Notice of a public meeting of
Health and Wellbeing Board

To: Councillors Runciman (Chair), Brooks, Cannon and Craghill

Keith Ramsay (Vice Chair)	Lay Chair NHS Vale of York Clinical Commissioning Group
Sharon Stoltz	Director of Public Health, City of York Council
Martin Farran	Director of Adult Social Care, City of York Council
Jon Stonehouse	Director of Children's Services, Education and Skills, City of York Council
Tim Madgwick	Acting Chief Constable, North Yorkshire Police
Sarah Armstrong	Chief Executive York CVS
Siân Balsom	Manager, Healthwatch York
Julie Warren	Locality Director (North) NHS England
Colin Martin	Chief Executive, Tees, Esk and Wear Valleys NHS Foundation Trust
Patrick Crowley	Chief Executive, York Teaching Hospital NHS Foundation Trust
Rachel Potts	Chief Operating Officer, NHS Vale of York Clinical Commissioning Group (CCG)
Mike Padgham	Chair of Independent Care Group

Date: Wednesday, 7 September 2016

Time: 4.30 pm
Venue: The Snow Room - Ground Floor, West Offices (G035)

A G E N D A

1. Declarations of Interest (Pages 3 - 4)
At this point in the meeting, Board Members are asked to declare:

- any personal interests not included on the Register of Interests
- any prejudicial interests or
- any disclosable pecuniary interests

which they may have in respect of business on this agenda. A list of general personal interests previously declared is attached.

2. Minutes (Pages 5 - 16)
To approve and sign the minutes of the last meeting of the Health and Wellbeing Board held on 20 July 2016.

3. Public Participation
It is at this point in the meeting that members of the public who have registered their wish to speak can do so. The deadline for registering is **Tuesday 6 September 2016** at **5.00 pm**

To register please contact the Democracy Officer for the meeting, on the details at the foot of this agenda.

Filming, Recording or Webcasting Meetings
Please note this meeting will be filmed and webcast and that includes any registered public speakers, who have given their permission. This broadcast can be viewed at http://www.york.gov.uk/webcasts.

Residents are welcome to photograph, film or record Councillors and Officers at all meetings open to the press and public. This includes the use of social media reporting, i.e. tweeting. Anyone wishing to film, record or take photos at any public meeting should contact the Democracy Officer (whose contact details are at the foot of this agenda) in advance of the meeting.

The Council's protocol on Webcasting, Filming & Recording of Meetings ensures that these practices are carried out in a manner both respectful to the conduct of the meeting and all those present. It can be viewed at: http://www.york.gov.uk/download/downloads/id/11406/protocol_for_webcasting_filming_and_recording_of_council_meetings_20160809.pdf

Governance

4. Appointments to York's Health and Wellbeing Board (Pages 17 - 20)
This report asks the Board to confirm two appointments to its membership.

Themed Meeting- Mental Health

5. Rehabilitation and Recovery, Adult Mental Health Service Developments in York and Selby (Pages 21 - 44)
This report updates the Health and Wellbeing Board on the progress to date around Rehabilitation and Recovery, adult mental health service developments in York and Selby.

6. Mental Health Inpatient Facilities for York (Pages 45 - 52)
This report updates the Health and Wellbeing Board around the current position for mental health facilities in York.

Core Business

7. Update on the work of the Joint Strategic Needs Assessment/Joint Health and Wellbeing Strategy Steering Group (Pages 53 - 118)
This report provides the Board with an update on the work that has been undertaken by the Joint Strategic Needs Assessment/Joint Health and Wellbeing Strategy Steering Group ('the Steering Group') since it was first established in late 2015.

8. Update from the Integration and Transformation Board (Pages 119 - 124)
This report summarises discussions that have taken place at the Integration and Transformation Board.

9. **Alcohol Strategy Consultation Response**(Pages 125 - 142)
The purpose of this report is to present the findings of the public consultation on the draft Alcohol Strategy for York 2016-2021.

10. **Verbal Update on Sustainability and Transformation Plans**
The Board will receive a verbal update on Sustainability and Transformation Plans in the NHS in the Vale of York area.

11. **Forward Plan** (Pages 143 - 144)
To consider the Board's Forward Plan.

12. **Urgent Business**
Any other business which the Chair considers urgent under the Local Government Act 1972.

Democracy Officer:
Name- Judith Betts
Telephone No. – 01904 551078
E-mail- judith.betts@york.gov.uk

For more information about any of the following please contact the Democracy Officer responsible for servicing this meeting:

- Registering to speak
- Business of the meeting
- Any special arrangements
- Copies of reports and
- For receiving reports in other formats

Contact details are set out above.

This information can be provided in your own language.

我們也用您們的語言提供這個信息 **(Cantonese)**

এই তথ্য আপনার নিজের ভাষায় দেয়া যেতে পারে। **(Bengali)**

Ta informacja może być dostarczona w twoim własnym języku. **(Polish)**

Bu bilgiyi kendi dilinizde almanız mümkündür. **(Turkish)**

یہ معلومات آپ کی اپنی زبان (بولی) میں بھی مہیا کی جاسکتی ہیں۔ **(Urdu)**

☎ **(01904) 551550**

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Agenda Annex

Extract from the
Terms of Reference of the Health and Wellbeing Board

Remit

York Health and Wellbeing Board will:

- Provide joint leadership across the city to create a more effective and efficient health and wellbeing system through integrated working and joint commissioning;
- Take responsibility for the quality of all commissioning arrangements;
- Work effectively with and through partnership bodies, with clear lines of accountability and communication;
- Share expertise and intelligence and use this synergy to provide creative solutions to complex issues;
- Agree the strategic health and wellbeing priorities for the city, as a Board and with NHS Vale of York Clinical Commissioning Group, respecting the fact that this Group covers a wider geographic area;
- Collaborate as appropriate with the Health and Wellbeing Boards for North Yorkshire and the East Riding;
- Make a positive difference, improving the outcomes for all our communities and those who use our services.

York Health and Wellbeing Board will not:

- Manage work programmes or oversee specific pieces of work – acknowledging that operational management needs to be given the freedom to manage.
- Be focused on the delivery of specific health and wellbeing services – the Board will concentrate on the “big picture”.
- Scrutinise the detailed performance of services or working groups – respecting the distinct role of the Health and Adult Social Care Policy and Scrutiny Committee.
- Take responsibility for the outputs and outcomes of specific services – these are best monitored at the level of the specific organisations responsible for them.
- Be the main vehicle for patient voice – this will be the responsibility of Health Watch. The Board will however regularly listen to and respect the views of residents, both individuals and communities.

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Health & Wellbeing Board
Declarations of Interest

Patrick Crowley, Chief Executive of York Hospital
None to declare

Rachel Potts, Chief Operating Officer, Vale of York Clinical Commissioning Group
None to declare

Mike Padgham, Chair Council of Independent Care Group

- Managing Director of St Cecilia's Care Services Ltd.
- Chair of Independent Care Group
- Chair of United Kingdom Home Care Association
- Commercial Director of Spirit Care Ltd.
- Director of Care Comm LLP

Siân Balsom, Manager Healthwatch York

- Chair of Scarborough and Ryedale Carer's Resource
- Shareholder in the Golden Ball Community Co-operative Pub

Councillor Douglas

- Member of Mental Health and Learning Disabilities Partnership Board
- Governor of Leeds and York Partnership NHS Foundation Trust
- Governor of Tees, Esk and Wear Valleys NHS Foundation Trust

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City of York Council	Committee Minutes
Meeting	Health and Wellbeing Board
Date	20 July 2016
Present	Councillors Runciman (Chair), Brooks, Funnell (Substitute for Councillor Cannon) Sharon Stoltz (Director of Public Health, City of York Council) Martin Farran (Director of Adult Social Care, City of York Council) Jon Stonehouse (Director of Children's Services, Education and Skills, City of York Council) Helen Hirst, Interim Accountable Officer, NHS Vale of York Clinical Commissioning Group (Substitute for Rachel Potts) Sarah Armstrong (Chief Executive, York CVS) Patrick Crowley (Chief Executive, York Teaching NHS Foundation Trust), Mike Padgham (Chair of Independent Care Group), Julie Warren (Locality Director (North) NHS England), Siân Balsom (Manager, Healthwatch York), Richard Anderson (Superintendent, North Yorkshire Police) (Substitute for Tim Madgwick) Brian Coupe (Head of Service, Mental Health Services for Older People, Tees, Esk and Wear Valleys NHS Foundation (York and Selby) (Substitute for Colin Martin)

Apologies	Councillors Cannon and Craghill, Rachel Potts, Tim Madgwick, Colin Martin

Part A- Matters Dealt with under Delegated Powers

1. Declarations of Interest

Board Members were invited to declare any personal, prejudicial or disclosable pecuniary interests, other than their standing interests, that they had in relation to the business on the agenda.

Councillor Funnell declared a personal interest in the remit of the Board as a Board Member of Be Independent, a social enterprise which provided equipment and a telecare response service to support people to live independently in their own homes.

No other interests were declared.

2. Minutes

Resolved: That the minutes of the Health and Wellbeing Board held on 18 May 2016 be approved as a correct record and then signed by the Chair.

3. Public Participation

It was reported that there had been one registration to speak at the meeting under the Council's Public Participation Scheme. Sally Hutchinson from York VCS Forum wished to share her thoughts in regards to the absence of a substructure under the Board for older people and people with long term conditions.

The Chair suggested that the Public Participation slot was not an appropriate point at which to discuss this topic and suggested that the speaker be invited back to a future Board meeting.

4. Appointments to York's Health and Wellbeing Board

The Board received a report which asked them to confirm the appointment of a Vice Chair to the Board and a number of substitutes.

Resolved:

That;

- Keith Ramsay, lay Chair of NHS Vale of York Clinical Commissioning Group be appointed as both a Board Member and Vice Chair.
- Sheenagh Powell, Lay Member and Audit Committee Chair of NHS Vale of York Clinical Commissioning Group (CCG) be appointed as a first substitute for Keith Ramsay
- David Booker, Lay Member and Chair of the Quality and Finance Committee of NHS Vale of York Clinical Commissioning Group as a second substitute for Keith Ramsay
- Brian Coupe, Head of Service, Mental Health Services for Older People (York and Selby), Tees, Esk and Wear Valleys (TEWV) NHS Foundation Trust be appointed as a second substitute for Colin Martin,Chief Executive, Tees, Esk and Wear Valleys, NHS Foundation Trust.

Reason: In order to make these appointments to the Board.

5. Presentation from the Independent Care Group- Social Care in 2016

Consideration was given to a report and presentation from the Chair of the Independent Care Group about Social Care.

They were told that;

- Recruitment and retention remained a major issue in the independent care sector.
- The independent care sector employed more staff than the NHS, however there needed to be additional higher quality staff and with this came the need for higher wages.
- The independent care sector did not feel engaged with the Better Care Fund.

- As the Care Quality Commission were not looking at small independent care providers, the sector felt that another instance of a social care provider failure might occur.
- The independent care sector felt that they had not been able to influence the Local Enterprise Partnership (LEP).

The Chair commented that the economic gain brought by the independent care sector needed to be made more visible. She added that she would raise the concerns identified by the Independent Care Group at the next meeting of the Education and Skills LEP Board of which she was a member.

Resolved: That the report and presentation be received and noted.

Reason: To keep members of the Board up to date regarding the Independent Care Sector.

6. Older People's Survey

Board Members received a report which asked them whether they wanted to revise and repeat an Older People's Survey which was last held in 2008.

The Director of Adult Social Care introduced the report to the Board, and informed them that the key question of the survey would be what would keep older people out of the health care system.

Board Members made the following comments;

- Effort should be made to survey people where they felt comfortable and could talk easily, such as community centres and lunch clubs.
- The survey needed to be owned by the Health and Wellbeing Board and a commitment made to use the information that arose from the survey
- All agencies around the Health and Wellbeing Board table were invited to help shape the questions
- A peer approach to the survey was important
- Were we being ambitious enough about the number of people we were intending to survey? Mention was made of the Acute Trust's membership being included

It was suggested that a small group be formed to support the survey.

The following Options were considered by the Board:

Option 1 – support a refreshed survey taking place and indicate the timescale in which they would like this to happen

Option 2 – request that no further action be taken in relation to a survey of older people for the time being

Resolved: (i) That Option 1 be supported and a refreshed Older People's Survey take place.

(ii) That a small group be formed to carry out the survey.

Reason: To ensure that the needs of the older population are fully understood when re-commissioning services.

7. Update on Service Delivery for Dementia Care in York and Selby

Board Members received an update report from the Head of Service for Mental Health Services for Older People from Tees, Esk and Wear Valleys NHS Foundation Trust on service delivery for Dementia/Cognitive Impairment in York.

It was noted that;

- The refurbishment of Peppermill Court was now complete and the unit would be reopening at the end of August.
- Tees, Esk and Wear Valleys NHS Foundation Trust had developing relationships with care homes to reduce Delayed Transfers of Care.
- The Trust were also working with voluntary services.

Board Members raised the following points;

- There were currently low levels of dementia diagnosis in the Vale of York compared to other areas. The Board

questioned whether the system would cope if diagnosis levels increased.

- Whilst dementia was not an inevitable consequence of ageing; prevention against dementia was key to ageing well.

- Dementia needed to be borne in mind in the refresh of the Joint Health and Wellbeing Strategy. It also needed to be focused on across the Sustainability Transformation Plan (STP).

- People with dementia appreciated being told their diagnosis, as this allowed them to put things into perspective.

Resolved: That the report be received and noted.

Reason: To keep the Board up to date in relation to mental health services for older people.

8. Annual Report-Safeguarding Adults Board

The Board received the 2015/16 Annual Report of the City of York Safeguarding Adults Board.

The Independent Chair of the City of York Safeguarding Adults Board presented the report and informed the Board that;

- The Care Act did not distinguish between someone reporting a safeguarding concern to the council and a full formal investigation.
- Elderly people were most at risk from abuse in their own homes.
- A Suicide Prevention Coordinator had been recruited following a Lessons Learned Review into an adult suicide. Their report would be received by the City of York Safeguarding Adults Board.
- The City of York Safeguarding Adults Board wanted to work with the voluntary sector in the city, particularly in regards to publicising how people could keep themselves safe from harm.

It was reported that a draft protocol was being drawn up between the City of York Safeguarding Adults Board and the City of York Children's Safeguarding Board given that the safeguarding issues encountered by both groups overlapped.

The Board were informed that the City of York Safeguarding Adults Board had a three year strategic plan and an annual action plan of improvement.

Resolved: That the City of York Safeguarding Adults Board Annual Report be noted.

Reason: To keep the Board appraised of the work of the City of York Safeguarding Adults Board.

9. Monitoring and Managing Performance

Board Members received a report which set out some suggestions to strengthen performance management to improve outcomes and the effectiveness of the health and social care system.

Questions about the report included how would the performance management framework would be implemented and how could the data be understood if there was a lack of solid intelligence. Concerns were also raised about oversight in the proposals and the current governance structure.

Officers thanked Board Members for their comments and confirmed that they would bring further information to a future Board development session. The aim was to begin the next financial year with a new performance management framework.

Resolved: That the report and work to date be noted.

Reason: To start the conversation about strengthening the performance management framework for the Health and Wellbeing Board.

10. Sustainability and Transformation Plans

Board Members received a report which updated them on the latest arrangements for the development of Sustainability and Transformation Plans (STP) in the NHS for the Vale of York area.

In regards to the plans for the Vale of York area, the Board were informed that full plans would be submitted to NHS England in September 2016.

An update on finances was provided and it was reported that there would be a £20-30m deficit over the STP area during the current year.

It was reported that the STP was a planning tool and had as its aim to return providers to financial sustainability. However, it was noted that as it was driven nationally it might not be what the community wanted and was therefore challenging.

Concerns were raised by Board Members about what the STP would do for the Health and Wellbeing Board. It was also felt that there had been little time for public engagement over the plans. As a result some Board Members suggested the word 'co-production' to be removed from documents.

Resolved: That the report be noted.

Reason: To keep Health and Wellbeing Board apprised of progress against the development of STPs.

11. Healthwatch York Report- Access to GP Services

The Board received a new Healthwatch York report entitled 'Access to GP Services'. The Board thanked Healthwatch York for the report.

Resolved: That the report be referred to the Joint Strategic Needs Assessment /Joint Health and Wellbeing Board Strategy Steering Group to be discussed further.

Reason: To keep members of the Board up to date regarding the work of Healthwatch York.

12. Progress in York with implementation of the Care Act 2014

Board Members received a report which updated them on York's implementation of the Care Act 2014.

The Director of Adult Social Care introduced the report. He informed Board Members that he would circulate Stocktake 6 via email, which was the final national review of progress towards implementation of the Care Act 2014.

It was noted that there still remained no national guidance around finance.

It was suggested that a report on universal information and advice be brought to a future meeting of the Board.

Resolved: (i) That the future monitoring of progress through the performance management arrangements across the health and social care system be agreed.

(ii) That a further report at the point that Phase 2 is confirmed to be implemented, highlighting the potential impact be received.

(iii) A report on universal information and advice be brought to a future meeting of the Health and Wellbeing Board

Reason: (i) To ensure the Act is considered a fundamental part of our system's approach to care in both detail and spirit of the Act.

(ii) To allow the Health and Wellbeing Board to understand the impact of Phase 2 across the health and social care system.

13. Better Care Fund Submission 2016/17

Board Members received an update report on progress to finalise a submission for the Better Care Fund in 2016/17 and beyond.

They were informed that;

- There was now a balanced plan that met NHS England's requirements.
- In order to meet the requirements, systems resilience schemes had not been included.
- The challenge of integration remained as did the creation of a financially sustainable base.
- There was a need for a risk management plan.
- The Integration and Transformation Board (ITB) would take on ownership and oversight of the BCF. They would regularly report to the HWBB and minutes from their meetings would be shared amongst Board Members.
- However, the ITB needed strong resources and a strong link with the Provider Alliance.

The draft narrative submission and details of the current financial position (which included spend on the various schemes included within the BCF) were circulated amongst Board Members.

A question was asked about what the BCF would mean for residents and how they would be able to tell it was making a difference. A response was given that indicated that risk analyses had taken place that showed that taking away schemes within the BCF would have an impact on the whole system. There was a need to inform the public that their behaviours could have an impact on the system as a whole and self management and self care would lessen the impact on the system and allow them to retain independence.

The Chair thanked all those who had been involved in the work and negotiations around the Better Care Fund.

Resolved: (i) That the intensive drive to deliver a balanced plan be noted.

(ii) That subject to agreement reached between senior managers from the Council and the Clinical Commissioning Group ahead of the meeting, the draft spending plan for submission to NHS England on 29 July 2016 be agreed.

(iii) That joint delegated authority be provided for the Chair of HWBB and Chair of the CCG Governing Body to authorise any final alterations to the narrative part of the submission, after receiving comments from members of the Board.

(iv) That the Chief Operating Officer and Director of Adult Social Care report the agreement to their respective executive management teams.

Reason: To keep the HWBB abreast of progress and to seek a decision from the Board in relation to a joint spending plan for 2016/17 and advise of the intention to submit the BCF documentation subject to local authorisation by delegated parties by the required deadline.

14. Forward Plan

Board Members were asked to consider the Board's Forward Plan for 2016/17.

Resolved: That the Forward Plan be approved.

Reason: To ensure that the Board have a planned programme of work in place.

Part B- Matters Referred to Full Council

15. Appointments to York's Health and Wellbeing Board

The Board received a report which asked them to confirm the appointment of a Vice Chair to the Board and;

Recommend: That Keith Ramsay, lay Chair of NHS Vale of York Clinical Commissioning Group be appointed as Vice Chair of the Health and Wellbeing Board.

Reason: In order to make the appointment of a Vice Chair to the Board.

To note that: The Vice Chair of the Health and Wellbeing Board will always be the lay Chair of the NHS Vale of York Clinical Commissioning Group.

Councillor C Runciman, Chair
[The meeting started at 4.30 pm and finished at 7.05 pm].

Health and Wellbeing Board **7 September 2016**

Report of the Assistant Director, Governance and ICT

Appointments to York's Health and Wellbeing Board

Summary

1. This report asks the Board to consider two appointments to its membership.

Background

2. The Council makes appointments at its Annual Meeting, to Committees for the coming year. However, the Health and Wellbeing Board is able to appoint its membership separate of Full Council.

Therefore, the following appointment has been put forward for the Board's endorsement:

- To appoint Fiona Phillips, Assistant Director-Consultant in Public Health, as a substitute for Sharon Stoltz, Director of Public Health, to replace Marion Gibbon, Assistant Director-Consultant in Public Health, with effect from October.

3. The Clinical Commissioning Group is responsible under the 2012 Act for making an appointment to represent it on the Board. The NHS Vale of York Clinical Commissioning Group (CCG) has notified the Council of its appointment of Phil Mettam, Accountable Officer at the CCG to replace Dr Mark Hayes, Chief Clinical Officer, with effect from October. The Board is asked to note that appointment.

Consultation

4. As these are direct replacements to the existing Health and Wellbeing Board membership no consultation has been necessary in respect of these appointments.

Options

5. There are no alternative nominations for these appointments.

Council Plan 2015-19

6. Maintaining an appropriate decision making structure, together with appropriate nominees to that, contribute to the Council delivering its core priorities set out in the current Council Plan, effectively. In particular, these appointments to the Health and Wellbeing Board ensure that partnership working is central to the Council working for the benefit to improve the overall wellbeing of the city.

Implications

7. There are no known implications in relation to the following in terms of dealing with the specific matters before Board Members:

- Financial
- Human Resources (HR)
- Equalities
- Crime and Disorder
- Property
- Other

Legal Implications

8. Statutorily the NHS Vale of York Clinical Commissioning Group (CCG) is responsible for appointing members to represent it on the Board. The Director of Public Health is a Member of the Board by virtue of her office. However, the issue of substitute appointments is a matter for local decision making and the Board has the power to make such appointments as it considers appropriate.

Risk Management

9. In compliance with the Council's risk management strategy, the only risk associated with the recommendations is that the Director of Public Health may not always be represented at meetings.

Recommendations

10. The Health and Wellbeing Board are asked to:

a) endorse the appointment of Fiona Phillips as a substitute member of the Board

b) note the appointment of Phil Mettam as the representative of Vale of York Clinical Commissioning Group

Reason: In order to ensure proper representation on the Health and Wellbeing Board.

Author:	**Chief Officer Responsible for the report:**
Judith Betts Democracy Officer Telephone: 01904 551078	Andy Docherty Assistant Director, Governance and ICT

Report Approved √ **Date** 26 August 2016

Specialist Implications Officers
Not applicable

Wards Affected: **All** ✔

For further information please contact the author of the report

Background Papers
None

Annexes
None

Abbreviations used in the Report

CCG- NHS Vale of York Clinical Commissioning Group
HR- Human Resources
NHS- National Health Service

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Health and Wellbeing Board **7 September 2016**
Report of Director of Operations,
Tees Esk and Wear Valleys NHS Foundation Trust

Rehabilitation and Recovery, Adult Mental Health Service Developments in York and Selby

Summary

1. This paper updates the Health and Wellbeing Board on the progress to date around Rehabilitation and Recovery, adult mental health service developments in York and Selby. Included is an overview of the work of the multi-agency stakeholder steering group and that of the Tees, Esk and Wear Valleys NHS Foundation Trust's (TEWV) project team.

Background

2. The paper outlines the background and context associated with the temporary closure of Acomb Garth, Adult Rehabilitation and Recovery Unit in York and the progress to date following a Quality Improvement event held 29 February -2 March 2016.

3. The decision by the Care Quality Commission (CQC), not to register Bootham Park Hospital for adult in- patient services had a number of consequential impacts on other services across York and Selby. The reinstatement of adult inpatient services at Peppermill Court has been a priority, but there were a number of associated estate impacts.

