Notice of a public meeting of
Health and Wellbeing Board

To: Councillors Coles (Chair), Ayre, Runciman and Webb
Siân Balsom – Manager, Healthwatch York
Dr Emma Broughton – Joint Chair of York Health & Care Collaborative
Zoe Campbell – Managing Director, Yorkshire, York & Selby - Tees, Esk & Wear Valleys NHS Foundation Trust
Sarah Coltman-Lovell - York Place Director
Jamaila Hussain - Director of Prevention & Commissioning, City of York Council
Shaun Jones – Interim Director, Humber and North Yorkshire Locality, NHS England and Improvement
Martin Kelly - Corporate Director of Children's and Education, City of York Council
Simon Morritt - Chief Executive, York & Scarborough Teaching Hospitals NHS Foundation Trust
Mike Padgham – Chair, Independent Care Group
Alison Semmence - Chief Executive, York CVS
Sharon Stoltz - Director of Public Health, City of York Council
Lisa Winward - Chief Constable, North Yorkshire Police

Date: Tuesday, 25 July 2023

Time: 4.30 pm

Venue: The George Hudson Board Room - 1st Floor West Offices (F045)

A G E N D A

1. Declarations of Interest (Pages 1 - 2)

At this point in the meeting, Members and co-opted members are asked to declare any disclosable pecuniary interest, or other registerable interest, they might have in respect of business on this agenda, if they have not already done so in advance on the Register of Interests. The disclosure must include the nature of the interest.

An interest must also be disclosed in the meeting when it becomes apparent to the member during the meeting.

[Please see attached sheet for further guidance for Members].

2. Minutes (Pages 3 - 10)

To approve and sign the minutes of the last meeting of the Health and Wellbeing Board held on 15 March 2023.

3. Public Participation

At this point in the meeting members of the public who have registered to speak can do so. Members of the public may speak on agenda items or on matters within the remit of the committee.

Please note that our registration deadlines have changed to 2 working days before the meeting. The deadline for registering at this meeting is at **5.00pm** on **Friday 21 July 2023**.

To register to speak please visit www.york.gov.uk/AttendCouncilMeetings to fill out an online registration form. If you have any questions about the registration form or the meeting please contact the Democracy Officer for the meeting whose details can be found at the foot of the agenda.

Webcasting of Public Meetings

Please note that, subject to available resources, this public meeting will be webcast including any registered public speakers who have given their permission. The public meeting can be viewed on demand at www.york.gov.uk/webcasts.

During coronavirus, we've made some changes to how we're running council meetings. See our coronavirus updates (www.york.gov.uk/COVIDDemocracy) for more information on meetings and decisions.

4. **Report of the York Health and Care Partnership** (Pages 11 - 194)
This report provides an update to the Health and Wellbeing Board regarding the work of the York Health and Care Partnership, progress to date and next steps. The report also provides an update on the development of Humber and North Yorkshire ICB's Joint Forward Plan.

5. **Discussion Paper: Review/Reset of York's Health and Wellbeing Board** (Pages 195 - 212)
This report is predominantly a discussion paper for Health and Wellbeing Board (HWBB) members to consider a variety of ideas to shape the Board going forward. The intention is to use the discussion to revise the HWBB Terms of Reference and present these at the September meeting of the Board for approval before they are submitted to Full Council for inclusion within the local authority's constitution.

6. **Healthwatch York Report: Breaking Point, A Recent History of Mental Health Crisis Care in York** (Pages 213 - 326)
This report is for the attention and action of Board members, sharing a report from Healthwatch York which shares local experiences of seeking support for a mental health crisis in the city.

7. **Healthwatch York Report: Health and the Cost of Living in York** (Pages 327 - 372)
This report is for the attention and action of Board members, sharing a report from Healthwatch York which looks at the results of the second Healthwatch York survey exploring the health impacts of the rising cost of living.

8. **For Information Only - Healthwatch York Annual Report** (Pages 373 - 400)
This report is for information only, sharing details about the activities of Healthwatch York in 2022/23 with the Health and Wellbeing Board.

9. Urgent Business

Any other business which the Chair considers urgent under the Local Government Act 1972.

