further reading, is a plan to integrate health & social care. If it works, it is a win-win, particularly during a period of low growth in NHS spending (essentially a reduction) and further cuts to local authority spending. (A significant amount of North Tyneside prevention, health and well being expertise has already been cut in 2016). I wish you well. Page 39-41 - Upscaling prevention, health & well being. I can only applaud your ambitious targets. Maybe a little more focus on mental health? Pages 43-44. New care models. This is where I had to carry out some background reading (NHS England MCP & contract framework July 2016). Too much to digest in too short a time - my

	one overall concern is that, with the timetable envisaged, there is a significant risk of a large number of different MCPs emerging nationally, which would increase fragmentation in the overall national system. Pages 47-52: Northumbria ACO model. I think I have already made my comments on this in a previous paragraph. As I am a resident of Northumberland, I will not comment on plans for other parts of the region. Page 66 - difficult to get the point here - not at all easy to read embedded chart. Page 67 - a challenging list of ambitions - particularly the first one, when, at themoment, hospitals are looking at an increase of 4% in A&E attendance. Page 69 - closing the financial gap - I would be very surprised if you could achieve 25% of the anticipated benefits of a new (not yet introduced) model of care by the end of next year? Page 70. I'm sure you all know what an STF is, but I'm blowed if I do. And twice as much on computers than on cancer care? Page 74. Workforce challenges are touched upon in several places in the document and basically, unless you are successful in staff motivation, recruitment, training & retention, the rest of the ambitions will not be attained. One slightly shocking piece of information which came my way last week was the comment by a friend who informed me that his son, a nursing graduate with a first class honours degree, had started work at the end of last year on a salary of £21,500. Page 80 - another new acronym - NECS?! Page 89 - Out of hospital collaboration. I would only add that you have an under-utilised Community Hospital just ripe for use as a clinical hub for north Northumberland. It is now 9.30pm January 15; I've been working on this for 2 weeks and have just reached the beginning of the delivery plans. I am also away from home 2 days next week, so this is as far as I feel able to comment.
29	Cllr John McCabe Each hospital trust should maintain its own Acute and emergency services. I believe in services being as local as possible and that was the case until the Tory govt has decided that you and the health service will not be funded correctly. I don't accept that case just as my forefathers did not accept dictats such as Adolf hitler proposed. Your scenario is not a cepable to me. Keep services and protest to the govt. That is the way forward.
30	Sunderland Health and Wellbeing Board **Response to the Publication of the Draft STP for Northumberland, Tyne and Wear and North Durham** We welcome the publication of the Draft STP and recognise the need for a radical new solution to address the sustainability of the health and social care system in the region. We recognise the three pillars of the STP – Health and Wellbeing, Care and Quality and Funding and Finance. It is a positive step that the STP specifically acknowledges the need for a “radical upgrade in…ill health prevention” and the need for “a significant cultural shift across all services”, as well as

	that needed by local people; however it also acknowledges these as key "system risks". Given the scale of change proposed we are concerned about the level of engagement to date and that the STP does not allocate sufficient value to social care or provide clarity over finance and systems including how a preventative agenda is to be funded. **Health and Wellbeing** We welcome health and wellbeing being one of the pillars of the STP as this echoes the Sunderland Health and Wellbeing Strategy which sets out a number of design principles in which health equity, prevention and early intervention, independence and self-care and addressing the factors that have a wider impact on health are key. However, the approach in the STP needs to have a more robust population approach to developing a preventative approach to health and social care. As detailed in the October 2016 North East Health and Social Care Commission report 'Health and wealth: closing the gap in the North East', despite having strong health and care services across the region and life expectancy increasing faster than other parts of the country, there are still too many residents suffering from poor health and wellbeing, with many unable to work and trapped in a cycle of poverty. The report goes on to recommend radically increasing spend on prevention which would include the establishment of a dedicated, cross-system prevention fund and including action to tackle inequalities in all policy decisions. Although the STP takes cognisance of this report, it does not deliver concrete recommendations on how this is to be delivered and the level of investment that will be required. **Care and Quality & Funding and Finance** The STP is currently focussed almost entirely on implications for the health sector at the exclusion of local authority and social care sustainability. The locally defined figure of £904 million shortfall includes the efficiencies due to be made in local authorities in social care, but the document bases its financial challenge discussion on the figure of £641 million which is the financial challenge only to the NHS. Proportionately the cuts being faced by the social care sector are deeper and more significant and without a whole system approach to health AND social care the sustainability of the models proposed is at risk, especially one that is focussed on moving care out of hospitals and into communities. All partners in the health and social care system need to be upfront about their efficiency requirements and these need to be factored into the STP alongside a robust model for addressing them as a system. These issues can not be faced in isolation as the sustainability of the system depends on all elements of it having a strong and sustainable future. An honest debate on the extent to which the changes are financially driven needs to occur. **Systems and Structures** 'Health and wealth: closing the gap in the North East' highlights that the only way to achieve the system-wide change necessary to achieve a sustainable health economy is by bringing together local authorities, NHS organisations and the community and voluntary sector through new governance arrangements to drive forward these recommendations. The STP as it currently stands provides no clarity of the systems, structures and governance for such a new way of working. **Engagement** The NHS England document "Engaging local people: a guide for local areas developing STPs" – sets out the expectation and legal basis that HWBB, local authority scrutiny and HealthWatch should all have *already* been an integral part of the process for developing STPs. Although the 3 consultative bodies have been informed of the STP development process and timeline, the overall engagement in the content of the whole STP has been limited to date although there has been engagement on the local content of the plan.

	The listening exercise that was carried out in early 2016 was exclusively an agency approach to the development of STPs and did not include patient or carer voice. Similarly elected members have not been engaged on the content of the STP with only the process behind the STP and broad principles being presented to the HWBB and no engagement with full Council or Cabinet. STP guidance clearly lays out the legislation and obligations we all have (local authorities and the NHS / CCG) to consult at every stage in the design and implementation of services. To date this has not happened in a meaningful way. Greater detail of the public engagement strategy and proposed methods need to be shared with partners. Existing local methods of engagement such as Sunderland's local area committees, publications such as the Vibrancy magazine which goes to every household and online engagement tools used, for example, in budget consultations should be utilised wherever possible to ensure a collaborative approach to maximising the level of engagement. We welcome your response about the issues raised.
31	Lesley Hanson The underfunding of our NHS will lead to a projected deficit of over £641 million pounds over the next five years in the North East alone - it is totally unrealistic to expect that health services will improve in quality and accessibility and, at the same time, try to manage with this huge underfunding. This situation is clearly not acceptable - the CCG needs to be honest, it needs to feedback our total dissatisfaction to NHS England, and it needs to cease the sham STP process forthwith. People are being asked to comment - but on what? We suggest that the language of the STP is only accessible to people working in management in the NHS. Lots of what I read is jargon and has gone straight over my head. People have not been consulted. I suggest that you are simply going through the motions of pretending to give people a chance to give input. STP contracts are being signed by 23rd December 2016, with a start date of 1st April 2017, and it is clear that these contracts will form part of the STP for the locality. Yet, there has been no public consultation. This is wholly disrespectful of the local population. We believe that the signing of these contracts (which form part of the STP for the next two years) demonstrates a willingness to enforce the share of the cuts inherent in the STP. We feel that many of the principles inherent in the STP are questionable. Clinical services are being closed down or amalgamated - with greater distances for people to travel - this is far from making services accessible. How can you state that they are going to be more accessible. People are already starting to struggle to attend Sunderland from places like Jarrow and Hebburn. Walk-In Centres have recently been closed, and there is uncertainty about A and E provision - this is hardly increasing safety and accessibility. Self help is being pushed - yes, people do need to accept personal responsibility for health, but what people ALSO need is timely access to medical and nursing staff, when required, and this is being reduced There are continued references to collaborative and partnership working - we have huge

	concerns around increased fragmentation, poor continuity and privatisation. Doctors are only open 4.5 days a week. Not all pharmacies practice 'Pharmacy First' due to time and staff limitations. Out of hospital access to care is already difficult due to GP hours and lack of pharmaceutical help. So money saved from cuts in hospitals will need to be spent on outside hospital care. How can you expect people to self care and prevent illness when they live in cold damp flats, or depend on handouts from food banks, or are homeless. Not exactly a recipe for a healthy population. Then on top of this you expect disadvantaged people to go trecking around to distant hospitals when they need help. Not painting a picture of a very social society! Disappointed
32	Letter sent from Carol Reeves to Healthwatch Durham I am extremely dissatisfied with the local sustainability and transformation plans being proposed for County Durham. It may not have escaped your notice that the 'local' STPs are in fact identical everywhere and that our local plan like others involves downgrading of A&E departments as well as consultant-led maternity and paediatric departments being stripped of their consultants. In addition these plans are more suitable for a densely populated urban area not for more rural areas with a scattered population and lack of reliable public transport. Public engagement is impossible when the draft plans are written in language inaccessible to the ordinary person. Healthwatch could play a very important role in at least ensuring that the draft STP document is written in plain English understandable to most people. The main figure in the document is the enormous amount of money(£641m) which will have to be saved over the next five years. This imperative precludes any improvement in quality and accessibility, in fact the opposite is true. In an early document outline cuts of one third to one half in services similar to those referenced above were shown. When UHND already see 65,000 patients per year come through their doors and other A&Es such as Darlington and North Tees are already under threat, how is that going to work? We are already being told not to use A&E, UNLESS OUR CONDITION/ILLNESS IS LIFE-THREATENING. Things have come to a pretty pass when other routes, e.g. walk-in centres, are in the process of being shut down. What are people supposed to do if they are urgently ill but not dying? Of course self-help is important, but timely access to medical care is also important and that is being reduced with these new plans, with wards in community hospitals and walk-in centres are being closed. The many references to partnership and collaborative working are not backed up with evidence of any kind. Community 'hubs' serving 50 - 90,000 population are suggested, but there is no flesh on the bones. What specialities/procedures would be covered? Or would it just be a case of increased fragmentation, poor continuity and privatisation. We request thatn the Healthwatch representative on the local Health and Wellbeing Board firmly rejects the STP proposals from the CCG. If Healthwatch aligns then they are colluding with an initiative with which the public has not properly engaged nor been consulted and which will radically diminish our NHS.

	I look forward to hearing from you, Yours sincerely, Carole Reeves writing in a private capacity, but also founder member of Keep Our NHS Public Durham
33	Mark Husmann
34	Not published or named at the request of the partcipant
35	Royal College of Physicians
36	Save South Tyneside Hospital

Save South Tyneside Hospital Campaign **Briefing On Northumbria, Tyne & Wear and north Durham Sustainability and Transformation Plan**

December 5 2016

The *Northumbria, Tyne & Wear and north Durham* Sustainability and Transformation Plan (*NTWND* STP) was finally released on November 9th as a "draft", with "local engagement" of 8 weeks from November 23, before the final plan will be released for "consultation" with the public sometime early in the new year. This is a crucial time where, especially elected members may be expected to sign off a draft plan which will shape the whole future of health and services in South Tyneside and Sunderland before the first phase of the "clinical reviews" are put forward for consultation next year. Already, at the Community Area forums people are being told about the "rebalancing" of "duplicated" acute services to Sunderland because they are no longer "safe or sustainable". This is being asserted without any detailed consultation on the proposals, or independent assessment, or the risks to sustainability and safety to patients if these services are moved from our hospitals. In this briefing we want to redress this balance by raising the questions and answers that show that the STP itself will not "sustain" our NHS and will not "transform" it into a safe health system for patients.

Summary

1. The *NTWND* STP is not a sustainable financial plan. It is the largest cut to the NHS budget ever seen in its history, and is a deliberate attempt to make the NHS unsustainable so that it can be privatised and people charged for care.
2. The *NTWND* STP will not transform our NHS into a safe health system for patients. It is full of policy objectives and models of care that have not been tested first and are not funded. It cuts vital acute services from A&E to full consultant led; ITU, emergency surgery and maternity services in our hospitals. The STP is a plan that will use NHS funding to prop-up the massive cuts to council social funding by massive cuts to health services. This will widen the crisis gap in both health and social care, and is a path to disaster.
3. The *NTWND* STP and its projected massive cut to funding will not close but is more likely to widen the "three gaps" that the STP talks about; health and well-being, care and quality and financial sustainability. No

specifics are given on how ill health prevention services that will take decades to have any effect are to be brought about. These preventative services have been slashed over recent years and new community care models have so far not reduced (in any significant way) acute admissions. They are simply advanced as a policy objective to try and justify reduced funding to acute services.

4 The *NTWND* STP 7 Day working plan will introduce - without increased NHS funding - 7 day elective care, but at the same time the same plan will close vital 24/7 acute and emergency services. This means that those who really need access to 7 day services 24 hours will be put at risk as this funding is reduced.

5 The *NTWND* STP not only fails to include independent impact assessments on health services (or any other service), but none of the documents and appendices that were provided to NHS England have been provided to those who are supposed to assess the impact of the *NTWND* STP.

6 The *NTWND* STP makes no attempt to address the crisis in clinical and medical staff that has been deliberately created but aims to just redesign the existing and diminishing workforce.

7 Whether people can self care, or not this does not abrogate the responsibility of the state to provide fully funded community, and acute mental and physical health services accessible to all.

8 The *NTWND* STP has an ulterior aim of copying highly inefficient but highly profitable US style elective care hospitals and Accountable Care Organisations (ACOs) under the control of merged "public" and private corporations with non profitable and reduced numbers of A&E and trauma hospitals paid for by the public sector.

9 **Summary Conclusion -** The *draft NTWND* STP is an attempt to pull the wool over our eyes and the eyes of clinicians, non clinicians and others alike. It is an attempt to try and justify the largest withdrawal of funding and resources from the NHS in its entire history. No serious plan for the NHS can be decided upon under the threat of such a massive reduction in the budget of the NHS. No draft can be put forward and taken seriously if it starts from the direction of a major attempt to destroy the NHS, further open up privatisation and further create the conditions to make people pay for health and social services. Regardless of peoples' views on the direction for our NHS how can we have a proper discussion on these issues in such a climate. Without establishing public bodies and public services accountable to the people and local communities to provide the services that they need, where health care is a right and its funding is guaranteed, nothing can be properly sorted out. No one should sign up to plans which are intent on massively underfunding, wrecking and privatising health care regardless of the

consequence to the well-being of the people. We are calling on everyone to join with us to block these plans and organise to get people involved in the fight with us to safeguard the future of our hospitals and our NHS.

Sustainability

The *NTWND* STP is not a sustainable financial plan quite the opposite! Just looking at the health budget for all these *NTWND* CCGs, this budget would be reduced to an annual shortfall by 2020/21 of £641m according to the plan. This is a reduction (at the present level of funding) of between 20-30% of the budgets. To put this into perspective, this would mean for South Tyneside, Sunderland and north Durham much more than the resources to run one of the three District hospitals. However, the plan leaves North Durham to be dealt with "from 2019/2020 onwards". Its main concentration up to that time is the South Tyneside and Sunderland and the "urgent need to rebalance services across both organisations as it is no longer safe or sustainable for either organisation to duplicate the provision of services in each location." If almost a third of the expected funding of our National health services both locally and nationally is removed, then all of a sudden hospitals up and down the country will no longer be sustainable or safe. But then neither will it be sustainable or safe for the remaining acute hospitals to treat larger areas that include 100,000s more patients when the expected reduction in acute activity (according to the *NTWND* STP) will only be 1%.[1] In other words it will not be sustainable or safe for people to travel increasingly long distances for services that will be more overstretched than they are now. The "Plan on a page" states that, "Ensuring every child has the best start in life." Yet maximum choice of maternity care will not be maintained at our hospitals and the threat of "reducing duplication" will increase the risk and safety of mother and child if services are not available locally. Also, Accident and Emergency services are often highly used by children – again, reducing the number of full capacity A&E providers will negatively impact on children and families.

The *Autumn Statement*[2] on health and social care prepared jointly by the Nuffield Trust, the Health Foundation and the Kings Fund gives the following as its conclusion on the government's funding and plan for the NHS and its 5 year forward view:

> "The Department of Health's budget will increase by just over £4 billion in real terms between 2015/16 and 2020/21. This is not enough to maintain standards of NHS care, meet rising demand from patients and deliver the transformation in services outlined in the NHS five year forward view. The pressures on the NHS will peak in 2018/19 and 2019/20, when there is almost no planned growth in real-terms funding. While there is significant scope for productivity improvements in the NHS, the huge pressures now being felt right across the health and care system mean that the pace of change required to deliver £22 billion of savings by 2020/21 is unrealistic. New inflationary pressures are also emerging that will increase costs and

> make pay restraint harder to sustain. The government will need to address the NHS funding settlement in future financial statements."

So even, whilst the direction is still the same, these think tanks are telling the government that these plans are not sustainable, or able to transform the NHS in the way that the STPs ostensibly intend. The *Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry*[3] pointed out the devastating effect on the health care in one hospital where management focused on "financial issues". Consider the implications of extending this strategy across our whole health service.

> "It is clear from the evidence at both inquiries that the Trust was operating in an environment in which its leadership was expected to focus on financial issues, and there is little doubt that this is what it did. Sadly, it paid insufficient attention to the risks in relation to the quality of service delivery this entailed."

So, by imposing unsafe and unsustainable funding for all our hospitals will not make them any safer if services are moved to a fewer number of acute hospital sites. This is not only likely to increase waiting times for more overstretched services but it means people have to travel further distances from their communities. This further impacts already overstretched ambulance services, bus services, car parking etc., further exhausting the resources of society and impacting on the most vulnerable.

If real sustainability and safety is the aim then most acute services including Accident and Emergency must be provided at the centre of our communities of South Tyneside and Sunderland (as with other similar towns and their communities) and these services properly funded as a claim of the people on the economy that should be made to serve their needs.

Another argument that is used in the STP on sustainability of services is the shortage of clinical and medical staff. Also, the number of patients that a service treats can be declared insufficient to be sustainable for clinical experience and so on. So, for example the transfer of the South Tyneside stroke unit is argued on the grounds of availability of clinical and medical staff and the number of patients it treats is too low for medical teams to gain necessary experience. However, both STFT and CHS are in an alliance so why are the two stroke units not considered in alliance and that the patients that they treat considered as one unit with one medical team, or a team in an alliance. This would have the advantage of organising clinical and medical teams that would operate both hospital stroke wards and yet would mean easy and safe access for both the people of South Tyneside and Sunderland. This already happens with other services. Once the training of clinical and medical staff is tackled, which should be part of the plan, then this could be reviewed into expanding acute stroke and stroke rehabilitation services to meet the increasing demands over the next decade. To close one overstretched stroke unit and leave another overstretched stroke unit to deal with an increased patient intake could be argued as equally unsustainable, not safe and maybe even worse! How is this direction of the STP going to safeguard the future of NHS stroke and other acute services? There is no desirability, or

capacity for CHS to take the 70,000 annual attendance at South Tyneside A&E, or the capacity to absorb the consultant led maternity services from South Tyneside.

Alex Scott-Samuel in a recent *British Medical Journal* Blog entitled *Tory plans for NHS privatisation released during parliamentary recess* concludes that:

> "it is no coincidence that the House of Lords is currently calling for evidence to be submitted to its new select committee on the long term sustainability of the NHS. This inquiry, supported by government ministers, is likely to make recommendations that will legitimise the aims of Stevens' five year plan, including the 'inevitability' of top-ups, co- payments, charges, and of the short term personal health budgets and longer term health insurance system that would be required to fund them. This toxic combination of an increasingly insurance based and increasingly privately provided health service will signal the final dismantling of what was once our National Health Service in England - a horrific and destructive act, which we now know to have been first proposed by Prime Minister Theresa May's predecessor Margaret Thatcher in 1982."[4]

The *NTWND* STP is not a sustainable financial plan. It is the largest cut to the NHS budget ever seen in its history, and is a deliberate attempt to make the NHS unsustainable so that it can be privatised and people charged for care.

Transformation

Whilst the NTWND STP is a massive downsizing of the budget of the NHS threatening its sustainability is it a transformation plan? Far from it! Health Trusts are simply signing up to these plans to survive and cover the short falls that they have been forced into by the annual cuts to their budgets dressed up as "efficiency savings". So, any "transformation" will be paid for by massive cuts to the acute and hospital services that they now provide. For example, the 2015/2016 independent auditors report for City Hospitals Sunderland pointed out:

> "The Trust expects to have sufficient cash for at least 12 months from the date of our report (31 March 2016) to meet its liabilities as they fall due, but this is contingent upon the achievement of a Cost Improvement Plan (CIP) target of £14.0m (of which £4.9m is yet to be identified) and receipt of additional Sustainability and Transformation Funding (STF) of £10.6m. This STF is contingent upon the achievement of a number of conditions. There is no certainty over the achievement of the 2016/17 CIP nor the conditions attached to the STF, either of which could have a significant adverse impact on the financial performance and cash flows of the Trust in 2016/17 to continue as a going concern."[5]

In other words, without the cuts to their spending via the "cost improvement plan" and the income "transformation money" from the STF the Trust will no longer be able to meet its cash flow at the end of March 2017. This demonstrates that the

Sustainability and Transformation Funding will struggle to be sufficient to enable City Hospitals Sunderland to "continue as a going concern" let alone transform itself to meet a new population of 150,000 from South Tyneside accessing its acute and emergency services.

Delayed transfers, delays to patients in hospital awaiting transfer to further NHS acute and non-acute care, or delays to patients awaiting transfer to social home provision, or awaiting community care packages in their own home are all in crisis because of the massive cuts to local authority social care budgets. According to the government's statistical service:

> "There were 196,200 total delayed days in September 2016, of which 134,300 were in acute care. This is an increase from September 2015, where there were 147,700 total delayed days, of which 97,700 were in acute care. The 196,200 delayed days this month is the highest figure since monthly data was first collected in August 2010."
>
> The data goes on to show; "The proportion of delays attributable to Social Care has increased over the last year to 34.4% in September 2016, compared to 30.8% in September 2015." and, "The main reason for Social Care delays in September 2016 was "patients awaiting care package in their own home". This accounted for 24,800 delayed days (36.7% of all Social Care delays), compared to 15,900 in September 2015. The number of delays attributable to this reason has been steadily increasing since February 2015."[6]

The logic of the government is to supplement the fast disappearing social care budget with the NHS budget which is itself unable to meet the needs of NHS services. The *NTWND* STP admits the "limitation and risk" that: "Local Authority funding pressures and the potential for additional costs across the health and social care economy with respect to such issues as

increases in DTOC (Delayed Transfers) have not been modelled in the financial plan." Therefore what they are advocating in this STP is a further transfer of funds from the NHS budget to social care. This can only further deplete the NHS budget, causing even more chaos and delayed health and social care for patients of all ages.

The *NTWND* STP will not transform our NHS into a safe health system for patients. It is full of policy objectives and models of care that have not been tested first and are not funded. It cuts vital acute services from A&E to full consultant led; ITU, emergency surgery and maternity services in our hospitals. The STP is a plan that will use NHS funding to prop-up the massive cuts to council social funding by massive cuts to health services. This will widen the crisis gap in both health and social care, and is a path to disaster.

The Three Gaps

Mark Adams lead for the *NTWND* STP project claims that: "As a footprint, NHS and Local Authority organisations in Northumberland Tyne and Wear and North Durham (NTWND) have come together to work in collaboration on closing the three gaps of health and well- being, care and quality and financial

sustainability." According to Mark Adams the gaps the *NTWND* STP addresses are:

a. Health and Well-being
b. Care and quality
c. Financial Sustainability

If the *NTWND* STP is not a financially sustainable plan that funds sustainable transformation it cannot close the other gaps the STP talks about. This is also confirmed by the *Autumn Statement* of the Nuffield Trust, Health Foundation and Kings Fund (ibid) in the comments above. The *NTWND* STP consists of a long wish list of health policy objectives that have been articulated previously almost in the exact same terms over many years and have never been realised. In fact the health and social care measures that achieved some advances in preventative health and primary health care in the community have over recent years been almost completely destroyed by the government's irrational austerity agenda and cuts to health, local government public health and social services budgets. For example the reduction of patients with Chronic Obstructive Pulmonary Disease (COPD) are hardly going to be achieved when smoking cessation teams have long been closed down in the period of this and the previous Parliament. No specifics are given on how local clinical services for this will be brought about. The same can be applied to diet, alcohol and many other health improvement initiatives spearheaded by primary health and public health over recent years which have now in the main ceased or been greatly reduced. At the same time, the *NTWND* STP fails to recognise that the cause of chronic illnesses in the northern region is not just down to "lifestyle choices" but to the centuries of industrial production and the harsh environment it produced for working people .

So, how is it when the health and social care funding has been massively reduced can we believe that the *NTWND* STP will suddenly make a break through on these fronts and greatly reduce the number of hospital and acute admissions when such preventative medicine takes decades and sometimes generations to make a difference.

For example, on November 23 at the Prime Minister's Question Time when questioned by the leader of the opposition in Parliament Jeremy Corbyn, Teresa May claimed that the Social care precept and the Better Care Fund would help halt hospital admissions for an underfunded NHS. Every councillor knows that the Social care precept is insufficient to halt ongoing social care service cuts. In July, the House of Commons Health Select Committee pointed out in its report that: "The cuts to public health budgets set out in the Spending Review threaten to undermine the necessary upgrade to prevention and public health set out in the Five Year Forward View. We believe that cutting public health is a false economy, creating avoidable additional costs in the future." Things are no better with the Better Care Fund. In South Tyneside the Better Care Fund uses existing budgets from our hospital and local authority and has not only gone over budget but has not reduced hospital admissions according to the figures released in any significant way.

In other words the claims made in the *NTWND* STP that there will be a

significantly high reduction in hospital admissions is not based on evidence but are highly speculative and should not be trusted.

The *NTWND* STP and its projected massive cut to funding will not close but is more likely to widen the "three gaps" that the STP talks about; health and well-being, care and quality and financial sustainability. No specifics are given on how ill health prevention services that will take decades to have any effect are to be brought about. These preventative services have been slashed over recent years and new community care models have so far not reduced (in any significant way) acute admissions. They are simply advanced as a policy objective to try and justify reduced funding to acute services.

10 Day Working

One of the prime recommendations in the *NTWND* STP is the move to a 7 day NHS. For South Tyneside and Sunderland it says page 29: "The Path to Excellence programme will continue to work to develop plans to deliver better quality care across the local populations and enable the delivery of 7 day services so that key quality standards can be achieved, which will ultimately allow financial stability for both organisations." It says for the "vision" on page 5 "Maintain and improve the quality hospital and specialist care across our entire provider sector- delivering highest levels of quality on a 7-day basis."

On this subject the whole document is as confusing as Jeremy Hunt the secretary of state for Health! Non-elective acute care is already a 7 day 24 hour service barring consistent access to some services such as MRI scanner, etc. at some hospitals. If the STP is proposing to make elective care on a 7 day basis then that is another story. But is such a service going to be funded, or will this lead to the reduction of 7 day 24 hour non-elective acute care. This seems to be the implication and what is being proposed with the downgrading of A&E services to non 24 hour Urgent Care Centres, or closing them altogether. It is both unacceptable and ironic that in order for Jeremy Hunt to declare a 7 day NHS so that the NHS can perform elective work at the weekends, without proper funding those that really need access to 7 day 24 hour services will be put at risk as this funding is reduced.

The *NTWND* STP 7 Day working plan will introduce - without increased NHS funding - 7 day elective care, but at the same time the same plan will close vital 24/7 acute and emergency services. This means that those who really need access to 7 day services 24 hours will be put at risk as this funding is reduced.

Risks

Apart from admitting that there are "Local Authority funding pressures and the potential for additional costs across the health and social economy", there is no independent risk/impact assessment on all of the "top down approach " of the *NTWND* STP. The Kings Fund points out; that they "need to be 'stress-test' STPs to ensure that the assumptions underpinning them are credible and the changes they describe can be delivered."

The *NTWND* STP not only fails to include independent impact assessments on health services (or any other service), but none of the documents and appendices that were provided to NHS England have been provided to those who are supposed to assess the impact of the *NTWND* STP.

Workforce

In the *NTWND* STP aim for health staff there is no attempt to address the chronic lack of clinical and medical staff. It suggests that the aim is just to redesign the existing and diminishing workforce. The workforce summary profile shows that "we will see a reduction in the overall workforce from 42,057 to 40,386. This is a reduction of 1,671 (Whole Time Equivalent) WTE (4%). This will be largely delivered by removing current vacancies, not replacing staff on a like for like basis when they leave in the future and also by using staff in a revised skill mix but within existing staff groups (e.g. nursing assistants, assistant practitioners, advanced practitioners etc.)." They continue that it "still requires an efficiency gain within the hospital based workforce of circa 4% to avoid the current reliance on agency staff to fill current vacancies."

In the community the aim is to "ensure a vibrant Out of Hospital Sector that wraps itself around the needs of their registered patients and attracts and retains the workforce it needs."

But will the NHS attract and retains the workforce it needs? The *Autumn Statement* of the Nuffield Trust, Health Foundation and Kings Fund (ibid.) points out:

> "It will also be very hard to deliver this change without a stable and engaged workforce. Around a quarter of the £22 billion is expected to come from capping pay increases at 1 per cent a year. NHS employees' pay has already fallen by 10 per cent in real terms between 2009/10 and 2014/15. With the fall in the value of the pound over recent months, most economic forecasts now expect inflation to increase. This will make pay restraint harder to maintain as the gap between rising living costs and earnings widens. With the service already struggling to recruit and retain enough staff and morale low among large parts of the workforce, it will be critically important to provide strong support for the 55,000 EU nationals working in the NHS to ensure as many of them as possible stay in the UK.
>
> In this context, with limited funds available to support service changes, cost pressures increasing and huge pressures now being felt right across the health and care system, the pace of change required to deliver £22 billion of savings by 2020/21 is unrealistic.

How is staff recruitment and retention to be improved against this backdrop? The *NTWND* STP makes no attempt to address the crisis in clinical and medical staff that has been deliberately created but aims to just redesign the existing and diminishing workforce.

What is "self care"?

If there is a word that stands out in the *NTWND* STP it is the use of the word "self-care". It is used in an extremely vague way and seems to go with the idea of "home as the hub" and "safe and sustainable health and care services that are joined up, closer to home and economically viable." It seems it is not referring to putting a sticking plaster on a cut, or taking a paracetamol for a headache but much more serious conditions.

In the 2013 consultation to close acute mental health services in South Tyneside and move them to Sunderland, a similar promise was made to provide more accessible community mental health services closer to home. Many mental health patients would probably agree that they are now "self caring." However, many would probably interpret this as not "self care" but "fending for oneself" without professional support most of the time because the service is so overstretched. In fact the *NTWND* STP in its section on *Transforming Mental Health* admits that by 2020/21 only "at least 35% of CYP patients with diagnosable mental heath conditions will receive treatment from NHS funded community Mental Health services" and only "at least 25% with common NH conditions will access psychological therapies each year." This is why it is difficult to believe the *NTWND* STP when it uses the word "self care" and the claim that we will become "empowered and supported people who can play a role in improving our own health and well being."

Whether people can self care or not, this does not abrogate the responsibility of the state to provide fully funded community and acute mental and physical health services accessible to all.

What is the Aim of the STPs?

The *NTWND* STP has an ulterior aim of copying highly inefficient but highly profitable US style elective care hospitals and Accountable Care Organisations (ACOs) under the control of merged "public" and private corporations with non profitable and reduced numbers of A&E and trauma hospitals paid for by the public sector.

Conclusion

The *draft NTWND* STP is an attempt to pull the wool over our eyes and the eyes of clinicians, non clinicians and others alike. It is an attempt to try and justify the largest withdrawal of funding and resources from the NHS in its entire history. No serious plan for the NHS can be decided upon under the threat of such a massive reduction in the budget of the NHS. No draft can be put forward and taken seriously if it starts from the direction of a major attempt to destroy the NHS, further open up privatisation and further create the conditions to make people pay for health and social services. Regardless of peoples' views on the direction for our NHS how can we have a proper discussion on these issues in such a climate. Without establishing public bodies and public services accountable to the people and local communities to provide the services that they need, where health care is a right and its funding is guaranteed, nothing can be properly sorted out.

