

19 January 2017

Mark Dornan
Chair, Newcastle Gateshead CCG

Dear Mark

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

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

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

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

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

It isn't clear how real the funding gap is and in the documentation, maybe unsurprisingly, there is no reference to the percentage decrease nationally on health spend of GDP (from 8.8% to 6.6%). Another approach is not just about reducing and changing the service to fit the available

resource, but also to increase the funding. There are discussions to be had about hypothecated taxes and increased taxation; and the UK still has a relatively low amount of taxation for such a developed country; as compared to other European countries.

There is also something about the national narrative of the 'failing NHS' and the 'out of date 1940s' model, when the boundaries between health and social care have shifted again, and people are expected to be discharged out of hospital back home where once they would have been sent to a convalescent hospital or long stay units such as the old Walkergate wards, Ponteland, Wylam and Lemington 'hospitals. The use of intermediate care and support is clearly vital to prevent unnecessary admissions and inappropriate discharges. One local power could be the use of health money for social care, as both Gateshead and Newcastle Councils have suffered significant loss of funding since 2010.

This is clearly a top down process and it isn't clear how much latitude and power exists at the local level. The process seems to be dictated by the centre. There is minimal reference in the documentation to the external funding environment, the impact of welfare reforms, the gross underfunding of the public sector and what happens to the STP area in 2020 when central government support through the Revenue Support Grant to local authorities comes to an end.

There are key problems with the NHS infrastructure - IT systems that don't talk to each other, workforce problems that will worsen under Brexit and tougher regulations on immigration, and the poor use of estate. These are clearly areas that need to be overtly tackled. It isn't clear how this fits in with the different organisational structures and their governance. The STP can only work if systems and budgets are shared, this goes against the culture and process of how many parts of the system work - e.g. Foundation Trusts, the independent contractor status of GPs.

We welcome the emphasis on prevention, but clearly the majority of prevention work happens outside the NHS, within communities, with voluntary and community groups, and through local authorities. The document still appears to define prevention through formal public health terms and priorities and future consultations needs to look more laterally at this.

How can integration with social care happen given the level of cuts of funding for local authorities; which are many times worse than reductions in NHS funding? The figures quoted just look at social care and not the other elements e.g. Housing provision, that also impact on health and wellbeing.

How is 'best care' defined; is it realistic to promote best care in terms of dwindling resources? There needs to be active involvement with local people and communities about realistic expectations and what is 'best' and what is 'good enough'.

There is not enough in the document about inequalities and the impact this has on health and wellbeing. Given the increasing population, the increased percentage of people with complex needs, in an environment of reduced resources, it is highly likely that inequalities both within and across communities will increase. This means greater demands on resources at a time of reduced capacity.

How does the CCG set up the conditions in advance to transform services to support people if there are no resources for double-running / bridging costs? How does transformation take place when existing services still have to deliver to national targets and time frames? Could additional freedoms be requested under the STP process?

Mental health provision came up through discussions. There were still a lot of questions about the impact of the Deciding Together consultation, and the concerns that if this (relatively small) part of the service couldn't be changed, how could other parts be shifted?

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

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

The engagement process

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

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

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

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

Clearly there is a disconnect between what is currently happening on the ground - e.g. Closures of Walk In Centres in the STP patch and the increases in the number of people presenting at A&E department.

How will the Voluntary and Community Sector representatives for the Reference Group be decided?

Summary

We recognise this is an iterative process and would request that Newcastle CVS and our members are involved more actively in future processes so we can all improve health and

wellbeing in Newcastle and Gateshead. The voluntary and community sector needs to be involved as a partner, advisor and integral to the process, and not an afterthought.

Yours sincerely

A handwritten signature in cursive script that reads "Sally Young".

Sally Young
Chief Executive

Cc Guy Pilkington, Mark Adams, Hillary Bellwood, Jane Mulholland