

Community Action on Health with Newcastle Council for Voluntary Service

Here's Looking at You

**Working with a different NHS:
Reflections from the Voluntary and Community Sector**

April 2012

A report for the Policy and Representation Partnership



Community Action on Health (CAOH) is a charity working within Newcastle to tackle health inequalities through patient, carer and public involvement.

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We employ a wide range of quantitative and qualitative data collection techniques to gather the views and opinions of patients, carers and the general public in relation to health services:

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Newcastle Council for Voluntary Service (NCVS) is a charity which works with voluntary and community organisations in Newcastle to promote voluntary action.

Newcastle CVS works to support, develop, promote, connect and represent voluntary and community organisations in Newcastle.

We support and develop local organisations to thrive by:

- group support work
- funding and sustainability advice,
- askNCVS our helpline and signposting service
- our information services including our weekly e-bulletin and our website
- training events and workshops

We encourage local organisations to network and become involved by:

- forums, networks and working groups facilitated and managed by NCVS to help organisations work together and share information
- various statutory bodies, groups and partnerships to influence local plans and decision-making

We provide representation and influence on behalf of the voluntary and community sector by:

- representing the views of the voluntary and community sector and acting as a link between our sector, the public sector and the statutory sector
- promoting and campaigning for the interests of voluntary and community organisations
- promoting participation in voluntary and community action and civil society

For more information about our services please contact Sally Young on 0191 232 7445 or email sally.young@cvsnewcastle.org.uk Visit our website at: www.cvsnewcastle.org.uk

NCVS works in partnership with Community Action on Health, and together we provide the host support for the Newcastle LINK (Local Involvement Network).

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Section 1: Introduction

1.0 Introduction

This report, which has been compiled by Community Action on Health (CAOH) and Newcastle Council for Voluntary Service (NCVS), analyses the findings of the third of three¹ pieces of research carried out as part of the wider project NHS Reform: Winners and Losers in the Voluntary and Community Sector.

1.1 The project and its aims

The project as a whole is funded by the Policy and Representation Partnership hosted by Voluntary Organisations Network North East (VONNE). It aims to:

- provide intelligence about commissioning groups' priorities and behaviour that Voluntary and Community Organisations (VCOs) throughout Newcastle can use to develop productive relationships with statutory health professionals across the city; and
- help raise awareness among clinicians of the effective interventions that the Voluntary and Community Sector (VCS) can offer.

This report examines VCS experience to date and future expectations of working with the statutory health sector as the recently-passed Health and Social Care Bill takes effect.

1.2 The context

The NHS reforms pose a complex set of challenges for clinical commissioning groups (CCGs) and voluntary sector providers alike; but the rhetoric surrounding the reforms has always emphasised the opportunities for innovation and collaboration that could lead to 'the largest and most vibrant social enterprise sector in the world'².

The VCS provides services that support the work of clinical practitioners in a huge variety of ways. These include, but are by no means confined to, condition-specific support, befriending services, employability and benefits advice.

Historically, Primary Care Trusts (PCTs) in and around Newcastle have provided some funding to some VCOs. This funding has included revenue (or 'core') funding and in some cases payment for the delivery of specific services.

¹ Our report into GPs' perceptions of the VCS is available online at <http://www.resourcebank.org.uk/resource.asp?resource=189>;
The report 'Choice and Control: views of patients, carers and the public' is available online at <http://www.resourcebank.org.uk/resource.asp?resource=190>

² Equity and Excellence: Liberating the NHS, Department of Health July 2010, page 36

The planned abolition of PCTs by April 2013 will result in significant, if not total, funding cuts; and there is as yet little sign that CCGs, either nationally or locally, are developing pathways for strategically funded collaborations with the VCS.

In Appendix 1 of this report Sally Young, Chief Executive of NCVS, examines the current policy context in detail and outlines the challenges facing the VCS in Newcastle.

Section 2 - Methodology

2.0 Methodology

In order to gain in-depth information about the views and experiences of a range of VCS service providers, CAOH and NCVS developed a questionnaire that could be completed online via SurveyMonkey, or in more depth as part of facilitated focus group discussions. We conducted our research between January and March 2012.

2.1 Questionnaire

The questionnaire was designed to collect quantitative and qualitative information, to help us understand the reasoning behind a range of opinions and preferences.

The questionnaire is included in this report as Appendix 2.

Questionnaire responses are set out in Appendix 3.

2.2 Participants

In order to capture the views and experiences of organisations with appropriate experience or relevant aspirations, we asked VCOs to take part in our research if they could answer 'Yes' to at least one of the following questions:

- Does your organisation provide a service that could benefit health service patients in Newcastle?
- Have you tried to 'sell' your organisation to local GP practices or Clinical Commissioning Groups?
- Has your organisation ever had PCT funding to deliver services?

We arranged and facilitated four focus groups, which 21 people attended from 19 organisations. Twenty of our focus group attendees completed the questionnaire, which a further 11 people also completed online. In the case of one organisation, two people participated from different service areas, reflecting the range of services and potential commissioners that some voluntary organisations are involved with.

Participating organisations are profiled in Appendix 1.

Section 3 - Findings

3.0 Findings

This section provides a summary of the findings of the Voluntary Sector experience research undertaken for this project.

3.1 Services provided and beneficiaries

The Voluntary and Community Sector Organisations who participated in this research had already identified themselves as meeting the criteria set out at the beginning of Section 2 (Methodology).

Our first question asked participants to describe in more detail the services they provide, or could provide, to GPs or other NHS commissioners.

Answers to this question are set out in full in Appendix 3. Overall, however, the overriding impact of the responses was to demonstrate the wide variety of services offered, and the range of user groups for whom those services have been developed.

Services included counselling (for specific user groups and also in a more generic form); arts-based community workshops; welfare rights support; a hospice; services and preventative support for older people and their carers; family support work; and recovery-focused specialist and primary services for people with mental health needs.

Others offered specialist services to more generic user groups. These included, but were not limited to, bereavement support; community food and nutrition initiatives; specialist support for children, families and young people; involvement with, and information about, the voluntary and community sector in Newcastle; hospice care for children and young adults; and health and skills improvement via bicycle maintenance and ownership.

We asked respondents to identify the beneficiary groups who would gain most from their service. Asked to tick as many groups as necessary from a list, eight respondents (25.8% of the cohort) ticked every category. In all, 23 (74.1%) ticked more than one patient group. Twenty-two respondents (71% of all responses) included 'People with mental health needs'.

The full list of beneficiary groups is included in Appendix 3 – Questionnaire responses.

In their answers to an open-ended question about their own service delivery, 21 organisations (67.7%) identified specific client groups, many of whom represented needs and interests beyond those we had offered in our question. These included people with eating disorders, rape and sexual assault victims,

bereaved people, teenage parents, people with learning difficulties, drug and alcohol misusers and people with sensory impairments.

3.2 Unique benefits

We asked all our respondents to identify the benefits patients could gain from their services that would not come from medication or other conventional treatments.

Here again, all 31 participants responded and their answers presented a rich picture of services that delve behind physical symptoms and look for holistic approaches to deep-rooted difficulties:

‘The ability to address underlying causes of poor long term physical and/or poor mental health i.e. sexual violence and thereby reducing reliance on medication, repeated GP visits, hospitalisation etc’

‘A holistic relationship-based response to overcoming problems of substance misuse in the family. This may take the form of emotional, practical and/or social support aimed at reducing the impact of substance misuse. Active engagement with our service may reduce or remove the need for medical intervention for mental distress such as depression and anxiety’

‘Specialist youth work and social work advice and support around contraception and sexual health, physical health (including healthy eating, smoking cessation, alcohol and drugs), mental health, parenting, housing benefits and homelessness, support into employment, education and training’

‘Allowing a grieving person the space to talk about their feelings and realise that they are normal responses to loss. This is done in a secure atmosphere and in a confidential setting eradicating the need for anti-depressants as well as self-medication (painkillers, alcohol and drugs) . . . bereavement support is cheaper and healthier for patients and the NHS and is personal’

3.3 PCT funding

Newcastle PCT is currently a substantial funder of the VCS; last year its support amounted to approximately £5 million, although economic and other ongoing uncertainties mean that the total has fallen for each of the last two financial years.

Twenty-five of our respondents (80.6%) are currently in receipt of PCT funding from Newcastle and/or other local PCTs.