	The plan whilst hiding all the detail of the "Alliance" between South Tyneside Hospital and City Hospitals Sunderland, claims that there is "the urgent need to rebalance services across both organisations as it is no longer safe or sustainable for either organisation to duplicate the provision of services in each location." SSTHC believes that this is an untrue statement that is deliberately misleading and should be removed from the document immediately. It seems to reveal a systematic intent to close down all services that are duplicated at our two hospitals by claiming that they are "unsustainable" and "unsafe". No such claim has been made by the South Tyneside Foundation Trust, City Hospitals Sunderland or by the inspection body Care Quality Commission (CQC). On the contrary South Tyneside Hospital won a 2016 award and was in the top 40 performing hospitals. Our stroke unit which has already been transferred on a "temporary basis" has won an award for its care over recent years. Our consultant led and community maternity services also are among the top performing in the region. Our staff were praised in the STFT annual report by "recognising the outstanding level of care provided by our staff" which was highlighted in particular by the recent Care Quality Commission inspection. It is the cuts driven by the *NTWND* STP which is clearly calling for the loss of all consultant led acute services including maternity services and not the sustainability and safety record of our hospital. The resulting loss of acute services will be a disaster for the people of South Tyneside and also for the people of Sunderland whose access to acute services will also be under even further pressure by the closure of acute services in South Tyneside. No one should sign up to plans which are intent on wrecking, massively underfunding and privatising health care regardless of the consequence to the well being of the people. Far from being Sustainability & Transformation Plans it is these plans that will create an unsustainable health service with people travelling further and further for even more diminishing NHS services. Health care is a right and the people should decide on the basis that it is a right and it is a claim on the economy that must be guaranteed. We are calling on everyone to join with us to block these plans and organise to get people involved in the fight with us to safeguard the future of our hospitals and our NHS. _____ *1* *NTWND* STP Workforce: When comparing the reductions in the workforce (4%) to the small reduction in the activity (1%) planned within the hospital setting it is important that we recognise this does not reflect a stand still position on the efficiency of the current staff in post, i.e. via the removal of vacancies. *2* *3* *The Autumn Statement:* joint statement on health and social care – November 2016 http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/autumn_statement_kings_fund_nov_2016.pdf 4http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf *4* http://blogs.bmj.com/bmj/2016/08/05/tory-plans-for-nhs-privatisation-released-during-parliamentary-recess/ *5* Independent Auditors' report to the Council of Governors of City Hospitals Sunderland NHS Foundation Trust – March 31 2016 (Included in and referred to in the published version of the Annual Accounts 2015/2016 page 204 and 205) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/542495/SUNDERLAND_Annual_Report_and_Accounts_2015-16.pdf *6* Statistical press notice monthly delayed transfers of care data, England, September 2016 https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/2016-17-data/
37	Newcastle CVS

Response to the sustainability and transformation plan (STP) for Northumberland, Tyne and Wear, and North Durham

Newcastle CVS is the lead infrastructure organisation for Newcastle and Gateshead's voluntary and community sector. As well as developing and supporting voluntary and community organisations to be more sustainable and resilient, we organise networks and events and represent the voluntary and community sector in strategic discussions. We carry our research and produce policy studies. We have over 750 member and associate organisations that are local voluntary and community organisations. This response is based on attendance at meetings related to the STP process and the views of some of our member organisations.

The overall vision should have a much greater commitment to reduce inequalities. We particularly support the commitment to prevention work. However, how these changes are to be achieved within a decreased budget isn't clear. Although there is reference to vanguards and transformation, clearly this level of change cannot be delivered within this timeframe, on decreased budgets, with current contracts signed until March 2019.

There is very little in the document about the role of the voluntary and community sector and how the can contribute to the prevention agenda and care both within and outside of hospital. However the sector should not be perceived as additional or 'nice to have', but instead as being central to health and wellbeing. Volunteering is not a free good, and even when volunteers are delivering services, there is a need for training, support, policies and process. Our experience demonstrates that volunteering works better when there is a safety net.

As an infrastructure organisation, together with our sister organisations throughout the STP area, we are disappointed not to have been actively involved and our expertise, knowledge and contacts should be used in any future engagement processes. We recognise and respect the involvement of Healthwatch organisations, but they do not represent/ reflect the voluntary and community sector but are voices of the public in health and wellbeing.

It isn't clear how real the funding gap is and in the documentation, maybe unsurprisingly, there is no reference to the percentage decrease nationally on health spend of GDP (from 8.8% to 6.6%). Another approach is not just about reducing and changing the service to fit the available resource, but also to increase the funding. There are discussions to be had about hypothecated taxes and increased taxation; and the UK still has a relatively low amount of taxation for such a developed country; as compared to other European countries.

There is also something about the national narrative of the 'failing NHS' and the 'out of date 1940s' model, when the boundaries between health and social care have shifted again, and people are expected to be discharged out of hospital back home where once they would have been sent to a convalescent hospital or long stay units such as the old Walkergate wards, Ponteland, Wylam and Lemington 'hospitals. The use of intermediate care and support is clearly vital to prevent unnecessary admissions and inappropriate discharges. One local power could be the use of health money for social care, as both Gateshead and

	Newcastle Councils have suffered significant loss of funding since 2010. This is clearly a top down process and it isn't clear how much latitude and power exists at the local level. The process seems to be dictated by the centre. There is minimal reference in the documentation to the external funding environment, the impact of welfare reforms, the gross underfunding of the public sector and what happens to the STP area in 2020 when central government support through the Revenue Support Grant to local authorities comes to an end. There are key problems with the NHS infrastructure - IT systems that don't talk to each other, workforce problems that will worsen under Brexit and tougher regulations on immigration, and the poor use of estate. These are clearly areas that need to be overtly tackled. It isn't clear how this fits in with the different organisational structures and their governance. The STP can only work if systems and budgets are shared, this goes against the culture and process of how many parts of the system work - e.g. Foundation Trusts, the independent contractor status of GPs. We welcome the emphasis on prevention, but clearly the majority of prevention work happens outside the NHS, within communities, with voluntary and community groups, and through local authorities. The document still appears to define prevention through formal public health terms and priorities and future consultations needs to look more laterally at this. How can integration with social care happen given the level of cuts of funding for local authorities; which are many times worse than reductions in NHS funding? The figures quoted just look at social care and not the other elements e.g. Housing provision, that also impact on health and wellbeing. How is 'best care' defined; is it realistic to promote best care in terms of dwindling resources? There needs to be active involvement with local people and communities about realistic expectations and what is ‘best’ and what is ‘good enough’. There is not enough in the document about inequalities and the impact this has on health and wellbeing. Given the increasing population, the increased percentage of people with complex needs, in an environment of reduced resources, it is highly likely that inequalities both within and across communities will increase. This means greater demands on resources at a time of reduced capacity. How does the CCG set up the conditions in advance to transform services to support people if there are no resources for double-running / bridging costs? How does transformation take place when existing services still have to deliver to national targets and time frames? Could additional freedoms be requested under the STP process? Mental health provision came up through discussions. There were still a lot of questions about the impact of the Deciding Together consultation, and the concerns that if this (relatively small) part of the service couldn't be changed, how could other parts be shifted?

There need to be discussions about support for people with long term conditions, people with disabilities, people with complex needs and the potential role of voluntary and community organisations in supporting people. There should be more of a focus on holistic care, rather than seeing people as set of conditions. There were a number of examples from the discussions about duplication of tests, people/ carers having to tell their stories / case histories multiple times, and the need to move towards genuine personalization and co-production.

The references to the voluntary and community sector are few and seem an afterthought. We are not just a provider of volunteers but also providers of statutory and other services, advocates for our beneficiaries/ communities, a route into communities and people who are usually excluded (and suffer the worst health and wellbeing) and have a consistent track record of flexibility, reach and delivery. .

The engagement process

A key criticism of the engagement process was the lack of formal proposals. It is a difficult process in which to engage and people will inevitably want detail about what this means for specific services, in particular hospitals, maternity services and Accident and Emergency Departments. In other areas, STPs were more specific as more work has been done previously. It is difficult as it is unclear how more specific proposals can be generated. But the amount of press interest was inevitable. It was suggested this was possibly the result of a lack of on-going engagement with the wider public on a regular basis; the practice locally has been to engage with relatively small groups of people and only consult more widely when there are specific proposals.

As the lead organisation supporting and representing the voluntary and community sector in Newcastle and Gateshead, and with representation on both the Health and Wellbeing Boards in Newcastle and Gateshead, it is not clear why Newcastle CVS was not informed as soon as possible about the public events in January. We were informed through Gateshead Council. We then communicated the information to our member organisations using a variety of techniques, and we think this is why there was a reasonable turnout for the two public meetings in Newcastle and Gateshead.

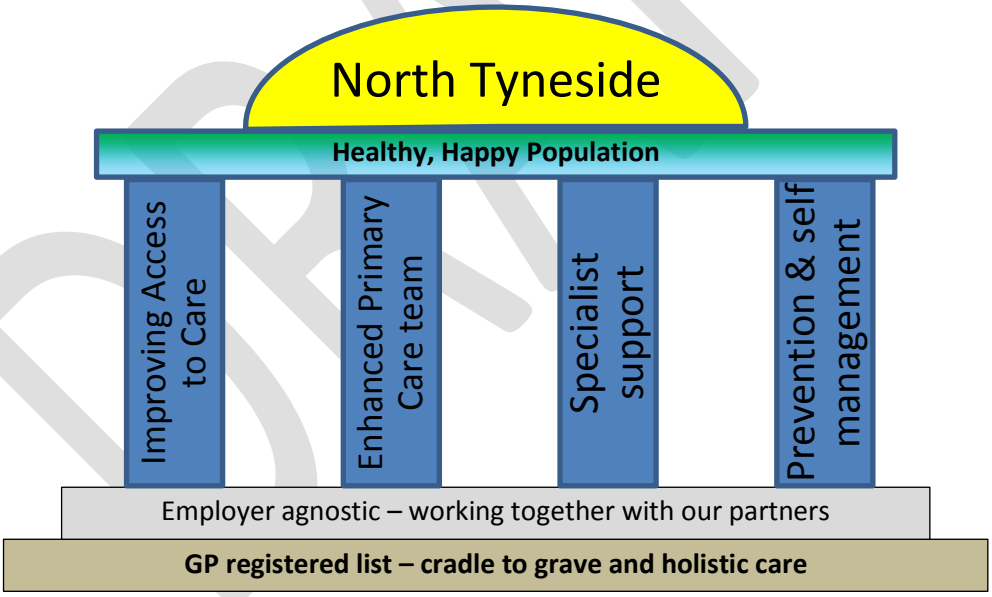
Throughout the process we have heard that there was minimal resource for communication - however it is the choice of the CCGs where and how to invest. We would suggest that community venues are used in the future rather than expensive private venues, e.g. not the Chandelier Room at Newcastle Assembly Rooms. The key purpose of the communication appears to be damage limitation to the NHS reputation, rather than genuine engagement. There is minimal awareness of the STP process among the general public

The general documentation isn't accessible; couldn't there be an accessible / more user-friendly way to provide a summary? There has to be a plan written in the technical format; but an easily understandable summary would have helped, as would a glossary.

	Clearly there is a disconnect between what is currently happening on the ground - e.g. Closures of Walk In Centres in the STP patch and the increases in the number of people presenting at A&E department. How will the Voluntary and Community Sector representatives for the Reference Group be decided? **Summary** We recognise this is an iterative process and would request that Newcastle CVS and our members are involved more actively in future processes so we can all improve health and wellbeing in Newcastle and Gateshead. The voluntary and community sector needs to be involved as a partner, advisor and integral to the process, and not an afterthought.
38	Steve Wood
39	Steven Ford Dear Colleagues For clarity – I am a retired GP. I see from the STP documents that you are leading on the topic of malignancies and new models of care respectively. Please may I offer a suggestion for your consideration: • to shorten time to diagnosis and treatment • improve outcomes • simplify and streamline the pathway • assist the role of primary care • reduce costs From a primary care perspective there are delays in initial diagnosis – simply waiting for results adds a few days. There are delays in the process – initial consultation, tests/protocol items, second (or subsequent) consultations, referral, hospital process/duplicated tests, await treatment, back to primary care... The proliferation of protocols, guidelines etc. is problematic in itself. I suggest that primary care should limit itself to prompt identification of 'red flag' symptoms or signs. Then a same-day referral should be made to a walk-in-with-referral-letter 'red flag clinic' that handles ALL initial presentations of potential malignancies and, there and then, institutes the relevant and current protocol – including all definitive tests on first visit (imaging, endoscopy, biopsies, bloods, stool, urine etc. Everything.). The RFC then triages onward to the relevant specialist/department –either same day or next clinic or arranges immediate admission if required. The new Cramlington Hospital and the local area suggests itself as a suitable site for a trial of the proposal. I look forward to hearing your thoughts and hope this is helpful
40	Sunderland ATB Provider Board

	The Sunderland ATB Provider Board welcomes the opportunity to comment on the draft Northumberland, Tyne and Wear, and North Durham Sustainability and Transformation Plan. Through our governance arrangements we form a comprehensive group of health and social care providers across the City of Sunderland working collectively together to deliver the best possible integrated care for our residents and patients. We have made substantial progress in recent years through the MCP Vanguard to develop and deliver an integrated Out of Hospital care model which has support and commitment at both strategic and operational level across the primary care sector, community care sector, social care sector, voluntary care sector and with the acute and Mental Health/LD care interface. We are also fully supported by and working jointly with our local commissioners to continue to drive forward the model of care and potential establishment of a single OOH MCP. We believe that the history of partnership working in Sunderland, which is long-standing and extremely robust, has contributed significantly to our success in leading and delivering the Out of Hospital integration programme. We note that the draft STP is built upon established programmes of work within each of the Local Health and Social Care Economies within the NTWD footprint as well as additional new proposals for prevention over the next 5 years with common priorities being delivered at an STP level. With the scale of the challenges facing health and social care, we accept the need for common priorities to be addressed, where appropriate, through broader partnership working but we would wish to ensure that this is complementary to (rather than in place of) local developments being scoped and driven forward in line with the needs of the local patch. Our learning and experience from the last few years is that relationships and partnerships are key to both planning and delivering change on the ground. Building trust between partners takes time and effort. It requires understanding of the relevant local issues, circumstances and potential solutions together with a joint sense of commitment and buy-in to scope and deliver transformational initiatives on the ground which will make a difference to both patients, clients, local communities and staff. We do not believe that simply adding another layer of partnership working without taking time to build effective relationships and trust will bring about that critical sense of commitment and unified drive for action and would be interested to understand how this is proposed to be achieved. We note that the draft STP is founded on the principle of: *"A place-based system ensuring that Northumberland, Tyne and Wear and North Durham is the best place for health and social care"* Whilst wishing to support sharing and learning on a wider scale, our reflection on our experience within Sunderland is that securing buy-in from staff to operate differently needs to be led and supported at a local level. Depending upon the change concerned, this might be best led at locality level or at service level or across teams. Based on this experience, we feel strongly that the delivery of this key STP aim will be dependent

	upon local place-based solutions within the NTWD footprint. We would wish to ensure, therefore, that the development of STP Workstreams across the NTWD footprint does not bring with it an additional layer of complexity and duplication which has the effect of preventing local work and initiatives from being scoped and delivered in a way which takes account of local cultures and local experiences/learning. Our hope would be that any additional structures put in place are permissive in nature to enable local decision-making and implementation to continue in the way and at the pace that is relevant and appropriate to the patch. We would value clarification and reassurance on this point. Finally, although the Provider Board has agreed this composite response, individual statutory organisations within Sunderland will also be making formal submissions from their own organsiational perspective. Please do not hesitate to contact me if you would wish to discuss further any of the points above.
41	Sue Ward I am writing to protest at the farce you are going through in drawing up a meaningless, jargon-ridden plan and then pretending to consult on it. Your document spells out that the underfunding of our NHS will lead to a projected deficit of over £641m over the next 5 years in the North East alone. It is simply unrealistic to expect that health services will improve in quality and accessibility while trying to manage with this huge underfunding. I don't understand why responsible people are colluding in this. The CCG needs to be honest, to feed back our total dissatisfaction to NHS England, and it needs to stop this sham process. There are continued references to collaborative and partnership working, when what we face in reality is increased fragmentation, poor continuity and privatisation. The language of the STP is only accessible to people working in management in the NHS, presumably because hiding behind jargon allows you to disguise the fact that this is actually a manifesto for cuts. And it is a manifesto being implemented without real consultation or discussion. STP contracts are being signed by 23rd December 2016, with a start date of 1st April 2017. We believe that the signing of these contracts (which form part of the STP for the next two years) demonstrates a willingness to enforce the share of the cuts inherent in the STP This is disrespectful towards taxpayers and no-one has given you a mandate to do this.. Walk-In Centres have recently been closed, and there is uncertainty about A and E provision. Proposals that clinical services should be closed down or amalgamated will mean greater distances for sick people and those wanting to visit them to travel. All this is the opposite of making services accessible. There are warm words in the document about self help. I agree that people need to accept personal responsibility for health, but what people ALSO need is timely access to medical and nursing staff, when required, and this is being reduced. Just to take one example, recent research has shown that many parents do not realise their children are obese until it is pointed out to them by medical practitioners. How are they going to find out without access to such practitioners, and how much extra will that cost the NHS over the child's lifetime? I would be grateful for a response to this.

43	Tyne Health Comments were invited to the Northumberland Tyne & Wear and North Durham Sustainability and Transformation Plan. TyneHealth is delighted to take this opportunity. In our response we address the key gaps that the STP is trying to bridge by 2020: ▪ Prevention, health and wellbeing ▪ Care and Quality (Out of hospital collaboration/use of acute sector) ▪ Funding and finance TyneHealth is a GP federation for all 29 GP practices in North Tyneside, with a combined registered population 217,000. TyneHealth, Newcastle and North Tyneside LMC (Local Medical Committee), and North Tyneside CCG have developed a Primary Care Strategy[i] during 2015/16, and are implementing it jointly. This Tripartite Primary Care Strategy informs this response. ## North Tyneside is an outstanding health area North Tyneside is a semi-urban geography and population density, similar to Newcastle which it borders, and uses the secondary and tertiary services of three Outstanding (CQC rated) Foundation Trusts which are all headquartered outside of North Tyneside. North Tyneside includes 5 CQC-rated Outstanding GP Practices (17%), which stands out compared with an average across England of 1% of practices rated as Outstanding and 4% across the North East region. North Tyneside has a considerable range of healthiness, morbidity, and deprivation, including relatively affluent (and healthy) and deprived (typically with higher levels of chronic disease) wards.  The Tripartite Primary Care Strategy aims to maintain, support, and where necessary, improve the health, wellbeing and happiness of the population. It's about strengthening communities – supporting groups (localities) of practices and the community and specialist services working with them around the natural communities of the population. TyneHealth believes that patients benefit from continuity of care. The relationship between the patient and their GP practice (**the GP Registered List)** means that we can help to deliver lifestyle changes and diagnosis/ treatment based on the patient history. We believe that, through this relationship, we can deliver programmes of support and prevention and so create well-being. We believe that patients can benefit if their GP practice has the **Prevention, Health and Wellbeing**

skills at the first point of contact to direct patients to the most appropriate support, whether it's the correct practitioner within the practice, or one of a myriad of practitioners and specialist teams (including memory clinics, get active groups and parenting support as well as statutory services) in the community.
TyneHealth believes that a collaborative, community approach to supporting the population not only offers better flexibility, it also means better care, and faster implementation of innovation. We therefore aim to work with our partners and remain **Employer agnostic** in how care is delivered.

Improving Access to Care

The 29 GP practices across North Tyneside provide around 1.3million clinical patient contacts per year – that's almost 5,000 per day. At times when other services are under pressure, such as the two weeks which include Christmas and New Year, GP practices replace some routine appointments (for managing chronic conditions to maximise mobility and quality of life, which promotes independence) with same-day bookable (equivalent to walk-in) at over 800 same-day bookable face-to-face consultations per day in addition to the telephone contacts, home visits, and the routines.

Care and Quality

There are three A&E sites accessible to the population of North Tyneside (1 within the boundaries) and one Walk-in Centre. These anonymous access points may treat every person as a medical problem with a medical solution (many are actually social or mental health), and may encourage a reactive response to patient condition.
TyneHealth is working with the GP practices, other providers of primary care, community services including social care and the Voluntary Sector, secondary care and the LMC and CCG to develop both extended hours (8-8 7 days) and in-hours same-day booked access to services booked into from their registered GP practice.

Enhanced Primary Care Team

It's acknowledged that there's a shortage of GPs. TyneHealth believes that the answer to retaining GPs is not to pressure them further, but rather to create a mix of skilled care professionals (Pharmacists, Physios, Counsellors, Advanced Practitioners, Physician Assistants etc) who can manage the patient's condition effectively.

Care and Quality

We're developing Multi-speciality Community Provider[ii] models (in the form of Primary Care Homes[iii]) for each of the four localities (Whitley Bay, North Shields, Wallsend and the North West) which can contract for these teams or integrate the rest of the team with those practices that already employ their own.
GP practices are pursuing special interests and encouraging inter-practice referrals – for example patients with a possible or suspected DVT can be referred from neighbouring practices to the practice in each locality which has the experience to make a diagnosis and manage the patient for the period necessary, which delivers care closer to home and at a much lower cost. We already have a GP-led Frail and Elderly Care MCP (multi-speciality community provider) which provides intensive support for patients at the point when they would previously have started to suffer the disruption and discomfort of deterioration, multiple hospital visits, inpatient stays, loss of neighbourhood support network, but the intensity of care requires specialist GPs and a specialist team, focussed on Frail and Elderly.
TyneHealth is able to offer Portfolio roles to match the aspirations of the workforce. Developing these specialist teams helps to retain skilled and experienced staff who are seeking further challenges. GPs will focus on the most complex patients, and will supervise the work and the talent mix of the care professionals who can then deliver appropriate care in a stimulating environment.
The Multi-speciality Community Providers based around localities will be in effect Accountable

Care Organisations with capitated budgets, delivering tailored solutions appropriate to the varied needs of the populations of these natural communities.

Specialist Support for Primary Care

GP practices already deliver the vast majority of patient clinical contacts in NHS in England – estimates vary between 75% and 90% of all patient clinical contacts. There are groups of patients, typically those with chronic conditions who are not responding well to the standard medications and regimes, who are often placed under shared care arrangements or transferred to hospital care. In many cases, these could be managed in their own homes by GP practices with the support of the hospital consultants and specialist nursing teams.

Care and Quality

We are in the process of planning consultant-led and specialist nurse-led community clinics, and perhaps most exciting, knowledge transfer through consultant-led case reviews, to support GP practices to keep these patients in amongst their family and friends where they have the best quality of life and the neighbourhood likely to promote well-being. Apart from the obvious benefits to clinical outcomes and population health, to patient experience, and to staff fulfilment, this will also save money from hotel services for inpatients, through Payment by Results transaction costs (because the clinics and case reviews won't be tariff based), to transport and risk costs and of course reduced health and social care cost for healthier and happier people.

Prevention and Self-Management

The close relationship between the patient and their practice enables us to discuss subjects such as personal responsibility for healthcare and lifestyle in ways that are simply ineffective without that relationship of trust. GP practices already ensure that the Public Health messages reach the patients and run many of the programmes such as Long-term Reversible Contraception, and NHS Health Checks, and have a risk stratification approach to case finding for prevention. GP practices promote other services such as stop smoking, Get Active, dry January, parenting support.

Prevention, Health and Wellbeing

Sustainability and Transformation needed for North Tyneside

Sustainability and Transformation may be best delivered bottom-up, and should certainly start with the needs of the population and registered list (function).

North Tyneside has approached Sustainability and Transformation in this pragmatic and at the same time far-sighted way. We're starting with the needs – needs for clinical outcomes, for patient experience, for meeting budget constraints, and to manage workforce (see Balanced Scorecard in the Primary Care Strategy available from https://portal.gpteamnet.co.uk/Library/ViewItem/5d6c8f16-19ef-4256-ae3b-a6f5012750f0).

Based on the development work to date, we can see forms of cooperation and collaboration emerging, and they are MCPs and PCHs. We ask for support to deliver what's best for our population, based on their requests and our local knowledge, and are concerned that STP seeks to impose a solution based on the inputs of a few NHS organisations which in any case see very few of the patients.

The North Tyneside Tripartite Primary Care Strategy is being implemented in stages. In 2016/17 we shortlisted 16 projects to take forward including laying the foundations for some of the major changes to be delivered in 2017/18. The main planning work for 2017/18 will be

	more ambitious and will involve a leap forward in each of the above four pillars, which are in any case complementary. There's a focus on creating the universal access (via the registered GP practice) during the first half of 2017/18, although we have no doubt that the initial model implemented will need to evolve and grow as we gain experience and the knowledge and expectations of the population develop. With a relatively small amount of additional support, TyneHealth, LMC and North Tyneside CCG can transform Access, the Primary Care Team, engagement of Specialists in the long-term and proactive care of patients, and the public health agenda. The scale of this additional support is tiny – since GP Practices currently represent 7% of NHS budget or 10% of the frontline care budget, funding for GP practices to deliver 50% increase in services close to patients will only cost NHS 3.5% of budget for potentially a multiple of savings (perhaps 20%) in secondary care use. **Funding and Finance** 1 North Tyneside's Tripartite Primary Care Strategy, written and endorsed jointly by TyneHealth, Newcastle and North Tyneside LMC, and North Tyneside CCG, can be downloaded from https://portal.gpteamnet.co.uk/Library/ViewItem/5d6c8f16-19ef-4256-ae3b-a6f5012750f0). [1] MCP and PCH are Five Year Forward View models for the future delivery of care. An MCP is what it says it is - a multispecialty, community-based, provider, of a new care model. It is a new type of integrated provider. It is not a new form of practice-based commissioning, total purchasing or GP multi-fund, or the recreation of a primary care trust (PCT). An MCP combines the delivery of primary care and community-based health and care services – not just planning and budgets. It also incorporates a much wider range of services and specialists wherever that is the best thing to do. This is likely to mean provision of some services currently based in hospitals, such as some outpatient clinics or care for frail older people as well as some diagnostics and day surgery; it will often mean mental as well as physical health services; and potentially social care provision together with NHS provision. https://www.england.nhs.uk/ourwork/new-care-models/vanguards/care-models/community-sites/ [1] The PCH is a form of *multispecialty community provider (MCP)* model. Its key features are: o provision of care to a defined, registered population of between 30,000 and 50,000; o aligned clinical financial drivers through a unified, capitated budget with appropriate shared risks and rewards o an integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care; and o a combined focus on personalisation of care with improvements in population health outcomes. http://www.napc.co.uk/primary-care-home
44	Women's Commissioning Support - Produced in collaboration with NEWomen's Network 1. What do you think about the STP vision for our area? Is there anything missing or more we should aim for?

- Everyone who lives, works, learns or visits the area will realise their full potential and equally enjoy positive health and well being
- Safe and sustainable health and care services that are joined up, closer to home and economically viable
- Local people are empowered and supported to play a role in improving their health and well being

The women's voluntary and community sector (VCS) are encouraged by the vision for everyone realising their full potential and equally enjoy positive health and wellbeing. We believe that in order to be sufficiently healthy (both mentally and physically) for work, women in particular need safe stepping stones along their pathway to recovery and employment.

2. What do you think about our ambitions for what health, wellbeing and services should look like by 2021? Is there anything missing or more we should aim for?

- The health inequalities in our area will be have reduced to be comparable to the rest of the country
- We will have thriving out of hospital services that attract and retain the staff they need to best support their patients
- There will be high quality hospital and specialist care across the whole area, seven days a week.

The women's VCS have many successful small scale projects that are improving the health and well-being of women, children families and the wider community. There is a mounting body of evidence to suggest that these project relieve the pressure and cost from acute health services. There needs to be investment to roll these out. This will require shift in the minds set of commissioners and policy makers. Along with thinking differently, commissioners and policy makers also need to act differently, moving services into communities to reach those who are most marginalised.

We believe that the NHS in partnership with CCGs and Local Authorities should use their existing powers, such as those inscribed in the Equality Act 2010 and international instruments such as The United Nations Convention for the Elimination of all Forms of Discrimination Against Women to address structural health inequalities and discrimination along the lines of gender, race and disability etc.

3. The Five Year Forward View identifies three main gaps – health and wellbeing, care and quality, funding – what do you think about the proposed actions to address those gaps locally? Is there anything missing or other actions we should take?

- Scaling up work on ill-health prevention and improving wellbeing
- Improving the quality and experience of care by increasing collaboration between organisations that provide out of hospital care and making the best use of acute or hospital based services
- Closing the gap in our finances which, if we do nothing we could be facing a funding gap in health of £641m by 2021 and could be as high as £904 million including social care

Increase efforts and money spent on health services by investing in prevention and recovery. Investment in women's prevention and recovery will make the biggest difference to the health and wellbeing of people in the North East. There needs to be services in place, both in the workplace and in the community for recovery in the broadest sense, from issues such as sexual and domestic violence and substance misuse, but also from impacts of poverty upon the lives of women, children and families.

Funding needs to be redirected towards specialist health services. There needs to be a long term view that recognises different models and approaches, such as those practiced by women's VCOs that bring long term outcomes. Commissioners and policy makers need to think differently and take their focus away from the medical model.

4. What do you think about the scale of the challenge facing us in making significant improvements to health and wellbeing, services and efficiencies? Are there any other actions we could take to make these changes or speed up the rate of improvement?

The women's VCS are willing and committed to working collaboratively with CCGs and other agencies to improve the health and wellbeing of people in the North East. We bring expertise in gender analysis and experience in an intersectional approach to tackling all health inequalities. To benefit from our broad knowledge and experiences of equalities and health and social care issues, CCGs need to take up our offer of involvement in its early planning processes.

5. We will only achieve these ambitions for our area by engaging local populations, the people who use our service, and the staff that provide care. Have you any ideas of who we can effectively engage with the 1.7m people in Northumberland, Tyne and Wear, and North Durham?

It is vital that the NHS though the vehicle of Local CCGs works closely with the women's VCS. We are already integrated into local services, strategies and forums.

NHS Sustainability and Transformation Plans mark a new beginning and women's organisation need to be involved from the start so that a women focused approach to tackling health equalities, our ethos of women's self-empowerment as the route to health and wellbeing and our creative and holistic ways of working are embedded in local systems, policies and strategies at the outset.

We are willing and committed to having early conversations and ongoing dialogue with local CCGs to help bring about the needed shift in thinking, systems, practices and approaches.

6. Have you any additional comments?

The women's VCS firmly believes that employers need to value the strategic importance and benefits of healthy workplaces, to encourage a consistent approach to health and wellbeing for all, and to make health and wellbeing a core priority for senior management. Women's VCOs can offer structured work placements in women's services, for the purpose of sharing learning and develop links with the business community

45	Personal Details redacted Ambulance: Drivers familiar with area. Ambulances clogged at new hospital. I spent time outside my house and at the hospital presumably because of the clogging. Whilst I waited in the hospital for a Dr. I was told they were quiet and it wouldn't be long. It took over two hours of me sitting mostly with nobody around, nobody on desk and no toilet except for door marked Men/Women Staff Only Out of Order. No indication of toilet anywhere and I was left without being told that if I left that waiting area I would lose my place in the queue. Four Ambulances had arrived with acute cases at the same time. I was extremely distressed. Eventually saw lovely Dr. and had to pay for an expensive taxi to go home. I hope never to see that hospital again. It is an abomination sick people having to travel long distances and then having to wait outside the hospital. Can't an area be set up to take these patients and let the ambulances get on their way? Bring back NHS Direct. I found that helpful and my friend in Whitley Bay was able to save her brother's life in East Anglia because she had worked as a nurse years ago and when his daughter explained how he was she rang NHS Direct who organised things down there. Reduce car parking fees. My daughter spent a fortune over six months when her husband was in Worcestshire Royal despite the reduction allowed. People need local care. We don't all have cars or are able to drive or have the money for taxis. I think the recent census stats say that more and more people are living alone. There are probably areas in the NHS which need to be looked at to see if they are really necessary perhaps they could be reduced. Sincerely, Sheila Henderson-Squara
46	RNIB
47	Clinical Council for Eye Health Commissioning **he Clinical Council for Eye Health Commissioning (CCEHC) urges all 44 Sustainability and Transformation Plan leaders to include eye care in their delivery plans** The CCEHC believes that working at Sustainability and Transformation Plan (STP) level has significant potential to improve care and prevention, and enable commissioners to transform services at scale within likely available resources. With the exception of two STP areas that are including eye care in their plans[1], the risk is that opportunities to transform and modernise these impactful and resource intensive services will be overlooked simply because eye disease is not in the news headlines like A&E waits. Yet, hospital eye service capacity and sustainability pressures are still increasing. With an average population of 1.2m, STPs provide the opportunity for groups of Clinical Commissioning Groups (CCGs) to work with eye care providers and Local Eye Health Networks (LEHNs) across whole pathways, and over acute trust footprints, to develop transformed and sustainable services – and deliver the ambitions of the *Five Year Forward View* – within a relatively short period.

Ophthalmology accounts for 8 per cent of the 90 million hospital outpatient appointments in England (NHS Digital 2016). Increasing eye health needs due to the ageing population and availability of new treatments are generating severe capacity issues within the hospital eye service. With an increase of up to 30% in eye clinic attendances over the last five years, we can no longer on the grounds of patient safety ignore the pressure building up in ophthalmic services[2].

The CCEHC has brought together groups of experienced clinical leaders and patient advocates to design commissioning frameworks for community ophthalmology[3] and primary eye care[4]. The frameworks are underpinned by Right Care principles i.e. that patients should be managed in the most appropriate service according to clinical risk stratification of their condition and the skills of the practitioner.

The main objective of the community ophthalmology framework is to release capacity and improve patient flows within the health system by managing and monitoring low risk and stable conditions within the community; and that of the primary eye care framework to improve the work up by specifying additional services prior to a referral, thereby both improving the quality of referral and reducing the number of referrals into the hospital eye service.

At a time of great challenges and opportunities for the NHS, it is essential to make sure we deliver cost effective quality care to patients in England. Having a more consistent approach to eye care pathways will lead to a more integrated and efficient overall service, with quicker access for those patients who need hospital services and treatment - so important for better outcomes for patients. Commissioning eye care at STP level will reduce the inequalities and variations in care that inevitably occur when commissioning at CCG level. It will also lead to better management of limited NHS resources.

About us

The Clinical Council for Eye Health Commissioning (CCEHC) is the national clinical voice for eye health in England.

It brings together the leading professional, patient and representative bodies involved in eye health, providing collective expertise to commissioners, providers, clinicians and policy-makers on the commissioning of eye health services, including social care and ophthalmic public health in England.

The CCEHC's recommendations are provided in the best interest of patients, on the best evidence available and independent of any professional or commercial interests.