4. The need to relocate mental health dementia services from Worsley Court to Acomb Garth led to the adult Rehabilitation and Recovery unit at Acomb Garth to be temporarily closed in March 2016. As a result of this closure the majority of patients were supported in the community with those requiring more health based support, transferring to other inpatient provision in Tees Esk and Wear Valleys NHS Foundation Trust.

5. This provided an opportunity to consider the current rehabilitation and recovery services and develop a model which has a clear focus on person-centred recovery and a community based pathway of care. To ensure recovery pathways are person-centered and seamless and people receive treatment in the least restrictive environment, it was acknowledged by the Trust that more work was required to review the service model to meet modern day mental health requirements. Our work plan has been focused on a number of elements to address this.

Main/Key Issues to be considered

6. Work is being undertaken with service users and carers and a wide range of stakeholders to consider service options around rehabilitation and recovery. There are a number of options being considered and further data is being collected to inform the proposals. A number of work streams are exploring good practice and innovative models of support within the rehabilitation and recovery umbrella which includes crisis house/ step down facilities and wider interface with housing support options.

7. This has been an iterative process, working with a range of stakeholders, but with a particular focus on involving service users and carers and applying the Trust's Quality Improvement System (QIS).

8. A half day workshop was held in December 2015, including members of the Rehabilitation and Recovery Stakeholder group, with other representation from health, social care and third sector, to look at current rehabilitation in-patients services. The recommendation was to develop a future model of person centred and recovery focused, multi-agency service, using the TEWV Quality Improvement System, Kaizen 3P (Production Process Preparation) workshop.

9. This event was held on 29th February, 1st and 2nd March 2016 and explored the improvement and development of future Rehabilitation and Recovery services in York & Selby. It provided an opportunity to consider a new vision and model of rehabilitation services and seamless care pathways in York & Selby, encompassing a wide spectrum of partner organisations that support individuals in their community. The 3 days included co-production of 18 service users and carers, and significant input from health, social care and third sector organisations. **Annex 1** provides an over view of the concept developed within a PowerPoint presentation.

10. The key desired outcomes, working in partnership with social care and the third sector are;

    - Improved partnership working to enable recovery in the community for more people
    - To reduce reliance on adult rehabilitation inpatient facilities, particularly for people whose needs could be better met out of a hospital setting
    - To realign our approach to support a community based rehabilitation service
    - To support people in Out of Area treatment placements to return to their home area

11. A multi-agency Stakeholder Steering Group has been established and has focused to date on the following areas;

    A. To develop detailed and costed proposals on how to meet the health support and housing needs of people with mental ill-health and other complex issues such as substance misuse, non-engagement with support or serious risk issues. Project led by Louise Waltham City of York Council (CYC)

12. (This links to the Whole Concept - The Hive and Nest) Annex 1

    Progress to date:

    - Good practice models have been explored and reviewed (Mental Health Provider Forum Examples of Innovative Practice and Design)
    - Exploration of spot contracting arrangements through personal budgets – rather than a block commissioned scheme it would be possible to support people with personal budgets, and revenue fund support through their eligible support needs.
    - Accommodation has been identified by CYC for conversion into Mental Health Supported Accommodation. Third sector organisations have been invited to describe models used elsewhere.

- The review of 22 The Avenue, New Lane and Shipton Road Accommodation has been added to this work stream. Allowing the development of a pathway of Mental Health supported accommodation.

- Continued effective partnership working with Adults and Housing in CYC, and health.

- Survey Monkey has been developed to identify level of need across health and social care, as well as considering needs in out of area treatment placements.

B. Identify people who are in Out of Area Treatment placements
Profiling their current mental health and accommodation support needs. (Out of Area Treatment placements were previously case managed by the Partnership Commissioning Unit [PCU] on behalf of the NHS Vale of York Clinical Commissioning Group [CCG])

13. (This links to the Whole Concept - The Hive and Nest) Annex 1

Progress to date:

- The out of area treatment placements information has being collated, and there is now a much better understanding of information pertaining to the individuals' needs and associated costs of the placements.

- The overall aim is to effectively support people to return to their home area with a range of housing and support options.

- Internal TEWV processes have been developed to ensure connectivity with the people who are in out of area treatment placements.

C. Review of current mental health directory information available in York and Selby.

14. (This links to the Whole Concept - Buttercups and flowers/ other flowers and overflowing roots) Annex 1

Progress to date:

15. 3 mental health directories have been identified;

- **Health Watch** – Mental Health and Wellbeing in York. This is in paper form and will be updated this year, 2016. (Part funded by TEWV)

- **York Directory for Mental Health**, an electronic version. This does not include Selby. It will be updated this year, 2016. (Part funded by TEWV)

- **Discovery Hub** – As part of the offer from the Discovery Hub there is an electronic directory which outlines details of learning opportunities (available through University and other sectors). The Hub is funded by TEWV.

16. These are reviewed as part of the Connect (this is a forum where voluntary and community sector work with TEWV in exploring service delivery). The group will explore formats, scope and methods of updating directories to ensure they meet need.

D. Mental Health Café / Crisis café / Safe Haven.

This is an alternative means of support for those experiencing mental health crises.

17. (This links to the Whole Concept - The Door, Queen Bee, Hive, Swing and Nest) Annex 1

Progress to date:

- This subgroup was initially chaired by Teri Sanders, Locality Manager, (TEWV) and Ruth Lambley, Expert by Experience.

- A joint meeting was held on 5th July 2016 with Voluntary Sector, Experts by Experience, CYC, PCU and TEWV.

- This Project subgroup is now chaired by Sheila Fletcher (PCU) linking with the action plan from the Crisis Concordat Committee.

- A group of TEWV staff and Experts by Experience visited Aldershot Safe Haven on 27th July 2016 to learn about this service and bring information back to the sub group.

- CYC have offered Sycamore house as a venue for the Safe Haven Crisis Cafe, on an evening and weekend. The model of support will be health, third sector and peer support. They will

facilitate direct access to mental health services via the Crisis Team if required.

Next steps

i. Develop and agree a project plan by 30 September 2016.

ii. Determine the exact scope with our Experts by Experience, Service users and carers.

iii. Experts by Experience are service users who have undertaken training within TEWV and work co productively to ensure projects and service developments are recovery focused.

iv. 3. Capital funding bid submitted to Department of Health (Sep 2016)

E. The International Whole Person, Whole Life-Whole System Recovery Symposium.

18. (This links to the Whole Concept - Snails, Bees, Buttercups and Flowers, Other flowers and overflowing roots, Swing) Annex 1

19. Earlier this year a Symposium was held with a number of representatives from across the mental health system, along with the International Mental Health Collaborating Network (IMHCN), stakeholders, service users and carers. Its focus was to provide new ways of approaching recovery, in a more holistic manner, using national and international best practice as a means to stimulate discussion and future work. As part of the follow up actions is was agreed to maintain momentum via Action Learning Sets. The symposium Action Learning Sets bring together health, service users, family members and community organisations to develop a process which involves working on the real needs and interests of people.

20. The Action Learning Sets have been established and will include five days over a period of six months covering themes of:

- Knowing the person
- Working alongside the person
- A whole life for the person

21. This work will enhance how we culturally change our approach to recovery; person centred care and promote increased co-production.

F. Scope the need for Inpatient Rehabilitation Services in York and Selby Locality.

22. This links to the Whole Concept - Nest, Queen Bee and Snails (Annex 1)

23. This work is closely linked to the Out of Area Placements work, as TEWV need to understand the current and future needs relating to inpatient rehabilitation and recovery provision in York and Selby. Once there is a good understanding of this an options appraisal will be developed as part of the project management framework. The Rehabilitation and Recovery Project team are overseeing this with the Rehabilitation and Recovery Stakeholder Steering Group informing the work. The timescale for reporting back on this is December 2016.

Consultation

24. A Stakeholder Communication and Engagement plan has been developed in conjunction with the Rehabilitation and Recovery, Stakeholder Steering Group and Project Team. There is wide-ranging attendance from stakeholders and an emphasis on co-production in supporting the work plan.

25. As specific plans develop there will be further engagement and consultation on any proposed changes.

Options

26. There are no specific options for the Health and Wellbeing Board to consider.

Strategic/Operational Plans

27. The NHS Vale of York Clinical Commissioning Group have committed to addressing Mental Health services and improving services based on the ‘Discover’ themes. Much of the Rehabilitation and Recovery work is aligned to these elements. e.g. improving access, seeing the wider context for service users and enhancing recovery.

Implications

28. **Financial -** There will be planned investment in Estate infrastructure as part of any identified programme for inpatient rehabilitation and recovery service. The specific costs at this time are unknown and will be identified within the project and will form part of the business case arrangements within Tees, Esk and Wear Valleys NHS Foundation Trust.

29. **Human Resources (HR) -** There are no specific implications.

30. **Equalities -** There are no specific implications.

31. **Legal -** There are no specific implications.

32. **Crime and Disorder -** There are no specific implications.

33. **Information Technology (IT) -** There are no specific implications.

34. **Property** - There may be estates implications relating to future options appraisal for inpatient rehabilitation and recovery services in York and Selby.

35. **Other** - There are no other implications.

Risk Management

36. As part of the Trust Business Case for Rehabilitation and Recovery Services there will be consideration of all relative risks associated with this project.

Recommendations

37. The Health and Wellbeing Board are asked to consider this update report on progress in relation to Rehabilitation and Recovery and identify any area for further consideration by either the Multi Agency Stakeholder Steering Group or the TEWV Rehabilitation Project Team, on the key areas identified;

    i. Health Support and Housing Needs

    ii. Out of Area Placements

    iii. Review of Mental Health Directories

    iv. Mental Health Crisis Café and Safe Haven

    v. International Whole Person, Whole Life-Whole System Recovery Symposium, Action Learning Sets

vi. TEWV Adult Rehabilitation and Recovery inpatient services

Reason: To keep the Health and Wellbeing Board updated in relation to progress

Contact Details

Author:	**Chief Officer Responsible for the report:**
Gill Boycott Head of Service Adult Mental Health Tees Esk and Wear Valleys NHS Foundation Trust Tel No. 01904 294613	Ruth Hill Director of Operations Tees,Esk and Wear Valleys NHS Foundation Trust Tel No. 01904 294613
Teri Sanders Locality Manager Adult Mental Health Tees Esk and Wear Valleys NHS Foundation Trust Tel No. 07983 323944	**Report Approved** ✓ **Date** 23.08.2016

Wards Affected: **All** √

For further information please contact the author of the report
Background Papers:
None

Annexes

Annex 1: TEWV Quality Improvement System, 3P presentation (from the Production Process Preparation workshop held 29 Feb-2 Mar 2016).

Glossary
CCG- NHS Vale of York Clinical Commissioning Group
CQC- Care Quality Commission
HR- Human Resources

IMHCN- International Mental Health Collaborating Network
IT- Information Technology
NHS- National Health Service
PCU- Partnership Commissioning Unit
TEWV- Tees, Esk and Wear Valleys NHS Foundation Trust

York and Selby

Future Rehabilitation and Recovery Model communication presentation

Current Position

- The adult inpatient Rehabilitation and Recovery service in the York & Selby locality is a mixed sex, sixteen bed unit, currently provided at Acomb Gables in York

- A review of the configuration of the Rehabilitation and Recovery service is required to ensure there are effective pathways across a network of services and wide spectrum of support, determined by local need.

Current position

- Some components of an effective Rehabilitation care pathway may be provided by independent and third sector organisations as well those provided by the Trust.

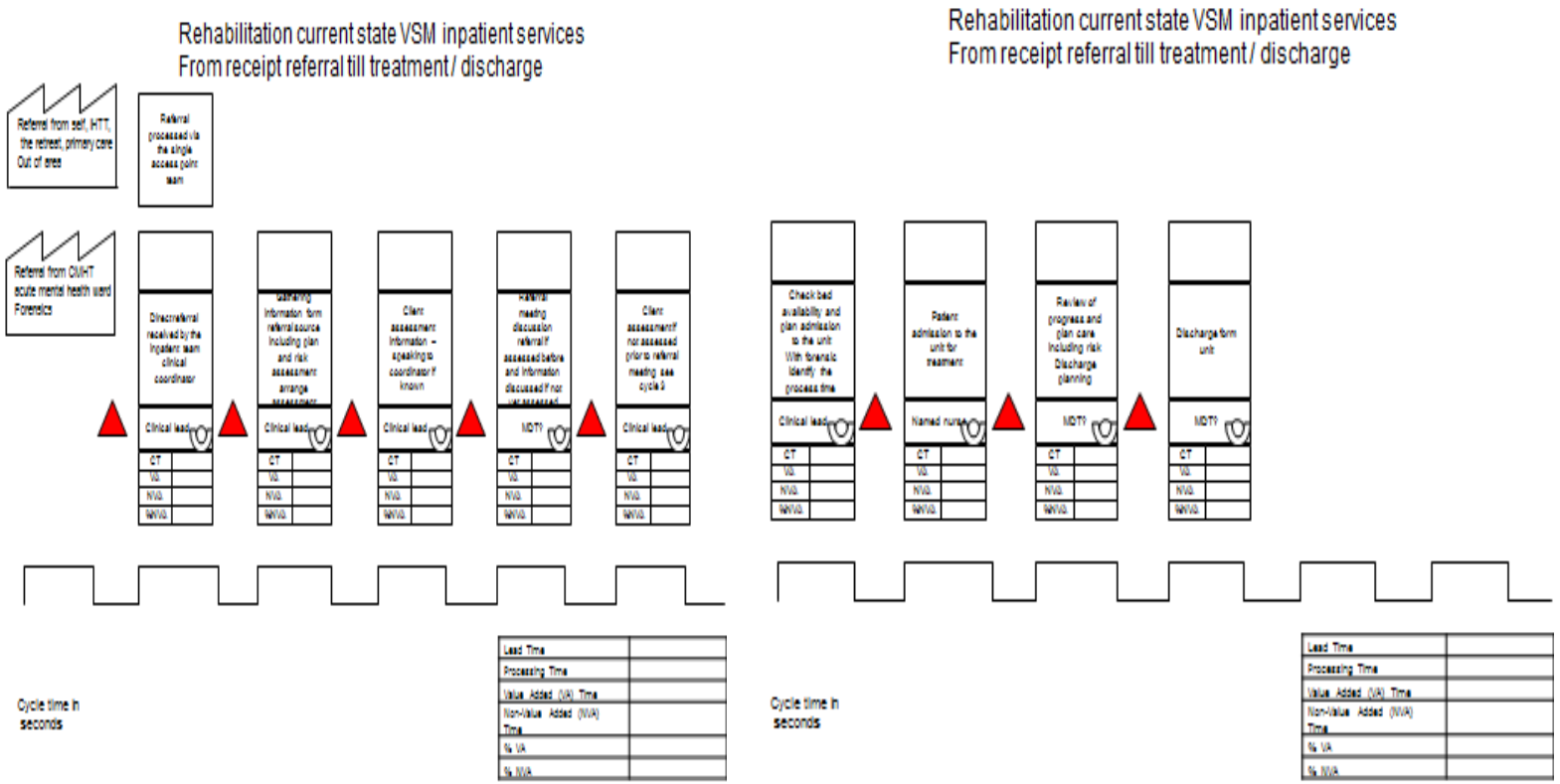
- Pathways through these services should be as seamless as possible, which will be dependent on good working partnerships across York & Selby Locality, comprising of:

a) community based rehabilitation units
b) community based recovery teams
c) supported accommodation services
d) support services for service users and carers
   - Local Authority
   - voluntary sector
   - occupation and work
   - advocacy services
   - peer support services.

There are five key desired service outcomes

- Reduce reliance on Rehabilitation inpatient facilities
- Ensure recovery pathways are as seamless as possible
- Improved partnership working to enable continued recovery in the community
- A more efficient, evidence based, high quality service
- To support people in Out of Area treatment placements to return to the York & Selby Locality

Current Value stream



Theme of the 3P

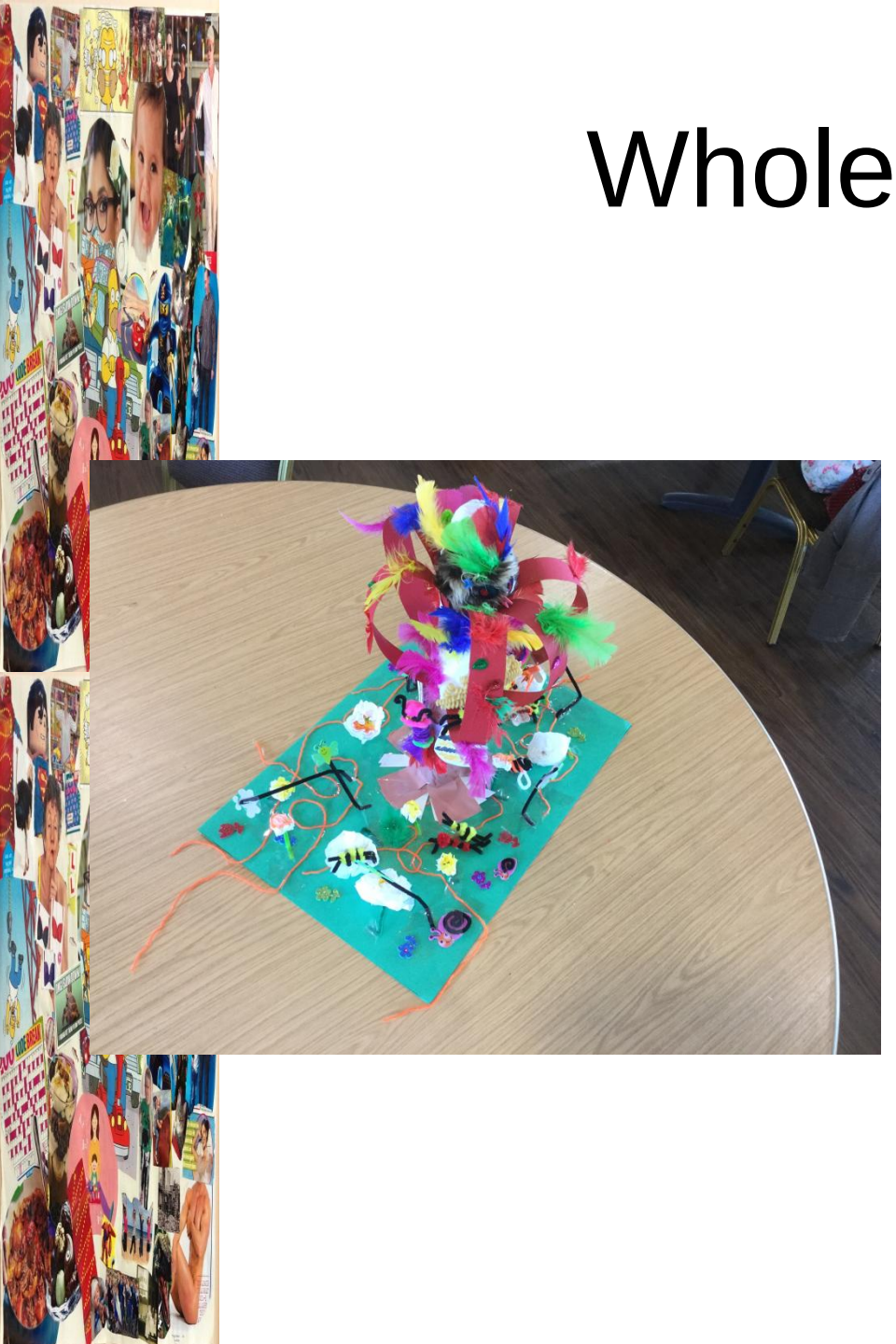
- To explore the development of future Rehabilitation and Recovery services in York & Selby. Provides an opportunity to consider a new vision and model of rehabilitation services and seamless care pathways in York & Selby, encompassing a wide spectrum of partner organisations that support individuals in their community

The final vision following voting

Mission Statement

- Creating a mental health service which gives people hope for positive change and recognises the importance of listening to the individual.
- Building pathways to recovery which allow individuals to go at their own pace, with the freedom to make informed choices about their care.
- Developing and maintaining partnerships with the community and other organisations to keep lines of communication clear and avoid leaving people with out support.
- Taking a holistic approach to the strengths and vulnerabilities of each individual, combining physical and mental health with life skills and self care.

Whole Concept



- Buttercup and flower network – representing the community working together for recovery.
- Tree at centre – represents knowledge, skills and experience, shared values, heart of network.
- Topped by the owl of wisdom and diversity.

The Door

- An obvious door at the centre of the tree represents clear, visible access.
- A straight forward route for urgent access.

Queen Bee

- A person seeking mental health support.
- They are at the heart of the network.
- All the worker bees are working for the queen bee.

Snails

- The service is paced to the individual and can go at the person's pace.

Hive

- The secure base for the queen bee – whether that is home or a resource in the community.
- The worker bees are working to make that place secure and comfortable.

Bees

- Are representative of all service workers with different connected roles.
- (Health workers, educators, researchers, council staff, volunteers, friends, carers, family.)

Buttercups and flowers

- Physical location of service provision.
- Health facilities
- Education facilities.
- Third sector organisations.
- Community organisations.
- Connected by a strong root network.

Other flowers and overflowing roots

- A wider range of resources and providers.
- The worker bees are constantly looking beyond their network for new connections.

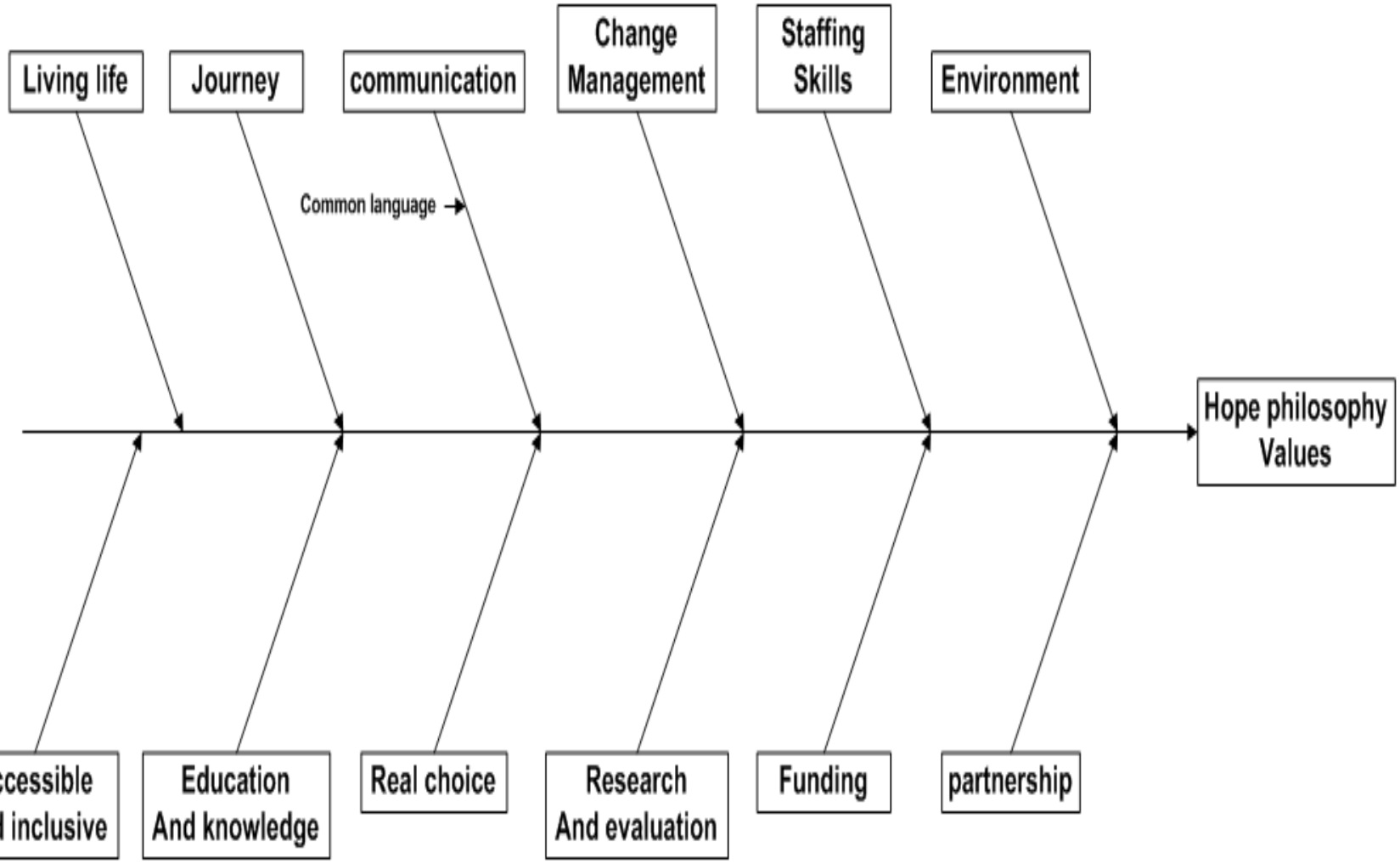
Swing

- A willingness to try things and to take risks.