In some cases this funding buys very specific types and levels of service delivery, for example:

'The funding is to support the CASH drop-in provision and provide our own sexual health drop-in service. We have targets within the service level agreement that cover the number of Chlamydia tests and c card inductions. We also have to deliver 11 training days over the year'

'Provision of BSL/English interpreting services'

'We have two Pathway Coordinators, one from health and one from social care, in each of the areas we work with including Newcastle. They jointly pay a nominal sum which currently equates to 26.5% per day of the operating cost for the service'

'A small contribution towards an Eye Clinic Liaison Officer working in Newcastle RVI Eye Department, to provide information, advice and guidance to patients newly diagnosed with permanent or a debilitating sight loss'

More commonly, however, the funding is only loosely tied to service delivery:

'Core contribution towards running costs and staff salaries e.g. counsellors, coordinator/fundraiser'

'Core work, but there is not enough funding to cover all we do'

'Core costs, providing a service. Only limited funding provided, which has been cut'

'To support the work that we do with families and children, and with the general community'

Participants in our focus groups were able to give some background to the way PCT funding has developed over the years:

'Historically, the organisation was grant-funded [by the PCT] and then that's turned into service level agreements. Although the funding is technically restricted because it technically funds one particular post, what it actually does is enable us to open the organisation at a particular time for drop-in so that the NHS staff can come in and deliver their work as well.'

'We were approached actually and asked if we needed anything, and at the time . . . they provided us with the shortfall for two years . . . but then the pot of funding apparently ended for them so we haven't had any word on any more funding.'

3.4 Work with GP practices

As the NHS Reforms take effect, Clinical Commissioning Groups (CCGs) will become the commissioners of some of the services that are currently funded by the PCTs. Public health services are transferring to local authorities, and the NHS Commissioning Board will commission specialised and some other services.

In cases where PCT funding has in effect commissioned specific service delivery, with targets and outcomes, it would be reasonable (although by no means certain) to assume that the CCGs might become the commissioners of some of the services in question.

However, it is not clear whether the CCGs will see themselves as the natural inheritor of non-clinical funding commitments. One of our focus group participants, who has been providing a service (originally funded by the Strategic Health Authority) to GPs, has been trying to get to the bottom of potential future funding arrangements:

‘When we asked the clinical commissioning groups they seemed not to be sure about where the money was coming from themselves.’

Our earlier research into GPs’ perceptions of the VCS³ suggested that GPs thought the sector may well be able to fill some of the gaps in their response to people whose problems had non-medical roots. However, very few of them felt able to develop links with the sector – or appeared to have considered that VCS provision might come with a price tag.

In order to establish some impression of the current relationship between Newcastle VCOs and the two CCGs, we asked our cohort of VCOs whether they were currently working with GP practices in Newcastle – bearing in mind that, until now, GPs themselves have rarely been the direct commissioners.

Twelve respondents (38.7%) said they work with local GPs – and most of those (10 organisations, or 83.3% of the 12) said they were working with three or more practices.

The services provided are set out in detail in Appendix 3 – but in practice they cover a wide range of provision from interpreting, counselling, family support, equipment loans and lunch clubs to support services for people with eating disorders.

As expected, none of these services are currently funded by the GP practices that benefit; seven VCOs identified the PCT as the sole or part-funder, while others said ‘we fundraise’ and identified the Newcastle Fund, Comic Relief and

³ The report ‘Working with the Voluntary Sector: The views of GPs in Newcastle upon Tyne’ is available online at <http://www.resourcebank.org.uk/resource.asp?resource=189>

Northern Rock Foundation among the primary income sources for the services provided.

3.5 Approaches to and from GP practices

We asked our participants whether they had ever approached a GP practice with a view to providing a service; and whether a GP practice had ever contacted them for the same purpose.

Thirteen organisations (42%) said they had approached a practice, and 11 (35.4%) said they had been approached.

Four organisations who had approached practices had received no response. Three said their suggestions had been 'very well received' and talked about hoping to develop something in future, but to date nothing concrete had resulted. One of these respondents said:

'The practices we personally met with were very keen to use our services, and we know our information is on some of their intranets, but time constraints make it difficult to search the system and, as a result, they probably choose 'services' they are familiar with . . . there is not enough time for GPs to deal with all that is on offer, and it is difficult to arrange meetings to discuss our role.'

Two organisations said they receive referrals from GP practices, and the number of referrals increased after one VCO made contact with practices. However, neither this nor any other approach resulted in payment for referrals, although one organisation is trying to identify and secure external funding for a service they would like to develop in partnership with a practice.

Some focus group participants aired their concerns about the lack of real follow-up or opportunities to report back when GPs refer patients to VCOs:

'We've found that, where GPs do refer to existing services such as befriending, bereavement counselling, lunch club, it's passing on – signposting in a way, rather than referring'

'Some GPs seem to think if they say 'You should get yourself to a pool' or 'go to a bereavement group' that's social prescribing, but it's just signposting. Unless the money follows along, then those people who run the pool [as a social enterprise] or run self-help groups can't do it indefinitely'

Perhaps not surprisingly, approaches from GPs to VCOs were slightly more likely to result in referrals or collaborative service development than approaches from VCOs to practices.

One organisation had been able to oblige when asked by a practice to provide a patient with a low-cost refurbished and guaranteed bicycle; and one respondent pointed out that their organisation had been established in 1997 in direct response to GP interest.

However, here again there was a pattern of initial interest that tailed off when it became clear that non-clinical services, as with drugs or hospital beds, cost money and need funding to ensure their availability.

One focus group participant gave an example that typified the dilemma VCOs face:

'We were approached by a practice a few months ago and we went out to talk to them and they were very interested . . . but they didn't have any money . . . we could have worked together to put in a funding bid somewhere, but then I'd have used one of my potential funding sources for something that's not essential to my organisation. It was a good idea and I could see the long term results from it but I couldn't afford to resource it.'

Another said:

'We get referrals [from GPs] for everything from the lunch club to befriending to loan equipment, but we don't get any payment . . . I wouldn't refuse a GP because I'm not getting any money from them or the PCT, I just wouldn't . . . but I think they all assume we get funding from Adult Services or foundations or trusts and they know that normally a charity won't stop providing a service . . . but then OTs [occupational therapists] and others will say yes but you know you're working for us and we have to say well actually no, you don't give us the money that we require to run.'

3.6 Giving commissioners what they want

When we asked if organisations could provide the kind of information GPs said they would need to help them commission with confidence from the VCS, 29 respondents said they could provide at least one of the pieces of evidence that GPs had asked for.

Twenty-six respondents said they could provide a clear pricing structure for their services, and the same number (not necessarily the same people) felt able to produce outcome-related statistics. Twenty-one people said their organisation could meet quality standards or accreditation, and 22 could provide evidence of economic value.

However, there were concerns about the 'Any Qualified Provider' (AQP) process embedded in the new legislation. Officially described⁴ as a process whereby 'patients can choose from a range of providers all of whom meet NHS standards

⁴ <http://www.supply2health.nhs.uk/AQPResourceCentre>

and price', AQP will incorporate a standard qualification process to ensure providers meet the appropriate quality requirements.

Participants in our research had few concerns about being able to reach appropriate quality standards, but feared that the standards and systems introduced would be bureaucratic and disproportionate to the size and approach of many VCS providers:

'AQP is excessive and unrealistic, and aimed at large and very large statutory organisations and providers. It won't work for smaller organisations who can meet non-medical needs in a way the bigger providers can't.'

Participants in one focus group expressed the hope that, if CCGs were to ask for this kind of information, they should ensure that their requirements tallied with the criteria already developed by the City Council's Newcastle Fund:

'It makes sense that there's some learning between those two bits of the system, rather than GPs having to come up with their own new framework.'

3.7 Demonstrating the benefits of services

We asked how else to demonstrate the benefits of services to potential customers, and received additional suggestions from 24 respondents. There was a very clear recognition of the importance of providing credible and persuasive evidence.

Fifteen participants, representing an even spread of type and size of organisation, referred to case studies and service user feedback, while six identified the importance of commissioner feedback. Two respondents (both from medium-sized local organisations) also referred to the outcomes of independent evaluations, and two others talked about highlighting the cost savings generated by preventative services.

Several respondents expressed confidence in their capacity to provide the right levels of information:

'We have developed our monitoring systems to record all the quantity data which is normally a pre-requisite. Additionally, we are able to provide historical data and case studies (confidentially produced).'

There was also clear recognition of the need to highlight the value of non-medical intervention – which GPs themselves had also identified in our research into their perceptions of the VCS:

'Illustrating that solutions lie with social rather than medical interventions and the value of people being active in both their own

wellbeing and the contribution they make to their local communities – and improved outcomes as a result of this involvement.’

3.8 Making it easier for the VCS to ‘sell’ its services

The evolution of the ‘commissioning culture’ between public sector agencies and voluntary sector providers has generated debate from all sides over the last few years, much of it focusing on mutual frustration at the potentially incompatible needs and capacities of the sectors.

One focus group participant highlighted the frustrations of providing information in different formats and at different intervals for multiple funders/ commissioners:

‘Each one wants a different thing. Somebody wants a report every three months, somebody else wants it every year. This one wants a case study, this one just wants the figures, these want the outcomes noted.’

This was echoed to some extent in questionnaire responses, some of which expressed frustration that commissioning processes are still very much ‘biased towards statutory provision’. Others talked about inaccessibility: ‘it is impossible to sell anything to a closed door!’