The CCEHC brings together the following organisations in the sector:

- Association of Directors of Adult Social Services
- Association of British Dispensing Opticians
- British and Irish Orthoptic Society
- College of Optometrists
- Faculty of Public Health

	• International Glaucoma Association • Macular Society • Optical Confederation (including the Local Optical Committee Support Unit) • Royal College of General Practitioners • Royal College of Nursing (ophthalmic section) • Royal College of Ophthalmologists • Royal National Institute of Blind People • VISION 2020 UK [1] Staffordshire STP and Birmingham & Solihull STP. [2] https://www.rcophth.ac.uk/2016/05/rcophths-three-step-plan-to-reduce-risk-for-eye-patients/ [3] http://www.college-optometrists.org/en/EyesAndTheNHS/devolved-nations/england/clinical-council-for- eye-health-commissioning/ccehc-framework.cfm [4] http://www.college-optometrists.org/en/EyesAndTheNHS/devolved-nations/england/clinical-council-for-eye-health-commissioning/ccehc-framework.cfm
48	Sunderland CCG
49	Unison **UNISON NORTHERN REGION RESPONSE TO NORTH SUSTAINABILITY AND TRANSFORMATION PLAN** We write further to our receipt of the letter to Trade Unions dated 9 November 2016. We did request that we do have a specific meeting with you to discuss our concerns, however, due to your team diary commitments I understand that this has not been possible up to now. As a consequence of comments made regarding consultation with the Trade Unions at the recent Public Engagement events, we wish to reinforce our request to meet up with you and your representatives as a matter of urgency. UNISON's overarching concerns over this STP process have been documented via our National Healthcare Unit, and Christina McAnea did submit a response to Rt Hon Jeremy Hunt in October 2016 (copy attached). We expressed our concerns in respect of the pace and decision-making processes to be adopted. We have also made the point that these plans will inevitably lead to changes to NHS Employees, and we do not have the appropriate Workforce Plans provided with the STP Plan. We have found that STPs are also supported by additional schedules of more detailed information, but these have generally not been made public at this stage. We feel that the STP is structured in a way that has made it hard to work out the most pressing issues for local staff and the services they provide. Similarly, when confronted with plans that are often quite far-reaching, it can be hard knowing where to start in responding to them. The STP Plan makes no reference to consultation with Trade Unions, however, we do appreciate that a process for staff consultation is currently being established via the North East Social Partnership Forum and UNISON is instrumental in the establishment of the 'North East STP Landscape' structure document. UNISON will be involved and co-ordinating the Workforce Action

	Group (WAG). We would urge early involvement in a WAG meeting for your STP. UNISON has endeavoured to encourage attendance at the recent public consultation events; however, we feel it is important to point out that the timescale for the notification of these events was extremely short. We feel that the events were poorly advertised, at times and venues that were inaccessible and the information referred to was not transparent. In respect of the Draft Plan itself, we do acknowledge the main vision and key aims for Health and Care by 2021 that you have reported. We do not disagree with the challenges that you are facing and the diagram of the evolving Health and Care Model is very comprehensive. We are disappointed that the 'Workforce' is represented by such a small box on this slide when we have such a major contribution to make to the delivery of the NHS. We do not feel at this stage that we can either approve or reject the STP Plan as we do need more information on how this Plan would be implemented. We are keen to establish how the next steps will be taken to make these proposals a reality, and what governance will be in place – i.e. the way in which staff, patients and the public will be involved in the further development and implementation of the Plan. We would also request more information on the 'Emerging Challenges' that you have reported in Section 2.1 of the Plan? What is meant by the challenges and what are the implications of the likely transformational changes to take place? <u>Funding and Finance</u> The most recent Plan circulated at the recent Engagement Events indicates a Funding Gap for Health and Social Care as high as £904m by 2021. How is the risk assessment and validation of the Plan to be undertaken? Has the STP considered the level of extra capital spending required and does this figure include elements of double running costs to allow for moves to new care models or new/existing premises? Reference has been made to the work already undertaken in the STP Area within Vanguards and the New Care Model; have any efficiency savings already been identified to count towards closing the funding gap, or is the STP to be reliant upon Transformation Funding to be received from the Centre? It is also important to point out to you that the Trade Unions have not been properly consulted on the Five Year Forward View Efficiencies identified in any Vanguard so far. It is understood that it was reported that 80% of efficiency savings is already accounted for in these initiatives. We request that we are informed of the implications of these Vanguard plans. What is the level of the Transformation Funding requested from NHS Improvement for this STP Plan to function? Emphasis has been made on the provision of 'more seamless care **close to or in the patient's home**' and 'Ensuring a **vibrant Out of Hospital Sector**'. Our

research has found that there is very little published evidence to support the claim that moving care out of hospital saves any money (at least in the short term), even if it may ultimately enhance the patient quality or experience of care. If this does involves links with Social Care from Local Authority providers, given the recent media focus in a crisis in this sector, has the STP honestly assessed that this new model of integrated working will deliver efficiency savings?

NTWND STP Impact – Finance and Efficiency

The NTWND Waterfall diagram shows the mapped out financial challenges and efficiency savings in the NHS in the next five years. We would like to ask the following questions in relation to this slide:

- Provider efficiencies of £241m - will these already planned annual savings run into the final NHS total of £641m or is there an additional requirement?
- What are the Pathology Service savings planned?
- What is meant by Shared back office? Please provide details of the STP Plans?
- What is the detail of the CCG Efficiencies?
- What is meant by Acute Consolidation?

We required more detailed information on how these efficiencies are to be made.

Workforce

We have referred above to the NE STP Landscape Document; however, we list below the questions that are important to protect the interests of our members:

- We require a copy of the workforce schedule for the STP to be provided to us?#
- What number of staff does the STP envisage as being affected by this Plan? Will there be any jobs lost or new ones created?
- Has the STP considered any 'flexibility' in the local workforce, what will be the consequences for particular groups of staff?
- Has the STP assessed properly the skills and staff numbers that are needed to make the new care models a reality? Will appropriate training be provided?
- Is there any suggestion of a need to alter Terms and Conditions or of how the workforce might be affected by any moves to integrate Health and Social Care Services?

	• How much importance is attached to the use of newer roles such as Nursing Associates or Physician Associates? • Has the STP sought to tackle issues such as local shortages in particular professions? <u>Governance</u> • Has an equality impact assessment been produced for the STP? • What, if any, plans are there to involve staff and patients in the development and implementation of plans? Is there any consideration for making staff co-producers of change? • How will this consultation process deliver the commitments to staff under the NHS Constitution? • In what ways has the STP sought to involve other key local players such as Local Government, the Voluntary Sector and Social Care providers? • What role does the STP envisage for future partnership working between staff and employers in the new system? The efficiency plans may result in local issues having to be addressed. How will local consultation mechanisms be dealt with in the STP? • What level of Local Authority scrutiny through Health and Wellbeing Boards or Health Overview and Scrutiny Committees is anticipated? What is the timescale for those consultations to take place? • Will there be a Board to oversee the development of the STP in future and who will be on it? We request that UNISON holds a seat on this Board. • Who will manage this change? We welcome your response to this submission.
50	Gateshead and South Tyneside LMC and Newcastle and North Tyneside LMC **<u>Response to the Sustainability and Transformation Plan (STP) of Northumberland, Tyne and Wear and North Durham.</u>** This is a joint response from the statutory GP representative bodies of Gateshead & South Tyneside Local Medical Committee (LMC) and Newcastle & North Tyneside Local Medical Committee. It covers our views on the

Sustainability and Transformation Plan (STP), and more specific comments on proposals in our individual Clinical Commissioning Groups (CCGs) areas, i.e. Newcastle Gateshead CCG, North Tyneside CCG and South Tyneside CCG.

Background.

The STP document builds upon the NHS Five Year Forward View that was published in late 2014 and also incorporates aspects of the GP Forward View, as published in early 2016. The idea of the STP is to produce a plan of change for the NHS to deliver its services that is sustainable and transforms the way that the NHS is structured in order to deliver these services. In addition, our area is also a National Transformation Area; therefore, it is intended that we proceed at a faster pace than the rest of the country.

On considering that the STP has the potential of being one of the biggest reorganisations and transformation of the NHS, one would think it incumbent upon NHS England and various bodies to take this process at a measured pace so that something as complex as NHS will have time to adapt, test new models and then implement after proper evaluation.

Instead this process is being done on a relatively short timescale, and whilst we accept this is the beginning of the process, these plans have been produced at unseemly haste and without proper consultation of key stakeholders in both health and social care.

We do not blame the CCGs for this, as the fault of this hasty process is entirely at the door of NHS England, who have imposed this top-down, rapid process to a timetable that fits more with a political agenda rather than a health agenda.

We feel that it is important that there is some background information before people read our report, and we wish to make the following points:

1. As a nation, we are now spending a decreasing percentage of gross domestic product on health whilst many comparable countries are holding the percentage level;

2. 1Due to demographic and treatment changes, NHS inflation runs consistently per cent above normal inflation;

3. In absolute terms, the amount of money is increasing but due to the gaps in funding identified above, efficiency savings are needed in order to standstill;

4. We often hear that £2.3 billion is to be invested in primary care under the GP Forward View by 2020, but we have to remember that this is not new money but money shifted from the secondary care system, who are already struggling financially;

5. That the spending of any extra money invested into the NHS needs to be determined locally and not tied to national schemes from those who "think they know best";

6. As been stated by a number of bodies, including the Chief Executive of NHS England, if general practice fails then the NHS fails; a small reduction in the capacity of general practice would lead to a much larger burden on hospital services e.g. a 6% reduction in GP capacity would double the numbers attending A& E departments.

7. At the present time, general practice is in a perilous state and this has been identified by both national and local surveys. General practice is having difficulty recruiting, workloads are unsustainable and the time bomb of GP retirement is very near on the horizon;

8. Around 90% of healthcare is undertaken in the primary care sector;

9. The political rhetoric around 7 day services and general practices opening 12 hours per day, 7 days per week is very damaging to the professions and is just unattainable until there is the extra resources in place to deliver these;

10. Despite all the above, the present system often equates to being one of the best in the world in terms of efficiency and cost effectiveness, as demonstrated in Commonwealth Fund Report.

We believe that it is very important to keep the above points in mind when discussing the STP and our responses to the various parts of that document. Many of the statements made in our discussions of one of CCG areas are applicable across the whole region but will not be restated.

The document identifies 3 gaps that it is trying to bridge by 2020:

- Prevention, health and wellbeing
- Care and Quality (Out of hospital collaboration/use of acute sector)
- Funding and finance

These gaps are well identified within the document and we will discuss these in more detail.

Prevention Health and Wellbeing.

This is perhaps one of the less contentious areas of the document and this section fully recognises that health care services has limited impact on the overall health of the population and these are largely determined by social factors that account for between 60- 85% of an individual's overall health and wellbeing. Clearly, we fully support working in smoking cessation, combating obesity, alcohol and low levels of physical activity.

It is commendable that we have been successful so far, but this is a long term goal and will clearly need some political support so that strategies for reducing

unemployment, better housing, better wages etc., as these are factors that would make an impact on the health and wellbeing of our population.

In summary, we are very supportive of the prevention, health and wellbeing section and congratulate the services on achieving what they have achieved so far; hopefully this will continue in the future.

The caveat that we have to be aware of is that prevention, health and wellbeing is a long- term project and any benefits are unlikely to be seen within the timescales of this STP.

A cause of great concern is that the budgets for public health are being reduced and public health is already looking at services that they have to cut.

As well as support for the public health issues, we are very supportive of transforming cancer services, as outlined in the document, and we hope that all the outcome measures as identified in the document are achievable and look for even better outcomes as time progresses past the 2020 target within this document. Of course, it is imperative that the resources will be available in terms of specialist and finance that may be needed to achieve these outcomes, especially when financial pressures are on the rest of the health care system.

<u>Care and Quality (Out of hospital collaboration/use of acute sector).</u>

Our main comments in this section are on those parts that affect general practice, as those are the bits that we represent, but there is lots of overlap within the different sections of the STP, as would be expected in a complex interrelating system like the NHS.

One of the identified main thrusts of this document is to move work out of hospital into the community care setting in the hope that this releases capacity and saves money that can be utilised in primary care to a greater extent. This is based on an assumption that the same or similar work can be undertaken in a primary care setting at a significantly reduced cost. This may have been demonstrated in small pilots looking at selective patient groups but evidence is lacking about the “savings” on a whole population service.

Along with this is an endeavour to integrate patient clinical pathways, which will always be supported by LMCs, if this is the right direction to follow and is good for the patient and providers of clinical care.

We have noted that the North East has been recognised as a National

Transformation Area so that extra investment support is available to accelerate transformational change, and this includes the accelerating spread of the new care model across the region. Two particular models are cited, the Multispecialty Community Provider (MCP) and Primary and Acute Care System (PACS), which are being piloted as vanguards in the North East, but these have just got going and we have not had full evaluations of the effect on the whole system.

Under the Five Year Forward View, these new care models are mentioned at length and there appears to be an almost "top down diktat" that this is the way that NHS services have to develop, but this may or may not be right and only experience will tell.

However, in both models there is a significant move of work from secondary to primary care, and general practice will be taking a significant amount of this extra work if indeed these models develop as planned. Under the Five Year Forward View, it was stated categorically that the first two years would shore up core general practice in order to develop and expand to take on this extra work.

After two years, there has been no significant investment in general practice, apart from some minor resilience funding for practices that are teetering on the brink, and general practice is not being shored up, as promised. This will create some difficulties in trying to move to new care models in the timescale envisaged under the STP. It is unlikely that general practice will be in a position to co-operate or implement these plans until significant resources (staff, premises & time) are in place and this is likely to take a few years in our estimation.

As mentioned above, one of the basic assumptions is that these new care models will provide better care for patients and at a more cost effective rate; therefore, releasing efficiencies as needed by 2020. However, the evidence to support this is not substantial or even credible at the present time, and care needs to be taken to develop new care models at the appropriate rate with the full engagement of those who are going to provide the care.

Accelerating transformation without the proper engagement of those doing the provision of services will fail, and any transformation must be done based on the following principles:

- Development of a new care model must be bottom up engagement of front-line clinicians;
- We expect general practice services to be delivered from multiple sites across the area through present general practices, i.e. the corner shop delivery model;
- We expect patient lists to be retained, as this provides continuity of care; one of the only things that has been shown to be beneficial;
- There has to be adequate resources and this means money, staff and time allowed to develop things. Ultimately this will mean that there has to be some pump- priming and parallel running of services;

- We will insist that GPs maintain their national GMS/PMS contracts, and we will resistany move to fragment such contracts, including local Quality & Outcome Frameworks (QoF).

A lot of the success of the STP is predicated on the success of the ambitions/assumptions made that will be achieved by 2020. These include:

- reducing A&E attendances by 15%;
- reducing emergency admissions by 15%;
- reducing outpatient activity by 10%.

We believe, given the demographics of society and the changes in the health system, that these are completely unachievable and have never been achieved in the past. Whilst we can see some successes with pilots dealing with small sections of the population, they do not equate to such savings when extrapolated up across whole systems and populations.

Many of these assumptions underlie the whole ethos of the STP and the closing of its financial gap, and we have great concerns that these cannot be achieved at all, but especially in the timescale dictated.

Some of the ambitions we certainly agree with and concur that it is admirable to try to achieve the rating of good and outstanding from all primary and secondary care providers. It is remarkable that in the present climate the majority are already rated good or outstanding.

We also will support some integration of services that make clinically good sense, e.g. stroke teams integration and collaboration between foundation trusts etc. These are often due to the lack of specialists and the required number of patients that are needed to ensure a high quality service. Clinically it makes sense for patients to travel that little bit further to access such services.

Another basic premise that needs to be challenged and explored is the fact that simply moving patients from the hospital to the community setting is more cost efficient and that the redirection of patients away from secondary care to somewhere else is also a cost efficient process.

The simple fact of the matter is that the work has to go somewhere; if we fragment the delivery of services, say through multiple teams within the community, more staff will be needed to deal with these patients who were on one hospital site, and this has to be taken into account.

Whilst it may be good for patient care and preferable, we are not in a position with general practice struggling to cope with the present workload, struggling to recruit and with inadequate premises to take this on at the present time.

With the pilots or vanguards it quite easy to almost “cherry pick” the results and it is known that if enough resources are thrown at a small part of the population, great results can be achieved, but this is not sustainable across large scaled up areas. As we have said above, the work has to go somewhere and a whole system approach is needed to see if the desirable outcomes have been achieved.

In times of monetary constraint there has to be some form of patient demand management so that only “needs” and not “wants” are met. This is a difficult area but good clinical triage at the beginning of the patient’s journey is necessary and we believe that the patient’s own general practice is best placed to do this.

NHS 111 has failed in the view of many clinicians and NHS 111 is seen as part of the problem and not part of the solution. A radical rethink is needed and investing in clinical hubs that are a duplication of the previous role of out of hours GP services is not the way forward as these only concentrate on a false non-clinical 4-hour target within a small part of the NHS system.

Whilst we have concentrated on NHS services it has to be remembered and has been stated often enough in the media that supporting patients in the community and not hospitals entails significant social care. We are, at present, seeing how the lack of investment in social care is causing a block in the discharge of patients from hospitals. The idea of moving work from the secondary to community care without significant increase in social care resources is complete and utter nonsense and whilst recognised by everyone, their budgets are being slashed by central government. This is a major obstacle to any reform of the NHS.

Newcastle Gateshead

The document makes a case for a new model of care when looking at the aging population and the pressures and growth in the needs of health care. Focusing on a cohort of the population, which consumes the greatest proportion of health services, especially about non-elective admissions, is very important and worthwhile doing.

We completely agree with the key work streams that have been identified, particularly enhancing primary care that is obviously our interest, but we do have concerns about the timing of all these things. If engagement of front line clinicians is needed, and it certainly is, then a timeline in which we are all comfortable is necessary to allow complex systems to adopt, adapt and implement.

It is essential that primary care is enhanced before work is shifted from secondary to primary care, and the additional work that nursing homes pass on to general practice, is recognised and resourced in an appropriate manner. This does mean that extra GPs, with a special interest in the care of the elderly, and dedicated community teams along with proper investment in end of life care and dementia pathways.

As mentioned previously, the first two years of the Five Year Forward View was to shore up general practice in order to take on these new models of care. To date, there has been very little investment in general practice, and until this happens with

increased workforce, premises development and really engaging frontline staff, nothing can happen to a great extent.

We also do have concerns about scaling up findings from the Enhanced Health and Care Homes Vanguard in Gateshead. This will not release the benefit expected, and we do not feel that simple extrapolation to a whole scale model is appropriate. There is evidence that throwing resources at small targeted groups of patients will reduce non-elective admissions and improve their care, but we still have to look at the overall effect on health care system, particularly the effective on general practice who will be picking up most of this work, at a time when they have no extra capacity. This is why we believe that any change to a new model of care will take time and resources, which is certainly not evidenced from this STP.

In addition, looking at the whole population, we are aware that the 65+ subset accounts for 31.5% of non-elective admissions, which leaves two-thirds of non-elective admissions from the rest of the population. This also needs investment in order to contain and curtail this growth in non-elective admissions, and hopefully the development of new structures such as an MCP model may make an impact on this but again, time, engagement and resources are needed and this needs to be identified in the STP.

North Tyneside

As we have stated previously, due to the fact that many of the statements in the STP are high level and lack detail, our comments regarding these statements can only be in a similar fashion.

The LMC is fully supportive of development of new models of care as long as it is based upon the criteria, which we have set out above. In North Tyneside, the LMC has been intimately involved in the tri-partite Primary Care Strategy, which looks at better access to General Practice, clinical pathways and long-term condition management. In addition the strategy also looks at preventative care, and we will support these movements as long as they are clinically led, properly resourced and implemented over a reasonable timescale.

However in North Tyneside, the new model of care, which is a PACS model headed by an Accountable Care Organisation (ACO) has been imposed, and there are concerns regarding the functionality of such a structure and the effects on general practice. However, we will be insisting that national GMS/PMS contracts are maintained with no local QoF arrangements and we will resist any financial exposure from new structures to general practice.

General practitioners are unique in that they are self-employed, and therefore any effect on their budgets affects their personal income, unlike those working in other sectors of the health service.

South Tyneside

Again, due to lack of detail and only high level comments within the

document, it is very difficult to comment specifically but we will make some general comments, as we have done elsewhere.

In South Tyneside we will fully support the development of the out of hospital integrated care model, as long as this fulfills the criteria we have set out above with bottom up development, local engagement and appropriate resources over an appropriate timescale.

Of course, we fully support focus on addressing the resilience of general practice and hopefully this will be delivered in a shorter timescale, as general practice is in crisis at the present time. We are also very happy to support redesigning of pathways across primary and secondary care, as long as they are clinically led.

In addition, we will be supportive of the hospital integrated care model and integration and how the two hospitals in South Tyneside and Sunderland work together and develop, again with the caveat that this is clinically and not financially led.

Funding and finance.

One of the most worrying aspects of this STP is the financial gap that has to be closed. We believe that this is the priority of the STP and that the other sections that we have discussed above are secondary to this. Of course, we are fully in agreement that all three gaps need to be closed somehow but we disagree about how quickly this can be done; we certainly do not agree with the financial assumptions that underlie this model.

The waterfall diagram illustrates how it is intended to close the financial gap, and whilst we agree there will be some efficiencies and savings in certain areas, such as shared back office pathology services etc., as they can be done on a bigger scale, it has to be remember when it comes to patient care that work does not go away but it is moved around the NHS system.

This means efficiency savings in one area becomes a problem for another area, and as the greatest costs for the NHS is in staff, we cannot understand how efficiency savings by moving patients from one sector to another can realise such savings. This is because the staff are needed to look after the patients and thus staff will have to move also. All staff are working at maximum capacity already so the implication that efficiencies are possible needs to be demonstrated beyond doubt.

We note from the waterfall diagram that there have been some identified efficiencies possible within the system, but we believe that these are speculative and probably unachievable in the timescale envisaged. However, it has to be noted that the biggest efficiency saving of £158 million is not identified; this is on top of the apparently identified efficiencies already being made.

It is also a little worrying that the CCG efficiencies and out of hospital efficiencies are dealt with separately, as a lot of this overlaps, but as said before the work has to be done somewhere, whether in secondary or primary care, and we need further detail on the financial assumptions and financial models that have been

	applied to this. It also has to be remembered that moving patients out of hospital to primary care has a major impact on social care. It is impossible to divorce health and social care in the community, and we are all aware of the massive financial cuts that the local authorities are facing. It seems fairly obvious to us that more money needs to be invested into social care in order to move patients out of hospital care, and this is not evident in the financial assumptions. Our view is that in order to even slightly make an impact on such financial efficiencies there will need to be a dismantling of the market and removal of the payment by results system so that secondary and primary care move back to fixed costs and fixed budgets with the consequence of perhaps longer waiting times and service cuts for both primary and secondary care services. **Summary.** In summary, we believe that whilst some of the aims of the STP are very laudable and we would support the clinical aspects of many of the developments, it has to be recognised that this can only be done with the engagement of frontline staff and, to date, this has been lacking. We are very happy to support new models of care where these are bottom up developments with good clinical reasons for doing so and where they have been properly resourced in order to cope with the shift of work around the system. This will entail extra money in the form of pump priming and parallel running of some services, and a really serious recruitment effort to ensure that the staff are in place in the primary care environment before the work is moved. This of course takes time and initial money before we will see any benefit, but it is unlikely we will see benefits before the year 2020, which is envisaged under the STP. We do not believe that the financial efficiencies are attainable unless there are cuts in services and/or increased waiting times, and we also believe that careful evaluation of the vanguards need to take place in order to show they are cost effective. It is also hoped that we will have some honesty about the situation that we are in as, in private, we hear often that the STP is not attainable but, in public, the view is that it is possible but challenging. Full engagement with frontline clinicians and patients is necessary, as the plans develop, and the LMCs are very happy to support publicly difficult decisions that will have to be made if they are clinically led. We fully accept that this is a difficult role for CCGs to take forward and it is fairly easy to be critical of their plans, but one of the roles of the LMC is to protect its constituents, i.e. GPs and general practice services, and challenging such plans in order to have an influence on future developments is important.
51	Sunderland Local Medical Committee

Response from Sunderland LMC to the Northumberland, Tyne and Wear, and North Durham Draft Sustainability & Transformation Plan (STP)

Introduction

This document is our response to the ***Northumberland, Tyne and Wear, and North Durham draft STP*** but with a particular focus on Sunderland. The draft STP document was debated at a fully attended Sunderland Local Medical Committee (LMC) meeting on Tuesday 3rd January 2017, a subsequent draft prepared and every member invited to amend and/or approve the content of our final document.

The LMC is the statutory, elected representative body of all GPs in the city and our full role is described in our website at http://www.sunderlandlmc.co.uk.

Context

The NHS, especially primary care (general practice), consistently ranks highly when health outcomes are independently evaluated against comparable western countries. This is despite ranking lowly in respect of health spending expressed as a percentage of Gross Domestic Product (GDP). The implication of this is that the NHS is comparably an efficient service and therefore further "efficiency savings" are difficult to envisage as achievable without the potential for adversely affecting patient care.

The largest cost of all health care systems is the investment in staff salaries and therefore attempts to achieve significant financial savings will inevitably require the capping of staff salary rises, the use of lesser qualified or more junior clinical staff, or an actual numerical reduction in the actual NHS workforce. There are obvious implications for patient care.

Although Government has consistently said that investment in the NHS is rising year on year, in relative terms there is actually a year on year fall. NHS inflation rises at a higher rate than "normal" inflation. Perversely, this is one of the consequences of the success of the NHS. The most obvious example is the continuing rise in life expectancy which means that people are living longer and developing more long term chronic diseases which require additional funding to manage successfully. Other examples are the development of new advanced techniques and treatments, and increasing drug costs.

As an LMC we are especially concerned at the sorry state of general practice in the UK. The documentary evidence is very clear that investment in general practice has fallen both in real terms and, perhaps even more significantly, as a percentage share of the total NHS budget. Most researchers and commentators on the NHS recognise that general practice is the key part of the vast majority of health care within the NHS. Even the Chief Executive of the NHS, Simon Stevens, believes that if general practice fails then the NHS fails. These relative cuts in funding to front line general practice are often described as being in the

interests of “efficiency savings” and yet this “efficiency” has brought us to the position we are in general practice. Readers may wish to access a report on a confidential survey conducted both in Sunderland and more widely across the North East in 2016 at http://www.sunderlandlmc.co.uk/styled-7/styled-36/index.html, but the problem is widespread across the UK.

Government has promised, via its “Five Year Forward View” published in 2015, that there will be significant investment in general practice but we are now in the second year of that five year plan and practices say they are not yet seeing that investment in their core services. One of the problems is that much of the money is expected to be from “efficiencies” generated largely in the secondary care hospital services and they may not be achievable. Additionally, that promised investment will probably not be used to support the currently deteriorating “core” general practice services, but will be directed towards political targets such as seven day general practice access and attempts at resourcing the shift of hospital services into the (assumed to be cheaper) community general practice setting. However, current core general practice services are continuing to deteriorate, recruitment is very difficult and yet the demand for existing GP services, without further transfers of work, continue to rise. There cannot be many of our patients or independent observers of the NHS who are not aware of this decline.

The STP identifies what it describes as three main gaps: Health and Wellbeing, Care and Quality, and Funding/Closing the Financial Gap. We will comment on each in turn.

Health and Wellbeing

This section draws on many aspects of Public Health and the content is largely uncontested. The worry is that Public Health, now a responsibility of hard-pressed Local Authorities, has been subject to its own budget reductions.

So much of health and wellbeing is acknowledged to depend on social factors and in this respect the North East has always fared badly. There have been many and continuing attempts to broach the subjects of smoking, alcohol and obesity both nationally and locally. Overall success has been achieved in respect of increased life expectancy and a significant reduction in smoking, although alcohol and obesity remain a problem. Perversely, increasing life expectancy contributes to increasing health care costs because of the higher incidence of chronic disease management required. There are also potential adverse effects on social care budgets. This then has a negative effect on what we believe is the main thrust of the STP, which is to hugely reduce health care costs. The point is that these are largely social issues and when combined with the very well established contributing factors of improving employment and housing requirements, are very challenging to address. Even if further improvements can be made in these social health reforms, they represent a long term prospect far in excess of the STP timeframe. The serious dangers associated with cigarette smoking have been well known for over 50 years, and yet levels of smoking remain stubbornly high.

We fully support the aspirations to reduce the number of early deaths from cancer and cardiovascular disease, but this will inevitably require increased

investment in health care.

The statement in the STP that ***"improving the health of our local population will over time reduce the demand for our health and care services"*** seems to fly in the face of common sense and ignores the realities of funding those improvements and increased life expectancy. Even if this statement was based in reality, the timescale is medium to long, and once again is beyond that of the STP. These types of improvement will surely require increased financial investment, at least in the short term of the STP, and not achieve the reductions in spending so fundamental to the success of the STP.

Care and Quality

In the STP "care and quality" this is addressed in conjunction with the heading of "Out of Hospital Collaboration and Making the Best Use of Hospital Services". The document majors on many aspects of how this could be achieved, but in summary we believe the major points are:

1. There are numerous references to the shifting of care from the secondary care sector to the community and hence general practice. It also describes how this can be achieved and expects those changes to release funding to facilitate the changes. Even if the suggested schemes to be employed could be delivered successfully (see later), there seems an absence of any real understanding of the current plight in general practice. There is also a risk that moving services, such as consultant clinics to a number of community locations, risks fragmenting those services and actually causing inefficiency. Such services may improve patient access but come at a cost.

2. Integrated pathways are heralded as the means of delivering both improvement in clinical care and financial savings for re-investment. The LMC supports clinically-led and proven pathways. However, proposed pathways may not always be supported by convincing evidence and may come with unrealistic expectations of both health and financial outcomes. We cannot envisage a situation where any such changes can possibly breach the financial gap described in the STP.

3. There is clearly an expectation of "rationalising" some existing services. Examples we may expect are the closure of urgent care facilities and changes to the siting of maternity services. The LMC would support changes that are likely to deliver better patient care and treatment outcomes such as improvement in Stroke Services by concentrating expertise. However, we would be reluctant to give our support purely on the grounds of financial savings. Furthermore, we understand the available evidence indicates that such changes rarely produce much financial saving because the patients still present with the illnesses, the same staff are needed, and proper facilities are still required.

4. Where there is acknowledgement of the current pressures in general practice, albeit without a full understanding of the potential impact of further expected deterioration in core services, there is an expectation that new ways and models of working by practices will not only alleviate the pressure in general practice but miraculously lead to the ability to undertake even more work. We refer to "working at scale", Multispecialty Community Providers (MCPs), and

Primary and Acute Care Systems (PACs). These are currently being piloted within NHS vanguards both in the North East and across the UK but there has been little evaluation and consequently there is no convincing evidence they will produce the improvements that some hope for. In Sunderland, we have recently asked for even an interim evaluation report on the vanguard, but it is not available and the full evaluation is not due until April/May 2018. A difficulty is that pilots inevitably predict optimistic outcomes because of the enthusiasm of the participants, the unwillingness to accept the disadvantages, and the often generous financial resources given to pilots. The result is that even successful pilots cannot always be reproduced on a wider scale and therefore to predicate a whole new system change on this is unwise and potentially risky. Sunderland has received very generous "vanguard" funding running into many millions of pounds annually. Very little of this resource has found its way into practices to support core services although there have been tangible benefits from the development of multidisciplinary community teams. The problem is that the rate of attendances at A&E and readmissions continue to rise, and although acute admissions appear to have levelled off for the moment this is offset by the significant rise in patients referred for Ambulatory Care. This is heading in the opposite direction to the ambitions of the STP, although would be expected in the context of an aging population with more chronic disease to treat.

Funding and Closing the Financial Gap

There are 44 STPs across the UK. The STP for our area alone predicts a funding gap for health care of £641million by 2021. If the anticipated financial gap in social care of £263million is added, the total gap by 2021 comes to an eye-watering £904million.

It is very helpful when this STP document exposes the Government's agenda insomuch that it states: ***"NHS budgets are only expected to rise in line with inflation and not to cover the cost of increasing demand, new treatments and developments".*** Nothing could be clearer.

We have seen no evidence and are therefore not convinced that the commissioners and current health care providers have efficiency plans that will address 60% of the gap as the document claims. Plans that rely on the implementation of models of community care that produce reductions of acute admissions of 15% and significant reductions of A&E attendance are simply not tenable. We are not opposed to the concept of GPs and their teams doing more complex health care in the community and perhaps even deliver better services. However, in the current circumstances of a rapidly declining core general practice, huge investment is needed just to shore up existing general practice. Crucially, even if that investment materialises, it will be many years before sufficient numbers of young doctors can be persuaded to consider and then be trained for GP as a career. Meanwhile it seems the main agenda is to push more work out into the community in the hope of closing an impossible financial gap.

