Proposed changes to healthcare in east and west Suffolk
Public Engagement Exercise

FEEDBACK REPORT

September 2016

Dr Steven Wilkinson
Consulting the Community
September 2016
Executive Summaries

Executive Summary - IVF

While the greatest number of comments supported the One Cycle option, this was backed up with overall support for the service. The next strongest response was to retain 2 cycles or increase the number of cycles offered. There was a strong case made for stopping the service altogether with the predominant view being that this was not something that should be NHS funded. Comments relating to funding ranged from reasons why the NHS should continue to fund this service to reasons why it should not – with suggestions such as means testing patients and part funding also being made. There was a strong narrative response to the proposal, mostly describing the detrimental impact it would have. The discussion regarding health care priorities ranged from including IVF services as a priority – to focusing more on core medical care. Suggestions were put regarding selection criteria for the service. A range of fertility conditions was discussed. Adoption as an alternative to IVF was suggested. Further specific information was requested relating to the service and the decision making processes. Communication and consultation issues were also raised.

Executive Summary – MVA

There was disagreement with this proposal on the grounds of equality and fairness. It was not felt that centralising services would provide advantage. There was also agreement with this proposal as it suggested economies of scale and efficiencies. Comments regarding the services ranged from issues concerning access and engagement with other bodies (joined up care). Strategic and collaborative planning was suggested. The need for services to be local was emphasized. Patient safety was a concern. Views were expressed regarding who this service should be provided for – with a preference for UK residents being expressed. Concerns about signposting were raised. Funding and cost saving was discussed raising questions about how this proposal meets the overall cost saving initiative. Transport and travel is a major issue in implementing this proposal. There was a suggestion that this service be stopped altogether – or that it should not be NHS funded. Information was requested regarding the construction and proposed delivery of this proposal, and pre consultation information such as equality impact assessment documentation was requested. Issues around the capacity of services to cope with this proposal were discussed. Healthcare priorities were also discussed and so too were matters concerning the consultation process.

Executive Summary – Suggestions

A wide range of ideas were suggested for the CCGs to potentially save money and/or generate income. Reorganisation and prioritisation of a range of services included withdrawing or limiting a range of surgical, medical and support services. A review of prescribing practices was suggested. Access to the NHS should be granted on the basis of entitlement and contribution. In particular health migration should be addressed. Charges should be considered for access to the NHS for all but essential services and for non-nationals. Part payment contributions and insurance contributions should also be considered. Tightening up of leadership and management included suggestions to reduce top tier management and bureaucracy were also made. Staffing and staff pay may also be an area where efficiencies can be made with an emphasis on moving away from ‘bank’ or ‘locum’ staffing. An improved training structure for doctors and nurses was suggested. The identification of waste, including materials and processes, could also reduce overall costs. Finding
efficiencies in communication was proposed. Solving the problem of bed blocking was also a critical problem. The education of patients in how to use the NHS and in how to maintain good health would lessen the demand on stretched services. The funding position would improve if the CCGs asked for more funding from the government – suggesting that more revenue could be raised through taxation. Better coordination of health, social service and voluntary organisations was called for. Medical appointment systems are deemed to be inefficient. CCG mergers and centralisation of services were suggested. A review of suppliers and supplier accountability will produce better value for money. A reduction in campaign spending was also proposed. Consideration can also be given to the use of estates to generate income.

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1 Background

From the public engagement document:

“The NHS in east and west Suffolk has managed significant financial challenges since 2013, funding new ways of working to manage demand. We have now reached a point where there is not enough money locally to continue delivering all the services in the way it does now.

Proposal 1
We are proposing that IVF services would be reduced to one cycle only, being made available to patients who meet the eligibility criteria OR that IVF services would be reduced to no cycles for all couples (restrictions apply and couples can apply for individual funding for clinical reasons).

Proposal 2
This proposal would better focus the support for people in the Ipswich area with complex health, housing and social needs, and stop the service in the west of the county. We would find ways to improve advocacy and signposting in west.

Further suggestions
Do you have any views or ideas on how the CCGs could improve their financial situation?”


The Public Engagement exercise ran from 19 July - 9 September 2016.
2 Process and Outputs

A database of all feedback was developed. A First Stage Analysis was then undertaken, which coded all responses. A Second Stage Analysis provides a summary of coded responses organised into themes. The first and second stage analysis documents are working documents and may contain personal information. Therefore, these are not available to the public.

This Public Engagement exercise had three key ‘elements’. In the survey respondents were asked five open questions. These questions have been presented in this report in the order they appear in the survey. Two questions concerning IVF, another two concerning marginalised and vulnerable adults (MVA) and a further question seeking ideas concerning NHS cost savings. Responses to these three ‘elements’ have been summarised in this report – however, each element may be read as a separate report.

This report has been written using (as far as possible) the words and phrases used in the responses. No corrections of fact, grammar or syntax have been made.

This report summarises the themes. The themes with the most responses are discussed first followed by the next in descending order. This provides a relative indication of the weighting of each theme. The number beside the theme provides a relative indication of the number of coded responses within that theme. Every attempt has been made to report the feedback provided for each of the respective questions, therefore there is some repetition within this report.

Questions raised by respondents have been summarized and reported at the end of the summary of each element of the report.

None of the views expressed in this report are those of the author or any organisation for whom the author may work.

The following table indicates the number of responses received for each element (rounded up):

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<th>Table 1 – Response count</th>
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<td>IVF</td>
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3 Changes to IVF services

**EITHER** that IVF services would be reduced to one cycle only, being made available to patients who meet the eligibility criteria **OR** that IVF services would be reduced to no cycles for all couples (restrictions apply and couples can apply for individual funding for clinical reasons).

**Question 1** – What comments do you have about Proposal 1? &
**Question 2** - Do you have any other comments about these proposals? (combined)

Executive Summary - IVF

While the greatest number of comments supported the One Cycle option, this was backed up with overall support for the service. The next strongest response was to retain 2 cycles or increase the number of cycles offered. There was a strong case made for stopping the service altogether with the predominant view being that this was not something that should be NHS funded. Comments relating to funding ranged from reasons why the NHS should continue to fund this service to reasons why it should not – with suggestions such as means testing patients and part funding also being made. There was a strong narrative response to the proposal, mostly describing the detrimental impact it would have. The discussion regarding health care priorities ranged from including IVF services as a priority – to focusing more on core medical care. Suggestions were put regarding selection criteria for the service. A range of fertility conditions was discussed. Adoption as an alternative to IVF was suggested. Further specific information was requested relating to the service and the decision making processes. Communication and consultation issues were also raised.
3.1 One Cycle 265 comments
I think that given the choice of the two, I support the reduction to just one cycle would be my choice, (support, appropriate, fair, agree, good idea, best compromise, reasonable, sensible, compassionate, generous, ok, acceptable, better than nothing, pragmatic, deserved, preferred, sufficient) over none as long as the criteria is met. Give all a chance. One cycle then go private. The chances of conceiving with IVF are 1 in 4. Reducing to no cycles at all is a bit harsh (not fair, too much, inequitable). Do not remove service completely. It is devastating to not be able to have children. Everyone should get at least one go. Difficult decision to make. Understand that things need to change.

3.2 Retain at 2 or increase Cycles 225 comments
No (strongly oppose, disagree, against) reduction in this (precious, vital) service. We strongly opposes these proposals, and we recommend that you do not continue with the proposed reduction in fertility services. If there was a chance to keep the service in its entirety, then I think this should be considered first. I feel dropping the funded cycles to 1 or even 0 would be a terrible (life changing, heart breaking, cruel, wrong, unjust, unethical, upsetting, disappointing, awful, devastating, despicable, discriminatory, bad move, unbelievable, playing with peoples lives, wrong, unacceptable, sad, unreasonable, harsh, unfair, unhappy about it, inequitable, marginalising and could be seen as discriminatory and would cause a lot of couples problems). 1 cycle almost seems worse that 0 cycles if you are giving people false hope. Keep the service as it is - fair and balanced, do not change it. If the service is actually successful and given 67.55% of couples fall pregnant, it sounds successful, then it would be terrible to withdraw the service. The first cycle of IVF is quite commonly an exercise in trial and error.

These services have already been reduced to 2. I think the importance of funding two cycles of IVF treatment to eligible couples is most important, and should be offered to everyone. To have fewer would be ludicrous. People need the opportunity. More than one cycle for childless parents would make more sense (is a good thing, provides the best chance). To reduce the service goes against the very ethos of the NHS Principles and Core values and the NHS Constitution.

The NHS has had 12 years to implement the original NICE guideline on fertility which has been updated and re-validated; it is unequivocally clear that three full cycles of IVF or ICSI should be provided to those in need. If Ipswich and East Suffolk approves this policy change it will become one of only four groups in the entire country not to offer any IVF treatment.

Increase the service to 3 cycles. NHS should provide unlimited IVF services. I think everybody should be given the same opportunities as everybody else in the country. It should not matter the location you live in (postcode lottery). Your consultation also states that ‘Other CCGs in the country, including neighbouring CCGs, have taken the decision to reduce IVF to only those people living with specific medical conditions’. We do not feel that the fact that other CCGs have chosen to ignore NICE guidance is an adequate excuse to decommission services in your area.

Promise to review this decision annually.

Petition - https://petition.parliament.uk/petitions/162534 = 582 signatures ‘Stop the CCG from Cutting NHS IVF Funded Services’ (accessed 14th September)
3.3 Stop the service 198 comments

I fully support (whole heartedly agree, have no problem, am ok, would not be opposed, am in favour) with this proposal to cut this service - this is a cut that needs to happen (good idea, acceptable, fantastic idea). I don't believe IVF should be available on the NHS at all (in the present financial climate, if money is tight). Uncertain if NHS should fund everything. It is not a vital (essential, priority, health) service - it's a lifestyle choice.

Having a child is a privilege, not a right. This is a drain on the NHS (too costly, can not be sustained). Should stop the automatic right to IVF treatment and reduce to 0 cycles. I (reluctantly, with sympathy, with sadness, have a gut instinct) agree with this proposal to cut IVF funding. No cycles other than in exceptional circumstances - (providing people can apply for individual funding). It's a service which feels like a bit of a luxury.

We need to slow down population growth – there are too many people as it is. If you're meant to have children then you'll have them. It is nature's way. In my day IVF didn't exist - it was never provided by the NHS in the past. I was not able to have children and I accepted that. Children aren't the be all and end all. Stop people having children that they can't then look after. We need to focus on the current population. People shouldn't have it as it can be traumatising to go through it and then not get anything at the end of it. This is devastating. There are more failures than successes. It is interfering with a natural process.

3.4 Funding 197 comments

This is an expensive treatment, which does put it out of reach for some couples (i.e. discrimination). Without IVF services, we probably (absolutely) couldn't afford to pay for private care. Many couples would not be able to go privately for IVF treatment, which would deprive them of becoming parents. This is a huge cost for the patients to be subjected to. Paying your NHS contributions should entitle you to some help. We have both worked hard all our lives, pay our taxes and lead healthy lives. The NHS has invested a lot of time and money in us to bring us this far.

Another outcome is potentially going into debt. Low maternity pay and high childcare costs means that potential parents, are most likely saving for the future or trying to as best they can in financially hard times. So being in even more in debt (also taking student loans and mortgages into the equation) before a child enters the world is far from ideal. I am struggling to work effectively and as a sole trader that means my earnings have been impacted. You are proposing cutting IVF services, the only chance some couples may have to start their own family yet the NHS funds thousands of terminations (and in treating alcoholics and drug users).