However, we were keen to use this research as a constructive opportunity to identify ways in which commissioners and providers might bridge, rather than widen, gaps.

When we asked how commissioners could make the process easier for VCS providers, a number of respondents acknowledged recent improvements:

‘Recently, PCT commissioners seem to be working more closely with us. They have written a service specification, and discussed ways to make our service more effective, and how we can work more collaboratively with them.’

Recommendations for further improvements tended to focus on transparency, consistency and clarity:

‘Clear commissioning criteria; clear and transparent process; workshops to explain how, what, when. Opportunities for VCS providers to meet GPs/commissioners.’

Others had more specific suggestions:

‘It would be helpful to us if there was a way of sending our information electronically to a central place that would then reach all GPs’

'Initially an opportunity to bid for small one-off pieces of work with particular communities or patient issues, so that we can build a relationship with GPs/commissioners and demonstrate our effectiveness'

'Have information 'open days' for the VCS to promote their services.'

3.9 Creating stronger relationships: what should the VCS do?

Given the need for stronger relationships, it is clear that change must come from commissioners and VCS providers alike. As one respondent said, 'breaking down those barriers and building relationships will only come from sustained effort on both sides.'

One focus group participant was very clear about the VCS's responsibility in this respect:

'We – the voluntary sector – have a job to do, and that's to educate the GPs. They are finding it very difficult to make the paradigm shift from the medical to the social model . . . And yes, we can provide services that are more effective – but it's going to cost. This notion that we can do it for nothing is the voluntary sector's fault. We should be putting it to them, "this is what we do and it's going to cost you that".'

Another focus group member picked up on the importance of putting a monetary value on services:

'We should challenge the notion that the voluntary sector is free . . . I bring half a million into Newcastle through the Lottery, Comic Relief, all the trusts and charities – we all do. So the services aren't free, we fundraise for them to provide them free . . . we should cost out the true cost of our services so they know actually each time we have an intervention with a young person or an adult, what the true cost of that is.'

There was also widespread agreement about the need to demonstrate a clear understanding of, and willingness to respond to, commissioners' needs:

'We must give them what they are asking for, e.g. a clear pricing structure, information about Quality Assurance etc'

'VCOs should provide better evidence about what they do, and demonstrate the integral role they can play in relation to health provision, prevention and promotion'

'Better information about our service and its effects'

There were a number of endorsements for more collaborative working:

‘Be more collaborative, adopt a non-proprietary approach thus reducing damaging competition and duplication’

Focus group participants were particularly aware of the need to act quickly, speaking frequently about ‘not just doing nothing’ and worrying that the sector might spend too long wondering how to proceed while others (including private sector providers) simply went ahead, developed working relationships with commissioners and slipped through the gaps left by VCS indecision.

3.10 Summary

It is clear from this research that voluntary organisations have a great deal to offer statutory health professionals and their patients; and in many cases they offer non-medical services with the potential to substantially improve patients’ health and wellbeing.

This supports our earlier research into GPs’ perceptions of the sector, which showed that, while GPs are not always sure where to find the VCOs that can support their patients, many believe that the sector can meet patients’ non-medical needs in a way that significantly improves their health.

However, the VCOs we spoke to – regardless of size – have struggled to break through the cultural and procedural barriers that make it hard to develop equitable commissioning relationships with the statutory sector.

In particular, it has proved difficult for voluntary sector organisations to negotiate payment from practices for the services they can offer.

There was general agreement among focus group participants that, far from being engaged in some kind of plot to avoid paying VCOs for their work with patients, most GPs simply do not know how the sector is funded and have not thought about what VCOs might need to ensure their continued ability to deliver valued services.

The next section of this report contains some recommendations for developing better pathways between the voluntary and statutory healthcare sectors, so that patients can benefit from the right kind of support, delivered by a viable, appropriately resourced Voluntary and Community Sector.

Section 4 - Recommendations

4.0 Recommendations

This section contains recommendations, based on the findings of our research, to support better working relationships and clearer commissioning pathways between the statutory and voluntary healthcare sectors.

4.1 Plugging the funding gaps

As current PCT funding to the VCS comes under threat from the abolition of PCTs and the £20bn 'efficiency cuts' at the heart of the Nicholson challenge, and as other sources of funding become more stretched, public sector commissioners will be less able to depend on VCOs providing their services free of charge.

VCOs who in the past have used their existing 'core' funding to meet the costs of working with referrals from GP practices and other statutory providers will be obliged to consider charging commissioners for their services.

Some respondents were concerned that occasions where GPs or other healthcare professionals had advised patients to contact VCOs were sometimes described as social prescribing when in fact they were more accurately examples of unpaid signposting.

We recommend:

For VCOs:

1. VCOs should develop clear figures showing how much each intervention costs them to deliver – and what they need to charge.
2. When VCOs are aware that a service user has come to them in response to a healthcare professional's recommendation, they should feed back information to the Practice in question. This information should include details of the intervention with its outcomes and – crucially – the resources involved.
3. VCOs should develop a clear way, possibly a common template, to describe what they do, what they are, who they work with, where they work, their quality control systems and contact details. This would inform entries in any database or directory developed to help GPs and other health professionals identify the services and providers best placed to meet their patients' needs.
4. VCOs must consider how they can demonstrate their impact, particularly in relation to health, and keeping people out of GPs surgeries and secondary care.

For GPs and Clinical Commissioning Groups:

1. Health professionals must think about the outcomes they want to see; these could include 'soft outcomes', not just demonstrating change.
2. Clinical Commissioning Groups could consider the value of grant aid to replace some PCT funding, particularly for smaller amounts of money and for some small and medium-sized organisations. This would enable these organisations to

continue offering the services whose value many GPs recognise and to which they informally refer patients.

3. Given the concerns of some respondents that the Any Qualified Provider system will be 'excessive and unrealistic', Clinical Commissioning Groups should consider a more proportionate, possibly lighter touch, way of identifying, evaluating and commissioning smaller providers and/or those who deliver less easily measurable services.
4. Clinical Commissioning Groups and the City Council should work closely together to develop complementary criteria, commissioning processes and monitoring systems. The criteria already developed by the Council's Newcastle Fund would be a helpful starting point.

4.2 Creating commissioning pathways

By April 2013, the transfer of commissioning to Clinical Commissioning Groups should be completed. Work needs to start now to clarify the commissioning pathways to ensure that voluntary and community organisations are not forgotten during this major structural reorganisation.

We recommend:

1. There is an emerging need, highlighted in this report and also in our report on GP perceptions of the Voluntary Sector, to identify a central, independent advocate to build links with the Clinical Commissioning Groups, become the recognised conduit between the groups and the voluntary and community sector and facilitate working relationships.

There would need to be a certain level of independence from service provision, so there were no conflicts of interest. This is a different role from any sign-posting or triage at the level when a patient approaches a GP. We suggest that Newcastle CVS starts active discussions now with the PCT, Clinical Commissioning Groups and the Local Authority about the best way to progress this

2. Voluntary organisations currently funded by the PCT will need assurances for future working. Other VCOs with services to offer who do not currently receive PCT grant funding will need the opportunity to look at potential opportunities. This can only happen through proactive work.

Appendix 1 – The Wider Context By Sally Young, Chief Executive Newcastle Council for Voluntary Service

Newcastle CVS has recently carried out three studies⁵ about the voluntary and community sector in Newcastle: Surviving or Thriving in Newcastle in February 2012; Changing Times: women's organisations in Newcastle in March 2012; and The Heart of the City: the voluntary and community sector in Newcastle in April 2012.

All three studies have highlighted the common problems facing the voluntary sector in Newcastle.

There are nearly 900 registered charities based in Newcastle, and one estimate is that there are three 'under the radar' community organisations, for every known organisation. This would translate to over 2,500 community associations and local groups (both formal and informal). These organisations are very diverse from local, community groups that are run by volunteers and very low levels of income, to large well-known charities, which often have their national headquarters in London. For the purpose of this research, the focus is on registered charities, most of whom will have an income of at least £100,000

In 2011 Newcastle City Council invested £46.43million into the local voluntary and community sector; over £33million was used to provide social care and care services. Newcastle PCT invested around £5million into the sector – the majority going to the two hospices (St Oswald's and Marie Curie), mental health organisations and other groups to provide services. There was also some funding through criminal justice services and national government departments.

There are over 6,500 people employed in the voluntary and community sector in Newcastle; this translates into around 5,000 Whole Time Equivalent (WTE) posts. Most organisations involve volunteers in delivering services. The volunteers are part of governance structures as trustees, directors or management committee members. Many volunteers provide core services – managing buildings, providing direct services, organising and staffing drop-ins, and offering advice and information.

The voluntary and community sector in Newcastle is facing one of its most difficult periods. This is due to the economic recession, the shift from grants to contracts, the movement to large contracts, the impact of the recession on the North East, the decrease in investment income for grant-making trusts, the future of the Northern Rock Foundation, the structural changes within the NHS, the loss of Area Based Grant and Working Neighbourhood Fund, the disproportionate cuts on Northern public sector organisations, and several national policy changes including the Open Public Services White Paper and the Localism Act.