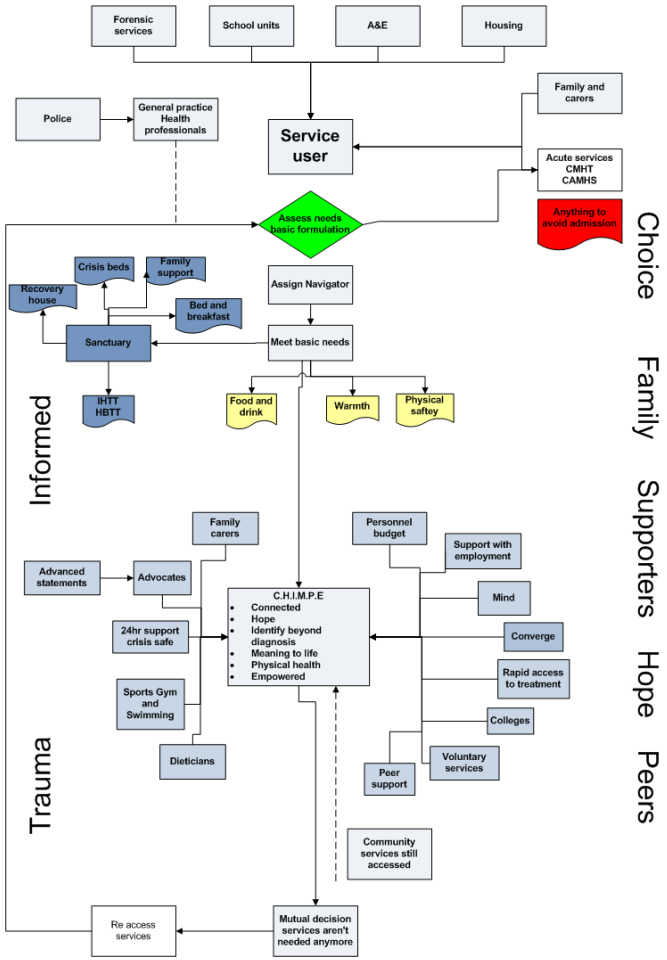
Nest

- Somewhere to feel safe /sanctuary when needed.
- Time out when needed

High level components



Concept pathway



- CHIMPE focused
- Individualised
- Avoiding categorisation
- Fluid
- Community oriented
- Trauma informed
- 24/7 (non-A&E)
- Valuing peers
- Easily accessible

Communication Strategy

ANNEX 1

What	Who	Why	How	When
Watch this space! New recovery pathway in progress – so far	Everybody	-Info re: closure of Acomb Gables -Prepare for coming changes -Info on engagement opportunities -Directory coming soon!	-Press releases -Website bulletins -Radio -Social Media	**Pre-launch**
Mission Statement (Focus on individual, vision, aims of project)	Everybody	-What the larger aims of the new initiative are -Building on the mission statement	-Web page -Social Media -Posters -Internal comms	**Pre-launch**
Model background (how we got here: process/reasoning)	Tier 1 & 2 Stakeholders Funds/Regulators Local Authority	-Credibility -Demonstrate grassroots engagement/involvement -Reduce cynicism	-Printed matter -Presentation at events -Web page -Internal comms (?) -Workshop photos	**Soft launch** (Detail) **Launch** (Main Points)
Structure of the model – network of services and providers	Tier 1 & 2 Stakeholders F/R Local Authority	-Notify people of changes -Visualise new shape of services -Show points of contact -What services are available?	-Diagrams/flowcharts -Email -Social media -Web page	**Soft launch** (Detail) **Launch** (Main Points)
Pathways: ways to recovery. How to access services	Tier 1& 2 Stakeholders F/R Local Authority	-Clear signposting to entry points -How to get referrals -Contact details -Directory	-Google Maps -Public events -Web page -Social media -Print/radio media	**Soft launch** (Detail) **Launch** (Main Points)
Directory of services (access)	Everybody	-Knowing what's available, who to contact, how to get referred	-Web page -Print version	**Soft launch** **Launch**

Concept implementation actions and milestones

- Sharing of the final presentation with the group
- The group have agreed to be a focused consultation group reporting to the project group
- Project group will now need to develop a project plan with deliverable milestones including implementing the communication strategy

Health and Wellbeing Board **7 September 2016**
Report of Director of Operations, Tees, Esk and Wear Valleys NHS Foundation Trust

Mental Health Inpatient Facilities for York

Summary

1. This paper updates the Health and Wellbeing Board around the current position for mental health facilities in York. Whilst the paper focuses on inpatient services there are additional updates on the development of our community plans as some of the service transformation plans are interlinked.

Background

2. This paper updates the Health & Wellbeing Board around the current position for mental health facilities in York. There have been previous verbal and written updates to the Board which have outlined the estate implications following the Care Quality Commission's (CQC) decision not to register Bootham Park Hospital for healthcare services.

3. There have been a number of significant changes to our facilities following the contract change to Tees Esk and Wear Valleys NHS Foundation Trust (TEWV). As outlined previously, both the S136 Suite (place of safety) and outpatient services have been reinstated at Bootham following estates work and review via Care Quality Commission (CQC).

4. During the last 9 months there continues to be further transformation of services, developing our recovery approach, migrating IT systems and investing in new models of care. Improving our estates infrastructure is a critical part of our transformation plan.

Main/Key Issues to be Considered

Peppermill Court – Adult Services

5. Work has been underway to reinstate adult beds within York and following renovation of the Peppermill Court Unit (off Huntington Road, York), the unit is anticipated to be opened shortly. The unit will offer 24 beds, the 136 suite (place of safety) and a base for the crisis team.

6. A number of service users and carers have been involved in the development of the unit plans, which has enhanced the operational arrangements for the ward.

Rehabilitation and Recovery Services

7. Work is being undertaken with service users and carers and a wide range of stakeholders to consider service options around rehabilitation and recovery. There are a number of options being considered and further data is being collected to inform the proposals. There are a number of other work streams being explored under the rehabilitation and recovery umbrella which includes crisis house/ step down facilities and wider interface with housing. A separate report on this work has been submitted to the Health and Wellbeing Board.

Older People Services

8. The assessment and treatment service continue to be provided at Cherry Tree House (York). Meadowfields (York) provides female dementia care. Currently Worsley Court (Selby) offers male dementia care but following a building programme at Acomb Gables the Dementia male beds will be re-provided within this unit. This will bring all dementia care within the York locality which will be important due to the connection with the acute hospital and physical healthcare. The transfer of the unit is anticipated during Winter 2016/17.

9. Both Meadowfields and Worsley Court have had a staff attack system put in place to bring the services up to TEWV standards.

Community Hubs

10. A review of the current buildings from which Community Mental Health Teams (CMHT's) operate has identified a number of constraints with the existing estate. Many of the buildings offer poor patient facing environments, inadequate staff facilities, do not meet Disability Discrimination Act (DDA) requirements and are not optimally configured to meet modern mental health estate expectations.

11. TEWV's tender response outlined new ways of working, building on the Vale of York Clinical Commissioning Group's engagement work ("Discover!"), which highlighted a wider community focus.

12. A hub will offer outpatient and treatment facilities as well as CMHT office space for adults and older people. Our planning assumptions also include providing appointments and services within patients own homes, GP surgeries and other community venues. We will want to continue to maximise the visibility of mental health practitioners within primary care settings and will continue to work to explore how this can be maximised.

13. A working group have considered a range of options and undertaken a full option appraisal on possible sites for Community Hubs. This assessment has indicated that there would ideally be 3 main CMHT hubs across the Vale of York. This would cover Selby, York East and York West.

14. Taking each of the Hub areas in turn:
    Selby – The CMHT currently use Worsley Court for accommodation and clinic appointments. Some estate work is planned to modify the facility (as part of further work around rehabilitation and recovery services) and this will also enhance the facility to increase the number of clinic rooms. This work is still in development.

    York West - Acomb – The CMHT currently has office space and a small number of clinic rooms at Acomb Gables. Estate works have been agreed as part of the plans to bring Mental Health Older People (MHSOP) beds into this unit. As part of these plans additional clinic space has been developed and will be available from Winter 2016/17.

York East – A new site has been identified – Huntington House at Monks Cross which would enable services from Bootham Park Hospital (including the chapel and driveway), Union Terrace, Huntington Road, (St Andrews) and 22 The Avenue to be relocated. A business case is being compiled to confirm the detailed plans and revenue costs relating to this hub development, but it is anticipated that the new site will be available for patient use from December 2017.

New Hospital Development

15. As part of the engagement work, TEWV have undertaken a range of events to enable patients, carers, stakeholders and the public to raise issues and concerns, as there was recognition that there were high levels of concern around mental health services. There were a number of questions about our plans for the new hospital so we undertook four workshops in May which gave people an early opportunity to be involved in the development of the new hospital. The sessions focussed on three main areas – the size and number of beds needed, potential sites for the new hospital and best practice in building design. At these sessions there was a long list of potential sites (10+) which were explored and the challenges to the existing Bootham Hospital site were highlighted.

16. The feedback received from these events is helping us develop the final options around the proposed short list of site options. The Trust is currently undertaking detailed work in refining the potential site options to inform the formal consultation process.

17. The formal consultation process will begin in Autumn (September) and will last for 12 weeks. The consultation elements are outlined below:

    The consultation document will outline the current inpatient services that are in place across the Vale of York, and give additional background to existing services. Within the document there will be an outline of the shortlisted site options with additional information on the rationale for inclusion and detail around the advantages and disadvantages of each site. We will seek feedback on the sites proposed.

    There will be detail on how we want to develop more services in the community. We will outline our plans to reduce the current number of beds within the Locality by enhancing the community services

and reducing reliance on beds. We will seek views on the proposed number and configuration of beds.

The consultation feedback will inform the next steps around the new hospital plans. In addition the option appraisal will take in consideration time factors, cost, achievability, site investigations and design review. The outcome of consultation and the preferred option will be reported back in the New Year.

Consultation

18. Formal Consultation on the new mental health hospital for York is scheduled in September for 12 weeks. A communications and engagement plan has been developed in close collaboration with the Vale of York Clinical Commissioning Group.

Strategic/Operational Plans

19. The NHS Vale of York Clinical Commissioning Group (CCG) have confirmed the strategic requirement for a new mental health hospital by 2019.

Implications

- **Financial** - There will be planned investment in Estate infrastructure as part of the programmes outlined above. The specific costs will be identified within each project and will form part of the business case arrangements within Tees, Esk and Wear Valleys NHS Foundation Trust.
- **Human Resources (HR) -** No specific issues identified
- **Equalities-** No specific issues identified
- **Legal-** No specific issues identified
- **Crime and Disorder -** No specific issues identified
- **Information Technology (IT) -** No specific issues identified
- **Property –** This report outlines the estate implications within the Vale of York for mental health and learning disability services.

Risk Management

20. As part of the Business Case for the new hospital there will be consideration of the relative risks associated with this project.

Recommendations

21. The Health and Wellbeing Board are asked to consider:

    i. The update on the work undertaken to address the transformation of mental health services and the proposed plans for the new hospital.

Reason: To keep the Health and Wellbeing Board up to date with developments in relation to mental health inpatient facilities for the city.

Contact Details

Author:	**Chief Officer Responsible for the report:**
Ruth Hill Director of Operations Tees Esk & Wear Valleys NHS Foundation Trust 01904 294623	Ruth Hill Director of Operations Tees Esk & Wear Valleys NHS Foundation Trust 01904 294623

Report Approved ✓ **Date** 23.08.2016

Specialist Implications Officers**:** None

Wards Affected: **All** X

Background Papers

None

Annexes

None

Glossary

CCG – Clinical Commissioning Group
CMHT – Community Mental Health Team
CQC – Care Quality Commission
DDA – Disability Discrimination Act

GP – General Practitioner
MHSOP – Mental Health Services for Older People
NHS – National Health Service
TEWV – Tees, Esk and Wear Valleys NHS Foundation Trust

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Health and Wellbeing Board **7 September 2016**
Report of the Chair of the Joint Strategic Needs Assessment/Joint Health and Wellbeing Strategy Steering Group

Update on the work of the Joint Strategic Needs Assessment/Joint Health and Wellbeing Strategy Steering Group

Summary

1. This report provides the Board with an update on the work that has been undertaken by the Joint Strategic Needs Assessment/Joint Health and Wellbeing Strategy Steering Group ('the Steering Group') since it was first established in late 2015.

2. The Board are asked to note the update and agree the recommendations at paragraph 36 of this report.

Background

3. Under the Health and Social Care Act 2012, all Health and Wellbeing Boards are under a duty to prepare a Joint Strategic Needs Assessment and from this a Joint Health and Wellbeing Strategy.

4. Under their Terms of Reference the Steering Group is responsible for developing the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWBS). The Steering Group are also responsible for assuring the Health and Wellbeing Board that the JHWBS is being implemented and delivering improvements in the health and wellbeing of the residents of York.

5. The Steering Group is accountable for the management of the JHWBS and JSNA process ensuring that both these products meet the needs of the Health and Wellbeing Board and that its use is embedded in strategic commissioning for health and social care.

6. By the time of this Health and Wellbeing Board meeting the Steering Group will have met on six occasions since they were first established.

The work of the group is now gathering pace and one of the next tasks for them will be to develop a work programme for the next 12 to 18 months.

Main/Key Issues to be Considered

The Joint Strategic Needs Assessment (JSNA)

7. The current York JSNA is a web based document that contains a wealth of information covering a wide range of health and wellbeing areas. Discussion about the JSNA takes place at every Steering Group meeting.

8. Tool kits - in the earlier meetings a number of tools were agreed including, to assist with undertaking topic specific needs assessments:

- A JSNA prioritisation tool; a set of key criteria that are considered when deciding whether a topic specific needs assessment should go ahead

- A JSNA process map which enables the Steering Group to keep ongoing topic specific needs assessments on track and ensure they follow the same stages of the process during production

9. The tools are reviewed on a regular basis to ensure they are responsive to the Steering Group's needs.

Topic specific needs assessments

10. The Steering Group have recently signed off the following two needs assessments as complete:

Learning Disabilities

11. The full version of the Learning Disabilities Needs Assessment is at **Annex A** to this report and an easy read version is currently being produced. The full needs assessment is a comprehensive document that focuses on adults with a learning disability. Any future needs assessment required will aim to cover all age groups.

12. Adults with learning disabilities are one of the most vulnerable groups in society, experiencing health inequalities, social exclusion and stigmatisation. In general, adults with learning disabilities have greater and more complex health needs than the general population, and often these needs are not identified or treated.

A number of national reports have highlighted that adults with learning disabilities often experience barriers to accessing healthcare services, and receive poor levels of care. Studies have highlighted that adults with learning disabilities are more likely to die from a preventable cause than the general population. Patterns of health needs amongst adults with a learning disability are different to the general population, and therefore current programmes that target health inequalities may exclude this population group.

13. There are an estimated 3,980 adults with learning disabilities resident in York, of this estimate 835 have moderate/severe learning disabilities, 199 have profound multiple learning disabilities, and 59 have behaviours which challenge.

14. The needs assessment sets out a number of recommendations as follows:

- Improve the quality of primary care learning disability registers, including improving the recording of adults with mild learning disabilities on practice registers.
- Ensure NHS Vale of York Clinical Commissioning Group (CCG) works towards developing York specific Health information.
- Ensure Health and Social Services work with adults who use services, their families and carers, in a way which looks at people's strengths and the capacity of the community.
- Ensure there is sufficient capability in the market to achieve the desired service models and outcomes in the community.
- Work with mainstream services and the community to ensure they are as inclusive as possible.
- Work with adults with a learning disability to understand their particular needs and experiences within the Health and Social Care system.
- Consult and engage with adults with a learning disability who use services to make sure that provider organisations are consistently delivering high-quality services and continued access to the community.
- Work with adults with a learning disability who are living longer into old age to better understand their needs.

- Scope information available with regards to individuals with a learning disability who are not known to the Local Authority. Assess robustness of information and any interventions which may assist in their continued independence from statutory services and inclusion in their community.

Further work to build on this needs assessment

- Assessment of primary care data to further understand the health needs of adults with learning disabilities in York, in particular in relation to lifestyle issues and prevalence of chronic diseases.
- Continue to assess the needs of adults with behaviours that may challenge and autism.
- Undertake an assessment of the level of demand for specialist services to ensure that provision is at required level.

15. It is suggested that implementing these recommendations and providing progress reports to the Steering Group is led by the Mental Health and Learning Disabilities Partnership Board and that Health and Wellbeing Board are advised to formally instruct them to produce a plan to fulfil this.

Self Harm

16. The summary version of the Self Harm Needs Assessment is at **Annex B** to this report, with the full version at **Annex C** (available to view online). Self-harm is reported to be a growing concern and issue locally. York does have slightly higher rates of hospital admissions due to self-harm than England average rates and anecdotal and audit information from a range of sources identifies growing concerns about increases in self-harm.

17. The needs assessment recommends the following four areas for local consideration:

i. To strengthen the identification and recording of self-harm related problems that do not result in a hospital admission. This will establish a baseline measurement of the extent of the issue and help raise the focus on the importance of accurately being able to identify self-harming behaviour. Without being able to

accurately identify how much self-harm is happening it is not possible to demonstrate a suitable response to it.

ii. To develop and enhance a local offer of information, advice and training to key staff groups and people most at risk of self-harm. This will reduce barriers to people who self-harm seeking help and improve the ability of staff to be able to respond to self-harming behaviour and risks effectively.

iii. To be able to offer evidence based interventions that are effective in reducing self-harming behaviour and clear referral routes into this support. This would also contribute to removing barriers for people to ask for help.

iv. To seek assurance that appropriate and adequate pathways exist which allow people who self-harm to receive support. This would include clarity that; self-harming behaviour among adults is assessed and risk assessed by service providers; there are clear pathways into support where self-harming behaviour is identified which should include consideration of referral processes for adults and children from Emergency Department and referral from schools into Child and Adolescent Mental Health Services (CAMHS).

18. It is suggested that implementation and progress reporting back to the Steering Group against these recommendations is led by the Mental Health and Learning Disabilities Partnership Board; joint working with the CAMHS Executive on issues for children and young people will be required. The Health and Wellbeing Board are advised to formally instruct the Mental Health and Learning Disabilities Partnership Board to lead on this work and ask them to produce a plan to fulfil this.

<u>Future needs assessments</u>

19. There are two further needs assessments that are due to commence during September 2016 and these will be focused around:

- Autism
- Student Health

20. Task and Finish Groups will be established to lead on the work and the Steering Group will receive regular reports back.

Once completed the key messages and recommended actions from these needs assessments will be presented to the Health and Wellbeing Board.

Maintaining the current web-based JSNA

21. The Steering Group have discussed this on a number of occasions and have concluded that the website currently lacks ownership and is unfortunately not being maintained due to a lack of resource. This means that there are a number of broken links, some out of date information and no new information being added. What had been originally developed as a 'live' web based JSNA has now become static. No decision as yet has been made on how to manage this or what a future website might look like. However, the Steering Group have looked at other JSNA websites and how they function.

22. Additionally, whilst the JSNA contains a wealth of information there is a real need to increase and improve the capacity to analyse data and information contained within it to produce a single source of intelligence to inform commissioning decisions. The Steering Group have considered an initial business case with options to increase capacity to support the JSNA and further discussions are taking place on this.

The Joint Health and Wellbeing Strategy (JHWBS)

23. Producing a Joint Health and Wellbeing Strategy is a statutory responsibility of Health and Wellbeing Boards. The JHWBS should set out the health and wellbeing priorities for the city based on the evidence in the local JSNA, other local intelligence and data and on engagement with stakeholders and the public.

24. The current Joint Health and Wellbeing Strategy for York runs from 2013 to 2016; as well as a number of cross cutting principles and actions it has five key themes:

- Making York a great place for older people to live
- Reducing health inequalities
- Improving mental health and intervening early
- Enabling all children to have the best start in life
- Creating a financially sustainable local health and wellbeing system

25. The proposal for the new Strategy is that it will run for 5 years from January 2017 until December 2021. It will be a high level strategy underpinned by targeted action plans and existing strategies (e.g. alcohol strategy and children and young people's plan) and will be based on what is known as the 'life course approach' with themes such as:

    - Starting and growing well
    - Living and working well
    - Ageing well
    - Dying well

26. Initial engagement has taken place in relation to renewing the JHWBS including two open engagement sessions, an online survey, a 'foyer' day at West Offices and visits to York Older People's Assembly and the VCS Forums.

27. The new JHWBS will be drafted throughout September and a formal 8 week consultation will take place throughout October and November. The Strategy will be launched at the January 2017 meeting of the Health and Wellbeing Board.

28. The Steering Group will continue to lead this piece of work to ensure a new JHWBS for the city is produced and action plans are in place to implement it.

Consultation

29. Consultation and engagement has taken place as both the learning disabilities and self harm needs assessments were being produced.

30. Engagement sessions have been held in relation to renewing the JHWBS as detailed above with a formal consultation scheduled to take place later in the year.

Options

31. The Board are asked to note the contents of this report. They are also asked to consider the following options:

    i. Agree or amend the recommendations arising from both the self harm and learning disabilities needs assessments

ii. Agree or suggest alternatives as to the lead group for implementing the recommendations

Analysis

32. Learning from previous needs assessments has highlighted the need for robust implementation plans to be put in place, clear leads to be identified at an early stage and clear reporting lines identified if recommendations are to be taken forward.

Strategic/Operational Plans

33. The Health and Wellbeing Board have a statutory duty to produce both a Joint Strategic Needs Assessment and a Joint Health and Wellbeing Strategy.

Implications

34. There are resource implications associated with delivering such complex projects. Currently the resources we do have are shrinking and the burden of work to undertake the JSNA is not evenly distributed. The Steering Group are actively seeking ways in which this can be addressed and will keep the Board updated on the progress with this discussions.

Risk Management

35. The production of a JSNA and a Joint Health and Wellbeing Strategy are statutory responsibilities for the HWBB. Delivering against both is resource intensive and needs to be managed to ensure a fit for purpose JSNA and Joint Health and Wellbeing Strategy are produced.