Lack of appropriate funding has led to inaccessibility for many who cannot afford to fund themselves, and an opaque mixture of services through NHS and non-NHS centres. Lack of equitable funding and exclusion of services from the NHS results in dissatisfaction for both patients and providers alike. The production of appropriate national tariffs would contribute to a more equitable approach. Fertility services are deemed to be a reasonable cost and clinical effective use of NHS resources. It was not a figure plucked out of thin air. This is not going to make much difference in the NHS budget, but it is extremely important for some couples. This would have a ripple effect through Ipswich. It would impact the local economy as well due to a reduced young labour force. So much money has already been spent on research and education in this field.
There must be other areas funded by the NHS that can be dealt with under alternative procedures and will lead to the cost cutting that is needed. In answering the question of how could you limit the effects of these changes, specifically in relation to these 2 proposals, we do not believe you need to make any changes with the proposed savings adding up to £1.06m. This represents only 13.25% of your overall cost saving requirement. Consider how much more difficult it will be for the CCG to return to any level of IVF funding if they entirely decommission the service and infrastructure is removed.

The NHS could offer a finance plan for people who wish to pay for treatment. Could be subsidised perhaps. Maybe part contribution. NHS to pay part of the cost and people fund part themselves. Consultations leading to private treatment should be funded and a pathway created for an NHS recommended/approved private IVF treatment.

If you can afford it then you should pay for it. People could save as soon as they discover they can’t have children without this help. I don’t agree with people expecting this service free. If people can afford to look after and bring up a child they can afford to pay for IVF. People should be means tested in order to qualify for free treatment. In recent years, fertility treatment abroad has become an increasingly affordable option for UK patients unable to access IVF on the NHS, and evidence suggests that the demand is increasing exponentially. The cost of bringing up a child is broadly speaking £10000/year. The cost in the first year alone is on average £11224. Centre of Economic and Business Research (CEBR). The cost of achieving private treatment is broadly in line with these figures, in many cases much less, so is/should be achievable by most couples.

The Individual Funding Request (IFR) process is still available for patients who believe that they have exceptional circumstances. If decommissioning occurs, IFR requests will be the only option for your patients which is administratively burdensome for clinicians and will increase following the policy change. Individual funding requests will be inundated if no cycles is the way forward. This would then possibly lead to less funding for other treatments on individual funding requests.

I do think cutting the IVF service is a cost saving potential. NHS could make big savings by not offering this service free. We shouldn't be wasting precious funds on IVF. If they really want kids they can self-fund. This is a highly expensive and unsuccessful procedure. It must be remembered that as a country we have a finite sum of money to spend on the NHS.

Shame the Brexit hasn't helped the NHS then.

3.5 Retain the IVF service 123 comments
We support IVF funding (Definitely, strongly positive, good idea). Let people have a go (chance, opportunity). Cant take that away from them (shouldn’t be deprived, the last thing you should be cutting, extreme, austerity at its worse, terrible, devastating, humiliating, very personal). Provide a suite of options. Treatment, health and well being is the very purpose of the NHS.

Difficult decision (too emotional, worrying, stressful, life changing, unfair) but want to continue funding it. Other places could be cut. Not wasteful thing. No to means testing. Shouldn't strip service for those people who are already vulnerable (easy targets).
Agree with reducing the service. Not sure whether it should be reduced to 0 cycles though. Would be against stopping it all together. I am currently pregnant through ivf and I can't explain to you how grateful I am every single day for the funding that I received. I really hope other couples can experience this.

These proposals completely disregard The National Institute for Clinical Excellence (NICE) guidelines, which are based on sound clinical evidence from specialists in treating the disease of infertility. Both the national multidisciplinary medical body, the British Infertility Society, and the Royal College of Nursing agree that the postcode lottery created by the varying interpretation of NICE guidelines across the country is thoroughly inequitable. This is not in keeping with the current equality policy of the government!

I will fight these proposals as much as I can. For me and every other couple going through this life changing experience. I will lobby my local MP, take a petition to government and do everything I can to stop this from happening.

3.6 Response to proposals 107 comments
The loss associated with not having my own family and having the opportunity taken away is far greater than I could ever articulate with words. This proposal is horrendous (sad, soul-destroying, heartbreaking, distressing, awful, harsh, emotive, upsetting, devastating, disastrous, unfair, despairing, uncompassionate, disheartening, abhorrent, catastrophic, frightening, discriminatory, shattering, a very bitter pill to swallow). The news of these proposals has had a devastating impact and affected all of the family. The decision to potentially stop IVF funding means people must potentially live childless and feel incomplete - as having a child / family being one of the most basic desires. Every time we hear of a friend or family member falling pregnant it becomes more and more difficult for us.

To say "it does not provide sufficient benefit to the overall health economy" is, to be honest extremely insulting and hurtful and I therefore don’t think you do "recognise that these services are hugely important for people" like us. I work for the NHS as an allied health professional. I have always felt that the NHS would provide for me as I have for it. I believe this proposal would be hugely detrimental both to individuals who are unable to have children but also to the wider community as a whole.

Infertility is not a choice. Infertility is already a cruel lottery. Creating a postcode lottery around something which causes such personal distress is heartless and unfair. There needs to be a national debate around supporting people with infertility, and a national policy applied across the board. Creating inequalities in our society leads to division and an even greater divide between the rich and poor. Basically, if you’re unlucky (in this case) to live in Suffolk, then there go your hopes and dreams of a family.

In reality most people have no understanding of how devastating it can be unless they have experienced it. It is an intensely private issue that is difficult to talk about publicly and is therefore goes largely unrecognised. This only adds to the sense of social isolation.

We can not be more thankful for what the NHS has given us, our chance to be parents and the baby we longed for.

3.7 Health service priorities 103 comments
In a country where ageing population is an issue and fertility rates are getting worse I believe IVF treatments should still be supported the current way. Supporting and
helping conception and child birth rate should be a priority for any western society. I understand that money has to be saved but surely there must be other options that can be looked at aside from IVF. If I were infertile I would find it very difficult to accept that cash continues to flow to type 2 diabetics (smokers, alcoholics) many of whom have bought on the disease by lifestyle choices, and a further proportion who make no effort to change lifestyles post diagnosis. Non-essential surgery, mostly cosmetic, is well documented in the media and would save the NHS money. Contraception is available on the NHS as is maternity care. IVF is an easy low hanging fruit service to consider cutting. Infertility is not viewed as a disease and seen as a luxury. Peoples wellbeing should came first.

Instead of proposals to cut services I would like to see proposals made public for working smarter and efficiently to show what the CCG needs to do to deliver all services that all patients need, without discrimination.

I know many people might not agree, but simply infertility does not rank for me as serious as people whose lives are at threat or are suffering constant pain or not able go about their lives unhindered by illness (an emergency service). Funding could be spent on other things – e.g. more money for A&E, disease, hip replacements, essential services, people who are ill, surgery, life threatened conditions or those that would significantly impede quality of life, vulnerable adults, cancer treatment, dementia medication, dealing with debilitating problems, the ambulance service, or caring for those not able to care for themselves - disability and accident matters come first.

Whilst infertility it is a medical classification the right to have a child is not. There are many more important medical needs than the ability to have a child. NHS should only fund health problems - I don't think it should be helping people who aren't suffering physically. The information given shows that 90 couples benefited from this last year where as they same amount of money could help 300 people with mental health issues if MVA service was kept.

I think the final decision should provide clarity to which services are still available through the NHS.

Not funding IVF on the NHS might mean fewer people which might help the NHS to manage long term.

I ask everyone reading to consider whether it would be more appropriate for the money available to be used to save a life or to create a new one.

More research should be done into infertility.

3.8 Health & care concerns

Whilst treatment overseas might represent a more affordable option for patients, it carries hidden costs to the NHS. The Human Fertilisation & Embryology Authority (HFEA) has always strictly regulated the number of embryo that can be transferred during IVF treatment to reduce the chance of multiple pregnancies. European Society of Human Reproduction and Embryology (ESHRE) shows that in some other European countries, and outside of the EU, there is often no statutory limit to the number of embryos transferred. The UK has pursued strict strategies to restrict multiple embryo transfers because of the complications for mothers and babies and high costs that arise out of multiple pregnancies. At least half of twins are born before 37 weeks (making them pre-term) with low birth weights, which puts them at a high risk of serious health problems. Over 90% of triplets are born before 37 weeks, and
many are born sufficiently prematurely that they are at high risk of long-lasting serious health problems and death.

People struggling with the consequences of not being able to conceive, through depression anxiety and other associated conditions, are more likely to present to their GPs many more times a year than other patients. Patients often struggle to hold down jobs whilst dealing with infertility, and face an increased rate of marriage breakdown. We feel that reducing the number of cycles being offered does not take into account individual healthcare needs of patients in the area.

As a result of cutting funding some may also turn to less safe options of becoming pregnant, increasing risks of sexually transmitted diseases, violence, relationship problems, anger, anxiety and sexual dysfunction. Multiple academic studies have found that the impacts are significant and the incidence of depression, anxiety and relationship problems are significantly higher in infertile couples than the general population.

Infertility is recognised by the WHO as a disease with life-changing negative psycho-social effects and it should be treated as such. The devastating social and psychological effect infertility can have has varied in the extreme. It plagues people at all the biggest moments in their friends lives: Christmas time, birthdays, christenings. Patients often struggle to hold down jobs. IVF is a major lifeline for a lot of people in our position, one which we are desperately holding on to.

Education could be provided for older mothers saying that IVF is not needed. Alternative care could include cheaper treatments such as acupuncture, nutrition and vitamin supplementation, dietary support and smoking cessation classes. Perhaps more counselling, could be a direction for women and couples. Let people start taking some responsibility for their own health.

3.9 Selection 69 comments
Simon Stevens, Chief Executive of NHS England, has recently in effect publically argued against the rationing of NHS treatment, stating that ultimately the basis on which people get care on the NHS should be their ability to benefit from treatment.

From your separate FAQ page we find 41% of couples only needed one cycle, 45% were successful on the second cycle. This means 32.45% were unsuccessful. If the success rate is very low nationally and Suffolk does as well as elsewhere, then the clinical criteria should be tightened to exclude those for whom there is no real prospect of success and providing they meet the criteria. Patients in receipt of NHS-funded IVF treatment are the cohort that are most likely to conceive as they will have been narrowed down by clinical selection criteria.

The current system is discriminatory against people in the higher age bracket aged 40-42. Age limit of 49 should be applied.

I do think there needs to be an age limit. Do not offer any treatment for people over 40. I think 30 - 35 would be a better age to give a deadline.

Keep it as it is for people with certain medical conditions e.g. cancer, or high risk of passing genetic conditions such as OI, Huntingdons, women who have suffered disease or trauma or childhood accident. It should be for heterosexual couples who are childless and have been in long term relationships. If there is already a child within the couple no treatment should be provided. Only to married couples.
Shouldn't be offered to overweight people or smokers or people who excessively drink, but where some people have polycystic ovaries they should have the support available to them.

It needs to be offered to all couples regardless of sexual orientation. If the person who is going to carry the child needs help to conceive whether she is with a man or woman should not come into play. She should get help regardless as it is discrimination.

Restrict everyone to 2 children and those that can't have them be pushed up list. No cycles offered for anyone with more than 2 children already. Should be assessed on a case by case basis. Need to ensure people aren't just having children to receive benefits. Also "Tourism" treatment should not be free, its time we took payment details before any treatment is given to non British citizens, not wait for them to hop off home without paying.

I think, if it is cut completely, we, and couples like us, who are already ‘in the system’ should also be entitled to it, as offered at the start of our journey.

How can Theresa May say in her first speech as Prime Minister that the mission of the Government she leads is to make "a Britain that works not for a privileged few, but for every one of us" and then let potential cuts like this take place, allowing only those privileged few to have IVF treatment.