Summary

The STP presents plans for the closing of a huge financial gap in the NHS. Much of that plan refers to efficiencies that are not fully described. There is much

	emphasis on shifting health care from hospitals to the community and an anticipation that this will be much cheaper. We are not convinced, especially as this is in the context of core general practice being in crisis and not coping with current workload. We would support schemes that are properly resourced, in both financial and manpower terms, and that are genuinely "clinically-led". However, these decisions may be made on the back of options being presented within strict financial limitations and are therefore only clinically-led insomuch as they highlight the least damaging options and not necessarily the option of choice. LMCs warned at the inception of CCGs that a funding crisis was on the way and warned that GPs and their fellow clinicians should beware being held responsible for difficult decisions. STPs are not locally driven, but are the result of top-down pressure from NHS England and Government. Never were those warnings more relevant to the profession. Finally, we note that ***"any proposal to substantially change any service will be subject to thorough and detailed engagement and consultation with those people affected by any suggested changes".*** Such public consultation is to be welcomed. However, many older GPs, patients and primary care staff will remember the imposition of the Darzi agenda in Sunderland a number of years ago in the face of overwhelming public opposition in the city. The scheme progressed anyway because it was a Government agenda. The STP is no different. We are not convinced that local NHS managers support the content of the STP as being a genuinely deliverable plan to close the financial gap. Weagree.
52	Not published or named by request of the participant
53	Unite the Union **RE: STP for Northumberland, Tyne & Wear, and North Durham** Thank you for your letter of 1ih February 2017, in response to my correspondence as part of the 'engagement' period. You say in your response to my comments around funding, that 'High-level financial modelling has been carried out' and you go on to advise that this information will be made available to the public in the next stages of the STP Process. Can you please confirm at which Stage of the 5 stage approach the STP is currently at, and what can be expected in terms of consultation going forward, as I note there has been no update on the relevant CCG website's for some time in relation to STP? I look forward to your response.
54	Following the publication for the draft 5 year forward which I have read with great interest. As an Emergency Clinical Care Manager with North East Ambulance Service NHS Foundation Trust (NEAS), I would like to know what are the expectations or ideas that the NGCCG have regarding NEAS role and involvement in each individual CCG 5YFR.

55	E Flett Will you please register me to attend the CCG meeting on Nov 23rd and I wish to ask a question as follows:- Will North Durham CCG commission and publish an impact assessment covering both the risks to the local health economy and to patients once the final STP is available?
56	Working Links The Department for Work and Pensions' (DWP) new **Work and Health Programme** is being commissioned to improve employment outcomes for people with health conditions or disabilities and those unemployed for more than two years. The **Work and Health Programme** provides an opportunity for local providers to collaborate and create positive futures for local people, their families and their communities. Focusing on ability rather than disability or time out of work, we make a difference. Working Links have been helping the government design and develop programmes like this since 2000 and we're widely recognised internationally as a best-in-class employability provider. We are pleased to announce that we have been successful in getting on the Department for Work and Pensions' (DWP) umbrella framework for the provision of Employment and Health Related Services in the area which covers your region, which means Working Links can now bid to run the Work and Health Programme in those areas, and any other DWP provision they commission in the future in these areas. We would welcome the opportunity to discuss how we could work together to add value to existing local infrastructure and community delivery within your STP area and most importantly to make a lasting and significant change in the circumstances of the lives of local people. Government statistics and our research shows that people living in County Durham and Tyne & Wear have some of the highest percentage of people on Employment and Support Allowance and deprived in the country. Please contact me at your earliest convenience, or let me know a convenient time to discuss this with you over the phone or in person. Kind regards
57	Healthwatch Newcastle I received an email on 4 January 2017 from the chair of Healthwatch Gateshead informing me of the STP consultation events which are to take place, the first of which is in Newcastle on Monday 9 January. He had been forwarded it by an officer at Gateshead Council. From this email I could see that you had sent it out on 29 December 2016. On Friday 6 January, we also received an invitation for partners/stakeholders to attend an event on Wednesday 16 January. Again this is extremely short notice, especially for a meeting taking place

	during the working day. My concerns are twofold. Firstly, Healthwatch does not seem to have been included on the initial circulation list, despite the fact that we have been part of the Joint Integrated Care Programme Board and have been meeting and working with Caroline Latta to discuss the CCG's approach to consultation and engagement on the STP. Secondly, and more importantly, the notice given for these meetings is woefully inadequate, particularly when you are asking us to promote the events through our networks. We want to support the CCG and we have been promoting the events despite the short timescale. As the STP plans were released in early November, consultation meetings could have been organised for January and publicised at that point. I am sure that you are aware that there is some scepticism about the STP in some quarters and arranging consultation events at such short notice I think will just help to confirm peoples view that decisions have already been made. I shall be attending the event on the 9 January, but wanted to let you know of my concerns, on behalf of Healthwatch Newcastle, prior to that event I note from your briefing that there will be further consultation events following this initial event and I would urge you to publicise the dates for this second round of consultation as soon as possible.
58	Constituents of Newcastle upon Tyne Central
59	Nicholas Murrell-Dowson
60	Royal College of Paediatrics and Child Health Infants, children and young people represent over a fifth of the population and are high users of health services; over 20% of emergency department attendances are by children and young people. In January, the Royal College of Paediatrics and Child Health (RCPCH) published the "State of Child Health" report which can be found here. A series of metrics point to the inescapable conclusion that child health in England, one of the world's richest countries, is in jeopardy; for example, there is a very large persisting gap between rich and poor, we have one of the highest mortality rates for children in Western Europe, an extraordinary proportion of children are afflicted by preventable conditions (e.g. dental caries 31%; obesity 34%), and immunisation coverage in England has fallen below the WHO target. Cohesive and robust action is needed now to secure better health outcomes for all children. The RCPCH welcomes the key aims of the STP, notably the focus on prevention, but the majority of plans provide little or no evidence that the needs of infants, children and young people have been taken into consideration. We therefore urge you to ensure that your STP includes the health and wellbeing of infants, children and young people as a key priority and in particular that your STP has:

	•Evidence that a population based assessment of need specifically focussed on infants, children and young people has been undertaken •A named and accountable lead for infants, children and young people •Evidence that you have engaged children, young people and families in the development and implementation of the plan •Ongoing involvement of local paediatricians and child health professionals in the development and implementation of the plan •Details of preventive and early intervention strategies for infants, children and young people •Collaboration with the education and youth justice sectors as well as social care to deliver integrated models of care for infants, children and young people We recognise the role of the sector in working with you to address these challenges and are committed to working with you, as well as with groups representing children and young people and their families, to achieve better healthcare for children, and an investment in improved health for the adults they will become. We have a range of standards and quality improvements tools to support you. For advice or support please contact me at health.policy@rcpch.ac.uk. The RCPCH Regional Lead for your area is Dr Neil Hopper (neil.hopper@chsft.nhs.uk) and he/she is available to provide support locally.
61	Gateshead Council To Mark Adams, STP Lead: Dear Mark, **Engagement on Sustainability & Transformation Plan for Northumberland, Tyne & Wear and North Durham** Thank you for your letter of 29th December regarding the period of engagement on the draft Sustainability & Transformation Plan (STP) for Northumberland, Tyne & Wear and North Durham. You mentioned that it would be useful to have feedback from organisations on their views as part of the engagement phase which will be used to inform the next version of the STP to be formally consulted upon as a draft strategic plan for the region. In summary, this letter seeks to raise three key issues that are further expanded upon below: - The fact that the STP process has been driven by NHS England using a top down approach, with a particular focus on how local areas can bridge a significant funding gap in health – estimated at £641m (£904m plus, including social care) across the STP footprint by 2021 – and the implications of this for the people of Gateshead. - The value of setting out a statement on the Council's understanding of the current position regarding the STP based on discussions at our Health and Wellbeing Board to-date and subsequent communications and dialogue regarding the status of the STP and plans to progress its development over the coming months.

- The importance of full and on-going engagement with local people and local partners, including the Council, on the future development of the direction of travel for each of the transformation areas identified within the STP.

It also sets out some suggestions for consideration when finalising the next version of the STP and future planning arrangements.

The Funding Gap:
The very significant financial challenge set by government to bridge the funding gap mentioned above by 2021 cannot be overstated. Inevitably, it has given rise to equally significant concerns about what this means for the future of local services and the people of Gateshead who depend upon them. It also raises concerns about the real scope to finance the shift towards prevention and early intervention across health and social care services that is clearly needed (as confirmed by the NECA Commission report 'Health and Wealth') when there is no new money in the system to help meet double running costs.

It needs to be acknowledged within the STP that a shift from hospital to community care has significant implications for social care. How associated financial pressures on social care are addressed needs to be a key focus of the STP.

Linked to the above, it will be important that there is ample time for the Council and other partners to give due and proper consideration to specific proposals that emerge in time to address the funding gap. However, as it is understood that much more work needs to be undertaken at a local level before such proposals can be identified, there is a danger that the scope for substantive and full consultation on proposals for service change may become constrained as the year 2021 comes closer. Proposals for change in one part of the system will inevitably have financial and knock-on implications for other parts of the same system: this is something we will need to be mindful of, especially if multiple proposals are identified for consultation at the same time. This is all the more important as the Council has a key role to play in providing a local democratic mandate for service changes that impact upon the people of Gateshead.

Statement of the Council's understanding of the current status of the STP:
As you will be aware, our Health and Wellbeing Board considered the STP that was submitted to NHS England on 21st October and a progress update was also provided to the Board at its meeting on 6th December. We acknowledge that there is no requirement for formal sign off of the Plan at this stage and it was clear from the Board's discussion that it would not have been minded to do so when the item was considered at its October meeting. The Board went on to make the following resolution:

"RESOLVED –

(i) That the STP and information presented to the Board be noted. The Board has not been asked to sign off the STP submission to NHS England.

(ii) That it will be important that there is full engagement and consultation in developing the detail of the STP going forward. This will need to be done in a way that is open and transparent.

(iii) That there needs to be a particular focus on prevention and early help as key themes across the STP as a whole. Opportunities to better meet the health and wellbeing needs of local people need to be explored further and the prevention and early intervention agenda needs to be a key focus of our approach.

(iv) That the governance arrangements in taking this work forward needs to be right for us locally and incorporate a local democratic dimension to decision making."

It is understood that the STP, insofar as it relates to the Gateshead area, seeks to describe the 'current state' regarding key challenges facing our health and care economy and to build upon existing programmes of work to address those challenges. Whilst in some areas of the country STPs are setting out substantive proposals for service transformation in response to the challenges they are facing, this is currently not the case for the Gateshead area as we are at an earlier stage in the development of our response to the challenges we face locally. It is recognised that local planning work for the Gateshead area is continuing as 'business as usual' e.g. work to progress our prevention and early help agenda, intermediate care development, and the integration of health and social care.

This is a key point as it means that the 'status' of STPs that were submitted to NHS England on 21st October varies from one area to another and, inevitably, has given rise to different interpretations of what STPs in their current state represent. It is noted that colleagues at NHS Newcastle Gateshead CCG clarified the matter along these lines when the STP was considered by our Health & Wellbeing Board and through subsequent dialogue and communications material provided to the Council and partner agencies. This clarification is useful and confirms that the STP covering the Gateshead area is more about setting out a direction of travel for key work streams for the future as distinct from substantive proposals for service reconfiguration at this stage.

The Importance of On-going Engagement:
Clearly, the Council will wish to be fully involved in progressing the direction of travel for each of the transformation areas of the STP:

- Prevention, health and wellbeing
- Neighbourhood and community services (out of hospital services)
- Optimal use of the acute sector and
- Mental health

The Health & Wellbeing Board welcomed the commitment provided by the CCG that this would be the case and it will be important that key issues linked to these transformation areas are considered at appropriate points by the Board, the Council's Cabinet and the Care, Health and Wellbeing Overview & Scrutiny Committee. We will continue to work with you to identify when issues should be brought to the HWB and other Council committees, which can then feed into

timelines relating to the future development of the STP.

It is also understood that any requirement for significant service changes in the local NHS would still be subject to its own separate formal consultation process and that the usual statutory requirements and NHS policy on significant service changes will apply. The Council will continue to champion the needs of local people and ways in which they can best be met and this will be the litmus test used when considering future proposals for change.

Feedback to inform the next version of the STP and future planning
Finally, with regard to the current engagement stage, you may wish to consider the following suggestions in finalising the next iteration of the STP and associated planning arrangements:

- In light of the points made above about the current status of the STP, it would be helpful if the consultation draft STP for NTW & ND makes it very clear at the outset what the document for our area is about and, just as important, what it is not about. It is felt that this will help to dispel the potential for misunderstanding locally of what the STP covering the Gateshead area represents, where it is currently at and what has yet has to be articulated following on-going engagement and consultation with local people and local stakeholders.

- Whilst it is clear that the STP needs to meet the requirements of NHS England planning guidance, it is felt that there also needs to be scope to go beyond those requirements to ensure that the STP is truly a whole system response to the challenges and financial pressures facing our local health and care economy. Such an approach would be consistent with the tenor of the recommendations set out within the NECA Commission report 'Health & Wealth'.

- With regard to the public engagement events in Gateshead and Newcastle (11th & 9th January respectively), it is understood that neither HealthWatch Gateshead, HealthWatch Newcastle nor Newcastle CVS (which currently provides support to the voluntary and community sector in Gateshead) were aware that they were taking place until contact was made by a Council officer in early January regarding arrangements being made to publicise the events through their own networks. All three organisations then promptly publicised the events just a few days before they were due to take place, but indicated that it would have been beneficial to have had advance notice of the dates/venues from the CCG.

  It is understood that the formal public consultation stage on the STP will be wider than the current engagement stage. I trust that there will be early communication with these organisations to help publicise the dates, times and venues for similar events in the future as part of a communications strategy that has input from local partners, including the Council and local CVS. Towards this end, the Council would also be happy to help publicise future consultation events through its communications team.

I hope that this response helps to clarify the Council's understanding of the current position regarding the STP that will cover the Gateshead area, as well as some issues of concern, and trust that the feedback within this letter will be considered in shaping the next stages of its development.

	Yours sincerely, Councillor Martin Gannon Leader of the Council
62	Durham County Council To Mark Adams, STP Lead: Dear Mark, **Northumberland, Tyne and Wear and North Durham Draft Sustainability and Transformation Plan** Following discussion on the draft Sustainability and Transformation Plan (STP) for Northumberland, Tyne and Wear and North Durham (NTWND) at the County Durham Health and Wellbeing Board on 31st January 2017, please find below comments that were made at the meeting. The Board provides this feedback as part of the engagement process for the draft plan and understands this will be taken into account in relation to the next version of the STP. The Board stressed their concerns about the initial engagement process of STPs and the importance of understanding the implications for County Durham. As you are aware County Durham is covered by two STP planning footprints, NTWND and Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby (DDTHRW). There will naturally be patient flow between the two STPs and it is important to members of the Board that colleagues work together to consider the impact for County Durham patients and for the workforce, to ensure that people in County Durham are not disadvantaged in any new acute hospital re-configuration. Many local residents of County Durham have contacted their local councillor expressing significant concerns that STPs are unrealistic about funding and they include untested assumptions. It was suggested at the Board that better communication was needed with members of the public and that local people need to be aware of the specific implications as the STP in its current form is very high level. The Board suggests that providing clear information about not only the proposals but also drivers for change in the next phases of engagement would be beneficial. A request was made by the board to ensure that communications to the public are simple, clear and concise in order for the key messages to be understood. County Durham's demographic encompasses a large proportion of rural communities and the Health and Wellbeing Board would like to stress the importance of transport services, parking facilities and visiting arrangements to

	enable patients to access services. The Health and Wellbeing Board is aware that Durham County Council's planning committee has approved plans for a new emergency department at University Hospital of North Durham. The Board requested clarification on what this meant for the North STP, moving forward. This is a confusing picture when local services are planning to make significant changes in what appears to be in isolation from the STP footprint. The Board sought clarity on the sign off process for the STP once consultation is complete. This is a question that has been left unanswered and I would request that this information is provided to the Board as soon as possible. The Health and Wellbeing Board will receive an update at their next meeting in March from the Integration Board following their consideration of the STPs in the context of the integration of health and social care services. Any further comments from this exercise will be provided to you in due course. The Board would suggest that clear, open, honest and timely communications with both partners and members of the public are key when moving this process forward. Healthwatch County Durham offered to support this work. The Board noted that a consultation timeline is being developed and should be available around the end of February 2017 and will await further information in relation to this. Thank you for your consideration of these issues. Yours sincerely **Cllr Lucy Hovvels** **Chair, County Durham Health and Wellbeing Board** **Portfolio Holder for Adult and Health Services**

i North Tyneside's Tripartite Primary Care Strategy, written and endorsed jointly by TyneHealth, Newcastle and North Tyneside LMC, and North Tyneside CCG, can be downloaded from https://portal.gpteamnet.co.uk/Library/ViewItem/5d6c8f16-19ef-4256-ae3b-a6f5012750f0).

[ii] MCP and PCH are Five Year Forward View models for the future delivery of care. An MCP is what it says it is - a multispecialty, community-based, provider, of a new care model. It is a new type of integrated provider. It is not a new form of practice-based commissioning, total purchasing or GP multi-fund, or the recreation of a primary care trust (PCT). An MCP combines the delivery of primary care and community-based health and care services – not just planning and budgets. It also incorporates a much wider range of services and specialists wherever that is the best thing to do. This is likely to mean provision of some services currently based in hospitals, such as some outpatient clinics or care for frail older people as well as some diagnostics and day surgery; it will often mean mental as well as physical health services; and potentially social care provision together with NHS provision.

https://www.england.nhs.uk/ourwork/new-care-models/vanguards/care-models/community-sites/

[iii] The PCH is a form of *multispecialty community provider (MCP)* model. Its key features are:

- provision of care to a defined, registered population of between 30,000 and 50,000;
- aligned clinical financial drivers through a unified, capitated budget with appropriate shared risks and rewards
- an integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care; and
- a combined focus on personalisation of care with improvements in population health outcomes.

http://www.napc.co.uk/primary-care-home

Appendix 2

PUBLIC MEETING – NEWCASTLE, 18 JANUARY 2017

1. **What do you think about the STP vision for our area? Is there anything missing or more we should aim for?**
    - Weight management services for adults and children
    - IT systems not talking to each other – makes it difficult to deliver – need one system across all organisations
    - Prevention needs to include education and start with schools
    - 22 different areas in NE in terms of BSL contracts
        - In isolation and don't talk to each other
        - Needs to be better managed
        - Needs centralising and save money
    - CCGs/LAs and other organisations – should work together better – be more streamlined and joined up
    - Prevention – can healthcare etc. learn from our (fire and rescue) experiences and knowledge?
    - What are the priorities and drains on resources – identify demand
    - Participants felt that they could not argue with the vision but that it is simply not achievable.
    - Engagement for all organisations
    - Improve raising awareness – not many people aware of the STP or engagement events. Some PPGs heard about this in October/November, therefore comms need to be improved
    - Important for GP practices to disseminate information as well as newspaper articles, billboards, posters, on TV screens – ensure individuals are not missed (was mentioned it was featured on Look North)
    - Critical dependency on workforce – frontline staff should be aware of STP vision
    - Union involvement – Social Partnership, Unite, etc.
    - Good LA involvement
    - General communication to be improved, such as computer systems
    - Generally don't disagree with vision but how will this be achieved given current cuts?
    - Need to decrease inequalities – would like to see this reflected
    - Inequalities – is it education? Could it be behaviours of services which create inequalities?
    - Is it more about what we could do differently?

2. **What do you think about our ambitions for what our health and wellbeing services should look like by 2021? Is there anything missing or more we should aim for?**
    - Health services are being cut – how can we deliver care in future?
    - Accessibility – educate – what is available? How can we access? Is it different across different CCG areas?
    - For instance; have specialised services in the areas where there is highest demand
    - Communicate via GPs? E.g. pulmonary rehab works but GPs not referring in (less than 15%) – patients don't know about it
    - No standardisation across CCGs in terms of services and patients don't know what they should expect and what is available
    - BLF thinks a patient with COPD should get a wallet card saying what is available
    - Limited re services
    - Need to address poverty and deprivation
    - Weaknesses of the plan – objectives high level
    - Time – length of time to train a GP? Where is the workforce? 1/3 expected to retire in the next 5 years
    - Removal of bursaries for nurses is bad
    - Need plans to tackle alcohol/sugar etc.
    - Funding issue needs addressing
    - Communication between organisations – work more cleverly together and use each other's experiences and skills
    - Investment in prevention – invest to save
    - Deciding together – missing the point; aiming at Mental Health for complex chronic conditions – early intervention needed so condition does not escalate
    - Stigma associated with using phrase 'mental health'
    - Annual action and delivery plan needed at key stages
    - Key line of enquiry – feed into governing body – monitor delivery
    - 5 year plan – areas in CCG have grown – each CCG has its own plan and agenda which results in fragmented working – how can that be eliminated?
    - It was felt that any preventative work would have to be long-term, over a generation (for example it has taken a generation to make drink-driving socially unacceptable) and therefore the effects of investment in this area would simply not be felt by 2021. Moreover, major preventative programmes such as reducing smoking or sugar intake have only been effective because Central Government has imposed bans or taxes, which is not something that the STP partners could do.

- Funding any preventative work will also be very difficult because there are huge funding pressures on local authorities who now have responsibility for public health and at present there is no statutory duty for local authorities to carry out preventative work. By 2020 Gateshead Council will not be able to meet its statutory duties therefore there is little chance that funding will be available for preventative work.
- There was also a request that previous preventative schemes are properly researched to understand their effectiveness before money is spent on new schemes.
- Not clear on funding
- Focus on quality, health & wellbeing and prevention
- It is unknown how much money will be recovered in future – unpredictable to rely on prevention – difficult to plan, although can review annually and look at past trends
- How many organisations promote messages of health and wellbeing to children and young people? Important to run education sessions in schools, scouts etc. through different funding
- Deliver messages quickly
- For example – paracetamol? 17p to buy or £7 per prescription. Agreement for those on table to do this for people not on benefits
- Concern over those who desperately need help but not on benefits
- One example – diagnosed as having Type 2 Diabetes which then meant all medication was free which is not necessary
- Clinical practice could be changed – not all clinicians are aware of what voluntary sectors offer, or they don't appreciate it
- In contracts for 2 years now so commissioners have their hands tied
- Some people offered Year of Care and some aren't – GPs are not obliged to offer this to patients
- GPs and hospitals are independent – unfortunately CCG cant mandate certain ways of working; however, STP brings those key parties around the table to work collaboratively
- Several different contracts for practices, but the way the NHS is set up we can't always influence
- Feel like we need two ways of working, running new models whilst dealing with current shortfall – but no money to do this

3. **The 5YFV identifies three main gaps – health and wellbeing, care and quality and funding – what do you think about the proposed actions to address those gaps locally? Is there anything missing or other actions we should take?**
    - Invest in prevention – statutory duty to prevent but possibly not see benefits straight away

- How can organisations learn from each other? Environmental factors too
- Invest to save – prevention needs money invested
- Social care – if LA spent all budget on social care – still a deficit by 2021
- Educate the kids about all the different organisations
- Key messages; national default (of £5b?) over 5 years is represented by 1p on income tax
- Comms between organisations is key to working together
- If we want public to invest in us we need to make sure they are informed
- Savings to be made in 5 years
- Discussion suggests there is no timeline for this plan – so why mention 5 years? There needs to be a date/deadline
- Some aspects of plan will be delivered before the 5 years, but training etc. may take longer
- Plan to be refreshed annually
- Health action zones – provided freedoms – do we have freedoms under STP?
- LTCs – how will the services work around these people? These people will end up using hospital/health services more if not supported the right way – need a holistic approach
- How do we manage people with complex needs to make the service more efficient? Integration is key for those with complex conditions
- Repeating the health history over and over again
- One example provided of one procedure carried out twice because health professionals don't trust one another
- Transferring patients unnecessarily – waste and cost
- Consultant to consultant referrals stopped, referred back to GP as usually being managed by GP who may action a review

4. **What do you think about the scale of the challenge facing us in making significant improvements to health and wellbeing, services and efficiencies? Are there any other actions we could take to make these changes or speed up the rate of improvement?**
    - Gateshead Vanguard work – hospital beds are being taken by the elderly without a care plan who are unable to remain in the community so being kept in hospital. Hospitals to work with nursing/residential homes to take their empty beds to reduce pressures of A&E
    - Care Home Vanguard – 90% of residential homes to pull out of programme – funding
    - Issues: some nurses required in some, not all
    - Identify elderly person's needs – carer/nurse/bed – place appropriately to get the care they need

5. **We will only achieve these ambitions for our area by engaging local populations, the people who use our service, and the staff that provide care. Have you any ideas of who we can effectively engage with the 1.7m people in Northumberland, Tyne and Wear and North Durham?**
    - Publicise – get the right people involved, especially vulnerable groups who would not attend engagement events – CCG should visit the groups and ask questions; day centres etc. for the hard to reach groups
    - Get messages back to PPGs, community, church etc. of information around local services and local groups
    - Patients are equivalent to partnerships and should be made to feel that way – important
    - The priority is the workforce

6. **General comments**
    - One person had an issue with the information provided in the STP; it is only looking at expenditure and not where the money is coming from and whether any of it is ring-fenced.
    - There needs to be a realisation from the general public that the NHS simply cannot provide everything and things have to be rationed and to this end it would be useful for the public to have an understanding of how much services cost. We need to go back to basics and ask the public what they want from an NHS, what they really need and what would be reasonable to remove.
    - One participant noted that one of the big failings of the NHS is publicity – we have got good services but people are not aware of them.
    - There should be caution taken when sharing the STP with staff working in the NHS as they may feel that they are being labelled as inefficient.

Appendix 2

PUBLIC MEETING – GATESHEAD 11 JANUARY 2017

1. **What do you think about the STP vision for our area? Is there anything missing or more we should aim for?**

- There is very little mention of the role of the CVS in the draft plan and the impact from the withdrawal of council funding

- Funding for the community and voluntary sector has been stopped – not just cut or reduced, there is no funding.

- The waterfall diagram within the plan is a very niche way of explaining of where funding can be saved. This could be supported by an explanation of how the diagram works.

- Acknowledged that it is a draft plan but need to show different ways of explaining the STP

- I hear a lot of statutory bodies saying that they're working with the voluntary sector, when in fact they're just working with one organisation…" There needs to be a better understanding of the size of the community and voluntary sector to work with it effectively.

- Examples given of local health bodies and voluntary sector working together - Learning disability health checks and cancer screening - this is saving the CCG money
- There needs to be a balanced structure from the voluntary sector so that the NHS knows to go to one central organisation that can be speaking on behalf of the whole structure.

- GVOC has closed in a crucial time that we feel under –represented (CVS)

- To attempt consultation on this level of detail seems to be not the correct process (explained it was pre-engagement and not at consultation stage)
- This is a plan which needs to fundamentally accept the funding gap – we do not accept it – we should reject this plan.

- Question 1 at this stage should be 'Do people agree with this funding cut?'

- The plan just seems to lead us all by the nose to just go along with this.

- We need to address the whole population in terms of getting everybody's views on this

- If health system doesn't learn to use CVS and talk to us the whole preventative aspect of this is lost - we cost very little for the amount of work that will save on prevention.

- The last bulletpoint on Q1: 'Local people are empowered and supported to play a role in improving their health and wellbeing' – this consultation isn't helping with this, it's very hard to understand these materials. There are different ways to present things. Accessible standards across the board.

- Groups – CBS, to consult and assist on this to make things more accessible, also Healthwatch can help with this. Example of Better Health Programme given; VONNE partnered with the CCG to facilitate '100 conversations' CCG gave them a toolkit and worked with them to shape materials.

- If the voluntary sector expires, vital work like this can't be done, the NHS won't be able to cope.

- To tackle austerity measures, examples given of social prescribing model work and community reassurance where Newcastle Gateshead CCG has worked with the voluntary sector to make effective efficiencies.

- Everybody isn't totally angry or negative – we want to help, I'm excited about the 20% where prevention lies and we (CVS) are talking more with the NHS.

- I applaud this attempt but it is fundamentally flawed, there is too much detail to provide feedback on

- This STP fundamentally accepts the gap in the funding plan, I do not accept this and people in this region do not accept it

- Statutory bodies say they are working with the voluntary sector but it is not representative. CCGs need to find a more creative and balanced way to speak to CVS. There has to be a balance as there is regularly just one voluntary group at the table and one group does not speak on behalf of all CVS.

- It is helpful to be asked what it missing, the second bullet point.

- The plan remit is to reflect the view of local communities but at the beginning it should say we do not accept this.

- Do the people in this STP agree with the funding cut?

- The last bullet point (in Q1), if we can't start with accessible consultation then how can we get things done. People do not have access to this consultation.

- Everyone in the room today is angry (talking about the group at the front who did not participate in the discussion at the table), we can't down tools and we are not all angry. It is 20% prevention and 80% fire fighting. You can't consult the public on every single decision.

- There is a gap in the conversations at an executive level. I speak to people at the local authority and when I mention STP they say they've heard of it but not sure what it is!

2. What can we do to make VCS feel involved, to help and make things easier?

- Use other forums, learning disability forums, GVOC

- In Tees Valley, the better health programme through VONNE, on behalf of the CCG in the area facilitated 100 conversations

- At Citizens Advice Bureau the audience serviced has changed, people are coming to us with debt and homelessness, people are in crisis

- It is the same at the bereavement charity, under Well Being the NHS should be doing this. We have had to cut the number of people we see. Access to money from the NHS would really help.

General questions

- It's good that proposals are vague and you want our input, but 80% is already going on in the background and we have no detail. How can you consult if you don't know the acute configuration?

- Is there a Learning disability transformation plan?

- Why not advertise better to let more people know about these events – tv for example?

- Will there be preventative health service cuts?

- Is this going to be an honest consultation, unlike the closure of the paediatric A&E at Queen Elizabeth where there were over 2000 replies which were ruled out and only 300 included because they didn't come to the right conclusion? What confidence should we have? It doesn't seem to be independent from the government.

- The Local Authority is accountable to people and the NHS report to Secretary for State of Health – there should be more accountability given to carers. Engaging with Carers has not been mentioned. Working more effectively with carers and the voluntary services, recognising the role could help funding go

further. Charitable funding through the Local Authority and PCP affects cuts. How are you going to do that?

- It is ambitious – one size fits all, doesn't work here. The massive reduction in council funding by 20/20 will fail. There is a chronic shortage of funding already for the adult and social care element. Agreement is needed to go ahead with the plan. What percentage relies on the Local Authority?

- How are our local services going to be affected. We need to be clear because the government is not prepared to fund the NHS. I would like to see this recorded: Mental Health – this isn't the way to do it, we need cash up front.

- Have you addressed the issue of Local Authority areas - NECCA?

- Understanding the £641M gap – what's the spend, what percentage is cut?

- Under NHS operational planning guidance stats'contracts' would be signed 23rd Dec. What are these contracts and have the already signed?

- If on about care closer to home for mental health care – how is this going to happen when you've cut beds in Gateshead. People are being transported miles to be cared for.

- Do and can the CCG lobby parliament to request more funding? Based on risk etc and duty of care?

General comments

- Provide acronym guide – glossary required for diagrams. Too much jargon.

- I'm questioning the language and tone of the presentation – does 'stretching' not mean 'reduction of money spent' We are heading to 6.5% - why not be transparent. £441k aren't cuts – the growth of the budget doesn't keep pace with the ageing population.

- Be open and honest – if there are going to be closures/ reduction in services – then tell us. On the overview slide – hospital facilities are going to be cut. It should say you are doing it.

- Advice and guidance – this should come from our NHS consultants not expensive private bodies.

Appendix 2

PUBLIC MEETING – DURHAM 13 DECEMBER 2016

Attendees questions:

- I would like evidence of how this plan will reduce A & E admissions
- What data has the Health and Wellbeing Board been given?
- I'm un-reassured by the timescale of all this happening. Its difficult to vote against the plans but there's no evidence to help me make a decision. I want to know how you know that this plan will reduce traffic into A & E.
- Aren't you just going to pass this off as consultation with the public?
- Will the NHS receive funding in line with inflation?
- Recruitment and training remains a big issue. How are we going to get the right level of staff?
- How many organisations created this STP?
- I want a statement from the CCG about how the process and findings inform the Staffordshire report. Old one said person's care is responsibility of NHS new one says persons care is THEIR responsibility. Who wrote this? Where did it come from? Who agreed it?
- How can you sign procurement contracts on 23rd December when all this isn't sorted out?
- What is happening to the outcomes of these sessions? What's the point of us? We should be your critical friends
- How can you provide 7 day services when you are cutting funding?
- If you close down Darlington A& E and North Tees – how will A&E in Durham cope? A&E admittances are rising by 4% how can that be reduced?
- This is a suggestion to all the CCGs – Why don't more of you turn around and say that this is not do-able???

Attendees comments:

- We need more beds in A & E - 120% occupied at present NHS grossly oversubscribed. The wheelchair service's a joke, a neighbour just received wheelchair after losing a leg last December. NHS getting worse not better.
- Doesn't take into account the latest NI increase - £450 per adult and child – per person. Please just be honest with us it's a financial model of carelessness. I've never seen a document with so many cloaks and mirrors
- Concerned you are throwing more work the way of GPs and that's why they are retiring or going somewhere
- Increasingly concerned that this STP arrived fully formed. You ask what do you think of the decision? The decision has already been made. We have to have all this sewn up by Feb? That's a short window.

- The NHS is being privatised – I'm getting leaflets from private health companies using the NHS logo. Money goes out of the NHS to private companies.
- Vanguards will tells us they are breaking even. We are hearing that you will make a 50% saving. I don't see how that is possible when you will need to double the social side for people if services are moving out of hospital.
- I get what you are trying to do. Self care, go to your pharmacy – the pharmacies are all closing down, VCS is crumbling. We are a very needy area – there's just no funding
- Biggest health issue is recruitment. Morale low on every level.& day NHS is terrible. & day NHS - Jeremy Hunt just wants it as a stick to beat the junior doctors with
- The Q & A document gave no reference to DCC. Its an abridged version. It says that there are 6 LA affected – its actually 7. This needs amending. It's a statutory requirement that this is amended before consultation. Only then will the Health and scrutiny committees see this. We will be looking at *finance*workforce modelling*impact on social care. These need to be thouroughly reported on .If they are not and we are not satisfied than we can refer this to the secretary of state.