Recommendations

36. The Health and Wellbeing Board are asked to note this update and are recommended to:

i. Agree the recommendations arising from both the self harm and learning disabilities needs assessments

ii. Agree the lead groups suggested for implementing the recommendations

Reason: To update the Board on progress made with the JSNA and the JHWBS

Contact Details

Author:	**Chief Officer Responsible for the report:**
Tracy Wallis Health and Wellbeing Partnerships Co-ordinator City of York Council/NHS Vale of York Clinical Commissioning Group	Sharon Stoltz Director of Public Health City of York Council

Report Approved ✓ **Date** 18.08.2016

Tel: 01904 551714

Specialist Implications Officer(s) None

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:
Joint Strategic Needs Assessment
Joint Health and Wellbeing Strategy 2013-16

Annexes
Annex A – Learning Disabilities Needs Assessment
Annex B – Summary Self Harm Needs Assessment
Annex C – Self Harm Needs Assessment (online only)

Glossary

CAMHS- Child and Adolescent Mental Health Services
CCG- NHS Vale of York Clinical Commissioning Group
HR- Human Resources
HWBB- Health and Wellbeing Board
IT- Information Technology
JHWBS- Joint Health and Wellbeing Strategy
JSNA- Joint Strategic Needs Assessment
VCS- Voluntary and Community Sector

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Annex A

Needs Assessment for Adults with Learning Disabilities

March 2016

Contents

Introduction

Learning disability is defined as the presence of:

> "A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence, often defined as an IQ level of 70 or less), with; a reduced ability to cope independently (impaired social functioning);which started before adulthood, with a lasting effect on development."[1]

In addtion, the Equality Act 2010 introduced the term "protected characteristics" to refer to groups that are protected under the Act. In the Act, a person has a disability if they have a physical or mental impairment and the impairment has a substantial and long-term adverse effect on their ability to perform normal day-to-day activities. In addition to an adult having a learning disability they may also have other conditions and disabilities which affect their daily living.

This needs assessment focuses on adults with a learning disability. In the future the aim is that the needs assessment will be an all age needs assessment.

Adults with learning disabilities are one of the most vulnerable groups in society, experiencing health inequalities, social exclusion and stigmatisation. In general, adults with learning disabilities have greater and more complex health needs than the general population, and often these needs are not identified or treated. A number of national reports have highlighted that adults with learning disabilities often experience barriers to accessing healthcare services, and receive poor levels of care. Studies have highlighted that adults with learning disabilities are more likely to die from a preventable cause than the general population. Patterns of health needs amongst adults with a learning disability are different to the general population, and therefore current programmes that target health inequalities may exclude this population group.

There are an estimated 3,980 adults with learning disabilities resident in York , of this estimate 835 have moderate/severe learning disabilities, 199 have profound multiple learning disabilities, and 59 have behaviours which challenge. [2]

Key issues and gaps

- There is forecast to be an increase in the prevalence of adults with learning disabilities over the next 10-15 years in line with the general population. It is to be noted that there will be a significant increase in those living longer with an estimated 31% increase in the 65+ age group and a 69% increase in the 85+ age group[3].

[1] Source: WHO, 2007

[2] Projecting Adult Needs and Service Information website (18-65) and Projecting Older People Population Information System website (65+), February 2016

[3] http://www.poppi.org.uk/index.php?pageNo=374&PHPSESSID=a704gnmd36e8l8pd0g68v53lv2&sc=1&loc=8301&np=1

- There will continue to be increase in the complex nature of young adults with learning disabilities entering transition that will require adult services.
- Current policy is to provide, where possible, services locally for those individuals transitioning from children to adult services. Therefore some individuals need adult Social Care input sooner than would have previously when a higher proportion went to residential college.
- There continues to be under-recording of adults with learning disabilities in primary care, especially in relation to adults with mild learning disabilities.
- Adults with learning disabilities in general suffer from poorer physical health than the general population, experiencing health inequalities.
- There continues to be limited knowledge regarding the needs of adults with learning disabilities from certain groups, such as within the Criminal Justice System.
- There is concern that services for adults with learning disabilities may come under considerable pressure due to the current economic climate and budget deficit measures.

The bigger picture – national policy

The **Valuing People White Paper**[4] was published in 2001, with the principles of rights, indpedence, choice and inclusion at it's heart.

Mental Capacity Act (MCA), 2005. The primary purpose of the MCA is to promote and safeguard decision making within a legal framework by empowering people to make decisions for themselves wherever possible, and by protecting people who lack capacity by providing a flexible framework that places individuals at the heart of the decision-making process.

Putting People First[5] in 2007 set out information to support the transformation of social care, as outlined in the Health White Paper, **Our Health, Our Care, Our Say: a New Direction for Community Services**[6] in 2006.

Healthcare for All[7] in 2008 was an Independent Inquiry into Access to Healthcare for People with Learning Disabilities. It emphasised the need for urgent change to improve grossly inadequate NHS healthcare.

Valuing People Now[8], 2009, reiterated Valuing People's principles and urged a more rapid implementation.

Equality Act 2010 legally protects people from discrimination in the workplace and in wider society. It replaced previous anti-discrimination laws with a single Act, making the law easier to understand and strengthening protection in some situations.

[4] *Valuing People White Paper*, revised Code of Practice (DfES),2001
[5] *Putting People First concordat*, Department of Health (DH) 2007
[6] Our *Health,Our Care, Our Say a new direction for community services*, White Paper, Deparment of Health, 2006
[7] *Healthcare for All*, Department of Health, 2008
[8] *Valuing People Now*, Department of Health, 2009

The Care Act 2014 builds on recent reviews and reforms and replaces numerous previous laws, in order to provide a coherent approach to adult social care in England. Part one of the Act (and its Statutory Guidance) consolidates and modernises the framework of care and support law; it set out new duties for local authorities and partners, and new rights for customers and carers.

In 2011 the Winterbourne View Hospital scandal occurred when a BBC Panorama programme revealed widespread abuse by staff of people with learning disabilities. The Department of Health undertook a review and In response to this **Transforming care: A national response to Winterbourne View Hospital**[9] was published which committed to producing a report 2 years later setting out the progress that had been made to ensure what happened at Winterbourne View is not repeated.

The subsequent report, **Winterbourne View: Transforming Care Two Years On**[10], set out what had been achieved but recognised that there was still progress to be made. The national plan, **Building the Right Support**[11], 2015, has been developed jointly by NHS England, the LGA and ADASS, and is the next key milestone in the cross-system Transforming Care programme.

No voice unheard, no right ignored – a consultation for people with learning disabilities, autism and mental health conditions[12], 2015,has four main headings; people in charge of their own support and supported by family and friends, inclusion and independence in their community, the right care in the right place, and, very clear accountability and responsibility throughout the system.

Also in 2015 was the **Government response to No voice unheard, no right ignored - a consultation for people with learning disabilities, autism and mental health conditions**[13] responded to the consultation with the aim of people leading as fuliffling and independed lives as possible with the right support to do so. This paper feeds into the Transforming Care agenda.

The level of need in the population

Criminal Justice System

The Criminal Justice System is a term used to mean the police, courts, prison and probation. It deals with people who break the law. These people are called ‘offenders’.

[9] *Transforming care: A national response to Winterbourne* View Hospital,Department of Health Review, 2012
[10] *Winterbourne View: Transforming Care Two Years On,* Department of Health Review, 2015
[11] *Building the Right support, A national plan to develop community services and close inpatient facilities for peple with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition*, NHS England, the LGA and ADASS, 2015
[12] *No voice unheard, no right ignored – a consultation for people with learning disabilities, autism and mental health conditions*, Department of Health, 2015
[13] *Government response to No voice unheard, no right ignored - a consultation for people with learning disabilities, autism and mental health conditions,* Department of Health, 2015

Nationally, 7% of adult prisoners have an IQ of less than 70 and a further 25% have an IQ between 70-79; it is generally acknowledged that between 5 and 10% of the adult offender population has a learning disability. A learning disability in this instances is defined as an IQ score of less than 70.[14]

Accommodation

Across England, 73.3% of adults with learning disabilities live in their own home or with their family. In York this figure is 91.8% which means York is first in the region and fifth when scored against all Local Authorities nationally.[15]

The accommodation measure shows the proportion of all adults with a learning disability who are known to councils and who are recorded as living in their own home or with their family.

Employment

In England, 6.0 per cent of adults with learning disabilities were in paid employment. In York this figure is 13.7% which means York is first in the region and ninth when scored against all Local Authorities nationally.[16]

This measure shows the proportion of adults with a learning disability who are known to councils and are recorded as being in paid employment.

Current services in relation to need

Primary care services

The Learning Disability Health Check Enhanced Service (ES) was designed to encourage practices to identify all patients aged 14 and over with learning disabilities, to maintain a learning disabilities 'health check' register and offer them an annual health check, which will include producing a health action plan.

Summary of key points from 2014/15 data[17]

- There was a 66% increase on the number of health checks done in the Vale of York compared with 2013/14.[18]
- The coverage rate in the Vale of York increased from 33% to 51% and is now slightly above the England average.[19]

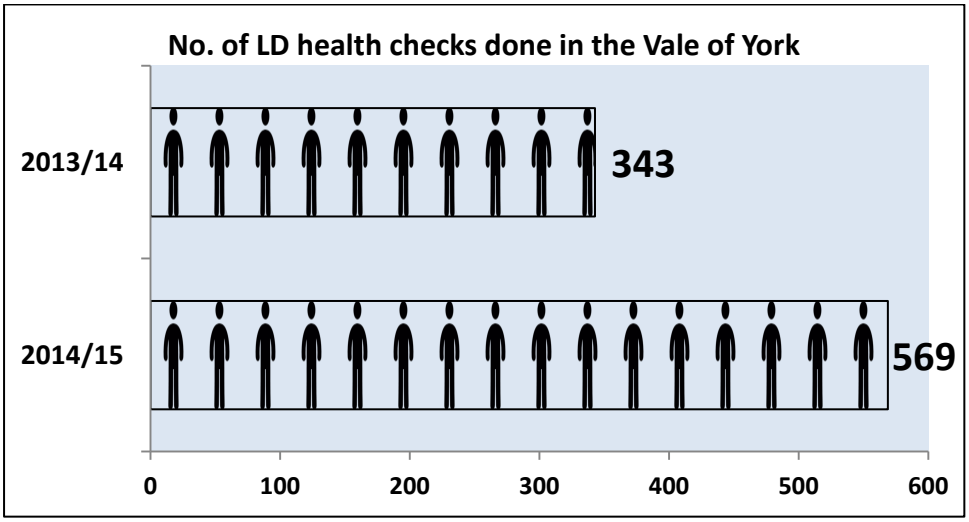
[14] *Fair Access to Justice? support for vulnerable defendants in the criminal courts*, Prison Reform Trust, 2012
[15] ASCOF, Reporting period 1 April 2014 to 31 March 2015. The Adult Social Care Outcomes Framework (ASCOF) measures performance of Local Authorities
[16] ASCOF, Reporting period 1 April 2014 to 31 March 2015. The Adult Social Care Outcomes Framework (ASCOF) measures performance of Local Authorities
[17] Data for 2014/15 is available at the Health and Social Care Information Centre (HSCIC) website.
[18] 2014/15 covered people aged 14+ whereas previously reported from aged 18+.
[19] 2014/15 data does not cover those who were offered a health check but declined to attend, this will be included in 2015/16 return.

- The coverage rate in the York area was slightly higher at 57%
- The GP participation rate stayed about the same so the increase in coverage was achieved by greater activity amongst existing practices.
- Just over a fifth of people with a learning disability in the Vale of York were registered with a practice which did not provide health checks.
- Limited data suggests that only about 20% of health checks result in the production of a health action plan.

Number of health checks carried out

A total of 569 learning disability health checks were conducted in 2014/15 in the Vale of York CCG area. This is a 66% increase on the number done in the previous year.

Figure 1: Number of Learning Disability Health Checks conducted in the Vale of York CCG.

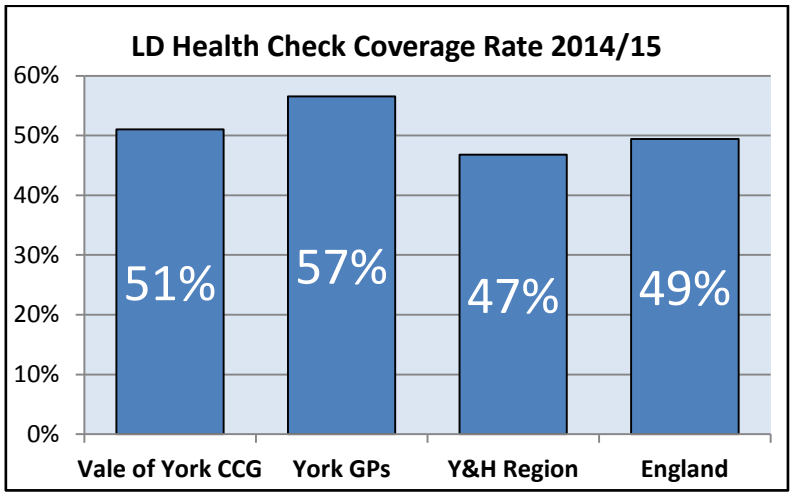


Health check coverage rate.

Coverage rate is usually calculated as the number of health checks carried out divided by the total number of patients identified as having a learning disability on the Quality and Outcomes Framework (QOF) register[20]. Coverage in the Vale of York for 2014/15 was 51% and for the practices based in York it was 57%. The England average was 49%.

[20] Health checks are now done for people aged 14+ but the denominator of people with a learning disability from GP QOF records includes people of all ages, not just those aged 14+. The coverage rate is therefore likely to be an underestimate.

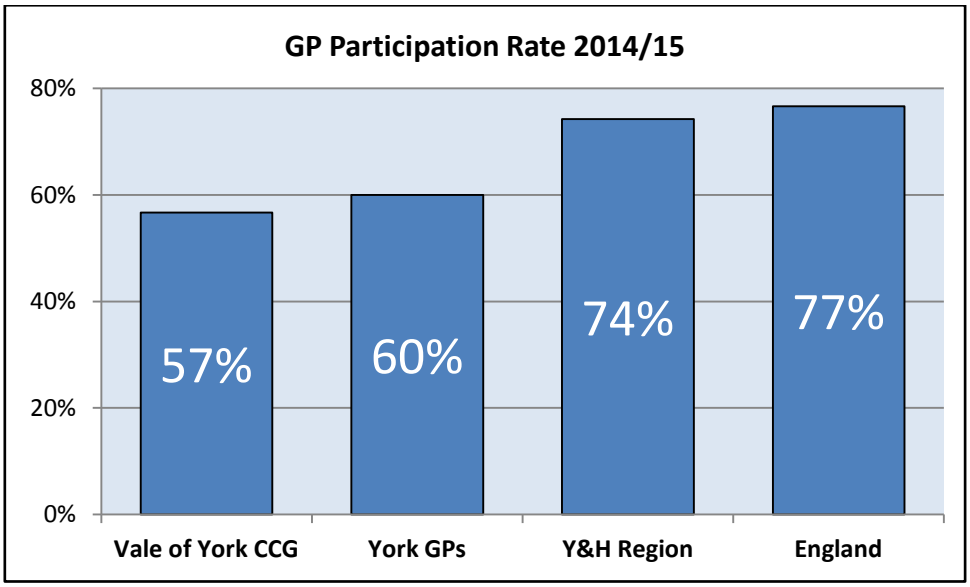
Figure: Learning disability health check coverage rate 2014/15 for York and Vale of York



GP participation rate[21]

The participation rate in the Vale of York was 57% and for the practices based in York it was 60%. The national average was 77%.

Figure: GP participation rate in Learning Disability health check programme 2014/15.



Studies[22] have highlighted that obesity prevalence amongst adults with learning disabilities is an issue nationally. Weight issues should be covered individually in the Annual Health Check and actions recorded in the individual Health Action Plan but to date they are not collated within the CCG.

Specific health issues will be covered within the Annual Health Check but information has not been collated.

[21] GP participation rate is calculated as the number of practices actively engaged in the Enhanced Service (i.e. reporting at least one health check in the reporting year) divided by the total number of practices.

[22] *Health Inequalities & People with Learning Disabilities in the UK:* 2011, E Emerson, S Baines, L Allerton & V Welch

Specialist Learning Disability services

Healthcare services provided by York

The Community Learning Disability Team is a multi-disciplinary and multi-agency team that includes a range of professionals (including Consultant Psychiatrist, Community Learning Disability Nurse, Social Worker, Physiotherapist, Occupational Therapist, Speech and Language Therapist, Clinical Psychologist and Administrative support). It acts as the gate-keeper to services for adults with a learning disability living in the community.

The Assessment and Treatment Service provides a service for those adults with a learning disability and associated challenging behaviour and mental health issues, providing specialist health interventions. Oak Rise is an 8 bedded community based inpatient unit for the area of York that provides acute assessment and treatment for customers with a learning disability who present with acute mental health problems. The service has two separate patient areas, one for female service users (4 beds) and the other for male service users (4 beds). In 2014/15, 17 adults from York were admitted to the Assessment and Treatment Units.

White Horse View was an 8 bedded community based unit based in North Yorkshire, near York's boundary, and provided continuing complex rehabilitation for customers who present with longer term and enduring mental health problems. The service was male only. In 2014/15 it was accessed by 2 adults from the York area. As part of a review under Building The Right Support we have been able to scale down the services required and White Horse View closed in April 2016.

Clinical Psychologists work within the Community Learning Disability Team and also provide services to in-patient and day care facilities providing specialist knowledge and skills. From July 2014 to March 2015[23], 125 adults accessed the service.

Speech and Language Therapy services provide communication and dysphagia (eating, drinking and swallowing difficulties) support for adults with a learning disability as well as to those who support them. From July 2014 to March 2015[24], 121 adults accessed the service.

Continuing Health Care

Continuing Health Care is provided over an extended period of time to meet physical and mental health needs and involves support for receipt of NHS and social care services. Fully-funded NHS 'Continuing Health Care' is a package of care arranged and funded solely by the NHS, whereas 'Continuing Health and Social Care' is a joint package of care that involves services from both the NHS and Social Care. As of March 2016, 58 adults with learning disabilities in the Vale of York area received

[23] No data for Q1 of 2014/2015. The LD community team in York were not using the main patient administration system during that time. In September 2014 they moved on to the primary patient administration system recognised by the Trust.
[24] As footnote above.

fully-funded NHS care (including those receiving continuing care under section 117 of the Mental Health Act) and 109 adults received joint funded care (including those receiving continuing care under section 117 of the Mental Health Act). These figures cannot at the moment be broken down to be York specific.

Personal Health Budgets (PHB)

A personal health budget is an amount of money to support identified health and wellbeing needs, planned and agreed between the person and their local NHS team. The aim is to give people with long-term conditions and disabilities greater choice and control over the healthcare and support they receive.

NHS England's ambition is that by 2020 PHB's will be part of the mainstream offer for patients in the NHS, representing 1-2 people per 1,000 population. For York and North Yorkshire based on 2011 CCG population estimates this would represent an estimate of 763 people (1 person per 1,000 population) and 343 for patients living in NHS Vale of York area.

As of February 2016, in the Vale of York, there were 23 referrals for a PHB and 8 referrals had been completed and were receiving a PHB.

Social Care services

During 2014/15, 482 adults with learning disabilities aged 18+ received a service from City of York Council Adult Social Care Services. For the same period, 97% of adults with a learning disability, known to social care, received a review of their package of support.

Day activities

There are various day activity opportunities in York which include some City of York Council managed day bases as well as activities at other sites. There is also access to one to one support to access activities in the community.

During 2014/15 there were 277 adults with a learning disability receiving some day support as part of their package of care.

Hydrotherapy

City of York Council has a hydrotherapy pool which adults with a learning disability can access as part of their weekly activity programme. 2,340 sessions were accessed in 2014/15.

Supported Living

As at March 2016, there are 173 adults with a learning disability in their own tenancies with support. In addition there are 26 adults with a learning disability in an Extra Care setting with individual support. In total this is 41% of adults with a learning disability, who are know to Social Care, are in their own tenancies with support.

Residential / Nursing Care

The majority of adults with a learning disability in York who are known to Social Care live in accommodation with support or with their families, with most of the remainder living in residential care.

In 2014/15, within the York boundary there were 69 adults with a learning disability in residential care and 4 were accessing nursing care.

For the same period, 47 adults with a learning disability were in residential care outside of the York boundary and 5 who were accessing nursing care.

Adult Placement Service

The Adult Placement Service offers long term placements where an individual lives with a non-related “carer”. In 2014/15 fifteen adults accessed the Adult Placement Service.

Respite Care / Short Breaks

Since April 2015 there are four Short Break beds available at the Flaxman Service which in 2015/16 was accessed by 33 adults for a total of 1,079 nights of which 852 were planned short breaks and 272 were emergency provision.

City of York Council also commission Avalon for a short breaks service. There were 276 nights commissioned in 2014/15 and 411 nights in 2015/16

Adults can and do also access short breaks through using a Direct Payment.

Direct payments

Direct Payments are cash payments made to individuals who have been assessed as needing services, in lieu of Social Care provision. The aim of a direct payment is to give more flexibility in how services are provided. By giving individuals money in lieu of Social Care services, adults have greater choice and control over their lives, and are able to make their own decisions about how their care is delivered. A snapshot in February 2016 indicated 87 adults with a learning disability were receiving direct payments.

Advocacy

Advocacy services support adults with a learning disability to use their voice and take action in their lives. Currently there is only one local provider of advocacy services for adults with a learning disability.

Transitions Team

The Transitions Team works with people from age to 14 to 25 years. The Transition Team begins by finding out about the young person’s hopes and aspirations. The team provides support to, access individual budgets, find an appropriate course or work experience, access training to increase independent travel skills as well as

develop plans to live increasingly independent lives. They work with young people 14-25 across the City, they are made up of four elements:-

- Children's Health and Disability Social Workers work with young people aged 14-18 who have physical and learning difficulties or complex health needs.
- Adult Social Workers work with a young person and their family from 16 years until they are settled in adulthood.
- Connexions Advisors workers provide impartial information, advice and guidance and personal development opportunities in education and employment to ensure a smooth transition to adulthood
- York Independent Living and Travel Skills (YILTS) supports young people to gain skills and confidence in travelling independently. YILTS works with young people aged 11+

There are currently 88 adults[25] (age 18 to 24) who the Transitions Team are working with.

Projected service use

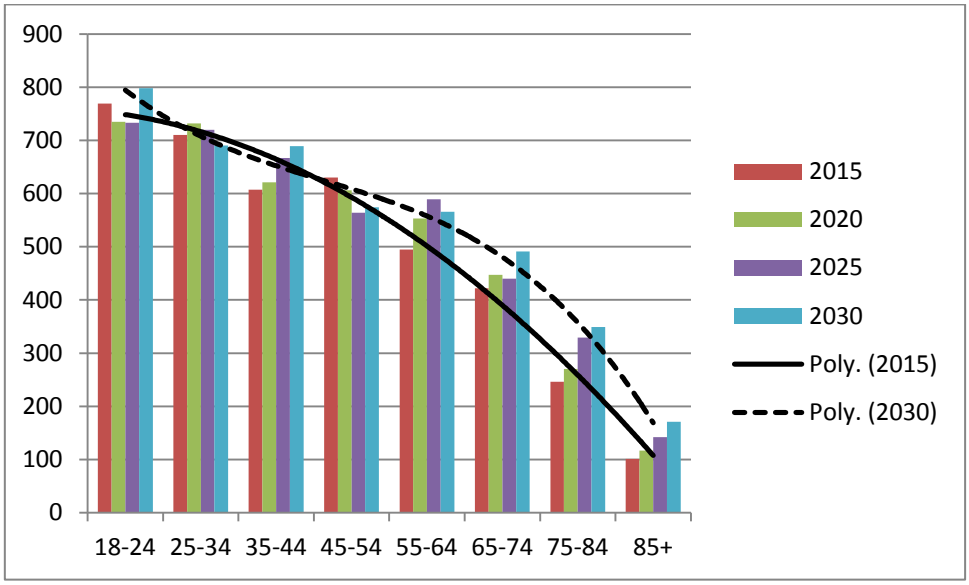
Learning Disabilities

Estimates suggest that the prevalence of adults with learning disabilities in England will increase over the next few years. There is a twofold reason; increased survival rates among young people with severe and complex disabilities and increased longevity among adults with learning disabilities, both due to improvements in medical care and reduced mortality.