### 3.10 Fertility conditions 55 comments

One in six couples in the UK have problems conceiving. Infertility is a disease as recognised by the World Health Organisation and, as with any other medical condition it is deserving of treatment. Fertility problems is an illness. it is not the fault of the women that they cannot have children naturally.

The personal nature of the infertility experience contributes to the failure of the public, politicians, healthcare professionals and the media to recognise infertility as a disease. There are individuals whom IVF is the only option such as LGBT and women with fertility conditions such as endometriosis. I myself am needing fertility assistance to help me conceive due to having factor 5 leiden and PCOS. My daughter has had both tubes removed. Polycystic ovaries runs in my family which suggests I may not be able to conceive. I didn't ask to be born without a womb. I carry the cystic fibrosis gene. Some people have suffered from cancer when young for example and have a medical reason (i.e. underlying genetic cause, ovulatory disorder) not to be able to conceive. Tests show no obvious reason for our failure to become pregnant so our diagnosis is classed as unexplained. As a male aged 45 I have been diagnosed with a very low sperm count - for no obvious reason.

The process (rightly so) takes time for the consultant to explore and rule-out different possible reasons for sub-fertility, we have as yet not been referred for IVF as I am being treated with a drug to stimulate ovulation. Pre-treatment diagnostic testing needs to be thorough as they may be infertile for reasons that IVF cannot help with. I was referred immediately and began a six-month programme of the fertility drug clomid with regular tracking scans and injections to trigger ovulation. The implications associated with eggs donation too is a huge ethical and moral consideration.

IVF is not a life threatening illness, it is a lifestyle choice. Clinical reasons is a joke as it would only apply to a tiny number of couples affected by fertility problems.
3.11 Adoption & alternative approaches to parenting 52 comments
With all the children waiting to be adopted it would be a good way of giving a child a home. We live in an overpopulated country & while children live in foster care there is always the option to foster or adopt. In the past you had to make do & adopt instead – should be this way now.

The rules need to be changed in order to make it easier to adopt as there are so many children wanting homes. If it was easier for people to adopt then maybe this would reduce the pressure on IVF services.

Other options include surrogacy.

We would most likely end up adopting a child. Yes this has its own rewards and merits, but it isn't quite the same. Mixed opinion as I know woman who want the overall experience of being pregnant and therefore the offer of adoption and fostering does not appeal.

3.12 Information concerns 25 Comments
Some years ago I was sitting as a lay person on Clinical Priorities when this subject was first discussed. I felt that the evidence brought to the group was fair and understandable to a lay person. I was surprised that the success after two IVF treatments was poor and this should be made widely known to the general public. I am pleased that this issue is being brought to the general public but the evidence should be made clear to everybody.

I don't know what IVF is. I don't know much about it. If I understood more about the success rate then I would have a better idea of how many people this would affect. Would need to know the implications of having only one cycle and not two. Would be easier to comment if cost of each cycle of treatment included & proportion of CCG funding.

I would be interested to hear how much would be saved by cutting from 2 to 1 cycle. If the majority of people conceive within one cycle then the costs will be negligible, if it usually takes more than one cycle then the suggestion of cutting it does not make economic sense either, you will be investing in something that you believe may well be unsuccessful.

CCGs in East Anglia are taking the decision to cut these services on the basis that the CCGs in the country, including neighbouring CCGs, have taken the decision to reduce IVF. It is difficult to believe that each of these CCGs has made a thorough and objective assessment of their populations needs. With other CCGs, such as Basildon and Brentwood CCG taking highly controversial (and quite possibly illegal) decisions to cease services for patients during their treatment, there is a worrying trend for CCGs to adopt decisions made by neighbouring organisations without following proper process.

We would really recommend that you read a book called Get A Life: His & Hers Survival Guide to IVF by Rosie Bray and Richard Mackney, which outlines the struggles of a couple who had not conceived naturally after years of trying and who finally realised their dream on their third round of IVF.

I am also keen to understand what engagement, research and impact assessments you have done while developing the proposals in greater detail than is available in the consultation document.
I understand the funding will be cut off almost immediately once the decision is made. A 5 year notice of any reductions in healthcare services should be given.

3.13 Communication & consultation 20 comments
Luckily my mother told me about this plan to cut NHS Funded IVF, as I didn't hear it on the news. So having looked into it I found your details online from the Bury Free Press website. I have seen it nowhere, except for after my mum telling me about it when she happened to hear it on BBC Suffolk.

We had an appointment at West Suffolk Hospital on Monday this week and was informed that instead of being referred as we'd prepared for (having had lots of tests over several years) the funding had been cut, literally the day before.

I have contacted Bourn hall (Cambridge) and they had heard nothing about it. Patients on other treatment programmes will not necessarily visit their clinic during this consultation period so will not be made aware of the proposal in time to have their say, essentially excluding them.

I only happened upon this consultation information by accident. The CCG has not done a good job of communicating this to the residents of the area and I would question the results of this feedback process as it is unlikely to be representative of the locals opinions.

NHS England states in their guidance Planning, assuring and delivering service change for patients that:

It is critical that patients and the public are involved throughout the development, planning and decision making of proposals for service reconfiguration.

And that the CCG should have:
A detailed plan for reaching all groups who will be interested in the change, including those that are hard to reach.

In this case minimal effort has been made to ensure that those affected by these changes are informed of the consultation. The CCG asked the Ipswich Infertility Clinic to inform patients attending clinic about the consultation, and secured a small article in the local newspaper.

I think coming out and listening to the general public about their views is very commendable. Good to see the NHS out talking to patients and the public. Thank you for engaging with us.
IVF Questions

Funding
10 Why should people have to fund IVF treatment themselves?
4 How could we limit the effects of these changes?
2 Is there a way of mean assessment to save money?
1 We would question where the rest of the £8m saving is expected to come from?

Fairness
7 Why shouldn’t we all have the same chances?
1 Has the NHS reduced treatment for those with self-inflicted illnesses?
1 Since when is creating life less important than taking it away?
1 People have access to the NHS for other illnesses or diseases, so what is the difference?
1 Fundamentally, is the NHS a service to simply keep people alive or does it have a duty (where it can) to also help improve the quality of people’s lives?

Consultation
8 Have you made efforts to target communications at the demographic who may be affected by these changes (i.e. all of the patients currently registered with the infertility clinic(s)) so that they are aware of the proposals?
1 Have you engaged with Fertility Network UK?
1 Could you tell me which organisation is independently assessing the consultation feedback?

Health Concerns
7 Have you prepared a pre-consultation business case for this proposal that can be shared - for example, have you explored whether there might be mental health impacts due to fact that couples cannot get IVF, and hence there will be a new cost to another part of the health system (i.e. counselling and anti-depressants)?

NICE Guidelines
5 NICE Guidelines and the Department of Health target is 3 cycles of treatment, so how can the CCG justify 2 cycles?
1 Are there any services being provided over and above the NICE guidelines?

Decision
3 Will both CCGs need to make the same decision or could they possibly make different decisions?
3 When will that decision be made and implemented?

Eligibility
2 Why should IVF be offered to transgender males (formerly women now men) or same-sex couples who need help having children when other people are being told they can no longer access this service?
1 Would this include those patients in the 40-42 age range?
1 It is not clear what medical conditions would be open to treatment beyond Cancer - would PCOs, low sperm counts etc be covered for treatment - this is not clear?

Priorities
2 If no IVF was approved what would happen to those already within the pathway?
1 HIV treatment is not something the NHS used to offer so why should it now?
1 Why is this consultation not being made more public?

Information
1 How does the Suffolk success rate compare with the national average?
1 Can you please explain the statement about the service being of no benefit to the overall health economy and / or provide the evidence behind this?

Adoption
2 What about adoption?
4 Re-focus MVA service where the need is most

To better focus the support for people in the Ipswich area with complex health, housing and social needs, and stop the service in the west of the county. We would find ways to improve advocacy and signposting in west.

Question 3 – What comments do you have about Proposal 2?
Question 4 - Do you have any other comments about these proposals? (combined)

Executive Summary – MVA

There was disagreement with this proposal on the grounds of equality and fairness. It was not felt that centralising services would provide advantage. There was also agreement with this proposal as it suggested economies of scale and efficiencies. Comments regarding the services ranged from issues concerning access and engagement with other bodies (joined up care). Strategic and collaborative planning was suggested. The need for services to be local was emphasised. Patient safety was a concern. Views were expressed regarding who this service should be provided for – with a preference for UK residents being expressed. Concerns about signposting were raised. Funding and cost saving was discussed raising questions about how this proposal meets the overall cost saving initiative. Transport and travel is a major issue in implementing this proposal. There was a suggestion that this service be stopped altogether – or that it should not be NHS funded. Information was requested regarding the construction and proposed delivery of this proposal, and pre-consultation information such as equality impact assessment documentation was requested. Issues around the capacity of services to cope with this proposal were discussed. Healthcare priorities were also discussed and so too were matters concerning the consultation process.
4.1 Disagree 153 comments

Good service. Not in favour of reducing refugee services to Ipswich. It is a top priority (vital). Continue funding. Loss of healthcare and travel costs would outweigh any gain. Certain groups are vulnerable (less able, forgotten about). We know what the future looks like for the displaced, poor and sick. They deserve the opportunities/second chances. Foreigners are an easy target for cuts. This is Discrimination (unfair). Would end up with more helpless people out there just because you need to save money. It would make the situation worse than it already is with regards to the amount of these people – especially those with children, the elderly and those with mental health concerns. Shouldn't take services away from people who really need help. Homelessness is on the increase and this would suggest MVA will increase.

Don't centralise. Keep the service across the whole of Suffolk. Important to keep the service in Bury St Edmunds and the west – could be devastating for Haverhill - there is also more of a need in the Waveney area, Newmarket, Sudbury and Felixstowe. Would like to see services more widely spread (including to country areas).

It doesn't impact on other services. You will still have the same amount of people to deal with, all that's happening is that the issue is being moved elsewhere. It would be a false economy. They may cluster in Ipswich and cause greater problems there. Anyone who pays taxes should be able to access the service that are provided – wouldn't like to see it become just an east-based service. The result will be the migration of MVA's into Ipswich and although health may save costs, other public bodies in Ipswich will have to manage the wider costs/implications. Which often involve the eventual relocation of those individuals back to their original communities.

Considering "The main aims of the service are to improve access to GP services..." the proposal to focus the service in Ipswich is laughable and contradicts the aim of the service. Unless equal funding is made available to the vulnerable people in West Suffolk I think this would cause an extreme reaction.

I cannot understand why West Suffolk should be singled out for closure of the MVA Service. It's a measure of how caring society is. It would appear services to vulnerable people do not feature very high on your agendas which does not reflect well upon your organisation & the level of health service Suffolk people can expect to receive from you. From my previous knowledge and experience (previous commissioner for MVA services) there are large numbers of vulnerable people in the west who need the service

This service is under resourced already so do not cut it further. I would rather pay more tax and keep the service as it is. This is against the NHS principles. The Clinical Commissioning Group has a duty of care to people across Suffolk. Equality of opportunity is a must.

4.2 Agree 102 comments

Seems like a sensible idea. Good idea (makes sense) to centralise and cut services in the West. I support the proposal. Ipswich is certainly the area of highest demand but also has the most services for MVAs - not least at the Chapman Centre. Not a high concentration of people in the west so it doesn't make sense to have a service. Helpful to centralise the service if it is not being used much elsewhere. Makes sense to have a concentrated area rather than spread support too thinly. If saves money and works then can see no reason why not to implement this. If it is centralised then it will be run better and more efficiently.
Centralise the service and reduce it elsewhere. As long as the service is not withdrawn completely then I agree with the proposals – i.e. if it still available to people in west Suffolk. Agree as asylum seekers are more likely to be placed in Ipswich and it is a place where drug addicts are more likely to go. Stop duplication of services.