Appendix 2

PUBLIC MEETING – NEWCASTLE - 9 JANUARY 2017

Attendees responses to questions:

1. **What do you think about the draft STP vision for our area? Is there anything missing or more we should aim for?**

- This is all about cuts, you can dress it up all you want. It really is about dismantling the NHS. It'll be about taking out insurance in the future.

- There's very little information, but is it a good or bad thing there is very little detail. I really don't like how the graphs are presented, they are confusing. It's not written in Plain English.

- It's about cuts, closing departments, you cannot improve services, we can't argue with this.

- The reality is that there is £600 million to be saved. It doesn't add up with all the window dressing about improving services and making things better.

- The largest proportion – the £158m is unidentified efficiencies – what is going to be identified? How have they came up with the figures? In the QE, there were people waiting on trollies in corridors to get a bed.

- These are meaningless statements, what exactly is it covering up?

- If we are to look at the vision – it should be honest in saying that there are no reassurances this will happen.

- Is the STP a shared vision?

- Intentions are noteable, no one would disagree.

- Issue of things that are missing, general public need to be involved in the discussion. There needs to be a process to engage with the public.

- This is a leading question, no one would disagree.

- Strange financial envelope of care and quality and health and wellbeing.

- They think big will save money but it is not the case, Durham proved big is beautiful is not a given. Big area does not deliver savings, it is not a given, could be opposite.

- If you want voluntary sector to deliver services, they need funding.

- General public need to be as involved as much as possible.

- Key target areas in health and well being and draft

- Lack of details involving public. Simplify the slides.

2. What do you think about our ambitions for what health, well being and services should look like by 2021? Is there anything missing or more we should aim for?

- The STP should address not just the NHS- it's about society as a whole.

- Look at if we do have the best healthcare system in the North East, why do we have the biggest health inequalities?

- Ambitions need more detail, looking at different areas to improve e.g. the pharmaceutical industry over charging the NHS; PFI – the debts that have been accrued; Charges on staffing, recruitment; these and other angles should be introduced to ambition.

- Education not always to be referred to the patient. Save GP referrals to other services in hospital by educating the GPs. More GPs in A&E to stop people coming in and staying, they refer them back to urgent care.

- GPs in A&E works very well.

- Funding gap, is it right to save as much as possible because then it will be cut again next time.

- The waterfall plan lacks detail. Where did the £9m come from for pathology, elaborate on how it will be done.

- Is there a commitment to aggressively go after the waste.

- Individual organisations have tried to do this.

- Estate and old estate, basic economies. The public will have to travel further to access services.

- Ill health prevention and improving wellbeing. Newcastle City Council are looking for ways to look after local parks, this will assist with health and well being.

- There is no detail but specifics on where the money saved comes from.

3. What do you think about the scale of the challenge facing us in making significant improvements to health and well being, services and efficiencies? Are there any other actions we could take to make these changes or speed up the rate of improvement?

- The significant impact is undoubted.

- This is unprecedented and must be daunting for everyone involved in the process, the public and staff. I think it will be very de-motivating for staff.

- This does not need to be speeded up. We shouldn't speed it up. It needs to be more considered."

General questions

- Can you see what charities can do for capital expenditure – equipment (thinking or recent equipment for Freeman)?

- STP plans seem far removed from staff on the ground. Leadership at every level is essential to meet the crisis. There are so many ways to save money that staff could you not included. How will you harness this knowledge and these skills?

- Are the Waterfall graph savings too specific given the fact that the rest of STP is so vague (without detail)?

- I welcome the statement that there will be a programme of consultation that will be published soon. When and where? However, can the NHS also commit to engagement and co-production with patients, particularly around more details service charges and service redesigns.

- I need to look older than the Dr & nurse motel. Will we see investment in AHP services? Proven to be more efficient and effective in prevention, treatment and recovery?

- How much would localisation and centralisation via collaboration and rationalisation be a contradiction? Even in terms of transport costs via buses and car parking?

- Learning disabilities – how do we reach them? It worries me that we are not going to reach those people.

General comments

- I am concerned with the news from the red cross regarding the Humanitarian disaster, Northern Ireland's GPs stressed by lack of funds etc

- This seems to be managing disaster of this government economically and politically. Prevention is an investment but doesn't happen without other areas suffering. There is lots of pressure on the 3rd sector and they need a democratic voice. You need demographic structure. You need to report what we say and this was ignored when Shotley Bridge hospital was shut down.

- I know you are being forced to put in privatisation and have cuts in health and social care but the £604m gap is misleading.

- It's difficult to find people in favour of STP in the medical world – people say it's a distraction. Gateshead council were disappointed with the lack of engagement to develop the plan. We could be involved a lot more. It is the local authority view that is would be useful to go further to make a response around the whole system not just the foundation trusts. There are lots of myths going round about the STP – let the people know what the STP is and isn't trying to achieve.

- The STP is reducing sight saving drugs – there is a capacity and resource crisis; 20 people per month losing their sight. The joined up data available from the 31st July under the Accessible data act which states people can get a copy of their health records in whatever format they wish isn't happening. I am concerned that this is now a legal requirement that is not happening.

- When looking at inequalities of access to healthcare please consider the people of rural Northumberland who now have to go to Cramlington if they have a stroke or MI – rapid intervention can reuce the damage of these events but I don't think it is clear they can reach Cramlington in time. Organisations need to do an audit of times between 999 calls and arrival and intervention. If performance is not adequate, risk mitigation measures need to be put in place. There is also a problem with paediatrics – hospitals like Hexham are telling parents to go to Cramlington.

- Rating they will be inclined to look after individual concerns rather than the area as a whole?

- Community pharmacy – A massive under resourced service

- Engage people who have links with patients. They will tell you how to make efficiencies.

- Preventative illness – community pharmacy can promote Health &Wellbing for stop smoking, diabetes monitoring, weight management and health life changes. Also BP monitoring, health checks LPC's and LPN's to be included in all STP meetings and how to support STP development.

- Mission statement – it should state 'A Person centred' not place based. People should be a No 1 position.

- Need a real focus on changing the admin side of things – that's where we will save efficiencies.

- Engage with the people – timeline and detail an issue.

Appendix 2

PUBLIC MEETING – WHITLEY BAY 16 JANUARY 2017

1. **What do you think about the STP vision for our area? Is there anything missing or more we should aim for?**
    - Weight management services for adults and children
    - IT systems not talking to each other – makes it difficult to deliver – need one system across all organisations
    - Prevention needs to include education and start with schools
    - 22 different areas in NE in terms of BSL contracts
        - In isolation and don't talk to each other
        - Needs to be better managed
        - Needs centralising and save money
        -
    - CCGs/LAs and other organisations – should work together better – be more streamlined and joined up
    - Prevention – can healthcare etc. learn from our (fire and rescue) experiences and knowledge?
    - What are the priorities and drains on resources – identify demand
    - Could not argue with the vision but that it is simply not achievable.
    - Generally don't disagree with vision but how will this be achieved given current cuts?
    - Need to decrease inequalities – would like to see this reflected
    - Inequalities – is it education? Could it be behaviours of services which create inequalities?
    - Is it more about what we could do differently?

2. **What do you think about our ambitions for what our health and wellbeing services should look like by 2021? Is there anything missing or more we should aim for?**

- Health services are being cut – how can we deliver care in future?

- Accessibility – educate – what is available? How can we access? Is it different across different CCG areas?

- For instance; have specialised services in the areas where there is highest demand

- Communicate via GPs? E.g. pulmonary rehab works but GPs not referring in (less than 15%) – patients don't know about it

- No standardisation across CCGs in terms of services and patients don't know what they should expect and what is available

- BLF thinks a patient with COPD should get a wallet card saying what is available

- Limited re services

- Need to address poverty and deprivation

- Weaknesses of the plan – objectives high level

- Time – length of time to train a GP? Where is the workforce? 1/3 expected to retire in the next 5 years

- Removal of bursaries for nurses is bad

- Need plans to tackle alcohol/sugar etc.

- Funding issue needs addressing

- Communication between organisations – work more cleverly together and use each other's experiences and skills

- Investment in prevention – invest to save

- It was felt that any preventative work would have to be long-term, over a generation (for example it has taken a generation to make drink-driving socially unacceptable) and therefore the effects of investment in this area would simply not be felt by 2021. Moreover, major preventative

programmes such as reducing smoking or sugar intake have only been effective because Central Government has imposed bans or taxes, which is not something that the STP partners could do.

- Funding any preventative work will also be very difficult because there are huge funding pressures on local authorities who now have responsibility for public health and at present there is no statutory duty for local authorities to carry out preventative work. By 2020 Gateshead Council will not be able to meet its statutory duties therefore there is little chance that funding will be available for preventative work.

- For example – paracetamol? 17p to buy or £7 per prescription. Agreement for those on table to do this for people not on benefits

- Concern over those who desperately need help but not on benefits

- One example – diagnosed as having Type 2 Diabetes which then meant all medication was free which is not necessary

- Clinical practice could be changed – not all clinicians are aware of what voluntary sectors offer, or they don't appreciate it

- In contracts for 2 years now so commissioners have their hands tied

- Some people offered Year of Care and some aren't – GPs are not obliged to offer this to patients

- GPs and hospitals are independent – unfortunately CCG cant mandate certain ways of working; however, STP brings those key parties around the table to work collaboratively

- Several different contracts for practices, but the way the NHS is set up we can't always influence

- Feel like we need two ways of working, running new models whilst dealing with current shortfall – but no money to do this

- There was also a request that previous preventative schemes are properly researched to understand their effectiveness before money is spent on new schemes.

3. **The 5YFV identifies three main gaps – health and wellbeing, care and quality and funding – what do you think about the proposed actions to address those gaps locally? Is there anything missing or other actions we should take?**

    - Invest in prevention – statutory duty to prevent but possibly not see benefits straight away
    - How can organisations learn from each other? Environmental factors too
    - Invest to save – prevention needs money invested
    - Social care – if LA spent all budget on social care – still a deficit by 2021
    - Educate the kids about all the different organisations
    - Key messages; national default (of £5b?) over 5 years is represented by 1p on income tax
    - Comms between organisations is key to working together
    - If we want public to invest in us we need to make sure they are informed
    - Health action zones – provided freedoms – do we have freedoms under STP?
    - LTCs – how will the services work around these people? These people will end up using hospital/health services more if not supported the right way – need a holistic approach
    - How do we manage people with complex needs to make the service more efficient? Integration is key for those with complex conditions
    - Repeating the health history over and over again
    - One example provided of one procedure carried out twice because health professionals don't trust one another
    - Transferring patients unnecessarily – waste and cost
    - Consultant to consultant referrals stopped, referred back to GP as usually being managed by GP who may action a review

General comments:

- The information provided in the STP; it is only looking at expenditure and not where the money is coming from and whether any of it is ring-fenced.

- There needs to be a realisation from the general public that the NHS simply cannot provide everything and things have to be rationed and to this end it would be useful for the public to have an understanding of how much services cost. We need to go back to basics and ask the public what they want from an NHS, what they really need and what would be reasonable to remove.

- One of the big failings of the NHS is publicity – we have got good services but people are not aware of them.

- There should be caution taken when sharing the STP with staff working in the NHS as they may feel that they are being labelled as inefficient.

Appendix 3

ENGAGEMENT EVENTS IN NORTHUMBRIA

As part of engagement work in Northumberland to help people understand more about the new local integrated accountable care organisation a series of events were held in January 2017.

These event (as detailed below) were also used to seek local views on the draft STP and attracted a total of 84 people:

- 10 January Hexham community centre
- 12 January Blyth community enterprise centre
- 12 January Ashington CVA
- 13 January Bellview resource centre, Belford.

In response to a presentation about the accountable care organisation, vanguard programme, Five Year Forward View and draft STP the following comments were feedback:

- All health and care providers across Northumberland need to be fully involved, including staff who work in partner organisations
- How will the voluntary sector be involved and integrated? They are delivering services at grassroots level and have lots to offer.
- Will there be more post-diagnosis support for those with dementia?
- Concern about maintaining local access/provision of local care/mental health
- Improved links/relationships between health and social care
- Growing problem of care for the elderly – how can we transfer from acute to community care?
- Better use of community hospitals
- Education the population on where to go for services/care
- Improve access to primary care
- GPs should be talking to their patients about health and wellbeing
- People are living longer and with multiple conditions. How do we support this?
- Lack of communication between different services results in people being passed around.
- The importance of local people's involvement to transform health services in local communities eg social prescribing, care in the community etc
- The importance of properly funded education programme for the ACO plans to work
- Positive about Northumberland being the first area to try the ACO model but wanted the health initiatives to be sustainable and were concerns about doing this against a backdrop of cuts to NHS budgets.
- Several people wanted to be "community connectors" and were keen to help get messages out.
- Systems need to be aligned so records can be shared.

- The importance of communication to the public re access and looking after their own health and grass roots engagement
- GPs need educating to educate the public. They should think of the person as a whole and not focus on just one issue.
- In terms of health and wellbeing, people need employment and leisure/social opportunities. Swimming pool prices have recently increased, bowling clubs are closing.
- Linking systems to ensure continuity of care
- Some have no trust or confidence in the STP plan – lots see it as cuts by stealth
- How will cultural change happen? What's the leadership going to be?
- How will private organisations be involved in the ACO eg care homes?
- How have local councillors been engaged about the STP? Some say they don't know anything about it.
- For care at home/in the community to work effectively district nurses need more time with people.

STP events Sunderland and south Tyneside	Attendance	Date/Time
Community and voluntary sector event	63	16 September -1pm
East People Board (Sunderland)	13	14 November – 3.30pm
West People Board (Sunderland)	12	14 November – 5.30pm
Coalfield People Board (Sunderland)	12	15 November – 5pm
North People Board (Sunderland)	11	16 November – 5pm
East Shields and Whitburn (ST)	25	16 November – 6pm
Jarrow and Boldon CAF	25	24 November – 5pm
Hebburn CAF (ST)	35	28 November – 10am
East (Sunderland) VCS Network	30	1 December – 1pm
West VCS Network	23	7 December – 10am
Jarrow Constituency Labour Party	45	6 December - 7pm
West Shields, Cleadon and East Boldon CAF	20	8 December – 10am
Riverside CAF (ST)	21	8 December - 6pm
South Tyneside CCG Council of Practices	28	15 December 3-4pm
North (Sunderland VCS Network)	20	15 December - 1pm
Washington People Board	15	16 January - 4pm
Washington VCS Network	16	24 January - 9.30am
Coalfield VCS Network	33	26 January - 10am
TOTAL	**447**	

Appendix 5

RESPONSES TO ON-LINE SURVEY

For the duration of the engagement period an on-line survey was available via partner websites for anyone to complete with an interest in the draft STP. The survey was promoted via media releases, social media and partner organisations communication tools and networks.

The survey posed the same five questions that were asked at engagement events and a total of 94 people and/or organisations took the time to respond to the survey. Each was asked to identify their gender and of the 69 who answered the question 37.7% said they were male, 52.2% identified themselves as female and 10.1% preferred not to say.

The majority of responders were individuals but the following organisations also took part in the survey:

- Newburn Surgery patient participation group
- Tyne and Wear Fire and Rescue Service
- Women's commissioning support unit
- North Tyneside VODA
- National Shop Stewards Network North East
- www.highereffect.co.uk

ROUND-UP OF RESPONSES

Question 1

What do you think about the draft STP vision for our area? Is there anything missing or more we should be aiming for?

Of the 94 people/organisations who responded to the survey, 86 answered this question:

- Excellent aims but How do the funding cuts relate to this? In reality, as much of a hoax as the '7 day claims'. Unevidenced, unfounded, are you part of a lie?
- Vision is admirable - BUT how on earth will savings be made with these goals above? sounds like you need extra funding... not finding ways to get by on less. Closer to home.... one huge emergency A&E in Cramlington... with transport needed for people ....how to get there easy by bus or taxi? And ambulances need to travel further for some people. And what if you can't afford taxi or car? And three walk in centres going but replaced by one 24/7 urgent care centre...how is this closer for everyone? ....very convenient that the A&E n walk ins not part of the STP... or are they? Walk ins part of QIPP but still happened in 2015 and STPs were started two years ago. And new model of urgent care?based on what evidence? and I'm pretty clued up...and first I hear about walk ins is in Dec last year and that it's decided...they are going. You had responses from 768 people...surely there must be some threshold for supposed consultation that has to be reached? Even IF an

urgent care centre is good... only 768 is not good enough or high enough...out of 1000s who live in N Tyneside. So very convenient to have economically viable above on point two. Mental health...yes good vision again...but where is the ring fencing of funds or guarantee of it?And forums and health watches and My NHS need to be promoted more. In the past I was confident that the NHS was in good hands - I'm not any longer .

- Very visionary and equitable. I would not use "will" realise their potential as things outside the STP affect this . STP is about health and social care not things such as equity of access to schooling Safe& sustainable services are not the same as good services. It's safe & sustainable to strap people at risks of fall in bed but it is not legal/good practice
- Difficult to argue with these aspiration. However point by point:difficult for everyone to "equally" enjoy positive health and well-being if some are sick and others aren't. Do we have to make the healthy sick to achieve this?Safe and sustainable is a little unambitious?Play a role is a little unambitious?
- The aims are laudible but they do not represent what the proposals will really mean for health services in our area. In reality, services will be cut and people's health will be put at risk by the increased rationing of provision.
- I would question whether Northumbria NHS Trust provides sufficiently prompt assessment and treatment for myocardial infarction and suspected stroke for people living in outlying rural areas of Northumberland. The outcomes for patient with MI or ischaemic stroke are now greatly improved with prompt treatment but this is only available at Cramlington. I would like to see an audit of the time between 999 call and the start of treatment for all patients. If there is a significant delay in the start of treatment for these patients, appropriate risk mitigation measures should be put in place or people told honestly that there risk of delayed treatment if they live in outlying areas. There are potentially similar problems with acutely ill children and it should be made clear to all parents (ante natal sessions?) when they should take children straight to Cramlington, having called 111 first.
- While the vision is laudable and would be hard to disagree with, it is written in language that is understood by health care professionals, language that would be difficult to understand for the ordinary patient in their GP surgery, outpatient clinic waiting area or an A&E department. The graphic illustration of the proposed model (page 7 of the summary document) looks pretty but is hard to understand unless you are familiar with such illustrations.The illustration showing the gaps to be addressed in the STP (page 9) is easier to understand and might make a better starting point for non health professionals to understand the context in which changes are proposed.
- Underlying the current plan is the money available to deliver better health outcomes and the current concerns that the government is not prepared either to provide the funding or the policy context in which sustainable improvements in health and well-being can be delivered. This is hinted at in the second bullet point by the two words "economically viable". Such words are not neutral in the context of past and current government policy in relation to the NHS and social care - if the money and the policy are not available, then the ambitions will founder.

- Encouraging citizens to take responsibility for their own health and well-being is fine, but it not an abstract concept - it requires good knowledge and information, good support services, access to facilities and so on. Yet since 2010, resources that could be applied to all of these areas have been sucked out of our region.
- Our experience in Newburn PPG with the development of a new surgery that would have allowed our practice to provide more services to our patients that would have improved health outcomes, demonstrates what happens when the money is pulled.
- Only recently, one of the local authorities in the STP footprint area - Newcastle - announced the closure of its Sure Start centres, critical infrastructure that would help citizens starting out on parenthood understand the skills and choices that allow them to take meaningful responsibility for their own and their families health.
- Looks rather vague in many respects. I am concerned about the possible bullying that may occur eg mothers being put under pressure to breast feed....in some parts of the country Trusts have tried to make mothers sign forms to the effect that if they fail to breast feed they are jeopardizing the baby's health. Any Trust doing this is actually guilty of a criminal offence...Harassment. So I think you need to be very clear about your methods of so called support and empowerment.
- Great aims. But point 2: explain, exactly, how a ~900 000 000 real terms CUT in funding across the whole region in the next 5 years makes that "aim" anything other than a cynical - empty hot air - contradiction? 'Economically viable'? According to whom - please spell it out. Who voted for the current wave of un-mandated policies from our anti-piblic-sector government? Nowadays, not even Mr Hunt bangs on about evidence for 7-day services anywhere that anyone can question him. It was a cynical, hollow lie. Let's have the debate in terms of % GDP, number of doctors, nurses, beds: population.Aim for better- funded- supported- education and healthcare. Not at this price.
- I do not believe that this cuts-driven plan is a single iota about better access/better patient care/better wealth and prosperity for anyone outside those in the health insurance business, and other business investors (I specifically am thinking about CDDFT's PFI outgoings) and private healthcare.
- Increase investing in schools, education, social care - don't pretend that cutting healthcare will have the same de facto outcome. Risible.
- Better access? I want to see explained how the population of- say- Shotley Bridge and Consett benefit from having their hospital removed? What access to transport have they (public or private)? How relatively comfortably off are they- and what is the mean age- compared to the rest of the county? How far will they have to travel for GP-led hospital beds? Maternity care?Emergency assessment? Let's address nursing homes and care-at-home, too. Let's look at hospital waits e.g. The ambulance waits over Christmas and New Year : I am ashamed at the "patients-should-not-be-so-stupid" recent news statement from the CEOs of our region: how do trivial illnesss impact in-patient bed capacity? Not at all. It is hurtful; message to genuine people is that they

shouldn't come unless dying. I have seen first-hand the calamitous effect of that fear. And where are we going to get more GPs, more nurses- or just endless dilution of skill and money? I speak specifically about the experience of NHSP in our hospitals - making millions of profit; proudly putting in all their literature and board reports their claim to be re-investing it straight back into the public's NHS. Their email response to my questions says they are simply putting more people through 2-day training to be an HCA; nothing to do with qualified nurses, professions allied to nursing, and medics. But they've spent millions on developing a 'great IT platform' - making them easier to use. Who owns the recently sold 40% stake in NHSP?!) ? We have a catastrophic shortage of permanent staff already. The older generations have paid in for all of their lives - we treat them deplorably by destroying their healthcare.

- This will only be achieved by a massive injection of funding from the Governement
- It is how you implement your vision that is important. The Plan as it stands lacks specifics about what will happen to healthcare services in the STP area. One huge issue is how will moving care into the community actually succeed when local authority funding has been cut to the bone and social care is in crisis. Concentrating care in specialist centre will place huge demands on the ambulance service which will need increased resources in terms of equipment and numbers of staff and increases in skilled paramedics who can carry out procedures in the person's home or on the ambulance.
- These aims may be laudable but they are meaningless when divorced from the detailed content of the draft STP, which is full of impenetrable jargon and manages to be very specific in some parts and very vague in others. Despite claims to the contrary, in practice the STP is about making cuts to accommodate services to the chronic underfunding and defunding of the NHS and social care by the government when it is glaringly obvious that, as many health professionals and experts have said, funding should be increased to ensure people's needs are properly met.
- The current crisis in the NHS is particularly acute in but not confined to A & E and hospitals partly because of cuts in government funding to local authorities to provide adequate social care for elderly and vulnerable people but also because there are too few beds and staff in hospitals and GP services are overstretched. Health and care services do need to be more joined up but without more funding they will still be inadequate. Even Surrey County Council plans to hold a referendum on increasing its council tax by 15% to fund social care because the government refuses to increase funding enough and because cuts have left it unable to cope. This is not an option in a poorer part of the country like the North East and if it became more common would increase health inequalities not decrease them.
- Under your plans many services will not be closer to people's homes but concentrated in larger centres (specialised hospitals and Primary Care Centres), a big problem in rural areas where travel and transport are often difficult. In Northumberland people in Hexham, Wansbeck and Morpeth are unhappy about the downgrading of A & E services in their local hospitals and their transfer to the new Emergency Care Centre in Cramlington, which has

proved disastrous. People in Rothbury have protested over the loss of services from their local hospital because they know the serious consequences this could have for people there.

- How are local people going to be empowered and supported to play a role in improving their health and well being when public health provision has been decimated by cuts and the Royal Pharmaceutical Society has warned that many local pharmacies will close because of cuts in government funding?
- The idea that rearranging services at the same time as saving £641m by 2021 (£904m including social care) will improve them when the overall population of England is growing and the number of frail elderly people with multiple conditions is going up at an even greater rate is simply not credible and means that your vision is pie in the sky.
- Tyne and Wear Fire and Rescue Service welcome the vision as set out in the STP and would also welcome the opportunity to discuss how we could work together with the Health community
- It looks reasonable..but....you state that GP services have not always kept up....well a case in point is Browney House Surgery Langley Park....closed every Thursday afternoon so working 4.5 days a week...so....if a person is discharged from hospital on a Thursday...no contact possible before Friday....is this representative of 7 day services in the 21st century? I imagine other surgeries are also working these short hours. Also you can't empower people if they are sent to inaccessible venues for screening etc...eg Stanley for breast screening rather than the nearest venue. Will you address these issues?
- If you want joined up services you need to consider Geographical distance....eg why was my husband sent an UNSOLICITED appointmnent for Aortic Aneurism screening in PETERLEE when we live in Langley Park??? We considered he was being used for research a!though why we don't know as he has no relevant medical history AND there is NO evidence of the existence of such a screening programme. We nearly informed police as we thought it was a scam but did manage to authenticate the letter...however... Who sent such a ridiculous letter.... To get from Langley Park to Peterlee means 2 buses and 2 hours travelling time!!! He was offered an appointment at Stanley.....no buses there either. He told the relevant person that he would not attend and felt he was not being told the truth about why he was sent the appointment....? Mistaken identity....? Research which is unethical as it had not been declared as such...? I think a senior manager and our GP should have issued a written apology for using his details without an opportunity for inforned consent
- It says nothing about mental health services, problems with discharging patients from hospital back to their own homes in the community or difficulties for the ambulance service being able to process patients at A&E
- I think you miss the obvious....people in the Langley Park areas who have been placed in the non existentDerwentside then northDurham are not going to go to Hexham General.... No transport!!! You are proposing to further reduce facilities at Shotley Bridge when the population is growing in that area.Have you ever attempted to get over to Hexham in winter without a 4

wheel drive vehicle and snow chains????? Sunderland has abysmal parking....poor transport links to the Langley Park area...2 buses needed if you travel by bus....this hardly supports or empowers people or facilitates health...why do people from Langley Park get sent to Stanley for breast screening when there us no public transport.... Why can't they go to Durham...15 mins on a direct bus!!!!!! Sheer madness. I don't believe it will happen

- Please proof read your wording...how can you assess the potential of VISITORS???? This is nonsense.
- Empowering and supporting means NOTHING unless people accept responsibility for themselves! They can't play a part in anything if they are not informed and given fair access and opportunity...eg transport to health facilities only available if you live in social housing??? (Durham Health Link never goes near private housing let alone offering lifts to private householders...) Review the stupid mass screening eg the invented disease of pre-diabetes which does noitexist according to WHO."
- Sorry but this is simply meaningless jargon! How can you 'empower' anyone regarding health when cutbacks are unrelenting....what do you mean by wellbeing??? Places like Langley Park have NO access to leisure facilities... NO community groups OPEN TO ALL....and councillors who have utter contempt for co Durham residents...look at all the pubs and the scandalous state of the area around North Rd...local people are continually ignored by a clique ridden elite. All the money will go to cities like Newcastle. We don't exist other than as a source of money via our excessive council tax for which we get nothing apart from a bin collection...how will people who visit the area reach their full potential as you claim??? For heavens sake proof read the meaningless rubbish you write!! Holidaymakers undergoing assessments maybe?????
- The plans are not detailed enough to demonstrate how the aims will be achieved in 5 years and at the same time close a funding gap of 641 million in health and 904 million in social care. How can all this be achieved with a reduction in the workforce by 4 % even though the NHS is completely stretched as we speak. What does full potential actually mean? How can people reach their full potential for example in employment if there are not skilled professional in place to help them do this. Paying associates 15 grand a year will not help someone with mental health difficulties get back into work. We are seriously missing the point if we do not invest in a skilled, quality workforce. Local people will not feel empowered if their is no quality support. The above aims are very unrealistic to achieve in 5 years!
- Many of the laudable aims are impossible with a conservative government bent on destroying welfare and reducing benefits. More people are living from food banks an living on benefits you cannot eat healthily. Mental health particularly for children is not helped by the current uncertainties for people achieving satisfying employment. Prevention costs more than treating the consequences and cannot be done in one area outside of the national strategies. 42% children do not attend a dentist, that mpacts on their oral

health as does the promotion of sugary foods and the government is doing no useful immediate action to prevent either of these.

- The documents published are lacking in detail about the aspects of STPs that the public are concerned about - there is no mention of the word "cut" in the document and no detail about how you will provide "7 day working" while saving millions and maintaining safe services. The aims as stated are laudable, but there is no real method of achieving the stated aims.
- This is not a vision, it is a set of generalised statements with no detail as to how these will be achieved. Facile and designed to deflect criticism since there is nothing really to disagree with.Nothing about mental health. As usual.
- One of the most important things is early diagnosis. Unfortunately this means increased access to specialist tests and services which are already stretched, however this is crucial and needs to be tackled with more staff, or even asking for some financial contribution from the patient eg as for NHS dental treatment. Mental health needs to be less stigmatised. And child mental health needs to be easily accessible. Social care for the elderly and tackling alzheimers/dementia also needs a lot of investment.
- To reduce the need for acute action and increase the provision of preventative measures.
- Laudable but what about people who have chronic degenerative health problems or those who can't afford to attend exercise classes?
- At present the plan for Northumberland is so vague I have no idea what is being proposed. I've read through the plan and the FAQ and I'm still none the wiser.
- encourage exercise and like dancing, swimming, keep fit, or walking.Support work life balance.Suggest max 30 hr week.Let people take short frequent breaks at work.Make sure people take a minimum of 45 minutes for lunch.This reduces stress and increases output.More time for keep fit and health and wellbeing.Give people on low incomes vouchers to help buy fruit and veg.Help reduce the cost of good quality fruit and veg in the region.
- The vision sounds great but where are the details? It sounds as if you are asking if we are against sin.
- These are great aims - BUT THERE IS NOTHING TO INDICATE HOW TO ACHIEVE THEM. They are utterly unrealistic
- With the increase in demand for elderly care it is imperative that care services remain local, in addition to improvements in outbound services currently existing.
- One cannot disagree with the ideas - just whether anything will actually happen.First of all it is a vision. That's all. Not a "yes we will achieve this" but a vision/wish. It is written in management speak and not in a register of language most people will understand
- The plan is not clear or transparent and I am totally opposed to the removal of acute services from South Tyneside because it is not in the best interest of South Tyneside residents.The women’s voluntary and community sector (VCS) are encouraged by the vision for everyone realising their full potential and equally enjoy positive health and wellbeing. We believe that in order to be

sufficiently healthy (both mentally and physically) for work, women in particular need safe stepping stones along their pathway to recovery and employment.

- I agree with the above. How are we going to finance this?
- Public resources work hard for local people not for shareholders of private companies profiting from NHS contracts
- urgent and emergency care already under huge strain - further cuts in funding cause me HUGE CONCERN
- The idea is Welcome but equity of service once at hospital is that the same a equal accessibility. I Welcome close to home, but that means STH not Sunderland or Newcastle
- The 'vision' is of course attractive. However, having read the entire STP technical document I am extremely concerned about the lack of detail for how these goals willbeachiveved, and the lack of evidence for efficiacy for the changes that are proposed.
- Seems to be a way to privatise and cut back on expenditure - more of austerity !
- How? More detail needed.
- The STP vision for the area looks well on paper, but does not reflect what is really happening with health services in the region i.e. greater centralisation of services, rather than services that are "closer to home". I refer to the downgrading of A and E services in Hexham and other areas and the concentration of services in Cramlington, an area which is not easily accessible for many.
- The only vision I can see is of much restricted services, less accessible. No basis for claims of improving potential or health, indeed unclear how this will happen with less spending by the CCG and local authorities in no position to spend more on public health.
- How are LA's going to put this into practice?
- The North East of England has more health inequality that other parts of the country and local people can play an active role in health improvement if given the opportunity however isn't that being taken away as part of austerity and the fact we fed cheap carbs by food processors.
- HONESTY AND TELL IT LIKE IT IS. THE BASIC ISSUE IS LACK OF FUNDS YOU NEED TO MAKE SAVINGS, WHAT PROPORTION OF A PERSONS TOTAL HEALTH CARE EXPENDITURE IS CONSUMED IN THE LAST YEAR OF LIFE ?THE MAIN WAY TO DO THAT IS FOR PEOPLE AT THE END OF THEIR LIVES TO DIE AT HOME OR IN CARE HOMES AND HAVE LESS CONTACT WITH MEDICAL ESPECIALLY SECONDARY CARE SERVICES IN THE RUN UP TO DEATH, CHANGING BEHAVIOR IN RELATION TO SMOKING DIET AND EXERCISE WILL NOT BE FIXED BY MEDICAL INITIATIVE THEY NEED MAJOR SOCIETAL CHANGE E.G. TOWN PLANNERS. ACTIVELY ENCOURAGING WALKING A DECENT SUGAR TAX
- Many of the terms used here are insufficiently specified to enable us to give a response; such as 'Safe and sustainable' and 'economically viable'. Who

decides how the economy should be run and what resources should be used to run our NHS?