In York, there is expected to be a 9% increase in adults with a learning disabilty from 2016-2030, in line with general population trends. The general population in York has a projected increase of older adults of 62%, however those with a learning disabilty projected to live to 85+ has a 69% increase which is a larger growth rate than the general population. Englands general population growth for 85+ is projected to be 74%, largely due to the increase in those expected to live over 90 within the population as a whole.

[25] At 31 March 2016

Learning Disability – Baseline Estimates



POPPI/PANSI, February 2016

There continues to be a steady increase of adults with a severe learning disability of 5% to age 65, there is no data for 65+.

In the next 5 years there are 45 young people with a learning disability that are currently know to services who will become 18 who are likely to need some degree of service from Adult Social Care. There are also 23 young people with a learning disability and autism that are currently known to services who are likely to need some service Adult Social Care.

These figures do not include those who are not known to Social Care / Education at present.

	Primary Need	
	Learning Disability	Learning Disability and Autism
2016	13	7
2017	10	8
2018	11	3
2019	6	4
2020	5	1

Residents Views

Customer views with regards to living in York and services provided to them are very important. Although staff and managers react to direct customer feedback on a day to day basis, and will always try to offer the best service possible, information from more formal customer feedback is recorded, collated and analysed for trends and service improvements.

In March 2015 a Public Meeting of the Mental Health and Learning Disabilities Partnership Board was held which was attended by 23 Individuals with learning disabilities / interested people. The key discussion point at this meeting was Annual Health Checks with GPs. As a result of this an easy read invitation letter (to Annual Health Checks) has been developed and is being actively promoted by the CCG.

Two consultation events were held specifically in regards to the Joint Strategic Needs Assessment during September 2015 to obtain the views of adults with learning disabilities, carers and other stakeholders. A total of 59 people attended both events; this included Partnership Board members and the Health and Wellbeing Partnerships Co-ordinator.

The engagement sessions was undertaken with 9 key themes and the customer feedback in each area is

Headline / Theme	What's good	What's not working	Other
Keeping healthy and active leisure	• Some good activities in place. • Hydrotherapy	• Good activities with good tutors • Timing of sessions • Mental health discussions • Need healthy living advice / classes	• Promote Connect to Support re groups, activities and classes
Keeping safe and hate crime	• York People First training • Good support from Council / Housing	• No safe place scheme in York • No enough public awareness re hate crime • Don't know who to tell	• Feel scared so limits evening activities • Not on buses when school children are on
People being placed in services out of their area		• Specialist services not in York so have to go out of York	• When people move need support to keep family connections
Personal budgets and direct payments	• Personal budget = choice • ILS helping with recruitment / legislation	• Being clear about rules for unspent personal budget • Need to understand in accessible format • Not sure people are always being supported in best way with their funds	

Headline / Theme	What's good	What's not working	Other
Travelling in York and accessibility	• Fleet transport • Audio bus stops • Independent travel training	• Travel card time restricted • Lack of consistency in public transport training • CYC car parks on disabled GO don't display number of disabled spaces	• More training courses for bus and taxi drivers • Accessible bus map /timetables / bus stops • Independent travel training should go wider • Disabled access varies across York, have to check before go
Young people going into adult services	• Good support during transition • Transition support at Applefields is a real positive	• Education / training – when you leave school there is none – lose literacy and numeracy skills • Move into adult services and there is nothing • Low level needs are not always met • Transitions – this varies between people, those at Applefields get a great service	• Make the transitions process more consistent • Improve the support available for young people who don't meet the threshold of care around learning disabilities • Need ongoing education / training so don't lose skills
Getting a job and learning new skills	• Having someone to support people to do jobs	• Employment opportunities limited • Proper pay • No help looking for a job	• Need more help with employment – low level support
Good information and living in York if you have a disability	• Self advocates forum • Sports team good at keeping people informed	• People feel rushed and would like more time either at home or at the doctors	• Need to have some sort of information guide abut what is accessible for customers would be good

Headline / Theme	What's good	What's not working	Other
Growing old and planning for the future	• Good quality accommodation in York • Good to stay in our own home with extra support	• Some people will need more support as they get older • Need more activities for older people	• Worried about losing local facilities – always need to have a car and not everyone does
Housing	• Have had good information about housing in the past • Feel safe and comfortable • Shared ownership housing scheme allows independence	• Housing needs to be linked to support • Getting difficult to recruit PAs • Housing linked to communities • Support arrangements need to be as good as they are now	• Most people like living in own home with support • Make sure there is enough housing that suits the needs of someone with a learning disability • Improve advice about housing options
Short breaks		• Would enjoy more time to talk to people who support me	• Have ordinary holidays / short breaks – what about using hotels for people to go and stay

What is happening now

Learning disabilities

In York we have a vibrant voluntary sector with lots of day activity opportunities for adults with a learning disability as well as some learning environments and employment training opportunities. There are lots of organisations which run groups as well as parents groups which provide support.

In 2014/15 York over 40% of the adult learning disability population, that are known to social services, were supported to live in their own tenancies. In the same period, 11% were living out of the local area in residential or nursing care and 15% were in the same type of setting in York. 3% used Adult Placement Services with 30% living at home with their families. As the majority of adults known to social care are in their own long term settled tenancies we need to find more accommodation opportunities in York.

Our main drivers with regards to developing new accommodation are from those adults who are currently out of area but who wish to return to York and those customers who are coming through transition services and will become adults and

require accommodation in the future. We also know that we have some properties which will not be fit for purpose for the tenants who live in them in the future. We are planning for this and have already developed three new bespoke supported living accommodation settings over the last year.

Alongside developing accommodation options, including shared lives, York is also reviewing what individuals do during the day. We need to consider younger people coming through transitions, people coming back to York who will often have more complex needs as well as older people who are reaching retirement age and perhaps want to have a quieter day but don't want to be at home every day.

What people do during the day has not been reviewed since the closure of our larger day services in 2009. As part of the transformation programme we consulted widely in 2014 with customers, their families and carers with regards to what they would like to do. Whilst parts of peoples days are working really well, for some, alternative options need to be considered.

The need for a specialist base for those with more a learning disability and complex autism has been highlighted and we are working in partnership with a support provide to create this space at Energise. We also have an opportunity to be part of the new Burnholme site in York which will have a variety of community partners included.

Unmet needs and information gaps

National and international evidence suggests that adults with learning disabilities have higher levels of unrecognised health needs than the general population. No information is currently available to highlight unrecognised health needs being identified in York through the annual Health Checks undertaken for adults with learning disabilities. If this becomes available this information would require monitoring and action, particularly in relation to identified health needs in the local population.

There are still significant issues in how information is recorded and there are gaps in available information that is needed to inform future policy and direction.

The main gaps with regards to information / information recording are:

- There is no information with regard to individuals with a learning disability who are not known to the Local Authority and if any low level interventions could assist in their continued independence from statutory services.
- A breakdown for York specific data with regard to Health information to separate it from the whole of the CCG Vale of York area.

Recommendations for consideration

- Improve the quality of primary care learning disability registers,including improving the recording of adults with mild learning disabilities on practice registers.
- Ensure the Vale of York CCG works towards developing York specific Health information.
- Ensure Health and Social Services work with adults who use services, their families and carers, in a way which looks at peoples strengths and the capacity of the community.
- Ensure there is sufficient capability in the market to achieve the desired service models and outcomes in the community.
- Work with mainstream services and the community to ensure they are as inclusive as possible.
- Work with adults with a learning disabilitiy to understand their particular needs and experiences within the Health and Social Care system.
- Consult and engage with adults with a learning disability who use services to make sure that provider organisations are consistently delivering high-quality services and continued access to the community.
- Work with adults with a learning disability who are living longer into old age to better understand their needs.
- Scope information available with regards to individuals with a learning disability who are not known to the Local Authority. Assess robustness of information and any interventions which may assist in their continued independence from statutory services and inclusion in their community.

Further work to build on this needs assessment

- Assessment of primary care data to further understand the health needs of adults with learning disabilities in York, in particular in relation to lifestyle issues and prevalence of chronic diseases.
- Continue to assess the needs of adults with behaviours that may challenge and autism.
- Undertake an assessment of the level of demand for specialist services to ensure that provision is at required level.

National good practice examples

Learning Disabilities Good Practice Project[26] was published in 2013. It set out parameters for good practice indicators:

> co-production - involving service users in planning their services and in some cases delivering them; a capabilities approach to disability - looking at people's

[26] *Learning Disabilities Good Practice Project*, Department of Health, 2013

> strengths and what they can do, rather than looking at what people cannot do for themselves, community capacity building - where people can gradually rely more on community-based support, a move towards more integrated services - bringing in care, health and often housing and leisure, and, a commitment to personalisation – not as a cost cutting measure[27]

Access to Public Health Services was one of the projects highlighted as a an area of good practice. The Health Improvement Partnership project came out of conversations between people working in Public Health Norfolk and Equal Lives (formerly Norfolk Coalition of Disabled People). The aim of the project was to provide action-based recommendations, information and advice leaflets, good practice guides on accessibility, and recommendations for training/development. The project was about people with learning disabilities working with professionals and others to make sure that disabled people get equal access to services. It was agreed that collecting the experiences and advice of people with learning disabilities was the best way to understand the difficulties people face. The project was designed to use these experiences to make recommendations about how to improve access – and so improve health outcomes. The project has tested co-production between people with learning disabilities, family carers and professionals. This has emphasised people's capabilities and highlighted the importance of disabled people being involved in service design and delivery to "make things work". It has also shown the value of building and supporting networks of disabled people/professionals across the county.

Supporting older people with learning disabilities: a toolkit for health and social care commissioners[28] provides some examples of good practice from across the country. For example, the **Older Voices**[29] project is funded by Comic Relief and facilited by Mencap, the project brings together people over 50 with a learning disability to discuss the issues that matter to them and to influence decision making. It provides older people with a learning disabilty the opportunity to influence their community through advocacy and campaigning intitiatives.

[27] *Learning Disabilities Good Practice Project, Department of Health, 2013, page 18-19*
28 Supporting older people with learning disabilities: a toolkit for health and social care commissioners, British Institute of Learning Disabilities (BILD), 2014
[29] https://www.mencap.org.uk/wales/projects/older-voices

Self-harm: local identification of needs

City of York Council

EXECUTIVE SUMMARY

Self-harm is reported to be a growing concern and issue locally. York does have slightly higher rates of hospital admissions due to self-harm than England average rates and anecdotal and audit information from a range of sources identifies growing concerns about increases in self-harm.

There is a current gap in the availability of comprehensive and robust data to be able to clearly identify the full scope of the issue. There are inconsistent ways of recording, reporting and sharing self-harm related information about risk and prevalence where an incident does not result in a hospital admission. Where self-harming behaviour does result in a hospital admission, there is a good availability of local data but this does not provide a full picture about the scope of self-harm.

A range of services and staff groups identify self-harm as a concern but information about the prevalence of this behaviour is not consistently collected or shared between services.

There is a lack of readily available advice and information for people to access about self-harm, how to identify when self-harming behaviour may be happening, what to do and how to support someone who is self-harming.

There is a reported lack of clear referral options for people who are known to be self-harming. Threshold criteria for access to mental health support services for people who are self harming but have no diagnosed mental health conditions are reported to be too high for people to be eligible to access. However, it should be noted that local child and adolescent mental health services are providing a good level of support to those young people who are accessing hospital services in relation to self-harm. There is also a joint pilot scheme to provide more support

into the York Hospital Emergency Department (ED) in order to be better able to support people with mental health needs who are not admitted to hospital. This includes supporting people who are presenting to the ED with self-harm injuries.

There still exists a stigma around self-harm and the local health and social care system might benefit from a focus on training key staffing groups to be able to better support people who are self-harming. By supporting staff to be able to respond effectively to someone who is self-harming, it may make it easier for people to ask for help around self-harm and mental health support needs.

From this paper, there are four areas recommended for local consideration:

- To strengthen the identification and recording of self-harm related problems that do not result in a hospital admission. This will establish a baseline measurement of the extent of the issue and help raise the focus on the importance of accurately being able to identify self-harming behaviour. Without being able to accurately identify how much self-harm is happening it is not possible to demonstrate a suitable response to it.

- To develop and enhance a local offer of information, advice and training to key staff groups and people most at risk of self-harm. This will reduce barriers to people who self-harm seeking help and improve the ability of staff to be able to respond to self-harming behaviour and risks effectively.

- To be able to offer evidence based interventions that are effective in reducing self-harming behaviour and clear referral routes into this support. This would also contribute to removing barriers for people to ask for help.

- To seek assurance that appropriate and adequate pathways exist which allow people who self-harm to receive support. This would include clarity that; self-harming behaviour among adults is assessed and risk assessed by service providers; there are clear pathways into support where self-harming behaviour is identified

which should include consideration of referral processes for adults and children from Emergency Department and referral from schools into CAMHS.

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Self-harm: local identification of needs

City of York Council

CONTENTS:

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INTRODUCTION

Self-harm can be quite difficult to define. There is not one wholly accepted definition but perhaps the most commonly accepted is the NICE (2011) definition:

> Any act of self-poisoning or self-injury carried out by an individual irrespective of motivation.

This definition is stated to exclude harm from excessive consumption of alcohol or recreational drugs, or from starvation through anorexia nervosa, or accidental harm to oneself. However, these sorts of risk taking behaviours are often associated with self-harm. Behaviours such as substance misuse and eating disorders, dangerous driving, dangerous sports, sexual risk taking and self-neglect can be referred to as instances of indirect self harm.

For the purposes of this report the NICE definition as above will be used and the use of self-harm related information will predominantly draw on instances of direct self-harm rather than a wider definition which would include a range of risky behaviours.

In terms of how people self-harm, the most common form is reported to be cutting but there are a range of other ways in which people self-harm. Locally, the cause of admission to hospital in relation to self-harm is overwhelmingly through poisoning by paracetamol. Across the NHS Vale of York Clinical Commissioning Group area, there were 659 admissions to hospital related to self-harm between April 2014 – March 2015. Of these, only 19 were recorded as open wounds i.e. 'cutting' and 581 were related to poisoning – the most common substance used to self-harm through poisoning was Paracetamol.

Some of the other ways to self-harm might include:

- cutting;
- biting self;
- burning, scalding, branding;
- picking at skin, reopening old wounds;
- breaking bones, punching;

- hair pulling;
- head banging;
- ingesting objects or toxic substances;
- Overdosing with a medicine.

Mental Health Foundation (2006).

Self-harm is not the same as suicide or attempted suicide, it is generally used as a way of coping with emotional distress and the majority of people who self-harm do so with no intention towards suicide.

Whilst self-harming behaviour is predominantly a coping strategy which carries with it low immediate risk for suicide, it is not completely separate to suicide. A range of research identifies that future risk of suicide is increased by between 50 – 100 times because of self-harming behaviour (Royal College of Psychiatrists, 2010). In relation specifically to young people aged under 20 years old, 54% of death by suicide between January 2014 and April 2015 were in young people who had previously self-harmed (Healthcare Quality Improvement Partnership, 2016).

An increased level of immediate risk is identified for those aged over 65 who self-harm where the risk of further self-harm and suicide is substantially higher than in other age groups. All acts of self-harm in people older than 65 years of age should be regarded as evidence of suicidal intent until proven otherwise because the number of people in this age range who go on to complete suicide is much higher than in younger adults (NICE, 2011).

For some, self-harming behaviour may only last for a short period of time where for others it might develop into a long-term coping strategy. Some people may stop self-harming but return to this behaviour at times of distress. It is often a secretive and hidden behaviour. This can make it difficult to identify and is not something that can always be changed easily. Even for those people who are receiving support from services, a recovery process can take a long time, particularly where self-harming behaviour has become a normal way of coping for that individual.

A recovery process from self-harm requires finding new coping strategies or using distraction techniques when a person has the urge to

self-harm. Different people find that different techniques work with varying levels of success and these may even vary in how well they work for a person depending on their mood or the situation they are in at that time. Finding the most useful alternative techniques takes time but trying different methods does work to find the most suitable for that person (Mental Health Foundation, 2006).

The reasons given by people who self-harm for their self-harm are varied but the most common is because of emotional distress:

- self-harm temporarily relieves intense feelings, pressure or anxiety;
- self-harm provides a sense of being real, being alive - of feeling something other than emotional numbness;
- harming oneself is a way to externalise emotional internal pain - to feel pain on the outside instead of the inside;
- self-harm is a way to control and manage pain - unlike the pain experienced through physical or sexual abuse;
- self-harm is self-soothing behaviour for someone who does not have other means to calm intense emotions;
- self-loathing - some people who self-harm are punishing themselves for having strong feelings (which they were usually not allowed to express as children), or for a sense that somehow they are bad and undeserving (for example, an outgrowth of abuse and a belief that it was deserved);
- self-harm followed by tending to wounds is a way to be self-nurturing, for someone who never was shown by an adult to express self-care;
- harming oneself can be a way to draw attention to the need for help, to ask for assistance in an indirect way;
- on rare occasions self-harm is used to manipulate others: make other people feel guilty or bad, make them care, or make them go away;
- self-harm can be influenced by alcohol and drug misuse.

NHS Tayside (2011)

Self-harm is an expression of personal distress, not an illness, and there are many varied reasons for a person to harm him or herself (NICE,

2011). A range of factors may cause a person to start self-harming and these might include: family problems; feeling stressed; relationship problems; exam or school work pressure; low self-esteem; bereavement; loneliness and isolation; feelings of guilt; bullying; difficulties associated with sexuality; feelings of rejection; mental health issues; reaction to trauma or abuse; peer pressure; poor body image; substance misuse (drugs and alcohol). There may be a range of other reasons that lead someone to self-harm and these reasons may differ from person to person or be a combination of several different reasons.

Groups at risk

Self-harming is not restricted to a particular group. People of different ages and gender might self-harm and because much self-harming behaviour goes unidentified, due to its secretive nature and its use as a way of coping, it is difficult to identify a clear picture of how often it happens. However, self-harm is known to be more common in younger people than older people and more common in women than men.

The UK has one of the highest self-harm rates in Europe, reported at about 400 per 100,000 people (Royal College of Psychiatrists, 2010).

The reported rate of people admitted to hospital as a direct result of self-harm is identified to be lower than this estimate and in 2013, was 203 per 100,000 people. This figure only reports people who are admitted to hospital and does not account for those who do not seek medical help for wounds, who manage their own wounds from self-harm or do seek medical help but are not admitted to hospital e.g. in an Emergency Department (ED) setting that does not result in a hospital admission.

Because of the secretive nature of self-harming behaviour and stigma associated with self-harm, much goes unreported and the actual rates of presentation to hospital for treatment are likely to represent only a proportion of self-harming behaviour. It is difficult to accurately identify how much goes unreported.

There is not a consistent way that known self-harming behaviour that does not result in a hospital admission is recorded. Where self-harming behaviour might be known about by a range of support services such as mental health support services or schools, there is no standardised reporting process to identify how many people are affected. Just over 40% of young people who died by suicide during 2014 – 2015 were not known to services and had not expressed ideas of suicide; however, self-harm is known to be a common risk factor (Healthcare Quality Improvement Partnership, 2016). This makes it particularly pertinent to consider how able young people feel to access support when problems exist which make them vulnerable to risk of suicide, and what responses will work best to reduce that risk.

Anecdotally, services report increasing concerns about the amount of young people engaging in self-harming behaviour but it is very difficult to clearly identify how many people might be affected. The one clear measure that is available, hospital admission data, is an under representation of the true level of self-harming behaviour that takes place.

Local self-harm data

Public Health Outcome Framework data published by Public Health England shows that between 2010–2013, York is reported to have slightly higher rates of hospital admissions for self-harm in young people aged 10 – 24 than the England rate. This equates to 368 admitted to hospital per 100,000 people compared to 352 per 100,000 people across England.

Across all age groups for the same period, the rate is still higher than the England average. It is 215 per 100,000 people in York compared to 203 across England.

In North Yorkshire for the same time period, the rate for admission in 10-24 year olds is lower than the England average at 310 per 100,000 people.

In North Yorkshire across all age groups for the same time period, this rate is also lower than the England average at 173 per 100,000 people compared to the England rate of 203.

This shows that self-harm cases presenting to hospitals are higher in York than the England average rate and that the rate of hospital admissions because of self-harm is higher in people aged 10-24 than in the rest of the population.

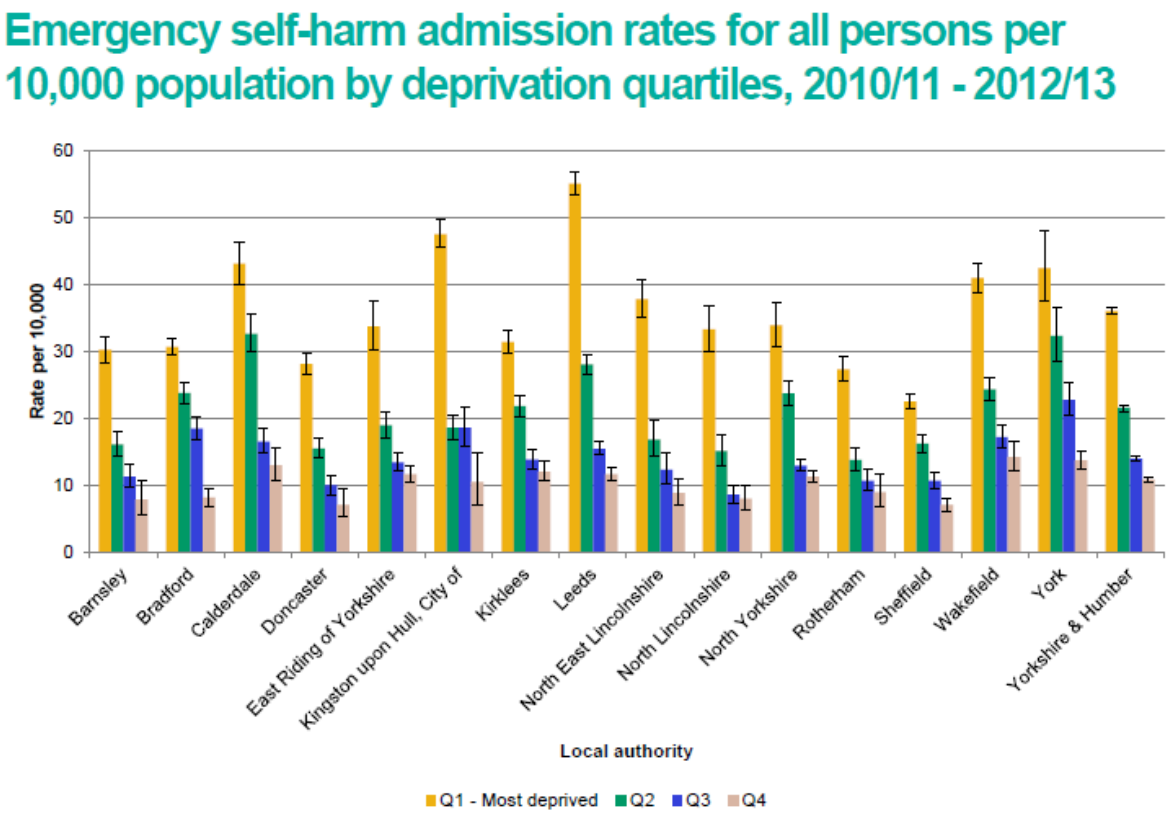
Survey information reports that among 15-16 year olds, over 10% of girls and 3% of boys reported self-harming in the previous 12 months (NICE, 2011).

There are groups of people who are identified as being most at risk of self-harming behaviour. These are:

- adolescent females;
- young people in residential care;
- lesbian, gay and bisexual and transgender people;
- women of South-Asian ethnicity;
- prisoners;
- asylum seekers;
- military veterans;
- children and young people in isolated rural settings;
- children and young people who have a friend who self-harms;
- groups of young people in some sub-cultures who self-harm;
- children and young people who have experienced physical, emotional or sexual abuse during childhood;
- people living in financial deprivation or being unemployed
- people who misuse substances
- people who live in areas that are socially fragmented and disconnected
- people who experience adverse life events
- people who have existing mental ill-health problems and / or previous suicide attempts

NHS Tayside (2011); Royal College of Psychiatrists (2010); NHS Health Scotland (2014)

Increased levels of self-harm related admissions are linked to living in areas of deprivation. The graph below highlights how emergency self-harm admission rates are higher in areas of deprivation across all local authority areas in the Yorkshire and Humber region.