I agree with this proposal as services such as the CAB can cover some if not all of the service currently offered.

4.3 Services 49 comments

Getting marginalised people the help they need when they probably would not engage with a professional gets things sorted before they get out of hand. Bad thing for people who need treatment not to get it. Self referral is not always an easy option! If they don't get treatment people could become a greater burden to hospitals/health services. This group is one of the most vulnerable in society with few voices to speak up for them. It is the CCG's responsibility, and especially that of the GPs on the CCG, to protect services for the most vulnerable.

There is a different type of registration document for people of no fixed abode. Need to get MVA people to register with a GP to reduce A&E attendances. A card to use at all GPs would be helpful. Reduce cover on outreach to one single method. Use this at A&E depts too. NHS hasn't moved with the times. GPs do need to be able to treat people who turn up on their doorsteps. Allow more access to Primary Care services.

Ipswich has often had better health/drug/alcohol/support services when compared to outlying areas, this has had the effect of pulling in MVA's from Essex and Lowestoft etc.

The proposal goes against the grain of strategic commitments made by both CCGs to work collaboratively across the Suffolk system to invest in joined-up approaches to prevention and support for those living with complex needs, for example as exemplified by the Suffolk Housing and Health Charter which was recently approved by Suffolk’s Health and Wellbeing Board. We would suggest that the CCGs work with Suffolk County Council and other partners to identify how the MVA service and other commissioned services which also support marginalised and vulnerable adults could be better integrated to meet the needs of this client group. These opportunities should be explored further before unilaterally withdrawing the existing service.

Service needs improvement. Savings and efficiency gains could surely be made by closer collaboration with other agencies and especially the Chapman Centre. The current MVA service should be working in partnership with what exists.

It needs to be more community driven as a concept – VCS's already exist and offer a very good service (e.g. Mulbury House/Sudbury, Citizens Advice Bureau, Porchlight in Canterbury, Ipswich Soup Kitchen & Ipswich Outreach Bus, Ipswich Locality Homelessness Partnership).

The issue comes when it is imperative for such a service work with the VCS's to be successful. However there is no money attached for the VCS's and the VCS's are expected to do it for nothing, so they do not always cooperate. This proposal could increase the workload for other local services from across the statutory and voluntary sector, without any additional resources to manage this. Use libraries.

Decisions relating to the individual budgets of one public sector organisation should not be considered in isolation from the rest of the sector. Services for this group
have been commissioned in a fragmented manner, with minimal collaborative working between agencies. Mental health, Turning Point, Special Allocation Scheme (SAS) and MVA frequently all see the same patient. Unfortunately being outside of Suffolk the links with our GP services can be substantially delayed causing distress to all concerned. There is a lack of communication between the medical and psychiatric teams at the hospital also a lack of communication and transfer procedures between the child and adult psychiatric team.

More housing is needed to combat homelessness. Currently there are 29 street homeless in Ipswich plus 8 - 12 direct access people on a regular basis. During the winter 12 SSEA beds plus and extra 12 via the Ipswich Winter night shelter in local churches). St Clement's church-yard currently have homeless campers. Homeless people should accept multi-residencies. There is a problem with Homelink. They offer temporary accommodation but they are saying they will only accept refugees if they have children.

A lot of the time we struggle to access vital NHS services and the MVA team has worked with us as Mulberry House staff and tenants to allow those routes of access to be opened up for the benefit of the client group. During this time they work on various health issues and ensure they are well supported - this in turn then carries on when the individual is housed as the rapport that is built up between MVA and Mulberry House benefits the individual going forward.

We would welcome discussions with the CCG about a potential joint funding model for a Making Every Adult Matter (MEAM) worker which might provide an alternative. There was no over-lap and minimum communication.

It was also suggested that schools be included in the sharing of the proposal, as some children act as interpreters for their parents.

4.4 Local services 39 comments
In effect it is contrary to key Suffolk strategies which emphasise the strengths of ‘locality based’ services, building community resilience and services being developed around people & places not organisations. Moreover, as the Suffolk Hidden Needs report and previous work by Oxford Consultants for Social Inclusion (OCSI) has shown, lower demand pressures on services from less densely populated areas of the county does not necessarily mean that needs are lower, rather it reflects the significant barriers some people living in these areas face in accessing services and that in rural areas needs are often hidden.

The proposals are not good for people in Bury St Edmunds, Haverhill, Stowmarket, Mildenhall, Babergh – which are constantly growing. People need more local services, not less. You can’ just have the service in Ipswich. It’s supposed to be a Suffolk-wide service. More localised care would lead to a reduction in transportation costs. There is already too much divide and lack of service in the rural areas.

The ILHP partners share a concern that if the proposal goes ahead then will a percentage of the 300 clients in the West of the County present to Ipswich, so increasing the demand on other services including the MVA service, but not exclusively there.

Provide a mobile unit for people to use, where staff tour the west in a van and set up to provide the same service. Have at least a couple of centres in areas of large populations e.g. a pop-up (Drop-In) centre in Bury, Haverhill. Suggested places to reach the MVA service users include libraries, churches and hostels. Services
accessible locally are a good thing, people use them more effectively and will have a knock on effect to other services.

I feel the elderly in our community should be cared for in as dignified manner as possible. Community Nurses to check on them and give treatment where appropriate in the patients home. Offer more care at home – if there is family support.

Should be semi-permanent sites for travellers, not just left to pitch up anywhere.

4.5 Patient safety 36 Comments
You are planning to make service restrictions to vulnerable people. This group of people are already disenfranchised and the CCG proposal risks compounding this further for this group. I doubt many or any will be able to advocate for themselves to argue against this proposal, therefore it will inevitable appear that the most vulnerable are the easiest target. I fear this group will suffer poorer health as a result which can only exacerbate their circumstances.

This group of patients is highly vulnerable with increased rates of illness and death. Skimping on this could drastically impact on their quality of life, even put them in danger. A very basic service would help and stop them having illnesses whilst in this country and seeking help elsewhere which could increase pressure on other NHS services. If people can't get help this could have an impact on MH services and the police. Anecdotally we are aware of at least three people who may not be alive today were it not for the ‘one-stop’ accessible services that are part of Bury Drop In. The average age at death of a homeless person is 46 years. Deaths of profoundly disadvantaged patients are rising - recently two more following prison release.

Like everywhere else, cases are becoming more complex as the recent TB outbreak shows. The situation is common where mental health won't see the patient until their drug problem is addressed, and Turning Point won't see them until after their mental health assessment. I think it is important that the other ways to improve advocacy ARE carried forward.

A lot of the people in the MVA category have self-inflicted medical issues. They shouldn't need this service if they didn't drink or do drugs. The MVA does fantastic work with clients but it seems like the clients do not have to do much for themselves or in return. This is not empowering and is holding rather than helping many of the clients.

4.6 Inclusion 36 comments
Certain people believe they have a right to NHS services and they don’t. Not keen on providing this service to refugees and asylum seekers, travellers and refugees or ex-offenders. If you are someone who doesn't pay taxes then you shouldn't receive NHS treatment.

People should only be entitled to receive help if they are here legally. I resent paying tax to support vulnerable people from other countries - if people in Ipswich need support then it should be to return to their own countries. People should be encouraged to stay in their own country and access care there. Make sure they are all registered before offering any help. There needs to be a change in policy with regards to immigration. Everyone should be checked before coming in to the country to stop the strain on services. Need some sort of check at the borders so we know they aren't bringing in any diseases.
This service should only support those in work. Fine to offer the service for homeless people, as long as they are UK citizens (long term residents). Put us first. Ex-servicemen should be helped more.

4.7 Signposting and education 33 comments
As long as the signposting is adequate and people are still able to access the help from the services. Clinics will service many people in the west with signposting - possibly through advocacy.

The idea of signposting people to Ipswich for the service is laughable. Signposting is of limited use because this group find it hard to engage with mainstream services and are often discriminated against by services they are signposted to. As an example, GP surgeries often require photo ID and proof of address to register patients - making it difficult for homeless people to register. As another example, a GP surgery in Ipswich recently removed a number of homeless people from its list by letter! As a signposting organisation, to lose health outreach work locally would significantly hollow out the services we are able to offer.

Support should be better publicised, people shouldn't have to go looking for it. Just need a simplified way to reach people - like a 111 card. People should have internet access and means to find info to help themselves. They need to be educated on how to use existing services correctly instead - and stop them from going directly to A&E. Provide resources to get support from Ipswich via phone or travelling, Skype via libraries or other time and cost saving options to link West to East.

NHS should empower people to manage their own health. EDUCATION info important. This would cut use of services.

4.8 Funding 32 comments
I think it would be ok if it would save money. Investment is probably needed elsewhere, including education, supporting families, addressing areas of multiple deprivation. Spending needs to be carefully monitored. Risk of wasting money trying to help client groups such as travellers who may not value the effort of the expenditure. There are other people in need who would value effort and expenditure helping them for example people with dyslexia and dyspraxia. It is important that some of these savings are reinvested into other existing services that support those in need.

Given the saving which is relatively modest (£369k equates to less than 3% of the £13m that needs to be identified), this proposal could represent a false economy both for the NHS in Suffolk as well as for the wider Suffolk system. Even if both proposals in the public consultation were to be implemented in full this would generate only around £1m savings. As Suffolk Health and Wellbeing Board partners, Babergh and Mid Suffolk District Councils would welcome an early indication as to the full range of options CCGs are considering to find the remaining £12m efficiencies and savings. As was said at the CCG forum in Aldeburgh, I hope that the two suggested areas of spend reduction - IVF and the disadvantaged - are not the only ones to be considered for cuts.

Looking at the numbers about the two CCGs (pages 5 & 6) of your consultation document, it seems that the cost per resident in West Suffolk is higher than the cost per resident in East Suffolk: West Budget is £298 million for a population of 235k; which means £1,268 is spent on each individual annually. East Budget is £467 million for a population of 385k; which means £1,213 is spent on each individual annually.
This would save almost £13 million annually - which is a much bigger saving than either of your two proposals.

The MVA service enables other agencies to work more effectively and efficiently, within the localities in which the MVA’s reside. In essence it enables other public services/funds & associated charitable funds/services to get better outcomes for the MVA’s. Providing the new way to improve advocacy and signposting will not be free. So I do not see how you are saving money.

There should be other places to save money without impacting on vulnerable people. West Suffolk funding should be increased or continued. I think funding for it should be coming from other organisations. It should not be an NHS responsibility. Transfer to social services - should sit elsewhere in the system – maybe county council should pick it up, not the NHS.

If they need help speaking English then they should pay to have a translator. Struggle to see why we should fund alcoholic services. Any foreigners accessing it should be made to contribute something.

In Ipswich 4 years ago, MVA delivered services in Ipswich on the present budget. It was then asked to go Suffolk-wide on the same budget. The result is that at present, non Ipswich funding subsidises Ipswich services where the greatest need is.

When the health budget was increasing, the acute sector took the lion’s share of the additional funding, yet it has been community services such as SCH, Community Primary Mental Health Services and now MVA who are disproportionately bearing the cuts.

Compared to 2004, Suffolk as a whole spends over £30m a year more on acute admissions, many of which are for less than 24 hours. The enormous amount of management and clinical waste at the acute hospitals must always be the first port of call for efficiencies, not cutting already threadbare community services. Setting up an APMS service for vulnerable patients may be another way in which money can be saved whilst preserving a service

4.9 Transport & Travel 32 comment
Travel a real issue in Suffolk. Buses don't run very frequently and can be very expensive. The travel would be too challenging for some people. Expecting people with these problems to travel to Ipswich is completely impractical, most of these have no means of transport and Haverhill is one of the most difficult areas as far as public transport is concerned.