The findings from Surviving or Thriving in Newcastle highlighted that at a time when more than half of voluntary groups were reporting a rise in demand for services, 59% had seen a decrease in funding, following the reduction of public sector budgets. 37% had lost staff and 57% were using their reserves.

⁵ All available online at <http://cvsnowcastle.org.uk/representinginfluencing/our-research>

The 53 organisations that replied to the survey reported a total of £2.8m in lost income last year, at least 75 staff made redundant, and redundancy facing another 45 staff. Four out of five respondents received grants from the public sector. With the region's public services facing budget reductions, many groups had their funding drastically reduced or pulled altogether. A number of organisations lost projects and staff at the end of March 2012.

The findings from Changing Times demonstrated that women's organisations were facing a loss of funding, but at the same time there was growing demand for their services. However there was pressure on them to provide services for men as well; yet there was a growing need for women only space and women only services. The value of work with women was often not recognised by funders. There was a particular issue around the loss of capacity to campaign and network and work jointly, as the emphasis was all about service provision.

The stories from the Heart of The City reflected similar themes. The initial research was carried out in November/December 2010, to obtain a snapshot of the situation affecting many voluntary and community organisations at a time of major change, and to promote a better understanding of the diversity, values and cultures of the sector. Interviews were carried out with 32 organisations based in Newcastle. The case studies were updated a year later to see what had changed and happened within that year.

The new case studies illustrated some key themes:

- During 2011, the organisations faced, on average, a funding cut of around 10%
- For many organisations 2012/2013 will be the 'make or break' time
- The funding climate is highly precarious, creating great stress and uncertainty
- Considerable time and resources have been spent on reorganisation and creating more business capacity
- Some organisations have struggled to hold onto their core values and beliefs
- There has been a shift away from community development work with a greater emphasis on service delivery and contracts
- There is less capacity for partnership and joint working with others
- Demand for services has risen and is expected to continue to grow, even as resources diminish

Although the Coalition Government announced its ideas and plans for Big Society in 2010, there have now been four launches of the concept, the ideology remains and is driving many policy initiatives. Whilst a number of commentators have reacted negatively to the Big Society, nevertheless many of the Government's initiatives, policies and new funding streams are based around its core principles.

There are three key principles to the Big Society agenda:

- Community empowerment - giving local councils and neighbourhoods more power to take decisions and shape their area
- Opening up public services - public service reforms will enable charities, social enterprises, private companies and employee-owned co-operatives to compete to offer people high quality services

- Social action - encouraging and enabling people to play a more active part in society

The Coalition Government has agreed legislation and policies which offer new opportunities, particularly around commissioning and access to loans, which were not previously available. Yet the reality is that many voluntary organisations are facing their most difficult time since they were established. This isn't just happening in Newcastle, and the national trends are well illustrated in the 2012 NCVO Civil Almanac⁶.

Operating in a more competitive environment brings challenges, as well as opportunities for voluntary organisations. There is evidence that small and medium-sized organisations without much experience of tendering processes and bid-writing will lose out. The scale of the changes proposed in the Open Public Services White Paper are potentially enormous and, in many cases, irreversible. It is based on the premise that competition improves standards and outcomes, and that commissioners know exactly what they are doing and what they want to achieve.

The second key concern is the tightening of public sector spending. In Newcastle, the Council made £43million of cuts last year; it is making over £30million this year, then a further £55million in the following two years. This will be a real cut of around a third of its budget over four years.

Newcastle City Council has been a comparatively generous funder of the voluntary sector (compared to neighbouring authorities) and has often passed on national grant to local organisations. For instance the Working Neighbourhood Fund was worth £9.3million to Newcastle, and the Council invested around £6.3million of this in voluntary sector delivery. The Area Based Grant was worth £13.4million. Both of these funding streams have now gone. Again most was invested into local voluntary organisations.

The Supporting People grant was cut by 39% last year. The Migration Impact Fund was stopped mid-stream, with organisations not paid for work they had already delivered. More Newcastle organisations are in receipt of local grant funding than many other areas (35% of the 900 constituted organisations).

In 2010, Newcastle City Council established the Newcastle Fund and invested £10million over four years. This is a different way of giving grant aid and is intended to provide a more open process. In the two grant rounds that have now taken place, requests for grant aid were between four and six times higher than the money available.

The third problem is that the demand on other funding sources is increasing. The Big Lottery is increasingly driven by government demands and its latest policy directions focus on social investment and social enterprise, with the promise that funds will be distributed 'primarily' to the voluntary and community sector. The value of Big Lottery Fund applications almost trebled in the past year.

The Northern Rock Foundation, which has funded more than £200million of activity in the sector, has an unclear future after 2013, with only 1% of pre-tax profits coming

⁶ Available online at <http://www.ncvo-vol.org.uk/almanac>

from the new Virgin-owned bank for the next two years. The Community Foundation (Tyne, Wear and Northumberland) continues to thrive, but offers smaller grants to mainly community groups. Other grant-making trusts are now receiving so many applications they note a backlog in dealing with applications and their decision-making is taking longer.

As people have less money to give, and unemployment increases, they give less to charities, although the figures show that the poorest people give a greater part of their income. Organisations that manage buildings are increasing their charges – but this means that their tenants (often other voluntary organisations) have to pay more.

The development of social finance has not yet had any impact in Newcastle; organisations will have to be of a certain size, be willing to take a risk and have a guaranteed income stream. This might be appropriate for some of the larger organisations, but it is hard to see how it could be attractive to medium-sized ones.

Adding to the picture are the changes in government grant, the NHS, welfare reform and social housing, which will disproportionately impact on the North East of England and basically take money from the north to put it into the south. As more funding streams are calculated on a head of population basis rather than need, this will again drain money away from the areas of greatest need.

This then means increasing pressure on the voluntary sector for more services. There have been notable increases in people wanting advice and information, mental health support, homelessness services. Many of the communities that the voluntary sector has traditionally supported (such as disabled people and people with learning disabilities) will be disproportionately hit by a number of changes.

Many of the organisations that are currently funded through Newcastle PCT and also others who would like to offer services to the Clinical Commissioning Groups are the organisations that are reliant on public sector funding and feel squeezed from all sides. Whilst voluntary organisations try to reduce costs and reorganise and reshape themselves into becoming more business-like, the question remains over who will be prepared to purchase their services.

As the squeeze on public sector funding gets tighter, and the full impact of the £20billion that is being taken out of the NHS becomes more apparent, there will be (naturally) demands made by the Foundation Trusts and the conventional NHS. It is hard for voluntary organisations to compete against large service providers. Some of the comments made within 'My body, my life' illustrate the lack of understanding by the general public around charity and the differences between 'volunteer' and 'voluntary'.

Sally Young
April 2012

Appendix 2 – Participating Organisation Profile

Size

	Number of respondents	% of respondents
Local	14	45.2
Regional	10	32.3
National	5	16.1
Not answered	2	6.4
Total	31	100.0

Turnover

	Number of respondents	% of respondents
Less than £50,000	3	9.7
£50,000-£500,000	16	51.6
More than £500,000	10	32.3
Not answered	2	6.4
Total	31	100.0

Main organisational focus (tick ONE)

	Number of respondents	% of respondents
Health promotion and support	5	16.1
Mental Health	8	25.8
Long term conditions	0	0
Older people	3	9.7
Cancer	0	0
Other	13	42.0
Not answered	2	6.4
Total	31	100.0

NHS Reform: VCS questionnaire

As part of our research into the impact of the NHS reforms on the VCS in Newcastle, Community Action on Health and Newcastle CVS are carrying out research to understand the VCS's experiences of working alongside the NHS before the reforms take effect.

- Is your organisation currently funded by a PCT to deliver services?
- Have you had PCT funding in the past?
- Have you tried to 'sell' your organisation to local GP practices or Clinical Commissioning Groups?
- Has a local GP practice referred patients to you?
- Do you provide a service that could benefit local patients?

If you can answer 'yes' to any of the questions above, we would really appreciate it if you could take some time to complete this questionnaire.

Section 1 – Your work

1. Please describe the service your organisation provides, or could provide, to GPs or other NHS commissioners:

.....
.....
.....
.....

2. What sort of patients would benefit from your service? (tick all that apply)

- | | |
|--|--------------------------|
| People with mental health needs | <input type="checkbox"/> |
| Older people | <input type="checkbox"/> |
| People with diabetes | <input type="checkbox"/> |
| People with other long term conditions | <input type="checkbox"/> |
| Children and families | <input type="checkbox"/> |
| Others (please specify) | <input type="checkbox"/> |

.....
.....
.....

Please turn over →

3. What benefit would patients get from your service that they could not receive from medication or other conventional treatments?

.....
.....
.....
.....