Source: Public Health England: Self-harm and suicide

Local hospital data for the period 2010–2013 for admission because of self-harm has been analysed to identify which wards that people who have been admitted to hospital because of self-harming live in.

This identifies a general trend of higher levels of self-harm related admissions among people who live in wards that have higher levels of deprivation (e.g. Westfield, Guildhall), or have higher proportions of students and people of Asian ethnicity (e.g. Heworth) than the local authority area average.

Three of the five most deprived wards in York have rates of hospital admission for self-harm those are among the 5 highest by ward: Westfield, Clifton and Heworth.

Hospital admissions for self-harm by Local Authority ward area

Admissions for self-harm	Population mid 2013 estimates	% Admissions per population	Ward Name	IMD 2015 (high score = more deprived)
131	13,809	0.95%	Westfield	25.8
94	9,626	0.98%	Guildhall	21.66
94	14,134	0.67%	Clifton	21.01
118	14,217	0.83%	Heworth	16.58
82	12,504	0.66%	Micklegate	15.64
98	11,073	0.89%	Hull Road	14.29
77	13,036	0.59%	Holgate	14.08
46	8,720	0.53%	Acomb	12.95
99	12,206	0.81%	Huntington and New Earswick	12.39
63	11,438	0.55%	Dringhouses and Woodthorpe	9.64
108	10,125	1.07%	Fishergate	9.14
10	3,733	0.27%	Osbaldwick	8.66
44	8,191	0.54%	Strensall	7.85
49	13,375	0.37%	Skelton, Rawcliffe and Clifton Without	7.03
8	2,820	0.28%	Fulford	6.76
9	3,603	0.25%	Heworth Without	5.46
40	5,497	0.73%	Heslington	5.42
12	3,991	0.30%	Bishopthorpe	5.4
6	3,623	0.17%	Derwent	5.08
42	11,972	0.35%	Haxby and Wigginton	4.76
*	4,214	n/a	Wheldrake	4.6
40	10,526	0.38%	Rural West York	4.57

Source: Public Health England; Hospital Episode Statistics; Office for National Statistics IMD

The wards used in this data analysis are old ward profile areas that have since been replaced but because of the data parameters of this data, it has not been possible to use the new ward boundaries.

Locally, hospital admissions among 10-24 year olds can be seen to have fluctuated year by year but that the most recent figures show an increase from 6 years earlier and are at the highest level in this 6 full year period.

These figures clearly show that self-harm admissions for girls and women are higher than in boys and men and are approximately 3 times as high. This reflects national trends in gender differences of self-harm.

Young people aged 10 to 24 years resident in York who were admitted to hospital as a result of self-harm

	Gender		
Financial year	Male	Female	Total
2007/08	43	125	168
2008/09	59	131	190
2009/10	61	132	193
2010/11	41	109	150
2011/12	43	111	154
2012/13	46	147	193

This data also identifies that the highest rates of hospital admission for self-harm are amongst 15-24 year olds.

Young people aged 10 to 24 years resident in York who were admitted to hospital as a result of self-harm

	Age group (years)				Total
Financial year	10-14	15-17	18-20	21-24	10-24
2007/08	18	42	66	42	168
2008/09	17	40	55	78	190
2009/10	13	50	74	56	193
2010/11	13	28	57	52	150
2011/12	18	32	51	53	154
2012/13	22	61	63	47	193

Source: Public Health England, Child and Maternal Health Intelligence Network; Hospital Episode Statistics (HES).

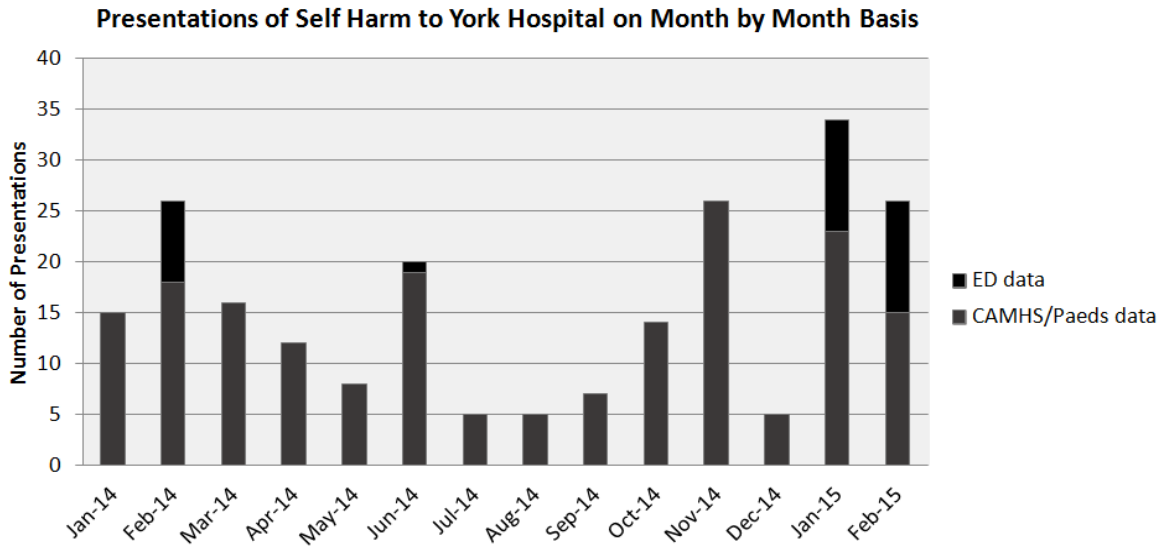
An audit into Child and Adolescent Mental Health Service (CAMHS) completed by Dr. Govenden and Dr. Sykes is summarised below.

Activity data was collected from hospital records of admission to the children's ward and CAMHS documentation of referrals received. Emergency department attendances for all conditions were reviewed for

certain key months between January 2014 and February 2015 for all children aged 10-18 years.

This reported that between January 2014 and February 2015 there were 214 presentations to York Hospital Emergency Department (ED) by 119 children and young people with self-harm and/or suicidal thoughts. Of these children, City of York residents accounted for 91 of 119 children (76%) and 167 (78%) attendances.

The graph below shows the number of children and young people presenting with self-harm. For February 2014, January 2015 and February 2015 data was checked against ED records and additional presentations were found. Shown is the combined total for all records.



The graph shows seasonal variation in presentations with self-harm. There is a rise during the exam period (June) but otherwise the summer months have fewer presentations. In the second half of the study period (July 2014-February 2015) there are more presentations, 117 in total, compared to the first half which saw 102 total presentations.

Key findings were as follows:

- 24 boys (20%) account for 47 (22%) attendances, 95 girls (80%) account for 167 (78%) attendances.
- Young people aged 16 and 17 years accounted for 50% of the total attendances, the youngest child seen was 9 years, the oldest was 18 years.

- Approximately 8% of children in this group are looked after, compared to a city rate of 245 per 10,000 population (2.5%), making them significantly over represented in this group.
- 89% of children seen had a documented risk assessment carried out by medical staff in ED, CAMHS or paediatrics.
- Of 214 presentations: 153 (71%) were admitted; 24 (11%) were discussed with CAMHS and discharged, 4 (2%) self discharged; 25 (12%) were seen and discharged with no risk assessment documented; 8 (4%) had other outcomes.
- 137 (64%) presentations involved overdose of medication or other harmful substances. Of these, 94 included paracetamol. 43 (20%) attendances were due to self injurious behaviour, including one young man found unconscious after an attempted hanging. 34 (16%) presentations were due to increasing thoughts of suicide, self-harm or feeling unsafe.
- Most children stated they felt very low in mood and where a particular trigger was documented, the majority of children and young people cited family issues and arguments as the reason for their self-harm. Issues with relationships, school or work stress, bullying, police visits or court cases and being the victim of sexual assault were also given as reasons for self-harm.
- Many of the children and young people seen in this audit presented only once to ED but a key minority presented over 3 times during the study period.

There were a number of limitations in gathering accurate data for this audit. Only presentations where there was documentation of self-harm intent or suicidal thoughts were included in the audit. Cases of indirect self-harm such as presenting with anxiety, intoxication from alcohol or other substances, or from punching a wall, whilst identified, were not included in the audit. This would indicate that if the criteria for identifying self-harm were broadened, that it would be likely that more children would be identified. The audit only looked at attendances of children and young people under 18.

The audit reported that the majority of the children and young people presenting with self-harming injuries were appropriately assessed and

referred for treatment. During the period of this audit, CAMHS carried out at 147 assessments on children and young people admitted to the paediatric ward. Comparison is made between this figure and data from the City of York Children's and Young People's mental health strategy 2013-2016 document which states that in 2011-2012 '80 young people were seen in hospital by the CAMHS duty team following an overdose or other serious form of deliberate self harm.'

From the data gathered it is clear that there are high levels of children and young people who self-harm in York. A disproportionate number of these children and young people are looked after and the majority of those seen in hospital cite difficult family relationships as the trigger for their self-harm. It is not surprising that those children and young people who lack robust emotional support appear to be at greater risk of harming themselves. Any actions that can be taken to strengthen vulnerable families and that foster emotional resilience in young people are likely to be of great benefit to the mental health of our community.

The audit identifies a range of suggested actions:

- Clear referral pathways: ED has already implemented a new referral pathway for children presenting with self-harm and they are transferred to paediatrics directly for further assessment.
- Consultant review after multiple presentations: CAMHS may consider that a person presenting for the 3rd time within a given period may need more senior review and possibly be considered for admission.
- Clearer coding: ED is currently planning to update their coding system to try to better capture the number of presentations to the department.
- Crisis team in ED: with additional staff training, the ED-based crisis team may be able to directly assess and manage 16 and 17 year olds presenting with self-harm which could potentially lead to more satisfactory outcomes for those young people and reduce the number of inpatient stays.

- Training: ensure all ED and paediatric staff are adequately trained in conducting risk assessments of children and young people.

It would be useful to replicate this audit assessment within the adult (18+) population to understand how well people in high risk groups for self-harming behaviour based on age e.g. 18-25 year olds and those in high risk groups of immediate risk of suicide e.g. over 65 year olds are being assessed for mental health support needs following identification of self-harm.

An Emergency Department Liaison Service is a year-long joint pilot scheme operating in York which was established in October 2014 in response to difficulties managing presentations involving mental ill-health in the ED, dissatisfaction with the service provided to York Hospital by local mental health services, and an overall national drive to improve the service provided for patients with complex physical and mental health needs.

Since January 2015, the team has provided on demand psychosocial assessments for anyone over 16 years of age, presenting to the ED department at York District Hospital 24 hours a day 7 days a week, with an expected response time of less than 3 hours becoming a 2 hour response time from April 2015.

The aims of this service are to reduce breaches, reduce inappropriate admissions, reduce repeat attendance, and facilitate early identification of mental health issues and appropriate signposting and onward referral to secondary mental health service, voluntary services or primary care.
Another function is providing supervision, education and support for the ED staff. The overall goal is to improve the service provided and experience of patients and carers attending the ED, improve collaborative working and links with ambulatory care pathways in ED, with primary care and community mental health services.

This service is limited to the ED so any patients moved on to the medical wards, presenting with mental ill-health on e.g. maternity wards or surgical wards, or presenting with labour and time intensive complex

physical and mental health needs are seen under existing arrangements on an ad hoc basis by the on call psychiatry staff.

A future aim of this provision following the pilot might be to extend the Liaison service in order to support all of York Hospital, working collaboratively with existing services such as psychology, the old age psychiatry team ('MHALT'), the substance misuse liaison team, and developing links between services such as maternity and the proposed perinatal psychiatry service. This would allow expert liaison psychiatry input to improve the psychological care of patients in York District Hospital, promote positive mental health, reduce stigma and ensure parity of esteem between mental and physical health and wellbeing needs.

Due to a recent transfer in service provider of this pilot programme access to activity data is not available for use in this report. This was further complicated by the CQC closure of parts of Bootham Park hospital where this service and its staff are based.

Gaps in data

There is a lack in data around how self-harming behaviour that does not result in presentation to emergency department services or results in a hospital admission is recorded.

A range of services were asked to contribute to the local intelligence about self-harm.

Whilst good practice was described across a number of services in a number of ways that ensured risks for an individual were being identified, it became apparent that self-harm is often not something that is quantified within services.

LOCAL SERVICES

GP Surgeries

GP practices across NHS Vale of York Clinical Commissioning Group were asked to contribute to this report about the scope of self-harm that is identified by GP's. Only one response was received which highlighted some concerns about:

- a lack of consistency in how self-harm is recorded on GP systems
- a lack of confidence in being able to identify those at risk of self-harm
- a lack of effective referral options where self-harm is identified
- a lack of information and support resources available
- attempts to use internet resources but there not being a clearly identified resource

Practices were asked to respond to a brief questionnaire and to supply any other additional information that would contribute to increasing local understanding about self-harming behaviour and its prevalence in the local area. Given the lack of responses to this request, it is difficult to know whether the views highlighted above are shared across all GP's in the clinical commissioning group.

Counselling Services

A number of services offering counselling support were approached to comment on how prevalent self-harm is within the local area. Many of the responses identified a lack of clearly available data around how many people accessing support services were doing so where self-harm was known to be an issue. That is not to say that services didn't feel able to identify self-harm through their assessment processes or through

the development of the therapeutic relationship which allowed the person being counselled to feel comfortable enough to tell their counsellor about their self-harming behaviour.

York St. Johns University Wellbeing Service responded to identify that from August 2015, quantitative information about students who report self-harming behaviour or / and suicidal ideation within their existing risk assessment processes will be recorded to give an overview of the service as a whole in relation to numbers of students presenting with self-harming behaviour. Currently, there are no figures available at a service level; however, risk assessments are routinely carried out with students at appointments using a CORE-34 tool which allows self-harm to be identified and to track changes in this and other risk factors.

The York St. Johns service supported over 700 students in the academic year 2014-15 and estimate that at least half will have presented with some form of self-harming behaviour. The most common self-harming behaviours supported were students who are cutting (usually arms/thighs/stomachs), overdosing (but not with the intent to end their life), head-banging, burning and engaging in damaging eating habits (starving, binging, purging).

The service reported that generally speaking students will either overtly want to discuss/show what they have done, or conversely they will be very reluctant to talk about or acknowledge their self-harm.

The range of support offered in relation to self-harm if students wish to reduce their risk and try to more safely manage their self harm a more detailed risk assessment and safety plan is completed with the student. The service may also do some work with them on how they can make the help-seeking process more accessible for them. For example, this might involve completion of a leaflet which communicates to healthcare professionals what injury they have sustained and how (we use the Indigo project template). This work is done by either our Mental Health Advisors or Counsellors.

The service operates a daily (Mon-Fri) drop-in service which allows staff to routinely assess risk in a prompt manner and take appropriate action.

We also respond to concerns from peers, family, academic staff and any other source who has a significant concern about a student's self-harm. The level of response to these concerns will vary depending on the information provided and any additional knowledge about the student.

The service manager wished to stress that, from her experience in this field, she believes this area to be significantly under-reported, especially in medical statistics, as the majority of people who are self-harming rarely seek support, and very few would actually seek medical intervention.

Castlegate provided a range of information about their counselling services and were also able to identify how many people accessing counselling support reported self-harming. During 2014-2015, 219 people were seen for counselling with an additional 94 expressing an interest in accessing counselling but not accessing it.

Of the 219 clients seen, 77 were people who were self-harming or had self-harmed. Of these, 27 were male and 50 female. 32 were aged 16 – 19 years old and 45 were aged 20 years old or over.

In addition to information about self-harming behaviour, information about suicidal thinking is recorded. Of the 219 clients seen, 87 reported suicidal thinking, 33 of these were male and 54 female. 33 were aged 16 – 19 years old and 54 were aged 20 years old or over.

Of the 219 clients seen, 26 reported having made a suicide attempt, 10 of these were male and 16 female. 9 were aged 16 – 19 years old and 17 were aged 20 years old or over.

Emergency Services

Yorkshire Ambulance Service (YAS) operate the non-emergency medical helpline number – 111 and have provided data about the calls received from people registered to any NHS Vale of York Clinical Commissioning Group GP practice between April 2014 – March 2015 where wound care / self-harm was the reason for calling.

There are some limitations with this data where some of the categories recorded may indicate wound care that is not directly a result of intentional self-harm.

During this period, there were 5,091 calls that were related to wound care or self-harm queries.

Calls to 111 non-emergency helpline in relation to wound care/self-harm

Age band	Apr -14	May-14	Jun -14	Jul -14	Aug -14	Sep -14	Oct -14	Nov -14	Dec -14	Jan -15	Feb -15	Mar-15	Grand Total
under18	153	152	158	150	122	156	159	159	122	138	126	158	1,753
18-64	160	166	156	149	159	151	185	210	202	233	179	226	2,176
over64	74	93	101	79	73	80	99	107	125	124	100	107	1,162
Grand Total	**387**	**411**	**415**	**378**	**354**	**387**	**443**	**476**	**449**	**495**	**405**	**491**	**5,091**

Source: Yorkshire Ambulance Service

Calls made to the emergency 999 number are not specifically coded as self-harm related so it is not possible to extract robust and reliable information about the number of calls to the emergency 999 number about self-harm related incidents. However, there are 7 codes that could be related to self-harm which would account for just under 3,000 out of over 15,000 calls from people registered to NHS Vale of York Clinical Commissioning Group practices.

The most likely codes to indicate self-harm are the ‘overdose/ingestion/poisoning’ and ‘psychiatric/suicide attempt’ codes.

Calls to emergency 999 number which may relate to self-harm

Row Labels	Under 18	18-64	over 64	NULL	Grand Total
Breathing Problems	73	310	447	19	849
Burns/Explosion	10	7	3	10	30

Haemorrhage/Lacerations	23	123	178	11	335
Overdose/Ingestion/Poisoning	51	228	16	24	319
Psychiatric/Suicide Attempt	31	247	15	27	320
Traumatic Injuries, Specific	68	200	67	20	355
Unconscious/Passing Out	44	356	268	41	709
Total (possible self-harm as above)	**300**	**1,471**	**994**	**152**	**2,917**
Grand Total (all reason 999 calls)	**1,139**	**5,796**	**7,085**	**1,631**	**15,651**

Source: Yorkshire Ambulance Service

North Yorkshire Police record known risk factors for the people they interact with. Between 1st April 2012 – 31st March 2015, 335 flags were recorded on the police database to identify self-harm as a known risk factor among children aged under 18.

There are limitations with this data because it is not clear how current and accurate this risk factor data is for all of these individuals and the only time a risk factor is recorded if this is made known to the police officer or PCSO. Risk factors around self-harm are only identified for the people that come into contact with North Yorkshire Police so do not represent a comprehensive prevalence rate across the entire population.

Of the 335 risk factors identified, this represented 251 individuals, 32 of whom were children in the care system. 147 of the risk flags were for males which represented 115 male individuals. 188 risk flags were for females which represented 136 female individuals.

Telephone Support Services

York Nightline is a student listening support service open from 8pm until 8am every night of the University of York term.

The service and organisation is 100% confidential. Nightline does not keep any records of individual callers, they don't ask anyone's name, and everything shared remains completely confidential.

Nightline was not asked to supply any information towards this piece of work because of their principles:

- Confidential: All calls to Nightline are confidential: we won't divulge anything in your call to anyone outside the service.
- Anonymous: We won't make any attempt to find out who you are – we won't even ask your name. Nightline volunteers are anonymous themselves. The reason that Nightline volunteers remain anonymous is to make clear that they only represent Nightline while on duty and that when not on duty they are just another student. The only exceptions to this rule are our Public Faces. However, they no longer do nights or take calls.
- Non-Judgmental: We have no political, religious, ethnic, cultural, political or moral bias. We accept and respect the views of any caller, and we won't criticise or judge you for anything you've done.
- Non-Directive: We won't try to steer you towards any particular course of action, or try to get you to think about your situation in any particular way.
- Non-Assumptive: We don't make assumptions about our callers; we let our callers explain their situation in their own words and in their own time.

Nightline can be contacted on **01904 323735** every night of term from 8pm - 8am or by dialling 3735 from any campus phone.

The Nightline website provides a range of information about self-harm and links to support for people who self-harm which can be accessed at: http://www.yorknightline.org.uk/new-page-66/

Samaritans are a national charity providing listening support to anyone about whatever is troubling them; you don't need to be suicidal to call. Similar to Nightline, because of their organisational principles of complete anonymity and confidentiality to whatever the caller says, Samaritans were not approached to contribute to this piece of work with any information or data. York Samaritans can be contacted on **01904 655 888** (local call charges apply) or free on **116 123** (this number is free to call). Their website is: http://www.samaritans.org/branches/york-samaritans

Schools

A local pilot programme to place qualified mental health support workers in local schools begun in November 2015. It is too early in this pilot approach to provide any information from this scheme for the purpose of this report. However, it is expected that this programme will bring a number of benefits to the mental wellbeing of local students by providing a visible point of contact for pupils who may be experiencing distress. By making access to support more accessible and safe for students whilst reducing the stigma associated with mental health problems, it is expected that there will be a range of positive outcomes for the schools and the pupils who attend them.

Personal Social Health Education programmes run in every school. No detailed information is given in this report about what elements of these lessons are provided within local schools that may help pupils to build resilience, raise awareness about self-harm risk factors, or to provide information to pupils on how to find alternate methods of coping, or to seek help in relation to mental health or self-harm specific issues.

Exams are identified as particular stress points for young people and local student support services report spikes in need for support and increases in self-harming behaviour at exam times.

Voluntary Sector

A range of support services for people experiencing mental ill health or distress are provided across the local authority and clinical commissioning group area, however, no specific information about the extent of self-harm that these services support has been identified. The type of support offered includes support groups for people, information, advocacy, counselling and training for people to build resilience and skills such as Mindfulness.

RESPONDING TO SELF HARM

Safeguarding

The City of York Safeguarding Children Board Threshold Guidance identifies self-harming behaviour among young people as requiring a level 3 statutory response across all age groups of children up to 18 years of age.

Universal	Level 2 emerging	Level 2 escalating	Level 3
Emotional Health	Good state of emotional health. Good emotional development and responses. Appropriate expression/ recognition of emotions. Appropriate facial expression.	Infrequent, inconsistent emotional problems/responses E.g. expression, recognition, facial expression. Vulnerable to emotional problems e.g. following divorce, separation or bereavement, relationship / friendship breakdown. Unduly anxious, angry, defiant or withdrawn.	Frequent significant emotional problems/responses e.g. expression, recognition, facial expression e.g. arising from divorce, separation, step parenting, bereavement, relationship/friendship breakdown. Emotional health/appearance deteriorating/problems emerging e.g. conduct disorder, Attention Deficit Hyperactivity Disorder, anxiety, eating disorders.

Where self-harming is identified, a level 3 response requires a Child in Need (S17) assessment and intervention. During 2014 – 2015, there were a total of 691 of these assessments completed and self-harm was

identified as the reason in 1.4% of these. For the year date since 1st April 2015, the assessments where self-harm featured equates to 4% of the 363 completed to date (as at 27th November, 2015).

Perceptions around self-harm

In 2006, The Mental Health Foundation published a report into self-harm called 'Truth Hurts' in which they identified how the young people they spoke with to help prepare the report identified negative experiences of asking for help which often made things worse for them. Many were met with ridicule or hostility from the professionals that they turned to.