Wouldn't be fair as they would need to pay for their travel. As a CAB volunteer we are often approached already by poor people in despair who are summoned to Ipswich to present themselves for DWP medicals. We have guests who have appointments in Ipswich for ESA assessments and other medical assessments but attending is difficult and appointments get missed.

If transport was provided then maybe. If the service is concentrated in Ipswich there would need to be transport provided - say once a month - for people out of the area. However it should
4.10 Stop the service 29 comments
Stop this service - it's not a 'health' service. NHS should only fund health problems. Shouldn't provide a service for these people. Can't see it is needed in the first place. There are plenty of other avenues and organisations that offer help.

4.11 Information 21 comments
The proposal reflects this in recognising the need to ‘find ways to improve advocacy and signposting in the West’. But unfortunately no indication is given of how this could be achieved or what it would look like in practice.

The level of detail contained in the engagement document is minimal and provides no rationale for the proposal, beyond the fact that more people use the service in the Ipswich area than elsewhere. However, this takes no account of the fact that there are more MVA referrals in Ipswich partially because there are more agencies working with vulnerable adults to identify and refer them.

Would be interested to see what the data is regarding the differences with the West and Ipswich. The document states that this proposal will save £369,000 across both CCGs but does not specify how much of that would be a saving to the West Suffolk CCG.

There is no information on risk, costs or consultation with relevant parties. It would be interesting to know how many clients are repeat visitors and for how long as the impression is that there are a cohort of clients who take up a disproportionate amount of the service's time and resources.

It would be helpful to be clearer about the remit of the MVA service. I understand the simple maths behind your proposals (both 1 & 2) - however, you have not stated anywhere what the potential impact might be on the individuals that might be in need of these services at the moment.

I would want to know in detail what your improvements would consist of!

No information is provided as to how much the service currently costs so it is not possible to calculate the cost per client seen in west Suffolk. Nor is any analysis provided about outcomes achieved so we are unclear whether there is any evaluation available to evidence if the service provides value for money. On this basis, we are not able to make an informed decision about the cost effectiveness of the service. We do not know whether the costs of the service relate to staff or property overheads and whether or not alternative options could be found to reduce these costs.

We would suggest that a Health Impact Assessment be undertaken on this proposal to better understand the impact on health deprivation in areas where the service is to be withdrawn. Makes sense to have a review in a year's time to see how well centralisation is working. An equality audit must be carried out on this proposal.

4.11 Capacity 14 comments
The number of profoundly disadvantaged patients is rising rapidly. GP referrals to MVA are up several-fold on last year. I'm not sure how GPs will cope with signposting however as they are already inundated. Those that do manage to register with GP surgeries will cause additional workload and strain to a GP system already at breaking point. Cutting the budget will therefore impact on Ipswich services. Appointments are hard enough to get as it is.
The result will be that more patients attend Ipswich Town centre GPs such as Barrack Lane, Burlington Road and Orchard Street, and ED at Ipswich Hospital. Cutting community services has been a key contributor to this trend with fewer community services meaning that GPs often have no option other than to admit, and that more patients attend ED and are often expensively and unnecessarily admitted from there.

Ipswich is certainly the area of highest demand but also has the most services for MVAs - not least at the Chapman Centre (a day advice service for marginalised adults and the 'homeless hub' for the Locality).

This proposal if implemented will place additional strain on already stretched resources with other bodies, both public and voluntary, especially NSFT.

We also receive referrals from the community for housing-unfortunately we are unable to accommodate everyone.

4.12 Priorities 11 comments
Unethical to cut services for this group. MVA is one of the few agencies able to deliver clinical and social services to this group.

Provide an emergency version of this service only.

It's hard to see any benefits from the separate commissioning of mental health and drug & alcohol services by the CCG and SCC.

People should have had the opportunity to decide which services they think should be cut back on rather than it being decided by the CCG. In my experience there are people who seem to get into the system & get lots of service & abuse it & some people who really need help often get overlooked. It's the crying baby gets fed first syndrome! Need to think about a good use of public money.

I would have thought that CCGs and trusts should demand what Theresa May was recently advocating, that there should be less inequality and this applies to the Health Service as well as everything else. The NHS must retain its principles.

4.13 Consultation 5 comments
The cost of a biased consultation (it looks like NHS has made up it's mind and just wants public agreement). Sounds a fudge to excuse the withdrawal of services.

Please also show respect. It is Gypsies and Travellers (capital G and capital T).

As schools will be closed throughout the 8 week period, it would be advised to publicise in places children may be present such as community centres, youth clubs, sports and leisure centres, libraries and churches.

Thank you for asking the local residents for our views, please continue to do so.
MVA Questions

Funding
9  Why do the NHS pay for MVA?
2  The estimated cost saving is £369,000 - will any of this money be coming to Ipswich to better join up the services (public sector agencies/sectors) for those people with complex needs in health, social care and housing?
2  What is the cost benefit of providing this service?
1  Intransigent, homeless, foreigners have not contributed in any way to the NHS so why should we use our valuable resources and money to help?
1  What is the cost per potential user?
1  If the main focus of this service is to link people to primary care, and other services as appropriate, then are there potential cost savings to be had by ‘handing over’ to these services earlier?
1  So is the money for the new contract less if these services are no longer going to be done in the West?

Travel & transport
14  How will people in the west get to Ipswich?
1  Will travel be paid for and will other charities be stepping into the breach?
1  How will rural people access services in Ipswich?
1  Will everyone have to travel to Ipswich to access this service?

Impact
6  Have you explored whether there might be further impact on this group (MVAs) due to fact that you are reducing your services?
3  What impact will this have on other services (i.e. GP services, A&E)?
2  Are you not in danger of just shifting the problem to somewhere else, either within the health system, or indeed the wider public services system?
1  I do agree the Ipswich & coastal areas are very underfunded and to refocus all your energies in one area would be preferable, but is it really possible?
1  Will it encourage more segregation?
1  Are you suggesting that all such vulnerable adults should go and live in Ipswich?
1  Do they really need this service?

West Suffolk
10  How will you continue to support people in the West?
1  Could an identified Doctor’s surgery/drop in area be open for MVA 1 day per week in Bury and include advocacy and signposting in addition to clinical at minimal cost?
1  Perhaps an outreach service could still be provided in the West?
1  Seems to be somewhat unfair to concentrate on a single area unless there is a convincing argument for that?
1  Could some sort of collaboration be done with other areas in the West e.g. Cambridgeshire?

Services
5  What does ‘finding ways to improve advocacy and signposting in the west’ look like – (i.e. what exactly will you replace the service with)?
1  How are larger towns such as Sudbury going to cope with no A&E department?
1  Is it possible to have information points in more than 2 places like triage?
1  Why is Haverhill not considered when these decisions are made?
1 Can we (GPs) have a break down of exactly what this service is providing - by whom and to whom and in what form? (mentioned is drop in clinics but are there roaming clinics too - traveller site visits?)
1 How is it tied up with Turning point?
1 Could the Suffolk Wellbeing Service be linked up with MVA?
1 Where can I see a comparison of the different services currently offered?

Inclusion
1 What about the elderly, are these not MVAs too?
1 How many people are eligible, (ie numbers of potential service-users)?)
1 Where are service users situated?
1 How vulnerable are they really?

Responsibility
2 Why don't people find their own help?
1 Why don't immigrant communities help their own?

Consultation
1 Will you actually listen to the feedback you get or is this just another tick box?
5. Suggestions

Question 5 - Do you have any views or ideas on how the CCGs could improve their financial situation?

Question 6 – Other submissions (combined)

Executive Summary – Suggestions

A wide range of ideas were suggested for the CCGs to potentially save money and/or generate income. Reorganisation and prioritisation of a range of services included withdrawing or limiting a range of surgical, medical and support services. A review of prescribing practices was suggested. Access to the NHS should be granted on the basis of entitlement and contribution. In particular health migration should be addressed. Charges should be considered for access to the NHS for all but essential services and for non-nationals. Part payment contributions and insurance contributions should also be considered. Tightening up of leadership and management included suggestions to reduce top tier management and bureaucracy. Staffing and staff pay may also be an area where efficiencies can be made with an emphasis on moving away from ‘bank’ or ‘locum’ staffing. An improved training structure for doctors and nurses was suggested. The identification of waste, including materials and processes, could also reduce overall costs. Finding efficiencies in communication was proposed. Solving the problem of ‘bed blocking’ was also a critical problem. The education of patients in how to use the NHS and in how to maintain good health would lessen the demand on stretched services. The funding position would improve if the CCGs asked for more funding from the government – suggesting that more revenue could be raised through taxation. Better coordination of health, social service and voluntary organisations was called for. Medical appointment systems are deemed to be inefficient. CCG mergers and centralisation of services were suggested. A review of suppliers and supplier accountability will produce better value for money. A reduction in campaign spending was also proposed. Consideration can also be given to the use of estates to generate income.
5. Health Services 215 comments
Non-essential services should be a cost-saving and could either be stopped or reduced. These include breast augmentation or reduction, IVF, breast surgery, and cosmetic surgery, SIP feeds in care home, Tattoo removal, Transgender surgery (sex change), bariatric surgery or gastric bands, abortions (terminations), straightening toes, varicose veins, routine male and female sterilisation, dental work, liposuction, Prep to those who have AIDS and having dialysis equipment flown overseas for patients on holiday.

Hearing aids should not be available on the NHS. Decrease the amount of physio. Remove the option for home births for mothers. Get rid of the 111 service. Do not provide services for overweight public. Cut treatment as a result of unhealthy or sedentary lifestyles. Cut alcohol services out of county and take more extreme measures to stop pubs allowing it. Stop providing so much for disabled tiny babies born prematurely. Too much money goes into social care provision. NHS spends too much money on drug addicts/alcoholics. Reduce non-essential treatments. Smaller cuts in more areas reduce massive changes. Wasteful clinical practices such as emergency admissions for children with viral illness, adults with tonsillitis or lymphadenopathy, elderly people with an exacerbation of existing chronic degenerative disease or care home patients should be addressed by the CCGs.

It is suggested the following services be prioritised; vasectomy. renal services at IHT, allergy treatments, support for the aging population, MH in the early years of life, Prioritise young people over the elderly, MH, a proper phlebotomy service, cancer, emergency services, ambulances, receiving A&E arrivals, triage at A and E. We would suggest that the CCGs makes all possible efforts to protect frontline clinical and support services.

Stop to think about what services are a right equal for all and what are not. Only spend money on keeping people healthy and well. Use the Risk and Harm matrix. Elderly care criteria equalisation. Use the Case Management approach (and at the very least MDT system). All support services reduce the cost of their service by 10% using a cost reduction programme. More services provided by hospitals need to filter down/be available in the community. NHS polices - focus more effort on services that produce success.

Open up the provision of nursing in practices and encourage greater usage locally as opposed to A&E being viewed as a first point of call. Reopen Riverside walk-in clinic and keep the minor injuries unit at Ely, and use Hartismere more for things like minor injuries, X-Rays.

The CCG cutting community services has been a key contributor to this trend with fewer community services meaning that GPs often have no option other than to admit, and that more patients attend ED and are often expensively and unnecessarily admitted from there. Increase the amount of local/community healthcare services. ED should be moved into the community and run by local GPs. Upskill GPs and nurses to deal with minor injuries. Practice Nurses need to be trained to take on more complex cases/procedures to cover the gap.

At some point the CCGs are going to have to stand up to the hospitals. Radical change is needed - the present arrangements are unsustainable.

Pathways of care don't deal with the patient holistically. Review clinical pathways tailoring services generally to individual needs. Keep reviewing patient procedures to
make sure they are working efficiently and effectively. Clear pathways for patients who already have a diagnosis, this will cut out unnecessary GP appointments.