Section 2 – Your experience of NHS Commissioning

4. Do you currently receive funding from a local PCT?

Yes No If no, please go straight to question 5 below ↓

4a What is this funding for?

.....
.....
.....

5. Are you currently working with any GP practices in Newcastle?

Yes No If no, please go to question 6 below ↓

5a How many practices do you work with?

For up to three practices you have worked with, please tell us...

• **Practice 1: What work are you doing for them?**

.....
.....
.....

Who pays you to deliver this work?

The surgery itself The PCT Nobody
Don't know We fundraise

Please turn over →

• **Practice 2: What work are you doing for them?**

.....
.....
.....
.....

Who pays you to deliver this work?

The surgery itself The PCT Nobody
Don't know We fundraise

• **Practice 3: What work are you doing for them?**

.....
.....
.....
.....

Who pays you to deliver this work?

The surgery itself The PCT Nobody
Don't know We fundraise

Section 3 – Promoting your service

6. Have you ever approached a GP practice with a view to providing a service?

Yes No If no, please go straight to question 7 below ↓

6a. What happened?

.....
.....
.....

6b. Do you receive payment from a GP practice or Commissioning Group for any referrals that have resulted from this contact?

Yes No Not applicable

7. Has a GP practice ever approached you with a view to providing a service?

Yes No If no, please go straight to question 8 overleaf ↓

Please turn over →

7a. What happened?

.....
.....

7b. Do you receive payment from a GP practice or Commissioning Group for any referrals that have resulted from this contact?

Yes No Not applicable

8. We asked Newcastle GPs what they would need from Voluntary Sector organisations to help them commission services in the future. We have listed some of their preferences below. Could your organisation provide any of these? (Please tick an answer for each option)

	Yes	No	Don't know
A clear pricing structure for the services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A quality standard/accreditation or National Commissioning Board approval	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outcome related statistics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A demonstration of economic value	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. How else would you demonstrate the benefits of your service to a potential commissioner?

.....
.....
.....

10. What do you think commissioners could do to make it easier for VCS providers to 'sell' their services to GPs and other NHS commissioners?

.....
.....
.....

11. What do you think the VCS could do to create stronger relationships with GPs and other NHS commissioners?

.....
.....
.....

Please turn over →

Section 4 – About your organisation

12. Is your organisation

Local Regional National

13. Is your annual turnover

Less than £50,000 £50,000-£500,000 More than £500,000

14. Which of these descriptions most closely describes your organisation's main focus? (please tick ONE)

Health promotion and support Mental health

Long term conditions Older people

Cancer Other (please specify below)

.....
.....

Many thanks for taking the time to complete this questionnaire.

We may want to contact you to ask you more about your experiences of working with NHS commissioners, and/or your views about improving pathways between commissioners and VCS providers.

If you have not taken part in a Focus Group for this research but would be willing to be interviewed in person or over the phone, please include your contact details in the space below:

Your name

Organisation

Email address:

Phone number:



Policy & Representation Partnership



LOTTERY FUNDED

Appendix 4 – Questionnaire Responses

1 Please describe the service your organisation provides, or could provide, to GPs or other NHS commissioners

- Specialist rape and sexual abuse counselling service. Also training and raising awareness sessions to local professionals including GPs. Out of hours evening helpline service offering immediate support to survivors of sexual violence. Website with referral criteria
- Outreach, peer support, advocacy and training to carers and family members of drug and alcohol users
- Rape and sexual assault counselling. This could have been in childhood or recently
- Counselling
- Community-based one-to-one support that enables visually impaired people have choice and control over their lives. This includes impartial information on local support groups and other services; and practical support to overcome barriers to independent living including accessing information and printed materials as well as mainstream activities and services eg shopping, leisure
- Involvement with, and information about, the voluntary and community sector in Newcastle
- Our Children and Young Adult Service is a nurse led unit providing specialist short breaks to children and young adults with progressive, life shortening conditions who require that nursing support to manage their care. The service also offers support with symptom management and end of life care with ongoing bereavement support for families.
- Low price bicycles, classes to learn bike maintenance and cycling safety and a workshop to work on your bike
- We provide activities and support to local people, focusing most of our work on families with children, migrants, women. We support positive wellbeing through providing social networking opportunities, and bring people together to address issues that affect them, their families and communities. We have a community centre and other space to let out on hire or rental terms.
- Counselling for bereaved children and young people
- Family Support Service for children from birth to 12 years old and their parents/carers, currently delivering into the West of the City
- Advice, information and support to teenage parents, including sexual health and pregnancy decision making
- Acknowledged leader in the field of community food and nutrition initiatives in Newcastle-upon-Tyne, and a trusted and recognised provider of health related services to many groups and communities in the city. Our work tackles health inequalities by working with disadvantaged and vulnerable groups living in one of the most deprived areas in the U.K. It works in partnership with communities and other food projects, both locally and nationally, to address inequalities in food, nutrition and health related issues and operates a number of school and community based services
- Sexual health and relationships advice, 121 Counselling, and therapeutic group counselling. We also provide generic information, advice and support for any issues that impact on a young person. We are moving to a new building in early 2012 and intend to develop this new facility to provide a full service provision for young people. This will include debt advice, housing support, employment support and advocacy and rights work. We will facilitate specialised agencies to deliver this work within our new premises
- Group work support and one to one counselling for women with mental health and wellbeing issues
- A range of services that support children, young people and families including; Hidden Harm, Intensive Family Support, Option 2, 121 Mental Health support, Sexual health services, C- Card, STI Screening, accredited courses, medical rooms, healthy eating, community cafe etc

- A community arts organisation which currently utilises creative arts based workshops / approaches through the following projects:
 - Theatre Pie is an issue based drama project working with vulnerable young women raising aspirations and achievements; the project provides a range of opportunities and works towards reducing inequalities; the participants are referred by one of a range of agencies working with young people
 - The Josephine project works with women with learning disabilities. Josephine is an anatomically correct “larger than life” cloth person and a creative learning resource. Through the use of drama, role playing and interactive group activities the project works with women with learning disabilities to promote awareness around vital health and relationship issues.
 - Glasshouse delivers creative mental health programmes, delivered in a range of settings including NHS units for both in-patient and day care patients, community and educational settings, responsive to the needs of young people and services working with them
- To maintain/increase independence we offer the following services: Small items of equipment; Benefits Advice; Laundry collection and delivery; Counselling; Lunch Club; Handyman; Aromatherapy massage
- A range of formal and preventative services and support for older people and their carers to enable them to continue living a normal life, ensure their basic care needs are met and prevent escalating health and care needs relating to mobility, physical and mental and emotional health
- Information and advice on all aspects of disability including: disability related benefits; direct payments; aids and adaptations. We carry out assessments by qualified occupational therapists and physiotherapists
- Services for people with eating disorders:
 1. A contact point (by telephone/email/post) for support and information to patients or community members with eating distress/disorder as well as carers. This includes people who are afraid of approaching their GP or NHS providers, and can help them in doing so. Includes all age groups, male and female. A one hour appointment is also provided
 2. Therapeutic groups for women of 18 years and upwards with eating distress/disorder of all kinds, to assist in addressing underlying issues and finding alternative coping strategies (Group counselling, art therapy by accredited practitioners)
 3. Carers Support Group (monthly) in conjunction with Newcastle Carers Centre for carers/supporters/family members of someone with eating disorder
 4. Survivors Group for those in recovery or who have recovered, who wish to gain experience in volunteering. They are able to help raise awareness and engage in preventative work
- Support locally and regionally in terms of understanding and accessing VCS MH resources, and specific issues such as implementing personalisation, in health and social care for people with mental health needs
- Sports and leisure related activities, to help in general health and weight loss or recovering from illness or surgery, e.g. swimming and a fitness suite, exercise classes
- Mental Health Service User Involvement (getting service users involved in the design, delivery and scrutiny of mental health services of all types and descriptions), plus peer support, self-help groups (our own and aiding others), information, signposting, advice. Creative activities and initiatives. Anti-stigma work. Training. A User Led Organisation
- A supported volunteering scheme to those diagnosed with a mental health condition and referred by a practitioner
- We currently provide a range of specialist services ranging from British Sign Language/ English Interpreting & Translation to Awareness Training and provision of British Sign Language Training from beginners to advanced level. The NHS currently contract out our services directly and through subcontracting.

- Help and support for people with mental health issues to prepare for, search for, secure and retain sustained employment
- A wide range of recovery-focused specialist and primary care services (including IAPT) for those with a range of mental health needs. and a range of specialist dementia care services from 24 hour nursing care for individuals who pose challenges to services; to bespoke community and domiciliary support
- A range of services for older people in West Newcastle. Welfare rights advice and information, community health activities, support for volunteers, informal consultation work.