- Many of the terms used here are insufficiently specified to enable us to give a response; such as 'Safe and sustainable' and 'economically viable'. Who decides how the economy should be run and what resources should be used to run our NHS?
- I think these are totally unrealistic, when you have to make huge cuts.
- I like the STP vision, it is very comprehensive.
- You should not be colluding with the Government in cuts. The underfunding of our NHS will lead to a projected deficit of over £641m over the next five years in the North East alone. It is totally unrealistic to pretend that health services will improve in quality and accessibility
- There is no explanation of how people can access services if they don't have their own transport, or access to public transport. There is no suggestion of how vulnerable people can improve their self care. If you are depending on handouts from food banks you have no control over a healthy diet. More money is what is missing from the STP vision. There is no way you can reduce budget and improve a service!
- Sounds great but the reality will be a huge reduction in services. The 'plan' does not convince me otherwise.
- The STP does not contain adequate or indeed any information on which a decision can be made about the future of NHS provision. It presents aspirations couched in meaningless jargon and suggests, without any evidence, that the unspecified STP Plan will result in the transformation of a projected deficit of £641m by 20/21. It fails to establish any basis for a meaningful consultation to be carried out with health professionals and members of the public.
- Joined up, closer to home they are not!
- I'm worried that cost is a higher priority than clinical care. Where is the evidence that the suggestions are any better than what's inplace now.
- Services are being closed or, at best, amalgamated with services from another hospital. I object to this - they are not closer to home.
- With these plans, people are not treated equally, when there are different levels of health provision in different localities
- Health care is UNSAFE with the recent closure of walk-in centres. Additionally, I disagree with the provision of a huge A and E at Cramlington - there is an A and E locally at RVI - why do people need to travel miles from north and west Northumberland for A and E - this is clearly unsafe.
- When a person is ill, they require professional input, not beefed up self help. There is good advice from pharmacy - no need for more - what is needed is responsive medical and nursing assistance
- Should mental health be included more directly in the first aim?
- how safe will it be for Durham residents when more people need to use our facilities due to closing A&Es?
- If they are joined up - I am doubt full this always works. Also GP referrals should not go to private companies to be reassessed!

- I believe the direction of travel is absolutely correct given the austerity measures we face.
- Swimming as with other activity sports and exercise are far to expensive, also they are not open at the correct times for working people
- I have been refused therapy as I have a personality disorder and have previously undergone several different forms of therapy. Because of this I have already spent hundreds of pounds on private therapy and continue to do so. This is absolutely disgusting, basically, I have had my 'quota' of therapy and so will not be allowed any more. The Crisis Team member who referred me for therapy has ignored my request for a copy of all letters regarding my health and had I not contacted Talking Therapies myself then I would have still been sitting here, waiting, waiting, waiting. Gateshead NHS have been playing Russian Roulette with my mental health for years now and unless I receive satisfaction I will sue for malpractice.
- Here in Durham City it looks as tho' expanding student numbers could seriously affect the delivery of services to an aging resident population. How will this be monitored?
- How can you aim for more with no money? Of course this vision is admirable - who could have a problem with it? But how is it achieved? What does 'more economically viable mean?'
- I would like to have seen more specific proposals. Objectives are very worthy and the underlying reasons for these but how you are going to achieve these is the $64,000 question !
- All very "motherhood and apple pie". Does the STP actually define the pathways to achieve this ?
- I am alarmed and disturbed by these plans. This is a tranche of £22b in stealth cuts. There is no positive manner in which to spin this. I am a resident of this borough, and a service user. I am not accepting of our Labour councillors giving their consent to these plans. STPs must be vigorously opposed by local authorities, including North Tyneside.
- Yes I agree with the above statement
- I will believe it when I see it. Certainly in UHND, my views counted for nothing
- I'd like to see the NHS becoming more open minded regarding mental health solutions and involving local social enterprises and national advances in the fields of linguistics and neuroscience to make our community national leaders.
- This is an opportunity to save thousands of pounds for the NHS and update their current services from techniques developed in the 1980's to innovative and more precise, bespoke and accurate interventions.
- This is not true we have run a cafe providing home made food, but over the past 2 years this has declined due to the opening of fast food chains - my own treatment at Bishop Auckland & Darlington hospital has been sub standard. In particular miss diagnosis long outpatient waiting times and dirty wards in the case of Darlington
- I want to start by stating that I disagree with the whole process and the way that the Government is forcing this agenda through in far too short a timescale and forcing local decision makers into a corner, expecting them to implement

radical change with no resource to achieve this.Saying that, I feel the STP vision for the area is still rather confusing and doesn't appear to look towards radical change to enable it to meet the target in the financial gap that is predicted over the coming years. We are still talking about supporting 6 CCG's, 6 Local Authorities, 7 hospitals and I feel that there is a need to think bigger geography in decision making and delivery otherwise it will be an exercise in rearranging the deck chairs rather than creating a new sun lounge. We have examples in our communities of organisations working very well across a bigger geography e.g. NTW and their recent CQC results and the North East Ambulance services, yet we want to retain localism when being forced to work on a sub regional basis. If we are retaining local organisations because of local needs and to make local differences, it obviously isn't working as we still have 27% of the population in the 20% most deprived communities in the country.There is no mention, as far as I could see, of the use / introduction of new technology to support new ways of working. We could achieve greater progress in bringing care closer to home if we were to have an IT system that would enable this, care records that can be accessed by key people whilst out and about and the ability to reach people in their homes without the need for visiting one of the 7 hospitals. If we are serious about provision of community care we need the technology to back this up. Again, it can be done...once we get rid of paper records and move to electronic systems. NTW have introduced systems that enable greater access to records and this is something that should be looked at across the area with links across all providers. Invest to save. There is talk of scaling up ill health prevention yet the amount of money that is spent on Public Health has been reduced dramatically over the past 3 years and will continue to fall in the coming years. How is the system going to be able scale up prevention when people who have been leading on issues like encouraging breastfeeding and reducing smoking in pregnancy find themselves out of work. How can Councils consider cutting funding to a Regional flagship for Tobacco Control which has been instrumental in the biggest fall in smoking prevalence across England over the past 10 years. The amount of money this has saved the system through reductions in CVD deaths and disease makes it a simple decision to make. Value for money, evidence based and life saving.The plan lacks ambition, although financially tied. If we are going to spend 80% of the available budget on what we already have, how are we going to impact change on the scale that is required. As the saying goes, do more of the same and you'll get more of the same. An example of the lack of ambition is to reduce Health Inequalities to be comparable with the rest of the country. Are we saying that it's acceptable for a large section of the population to have lower health outcomes and life chances than others. Ambition would be looking at our current position and aiming for a best in the country position. We're getting there with other areas, why not Health Inequalities?

- Closer to home. There is a lack of bus services to the hospital on evenings, from many Washington villages.
- Agree with the principles, but the devil is in the details; are these aspirations to be achieved by diktat, or ia reasoned discussion?

- 1ST STATEMENT IS TOO AMBITIOUS
- Health care that is joined up - services/gps need to think how this can be best achieved especially when referrals and appointments are made for similar issues at inconvienent times.
- This is one of the most useless documents I have read. No detail given, massive unquantified assumptions with what appears to be guess work. Calculation of expenditure savings unquantified with no deatils given of service reduction/ centralisation. Generally a poor document.
- These are worthy aspirations but without Government commitment to increase funding I cannot see how they can be acheived

Question 2

What do you think about our ambitions for what health, well being and services should look like by 2021? Is there anything missing or more we should aim for?

Some 88 people/organisations answered this question and six chose not to. They said:

- Seven day working on year-on-year real terms funding cuts? Are you magicians- or complicit? There are not enough doctors, nurses, HCAs, PAMs to run 5 days elective and emergency care on weekends: tell me exactly what the rota gaps and agency bills and PFI payments are in County Durham. Ask the families of NHS employees - and the public- and then discuss again the words 'mandate', ' evidence' and 'integrity'?
- I really doubt you have the funds or can make the savings to have this happen...attract and retain staff...my son is a junior doctor...and the hours he works and the way the government vilify them - I don't wonder med school applications are down...and applications to nursing...I was at the meeting on Monday, I heard the woman from our Uni speak. And GPs....my GP practice can't recruit!!! Again they are vilified...why would anyone now choose a medical career?And now to the big issue....7 day care....there isn't enough for 5 day care? not enough staff, funds, beds, And what kind of care? define it please. 7 days of routine care? 7 days of just urgent and emergency? And I want to see the same GP for continuity so I don't want them available 7 days per week. Plus you will have to recruit more GPs to do that and pilot studies show that the DNA at weekends means it is a waste of money to have 7 day GP service.
- Should first point read "will have to be reduced " ? If so - good.
- Great ambitions and agree with all . Is a major undertaking and can not see how would be delivered without pump prime funding.
- Unclear why everything is so hospital-centric, in other words why we talk about "out of hospital services" when 90% of clinical and care contacts are already in the community.Unclear whether high quality hospital and specialist care 7 days is relevant? we might want excellent care 5 days and sustaining services for 2

- Whilst economic and social inequalities persist, the general poor health and well being of people in our region will continue to be greater than it is elsewhere in the country. Dismantling provision in some of our hospitals will do nothing to attract and retain staff. (I also think you should read through your questionnaire more carefully before putting it before the public. The first bullet point in this question does not make sense!)
- Out of hospital services - salaried GPs should be considered when GP practices close and an area will be left without an adequate GP service.GPs should be encouraged to work in group practices - safer and more able to offer extended consulting hours.When the new GP contract was introduced by the last Labour government, out of hours was covered by a GP out of hours service, walk in clinics and NHS Direct. Walk in clinics in my area close at 8pm and the GP out of hours service and NHS Direct have been replaced by the 111 service. My own use of the 111 service has not given me any confidence in it and I have heard many similar experiences to mine. I would like to see continuing audit of the service with follow up of patients to investigate whether appropriate advice was given by the call handlers.If any problems are found that are due to the algorithm used, these must be reported to the appropriate authority (?NHS England).In addition all A&E units should have a GP section as well as a Minor Injuries section to ensure that true emergencies are dealt with promptly. Data should be collected on GPs that have not offered a same day appointment for urgent conditions.
- The government must be pressed on what is meant by 7 day a week care - you cannot plan for it if you don't understand what it entails. Does it include GP services and Outpatient Clinics. The organisation needs to be aware of possible chaos if employers get the idea that their employees can get an Outpatient Clinic appointment at the weekends and insist that they do so.
- Again, the ambition is fine and hard to disagree with but the critical issues are the funding and whether there is adequate and modern infrastructure in communities outside of hospital services that will allow care to be delivered in new ways.It is widely accepted that some patients who do not need to be in hospital have to occupy their hospital beds because there is no safe way to discharge them to currently missing "thriving out of hospital services" in the community, where appropriate care could be delivered for less cost. While hospitals are paid for the beds that are occupied, there seems to be no proposal to move some of this money into community facilities that would allow the hospital beds to be freed up for patients that really need to occupy them.
- We think that the STP should say more about the care choices available to patients, whether in hospital, at home or in community care facilities, and how those might be funded, by transferring resources form the secondary to primary care sectors.The absence of intermediate care options in the community is not helped by the current crisis in funding for social care, that shows no signs of being resolved. The failure of government to allocate any funding in the 2016 Autumn Statement must have come as a shock to all those involved, and makes it more difficult to deliver what the STP aspires to.

- Suggesting that patients do not already have 7-day access to high quality hospital and specialist care at present seems perverse - the experience of our PPG is that they do.
- In terms of retaining the best staff, one has only to look at the Local Authority social care sector to see staff who are run off their feet, who are exploited and paid badly and who are expected to deliver miracles.
- Reducing our regional health inequalities to say, those in Surrey, will require both additional resources (which don't appear to be on offer) and substantial policy interventions in areas like smoking, diabetes and obesity, policy interventions that government appears reluctant to consider.
- I can't see how 7 day care can be offered unless there are cuts to services....you admit to staff shortages...
- At what point will you acknowledge that less money= less staff = it is an overt lie to claim we can have better 7-day services in less than the current 5-day plus emergency weekend cover?! I find this insulting! And beggars any economic thought. Have you asked your doctors why they are not going into specialty training, why GPs struggle to recruit, what services we need in terms of radiography, pathology, extra nursing care over the weekends? Please release any credible evidence you have that that operating as a seven-day, shiftwork, factory, improves patient outcome? I object very specifically to this aim. Remove it. Or find a)evidence backed up by b) funding.
- Invest in education and social care better; stop flogging the already-demoralised hospital staff on the whim of some ideologically driven and wholly unevidenced political narrative.
- do not replace health promotion for heath care. More money is needed to support both.
- Seven Day NHS vs sustainability: I agree that many NHS services should operate seven days, however I am not convinced by the political rhetoric that all services need to be seven day or that is sustainable. Hence clinical judgement should come first (i) where it is clear that there is no patient call for seven day services, (ii) it would result in over tired staff, (iii) it would compromise staff training, (iv) it would compromise staff recruitment, or (v) where insisting on operating services would result in unnecessary increased costs which put the CCG services and finances at risk.
- Once again details and specifics of how this will be achieved is completely lacking in the STP. Without this detail and a realistic financial plan of how this will be achieved while at the same time you are cutting expenditure these ambitions are just pie in the sky. I would note that health inequalities in the North East are long standing and the causes are mostly driven by economics and pollution. This needs action by government to address these causes.
- Once again this an unrealistic wish list without more not less funding for all aspects of the NHS, social care and public health provision.
- The idea that health inequalities will have been reduced to be comparable to the rest of the country by 2021 is highly desirable but just not credible. These inequalities are truly shocking. Although a lot of things have changed since 1980, many of the findings in the Black Report of that year on "Inequalities in

Health" do not seem to have fundamentally altered and some, like the incidence of obesity, have got worse. Health inequalities reflect and act on deeper social, economic, cultural and educational inequalities, which have become worse and are still getting worse and are not simply the result of individual failings. They are even more pronounced in the North East because of the high levels of deprivation. Such deep-seated social problems cannot be genuinely tackled without the greater investment of money, resources and people, which the STP plan is not going to achieve.

- It is also impossible to see how thriving out of hospital services that attract and retain the staff they need will be achieved under your plan. Changing the way things work may achieve some limited results but not on the scale and in the timespan you envisage. In the words of Dr. Mark Porter, Chair of the BMA Council, in his letter to Theresa May of 17th January 2017, "The current crisis in the health service extends well beyond A&Es, with all parts of the NHS, including GP surgeries, working as hard as possible to keep up with demand. As the chair of the BMA general practice committee has made clear, GPs are seeing more patients than ever before, this is despite a severe workforce shortage of one in three practices with unfilled GP vacancies, and a recent BMA survey of more than 5,000 GPs finding that 84 per cent said their workload is unmanageable and having a direct impact on the quality and safety of patient care. The issues which we are seeing...[with hospitals]...are not due to a difficulty in accessing a GP and certainly will not be solved by penalising and scapegoating an already critically under-resourced and understaffed general practice. The BMA has repeatedly raised with the government that the current NHS funding settlement is inadequate to deliver the standard of care which patients deserve and that doctors and our colleagues in health and social care want to be able to provide. The government position that it 'fully funded' the NHS' own plan for modernising services is now widely discredited - not least by the chief executive of NHS England - and the facts simply speak for themselves. Services are failing patients and their families, in the face of titanic pressures across the system.
- Do you really think the demoralisation and disillusionment of GPs, nurses, paramedics, physiotherapists and other NHS staff leading many of them to go abroad to work or to choose to work for agencies will be solved by the STP's proposals? Problems of the recruitment and retention of high quality staff will only be made worse by things like the ending of bursaries for nurse training. The uncertain situation surrounding Brexit may well make it harder to bring in staff from the EU. Or are we, the members of the public, meant to put up with being treated more and more by less well qualified staff like associates, which are mentioned in the draft STP?
- The idea that the STP proposals will bring about high quality hospital and specialist care across the whole area, like many claims in the plan, does not appear to be backed up by any real evidence. These services will be further away from many people's homes and will create problems of travel and transport for some patients and their visitors. As has already been stated the example of the Emergency Care Centre in Cramlington is hardly a shining success, with 7000 hours of ambulance personnel's time wasted in a year

because of the difficulties of admitting patients. In an interview on BBC News 24, Professor Sir Brian Jarman of Imperial College Medical School and former President of the BMA stated that alongside the growing overall population, the growing number of elderly people, the shortage of doctors, the lack of funding for social care etc the current crisis in the NHS has been made worse by the fact that over the last 30 years the number of hospital beds has halved while admissions have doubled so that occupancy rates are over 91%, an unsustainable level which doesn't work and leads to chaos; ideally they should be no higher than 85%. His message to Jeremy Hunt was to, "close down the denial machine at the centre of the NHS and get some more hospital beds.

- None of these problems can be solved at the same time as making £641m of savings.
- The STP is very ambitious and Tyne and Wear Fire and Rescue Service welcome the direction it is setting
- Well to do this you need accessible services as I suggest above
- Simply cut back on managers and use qualified doctors and nurses to run the NHS....people in rural areas will be left with nothing
- These aims are laudable but will cost money so it is unrealistic to expect a better service for less mo"You can't address inequalities if people can't access services... And if course GPs need to know where these services are..THE Following incident is TRUE...and demonstrates appalling lack of knowledge.. I went to (locum) GP..shingles affecting eye (can lead to blindness).... The doctor had no idea where to refer me...just vaguely said Sunderland....told me to go to the general hospital (WRONG) fortunately I realised it should be The Eye Infirmary.... reception staff at GP surgery Useless... Seemed never to have heard of Eye Infirmary when GP asked them where I should go....Eye Infirmary staff told me simply to go back directly to them NOT GP in case of future problems..... GPs need to be aware of services.... Otherwise high quality care can never happen!! And how can you guarantee 7 day cover??? There is a shortage of qualified nurses and doctors.. I refuse to be treated by unqualified people or inadequately qualified NVQ support workers!!!!! And the 111 NHS helpline is DANGEROUS especially for children... Sorry...I will always go to casualty or ring 999 if I am worried ..as a retired nurse I know far more than a call handler reading off a script....
- I have concerns that it will become increasingly difficult to access hospital care and to access that care locally. Recent changes have already had a negative impact on ability of carers/visitors to visit relatives in hospital due to unreasonable travel
- Seven days a week? Where are the qualified staff coming from??? I want qualified people not NVQ staff who might be dangerous and if you take staff from overseas where are the safeguards????
- You will only address health inequalities by improving GP services for ALL regardless of social status/income etc...AND by allowing Non discriminatory access to all. NOT just those on benefits!!!I I hope the women only swimming trip by minibus from Langley Park has been acknowledged as discriminatory and discontinued!! Also it would be illegal as only selected people are invited.

It is not advertised and it should be as it us part council funded and therefore must be open to all, irrespective of where they were born or who their parents and grandparents were...time to stop ignorant parochiaism in your services..

- Rubbish. False promises. 7 days a week????? Where are the staff coming from???? Are you replacing qualified doctors and nurses with NVQ aka not very qualified workers who will be a danger to everyone!!..
- As an NHS worker, I have been impacted by unrealistic targets and the consequences of burn out. is we are not compassionate towards staff how can we build a compassionate community. I think that there fundamental details missing from the plan is how can you achieve this in 5 years with less money and fewer staff. There has been a distinct lack of consulting actually staff on the ground with these plans
- That is impossible without spending money. There is a surge in demand now and I do not accept this is from lack of Gps. The fact that residential and nursing care is profit driven but funded either by individuals who can afford it or by financially impoverished councils makes it impossible to get people ut of hospitals that no longer need acute care.
- And you'll do this how? With less money?
- How will you do this? Where is the structure which will deliver? How will you retain staff who are leaving NOW? How will you finance 24/7 care when you can't deliver this NOW even before any further CUTS.
- Most of the ambitions sound very good particularly the increase in emphasis on prevention and wellbeing and care closer to home. However within the current context of underfunding, understaffing and increasing demands and costs, the ambitions look like pure fantasy and make me question whether the whole plan is realistic. It looks as though the excellent aspects of the plan may be outweighed by those aspects which are present mainly to balance the books.
- 7 days a week health care is only reasonable in a few areas (more urgent areas of care). Otherwise it is unnecessary and unrealistic- it becomes a matter of convenience and hence should be paid for by the patient. It's not realistic to focus on on equalising health outcomes with more affluent areas of the UK. As mentioned above, more hospital/specialist services/test area needed for prevention/early diagnosis- it will be cheaper in the long term.
- A service that keeps pace with a projected growth in Population and as a consequence a greater need to provide a first class consistent service.
- What are you doing about recruitment and retention of staff?
- Again I have seen little published for the plan for Northumberland. So I cannot answer this question. More detail is needed!
- let customers get a taxi and charge it to hospital or GP services instead of waiting 2-3 hrs for patient transport to and from hospital. As a waste of resources always having to get an amunlance, when not necessary in all cases so reducing costs.
- At least four things missing:No mention of the importance of carers.No mention of the crucial problem of local authority under-funding with its impact on social care.No mention of the geographical issues relating to proposed

constituency boundary changes - in particular for Winlaton/Rowlands Gill and Chopwell/High Spen wards which will be part of an altogether different part of the country.Too many acronyms which make the document inaccessible and meaningless to most people.No mention of the role of private companies such as Connect Health and About Health.

- An omission of comparisons on the percentage spend on health per head of population in relation to other parts of the country and to other equally rich nations.
- Again, details are missing. How will you evaluate if the health inequalities have been reduced. How will you be sure to retain staff. Where will the increased numbers of staff and money to pay them come from? You cannot fill the vacancies you already have.
- HOW - USELESS TO SIMPLY CITE WHAT IS THE IDEAL WHEN THERE IS SO LITTLE MONEY
- Some of the "health inequalities" in our area are down to the legacy of heavy industry and mining as well as poverty. I fail to see how this can be reduced for the near future.
- Again, one cannot disagree - but how is anything going to be done?
- These are laudable aims, especially reducing the health inequalities in our area. However, I believe we already have high quality care and specialist care 7 days a week. The problem is they have been systematically underfunded and run down since 2010. Things do not need to be reorganised. They need to be properly funded. That does not mean closing A&E units. It means funding them all properly
- Fine words but what it means in practice is not clear. The best facilities are no good if they are not accessible to the people they serve.
- The women's VCS have many successful small scale projects that are improving the health and well-being of women, children families and the wider community. There is a mounting body of evidence to suggest that these project relieve the pressure and cost from acute health services. There needs to be investment to roll these out. This will require shift in the minds set of commissioners and policy makers. Along with thinking differently, commissioners and policy makers also need to act differently, moving services into communities to reach those who are most marginalised.We believe that the NHS in partnership with CCGs and Local Authorities should use their existing powers, such as those inscribed in the Equality Act 2010 and international instruments such as The United Nations Convention for the Elimination of all Forms of Discrimination Against Women to address structural health inequalities and discrimination along the lines of gender, race and disability etc.
- I do not understand 'we will have thriving out of hospital services...' It sounds ok but to me is almost meaningless.
- Again, where are the finances coming from to attract & train the staff?
- To address health inequalities the wider determinants of health need to be a focus of this strategy.

- Acute and Emergency services need to be poached at both Sunderland and South Tyneside
- It is clear that we cannot even sustain emergency services 7 days a week at present, as evidenced by the crisis in ED services. There is no meaningful plan to address the staffing crisis in the STP and as such a goal for 7 day specialist services is so unrealistic as to be laughable. In addition I have seen no convincing evidence that is desirable, either from a patient access perspective, or improvement of outcomes.
- We have some of the poorest health outcome data for the UK, despite having more doctors per head than the rest of the UK and some of the best hospital trusts. The poor outcomes are due to the endemic poverty of the north east. A goal to 'reduce health inequalities to be comparable with the rest of the UK' is similarly a ludicrous goal. Absolutely agree we need to narrow the gap but I don't see any meaningful plans for this in the STP.
- Reduced availability of hospitals - more privately provided provision and less support for elderly. Some impossible objectives - seven days with LESS funding !
- These are just statements people need the facts on how these statements will be achieved. This is health and this needs to be given firm descriptions of plans.
- With fewer, more scattered services health inequalities are unlikely to have improved. Ideas for local community hubs have no flesh on the bones. Who is going to pay for the prevention and well-being work? I'd like to see some evidence of these new more collaborative services. Where have they been trialled?
- Where is the money coming from to achieve this?Where are the staff coming from?
- In my experience this is being achieved on some level although can it be sustained as communities become more desolate and people isolated due to cut backs in services
- AS A PROFESSIONAL I DON'T WANT TO BE COVERTLY RATIONING CARE TO ELDERLY PEOPLE YOU NEED TO BE HONEST.PROFESSIONALS WON'T WORK FOR NOTHING
- Sounds admirable, if the country wide standard is high, but the devil is in the detail and he is hiding at the moment.
- I think the ambitions are good, but I wonder how they are going to be met. I have witnessed a reduction in spending for health checks and a loss of smoking cessation support in the community, so I am wondering how this helps with reducing health inequalities?
- I like the ambitions set out for NTWND.
- You know as well as anyone else that these 'ambitions' are unrealistic given the funding cuts. Your 'plans' are blueprints for cuts wrapped up in high-sounding jargon. You owe it to the NHS-using public to be honest.
- Access to services is key to improving health inequalities. If disadvantaged people cannot access services health inequalities will increase. Out of hospital services are only available 4.5 days a week via a GP, if you can get

an appointment. Not all pharmacies engage in Pharmacy First and indeed have not carried out training of staff. Why? Because they can't execute it due to staffing levels and time consumed by a single pharmacist who is stressed to the hilt and cannot deliver due to time constraints. Out of hospital services are flaging and failing. If all acute services move to Sunderland then the A & E in STDH will not be sustainable. So money saved by cutting hospital funds will have to be spent on out of hospital services which at present are inadequate.

- This all would sound fantastic if investment in healthcare were increasing, how are you going to achieve this exactly with £641m less to work with, when things have already been cut to the bone?
- I agree that significant investment in interventions to reduce health inequalities and prevent poor health and illness are very important, and believes that such services are at particular risk when pressures on the NHS are scheduled to rise faster than funding. It therefore asks the CCG to prioritise investments which will reduce health inequality and support services towards groups suffering from health inequalities.
- There appears rhetoric regarding the proposed plan being jointly developed between CCGs and Local Authorities. This is clearly not happening. Councillors seem to know very little about their local STP.
- I feel that many of the principles inherent in the STP are questionable, when public health budgets are being reduced and social care is crumbling putting even more demands on the NHS. Clinical services are being closed down or amalgamated - with greater distances for people to travel – this is far from making services accessible,
- Walk-In Centres have recently been closed, pharmacies are to close and there is uncertainty about A and E provision - this is hardly increasing safety and accessibility. Staff numbers and skiil sets appear to be cut under the STP.
- Is this a follow on to that disasterous process currently called Cramlington Hospital?
- Not sure you can prove any of these statements and with the track record of NHS reorganisations there is never any evalustion of what the impact has been.
- The Government needs to stop underfunding the NHS.
- We need to guard against privatisation, which provides inferior treatments - individuals should not make money out of a persons ill health"
- Health services should be accessible
- I'm worried that the privatisation of health services will create a 2 tier system where only the rich can afford decent healthcare. Also don't see why private companies should make a profit from something that is funded by tax payers
- We should be at least comparable to the rest of the country not the gap reduced
- Laudable principles. However we also need to ensure seamless services aligned with social care and primary care. Refocussing upstream is the right thing to do.

- The social service for health at the month are not very helpful and are only interested in budgets
- Wonderful, if it actually happens but given my recent encounters with my local NHS, I have serious doubts.
- Ambitions need to be realistic - there is little current evidence that the middle of these is achievable.
- Looks fine - again who could disagree? But ambitions are very different to what will actually happen in reality to save the money?
- All admirable but I want to see HOW you will implement proposals.
- I think having specialist care 7 days a week would be a huge benefit
- What is "comparable" ? Why not be more ambitious and aim for "better than the rest of the country"?
- All three walk-in centres must remain open, and the maternity unit must be returned to North Tyneside General. Mental health services in the borough must be expanded. An NTC study from 2009 determined that from Front Street in Tynemouth, to Waterville Road in North Shields, life expectancy drops by seven years. This valuable piece of data underscores the inequality in this borough, which will be aggravated severely by the unavailability of quality care administered throughout the community. As few as four ambulances service North Tyneside and Northumberland after-hours. People cannot and should not be expected to taxi to Cramlington for treatment.
- I feel our nhs is very forward thinking not just with fore site of the specialist centre at cramlington but also the temporary measure with a e during winter period
- After my recent experience as a patient at UHND, I wouldn't pin my hopes on this. I was left for 4 hours without pain relief as they reckoned they couldn't find a doctor to prescribe. I left unable to walk unaided as they had fitted the compression socks without measuring me. I could go on but since I came home I have encountered several people with bad experiences of UHND.
- 'd like to see the NHS becoming more open minded regarding mental health solutions and involving local social enterprises and national advances in the fields of linguistics and neuroscience to make our community national leaders.
- This is an opportunity to save thousands of pounds for the NHS and update their current services from techniques developed in the 1980's to innovative and more precise, bespoke and accurate interventions.
- This is nonsense - I have been diagnosed with Hepatitis C which I am sure was contracted from Darlington Hospital - have received no treatment in one year due lack of funds for medication.
- Hospital and specialist care should be easy to reach by public transport
- The plan lacks ambition, although financially tied. If we are going to spend 80% of the available budget on what we already have, how are we going to impact change on the scale that is required. As the saying goes, do more of the same and you'll get more of the same. An example of the lack of ambition is to reduce Health Inequalities to be comparable with the rest of the country. Are we saying that it's acceptable for a large section of the population to have lower health outcomes and life chances than others. Ambition would be

looking at our current position and aiming for a best in the country position. We're getting there with other areas, why not Health Inequalities?

- I feel that out of hospital services need to be supported by appropriate IT to help them to become thriving. If we are to start delivering more in the community we will need the additional capacity moved within the system. Less resource for secondary care and more for Community health services. The transition is key to enable this to happen smoothly and not to overload community health care with issues that can be addressed in the community but are currently provided in the hospital setting.Additionally, with 6 Local Authorities there is a sense that there are vested interests to be protected. All want to have a hospital in their area and it will take a big political change to get areas to be accepting of the need to centralise services and reduce the number of hospitals in the area. There is a need to be realistic about access to care and not expect a high class facility to be within 10 miles of your doorstep. Some areas of the country have one facility to cover a 60 miles geographical area and although a greater density of population, there is an unsustainable number of hospitals.
- There is no mention of the impact that the ageing population and the increase in older people and people with Long Term Conditions will have on Hospital based and community services. If we are to deliver more care in the community we will need to invest in workforce planning to ensure that we have the necessary skills in the right places for the right people.
- The focus appears to be on physical health with Mental Health issues once more being the Cinderella offer. No health without mental health and parity of esteem are good sound bites but the sad case is Physical health is still the dominant provision."
- Can the hospitals keep the specialist staff? I know that in some areas this has been impossible to do.
- Suggest 1st sentence should read `will have to be reduced`; how?
- OK, 2ND STATEMENT DOES NOT READ WELL
- No detail given in the document. mainly waffle and crystall ball gazing.
- There has been a social care crisis looming for at least 20 years and hospitals are spending a considerable portion of their funding on agency staff to plug gaps in staffing how do you propose to deal with these very real difficulties?

Question 3

The Five Year Forward View identifies three main gaps – health and wellbeing, care and quality, funding – what do you think about the proposed actions to address those gaps locally? Is there anything missing or other actions we should take?

Some 86 people/organisations answered this question and eight chose not to. They said:

- How do you close an artificial funding 'gap' when the problem is underfunding - overt, deliberate, specific underfunding to the point of collapse? Please read the chapter in ' Direct Democracy- a new agenda for a new model party' (co-

authors include Jeremy Hunt) starting from page 74 and understand the destruction as an ideological goal of the NHS - and start being honest with the 1.7 million people of the North East. Where is your opposition to this? Where is the honest debate about funding and finance? Either you debate, or you are as broken as the politicians and businessmen who came up with this.

- Health can not be addressed without good jobs, wages, housing, education.... you are fighting a losing battle with austerity measures and people living on zero hour contracts or min wage or benefits.
- Collaboration - good. But big job...NHS not used to doing it though!
- Closing the gap....in this footprint...we need to definitely know what IMPACT these savings will have...and don't fob me off with -We can't predict that far.... if you have been asked to come up with a FYFV ---then say to them that you can't do it...or give us answers for the next five years. You should be saying to Simon Stevens --- we can't do this and need to be honest and transparent enough with the public.
- Social care has been cut and staff cut, mental health nurses and beds and hospital beds already - how do you propose to improve services when you have to close this financial gap...the NHS is already under strain and in crisis. not due to lazy greedy doctors or immigrants or people living longer ....not enough funds are put in and there have been cuts. No amount of transforming will conjure up more staff or more beds or more social care. Transforming may bring about some efficiencies , but what exactly? And what has to be transformed ...as in ....has to go? I need to know what goes and what stays and what changes.
- Transparancy needed. STP commisioned by government to make a plan to fill this gap. Different agenda to improving services.Has evidence based work already done by Kings Fund been considered in these plans ? Of concern - since this draft was drawn up - both the Kings Fund and Simon Stevens (NHS England) have publicly commented that NHS currently (before the £641 figure) is underfunded.
- cart" and "horse" come to mind here. I'd start with building communities, use the GP registered list and patient's own GP practice as the foundation for all further work, and use this to deliver health and well-being (which by its shining a light, better than shining a "non-dark"). I'd deliver services in the community where in any case they are 1/10 the cost - a 50% increase in access in the community can be achieved by a 5% transfer of budget from acute provision.
- We need to campaign to make our government spend more on social care as well as the NHS. There needs to be joined up provision and meaningful links between health and social care services.
- It is extremely difficult to save money in one area of the service without causing a knock-on increase in expenditure in another part of the service. Cuts should be made with this in mind.
- Probably the first step should be identification of unproductive staff - either because of lack of competence, insufficient workload to keep them fully occupied, or the disruptive effect they have on their colleagues. Adequate Human Resources support would be essential to address

this.Rationalisationof services can save money but may disadvantage some of the population by moving services further away. Providing a monopoly service at one site may lead to complacency and remove the drive towards efficiency.