Losing weight and stopping smoking and being more active should not be left to charities because real benefits can be made to save NHS costs as a whole. Park run - prevention better than cure. Similarly group work for social issues and loneliness which again takes up gp time - to have these run in surgeries would validate them to patients. Provide earlier and better interventions so that vulnerable children don't turn into vulnerable adults. More needs to be done to help children and adults which could lead to savings further down the road.

End of life choice for people so they can choose when to end their life. Stop treating old age as a disease. Look at the NHS from a patient's point of view. NHS is very bureaucratic and should treat the person rather than the system. Stop people being sent home too early, make sure they are fit to be discharged otherwise they only get re-admitted. Less failed discharges from hospital. Better support for those discharged after falls. Return to social care service of the 1980s – public sector based model.

Increased screening to prevent certain conditions. Drs should test people more. Introduce well man and well woman check ups. Earlier screening and prevention for certain health problems e.g. diabetes. NHS should be like the dentist and offer health checks on a yearly basis.

Go and see a pharmacist as opposed to taking up GP appointment times. Encourage better use of pharmacies, they can be very helpful for minor injuries/coughs & colds. Make people aware of what a pharmacist can do to avoid them making a doctor's appointment.

Reduce testing. There is a 7 day backlog clearing use of diagnostic facilities e.g. X-rays, CT scanner. Too many of us have to make numerous trips for bloods to be taken for different conditions. Perhaps bloods could be taken during one session in any given month. I hear how easily clinicians in secondary care order tests and investigations – often simply because they can. Is there a way to enforce every clinician to question why they are ordering a test – from LFTs (when GPs are good at ordering only ALT now) to echoes (cardiology). I encourage us all and I get all our trainees to justify everything they request, it does not stand up that over ordering tests is defensive medicine because if we are not thinking accurately and with focus about what we are testing that in itself shows concern.

Embrace alternative therapies. People overuse drugs. There's more natural remedies people could use. Look at increasing preventative health care i.e.: diabetes patients having free access to slimming world. Social prescribing with research - led outcome. Stop the fruit drop.

Not right that funds go to owners/shareholders. Stop putting things into private companies – Care UK take loads of money. Stop providing taxi and patient transport unless it is absolutely essential.

Don't allow consultants to do private work. Do not lease employees cars. Cleaning services should be in house.

Do more to encourage organ donation. Make organ donation and opt out system. Use sperm and egg donation initiatives in return for NHS IVF treatment.
Close GPs on Sundays - they milk the system. Shouldn't work all hours. Get the sugar tax sorted! Stop sending Scotland money

5.2 Prescribing 166 comments
There is a difference in costs of prescribed drugs as opposed to OTC purchases. Given the huge difference, I would challenge both the procurement and administrative processes - woefully inadequate - and the accounting mechanisms. Where people have chronic conditions and need on-going medications - even simple ones like paracetamol - they should continue. For one-off or occasional simple medication, patients should be told where to buy what products and referred to local pharmacies.

Stop prescribing for drugs that are available over the counter, paracetamol, drops for dry eyes, Aspirin, IBU, vitamins, Sun cream.

At present if someone has a chronic condition ALL their medication is paid for. All prescriptions under £5 should be paid for by the patient. Can't change any more for prescription – the current level is just right. Generic drugs only. Savings could be made by using different drugs. Clamp down on the use of expensive drugs in hospitals.

GPs over-prescribe e.g. the overuse of antibiotics. More shared decision-making. I think would reduce wasted medicines. More testing for people with lyme disease/infectious diseases - diagnose correctly = less drugs = save money.

I have personal experience of the dosage of regular medication being reduced in a consultation but this information not recorded on the repeat system, resulting in too many tablets being dispensed at each subsequent request for a repeat. Target prescriptions. 3 month prescriptions for End of Life patients are not feasible.

It could also be a cheaper option for GP's to prescribe Clomid for couples having problems when trying for a baby as this again might reduce the number of referrals for IVF.

Increase availability of medicinal marijuana.

Stop over-prescribing. Elderly people especially, stock pile. Doctors prescribe too large quantities (cancer cream, continence products for dying people who get huge deliveries and don't need them all). Not enough checking done with regards to repeat prescriptions. Medication – taking it and not using it – this is a waste of money. People abuse their scripts and don't finish their prescriptions. Crack down on this. Doctors change medications and it can’t be returned and re-issued to someone else even if I haven’t opened the old (still sealed) one.

Medication reviews: where possible patients should be encouraged to telephone surgeries to report non-adherence to prescribed medications to avoid repeated prescriptions for medications that are not taken. If necessary a follow-up appointment then can be booked.

Pharmacy should repackage their medications waste of packaging.

5.3 Access 133 comments
NHS has outgrown its remit – too many people. Reduce Health tourism and impose a qualifying period for free NHS prescriptions. There are more people using the NHS who shouldn’t be allowed to use it and who don’t pay into the service. You should introduce a system where all non-British nationals have to bring health insurance with
them to use NHS, & emergency care provided only without it. Foreign nationals should pay up front for treatment or don’t provide any treatment until you can prove you have insurance or an E111 card.

Don’t treat for free those who have self-inflicted problems – drugs and alcohol – users, time wasters and people who use the health services for trivial things. Consider cutting budgets on areas where individuals can start to help themselves. An incentive perhaps, people can have help and support if they lose some weight themselves. Treatments only offered to patients who have stopped smoking and can prove this. Cuts should be made to services where people’s lifestyle choices have caused their condition; smoking, drinking, obesity, etc. Potentially refuse more operations unless people first change their lifestyles, with support.

Prioritise A&E (e.g. stop treating people in A&E who have a little cold). A&E staff should be allowed to turn away non-emergency attendees. After triage at A&E customers should be advised that if not deemed urgent or life threatening they should take their problem to their GP or the GP drop in centre at the hospitals concerned or the wait for treatment will be lengthy (no target). There are lots of examples of alternatives to a and e for people with mental health issues, more suitable services I am sure would ease pressures. Prevent the misuse of ambulances (e.g. sending ambulances to people who are drunk or have cut their toe) Anyone with general aches and pains complaints should pay for private sessions.

There are lots of people who claim to be sick yet claiming DLA. That money should be for those who need it.

People are still getting NHS treatment irrespective of whether they have a history of missing appointments. GP appointment missed - give 3 strikes and out! I have been reading in the national press that the NHS are looking to check that people are using their GP. If a patient has not been seen for 5 years they could be struck off. Another way of reducing costs.

There could be significant mileage in this approach for both improving Health and Wellbeing and also saving costs by getting services more embedded locally. For example, pilot using the treatment room at (e.g. Chapman Centre) for other primary care services, such as dentistry and podiatry, with a view to reducing demand on emergency and secondary care services. Potentially, a sessional GP available at the Centre could reduce the amount of DNA’s in primary care or a satellite Dental service could reduce presentations to emergency dental services etc. Also consider using the Christopher Centre and Kettle & Fish for local services.

Provide more specialist support locally within surgeries. More community nursing is needed and a greater focus on localised healthcare. Social prescribing - do more in the community. Support people more with living at home in order to reduce hospital admissions and GP appointments amongst the elderly. Keep patients in county instead of sending them elsewhere e.g. London. Locally we should be more autonomous.

Haverhill medical services just cannot be cut any further, as the fourth largest town I feel we are at the tail tend of medical services and this should be addressed as soon as possible. Stop closing community hospitals. Base more services in Eye Hospital, especially after money has been invested in refurbishing it (e.g. X-Rays, dialysis etc.) It will stop people having to travel to Bury, Ipswich and Norwich. Have Hartismere Hospital more utilised - cancer treatment for example and community services.
Bring back the walk in centre. Makes all the difference. They treated children much better. Need more local hospitals and walk-in centres.

5.4 Charges 123 comments
There being no repercussions for those that miss hospital appointments, costing the taxpayers a quote £108 per missed appointment - £10.5m relating to Ipswich hospital alone over the last 3 years. Start charging DNA's (missed appointments). Any missed appointments charge and no further appointments with the GP or Hospital be allowed until that is paid.

Patients in Suffolk and Essex have missed 270,000 appointments in three years, equating to 90,000 per year. A £15 penalty per missed appointment, for example, would provide £1.35m of income for these regions. Charge for missed appointments unless someone can provide a valid reason. At Leiston surgery the rate of missed appointments is particularly bad. For missed GP appointments there should be warnings and then charge if this is a repeat occurrence. Charge £5 to make an appointment if they have previous instances of missed attendance.

Pay to see a GP (e.g. £5, £10, £25, £28). If people can afford to pay for GP appointment they should do so. If treatment is given payment should be taken in advance (as much as possible). People should pay a deposit for their appointments which is refunded if they turn up. After so many visits/appointments for “frequent flyers,” make them patients pay for appointments/hospital stays. Should pay to see GPs out of hours.

Charge for NHS treatment. Agree to fund NHS core, then people to pay more for NHS plus (contribute to IVF for e.g.). If you are contributing then you are more committed to taking responsibility for yourself and your family. Quote & charge for dental treatment. Invoice relevant insurance company for treatment following car accidents including costs of ambulance. Charge visitors to A & E £10 a visit. Charge a very small amount for non-life threatening visits to accident and emergency. It was really annoying to see people going abroad or private clinics and expect the N.H.S. to pay for correction treatment when something goes wrong they have already paid to have done so make them pay to put it right.

Private patients should pay more if they are using NHS services. Move towards a more privatised healthcare system (with a safety net). Pay for own health care (inhalers, prescriptions, knee operation – private). People who take part in extreme sports or activities that are highly likely to involve injuries should pay insurance. Please start charging for lifestyle related illnesses such as smoking and alcohol. These are not covered by insurance companies hence should not be funded by taxpayer.

Charge for Ambulance callouts or fine for unnecessary call outs. Any call out by ambulance to drink/drug abuse related incidents should be charged.

Meals could be charged for as people would have to pay for there meals while at home even a small charge of say £5 would not be too bad as meals on wheels charge £6.10 and an invoice could be sent at the end of there stay. Charge for 'house keeping' per day when patients are admitted. Perhaps introduce a small charge for heating when in hospital in wintertime (50p? Nominal amount). Don't think health service should go private but everyone should pay a little bit towards their care (e.g. £5)
If people can afford to pay for things such as hearing aids and medications then they should.

Part funding so people only pay for part of the treatment. The CCG’s could potentially improve their funding situation if a clearly defined advantage could be available to customers, either personally or via private health insurance, who were willing and able to contribute an agreed proportion of the cost of a treatment by the NHS - say, 50% - where their alternative choice would be either NHS at zero cost or 100% of the cost of equivalent private treatment.

More means testing. Means test continuing healthcare. Means tested benefits. If you have a certain income/pension then you should contribute towards your care/ambulance transport/pensions. Make the treatment “means tested” so that those who can afford to go private do so, while those who cannot afford that option can still be considered.

Introduce co-payments from patients for some services. More than 50,000 woman have IVF per year, charge maybe £100 per cycle to go towards the NHS funding that would be 5 million per year, surely that would help. A subsidised treatment plan could be put in place for all couples. This still represents an average saving of 37.5% across two cycles, which would contribute to a saving of £258,750 based on the statistics you have provided.

5.5 Leadership and management 115 comments
We definitely need good managers & admin staff to run the NHS but it seems to me to be very overstuffed in these areas & Doctors should be the 'deciders' on clinical needs. There are too many managers not doing the right thing! Reduce top tier management and middle management within the NHS. Take out all managerial roles over £75k. Review CEO’s salaries. Ward managers should be got rid of - they don't do anything! Don't let the ideas and knowledge of those who leave the health service disappear with them.