2 What sort of patients would benefit from your service? (tick all that apply)

	No. of responses	% of responses	% of respondents*
People with mental health needs	21	22.6	67.7
Older people	15	16.1	48.3
People with diabetes	17	18.3	54.8
People with long term conditions	14	15	45.2
Children and families	14	15	45.2
Other	12	13	38.7
Total	93	100	

*Number of respondents answering this question - 31

3 What benefit would patients get from your service that they could not get from medication or other conventional treatments?

- The ability to address underlying causes of poor long term physical and/or poor mental health i.e. sexual violence and thereby reducing reliance on medication, repeated GP visits, hospitalisation etc. Positive changes are brought about in the person's life by accessing our specialist support. A health outcomes tool is used to measure the impact of our counselling (showing regular issues for clients including suicidal thoughts, self harm, eating distress, depression etc). Other feedback from clients shows the benefits of accessing our service
- The service provides a holistic relationship based response to overcoming problems of substance misuse in the family. This may take the form of emotional, practical and/or social support aimed at reducing the impact of substance misuse. Active engagement with our service may reduce or remove the need for medical intervention for mental distress such as depression and anxiety. Families are offered opportunities for respite and peer support as well as advocacy and access to other support services
- The opportunity to work through, at depth, in their own time with the issues affecting the person's life in a non-directional way (i.e. NOT CBT)
- Talking Therapy, Women Only Space and Specialist service for rape and childhood sexual abuse
- Emotional support through peer support groups. Confidence-building and mental health wellbeing through social interaction. Empowerment through information, choice and control. Independence through practical support and tailored interventions to overcome barriers including stereotyping and discrimination. Introduction to new technologies and developing skills and confidence to utilise aids as part of daily living. Support and guidance in achieving equal opportunities in employment and education - stimulating ambition and broadening horizons
- Information about the range of support from voluntary and community groups
- The opportunity to come and spend time with a peer group in a home from home environment. Enables children and young adults to access activities and therapies both within the hospice and in the wider community. It is about trying to allow them to have fun so they enjoy their stays and want to come again. At all times their health and social

needs are met by a dedicated care team, who include nurses, nursery nurses, health care assistants, support worker, physiotherapists and a music therapist and administration staff. In addition we have doctors, chaplaincy, housekeepers, catering, complimentary therapists, maintenance, and other administration staff who support the work of the service

- A supportive cycling provider which encourages them to take up and stick to cycling
- Through activities, support, social networking and informal education, they can build confidence and self esteem. Thereby avoiding and addressing low mood, and anxiety.
- Unaware of other service with service level agreement with North of Tyne PCT
- Holistic service, addressing needs identified by the family and ensuring that service users are linked into community activities to ensure long-term support continues
- Specialist youth work and social work advice and support around contraception and sexual health, physical health (including healthy eating, smoking cessation, alcohol and drugs), mental health, parenting, housing benefits and homelessness, support into employment, education and training
- Our services would:
 - Inspire people to cook good quality, sustainable and healthy food
 - Establish excellent eating habits at an early age and transform school food culture, especially in disadvantaged communities
 - Offer personalised services that educate and reconnect people about the links between food and health
 - Educate people about the connection between food and health
 - Provide innovative nutrition programmes for the management of overweight and obese communities
- Early intervention and prevention to stop mental health problems from escalating. An alternative or complement to medication. An opportunity to ask questions about sexual health and relationships, in a young person friendly setting
- Peer support in a women only environment.
- An holistic approach to supporting them in their lived lives, listening, advice, guidance, access to resources, support services, training, lifestyle skills, empowerment, social prescribing, exercise, self awareness, early intervention and preventative support.
- A creative and holistic approach to supporting the development of young peoples' self-esteem and the esteem of young women and learning disabled women Issue – based workshops and performances on issues of mental health and personal wellbeing created by young people for young people A unique model of learning disabled women's health and sexual health education through Josephine: a model created by women with learning disabilities for women with learning disabilities
- Social wellbeing Increased independence- reduction of falls eg through small aids Social interaction, reducing isolation eg through lunch clubs Increased self confidence/awareness eg through counselling Increased Personal Hygiene eg through laundry collection and delivery Etc
- Reduced isolation and improved social wellbeing which has been proven to prevent and help alleviate loneliness and depression and also prevent deterioration of physical health. Support to maintain independent living and have control and choice over their lives. Promote and facilitate appropriate physical exercise and mental activities to help people stay sharp and prevent deterioration and physical health and brain functioning.
- Reduced waiting time for professional assessments in relation to independent living / aids/ adaptations. We plug the gap in existing provision. Access to these services means less reliance on statutory provision.
- We offer interpersonal therapy in a group setting, providing the opportunity for women with eating distress/ disorder to gain insight into the emotional factors underlying their eating problems. It enables women to gain mutual support from each other as well as exploring other coping strategies. It is a 'women only' space, which can be especially beneficial to those women who have experienced sexual violence or abuse. The support and information offered to other clients enables them to find and engage with services that could help them, and for carers we offer a facilitated Carers Support Group in conjunction with Newcastle Carers Centre. Our service continues to support women after

they have attended groups, and so they can have the sense of the continuity that can be so important for these often long term conditions. Women who are in recovery or have recovered and feel they want to contribute can join a Survivors' Group in awareness raising and preventative work with our agency

- Allowing a grieving person the space to talk about their feelings and realise that they are normal responses to loss. This is done in a secure atmosphere and in a confidential setting eradicating the need for anti depressants as well as self medication (painkillers, alcohol and drugs). Cruse bereavement support is cheaper and healthier for patients and the NHS and is personal
- Support, advice, opportunity to participate in their local community. Access to activities in their local community. Opportunity to be part of self help groups, health promotion activities. Access to advocacy and IMCA services
- As a regional infrastructure organisation the benefit to service users is indirect but without support and networking, advice, training and development there are risks that the VCS will struggle to maintain its historic contribution to everyday lives of the people who depend on it for their care and support. This includes access to social inclusion and help to connect to mainstream community activities such as education, meaningful occupation, social interaction, housing and benefits advice etc etc. The VCS has a much better track record of connecting people into ordinary everyday life in their communities
- The use of a purpose-built facility, with experienced qualified staff, and the ability to work alongside other people with similar needs
- Empowerment, peer support, a say in how services and the system works. Mutual understanding, Community. A chance to combat prejudice and stigma
- Providing a supported and learning service in Newcastle for adults experiencing mental health issues which enables them to access volunteering and supports them to deliver their volunteering roles effectively. Participating in the project helps them to overcome isolation as well as improving their confidence and well being. People with mental health issues have historically been excluded from community, work and social opportunities. The existing Positive Choices project provides specialist advice, guidance and support which empowers people who are users of mental health services to gain independence and support through volunteering
- The provision of British Sign Language/ English Interpreting is a legal and also a moral requirement so the provision of such services is essential. Communication and understanding is a basic human need. However 99.9% of GPs, Doctors, Nurses and Health Care Professionals are not Deaf Aware, unable to converse in British Sign Language and therefore such services are needed and we bridge that gap but the unique aspect of our service is that it's delivered by the community itself
- Talking therapy rather than medication for those with mild to moderate conditions - returning to work (or retaining it) is often the final therapy in recovering from mental illness
- Our services are focused on providing interventions that support meaningful outcomes in people's lives. Such person-centred and recovery-focused services can be utilised by GPs as an alternative to traditional statutory services or as an additional complementary part of a care package that will help people live more valued lives within their communities
- A holistic approach, which means they are able to access a range of support, social opportunities and improved income.

3 Do you currently receive funding from a local PCT?

	Number of respondents	% of respondents
Yes	25	80.6
No	6	19.4
Not answered	0	0
Total	31	100

4 What is this funding for?

- Core contribution towards running costs and staff salaries eg counsellors, coordinator/fundraiser
- Core work, but there is not enough funding to cover all we do
- Core costs, providing a service. Only limited funding provided, which has been cut
- A small contribution towards an Eye Clinic Liaison Officer working in Newcastle RVI Eye Department, to provide information, advice and guidance to patients newly diagnosed with permanent or a debilitating sight loss
- Producing information for the voluntary sector about NHS and social care issues, changes and policies
- We have 2 Pathway coordinators, one from health and one from social care, in each of the areas we work with including Newcastle. They jointly pay a nominal sum which currently equates to 26.5% per day of the operating cost for the service
- To support the work that we do with families and children, and with the general community.
- Bereavement Counselling with Children and Young People in North of Tyne Counselling for C&YP affected by Sexual Abuse Northumberland contract
- Family Support Service for children from birth to 12 years old and their parents/carers, delivering into the West of the City
- Work with young people aged 16-25, to prevent homelessness and improve health outcomes
- Mainly salaries and premises costs
- The funding is to support the CASH drop in provision and provide our own sexual health drop in service. We have targets within the service level agreement that cover the number of Chlamydia tests and c card inductions. We also have to deliver 11 training days over the year
- A grant for delivery of our services (a small portion of the overall cost) and specific funding in relation to meeting the needs of BME women and lesbian & bisexual women
- To provide sexual health services, including C-Card, STI screening, nurse drop in, advice drop in, accredited training opportunities for young people, sexual health outreach sessions
- My Health My Say: we are currently jointly commissioned with Skills for People by SHA to deliver a series of creative consultations with patients with learning disabilities across 3 practices in North Tyneside to explore the services they are getting and improvements / developments that can be made. This model uses Josephine as a way of exploring how patients feel about the service they are getting and how we can make it more accessible to people with learning disabilities. We have also delivered Josephine Course Northumberland: a ten week course for women with learning disabilities exploring sex and relationships in partnership with Northumbria Healthcare. Also funded by Northumbria Healthcare is Walking in Their Shoes: Interactive performance and training package for professionals to raise awareness of the issues affecting Asylum Seekers and Refugees and how the issues impact on their mental health. Delivered as part of Theatre PIE programme
- Day Centre Provision for older people with high support needs and disabilities (Belsay Unit)
- Information and advice on disability issues. Assessments in relation to independent living carried out by qualified staff
- Support and information (email, postal, telephone) on services and a one to one consultation to anyone whose life is affected by eating distress/ disorders – men, women, young people, carers. 2. Therapeutic group working the community for women of 18 years upwards (no upper age limit) who have eating distress/ disorders. The aims of groupwork are to reduce isolation, enhance personal understanding of eating behaviours