Democracy Officer:

Reece Williams
Telephone No – 01904 551088
Email – reece.williams@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**

Agenda Item 1

Declarations of Interest – guidance for Members

(1) Members must consider their interests, and act according to the following:

Type of Interest	**You must**
Disclosable Pecuniary Interests	Disclose the interest, not participate in the discussion or vote, and leave the meeting unless you have a dispensation.
Other Registrable Interests (Directly Related) **OR** Non-Registrable Interests (Directly Related)	Disclose the interest; speak on the item only if the public are also allowed to speak, but otherwise not participate in the discussion or vote, and leave the meeting unless you have a dispensation.
Other Registrable Interests (Affects) **OR** Non-Registrable Interests (Affects)	Disclose the interest; remain in the meeting, participate and vote unless the matter affects the financial interest or well-being: (a) to a greater extent than it affects the financial interest or well-being of a majority of inhabitants of the affected ward; and (b) a reasonable member of the public knowing all the facts would believe that it would affect your view of the wider public interest. In which case, speak on the item only if the public are also allowed to speak, but otherwise do not participate in the discussion or vote, and leave the meeting unless you have a dispensation.

(2) Disclosable pecuniary interests relate to the Member concerned or their spouse/partner.

(3) Members in arrears of Council Tax by more than two months must not vote in decisions on, or which might affect, budget calculations,

and must disclose at the meeting that this restriction applies to them. A failure to comply with these requirements is a criminal offence under section 106 of the Local Government Finance Act 1992.

City of York Council	Committee Minutes
Meeting	Health and Wellbeing Board
Date	15 March 2023
Present	Councillors Runciman, Looker and Waller Siân Balsom - Manager, Healthwatch York Dr Emma Broughton - Joint Chair of York Health & Care Collaborative Brian Cranna - Director of Operations and Transformation, Tees, Esk & Wear Valleys NHS Foundation Trust (substitute for Zoe Campbell) Sarah Coltman-Lovell - York Place Director Shaun Jones - Interim Director Humber and North Yorkshire Locality, NHS England and Improvement Martin Kelly - Corporate Director of Children's and Education Services, City of York Council Simon Morritt - Chief Executive, York & Scarborough Teaching Hospitals NHS Foundation Trust John Pattinson - Operations Director, Independent Care Group (substitute for Mike Padgham) Alison Semmence - Chief Executive, York CVS Sharon Stoltz - Director of Public Health, City of York Council
In attendance	Peter Roderick - Consultant in Public Health, City of York Council/NHS Vale of York Clinical Commissioning Group Tracy Wallis - Health and Wellbeing Partnerships Coordinator, City of York Council
Apologies	Councillor Craghill Zoe Campbell – Managing Director, Yorkshire, York & Selby - Tees, Esk & Wear Valleys NHS Foundation Trust Jamaila Hussain - Corporate Director Adult Social Care and Integration, City of York Council

Mike Padgham – Chair, Independent Care Group
Lisa Winward - Chief Constable, North Yorkshire Police

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133. Declarations of Interest (16:32)

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. None were declared.

134. Minutes (16:33)

Resolved: That the minutes of the last meeting of the Health and Wellbeing Board held on 18 January 2023 be approved as an accurate record.

135. Public Participation (16:33)

It was reported that there had been no registrations to speak under the Council's Public Participation Scheme.

136. Joint Strategic Needs Assessment - Annual Update (16:35)

The Public Health Specialist Practitioner Advanced, City of York Council, outlined a report which provided an update on the Joint Strategic Needs Assessment (JSNA), including work undertaken in the last year by the York Population Health Hub and planned work for the coming year.

He provided an overview of the needs of the city before stating that the JSNA is themed across the four 'life courses' which were Start Well, Live Well, Mental Health and Age Well. He then noted that in 2022 there were five topic specific needs assessments undertaken which were: Special Education Needs and Disabilities Phase 2, Pharmaceutical Needs Assessment, Early Years, Sexual Health, and Drugs and Alcohol. He stated that these assessments formed a part of a larger work programme of the Population Health Hub with three key strands: enabling, analysing, and doing.

He explained that for 2023/2024, there were three needs assessments planned for completion which were: Gypsy Traveller, Women's Health and Population Planning and concluded by stating that the JSNA website will also be updated during the 2023/2024 year.

The Director of Public Health, City of York Council, then asked Board Members to champion the JSNA more in their organisations to encourage its use before asking for ideas on how the profile of the JSNA could be raised.

The Board Members discussed the JSNA and stated how they use it within their organisations and collectively throughout York. They also suggested giving consideration to renaming the JSNA to something more user friendly.

Resolved:

i. That the contents of the report be noted, and that Board Members commented on how the JSNA, and work of the Population Health Hub could be further disseminated.

ii. That Board Members commented on the use of the JSNA within their brown organisations and suggested how this could be increased.

Reason: To keep the HWBB updated on the work of the Population Health Hub and the JSNA.

137. Framework for the Action Plan and Population Health Outcomes Monitor of the new Joint Health and Wellbeing Strategy 2022-2032 (16:48)

The Consultant in Public Health, City of York Council, presented a report which detailed a populated action plan and an amended Population Health Outcomes Monitor for the new Joint Health and Wellbeing Strategy 2022-2023.