It should not be down to CCGs to make decisions that affect peoples lives so dramatically. It needs to be fair across the country. 5 year Strategic planning should be dramatically improved to avoid this annual culling of services. A streamlining of services is needed. Chipping away at services is shortsighted, inefficient and will not solve the larger problem. If resources continue to be tight the NHS needs to a fundamental reconsider how services are provided as a whole. The current infrastructure is not working well to cope with the volume of demand - this needs to change. Make it less system orientated.

Reduce the amount of admin (red tape) in the NHS system. Systems and paperwork are complicated and confusing. Too much time is spent filling in forms. Clinicians are too overwhelmed with paperwork and can’t spend enough time with patients. ENT department at Bury St Edmunds does not seem very efficient. Staffs appear to be doing other things instead of attending to patients.

The enormous amount of management and clinical waste at the acute hospitals must always be the first port of call for efficiencies. The acute sector is hugely wasteful in terms of bureaucracy. Reduce unnecessary checking of records e.g. confirming appointments. Reduce delays of surgical appointments causing the need to repeat scans etc.
Ward was raising money for a new window. Money was raised but it took over a year to get work started in it. Wanted a TV as well for the ward. Was told need to get various permissions rather than just going to Dixons to buy one.

Cut back on administration. Too many meetings. Less talk more action. The whole NHS system is top heavy with people who love to sit round a table and 'talk'. In my opinion it would be more practical to hold one meeting in one place the whole time instead of dozens of workshops. Stop allowing people to talk endlessly in meetings about their own agenda, also explaining that's not the idea in a PPG meeting either. Too many meetings about meetings. Meetings pull clinical staff away from their duties. Conversations go round and round and no action is taken or consultation isn't done properly. Less talking round a table amongst yourselves and more co produced action.

The NHS needs a culture change. Stop chasing targets. Give the hospitals an allocated budget and once it's gone then it's gone. Delivering these types of changes has clearly a challenge in recent years because it is difficult to persuade people to travel further for specialist care, even if that care is of higher quality. Relocating local healthcare services is generally not a vote-winner, however tough decisions need to be made when there is compelling clinical and financial evidence to support them. Share good ideas and good practise across the country.

The huge scale of the financial deficit of NHS organisations across the country will not be fixed by cutting vital services for small groups of marginalised patients. The two combined Suffolk CCG’s are facing £14mion deficits in the next few years and will save at the most £690,000 with these proposals. It is clear that without a whole system review the deficit cannot be met.

The NHS is fantastic and we are lucky to have it, however we shouldn't be afraid to give it critique. There are those in the NHS who don't know how to handle large sums of money. Get someone in who knows a thing or two about money matters. You need to get in some better finance people who know what they're doing. The public duly pay their taxes and NI, how this is distributed and shared is out of their hands. The money exists somewhere. Look at the finances from a business perspective. If the NHS is to be protected then we must support cuts.

Stop re-organising, moving offices, changing stationery etc. This is a waste of money, disruptive and destroying relationships with patients. Changes to teams, particularly MH/LD teams can have a dramatic impact on those patients they cover who have learning disabilities. Get rid of Projects 2000. The NHS has become a business and this should never have happened. Go back to basics. Too much time wasted by discussing changes to health services instead of just doing. Constantly trying to reinvent the wheel. Service are yet again transformed into something equally terrible. Stop interfering with what was a perfectly successful and financially stable community services provider. Stop centralising things as people then apply for funds for transport.

Explain EXACTLY what a PPG does and should be doing to help their Dr’s Practice.

5.6 Staffing 112 comments
The pay structure in the NHS is not good enough and not attracting staff so you end up paying for more agency staff which is expensive. A lot of money is wasted on agency and temp (agency) staff - they get preferential treatment. Increase the amount of full time contracts. Do more permanent staff recruitment.
Publish the headcount as direct patient facing and non patient facing to highlight the wastage on overheads (nearly 3000 staff but NO statistics published)! Too many non-clinical NHS staff. More doctors in hospitals can reduce acute cases.  

You need to look at money wasted on poor staff management before cutting patient services. You have wasted thousands of pounds dismissing and then re-recruiting & training. Senior staff getting payouts and then moving on to other jobs.  

Less administrators and more doctors/nurses. There should also be fewer office staff. Stop using foreign staff. Cut down on the amount of locums. Saxmundham surgery has too many locums and not enough GPs.  

Introduce salary caps. Reduce the pay to managers. Exec pay cuts to help plug the gap. Look at expenses - and over-time costs.  

Nurses shouldn't have to have degrees. Have 2 separate streams of nursing, those who are common sense with good caring qualities for basic care and another tier of more highly trained nurses for specialist care. Use more foreign nurses. Employ more Nurse Practitioners. Remove the ward managers and bring back matrons! Reinstate nurses handling Call 111 centres.  

All staff to speak fluent English. Introduce literacy tests for doctors.  

Don't deny there are wards in hospital, which are not properly staffed or supplied because they are really meant as overflow, but funnily enough are always busy.  

Ensure the right people are in the right posts, reducing duplication of services. GPs are far better than very junior casualty officers in assessing undifferentiated urgent cases. Staffing resource exists as GP+ has demonstrated.  

More money should be invested in doctors and nurses from England to help keep them in this country. Make it easier for existing staff to receive training. Nurse training – my daughter did a 3 year diploma but it was out of date by the time she came to get a nursing job so she has had to start again. A refresher course at least would have been better. Make more nursing bursaries available. Nurses should not be charged for their training, this would cut down on agency spending and aid staff retention. Lots of EU staff are very good nurses but Brexit may have an impact on this. Nursing places at university are too competitive. More information on nurse training needs to be available. I am currently doing a work-based course at West Suffolk Hospital but it wasn't advertised well. More work-based training is needed and this would lead to long term savings for the NHS.  

Increase funding for GPs. Increase the amount of GPs so that you can offer more appointment times and a better service. Under staffing is horrendous. There are currently too many patients and not enough doctors. Improve the availability of GPs so that fewer people go to A&E.  

Doctors leaving Combs Ford and not being replacement. In Eye there are 250 new houses being built and the GP practice won't be able to cope with this. Need more doctors surgeries in Stowmarket not enough because keep building more houses (Cedars). Make sure you have the resources in place before building new homes.  

Better career structure for NHS staff - more money for training & salaries - reverse the trends and pay them properly. My daughter left the NHS because GPs would not pay her a proper salary.
NHS is a bullying culture. Doctors and hospital staff are overworked and stressed. Lost time/costs in NHS staff sick leave due to psychological issue 750 days in June 2016 at Ipswich Hospital. Nurses are always very rushed, matrons should be there to run and organise the wards. Current nurses are too overworked. Agency staff are not properly trained and under too much pressure. Giving them more breaks will lead to better productivity. Better conditions for NHS staff will produce better results in the long run.

Continue to support the good work of the acute hospitals and critical care. There should also be zero tolerance for violent actions.

The NHS needs manpower. Improve staff to patient ratio so patients are treated faster, and staff are more efficient. Concerned about long waiting times for appointments and in A&E. There needs to be additional staff to cope with this. Use the Trustees more - they are intelligent people who want to be involved - they could do some of the managerial work.

5.7 Waste 103 comments
Do more to stop waste in the NHS - of money, equipment, resources, time. Cut out waste in the system – hospitals in particular who change (for e.g. the colour of scrubs or type of scalpel on the whim of a consultant, which means all the old (perfectly fine) stuff is just thrown away). Staff to avoid everyday wastage, for example use of dressings etc. If I want to put in an IV, I need to wash my hands, put on gloves and put on an apron and then throw these away when I'm finished. I think that if I've washed my hands thoroughly I shouldn't have to also then wear gloves. Only using certain expensive tools once rather than sterilisation.

Review how money is spent in a more targeted way i.e. how to get "value for money.". Investigate further areas for savings and potential ways to access alternative funding. Review how funding is spent in the government departments. Too much waste in government departments.

Going green on equipment and electricity usage where possible - put solar panels on the roofs of all your buildings and making sure that all lighting is turned off when not in use either by switching it off or by sensor. Hospital wastage needs to be reduced.

Ask staff to come up with ideas to improve every day life in a hospital, ask them to question why they do certain things just because they have always done things a certain way doesn't mean there isn't an alternative way and save at the same time.

More efficiency, less cancellations of operations. Review rest of the contracts and look for savings in your internal processes. Improve the internal use of facilities that are available without increasing costs. We are very lucky in this country to have the NHS but it is being abused.

Hospitals should also be more economical with regards to food in hospitals. There are too many options.

Both NICE and the former All Party Parliamentary Group on Infertility have highlighted common inefficiencies and opportunities for savings within fertility pathways.

Highly expensive IT systems. IT in different hospitals should talk to each other. Joined up records. There is a lack of communication between Bury/Ipswich/Addenbrooke's hospitals.
Video link, on call 24/7 The Big White Wall for patients to talk to doctor/social worker/professional at any time of the day. Electronic communication & consultations via Skype or the like.

Continue the programme of computerisation. Communication systems need to improve. Still using post to communicate within NHS - too much paper in the system (medical records etc). Letters not passed between departments or to patients and lots of time spent chasing these up.

We receive text messages updating and reminding us of appointments yet we still get letters in the post too. Leading up to my appointment I received two letters which when I investigated, I was told these were sent out by 'mistake'. GP send letters when could use email.

Bed stays are too long - some patients stay in hospital when they don't need to be there. Invest more in more money social services. Should re-open cottage hospitals as convalescent homes to stop bed blocking. Link up hospital care with after care. Tightening up of hospital discharge and hospital transport arrangements. Carers can help patients get out of hospital earlier and help support and care for them instead of staying in hospitals.

My parents have ended up staying in hospital longer than they need to because of administrative errors.

Returning and reusing equipment (wheelchairs, crutches, hospital blankets, under bed commodes etc). No-one collects the equipment and no-one signposts to where it needs to be returned to when used. Do something about equipment waste. I used to work for a CAMHS centre which had moved into an old building, however we were not able to use any of the old equipment even though it was all in good working order. Instead we had to buy all new equipment. Massive waste.

By working with partners to redesign, rather than relocate, services.

5.8 Education & training 95 comments

Campaign and educate proactively on using health services. Got to stop assuming the NHS can step in and fix everything. Improved the education of the public as to what services are available, and what they should use and when. Much more information about what is available in terms of prevention, care and support services. Raising awareness of community NHS services so that the public are more aware and can access the correct service. Education for emergency use should also be taught at school and Freshers’s week at Uni. WSH do good talks at AGM (educational)

Encourage greater competence and confidence in self-management of long-term conditions. (e.g. MS, Type II diabetes, mental health).

Prevention is better than cure. Encourage people to do more for themselves e.g. diet, being more active, healthy lifestyles, alcohol, holistic therapies, cooking lessons for people to know more about nutrition.

Publicise how much interventions and medicines cost. Need to educate public more on costs i.e. ambulance outpatient appointments. It seems that elderly people phone up their doctor a lot to ask for an appointment because they think there's something wrong with them.
If patients were seen by their GP's earlier and more consistently the NHS would save money in the long run as we would catch more earlier and save money on lengthy treatment. Need to understand why these people are abusing substances.

**5.9 Funding** 62 comments
Pay more tax resulting in a better service of healthcare. Can’t have a first class service without increased taxes – no politicians want this. Pay a bit more National Insurance (even as pensioners we’d be happy to pay more). People age 60+ should have to continue to pay NI contributions.