and contributing factors, to assist any possible improvements in eating behaviour and confidence in life more generally. 3. Talks and training to individuals, groups and agencies in the community to inform and raise awareness of eating distress/disorders, especially with a view to prevention and to early recognition and support to those affected

- Core running costs including administration, office space, counselling rooms, and volunteer expenses
- Health promotion activity, currently have funding from NHS North East to carry out Health Quality Checks
- We have received amounts of NHS funding for core costs, specific projects, programmes and development work. This has been mainly regional funding, but increasingly includes more local sources
- Mental Health Service User involvement
- Provision of BSL/English interpreting services
- Full range of services as outlined in Q1
- co-ordination of community health work with older people

5 Are you currently working with any GP practices in Newcastle?

	Number of respondents	% of respondents
Yes	12	38.7
No	19	61.3
Not answered	0	0
Total	31	100

6 How many practices do you work with?

	Number of respondents	% of respondents
One	1	8.33
Two	1	8.33
Three	0	0
More than three	10	83.33
Not answered	0	0
Total	12	100

7 What work are you doing for each practice you work with, and who funds it?

- We have made contact with the Bridges Consortium to ask if they would fund health quality checks carried out by people with a learning disability.
Funded by: This was part of a project supported by NHS North East
- They refer patients to us for exercise referrals and we allow them reduced prices and priority (for two practices)
Funded by: Nobody
- Provision of BSL/English interpreting (for more than three practices)
Funded by: The PCT
- All services (for more than three practices)
Funded by: The PCT
- We take referrals for counselling and provide information and training (for more than three practices)
Funded by: The PCT / Nobody
- We take referrals for counselling (for more than three practices)
Funded by: Mixed funders, including statutory and grants, Northern Rock Foundation etc (we fundraise)

- Counselling (for more than three practices)
Funded by: The PCT
- Family Support Service for children from birth to 12 years old and their parents/carers (for more than three practices)
Funded by: The PCT
- We take referrals for 121 Counselling for young people (for more than three practices)
Funded by: We fundraise
- Receive referrals for mental health 121 sessions for young people. Advise GP's re how to involve young people in their practices (for more than three practices)
Funded by: Comic Relief, Newcastle Fund
- Providing small items of equipment to support independence of an individual Providing lunch club places Advice and information on other providers
Funded by: We fundraise
- Counselling Sessions; Small items of equipment provided to individuals; Advice and information on other providers
Funded by: We fundraise
- Small items of equipment provided Aromatherapy massage Advice and information on other providers
Funded by: We fundraise
- Range of support for people with eating disorders – as described in Question 1 (for more than three practices)
Funded by: The PCT

Have you ever approached a GP with a view to providing a service?

	Number of respondents	% of respondents
Yes	13	42.0
No	17	54.8
Not answered	1	3.2
Total	31	100

What happened?

- We are working to pull together an application to set up a dedicated Children's GP practice in WEYES.
- Sadly GPs do not have the time to meet with everyone and when they do there is too much information which they are asked to view. It was our experience that the practice we personally met with were very keen to use our services, we know that our information in on the intranet in some GP centres, but believe that their time constraints make it difficult to search the system and as a result, they probably choose 'services' they are familiar with. Our 'Breakfast Meeting' through CAOHS was most informative for all parties, but again there is not enough time for the GPs to deal with all that is on offer, it is difficult to arrange meetings to discuss our role and what it has to offer, this is simply an unfortunate situation which needs to be addressed if we are to work together
- We discussed funding for Health Quality Checks. currently we have not been fortunate to gain support.
- Nothing. Our letters went unanswered.
- They didn't get back to me
- Promoted Pregnancy Decision Making service and broader teenage Pregnancy Support Team - resulting in slight increase in referrals from GPs
- The idea of GPs referring patients to EEH cooking skills courses was well received. We hope to establish a relationship with a local GP practice in the near future.

- We do get lots of referrals from GP practices (so in that sense perhaps you could say we are working with practices) and we do contact GP's when we have concerns about the self harm or suicide risk levels of women we support.
- We contacted a GP practice in Northumberland (Tynedale) to explore the possibility of delivering a series of Josephine workshops at the practice, but they did not get back to us
- We have had an early dialogue with Saville Row Medical Practice and have been actively involved in the Joining the Dots project around prevention work with frail older people to see preventative systems develop with referral pathways including GPs.
- Not answered x 2

Do you receive payment from a GP practice or Commissioning Group for any referrals that have resulted from this contact?

	Number of respondents	% of respondents
Yes	0	0.0
No	6	46.2
Not applicable	7	53.8
Total	13	100

Has a GP practice ever approached you with a view to providing a service?

	Number of respondents	% of respondents
Yes	11	35.5
No	19	61.3
Not answered	1	3.2
Total	31	100

What happened?

- Usually we can offer a service or helpline, but sometimes our waiting list is full. We are a charity.
- Newcastle Family Support Service established, in 1997
- GP practice has asked us to provide a Counselling service in their surgery. We also spoke about developing this into a full young persons drop in. However, they had no funding available and we would have been struggling with the staff resource to take someone out of the project without replacing them
- We were able to provide the service they requested as we were already offering the service. We have not been approached to provide or design a new service but would be most willing to consider this – we have been able to direct enquiries to a more suitable organisation and continue to do so if this is the best response we can offer
- A Practice Manager approached us many years ago but though we were interested nothing further resulted from the GP practice side of things
- Still in negotiations but it's all dependent on funding!
- Referrals have been made by GPs to our service
- We provided their patient with a low cost refurbished and guaranteed bike
- We tell them about the services we offer and then we receive referrals of women in need
- Re: My Health My Say. We are currently working with Dr. Clare Scarlett GP at Spring Terrace Medical Practice, North Shields on the delivery of My Health My Say, and we are going to be engaging with two other North Tyneside practices by end of March to complete our consultation process. Clare has been working with us to assess the value of the My Health My Say model for practices and with particular interest in assessing the value for practices in terms of gathering qualitative data from patients about the services

they are getting. A number of GPs have attended our Eating Disorders Training delivered by Theatre PIE

- We occasionally receive referrals of individual clients from GP practices for our various services

Do you receive payment from a GP practice or Commissioning Group for any referrals that have resulted from this contact?

	Number of respondents	% of respondents
Yes	1	9.0
No	5	45.5
Not applicable	5	45.5
Total	11	100

We asked Newcastle GPs what they would need from Voluntary Sector organisations to help them commission services in the future. We have listed their preferences below. Could your organisation provide any of these? (please tick an answer for each option)

	No. of Yes responses	% of Yes responses	% of respondents*
A clear pricing structure for services	26	27.4	89.7
A quality standard/accreditation or National Commissioning Board approval	21	22.1	72.4
Outcome-related statistics	26	27.4	89.7
A demonstration of economic value	22	23.1	75.8
Total	95	100	

*Number of respondents answering this question - 29

How else would you demonstrate the benefits of your service to a potential customer?

- Feedback from evaluations of previous clients. Annual reports.
- We have added benefit as part of Barnardos
- Robust in-house systems for evidencing outcomes; Case Studies; Testimonials from other commissioners (Newcastle City Council)
- We are able to show a long history of both providing service and responding to changing needs in developing new aspects of our service. Our biggest strength is our skill in working effectively with young people. We know we do this well because of the number of young people who return to us, the number of young people who recommend friends and the comments they make on the evaluation sheets. We already provide monitoring information to a range of funders where we demonstrate the impact we make on the lives of individuals
- Case studies, added value, engagement with 'hard to reach' patients, preventative costs.
- This would be dependent on the service, but in general terms, we have been established for nearly twenty years and have developed our monitoring systems to record all of the quantity data which is normally a pre requisite – additionally – we are able to provide historical data and case studies (confidentially produced)
- Anonymous case studies, service user views / personal accounts
- We are a user led organisation who can provide quality checks and other support to GPs so as they can ensure that people with a learning disability are getting equal access to their services and a good quality of care. These are important factors to reducing health inequalities.