The Officer stated that the aim of these documents was to assure Members that the strategy was making a difference by showing the actions put in place and how they were tracked. He explained that there were 28 actions put forward in the action plan, which was focussed around the six big ambitions and ten big goals set out in the new ten year Joint Health and Wellbeing Strategy. He concluded by outlining the monitoring framework and explaining that it was also linked to the ten big goals and

was designed to provide Board Members with a holistic view of whether the strategy was making a difference to the health and wellbeing of York's population by using outcome data.

Board Members then discussed the report and raised some concerns with the action plan, namely on the need for recreational/green spaces and mental health issues, amongst others. They also commented on the need for clear communication with residents and suggested that the Board creates a coherent response on the impact of Covid-19 on a number of different health issues in the city.

The Consultant in Public Health then stated he would pick up the comments raised in the next report to the Board and signposted Members to the Wider Impacts of Covid-19 on Health monitoring tool, which allows for the exploration of the indirect effects of the pandemic.

Resolved:

i. That the documentation at Annexes A, B and C be approved.

Reason: To ensure that the Health and Wellbeing Board fulfils its statutory duty to deliver on their Joint Health and Wellbeing Strategy 2022-2032.

138. Joint Forward Plan Presentation (17:19)

The Director of York Place delivered a presentation which summarised York's contribution to the Joint Forward Plan (JFP) and noted that the Plan was aligned to York's Joint Health and Wellbeing Strategy.

She stated that the purpose of the JFP was to describe how the health and care system would arrange and/or provide NHS services to meet their population's needs. The Director first explained how the Place and Sector collaboratives would deliver the vision for integration and health inequalities over the next year through its six priorities before noting that it also focuses on addressing the needs of specific people, such as children and young people, and victims of domestic abuse. She concluded by explaining how the JFP was enabling the conditions to achieve the vision and meet the requirements of the Integrated Care Boards through its six focuses.

Board Members then discussed the presentation and raised a number of issues, including on the need for early intervention and prevention work, the existing partnership work on domestic violence and on the mental health of children and young people, amongst others.

Board members were keen to look at the opportunities available for York to be properly represented at the wide range of Humber and North Yorkshire meetings and the importance of York having a strong voice at these.

They also requested some further clarity on the relationship between the Health and Wellbeing Board and the Place Board and it was suggested that a workshop was held after the local elections to explore this further.

Resolved:

i. That the presentation be noted.

Reason: To keep the Board updated on the Joint Forward Plan.

139. Update following the Children's Mental Health report to the Health and Wellbeing Board meeting, November 2022 (17:59)

The Manager of Healthwatch York presented the report which provided an update following the presentation of the Healthwatch York snapshot report on Children's Mental Health at the November meeting of the Health and Wellbeing Board.

She stated that the communication methods had improved with parents providing positive comments regarding letters being sent out whilst children were awaiting assessments and that the signposting had also improved. She also commented on the new activities and work that had commenced, including on the second Wellbeing in Mind Team before stating that the projected timeline and the accessible information report were not yet available.

Board Members then discussed the report. They commented on several issues, including on the difficulty of diagnoses and the gap in resources, the move towards a social model of intervention and the move towards prevention work.

The Director of Operations and Transformation for Tees, Esk and Wear Valleys NHS Foundation Trust then commented on the report and explained that their business priorities next year would be focused on working and supporting the development and implementation of the iThrive model. He also noted that there was an improvement on waiting times for assessments with people waiting 150 days on average as opposed to 315.

Resolved:

i. That the updated report be received by the Board.

Reason: To keep the Board informed on progress in improving support for children's mental wellbeing in the city.

140. Better Care Fund Update Presentation (18:13)

The Corporate Director of Adult Social Care and Integration, City of York Council, was unable to attend the meeting and so it was;

Resolved:

i. That the update on the Better Care Fund be deferred until the next scheduled meeting.

Reason: To allow the Corporate Director of Adult Social Care and Integration to present the item.

141. Update on the Appointment of Independent Co-Chairs of the York Mental Health Partnership (18:14)

The Director of Public Health, City of York Council, provided a verbal update on the progress on the appointment of a new Independent Chair to the Mental Health Partnership.

She stated the role was advertised again and the post was offered to two people who would act as co-chairs for the Partnership. She informed the Board that the co-chairs would be Professor Lynne Gabriel and Dr Stephen Wright.

Resolved:

i. That the update be noted by the Board.