For the purpose of this report, three people from the local area who have self-harmed were interviewed about their experiences of self-harming, seeking help and recovery in this area. These three people's experiences differed because of their personal circumstances, the routes they explored to get help, the support they received and their recovery proves. All talked directly about experiences of support in York and all had sought and received help and were now in a position where they reported no longer self-harming. However, all identified similar issues of not feeling able to easily ask for help; not knowing who or where to go to for help; of feeling dismissed when talking about their self-harm as identified in the 'Truth Hurts' report.

Other feedback of their local experiences included:

- A lack of awareness amongst health professionals about self-harm. This ranged from:
    - staff using self-reported harming behaviour as a means to assess the stability of depression.
    - being told that the self-harming would never stop
    - never feeling able to go to A&E because of the lack of empathy and compassion experienced
    - never being given any advice about other ways of coping or about harm minimisation or wound care

- feeling that the support offered took too long to be given, particularly if experiencing a crisis;
- that there was a distinct lack of advice given about other ways of coping;
- a lack of harm reduction advice given and an expectation from staff in services supporting these people that they should stop their self-harming behaviour. Examples of situations were given where self-harming behaviour was not tolerated by ward staff in hospitals with a result being to discharge a person who had self-harmed whilst on the ward. Other examples were given where teaching staff were asking to see pupil's arms to make sure that they were not cutting themselves which had the effect of pupils choosing other sites on their bodies to cut and then not wanting to talk to anyone about their self-harming behaviour;
- that ongoing support is crucial to help maintain recovery from self-harming behaviour. This could include having access to a mental health support line to turn to. For one of the people, this resource had been invaluable but was being withdrawn as a resource.
- all had tried accessing support groups, either in person or on-line but predominantly on-line and these were reported to be good supportive groups. However, the risk associated with on-line groups was raised as a concern because some sites can be harmful and it is essential to find a well moderated site that was run with the interests of the safety of the people using it in mind.

A report written by NHS Health Scotland in 2014 also identified a need to improve the experience of care for people who have self-harmed. The experiential evidence provided above and the fact that the issue of improving patient experience around self-harm is still being identified as a need, suggests that people who self-harm are still having negative experiences of seeking help. Whilst this is still the case, it is likely that the numbers of people feeling able to ask for help in connection to their self-harming behaviour will remain low.

NICE CG16 and CG133 (2004; 2011) guidance identifies a number of areas requiring implementation in the care of someone who has self-harmed which includes a focus on developing a supportive relationship

with the person; completing a comprehensive assessment of need and risk; developing a care plan; sharing information with the person's GP and offering an appropriate level of ongoing support which accounts for other mental health support needs and personal circumstances.

The Royal College of Psychiatrists (2010, 2014) recommends that a public health approach towards self-harm should include elements of staff training across a range of sectors; the provision of information and advice; and should identify responses to growing concerns about the internet, social media and social isolation.

Evidence for Interventions

A 2010 evidence review (Wood, S. et al, 2010) report which reviewed a range of interventions effective in preventing, supporting and reducing self-harm and suicide suggests that the following interventions might have some benefits if applied locally:

Developing awareness and skills: School-based education programmes can improve knowledge, attitudes and help-seeking behaviours. Programmes that develop coping skills can improve attitudes towards suicide and reduce suicidal ideation. They have shown promise in reducing both completed and attempted suicides.

Increasing identification and referral: Although findings have been inconsistent, training for health care professionals to improve awareness of suicide has had positive short term effects on suicides and suicide attempts. Training for gatekeepers (other professionals in contact with at-risk groups) can reduce suicide and increase use of mental health services when used as part of wider multi-component interventions.

Supporting and treating those at risk: Help lines can have small effects on levels of suicide when included in services at suicide prevention centres (that also provide outreach and awareness campaigns). There is some evidence that psychotherapy can reduce suicidal ideation, suicide attempts, and repetition of suicidal/self harm behaviour. Among people attempting suicide, professional contact a year after discharge from hospital can reduce the number of reattempts.

Among some high-risk groups (e.g. those with mood disorders), drug treatments can prevent suicide attempts.

Community interventions: At hotspot areas, the use of safety fencing or signposting to support services can reduce suicides. Multicomponent community interventions that combine a variety of initiatives (e.g. education, training for professionals and support) can also reduce rates of suicide.

Societal measures: Restriction of access to lethal means can be effective in reducing suicide rates. Although evidence is limited, the introduction of media guidelines on suicide reporting has been associated with positive changes in reporting as well as decreases in annual suicide levels.

NHS Health Scotland (2014) identifies a range of measures that are recommended to include in local service provision arrangements:

Focus	Actions and interventions
Society	Social protection
	Restricting availability and access to lethal means
	Reducing affordability of alcohol
	Improved media reporting
	Public education campaigns
	National suicide prevention programmes
Community	Building community resilience and connectedness
Individuals	Gatekeeper training
	Screening
	Primary care interventions
	Assistance to family/friends of high-risk individuals
	Postvention
Specific populations	School-based suicide prevention programmes
	Prison-based prevention programmes
	Drug misuse programmes

Source: NHS Health Scotland

Social media is a resource that has potential for benefits and harms to those who use it in relation to self-harm. There is concern over the influence of social media but limited systematic evidence, despite stories

of individuals who have been bullied or encouraged to self-harm. This has to be balanced against the support that vulnerable people may find through social networks. A recent systematic review of the research literature has confirmed that young people who self-harm or are suicidal often make use of the internet. It is most commonly used for constructive reasons such as seeking support and coping strategies, but may exert a negative influence, normalising self-harm and potentially discouraging disclosure or professional help-seeking (Department of Health, 2015).

Locally defined approach

Developing a co-ordinated approach across services which supports increased understanding of the needs of our local population around self-harm, the prevalence of it and an ability to be better able to respond to at risk groups; training and development to more effectively identify and support people who do self-harm along with improved data collection; a defined approach which allows support and services to be developed in line with best practice guidance such as NICE CG16 and CG133 self-harm guidance for short and long term management and prevention of self-harm.

Developing a co-ordinated approach between local suicide prevention plans and self-harm would acknowledge the interconnectedness of these two issues.

Developing a locally relevant training, information and advice offer around self-harm would support recommended approaches to improve the patient journey for someone who self-harms, to be able to offer support based on best practice and to create accessible and high quality resources for a range of people.

Developing local pathways into support services for someone who self-harms would help to more clearly identify how people could access support and to make the offer of support much more visible.

Exploring how technology and resources like social media can be better utilised to allow people who self-harm to be able to support themselves in a safe way and to access information and advice.

To consider how family and friends can be supported where self-harming behaviour is occurring in someone they care about.

The North Yorkshire Police / York University Mental Health Research Project has an objective to produce some locally relevant research into self-harm.

There is a clear need to improve the experience of care for those who have self-harmed.

Self-harm is a complex mix of risk and protective factors which vary across the course of a person's life. It is likely that a range of preventative actions and interventions will be needed.

Consideration could be given to local evaluation of interventions so that clear outcomes can be measured which will contribute to our understanding of what works.

References

Department of Health (2015). Preventing suicide in England: two years on. https://www.gov.uk/government/publications/suicide-prevention-second-annual-report

Govenden, S. & Sykes, N., City of York Child and Adolescent Mental Health Executive (2015). Audit of Children and Young People Presenting to York Hospital Emergency Department with Self-Harm between January 2014 and February 2015.

Healthcare Quality Improvement Partnership (2016). Suicide by Children and Young People in England. http://www.bbmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/

Mental Health Foundation (2006). Truth Hurts. http://www.mentalhealth.org.uk/publications/truth-hurts-report1/

National Institute for Health and Care Excellence (2004). CG16 Self-harm in over 8's short term management and recurrence of problem. https://www.nice.org.uk/guidance/cg16

National Institute for Health and Care Excellence (2011). CG133 Self-harm in over 8's long term management. https://www.nice.org.uk/guidance/cg133

NHS Health Scotland (2014). Prevention of suicide and self-harm: research briefing. http://www.chooselife.net/uploads/documents/135-23356Research%20briefing%20on%20prevention%20of%20suicide%20and%20self-harm.pdf

NHS Tayside (2011). Supporting children and young people at risk of self-harm and suicide. http://www.nhstayside.scot.nhs.uk/YourHealthWellbeing/PROD_213126/index.htm?wb48617274=6520F190

Public Health England (2015). Public Health Outcomes Framework. http://www.phoutcomes.info/

Royal College of Psychiatrists (2010). Self-harm, suicide and risk: helping people who self-harm.
http://www.rcpsych.ac.uk/files/pdfversion/CR158.pdf

The Royal College of Psychiatrists (2014). Managing self-harm in young people.
http://www.rcpsych.ac.uk/usefulresources/publications/collegereports/cr/cr192.aspx?wb48617274=70336D95

Wood, S., Bellis, M.A., Mathieson, J., Foster, K. (2010). Self-harm and suicide a review of the evidence for prevention.
http://www.cph.org.uk/wp-content/uploads/2012/08/self-harm-and-suicide-a-review-of-evidence-for-prevention.pdf

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Health and Wellbeing Board **7 September 2016**

Joint Report of the Chair of the York, Easingwold and Selby Integration and Transformation Board and the Director of Adult Social Care, City of York Council.

Update from the Integration and Transformation Board

Summary

1. This report summarises discussions that have taken place at the Integration and Transformation Board.

Background

2. At the May 2016 meeting of Health and Wellbeing Board it was agreed to establish an Integration and Transformation Board as a sub board, accountable to the York Health and Wellbeing Board for the area of York. It is also accountable to North Yorkshire's Health and Wellbeing Board for the area of Easingwold and Selby.

3. The Integration and Transformation Board (ITB) has been set up to bring together local leaders to develop a vision and single transformation plan for the local footprint. This plan will inform the larger footprint Sustainability and Transformation Plan (STP) for Humber Coast and Vale and will reflect a bottom up approach to transformation. It takes a community focussed, asset based approach – building upon people's strengths and abilities, rather than being reliant upon traditional statutory services. It is developing actions from the whole system and identifying projects that involve activities that directly interface with one another to enable a focus on breaking down professional, organisational and cultural barriers that impede progress towards integration. The local plan will become an integral part of the Health and Wellbeing Board's (HWBB) vision and strategy and will both reflect and inform discussions at the larger geographical footprint.

Main/Key Issues to be Considered

4. Since its conception in March 2016, multi-agency discussions, including a workshop, have taken place to create the conditions locally that will allow us to develop the single plan for the health and social care economy plan.

5. Early meetings naturally focused on defining purpose, terms of reference and the behaviours required, to form a different relationship between partners, so that we are able to shape a radically different offer for local people.

6. Through these meetings a very strong consensus, has developed amongst local system leaders, about the need to work differently in future. They recognise the need to improve outcomes and meet rising expectations within a difficult historical financial context locally, exacerbated by increasing demographic, population and cost pressures. In essence, we need to bring about a paradigm shift, changing expectations, thinking and behaviours of local people and partners, fundamentally changing the nature of our relationships. There is a need to reshape the way we commission services, the way services are organised and the relationship between different parts of the system. This has implications for the whole architecture supporting the health and social care economy.

7. The Integration and Transformation Board have identified an immediate priority to agree a joint commissioning strategy to: reduce duplication of activity, maximise efficiency and therefore value for money, develop co-ordinated services that integrate seamlessly around the customer and effectively utilise evidence, intelligence and data to identify need. This Joint Commissioning Strategy should cover the same timeframe as the new Joint Health and Wellbeing Strategy. The Joint Commissioning Strategy must also support the separate but linked priorities of local authorities and NHS organisations in the area, in addition to the delivery of the local ITB Plan (STP)

8. Although the ITB have asked for lead commissioners to take this forward additional support is required to help get the views of all stakeholders, gather and analyse financial and non-financial data and signpost us to good practice developed elsewhere. This is a vital piece of work that will need to be completed to enable planning for 2017/18 financial year.

9. A Joint Commissioning Plan should ideally be produced after agreeing a joint commissioning strategy. This plan would incorporate the linked priorities of commissioners and grow the pooled budget. The thinking so far is that any joint commissioning plan is needed should be reviewed annually, following refresh of the Joint Strategic Needs Assessment (JSNA) but roll over to cover at least 18 months to see projects through a standard procurement cycle.

10. Discussions have taken place at ITB and HWBB Development sessions about the need to set up a Joint Commissioning Board/Forum. It is proposed that this should report to the HWBB not ITB, as some commissioning activity may take place outside remit of ITB. A Joint Commissioning Board would provide a multi agency partnership forum able to carry out detailed appraisal of options for reshaping provision (one of the first proposals to be presented to the Integration and Transformation Board, to change the way the system supports people with care and support needs is the Archway Proposal). This involves the development of a community base model and a shift in resources to deliver better outcomes, closer to home. As a first step it has been agreed with the NHS Vale of York Clinical Commissioning Group and North Yorkshire County Council the need to develop a Joint Commissioning Strategy, following which we would then consider development of a joint commissioning plan and greater pooling of resources (development of a Joint Commissioning Board will improve partnership working, integration and planning in the future).

11. A review of local authority and NHS Commissioning arrangements, should logically explore opportunities for creating some form of shared or joint resource. The final form will depend upon the model of health and social care integration adopted in York and North Yorkshire.

12. On 28th July 2016, a Better Care Fund (BCF) plan for 2016/17 was submitted to NHSE. The difficulties in concluding negotiations around this plan are well documented and there has been an acceptance by all partners of a need to grow the BCF, both in scope and pooled funding. The Integration and Transformation Board has direct responsibility to managing this programme and growing the pooled budget. At the ITB initial thoughts were to include Continuing Health Care, mental health services and Integrated Personal Budgets within the bigger pool, at the earliest opportunity with work with reviews beginning this year.

13. On 15 August 2016 confirmation was received from NHS England (NHSE) that the BCF plan for 2016/17 had been approved following assessment against the BCF assurance process. A formal letter of approval will be sent. Work is taking place, involving the council and NHS Vale of York Clinical Commissioning Group (CCG) to update and renegotiate the Section 75 Agreement. Crucially this agreement needs to set out risk management principles, risk sharing arrangements linked to a detailed breakdown of funding and savings.

14. A multi agency BCF Task Group has been set up to support and challenge delivery of the programme and widen involvement in the programme. This group will report on an exception basis to the Integration and Transformation Board, as well as help produce the quarterly report for the Health and Wellbeing Board. The group will also support production of the quarterly monitoring report required to be submitted to NHS England for the York HWBB.

15. A facilitated workshop is being organised for the September meeting of the Integration and Transformation Board; to create a better understanding of the separate activities of key partners, achieve better alignment, aiming towards the production of a shared high level plan of activities for the whole system.

16. The ITB have already recognised that this transformation programme is drawing on increasing reserves of existing resources and the need to invest in addition dedicated capacity is essential if we are to keep building momentum. Agreement has been reached to fund a new programme manager post to support the work of the Integration and Transformation Board.

Consultation

17. These issues summarised in this report have been subject to discussion and agreement involving a wide range of partner organisations with York and North Yorkshire.

Options

18. There are no options provided in this report.

Strategic/Operational Plans

19. The plans produced by the ITB will build on the strategic plans of all partner organisations, including the CCG and City of York

Council. The plan will also need to align to the Sustainability and Transformation Plan for the area and the York's renewed Joint Heath and Wellbeing Strategy.

Implications

20. The health and social care system in York is under severe pressure. The work of the Integration and transformation Board is critical to developing approaches across the different parts of the system to develop sustainable solutions.

    The creation and appointment of a dedicated Programme Manager post is essential to maintain momentum and provide much needed support to all partners.

Risk Management

21. The establishment of an Integration and Transformation Board provides a platform for local system leaders to meet with a focus on delivery. The Board will identify and lead breakthrough projects that will help break through organisational and professional barriers and bring about culture change. These projects probably represent the biggest risks to the system and to single agencies.

22. Integrated solutions, co-produced with local people, in a spirit of shared enterprise will provide a model of risk management on the largest scale. All partners need to recognise that decisions made in this forum will impact on the whole system, as will the consequences of success or failure.

Recommendations

23. The Health and Wellbeing Board are asked to:

    I. Note the progress being made
    II. Support the work being done to develop a joint commissioning strategy
    III. Consider the comments around the need for a Joint Commissioning Board
    IV. Receive a further report on the Section 75 Agreement at its next meeting

    Reason: to keep the HWBB updated on progress being made by the Integration and Transformation Board.

Contact Details

Author:

Tom Cray
Senior Strategic Commissioning Lead
Health and Wellbeing
City of York Council
01904 554070

Chief Officer Responsible for the report:

Martin Farran
Director of Adult Social Care
City of York Council
01904 554045

Report Approved ✓ **Date** 24.08.2016

Specialist Implications Officer(s)

Ewan King,
Director,
Social Care Institute for Excellence

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:
None

Annexes
None

Glossary
BCF – Better Care Fund
CCG – NHS Vale of York Clinical Commissioning Group
HWBB – Health and Wellbeing Board
ITB – Integration and Transformation Board
JSNA – Joint Strategic Needs Assessment
NHS – National Health Service
NHSE – NHS England
STP – Sustainability and Transformation Plan

Health and Wellbeing Board **7 September 2016**

Report of the Director of Public Health

Alcohol Strategy Consultation Response

Summary

1. The purpose of this report is to present the findings of the public consultation on the draft Alcohol Strategy for York 2016-2021.

Background

2. The Health and Wellbeing Board approved the draft alcohol strategy for consultation at the meeting of the Board held on 18 May 2016.

3. The consultation was held for a six week period until 6 July 2016 which was then extended for a further period to 31 July 2016 following discussion at the Communities and Environment Policy and Scrutiny Committee to allow more time for comments.

4. There were 26 responses to the online survey. A number of these were individual responses submitted on behalf of partnership groups or organisations including the Safer York Partnership, North Yorkshire Fire and Rescue Service, North Yorkshire Police, the NHS Vale of York Clinical Commissioning Group and City of York Council. In addition, feedback was received from members of the public and through discussion at various groups including the Communities and Environment Policy and Scrutiny Committee.

Main/Key Issues to be Considered

5. The feedback has generally been supportive with the majority of respondents in agreement with the stated vision and aims of the strategy.

6. However there were a number of key themes emerging from the consultation that need to be considered. These include:

- The need to more clearly acknowledge the benefits that alcohol brings to the City and balance this against the harms that alcohol may cause or contribute to

- Provide a clearer acknowledgement and focus on tackling alcohol-related issues that are connected to crime and disorder

- More clearly identify the governance arrangements for delivery of the strategy

7. The strategy is being re-drafted in response to the feedback received and will be published shortly.

8. All the comments and contributions have been collated and analysed and are presented as an **Annex** to this report.

Consultation

9. The draft strategy has been subject to public consultation and the results of this consultation are set out in the **Annex** as stated above.

Options

10. It is proposed that the responsibility for providing strategic oversight of the delivery of the alcohol strategy, and making the strategic links across partnership groups, is delegated to the Safer York Partnership with an annual report on progress with implementation being submitted to the Health and Wellbeing Board.

Analysis

11. The Modern Crime Prevention Strategy (March 2016) recognises the impact that alcohol has on communities and the association between alcohol use and violence. The actions outlined in the Modern Crime Prevention Strategy are based on evidence that reducing the availability of alcohol, providing targeted treatment and brief advice and intervention approaches that build life skills and resilience can be effective in reducing alcohol harm.

12. We recognise that many partnership agencies already tackle alcohol related issues on a daily basis as part of their core business. Tackling under-age sales, licence compliance, protecting communities from anti-social behaviour and managing the health impacts of alcohol misuse are just some of the activities

undertaken. We also recognise the benefits that alcohol can bring to the City in terms of the economy and jobs in the leisure industry.

13. Based on the above, it is argued that the Safer York Partnership is best placed to take the strategic lead on the alcohol agenda and to be responsible for the strategic oversight of the delivery of the alcohol strategy for York.

Strategic / Operational Plans

14. The proposals outlined in this report will enable an alcohol strategy for York to be put in place that will reduce the burden of alcohol-related harm across the life course with a focus on delivery of the following outcomes.

Promoting safer communities:

a. Reduce the incidence of alcohol-related crime and anti-social behaviour

b. Improve the management and planning of the night-time economy

c. Work with local communities to build their capacity to develop resilience and local solutions to problems, working in partnership with local agencies

Improve Health and Wellbeing:

d. Promote sensible drinking within recommended guidelines

e. Ensure alcohol treatment and recovery services are available to those that require them

f. Seek to prevent further increases in levels of chronic and acute ill-health caused by alcohol

Protect Children and Young People

g. Reduce alcohol related harm among children and young people

Create Capacity

h. Strengthen data collection and utilisation across stakeholders to support the development of future plans

i. Increase capacity for delivering the strategy through workforce planning, training and development

Council Plan

15. The proposal directly relates to the Council Plan 2015-19 priorities:

- **‘A prosperous city for all’**
- ‘**A focus on frontline services’** - to ensure all residents, particularly the least advantaged, can access reliable services and community facilities.
- **‘A Council that listens to residents’** – to ensure it delivers the services they want and works in partnership with local communities

Specialist Implications

Financial

16. There are no financial implications from this report.

Human Resources (HR)

17. There are no Human Resources implications from this report.

Equalities

18. There are no equalities implications from this report.

Legal

19. There are no legal implications from this report.

Crime and Disorder

20. There is both crime and anti-social behaviour associated with alcohol misuse. Effective and accessible treatment opportunities, together with partnership working across police and community safety teams, will contribute to improved community safety.

Information Technology (IT)

21. There are no IT implications from this report.

Property

22. There are no property implications from this report.

Risk Management

23. There are no risks associated with this report.

Recommendations

24. The Health and Wellbeing Board is asked to:

- Note the consultation response to the draft alcohol strategy and acknowledge that the strategy is being amended to take account of these prior to being finalised for publication.
- Approve the delegation of responsibility for strategic oversight of the delivery of the alcohol strategy to the Safer York Partnership
- Agree to receive annual reports detailing progress on implementation of the alcohol strategy.

Reason: To support the delivery of an alcohol strategy for York that will reduce alcohol-related harm across the City.

Contact Details

Author:

Nick Sinclair
Public Health Specialist Practitioner Advanced
01904 554353

Marion Gibbon
Assistant Director- Consultant in Public Health
01904 552095

Chief Officer Responsible for the report:
Sharon Stoltz
Director of Public Health

Report Approved	√	**Date**	25/08/16

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers

Draft Alcohol Strategy for York 2016-2021 report to the Health and Wellbeing Board 18 May 2016

http://modgov.york.gov.uk/documents/s105953/HWBB%20Alcohol%20Strategy%20Report.pdf

Modern Crime Prevention Strategy 2016

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/509831/6.1770_Modern_Crime_Prevention_Strategy_final_WEB_version.pdf

Annex

Draft York Alcohol Strategy 2016-2021 Consultation Response

Annex A

Summary of the consultation response to the alcohol strategy

The draft alcohol strategy was open for consultation for a 6 week period until 6th July which was then further extended until 29th July to enable further responses to be submitted.

There were 26 responses to the online survey that included feedback submitted by individuals from a range of professional groups or organisations such as the Safer York Partnership; North Yorkshire Fire and Rescue Service; NHS Vale of York Clinical Commissioning Group; North Yorkshire Police; City of York Council. In addition, feedback was received from various individuals, boards and the community safety scrutiny committee.

On the whole, feedback was supportive, positive and in agreement with the stated vision and aims. However, some key themes that have been raised through the consultation process were:

- More clearly acknowledge the benefits that alcohol brings to our city and balance this against the harms that alcohol causes or contributes to
- Provide a clearer acknowledgment and focus on tackling alcohol related issues that are connected to crime and disorder
- More clearly identify governance arrangements for the delivery of the strategic aims.

The various comments and contributions to the consultation have been collated and are being used to revise the strategy prior to being published.