- Testimonials from current and previous users, and comments from their GPs
- This depends on what the commissioning is for - actual direct frontline services such as interpreting, or training.
- It is important that we capture narrative testimonies of service users
- Through additional money brought in eg each £1 from local GP enables £xx pounds to be brought into the service and thereby stabilising the service and ensuring efficiency. Feedback from current and ex users. Feedback from existing funders about reasons for funding the service
- We are awaiting the results of an independent evaluation of our service which will be available for potential customers to demonstrate the benefits of our service. This was initially started as a SROI evaluation, however the SROI model cannot be successfully applied to our service model.
- We use case studies/real life examples which demonstrate the customer journey and the interventions that were required to support the individual to reach their goals.
- The value of the sector in prevention terms
- Explain results from research into the benefits and goals that can be reached through cycling
- We monitor and evaluate all of our work internally, and get the views of users. We count how many people who attend and what they do. We produce case studies to demonstrate in a qualitative way the outcomes of the work. Some of the work we do is evaluated externally.
- Service user feedback and other agency feedback
- Evaluation/research studies with academic partners of services. - Case studies with existing service users
- I would like to give a comment in relation to the above - we could give a clear pricing structure after a time (we would need time to put it together as we have never sold our services in this way before). All other priorities we could meet as a matter of course. We would demonstrate the benefits by using feedback from our service users and referrers on the benefits they have experienced e.g. increased confidence, reduced anxiety, reduced isolation etc.
- Endorsements from commissioners, partners and funding partners on the quality and standard of our work. Endorsements from service users and beneficiaries
- Illustrating the solutions lie with social rather than medical interventions and the value of people being active in both their own wellbeing and the contribution they make to their local communities and improved outcomes as a result of this involvement.
- Service user evaluations
- Evaluation from clients. outcomes for clients in terms of reduction in number of GP visits. reduction in medication
- Not answered x 3

What do you think commissioners could do to make it easier for VCS providers to 'sell' their services to GPs and other NHS commissioners?

- Have clear guidelines and just be willing to pay for the specialist service. We have very limited resources.
- It would be helpful to us if there was away of sending our information electronically to a central place that would then reach all GP's
- Named contacts Clarity re. what services are required Information from needs analysis
- Maintain a good understanding of the diversity of the sector. Understand our need for longer term sustainable funding that includes our additional costs
- Be aware of what VCS services are available. Ensure they value the VCS as credible and professional providers of services, support the CVS as a 'broker' 'filter' for commissioners to reach the VCS.

- Commissioners place a great deal of 'red tape' in the provider's path. The time and effort spent on the service provision and management valuable and unless an organisation is large enough to have a dedicated commissioning person/team it is normally an extremely time consuming process. Although we all agree, certain criteria must be met when commissioning, the documentation we are asked to produce is often practically duplicated: e.g. a solution may be to agree that if a VCS is providing services to for instance, Council, then their 'credentials' would have been scrutinised already, this could be a sign of confidence in the provider? and vice versa
- Initially to offer an opportunity to bid for small one off pieces of work with particular communities or patient issues, so that we can build a relationship with the GPs/commissioners and demonstrate our effectiveness. If we are already funded by the PCTs, offer a chance to present our work to them.
- Be open and listen to what they can offer, through workshops
- Provide a database of accredited suppliers, and provide details to organisations of what is required of them
- The problem with current contracts is that they are being awarded to large corporate companies who can offer a one stop shop for all services but this is reflected in the price. These companies go back to local organisations and sub contract them. This becomes pricey and also there is no local knowledge or skills base. It becomes very impersonal. Perhaps there need to be more local networking and partnerships? Perhaps a transparent scoring system backed up by evidence from local communities?
- Although improving, the process and format are still biased towards existing statutory provision. Commissioners, in partnership with the sector, should develop a more 'solution focused' approach to addressing health needs, i.e. focussing on what outcomes we want to achieve rather than what services are on offer. This will encourage innovation and help the VCS demonstrate how they can be part of the solution.
- Compile a list of specialist local services and issues covered (perhaps we could supply 2-3 paragraphs along with our history/expertise/approach/achievements).
- Provide concise knowledge of the commissioning process and opportunities for commissioning. The NEPO portal used by the LA's provides a useful and clear model for procurement, could a similar system be utilised for GP commissioning.
- More engagement opportunities - it is impossible to sell anything to a closed door.
- Develop an understanding and interest on what the voluntary and community sector is and what it can offer
- Not sure
- Recently, PCT commissioners seem to be working more closely with us. They have written a service specification, and discussed ways to make our service more effective, and how we can work more collaboratively with them.
- Clear commissioning criteria; clear and transparent process; workshops to explain how, what, when. Provide opportunities for VCS providers to meet GPs/commissioners. Highlight the quality of services provided by the VCS. Help the VCS sector demonstrate the impact of their services
- Help us by sharing their expectations with us on how to benchmark our prices as this is a whole new area for us.
- Be the broker: get people in the room at the same time Have a mechanism for a 'central call out' for services needed: this could be a regular e-bulletin for example
- Ongoing dialogue and discussion and working together to co-design and develop preventative solutions with a strong evidence base. Opportunities to broker conversations and potential relationships to enable both sides to understand the other's priorities and what they have to offer.
- Have information 'open days' for the VCS to promote their services. Manage the transition between PCT and clinical commissioning groups effectively.
- Common language to discuss benefits and outcomes. Recognition of need for support for developing a collective voice, and transparent and effective routes of communication.

Development work that helps GPs understand social care and how the VCS delivers this – improve understanding of social models of disability and core values of the social model etc. Recognition of the value of local providers and community based service delivery over and above national corporations that can offer cheaper rates but ultimately lower user satisfaction

- In previous answers we indicated not working with GPs, but that isn't quite true. We do, but not in a direct, formally contracted manner. This work has been via the intermediary of commissioners, who ought to continue such "brokerage".
- Transparent process and criteria
- Something along the lines of the NEPO portal
- Not answered x 4

What do you think the VCS could do to create stronger relationships with GPs and other NHS commissioners?

- We already have good relationships and our service is constantly used by GPs for their patients
- Maybe meetings with practice managers
- Promotion of breadth of services available in VCS
- Work together to market and promote their services, ensure they are all registered with CAOH and NCVS. Organise ourselves better and support consortia approaches?
- Use and help NCVS to raise awareness of the added value of VCS organisations. Take all opportunities for dialogue with GPs and NHS commissioners and to showcase our work
- Ensure there is a comprehensive list of local services and what they can do to support local health providers. Organise events and workshops
- VCOs need to better evidence what they do, and demonstrate the integral role they can play in relation to health provision, prevention and promotion
- Profile our work. Attend forums/meetings and contribute to discussions/developments. Use local CVS reps. Provide data/information as requested
- The VCS needs to be represented at all levels of the commissioning process to raise the profile of our sector
- The VCS often feel undervalued as a sector and 'hard done by' when it comes to commissioning processes and the resulting monitoring requirements which only give part of the story. Breaking down those barriers and building relationships will only come with sustained effort from both sides - perhaps assigning or buddying GP's/Commissioners to specific groups / organisations for a short term may help to start a dialogue and understanding of not only the organisation and sector but also the patient journey outside of the medical world. I appreciate this may not be practical for every GP/commissioner to undertake but I believe it would be extremely insightful and beneficial to all stakeholders involved. We in the VCS have a vast amount of local and national intelligence that we gather almost daily and that could be better used to inform decision-making processes, enable more joined up working, reduce waste and duplication and ultimately save money
- Clearer information on their benefits
- Sell ourselves more
- We are writing a short paper on what we do and what we want GPs to know
- Links via networks like CAOH or CHYPN - regular and open forum meetings to update on work delivered, commissioning arrangements etc. Provide opportunities for VCS providers to meet GPs/commissioners. Take a more commercial attitude. Get out there and meet the GPs/commissioners and tell them why they should be working together
- Give them what they are asking for e.g. a clear pricing structure, inform them about our Quality Assurance etc

- A central point where we can share what we do: could this be the same 'central call out' mechanism for commissioners to identify the services they need?
- Make sure communication is open and transparent. Keep up to date with changes, timetables, requirements and contacts
- Greater contact and better information of our service and knowledge of its effects
- Be more collaborative, adopt a non-proprietary approach thus reducing damaging competition and duplication
- Quarterly forum, info sharing etc
- Awareness-raising sessions around the services that are currently available, especially online. Ideally we should aim to provide a 'Google' search service for GPs and other commissioners
- Not answered x 9