- Again, fine words that are hard to disagree with, but all of them depend on the resources available to us. A key question is whether the enablers that will make this happen are in place, and we suspect that they are not.
- Scaling up on ill-health prevention and well-being is welcome and long overdue, but will need a significant expansion in the number of people who can deliver this and the social infrastructure where it can be delivered. This will cost a lot of money but will be worth the investment if it delivers the desired outcomes.Similarly, improving the experience of social care will cost money - providers are already saying that the rates offered by local authorities are insufficient to deliver the quality of service needed (and presumably to make profits for the companies involved). Unless there is a significant increase in funding it is hard to see how this ambition will be achieved.
- With GP services, we are already seeing shortages of doctors going into general practice and action needed to be taken to reverse that. There needs to be substantial investment in GP services, given that it takes up to 12 years to produce fully trained GPs. The suggestion that centres of GP practice based on 30,000-50,000 patients seems to be counter-intuitive and may give patients concerns, for example, how will patients get to know their GP and vice-versa?There is scope for GP practices, essentially independent small businesses - to work together, but that raises other issues such as patient confidentiality and access to records and IT systems that work. The assumption that the STP will deliver significant savings from IT needs to be treated with some care, given the recent experience of NHS IT projects.
- Funding is the critical issue - nothing in the documents directly acknowledges the huge amount of money taken out of the NHS since 2010 or the huge waste of money arising from the Lansley "reforms" that created the CCG network, now morphing into Primary Care Trusts under another name. The CCG savings of £105 million will presumably see further rationalisation and mergers and take us back to the pre-2010 position. That seems inevitable and honest, as the notion of locally-taken clinician-led decisions seems to be receding.
- Looked at from one perspective, the STP is the latest attempt to fill the funding gap caused as a direct result of the policy choices taken in and since 2010.
- The STP proposes to close the gap by making £385 million of efficiencies, usually code for cuts in services, buildings and staff. Taking that amount of money out of a system already under pressure due to shortage of resources seems ill-advised.
- Similarly, delivering more services closer to home rather than in hospitals, has got costs - modern buildings for GP and other local services, sufficient trained people to deliver care closer to home and so on. Yet there is no "transformation funding" which suggests that the suggested savings may be optimistic.

- I am concerned at the issue of registering people with certain conditions eg diabetes....this has echoes of Germany in the 1930's.....how is confidentiality guaranteed with such dreadful problems with NHS IT systems??? Remember the wasted money and appallingly unsuccessful Care Data fiasco???? If it had been implemented... Individuals could easily be identified via date of birth and postcode...esp. If they had unusual names
- You cannot close a funding gap whilst simultaneously claiming any credible wide-reaching improvements. Please tell me, where exactly is the money coming from other than directly from health care - and health is one side, wealth the other - of your population. Why does no-one question the cuts?! We are being, it seems, bothers let down and deceived.
- Does this mean there will be more money and an intergrated health and social care service, in public control?
- A&E and Out of Hours GPs: I believe it would be useful to have GPs co-located with A&E especially out of hours. This system was in operation in Hertfordshire where I lived about 10 years ago and I found it very useful. It allows GP access but avoids having to have surgeries open out of hours. The GPs could still be part of the CCG structure, perhaps rotating staff between surgeries. Political and press claims that too many people are unjustifiably going to A&E when they could be seen elsewhere or use 111out of hours are wilfully over-simplistic. After a more recent experience with 111 my confidence in it has been undermined. I suspect lack of confidence in 111 has been responsible for an increase in use of A&E - for any individual patient it can be a completely rational course of action to seek out properly qualified medical care instead of taking a chance on 111 being right about a potentially serious condition.
- As above ill-health is caused by factors far wider than those within the control of the NHS or of the individual themselves. These factors require government action; another example I might cite is control of food producers to decrease the quantities of sugar, fat and salt in food. Increased collaboration between hospital and community doesn't necessarily reduce costs though it can improve quality. If you are moving to a community-based health care service then the new and the old services have to be run in parrallel whilst the new services are tested and crucially actually put in place to the required level. I can cte the move of people with mental health probelems into comunity care which has been a failure as there were not sufficient services in the community to cope. The financial gap is a political choice. We could afford as a country to spend more on health. Most people are willing to pay increased taxes if this money is ring-fenced for the NHS. There is much to believ in the argument that running down the NHS is a political ply to bring in privatised health care on the US model (a financial and health disaster in the making!)
- It would be difficult to disagree with the very generalised way in which the first two of these three aims are expressed but it is impossible to see how they can be achieved whilst making the scale of financial cuts mentioned in the third aim.
- Statistics from the Durham Health and Wellbeing Strategy Performance Report of 17th November 2016 suggest that some of the aims expressed in

the STP for improvements in ill-health prevention and improving well being whilst they may be desirable are not realistic. The figures show that some measures to improve public health are heading in the wrong direction, with some indicators down on the previous year, below target and below national average, e.g. the percentage of successful completions of those in drug treatment - for non-opiates they were down to 22.5% from 40.9% previously against a national average of 36.8% (140 successful completions out of 622 participants).Wishful thinking is also evident in the proposal to get long-term unemployed people, especially those with mental health and musculo-skeletal problems into work. It is highly questionable how realistic this is when the difficulties faced by disabled people with very good qualifications finding paid work in the North East, the area of England with the highest rate of unemployment, are taken into consideration.As for improving the quality and experience of care by increasing collaboration between organisations that provide out of hospital care please see the points raised about primary care in the response to question 2. Furthermore, even before the cuts brought about by government austerity policies since 2010, many people will know from their own or their relatives' experience that social care provided in frail elderly or disabled people's homes by a string of different carers in 3 short, sometimes rushed and often very unevenly spaced home visits, was inadequate to meet people's needs. Since then the situation has got much worse because of government funding cuts to local authorities. A properly resourced, first class social care system, however well integrated with health services, would require greatly increased funding not a bigger share of a smaller overall pot.

- Nobody is opposed to greater efficiency in the provision of public services but the proposals in the STP concerning financial "savings", i.e. cuts, are also unrealistic. Out of £241m of Provider Efficiencies, £158m are to come from as yet unspecified efficiencies, which means that it is not known where approximately 25% of the money to be saved by 2021 is to come from.The draft STP also states that:"Local authority funding pressures and the potential for additional costs across the health and social care economy...have not been modelled in the financial plan."In other words, the whole edifice of the STP could well be based on very shaky financial foundations, especially given the economic uncertainties the country faces in the wake of the decision to leave the EU.Even Simon Stevens has finally said that the NHS and social care are not currently receiving enough funding. Instead of seeking to reorganise services to cope with there being less money the people who have drawn up the STP should be pressing for properly funded services and for the freeing up of funds by ending things like the crippling costs of PFI deals, the wastefulness of servicing the purchaser/provider split and the use of private service providers all of which take money from the public purse which could be used for front line services.
- Tyne and Wear Fire and Rescue Service support the inclusion of prevention within the STP and would welcome the opportunity to be involved in discussions how we could work together with the Health community
- Every reorganisation results in huge expenditure and appears to achieve little for patients

- Get rid of all the so called managers
- Quality services cost money and their needs to be investment up front which may ultimately lead to some savings in future. In the short term however there needs to be investment to release hospital beds by funding social care more effectively. There also needs to be more transparency about how much of the health budget is being used to service debt.
- Health can only be improved if people are treated as individuals....mass screening and mass medication without reference to individual medical history is extremely dangerous.. And a potential waste of money.. I am also appalled by local GP staff cold calling elderly people, addressing them by first names.. The height of disrespect in my opinion, and these staff never give their full names!!!. That is poor service and shows poor management and oversight....these cold calls are merely abox ticking exercise to raise money by diagnosing pseudo diseases eg pre diabetes...which is not a disease according to WHO definition....I am also aware that one surgery in Langley Park invited patients to have blood pressure checked AND REFUSED to tell patient how high the reading was.....What about the legal requirement for informed consent before medication is prescribed??? What would the GMC and Nursing and Midwifery Council have to say?? Nurse likely to be suspended for withholding information and doctor for negligent prescribing!!!!! And you think you can offer high quality care????? I don't think so...
- Further work should be done on securung additional funding. Spending money on constant reorganization and privatisation of the nhs has reduced fundig available for services
- None of it is given to small communities with poor transport
- Well you need to stop disgraceful levels of council tax and large increases. Try cutting back on stupid schemes like asking 11year olds what they want...and councillors on a jolly playing at living like care leavers...utter waste of tax payers money!! Quality care is impossible unless central government gives money . Stop wasting money on pointless schemes of political correctness
- Forget about trying to be socially decisive and recognise reliable research that demonstrates anyone from any background can develop illness!!! PS pre diabetes is made up. Not a recognised disease according to WHO definition
- Closing the gap in our finances. Under-funding and understaffing will lead to an overall reduction in the quality and or provision of health services. How do you propose to bring about the first two aims?.
- Where are the places for GPs to train, our local hospital no longer has Gp registrars training in paediatrics. That was planned by the CCG's
- I have not seen any method for closing the finances gap in this document which appears credible. There are efficiency savings talked about - I am unclear why these have not already been done.
- The sheer number of change programmes planned raises questions about whether enough resources or hours in the day exist to do them in the time available. Experience in developing accountable care indicates that success requires several years and a substantial investment that may initially return a

loss. How will health and social care work together when Local Authorities have suffered drastic cuts in funding and do not have the structures or staff to deliver?

- The ambitions are mainly laudable but again totally unrealistic particularly in the timescale suggested. We have known about the social determinants of illhealth for many years and have failed to resolve the inequalities. I would ask where is the investment in housing, good jobs, transport, education and the environment that is required to support the changes to deliver the aims? How can public health bring about behavioural changes to improve health without better funding – as you know funding will be reduced this year in Durham County Council's Drugs and Alcohol service, the Sexual health services, the NHS Health Checks and the Stop Smoking and the Nicotine Replacement Therapy service. This is a political issue when deprivation factors have been removed from the allocation of funding by the government and we need much more action nationally to support changes such as improving air quality and reducing sugar and alcohol consumption. I question if the government is up to deliver their part of what is required.
- I totally support the need to enhance out of hospital services particularly GP and social care services but do not want watered down services in order to meet the 2021 target. There appears to be inadequate recognition in the STP of the huge deficit in funding of social care.
- The increase in hospital activity over 7 days needs to be managed carefully not to damage existing services and it would be helpful if the STP explained more clearly to the general public how the necessary staff can be recruited, what the initiative involves and the impact on other services rather than simply list the clinical services to be assessed and remodelled
- The plans to upscale prevention, health and wellbeing should include more strategies to improve social care and suggests insufficient involvement of local authorities in the plan. As more people with multiple conditions remain at home so social care staff are needed with enhanced skills to provide the day to day support, continuity and close working with health colleagues. Longterm support for those with complex needs has been eroded and the focus needs to be here and not only in crisis intervention with intermediate care. I see the plan itseld recognises that LA funding reductions are a main risk which could destabilise the plan.
- My concern is that there may be disinvestment in hospital services in order to fund care nearer to home without an adequate time to ensure that community services are able to cope. Even if the financial strategy included adequate time during the transformative period to fund the work on prevention and improved care closer to home until such time as it is evident that hospital services can be reduced, there are certainly insufficient staff to provide overlapping services . Hasty reductions in bed numbers may exacerbate NHS problems and I would hope for instance in the reduction of learning disability beds there is suitable alternative provision in the community and we are not simply increasing unmet needs and pressures on carers.
- Currently it appears that increased bed numbers are required particularly at UHND to facilitate better functioning of A and E.

- I wonder if adequate account has been taken of the fact that expensive equipment within the NHS is in need of updating which has not been completed because of the efficiency drives.
- I would like to see more explanation of the way that Northern and Southern footprints across County Durham will complement each other and take account of the others decisions. Consideration should also be given to additional allocation of funding for public health and social care as Durham County Council responds to the demands of 2 different plans across the county.
- The funding gap is enormous particularly as the NHS has only ever achieved efficiency savings of 2% and now across the NHS provider savings of at least 4% are expected. The STP itself acknowledges that 1.2% of the savings have not yet been identified. Savings identified in the vanguards may not translate into savings across the whole area. The Sunderland Vanguard expects to balance financially whilst there is an assumption of 50% savings for this type of scheme across the wider footprint. I would like to know the evidence for this.
- What is the evidence for success of various prevention programmes- eg smoking cessation, breast feeding, reducing alcohol consumption? Is it really worth pouring more good money after bad if they are not very successful?
- 66% wanting to die at home and 55% dying in hospital is not really very different! Discharges need to be more efficient and a greater emphasis on social care and care in the community.
- There is an opportunity to create income streams from the NHS Assets, the formation of a energy company using those assets to provide energy sources for the existing services and collaborative working with other Public Sector Partners to deliver and sell energy to the public. See Robin Hood Energy a Public Sector Company doing exactly what I have suggested.
- Increase taxation, charge people for missing appointments without good reason
- Everyone wants to see a "scaling up" of provision. However this plan doesn't say how this will be produced. If it is through any form of farming out NHS services to private companies then this is extremely worrying. But the plan is so vague I have no idea what the plan is.
- exceptwomens health care seems underfunded, the procedures could be greately improved. So woman can have healthy lives and continue to work.
- All water tests should go to the hospital for full testing. Preliminary tests don't show enough or don't seem good enough. It was on the news that new tests were to come out. If A patient goes to the GP or to northern doctors urgent care at north Tyneside hospital with a water sample in you hand they should take it off you and pass it to the appropriate department in the hospital this is not happening. Sometimes it is not being recorded. This is an area for service improvement.Women need better support 45 upwards.Women should be able to get tenner towels from the GP.women need better antibiotics that don't have nasty side effects.

- Social care seems missing. I see no arrangements for social workers to work 7 days a week. The two branches must work together. How about increasing taxes to raise money? Why is so much spent on agency nurses and doctors who are very expensive. How about reducing waste through over-prescription.
- Why not just tell Jeremy Hunt that these plans are impossible to implement. BE HONEST. Nothing has been properly thought out.
- HOW - USELESS.STOP WASTING PUBLIC MONEY ON NOTHING - THIS IS NOT GETTING ANYONE ANYWHERE
- Agree that our of hospital community care should be more experienced and better quality as well as work in a joined up manner with GP and hospital based services
- It would be nice - but I'll believe it when I see anything happen.
- Yes scale up work on ill-health prevention. However, I do not believe the figures quoted. The reason there is a funding gap is because the social care funding has been cut. This leads to more pressure on GPs and hospitals and causes bed blocking. Fund social care properly and a lot of problems will be resolved
- Undoubtedly more finance is needed and funding for social care, which is impacting on hospital services needs addressing. Central government needs to address this issue. Evidence from replies to this consultation etc. should be forwarded to central government so they are fully aware that many strongly oppose their STP plans. Again the proposals given do not explain what all of this will mean in practice.
- Increase efforts and money spent on health services by investing in prevention and recovery. Investment in women's prevention and recovery will make the biggest difference to the health and wellbeing of people in the North East. There needs to be services in place, both in the workplace and in the community for recovery in the broadest sense, from issues such as sexual and domestic violence and substance misuse, but also from impacts of poverty upon the lives of women, children and families.
- Funding needs to be redirected towards specialist health services. There needs to be a long term view that recognises different models and approaches, such as those practiced by women's VCOs that bring long term outcomes. Commissioners and policy makers need to think differently and take their focus away from the medical model.
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- There is need for a massive investment in the NHS by Westminster and that can only be achieved by a raise in taxation. The need for a raise of 2p in the £1 is the minimum that the country can afford.
- Cutting costs & improving services is impossible
- Scaling up work on the wider determinants of health by addressing the causes of the causes ... being bold and brave.
- urgent and emergency care already under huge strain - further cuts in funding cause me HUGE CONCERN. The government needs to increase funding. Their current plan is not feasible
- The national picture for adult social care needs to be tackled nationally, it's not something we can address locally without causing residents long travel times between home and hospital
- The cuts to NHS funding make the NHS as it stands unsustainable. Experts have repeatedly stated that the gfinancial constraints contained with the STPs are unachievable. I expect my local health authority to speak out about this rather than pretend these 'financial gaps' can be closed. In addition it is willfully misleading to suggest that it is possible to 'scale up' prevention projects whilst cutting funding - this will not work and you know that.
- Cost cutting to reduce the funding to what the private sponsers of tories asked for.
- Very important but details are needed.
- These are incredible amounts of money. Where did these figures come from? There is an unaccounted-for gap of £158m in the draft STP. Why?How?
- Good luck with that one as it's the same old rhetoric about doing things differently really if you actual believe a little bit partnership work can achieve the impossible and to quote fictional person we're all doomed.
- BE HONEST WITH THE PUBLIC THERE IS NO MONEY "THEY" NEED TO THINK BEFORE THEY CONTACT US
- I'm all in favour of policies such as Social Prescribing and I'm involved in promoting these within my PPG, but they need to be properly developed and resourced, otherwise they will become useless window dressing.
- I think we need an investment in the NHS not a reduction. These are only words, what are you actually going to do? and where is the evidence to prove that these aims will be realised?
- I am very concerned that the plans will not deliver to close the funding gap. I think more national funds are essential if we are to do this. The efficiency savings required are extremely ambitious and the timescales for impact of preventive work uncertain.
- I think you have no hope of filling any of these gaps with a £641m gap in funding, and you should stop pretending.
- Ill health prevention depends upon good healthy diet-not starving in between handouts from food banks. It depends on warm comfortable housing-not cold damp inadequate flats, or worse, living outside. How will you keep our increasingly homeless healthy? Depression is also born from deprivation.

There is a huge hole in the funding for care. Where is the money for the care coming from? Oh yes! Us! The finances do not work. As long as private companies are making indecent amounts of profit from the Health SERVICE you can keep throwing money in a bottomless pit of shareholders and capitalists creaming off profits instead of investing in people.

- Not enough detail in the plan to be able to suggest anything to add to it.
- I think the first two objectives although laudable are sacrificed to achieve the third.the plan is clearly a vehicle for delivering the massive and unprecedented cuts to the NHS imposed by the Government and driven by NHS England. I take exception to a plan in which a slashed NHS is hidden behind a notion of improved services. How is it at all feasible to "improve services" and, at the same time,save £641 million pounds from the NHS budget over the next five years?
- Lovely phraseology but as usual without true meaning or input from the general public.
- I'm concerned that the latter is the main driver.
- Need to ensure that ill health prevention is there ALONGSIDE treatment for those already ill.Need to ensure that out of hospital care does not equate with inferior services. Need to stand up and be counted - it is unrealistic to even think of providing improved services with a £600 million short-fall. we need to stand up against the continued underfunding from the Government.
- Could the NHS take over social care from local authorities, and the funding that goes with it, to deliver a more joined up service?
- Instead of closing the gap in our finances I think we should stand up for what is right - and for services to receive the funding they need to operate effectively
- I'm sure there are layers of bureaucracy in existence still which could be thinned. However, learn from the local authority and don't just remove all back office staff
- Drive efficiency measures. Invest in upstream activity to prevent illness. Systematic/ seamless leadership will be required.
- Again you have to make it so working people can access it as well
- I would suggest that those involved actually listen to their clients and follow through with after care instead of simply discharging them and then leaving them to 'get on with things' alone as they have done with me.
- Scaling up on prevention is vital. But again - how can you do this given the massive funding gap? 'Closing the gap on our finances' - no brainer - but how?? If it was simple there wouldn't be a gap.
- I don't think specific actions are set out sufficiently clearly - it all looks a bit "wooly" ,laudible but I just felt the action side of the plan is unclear.
- The draft STP says that the funding gap will be closed by "closing the gap".....??!! HOW?
- Only complete opposition and reversal of these central government cuts will ensure a functioning NHS in North Tyneside. Austerity is a lie, and implementing it is a choice. North Tyneside Council's Labour group must now stand and fight. Leave the business of closing deficits to the Tories

atWestminster. Let them tax their business tycoons and banker friends to raise funds for any shortfalls, and restore our NHS to full solvency.

- I feel the government must make additional finances available to the nhs also to local authorities in social care
- I'd like to see the NHS becoming more open minded regarding mental health solutions and involving local social enterprises and national advances in the fields of linguistics and neuroscience to make our community national leaders.
- This is an opportunity to save thousands of pounds for the NHS and update their current services from techniques developed in the 1980's to innovative and more precise, bespoke and accurate interventions.
- The car parking at all local hospitals is inadequate, and expensive - there should be an improved community bus service. All patients should pay a percentage - in the ward of 6 people that I was in 2 of the patients were bragging they were on there to save goigting to Prison
- Introduce annual health checks particularly for the over 60's, (I am 73).
- I would welcome and support scaling up work on ill-health prevention and improving well being if it actually resulted in a greater focus on prevention. However with so many targets to meet in other areas prevention is always one of the first areas to suffer while people get on with treating the fall out of a lack of prevention. Wanless suggested that you needed a fully engaged system, Marmott makes the case for the benefits of prevention but we still have huge health inequalities and sections of the community that have little aspiration as the infrastructure to thrive doesn't exist. Young people need to feel excited about the potential opportunities for the future rather than worry about whether there is a job, can they afford a University place, will they be able to afford a home for the future and the Caring of ageing parents as people live longer. Support being withdrawn from Local Authorities due to budget reductions and a greater demand put back on individuals in the community to cope. It will have its toll.I would welcome increased collaboration between organisations that provide out of hospital care but feel that with our present structure it is going to be fragmented. We tak about Health and Social Care but at the same time we are talking about two large, very different organisations who do not want to come together to address the needs of the population. So really we have Health care and Social care as opposed to Health and Social Care. The two need to be integrated. Not a few staff from Health being employed by Social Care or vice versa but real integration where people are employed and have a contract with one organisation which has the remit to deliver on this.
- I don't believe that the funding gaps will be very different to predicted by 2021 as there is no time to implement radical change to help to make the difference and stop the run down of the health services that the Government seems hell bent on. I believe that the Government can afford to finance the system as required but don't have the political will to do so. Regardless of what is achieved there will be more stick to follow. So really you are paying lip service to this whole grand idea, by the funding cuts of our current government.
- No problems with hopes, but can it be done. The Isrealites could not make bricks without straw!

- MORE INFO SHARING, USE MORE TECHNOLOGY AND REDUCE BACK OFFICE STAFF
- How are Health and Social working together? Integration has been talked about for years. What evidence is their that this is happening. When can pooled budgets be used so that a persons overall H&SC is looked at.
- As people get older the requirement for hospitalisation will increase not decrease. If budgets are cut the general health will decrease which will increase the work of services.
- Money does not grow on trees. So many people already give so much unpaid time to their communities trying to keep lunch clubs foodbanks and reading support in schools going. How much more do you expect from our sadly underfunded rural and inner city communities.

Question 4

What do you think about the scale of the challenge facing us in making signification improvements to health and wellbeing, services and efficiencies? Are there any actions we could take to make these changes or speed up the rate of improvement?

Some 84 people/organisations answered this question and 10 chose not to. They said:

- Make erroneous, victimising-of-the-vulnerable changes? Quicker? I am appalled. No wonder it is so hard to get facts, answers, true public consultation.
- The scale is huge... it will cost a fortune to do, ie advisers and managers and financial advisers and CCG team wages... and is it evidence based? And why should users be at the brunt of austerity? You need more resources... more money...I'm all for efficiency, yes payroll needs to be centralised - as do your IT systems...and sharing of Pathology info...I heard it all on Monday in Whitley Bay library ... but the biggest savings won't be made with those things as your waterfall slide showed. And you say 80% done? so do we get a say about the 80% done? and what is the 80%. And if we don't want most or some or all of the 20% can we say no too?
- Time scale so short as to be unattainable. Recruitment/retention of new community staff a huge hurdle. Are there enough skilled community staff in the national pool to fill these (and presumably other regions) needs. Uncertain effect of brexit in recruitment.
- To me, the scale of the challenge is overcoming silos and form of organisation. this does NOT mean inventing new organisations, new structures, new legal agreements. It DOES involve getting people to talk to people and work towards a common goal. It might mean removing Payment by Results to allow contractual alignment. One of the key challenges is that care is delivered at present by a wide range of statutory, public sector, voluntary sector and private sector companies, and this works well. To bring it all within a few huge commercial (or effectively commercial NHS-owned) companies runs a huge risk of lack of breadth

- The current situation in the NHS cannot be changed without addressing the issue of underfunding. Dressing up cuts in services by calling them efficiencies and improvements can only serve to make the situation worse.
- Bed blocking - think about having a convalescent section in every hospital for patients who are clinically able to go home with normal beds, a kitchen and a common room. This could be staffed with care workers and a supervisor, with reablement and rehabilitation services adjacent to it so that people are encouraged to dress themselves, cook their own food etc. A proper assessment of their capability and any support needed could then be made before they go home or to a care home.
- Comparison of costs for each procedure at each site within the region could help to identify outliers and ways to save money, but it is important to also consider quality of the service in conjunction with the costs.
- The challenge is enormous. To move more patients from hospital to community based care means that you have to ensure that facilities in the community are modern and adequate. That requires investment in both facilities and staff.
- Before removing services from hospitals/hospital sites the infrastructure in the community needs to be available - if it is not, ambitions will not be realised and there will be chaotic care.
- I think you are taking on too much. People need to take responsibility for themselves. I also worry about the misdiagnosis of Asthma and type 2 diabetes...Also..how can you know how many people are overweight or obese if you haven't weighed the whole population???? No body has weighed me for 25 years!!! Is this misuse of statistics?? I suspect so.
- Oppose the cuts. Stop outsourcing and privatising: Look at the evidence
- Let's look at CAB; the specific healthcare impact of the Admin Reviews in patient care in CDDFT, the problems with recruitment and retention, and GP services in our area- not to mention what is happening in social care. And let's look at UHND's PFI 'problem'. And let's stop blaming the staff! I cannot think of a time when people felt more unhappy, unappreciated, pressured and angry. The 'us and them' with management is toxic.
- How could anyone speed improvement? Stop selling us all the lie that the problems are our fault, already; how could I ever get on board with this wholly duplicitous task when I see NO true voice calling out to the government that the spending cuts are Not Acceptable. Not safe. Not fair. And definitely Not Necesay (let's talk austerity economics and evidence- it is a political lie).
- %GDP? Healthcare:polpulation figures?
- You will not get the results you claim unless you address the appearance of this whole project as shady, dishonest, disengenouos.
- Why do little publicity, and why no proper disabled access, for the last meeting Jan 12th? You have a massive credibility problem that will lead to suffering for the people of this county unless someone starts to address it.
- fund services so that the spend on health in this country is comparable with France.

- These challenges are huge because of the contradictions within what you and the government behind you are trying to do. You should challenge the government on their funding choices for the NHS.
- The most important action you could take would be to be honest with the public about what is really happening in the NHS and to join with others in demanding more government funding for health and social care. Some of the ideas in the STP and others like it around the country may be valid and may improve services but whilst they are linked to the need to save £22bn in the NHS in England by 2021 they cannot be taken seriously.
- We need a properly funded, publicly provided and publicly accountable NHS, spending a proportion of GDP closer to the European average where money is not being bled from it by private corporate interests. All international studies have shown that the NHS is the most cost effective system for providing universal healthcare and it is under threat as never before from privatisation.
- The scale of challenge is significant and we feel it is essential that all relevant organisations, agencies etc work together to help achieve improvement. consideration should also be given to what investment may be required to achieve the outcomes of the STP by 2021
- Could be made worse by expensive reorganisation
- Stop acting like a nanny state with unaccountable managers who are not occupationally competent
- Cutting services leads to poorer outcomes and a demoralised workforce. As one of the largest economies we need to be spending a greater proportion of GDP on health and social care which would bring us into line with some of our neighbours
- I don't think anything will improve for the reasons outlined above...also...you need to acknowledge that anyone can become ill...it is not all associated with social class ....so you need to make sure people are not excluded because they are not receiving benefits....everyone needs to know about every service.
- Access improved funding
- Impossible unless central government sorts it out
- A lot is self perpetuating...people won't take responsibility for themselves so nanny stare has too...a vicious circle...stop pnpandering to scroungers and accept that hardworking tax payers from high soicial classes can also need health care through no fault of their own... Oh...and make sure you are aware of the difference between type 1 and type 2 Diabetes in your literature
- You will never succeed because you base everything according to entitlement by social class...
- Speed up? - I think 5 years is not realistic target. Actions you could do - Spend a period of time talking to staff - and make sure the people whom are completing the research have no vested interests
- It is impossible. The government is committed to a different model of care and this is part of that plan. You cannot blame GP's for things that are far more complex whilst at the same allowing private companies to slice of the easily profitable areas and not even making sure they provide the same quality service. For example diabetic eye screening recall and cervical smear or GP

records transfer which are all much worse since private companies have taken over.

- It is very concerning how quickly these plans have had to be put together. Involvement of clinicians, local politicians and others with a stake in local services is lacking, creating a very significant risk. The tight and often optimistic timetables for change will hit trouble as local people object to proposals. You will still have to consult on changes as per NHS legislation.
- The expectations about what can be achieved in the next 4 years are amazing but at this stage the plan lacks the detail and robust evidence to demonstrate that they can be realised.
- Improvements to health and wellbeing will be welcome but the timescale is likely to be over optimistic.
- It is very difficult for a member of the public to distinguish between those changes which are evidence based and real improvements and those which are purely cost driven. My fear is that many of the suggestions are not about best care but are driven by cost saving.
- The increasing specialisation of hospitals and the provision of community hubs gives rise to concerns about the adequacy of travel and transport arrangements across the region. This includes the pressure on the ambulance service and the STP must explore and resource this.
- There may be a lack of recognition about how far the public value local services and it feels as though rural areas are disadvantaged by more specialisation and collaboration between hospitals.
- I would urge managers to work with partners to seek sources of funding for investment which do not lead to the horrendous problems arising from PFI.
- The issues are not insurmountable at all. However, there needs to be an increase in staff and staff need to be valued and treated well. 10 minute appts to see GP's is appalling. They are already overstretched.
- The world is a constantly changing landscape, but too much change can be costly and difficult to judge the positive outcomes. You can only eat the elephant one bite at a time.
- Strategy needed to coordinate services for chronically sick and those with dual diagnosis ; people with incurable illness will suffer from depression
- The challenges are great. What is required is for the government to release more funding for the NHS. This is, in my opinion, the only way we can fix our failing health service. Any attempts to fix it through gradual privatisation, or closure of services and facilities will only result in disaster.
- The scale of challenge is overwhelming. It cannot be done. See above.
- HUGE SCALE REDUCE RED TAPE
- Why not utilise existing underused services such as Palmer's hospital in JARROW for some out of hours services.
- Given the ongoing cuts by a goverrnment that cares nothing for the poorer sections of society, the first three points seem like just pie in the sky.
- I question whether the plan can be viable because of ongoing cuts to NHS funding. The Tories are underfunding the NHS so it can be privatised and then sold off to private companies. It is doubtful that the plan can be achieved

when there is such an appalling lack of about the lack of mental health services in our area. I know from personal experience that waiting times in my area for mental health services have quadrupled since 2010 because of cuts to funding. It's not rocket science. I am also concerned the issues about how A&E will be viable in Durham if Darlington A&E closes. Surely this will only increase pressure on UHND A&E by increasing the number of patients to be treated. It will also stretch ambulance services further if they have to make longer journeys. Furthermore, it will put patients at risk and will I believe increase deaths. Quite frankly, this plan terrifies me

- There is no evidence that the proposals will lead to significant improvements. Providing honest, clear and accessible information on the details of the proposals and listening to local areas affected would be a step forward.
- The women's VCS are willing and committed to working collaboratively with CCGs and other agencies to improve the health and wellbeing of people in the North East. We bring expertise in gender analysis and experience in an intersectional approach to tackling all health inequalities. To benefit from our broad knowledge and experiences of equalities and health and social care issues, CCGs need to take up our offer of involvement in its early planning processes.
- The joining up of Social Services and the Health service is essential.
- Stop sending money on more top down reorganisation & fund the frontline
- Recognising that welfare reform and the reduction in the support infrastructure within and across comminities is impacting upon the NHS.
- Insist on more funding from Government. There has to be a big debate on the future of the NHS. All this is just avoiding the real problem and allowing the Government to have other people to blame when things don't work out
- Include the staff at the beginning of consultation, not at the inception of any changes.
- The scale is unachievable - I would applaud the goals of improving health and wellbeing if they were not accompanied by cuts, but rather by increases in funding. Your action SHOULD be to speak out against the Deoartment of Health, explaining why the most impoverished area of the UK cannot deliver on these goals with such severe budget constraints. Any other action is disingenuous.
- Will NEVER be achieved until the whole service degenerates into a private service. Those who can afford will get medical services while poor and elderly will die.
- No stereotyping of individuals and conditions. Proper public health education on health care for all ages. Holistic view of patient care-mind and body.
- The scale of the challenge of meeting the continuing un- derfunding of the NHS is a huge one. It is also a self-inflicted challenge which could be met by replacing the effective cut in funding to the NHS since 2010. NHS inflation stands at about 4% but currently NHS spending is only increasing by 1% p.a. hence the problem. If our spending was increased to the European average of health spending, there would not be a problem.