I am a huge supporter of the NHS! I feel that this should not entirely be the responsibility of local CCG’s. Tell the government that the budget is too small. Make the Department of Health give you more money. Increase funding to NHS rather than cuts. CCG’s should also be knocking on the government's door as the population keeps on growing but yet they keep cutting funds to NHS and then government staff levels keep growing and CCG’s keep having funding cuts. If you start charging nominal sums it will be the thin end of the wedge.

It seems to me that Government should increase taxation and recoup taxes from the rich viz: Grosvenor. Electoral reform - to challenge government to collect all taxes / crackdown on avoidance of tax. We have been promised that funds saved thanks to Brexit will be spend on NHS services. Sugar tax. Scrap Trident. Companies should pay more corporate gains tax as they benefit from a healthy population in the long run. Tax the rich more. Healthy food is very expensive, reduce the price and it may encourage people to eat better.

Petition the government to wipe Trust "debt" and start from scratch. Campaign with government to give tax incentives to people who can afford private insurance. This will free up NHS spaces for the needy and encourage more people to buy one.

NHS should do “charity collections” door to door/on the streets, run charity events to raise local money, raise funds in any way you can – e.g. coffee mornings.

Work closely with the department of health and propose to them to lift their ban / red tape around sponsoring. Local health care providers could get sponsored by local businesses and have extra money coming in that way; also strengthening community spirit and aid devolution

Invest to save. Build some new community hub surgeries. Invest more money in EEAST services. Care in the home for the elderly and care in the community needs more investment. CCG’s must stop transferring resource out of the community whilst protecting the powerful acute sector. If we carry on as we are, in due course there will be no community services left at all - just the hospitals. Put in place a new community based system of urgent care represents the obvious way for CCG’s to address their funding constraints. It is unfortunate the recent work in this area made no progress, but it could easily be resurrected.

**5.10 Other services** 50 comments
Better coordination (Closer working is needed) of services and knowledge and information sharing. Combined health and social care instead of competing. There is too much bickering about who pays for things between the health services and social care services. A central point of contact for patients where all relevant statutory and voluntary services are together promoting prevention and reducing access to A and E. Ensure advocacy is readily available.
Savings should be made by learning more about the Suffolk System and how nearly all public services impact each other in some way. Working more closely with local government partners to understand how they can deliver messages about public health and embed these into communities is essentially in reducing duplication, enabling growth and delivering a more sustainable public health model.

Closer working together between different parts of the healthcare system. Join up physical and mental health services more. Lots of physical, long-term chronic illness is made worse by poor mental health and is greatly improved and accepted with good mental health. With more support for mental health early and close to diagnosis will cut down on costs and increase the likelihood of better outcomes. The links between hospitals and practices and other healthcare services need to be improved/streamlined in order to prevent inconvenience to patients which can cost time and money.

Demand could be lessened on GP services if they worked more inclusively with the third sector. The route of much anxiety is often in social issues, if GP's had an on site advisor I am sure this would decrease dependency on GP's and medication More integrated working; Government quangos have no business having any say on healthcare services.

Commissioning processes are too wayward.

There are a few agencies that deal with social economic problems people face - these problems (debt and benefits stopping) affect health. Good signposting to these areas may help alleviate some health problems.

Invest in local communities and the voluntary sector so that communities develop resilience and a preventative culture e.g. Age Concern, Suffolk Mind. Focus on recruiting more volunteers to help patients in hospitals, volunteer to drive patients to and from various medical appointments.

Volunteering is all very well but you need people who are properly trained.

Possible use of PPG to facilitate social prescribing similar to a Timebank (being done in Colchester).

Something needs to be done about transportation for those who have difficulty getting to and from hospital/GP appointments. It is difficult and expensive to get to the larger hospitals e.g. Addenbrookes. Location of Eye makes travel difficult. No transport available to get to OOH at weekends.

Nationalise all NHS car parks. Look at car parking charges at hospitals. It's a captive audience (people have to park there) and the charges are unfair.

5.11 Appointments 36 comments

Improve access to primary care services and appointments. Appointments at GP practices locally are a big issue. The appointments system seems to blame people for being healthy by threatening to remove them from lists if they haven't had an appointment for a long time. You have to wait weeks for an appointment as their lists are full. Increase the amount of GP appointments available to people. You have to phone in at 8 a, or 1.30 and there are never any appointments left. Appointment information not always received properly. Allow people to call up for advice rather than book an appointment. Ensure admin of appointments is correct and stop wasted
visits.

More receptionists available. I spend ages on the phone waiting to speak to a receptionist to make an appointment – sometimes 10-15mins at a time. Stop receptionists from asking what the appointment is about

Extend appointments beyond 10 mins. Days don't seem to be maximised for appointment. Possible longer days, progressing more people quicker thru system. NHS should be open seven days a week.

More common sense is needed as well as better communication. Multiple appointments in one location should be better managed.

Take a very serious look at the appointment service at the hospital and associated clinics, which only works in the diabetes clinic, everywhere else is a shambles. There should be a cancellation system for people to join a list for appointments and fill the slots when people have to cancel (like they have in dentists and GPs) There are too many outpatient appointments with no real benefit just follow ups. Reduce these to save money

5.12 Mergers and centralisation 27 comments
Amalgamate services and co-locate buildings. Get rid of CCGs - Suffolk does not need 2. Are there savings and efficiencies that could be made on the administration work of the CCGs by sharing back office services across the two CCG areas and reducing duplication of functions and roles. If the CCG would like to make more savings there should one Suffolk as a whole and services commissioned not split into east and west this would lead to many savings if implemented I cant see why the east west split is there. The CCG is just another layer of executive.

Merging the surgeries Linnet and Sawston for pharmacy has worked well. Fund partnerships for services like this rather than one service that needs to work in partnership, but fails to do so.

Encourage VCSs to come together as one partnership. Do more collaboration with public sector organisations, Contracts - one arm of the NHS pays for the other. More centralisation is needed.

5.13 Suppliers 23 comments
Preferred or contractual supplier lists should be reviewed to determine if they offer value for money and in which areas. Purchasing equipment, supplies and furniture from one or several large suppliers may mean savings in one area e.g. IT and additional expense in another e.g. furniture. Online one-off /small volume items may well prove less expensive if purchased in this method. Procurement is done through many different organisations. NHS should be more centralised. Look into who supplies the GP practices and pharmacies. Hospitals should try and get the best deals to buy things at the best value. Economies of scale (able to buy administrative supplies cheaper from eBay than NHS suppliers). Too much money spent on small items. Focus on more large-scale procurement. Additionally collaboration for bulk purchasing combined across the CCG, County Council and Local Councils may offer economies of scale.

Millions wasted on useless computer software. Review equipment costs and purchase things truly beneficial and cost effective.
Come to an agreement with pharmaceutical companies to reduce drug costs. Don't accept drugs without full shelf life. Check use by dates on arrival at pharmacies. Rather than having primary and secondary drug budgets, have one disease/drug budget (covers admissions costs).

Improve contractual accountability. Hold Providers to account in delivering contractual outcomes. Major issues involved with regards to private carers. I work in the Finance department for a private care firm and we are part funded by the NHS. I know for a fact that some carers only go in for 10 minutes and then bill us for 30 mins which the NHS contributes towards.

Outsourcing and subcontracting to private companies could be an option but ONLY if it is overseen by the NHS. It should be stressed that this would be a customer OPTION, with no diminution of the standard NHS treatment that would be available if it were not taken up.

5.14 Spending 12 comments
Too much money spent on commissioning surveys. There have been a lot of meetings held at great expense with lots of leaflets handed out but no real benefits felt from this in Haverhill. Cut the meetings give out less meaningless leaflets and spend the money on services. Stop spending money sending text messages to people about if they would recommend hospitals.

Less investment in costly health promotion campaigns, which have limited measurable outcomes. People are in a position to take care of their health and no amount of advertising will change this. Yet despite this funding is allocated potentially ineffective and costly health campaigns. National campaigns such as FAST should be coordinated and paid for nationally and investment in local bus backs, newspaper advertising, bus stop and billboard adverts should be discontinued.

Spend allocated funds before deadlines to be able to receive full funding next financial year.

5.15 Estates 5 comments
Another way of improving the CCG’s/ NHS financial situation might be to creatively assess opportunities to release equity from the property assets held by the NHS trusts. I am confident that significant income could be generated in this way without detrimental impact on existing facilities.

I recently saw a tv programme hosted by David Robinson on the NHS Emergency Operating Theatres. Operating theatres are not in use at weekends. The NHS could offer up these theatres to private companies for a fee.

Review building usage and costs i.e the Hertismere white elephant & “tarting up” of Hadleigh Health Centre as an example.

Rent out meeting room space out of hours in some of the lovely Health centres.
Suggestions

Questions

Charges
3 If people are not British nationals, why do we not get them to pay to access the NHS?
2 Why not charge for missed appointments?
2 Could the NHS charge a percentage towards IVF treatment, if necessary?
2 We pay for opticians/dentists treatments so why not GPs?
1 Why provide food in A&E and hospitals free of charge?
1 Do we need a private insurance-based system?

Prescriptions
5 Wasted prescription medicines £3.4m in one year - although similar press articles on the same subject are available from 2011 - so why is this still happening - how long does it take for someone to take action?
2 Do patients need all the medication they are being given?
1 I am advised Kesgrave is not exactly the cheapest option - so why use it when cheaper options are readily available...
1 Drugs - checking of sell by date - could these be extended?

Spending
2 Although CCG staff costs are relatively low in Suffolk, could further efficiency be achieved through more joint appointments or the creation of a single corporate organisation serving two sovereign clinical executives?
1 How much has the endless reorganisation of Suffolk Community Healthcare cost the taxpayer?
1 How is purchasing managed, is there a dedicated team, are the best prices being sought, is this measured and audited, are best practices being followed?
1 Why is the spent per head lower in the East than the West? Would you be able to apply the East model to the West?
1 NHS doesn't collect equipment - should they be responsible for this?

Information
2 Please could we have a list of all the services/contracts being considered for cuts or changes?
1 Why is the NHS so focussed on number of beds?
1 What treatments are currently being provided above the NICE guidelines or best practice?
1 What services are delivered in multiple locations?
1 Are targets good?
1 Where did 465,000 come from - I thought it was 385,000 total population or am I missing something?
1 There are massive [mental health] reforms required locally and I hope somebody can let me know how this will be possible in light of the recent cuts announcement?

Appointments
3 Think twice about needing a GP appointment. Is it really necessary or can you self-care?
1 Missed hospital appointments - maybe a better appointments system is needed?
1 If you have multiple hospital appointments, why can't you have them all on the same day?

Staffing
Could further work be done around Recruitment and Retention policies to help reduce the use of costly agency staff?
1  Do staff work most effectively all of the time – doctors?
1  I was therefore astonished to hear recently about the proposed cuts to 90 staff within NSFT - when the Government has made extra money available to treat mental health, how can this be justified?

Health care alternatives
1  For long term conditions such as depression are people being referred to alternative support such as charities and local groups?
1  Is it clear what additional services are available?
1  Have partnerships been considered with higher and further education facilities been considered allowing those in education to help care or befriend those who are vulnerable?

Leadership and management
1  How strong is the management?
1  Surely the priority in the face of an imminent deficit is to concentrate resources on the provision of primary care, not to try to emulate commercial organisations?

Access
2  In national newspapers last week it was reported that transgender males (treatment paid for by the NHS) are also accessing IVF treatment on the NHS - how can this be?

Technology
1  Is there a not a way that records and paperwork can be digitised to ensure quicker processing?

6 Report Outcomes

This report has been developed independently using the feedback provide. All queries concerning this report can be forwarded to the author. All further correspondence should be forwarded to the respective CCG.

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September 2016

* Consulting the community is a research centre of academics from the social sciences. This method for analyzing feedback has been developed by colleagues from this centre. Enquiries can be made by contacting the CCG.
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