Amendments to the strategy made on the basis of the consultation feedback are to:

- Update the local data references where this was available
- Amend the stated priority areas in order to more clearly acknowledge crime and disorder harm; more clearly state how the focus on data collection and use can contribute to a reduction in alcohol related harms
- Governance arrangements

Results

In addition to the feedback from the survey, comments were received in a number of other ways and have included comments about:

- Data used to represent the picture around alcohol needing to be more locally specific
- A clearer link between alcohol and local deaths on the river
- A clear commitment that a specific number of people will not die from alcohol
- That the need to share and use date is, whilst important, perhaps not necessary as a specific outcome
- That the strategy is inward facing

Survey Results

The survey asked seven questions and the results are presented below

Number	Question	Responses
1	Our vision for alcohol is to reduce the harms from alcohol by encouraging responsible drinking, providing support and treatment. What do you think of this vision?	26/26
2	This document sets out four objectives. Are these the objectives that you would like to see?	24/26
3	Has the strategy set out the achievements you would like to see?	26/26
4	Has the strategy set out the outcomes you would like to see?	24/26
5	What resources should be used to help reduce alcohol harm?	23/26
6	Who should be involved in helping to reduce alcohol harms?	25/26
7	Would you like to be involved in helping to reduce alcohol related harm?	24/26

Annex A

Respondents were offered the opportunity to comment on their answers to each of these questions. The key responses are summarised in the table below:

Number	Key themes
1	Improved understanding; joint commitment; achievability; specific alcohol problems; action plans required
2	Research; joint approach; enforcement; community engagement
3	Plain English; clear objectives; strategy needed; prevention and early intervention
4	Commitment from stakeholders; prevention and early intervention; understanding; interventions
5	Multi-agency approach; research; awareness; public involvement; education; responsibility
6	Multi-agency approach; Public Health; City of York Council; Range of stakeholder involvement
7	Not applicable

The majority of the feedback received has been supportive of the strategy and whilst there are some detailed actions to develop as part of a delivery plan, the responses have identified that the majority of respondents support the strategy.

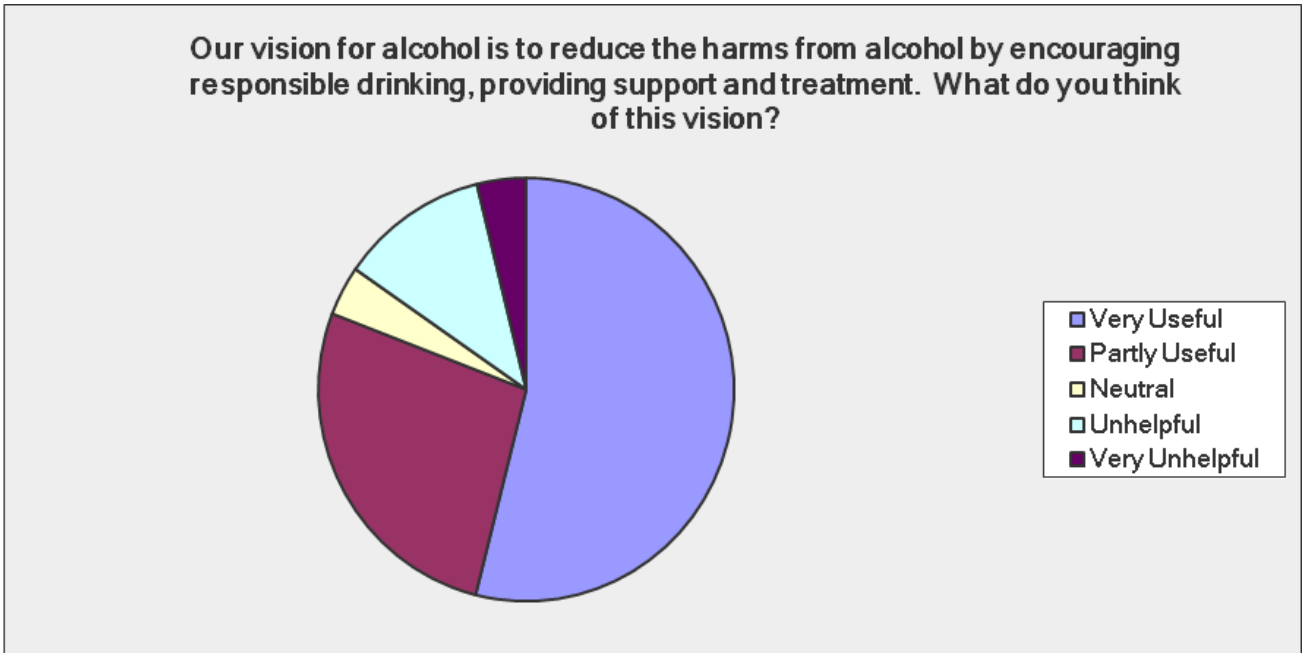
Question	What do you think of the vision for this strategy?			
Very useful	Partly useful	Neutral	Unhelpful	Very unhelpful
53.8%	26.9%	3.8%	11.5%	3.8%

Question	Yes	No
Are these the objectives that you would like to see?	70.8%	29.2%
Has the strategy set out the achievements you would like to see?	76.9%	23.1%
Has the strategy set out the outcomes you would like to see?	66.7%	33.3%

Annex A

Question 1:

Our vision for alcohol is to reduce the harms from alcohol by encouraging responsible drinking, providing support and treatment. What do you think of this vision?		
Answer Options	**Response Percent**	**Response Count**
Very Useful	53.8%	14
Partly Useful	26.9%	7
Neutral	3.8%	1
Unhelpful	11.5%	3
Very Unhelpful	3.8%	1
Please explain why you think this		25
	answered question	**26**
	skipped question	**0**



A range of reasons were supplied to support the answers to Question 1 and these included comments about:

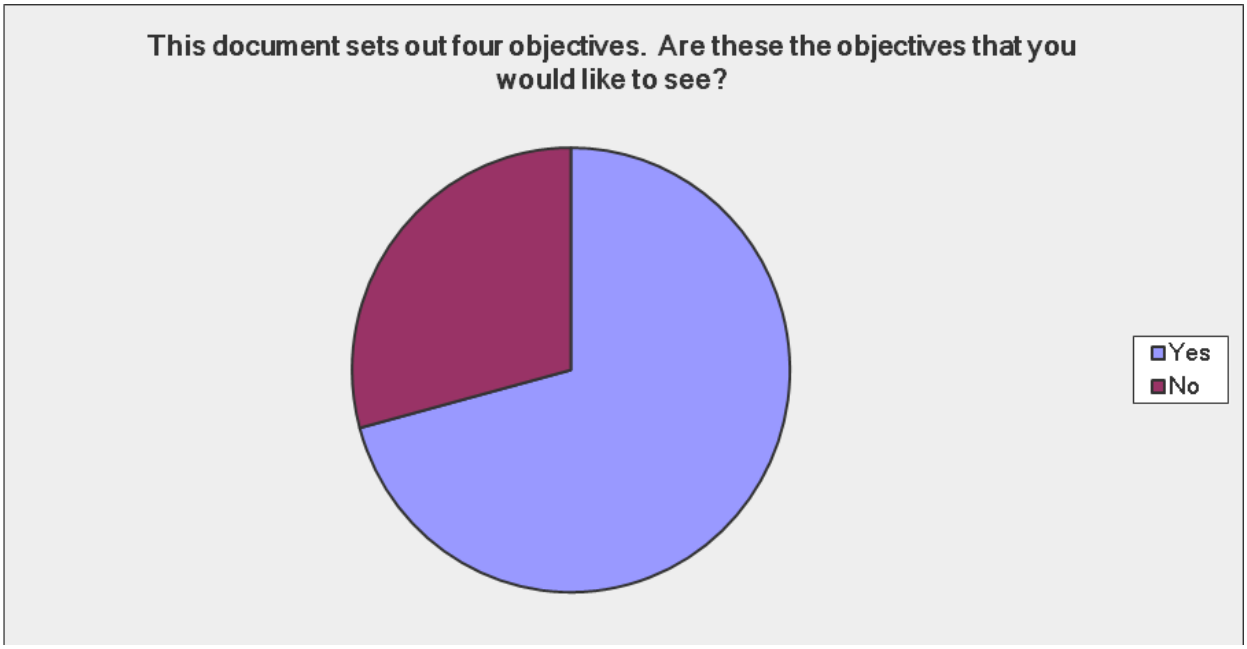
- Acknowledging the wider harms from alcohol
- The need for services who support carers to be funded
- Needing to understand why people drink
- Alcohol is legal and there should be no judgement about how people choose to use it
- Nobody who is drunk should be allowed into A&E
- Some responses are set up but not enforced i.e. alcohol zones

- Accreditation scheme to promote responsible selling of alcohol
- There is a shared responsibility when it comes to alcohol
- The use of language in the strategy is poor
- A balance needs to be struck between the harms and benefits
- A joined approach would allow consistent messages
- Personal responsibility is only realistic alongside cuts to services
- City wide commitment is essential
- Alcohol related anti-social behaviour is a growing issue
- Public safety should be prioritised and access to treatment should be encouraged
- The strategy has gaps and does not consider: alcohol and mental health; alcohol and drugs; preventing alcohol harm; changing the culture around alcohol
- Street drinking and availability of cheap alcohol is a problem
- The action plans that need to sit under the strategy are key
- Good idea but is it realistic
- Public education is vital
- There is no detail about the health impact of alcohol in pregnancy
- Encouraging moderate and responsible drinking is a good approach
- People who don't drink are socially excluded because alcohol underpins social interactions
- In principle it is good but difficult to 'police'
- Positive approach, not sure how you achieve it

Question 2:

This document sets out four objectives. Are these the objectives that you would like to see?		
Answer Options	**Response Percent**	**Response Count**
Yes	70.8%	17
No	29.2%	7
If no, what else would you want to be included?		14
answered question		**24**
skipped question		**2**

Annex A



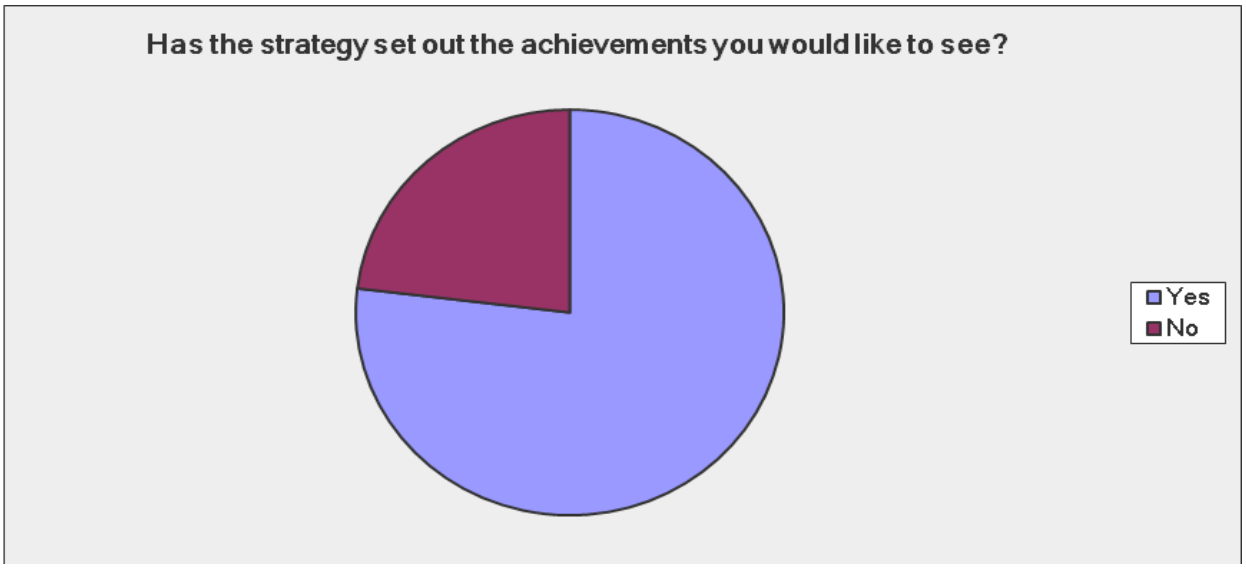
A range of reasons were supplied to support the answers to Question 2 and these included comments about:

- No, money should not be spent influencing behaviour around a legal product
- More policing needed to enforce laws
- Review licensing strategy and provide alternative social offers not focussed on alcohol
- Building community capacity is the key element
- This is not a simple yes or no response and requires expert research
- Professional principles should be considered in line with the strategy
- Joined up use of public money, commitment to services and capacity for services to work with people who have dual diagnosis
- Improve early intervention and community support
- More research needed about why people drink
- Should be aiming to influence national policy

Annex A

Question 3:

Has the strategy set out the achievements you would like to see?		
Answer Options	**Response Percent**	**Response Count**
Yes	76.9%	20
No	23.1%	6
If no, what else do you think is needed?		13
answered question		**26**
skipped question		**0**



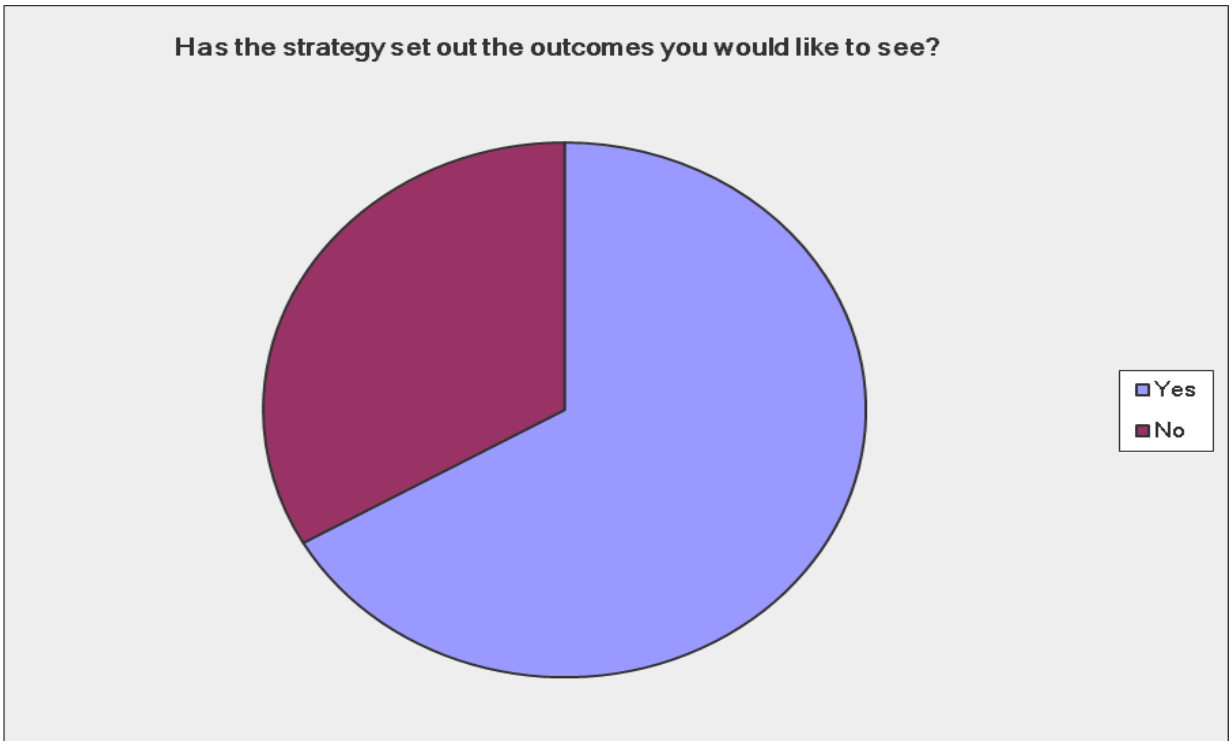
A range of reasons were supplied to support the answers to Question 3 and these included comments about:

- A reduction in alcohol harms is too vague and needs to have a figure attached to it
- Where is the help for families who are affected
- Need simple honest concepts in plain English
- All of anti-social behaviour isn't reported or recorded
- The action plan to implement this is key
- How will the aims be achieved
- No, this is an example of meaningless 'council speak'
- Better access to prevention is needed and to be able to quantify how many people are seen in primary care
- Dealing with the gangs of daytime drinkers should be a priority
- A strategy is needed to prevent York from being seen as somewhere to visit that is one long pub crawl

- Not sure if this is achievable

Question 4:

Has the strategy set out the outcomes you would like to see?		
Answer Options	**Response Percent**	**Response Count**
Yes	66.7%	16
No	33.3%	8
If no, what else do you think is needed?		13
answered question		**24**
skipped question		**2**



A range of reasons were supplied to support the answers to Question 4 and these included comments about:

- The strategy should include a way to seek commitment from local businesses (pubs / clubs) to support its objectives
- Need to see evidence for the support of these objectives
- More empathy to understand the reasons people drink
- The council should have no interest in trying to influence how much of a legal product that people consume

- Outcomes should be more responsible drinking and better behaviour and consider street drinking and hidden drinking
- This can only be achieved by understanding the need and having front-line staff
- Read what I have suggested and change your ways
- In addition to personal responsibility there must also be commerce, education and economical responsibility
- Better access to early intervention and improved step-down care
- More interventions to prevent drunk people entering bars

Question 5:

What resources should be used to help reduce alcohol harm?	
Answer Options	**Response Count**
	23
answered question	**23**
skipped question	**3**

A range of reasons were supplied to support the answers to Question 5 and these included comments about:

- General Practice active involvement.
- School Education.
- Responsible drinking advocacy in the Universities.
- Business Rate Tariffs for businesses selling alcohol.
- Licensing Policy to reflect the Alcohol Strategy.
- Zero Toleration of Binge drinking associated impact on the local community (behaviours, littering, violence, vomiting in public places, etc, etc)
- Funding to support the Strategy.
- Promoting awareness in the Public.
- Funding for York carers
- Better alternatives to ensure people do not need to anaesthetise themselves to forget their problems
- None. If people are harmed as a result of their level of alcohol consumption that is due to their own poor life choices. The state should not step in.
- Stop the sale of cheap high volume % beer, cider etc - only sold to make you drunk quickly e.g. super tenants, special brew, frost jack
- Ideally a broad range of agencies should be involved

- Health needs assessment, Measurement tools, Audit, Targeted interventions by front line staff
- Get some professionals to analyse the problems and research the best ways of tackling them
- As many as possible, need linking up and use volunteer sector too
- Greater involvement of our health colleagues and commissioners (CCG) to lead on the health initiatives
- What resources and models of service have provided evidence based responses to the effectiveness of the integrated working and workforce
- As many as possible across the city.....including licensing
- More police on the streets
- Public input, Charities, Health Needs Assessment, Local schools / colleges, Local Hospital, Mental Health service, Primary Care / GP Practices
- A coordinated approach across all parties to define objectives
- I feel that all parties need to work together, including the police, council, pub staff (through the Pubwatch scheme)
- The involvement of all relevant stakeholders to ensure a multi-agency approach will be essential in defining and achieving action plan objectives to delivery the strategy
- recovery unit, counselling / talking treatments and support, interagency working with MH services in particular n- possible co-located, alternatives to drinking - social activities, social enterprise etc
- Reliable method of data collection. Review of systems that work nationally/ internationally. Public health message campaign. better access to services at all stages of care
- The multi-agency approach seems the right way to go about tackling the issue, the data and insights from the hospital admissions and police teams seem especially important. This should involve pubs, taxis, universities and railway companies
- A multi agency approach involving commissioners for Public Health England, NHS (including mental health), Alcohol and Substance Misuse agencies and the local Well Being initiatives
- More research is needed
- More focus on prevention and education
- relevant agencies such as the council, police, hospital and public health should work together.
- Input from the licensed trade
- I think that the resources can only be defined when priorities and actions are set out and clear focus for action is given

Question 6:

Who should be involved in helping to reduce alcohol harms?	
Answer Options	**Response Count**
	25
answered question	**25**
skipped question	**1**

A range of reasons were supplied to support the answers to Question 5 and these included comments about:

- Local Authority. Police. Health Teams - General Practice, Mental Health Service Providers. Local Media. Schools. Universities (note York University is rated the highest in the country for Universities Social Enjoyment Time)
- Support for carers and addicts
- Put a lot more money into Healthwatch ,York which is the one organisation that might be able to solve some of the indepth problems we are facing
- Anyone but the government
- Private clinics
- Police
- Substance Abuse charities
- Public Health facilitating a partnership via the health and well being board
- children; young people; families; health and wellbeing board; midwives; health visitors; school nurses; education (schools); substance abuse services; GPs; public health teams; CCGs
- I assume that by asking "Who" rather than you think there is a suitable individual Coucillor of Council Officer capable of doing this.I doubt it!
- Public Health; City of York Council
- The relevant people; Crime – police; Health – CCG; Night time economy - Safer partnership; General population health - Public health; etc
- Life line with support from public health
- Joint lead by agencies involved
- All parties concerned: Local businesses Police Local Authority Public Health Mental Health organisations Addiction charities Clinical Commissioning Group

- I feel that the Council should be the lead partner but that all parties involvement is needed
- NYFRS agrees that the Health and Wellbeing Board is responsible for the achievements of the objectives and that the Alcohol and Illicit Drugs Strategic Forum group will be responsible for and report progress on the York Alcohol Strategic objectives
- Public Health via H&W Board presuming TEWV actually turn up and work with you
- One with the greatest knowledge and ability to lead on the transform the current landscape...
- Public Health
- City of York Council
- This is about partnership working between all agencies, including utilising the third sector/voluntary organisations who have a significant role to play, especially in dealing with the after effects of drink related violence/mental health etc
- public health should take the lead
- I think the leading groups are clearly articulated, however, I do have a concern that until the actions underpinning the strategies are outlined then it is difficult to identify others who should be involved

Question 7:

Would you like to be involved in helping to reduce alcohol related harm?		
Answer Options	**Response Percent**	**Response Count**
Yes	54.2%	13
No	45.8%	11
If yes, please send your contact details to: nick.sinclair@york.gov.uk		8
answered question		**24**
skipped question		**2**

Individuals who answered yes and supplied contact details have not yet been contacted but will be offered some inclusion in the development of the action plans that are proposed to underpin the strategy.

DRAFT - Health and Wellbeing Board Forward Plan 2015/16 and 2016/17

Date	Item
7th September 2016	**Mental Health Focused Meeting**
	Report from TEWV – Rehabilitation and Recovery, Adult Mental Health Service Developments in York and Selby
	Report from TEWV – Mental Health Inpatient Facilities for York
	Other Business
	Update from the JSNA/Joint Health and Wellbeing Strategy Steering Group (including strategy renewal)
	Update from Integration and Transformation Board
	Alcohol Strategy Consultation Response
	Verbal Update on Sustainability & Transformation Plans
23rd November 2016	**Children & Young People Focused Meeting**
	Healthy Child Service
	Report of Children's Safeguarding Board
	Action taken to address the key issues highlighted in the Higher York report [Everybody's Business Conference]
	Report on the Local Transformation Plan/Future in Mind
	Other Business
	Healthwatch York Report (topic to be confirmed)
	Annual Report on Health Protection 2015/16
	Draft of the New Joint Health and Wellbeing Strategy
	Update from Integration and Transformation Board
	Governance of the Health and Wellbeing Board *[to be confirmed]*

DRAFT - Health and Wellbeing Board Forward Plan 2015/16 and 2016/17

Date	Item
18th January 2017	Annual Report of the YorOK Board
	Performance & Monitoring (to include Health and Wellbeing Board Indicators, Better Care Fund and Futures in Mind)
	Update from Integration and Transformation Board
	Launch of the New Joint Health and Wellbeing Strategy
8th March 2017	Annual Report of the Mental Health and Learning Disabilities Partnership Board
	Mental Health Strategy for Vale of York
	Update from Integration and Transformation Board
	Annual Report of the Director of Public Health
17th May 2017	Healthwatch York Report (topic to be confirmed)
	Update from Integration and Transformation Board

To add (dates tbc)

One Planet York

Managing Performance and Monitoring

PNA 2017/18