- There have been meetings in the past about how to improve dialogue between health service users & different departments of the NHS. As usual nothing has changed.
- I believe the task is big in fact you can't visualise the size. Where's my brush as painting the forth road bridge is smaller and that's never ending.
- It is enormous, but Central Government will have to take a more active role in developing funding. I'm a pensioner, but I believe that pensioners should pay some form of graduated National Insurance based upon earnings above a certain figure, such as £10,000.
- INVEST IN THE NHS
- really invest in preventative care-invest in health checks, do huge campaigns about sugar and processed foods, increase staffing levels in hospitals then services will be more efficient.
- The challenge is a huge one. It has been historically difficult to achieve transformation without investment. I fear making a commitment to a plan which cannot be delivered simply undermines the CCG's credibility.
- I think the 'challenge' makes it quite impossible to make significant improvements to health and well being, services and efficiencies. You will be cutting out badly-needed services and you shoudl say so.
- Yes! Nationalise the NHS.
- Go back to NHS England and the Government and tell them the reality that the NHS needs extra funding to maintain a safe and sustainable NHS
- To ensure there is a safe way to reduce the current level of NHS provision by £641 million (the gap identified by the CCG) by 2020-21 there should be an independent impact assessment of any proposed changes in health services to ensure the assumptions made in drawing up the STP are realistic.
- You could start by advising the NHS hierarchy that we need a lot less chiefs on excessive pay, pensions and perks and more useful frontline staff.
- Where is the work on homelessness, poor housing stock and mental health.
- People have not been consulted.
- The STP document is not understandable.
- It was brought in in secrecy, with no access to supplementary documents or appendices
- Councillors are not involved.
- All in all, the STP process is a sham and a truly embarrassing disgrace for you.
- It is regrettable that Government is forcing more cuts on local health services, resulting in more limited and remote provision that ill-serves patients, carers and their families and friends
- I don't think any improvements will be made, I think services will deteriorate and then we will be told that everything has been privatised in order to improve the NHS. The only issue facing the NHS is under funding (and who decided that this should happen? I certainly didn't agree to this and I pay the same taxes as I did last year!)

- It is a huge challenge but effective monitoring and review and challenges need to be made early in areas which are underperforming in order to reduce much larger complications down the line.
- HMS NHS will take a long time to turn around so that it can sail in a different direction. God chsllenge is huge and cannot be overestimated. Good luck
- Start at school level so people grow up with health and exercise
- I think that we are fast becoming a nation where those (like myself), who are self-aware and intelligent, will continue to be ignored and left to our own devices simply because we are not taken seriously. I should not be ignored or refused help because of my intelligence. We follow America in everything, mental health is just another example of us doing the same again. It won't be long until we collapse in the street and are asked if we have insurance.
- Closing the gap on all 3 of the above currently seems achievable except to a very small degree.
- This can't be dealt with in the context of local health and care bodies working under a unfit for purpose national system.
- The challenge is huge and in my view it will not be possible to reduce the finances to the level required - even if hospitals are closed. I don't know what actions you can take - I think the idea that you need to reduce costs to this level is nonsense.
- No doubting the scale of financial challenge although a figure for your TOTAL BUDGET would put the scale in better context ,.i.e 10% , 15% , 20% ??
- Without acknowledgement, and a significant £ contribution, from Central Government the scale of the challenge will defy satisfactory resolution. Issues such as Living Wage and immigration controls will compound the problem.
- Think instead about the trust that will be lost in the local authority if North Tyneside Council rubber stamps these plans, implementing stealth cuts. People in the community are aware of what's happening. They're not politically despondent, and they're angry at this perceived and real betrayal of the borough by its local government.
- I feel as any business there has to be efficiencies savings maybe adjacent nhs trusts can come together to purchase goods in bulk for better value also to share under used resources
- They are huge but considering all post war children were told they were part of the post War Bulge so the authorities needed to start planning then forour old age, precious little has been done about it and now we are being slated for having been "fortunate" in life.
- Mental Health services have fallen behind, solutions for mild to moderate mental health are available. 40 sessions of CBT, reduced to 3 of IEMT and MoM from above websites.
- NICE prevent progress in these cases.
- I am personally witnessing vast changes in wellbeing and mental health.
- Cambridge GP surgeries are suing these techniques. Why aren't we?"
- The local community should be given funds to enable the elderly to eat correctly and warm their homes, fast food chains and Supermarkets should be taxed on unhealthy food alcohol and cigarettes

- There are still obvious inefficiencies in the NHS, I have experienced it on the administrative side where I suspect a lot of potential hospital out-patient appointments are lost.
- The timescale that has been given to achieve the outcomes is unrealistic. The scale of the challenge facing us in making significant improvements to health and well being, services and efficiencies will not be achieved through this process. To turnaround financial investments and focus of delivery before 2021 would require an inspirational and radical intervention and there is neither the time nor the money to achieve this. There probably isn't the will either. The main action we could take to make these changes or speed up the rate of improvement would include change at a scale that will be too big to consider over a 5 year period or with the same level / reduced levels of funding.
- Employ staff you can retain. Train up staff that want to work in this area. There is a lack of universities here locally that can provide the staff you need.
- Thw challenge is huge, & this document does little to help us progress.
- LOOK AT PRIVATE SECTOR PROCESSES AND CUT BACK ON MANAGING BY COMMITTEE.
- The funding gap that is faced seems to extremely unrealistic and nothing in the plan suggest how we will be able to meet the gap. There is no breakdown of how much is being spent in each area e.g improving health inequalities so how can people determine how this will be sustainable.
- You should turn round and point out that budget needs to match medical inflation.
- Give all citizens on low incomes free access to local gyms rather than piecemeal health initiatives in local communities. Bearpark had Healthy Horizons excercise class funding withdrawn and aq year later the village was offered Tea and Tango!

Question 5

We will only achieve these ambitions for our area by engaging local populations, the people who use our services and the staff that provide care. Have you any ideas of how we can effectively engage with the 1.7m people in Northumberland, Tyne and Wear, and North Durham?

Some 86 people/organisations answered this question and eight chose not to. They said:

- Start being open and engaging genuinely!
- Provide dates and times and access publicly and the public will engage!
- First of all there is a typo above (and one in one of the other boxes)...I presume you mean how we can etc, not who.
- Yes you have a problem -My son ...and my family and friends had no idea about STPs ...what they mean ...and how to engage...it was only through me...so how many more not engaging?

- The walk ins consultation only managed to get answers from 768 people...so yes you must see you have a serious problem here.
- But it's not just how to tell the public...but in what form...you need paper surveys...you need help for people to read and understand it all....the slides and presentation on Monday was - 1) last minute 2) only in Whitley Bay and 3) abysmal
- The slides were far too complicated ...the table discussion is divide and conquer! Although it does have a place at some point ...but after more open floor explanation and discussion and questions.
- I looked at the slides for Newcastle and Northumberland ...they were much easier to understand ...why?
- Has to be much better than to date.
- Posters in GP / dentist/ outpatient clinics/ inpatient wards / A+E. Possible monthly slot on local tv news to answer questions/ possible video on line going through basics of plan / possible programme on freeview Tyne & Wear channel/local radio phone in. Collaboration with BBC (public service broadcaster) to raise national awareness that this consultation process occuring across whole country. 1 page leaflet of headline issue through every door in the area.
- Yes. Next question?
- Coming back to the answer given in 3. - communities is the way to engage. GP practices with registered lists of the population naturally cluster around the natural communities of the population, so a lot can be achieved by aligning community teams of health and social care (and voluntary sector/ private sector) to the GP practice clusters
- I think you mean 'how' not 'who'! If your plans are as reliable as your proof-reading then heaven help us! You will not engage with people if you do not publicise the public meetings effectively. The presentations that you have been giving at those public meetings need to be clear and meaningful not a series of vague and general statements illustrated by incomprehensible charts and diagrams.
- Try to get other organisations to retweet (or advertise on their websites) invitations to consultations (eg Diabetes UK, Age UK, Asthma Uk, Newcastle Elders Council, Patient Support Groups, the Maggie's Centre at the Freeman Hospital, Womens Institutes, Round Table organisations). Notices and fliers in GP surgeries and Outpatient Departments.
- The material produced so far seems unlikely to engage with our regional population because it is technical and not written with them in mind. The funding issues should be more obvious as the driver of the STP and it would be helpful to understand what the current community infrastructure for delivering care closer to home looks like, and what it should look like in 3-4 years time.
- At the moment, worthy though the material is, it feels as if something is being done to us rather than with us - that can only diminish engagement.
- You have to publicise properly...not shoving leaflets through doors hidden inside other adverts as they were with Care Data info.

- Start by having better publicised, more accessible, more transparent meetings: and We all need to Come, with an open mind! No-one can simply cannot fob off the whole population that 'these are the hits they should take because the government in Westminster say so' - seen as the rich political elite who might not pay fair taxes, didn't go to public schools, don't use the NHS, and have vested interests. Publicise in the paper and on social media: people will come. You are perceived as hiding at the moment - therefore untrustworthy.
- Personally, I cannot support what is based on a lie (the 7 day lie, the austerity lie, and the 'mandate' - where did they officially say that they are aiming for HMO Kaiser Permanente, or Valencia, models? But I've watched the 9th May PAC where Jeremy Hunt openly calls for them).
- everyone, it is our NHS. Send information through the post to every household, as well as working through organisations and communities.
- 1. "who": organisations such as NUFC, Falcons, amateur sports clubs, St John Ambulance, British Red Cross, Local Schools - as below. 2. "how". Communication is very important to patient engagement especially on prevention. I follow the NG CCG on twitter but I see that the CCG has less than 2,000 followers. I think it would be useful for the CCG to expand its reach. The current introductory paragraph is factual but does not mention either GPs or patients and hence doesn't spark any direct relevance for the public. Could thought be given to re-launching NG CCG twitter and ensuring the introductory message directly addresses patients and their concerns?
- Can you ask other organisations eg professional (NUFC) and amateur sports clubs, charities etc to retweet your messages – tailored to particular demographic groups eg 'flu vaccinations, smoking cessation etc?
- The letter in the Journal on 4th January announcing this consultation only mentioned the CCG website. In future communications it would be useful to mention (and promote) social media, I'm not sure how many people have the time to search web sites - mobile based communication is so much easier – though it is still the relevance of the content that matters most.
- Do you/can you work with charities such as St John Ambulance, British Red cross to encourage CPR training in local schools? That could have life-long benefit to students and also working age/older members of the public. The same could apply to sports clubs.
- Talk to us honestly without management speak. Give us the details of what you are going to do to our health services and what this will mean for us in practice. Listen to our ideas and take them on board! Consult properly don't just tick the box.
- From events that I have attended over the past 9 months or so your efforts to engage local people have been woefully inadequate. Most people, including many health workers, have no idea about the monumental changes that are being proposed. Instead of peddling the false ideas contained in your jargon ridden documents you should use the media to publicise the truth about what the real situation is with the NHS and social care and about what really needs to be done to improve both.

- No doubt a clear communications and engagement strategy will be in the planning stages as part of the STP process. We feel that it is essential to utilise all relevant partners, organisations, groups and sectors within this strategy to achieve the scale of communication that will be required
- Publicise widely as possible just don't restrict information to surgeries....adverts in newspapers and TV as well as internet.
- Publicise on TV and all other media
- Documents need to be written in plain English rather than management speak. There also needs to be greater transparency about the proposals to reduce services. Whilst there are some good arguments for developing specialist services there is still a need for services to be delivered locally so that people are able to access hospitals whether as patients or visitors without incurring excessive costs or significant travel times. It is also important that the workforce are consulted in a meaningful way as they are the people that know what is happening day by day.
- I think all changes needs to be publicised on TV and in newspapers...not merely internet.... Also...consider that only putting information in GP surgeries will exclude people who rarely visit GP. Public must trust staff...trust is difficult when there is no privacy/confidentiality in surgery...eg new patients filling in forms at reception in full view...and nowhere private to go...also...MOBILE PHONES being openly used in waiting areas...reception staff not taking action...HOW LONG BEFORE THINGS APPEAR ON YOU TUBE???? What a disgrace.... So much for trust and confidentiality.... This was a surgery in Langley Park!!!!
- Offer say on improving services. Do not implement health care rationing
- Newspaper and TV adverts. Internet too but not just internet
- You never will unless you send everyone informatioin and put it in newspapers...not everyone has the internet ..all the resources will go to Newcastle anyway.
- Try talking face to face using plain English
- Make this all more public - go on the news, inform people and staff. Have their managers set out time to discuss the plans and feed information back.
- Be honest. But actually what can you say. We will close your local hospitals and you will have to go on public trasnort 20-30 miles to get a test and another 10 miles to see someone who then wont be able to see your test and then another 10 miles to get your operation. You are aiming low. 35% people with identified MH conditions to see NHS mental health worker.
- By producing a plain worded plan which spells out in english not management speak how the services in the area, especially actute hospital and GP services, are going to look at the end of 3 years.
- No, I am not prepared to 'engage' and support lack of financial detail, uncertainty, risk, pressure to cut an already resource-starved service, a system where staff are in despair, a drive towards increased privatisation.
- There is a huge challenge in engaging with the public especially in North Durham where it feels a bit of an add-on to a plan that was already well developed before we joined the northern footprint. I tend to be mistrustful of

the whole initiative for the following reasons: - 1 The summary plan is so general that it cannot give any real picture of what the changes involve. The technical submission gives more detail but is not designed for the public and so full of abbreviations and NHS management speak that is not easy for an outsider. 2 Awareness of government misleading the public on health issues eg. the funding of £10bn which according to the economists at the Nuffield Trust is worth less tham £1bn, the evidence re 7 day elective working in relation to junior doctors and more recently the need for GP surgeries to be open 12 hours daily which does not appear to be supported by evidence of need. 3 Awareness of the impact of a decade of the lowest increase in funding ever across the NHS which makes this a very difficult time to invest in improvements.4 The hints and suggestions from within the NHS that it is not acceptable for staff to question the plansand the awareness that the plans are centrally driven.5 Many NHS staff are so focused on their work that they seem unaware of the government aim to increase input of the private sector and that ACOs, MSPs and PACS are of great interest to private firms. Further fragmentation would work against the integration and co-operation on which the plan rests.

- I believe that you should aim to increase the trust of the public in NHS Managers and this can only be done if you are as open about the plans as possible at every stage. This means being explicit about the implications of what is proposed and giving examples about how it would work. It may be that you need to describe what could be done if we fund and staff the service in line with OECD averages and then show what we can actually afford to do. This may deflect some of the anger that I have observed at meetings and indeed I believe the public should be holding the government to account. It is too late to change what has already gone out but at the next step can you update us about what has already been put in place and ensure that information does not leave us just guessing what is going to change.
- Can you publish a summary with reference to website in the local free press to encourage wider involvement?
- At the stage when there is consultation over cuts/ collaborations and staffing reductions it is too late to win over hearts and minds.
- This consultation has been very poorly advertised. I only stumbles across it on the durham.gov website whilst completing the 'letting boards' consultation!!
- Target our young people as a priority, use school pupil councils as a sounding board and they will become healthy ambassadors for their parents and family members. Make our young people count and value their contributions.
- Health Watch, Pals local patient for a
- Actually engage with people! Talk about it in the press, hold local public meetings. I only found out about this survey by chance. There has been little public engagement thus far in Northumberland.
- I presume you mean "how" no "who".Frankly this is nigh on impossible especially as you initially made it so difficult to discover what the plans actually entailed.
- Don;t just ask but accept and act on suggestions made

- TV will reach the fastest and widest medium. Or meetings within local areas such as community forums?
- No.
- stop using management speak and terms like empower. Many people do not understand what they mean. Stop hiding behind jargon. Use plain an simple facts. For example say "we are going to close Darlington A&E so you will now have to be taken to Durham in an emergency"
- Publish clear, honest, transparent proposals that really show what is being proposed and use press, television, social media to ensure people are aware. Listen to health professionals, unions etc. who work in the services. Go back to central government and tell them their plans are not acceptable.
- It is vital that the NHS though the vehicle of Local CCGs works closely with the women's VCS. We are already integrated into local services, strategies and forums. NHS Sustainability and Transformation Plans mark a new beginning and women's organisation need to be involved from the start so that a women focused approach to tackling health equalities, our ethos of women's self-empowerment as the route to health and wellbeing and our creative and holistic ways of working are embedded in local systems, policies and strategies at the outset. We are willing and committed to having early conversations and ongoing dialogue with local CCGs to help bring about the
- BY TELLING THE TRUTH! More investment and hence a rise in taxation is essential.
- Via the trade union movement
- The Plan is very light on detail and it is difficult to feel very engaged in some high level statements that do not clearly set out what they actually mean on the ground. Transparency and real time access to full information throughout the process is important.
- The Government by finally having an open and honest debate and not hiding behind initiatives like this
- Local direct marketing
- I don't believe you wish to engage the public - a couple of very poorly publicised events a week before the end of the consultation process does not constitute effort. If you want opinions you could share across social media platforms much more widely (including with health campaign groups who could easily get more people engaged), you could email NHS staff (I know that hasn't happened universally) you could hand out leaftlets at GP practices, primary schools, community centres, shopping centres, supermarkets, have a bus road show- there are many fairly low cost options. YOur website could be easier to navigate.
- TALK to actual people instead of so called professionals who only want to feather their nests like the politicians of all colours !
- Use of social media, education on health target in schools and colleges, education on how diet and drugs affect the mind and body-preventing side effects etc.
- I was not aware of this policy document until I read a letter in the Journal written by your senior communications officer. I suggest that, in order to

effectively engage with the 1.7 million people in our region it would be better to avoid jargon and use more prosaic language. How many people know what CCG stands for and what a CCG does? There is a real risk that yet again an opportunity for the public to have their say in the running of their health service is being missed.

- You can engage by telling the truth: the STP is a way of reducing funding to our local NHS. Return to the government with the news that NHS staff and public alike are sceptical that these plans a) will work, b) will be good for us or the NHS.
- Possibly a meeting hosted by the CHCF with a hospital administrator; dr. or surgeon' ward sister; G.P.
- Really, TV radio and social media may be a good start. But it's not about the message it's about people having opportunities to be healthy and not self defeatist
- USE MEDIA AND COMMISION tv SOAP TO TALK ABOUT THE ISSUES
- Use local media for discussion and forums.
- Yes make your plans clearer? Actually publicise that you want to hear about people views? use social media? Start a local meetings, where people feel listened to.
- I agree that engagement is vital. Sadly the timescale allowed for discussion of this draft STP is not adequate for it to reach many local groups who might be interested in its implications, and it is not presented in a user friendly way.
- What does this mean?' ideas of who we can effectively engage'. Is 'who' a typo for 'how'? The fact that no-one has proofread properly does not fill one with confidence about the care you are taking over this consultation.
- I assume you mean 'how' not 'who'. OUR NHS should not be run as a business. It should not be carved up and sold off. It belongs to us.
- You haven't even bothered to get your wording right: ideas of who we can effectively engage with the 1.7m people - you could at least get your language correct.
- The CCG should engage the public more widely to get their views on the services reductions and changes. Take out a slot on main local TV channels and actually tell people the physical effects that this STP would have on their NHS services. Go on Sunday politics and do the same. Use web sites including councils as well as social media.
- Listening to BBC radio Newcastle this morning it was stated that after taking consultative advice 700 people were interviewed in North Tyneside?
- Maybe you should be engaging with the residents of the old local authority housing stock before they merge and loose touch with their housholds.
- People need to have been consulted PRIOR to the signing off of contracts on 23rd December 2016. What has happened is wholly disrespectful. How can you even hope to involve people, when this lack of consultation has led to a breach of trust
- Talking to people in town centres and at consultation events.
- How about a short video on Youtube, explaining how the plan could play out in practice, what it might mean for people, and what the issues are?

- I have friends who are nurses and work in hospitals. All of them are worried about the level of services and feel under pressure not to discuss this outside of the hospital
- Get out to every town centre, coffee morning, social group and speak to people - community facebook pages, linked in, twitter etc radio and TV advertising, local newspapers, be clear about what you are asking and aim at low levels of literacy.
- Community leaders/ LA's/ VCS/ the public/ academic institutions/ business community etc.....
- Essential we engage and inform (educate) people about the forthcoming tidal wave. Engage people in option appraisal and engsge people in consultation processes."
- Set up trading session that are in reach of the people of Durham not just the professional wage earners
- I think that you should try and actively engage those people with both physical and mental health problems in their own 'path' towards wellbeing. Stop treating us like fools, stop acting like God's and start respecting us and, most importantly of all, start LISTENING TO US.
- Use the local VCS infrastructure organisations in each area - which have hundreds of members each. Through them you can effectively reach thousands of people - and crucially you can reach the ones that are harder to reach.
- Yes, if you are going to seriously listen to the public opinion - but having seen Durham CCC consultations and ultimate decisions , forgive me if I am rather sceptical.
- Health education and promotion via local news
- Grass roots' discussion rather than trial by media
- The BFAWU, GMB, NASUWT, North Tyneside Trades Council, NSSN, NUT, RMT, UNISON, Unite, Usdaw, and any and all other trade unions active in the Metropolitan Borough of North Tyneside.
- By joint consultation meeting in various venues with nhs , local authorities and local voluntary charities
- Tell them the Truth... stop the dependency you have created, open your mind to models outside of NHS assumptions, take a holistic and larger perspective on public health, empower us to lead ourselves, educate the population in the truth...
- www.highereffct.co.uk
- The teaches / pupils of our schools are the most important influence of future generations
- Systems leaders need to buy into this change and then need to refocus considerable efforts of their respective organisations to communicate what is being planned, giving the case for change. This will need to be led by people who believe in what can be achieved as they need to take 1.7 million people, from some very different geographical and economical backgrounds along with them. Good luck!

- use the VCS and target populations through sporting venues, home care, shopping centers.
- Why is North Durham "lopped off" the CDDNHS Trust? & why is Durham/Darlington the only split count in England?
- WHO OR HOW? ASK PEOPLE HOW THEY WOULD LIKE SERVICES TO OPERATE, LEARN FROM PAST MISTAKES AND INNOVATE
- Some real engagement with all groups needs to be done so that people can understand how the STP differs from the 5YFV. There are many hard to reach groups that need a real understanding on how CCG's aim to achieve this very ambitious plan. Vol orgs and community groups, as well as schools and workplaces should have a real input.
- Their will be a huge amount of public upset when closing hospitals and reducing services.
- I suspect that most of these 1.7 million have heard all the grand schemes before only to find that nothing seems to change and our hard working under valued NHS staff are keeping their finger in the dyke. No one can do more with less. All plans need first to be funded

Question 6

Any further comments?

Some 68 people/organisations offered further comments on the draft STP and 26 chose not to. They said:

- I appreciate you have a job to do, but if you close or down grade services at the same time as these plans are having to happen then people will be right to be suspicious that STPs mean cuts...and not improvement...I have no doubt some things will be for the better ....but I also truly believe that you will find evidence to fit your vision and that the Tories really are trying to run down services and have a private insurance system...I will campaign for and support all of this process being under the strictest scrutiny. Also, finally, where in the Tory manifesto did they say we would have to have the NHS go through these STPs? They were kept quiet for the past year or so too...why? And how about pushing for the PFIs being cancelled and the debt wiped clean? Maybe then you wouldn't have to fill the financial gap above.Finally the 44 Footprints have to find £22bn...theGovt only has to put up £8bn... that is not right or fair ...is it? It's not like the NHS has been squandering money...well maybe on managers wages ... so why did Simon Stevens agree to it? And why are you trying to fulfil the deal?
- I hope when I press next on this page there will be a overview of all my answers and they are stored or emailed to me for me to keep as reference...I will be most perturbed if they are not.
- Finally how will you analyse such detailed written answers? Again where's the objectivity...surely a scoring on a scale would be easier to analyse? with maybe just one box for additional comments.
- Attended 18 1.17 public engagement meeting Newcastle. Presentation was not pitched at a level to be of use to all members of audience. Abbreviations

need glossary. An easy read – Help us decide how to save £640m and improve our health and social care" would probably increase public engagement. "

- The current crisis in the NHS is being deliberatley used to pave the way for private healthcare. As Bevan said, "The NHS will last as long as there are folk left with faith to fight for it." We don't need you to re-arrange the deckchairs on the Titanic- we need you to avoid the iceberg.
- It is essential to keep pressing the government for more money for health and social care and to challenge the premise that the "NHS model is broken or unsustainable". The need for healthcare will increase as the population and life expectancy increases and this need will have to be met one way or another. The NHS is almost certainly the most efficient way to achieve this.
- Improving healthcare and wealth and fairness should be aims we ALL get behind; our region has suffered more from the Austerity Budget victimisation of the poor, the ill, the disabled; we will also suffer more from post-Brexit trade and funding changes; so swallowing a message of 'cuts to healthcare are Good for us' is the bitterest pill - likely impossible.
- Start being HONEST, and representing the 1.7 million people - by which I mean actually raising public concern, not pretending this is a clinically-driven thing, which it will never be.
- This crisis has been looming for decades, rejigging and selling bits of to private enterprise will only make things work. The principle of care from the cradle to the grave should be integrated and properly funded through taxation.
- This plan should be halted whilst all the details are worked out and the problems (a few of which I've highlighted; there are many more) are sorted out. It should not be signed off at this stage.
- I don't believe that you will take account of my views because they are not what you want to hear and do not fit into the official line, even though I am one of those who has taken the trouble to read the whole draft STP very carefully.
- A minor point, if you took communication with the public more seriously you would have made sure that the first aim outlined in question 2 had been proof read properly so that it was written in good English that makes sense.
- Tyne and Wear Fire and Rescue Service wish you well in the STP process and would welcome the opportunity to be involved in future discussions particularly in the area of prevention
- It all sounds very promising, but bewilderingly complex. I suppose I will have to trust in your competence, as I do when I need your health advice or treatment. Some of the language is difficult, e.g. how many readers would know what "coterminous" means.Good communication needs plain English!
- At the next stage there should be a wider opportunity for public meetings than during this first round of engagement. The VCS sector could be used as a means of drawing people together to learn more about the plans.
- Just make sure all services are open to all...no social selection..and absolute confidentiality for all!!!!
- You need to listen to ordinary people

- What about addressing the so called community groups that only allow membership to selected people? If public money is involved you are legally obligedtp to have inclusive membership. We need facilities for all the new estates around Durham...villages have nothing in the way of swimming pools etc
- You need to involve health service professionals and not accountants to decide our future. PS re health and safety...tell your contracted bin lorry crews that it is a criminal offence to leave a vehicle unattended with engine running!!! Langley Park Dec 2016. Remember the Glasgow bin lorry??? You will end up paying massive compensation when there is a fatality
- I think this plan has not been brought into the public spot light enough and for that reason the plans can then be rushed through with no debate. I feel incredibly sad that insread of investing money into the NHS we are looking for cost cutting measures, employing staff to work either work at a higher level on less pay and also creating an environment where staff will burn out due to over work.
- Save money by reducing the influence of drug companies on prices of medication and direct marketing. Gp's make more profit for Flu jabs if they prescribe the more expensive brands. There is really no convincing evidence for influenza vaccines in most circumstances.
- The government could have a proper Public health policy on transport, farming food, education alcohol pricing where the evidence is quite clear that this matters and it would save more money than you ever can with STP plans
- The documents are very heavy on management speak and very light on actual practical detail in plain english about what will change. Ambition is all very well, and it's hard to argue with motherhood and apple pie, but the published document is so light on practical changes to be made, I am none the wiser how your aims are going to be achieved. I am aware you will not achieve the savings you need without cuts - please spell out what will be cut / reconfigured to save the money you need to save. The rest is fluff.
- I fully accept the need to change the way services are provided moving to prevention and care closer to home but cannot accept that the plan should be so focused on saving money when we do not fund the NHS adequately.
- Assess the debt and refinance some of the loans and make better use of the low interest rates. I wish you well in your quest and you will have my support in the ambitions you have outlined.
- Please address the issues surrounding people with chronic health problems in terms of delivery and support, all the prevention, dietary advice and exercise in the world will not prevent MS
- Plans like this are idealistic. Much better to spend the money you are wasting on this plan by simply allowing staff to function.
- Agree with reducing duplication of services, but it is important to keep services local. Reduce pharmaceutical over prescribing and waste within departments
- I see little point in all the planning given that no money will be forthcoming from the government.

- The women's VCS firmly believes that employers need to value the strategic importance and benefits of healthy workplaces, to encourage a consistent approach to health and wellbeing for all, and to make health and wellbeing a core priority for senior management. Women's VCOs can offer structured work placements in women's services, for the purpose of sharing learning and develop links with the business community.
- No
- The STP is simply setting the nhs up to fail. It is reconfiguring our NHS to make it easily adaptable to private care at a cost to the taxpayer. It is rotten to the core
- I hope my comments will be fed back to whoever has the authority to escalate them to the Government. I am just one of countless people who feel the Government dodging the big issues is the biggest problem
- I look forward to seeing an STP plan which is written with the public in mind an contains the hard facts that, to date, you have held back - such as the intention to close South Tyneside Hospital, the number of hospital beds and jobs that will be cut and how you will start rationing services.
- This is rubbish way to treat a well thought of NHS.
- My main concern is about mental health services, which are lamentable. In my experience they are either operating under crisis management, dealing with only the most serious cases and thus leaving people who have anything other than psychosis or schizophrenia to fester and worsen, or practitioners are simply unable to correctly diagnose anything other than the most obvious condition, again leaving people suffering and deteriorating.
- Services do not operate according to the NICE guidelines and waiting times for treatment are a joke, so patients are left without treatment or support. There is no support at all for carers and families at all.
- My view is that you should follow the lead of a growing number of local authorities (latest: Conservative-controlled Warwickshire) to reject their STP as unworkable and unsustainable.
- Make it about the delivery of the plan in everything you do and think. Don't make it about the plan as if it's not delivered you've only got paper or pixels. Good luck you're going to need it...remember the health of the nation.
- I AGREE THAT THERE IS SOMETIMES DUPLICATION OF EFFORT AND BEING HONEST WITH THE PUBLIC ABOUT HOW MUCH IT COSTS TO ACCESS CARE , E.G. GIVING THEM A VIRTUAL BILL " YOUR CARE TODAT COST" "YOUR MEDICATION COST THE NHS XXXX AMOUNT
- I think the level of detail about mental health is shockingly lacking - you say there will be no health without mental health but give no idea how you will scale up services to meet current needs. Levels of spending on mental health are already very low - and there is no indication of what will improve.
- The current system which is IAPT is well intentioned but recovery rates of less than 50%, long waiting times, and lack of choice of service is appalling. Local non-profits like the organisation I work for pick up the slack - but we only have funding to deal with certain people under grants and people have to pay for effective treatment.You should be funding what works (our recovery rates

exceed 50% by a long way) and not pouring money into systems which are not fit for purpose

- Need for National action
- As I have already said, a national funding formula is needed now.
- Please do not close any vital services
- I think the implications for County Durham which is part of 2 different STPs need some special attention. For example the closure of A and E in Darlington could have a major impact on Durham.
- Yes. Stop pretending, announce that the Government is requiring to you to make vicious cuts, and rewrite your documents in plain English.
- Yes! SHAME ON YOU.
- No
- Go back to the drawing board.
- Only 1 speak to people not only patients but local staff as well and listen - something you do not appear to be good at!!
- Do more work to reassure the health staff and stop being so self assured at every media encounter. You may have been working on these plans for ages but it's a lot for Jo and Jen Public to take in. Especially when you are so dismissive of those organisations that are trying to raise the public awareness at the same time as you. May be try a platform or forum where you are joined by KONP Durham they have a lot of valid points.
- Collaboration can be a good thing, but at the same time these "footprints" re-create another layer of NHS governance. Are we in danger of continually reinventing the wheel, and never giving the NHS the chance to settle down with its organisational structure?
- I think the plan should be honest. You cant cut funding and cut services whilst improving them. So which is it?
- Good luck!
- Good luck
- Start at school age. Not like the schools at the moment we're most pupils missed there swimming lessons due to strikes
- As a resident of Gateshead who had a nervous breakdown in October of this year and whose GP actually STOPPED her anti-depressants, leading to me self-harming and almost committing suicide, I am disgusted with the way 'so called' professionals have passed me by. They should all be ashamed of themselves.
- perhaps the deliberate mistake in para 5 points to part of the problem? The need to generate more paperwork - albeit with the best intentions - but not process it most usefully. Notes unreadable by nurses, records not passed between institutions, staff too busy writing docs. to attend essential meetings etc.
- Good luck. And please keep local community groups informed about what the actions to 'close the finance gap' will be.
- I currently work for cddft and am excited to see the whole of the northeast come together to work as one large team. I would like to see specialist care more available to ensure the correct care is provided 7 days a week.

However, that should not mean overstretching staff who are already under pressure to provide the care that is needed. There should be more services available for end of life care. Extra hospice beds would help this and also ease bed pressures. Community and in hospital services should work more in harmony and I think that it is important to build better relationships between the two.

- Take a bold stand against the creeping privatisation of NHS services and the imposition of 'gatekeeper' roles (such as passport checks) at the expense of quality care.
- Do not do this.
- Local authority engagement residents could help in finding out the views of residents in Tyne wear
- It would be an amazing and beautiful experience if you actually took notice of these links, researched both sites and took action to test and trail, train and revolutionise. There is vast evidence, it just isn't double blinded and NICE accredited.We heal humans faster, cheaper and more safely than you.
- I wish more than anything, that you would open your mind and allow new perspectives and technqiues which are scientific and outside of belief.
- There is no pride in the community - people are attracted to material wealth rather than caring for there health
- The ambitions are commendable but you'll never get the resources while there is a Tory government in power.
- Good Luck!
- Look at the vast area you cover and make sure that people can get to the centers at any time of the day. Nothing worse than being stuck in a hospital with no where to go or to get home or to visit.
- All pious hopes & vague ideas so far; no signs of concrete thought or solutions!
- Does anyone actually take any notice of what we say or is this just another tick box excercise labelled consultation