Reason: To keep the Board updated on the appointment of an Independent Co-Chairs to the Mental Health Partnership

142. Report of the Chair of the York Health and Care Collaborative (18:19)

The Joint Chair of York Health & Care Collaborative (YHCC) outlined a report which provided an update on the work of the YHCC over the last year.

She explained that the YHCC and its work was closely aligned with the ten big goals, as outlined in the York Health and Wellbeing Strategy, and that the Collaborative has been analysing its metrics and delivering some improvements. She also noted some current challenges in healthcare before outlining some of the work the Collaborative has completed, including the execution of deprivation workshops, amongst others.

Resolved:

i. That the report of the Chair of the York Health and Care Collaborative be noted.

Reason: There is a shared objective of improving the health and wellbeing of the population. The York Health and Care Collaborative is unique in bringing together; providers and commissioners of health and social care services (from the NHS and City of York Council), colleagues from City of York Public Health together with the voluntary sector as a means of working on joint priorities to achieve this objective. The York Health and Care Collaborative agreed to provide regular updates on its work and progress.

143. Healthwatch York Reports: Dementia Support - Listening to People Living with Dementia in York (18:22)

The Manager of Healthwatch York presented the report which aimed to complete reporting of the work undertaken to help shape the dementia strategy through local engagement. She also noted that the dementia action plan was being drafted and therefore would be brought to the Board once completed.

The Director of Public Health, City of York Council, also explained that the action plan was still being developed and had not yet been signed off by the Dementia Strategy Working Group, but that it would be shared with the Board once completed.

Resolved:

i. That Healthwatch York's report, Dementia Support: Listening to People Living with Dementia in York be received.

Reason: To keep up to date with the work of Healthwatch York and acknowledge the voices heard during the development of the Dementia Strategy.

Councillor Runciman, Chair
[The meeting started at 4.32 pm and finished at 6.26 pm].

Health and Wellbeing Board 25 July 2023

Report of the York Health and Care Partnership

Summary

1. This report provides an update to the Health and Wellbeing Board (HWB) regarding the work of the York Health and Care Partnership (YHCP), progress to date and next steps. The report also provides an update on the development of Humber and North Yorkshire ICB's Joint Forward Plan.

Background

2. Partners across York Place continue to work closely together to commission and deliver integrated services for our population. The YHCP shares the vision of the York Health and Wellbeing Strategy that in 2032, York will be healthier, and that health will be fairer.

   The YHCP has an Executive Committee (shadow) which is the forum through which senior Partnership leaders collaborate to oversee the delivery of the Partnership priorities. The Executive Committee meets monthly, and minutes from meetings held in 2023 are available in Annexes A to G.

   This report provides an update to the York Health and Wellbeing Board on the YHCP's progress since the last report provided in January 2023.

3. **Update on the work of the YHCP**

   YHCP Priorities

   Since the January 2023 update the YHCP has agreed a set of priorities for the next five years. This five-year period aligns with Humber and North Yorkshire's Joint Forward Plan, which sets out how the ICB and its partners will contribute and deliver its strategy from 2023-2028 (see section of this report).

These priorities build on those identified in 2022 and provide a longer-term view for our ambitions around integration. The priorities are aligned to the ICB's priorities and the Health and Wellbeing Strategy, with a focus reducing health inequalities and improving population health. The priorities and what they will mean for our citizens are listed in table 1 below.

Table 1: YHCP priorities

Priority	What will this mean for citizens?
Strengthen York's Integrated Community Offer	Greater access to personalised support and integrated care outside of hospital, with tailored support that helps people live well and independently at home for longer.
Implement an integrated UEC offer for York	A safe, reliable, and resilient service.
Further develop Primary/Secondary shared-care models	Shared care models between patients, GPs, and other specialists, so patients receive a personalised, seamless and holistic care experience.
Develop a partnership based, inclusive model for children, young people, and families	Working together for children, young people, and families to raise a healthy generation of children.
Embed an integrated prevention and early intervention model	A shift to prevention and early intervention across the life course, enabling people to live a healthier, longer life, reducing the gap in health inequalities between the most and least deprived communities in York.
Drive social and economic development	Working at the heart of our communities to use and grow the assets we have, maximising our collective capability, working in partnership taking a cradle to career approach.

- These priorities are underpinned by our integrated Place Plan that has been agreed by the Executive Committee, and will be delivered through the behaviours of the Partnership (see the York Health and Care Prospectus, our 'pledges'):
    - We are in it together
    - We will trust in people
    - We will be permission-giving and empower staff
    - We are person-centred
    - We will free the power of the community
    - We are committed to improving population health
    - We will connect clinicians and professionals
    - Our finances will align
- In our Place Plan we have identified our 'system team', the leaders and operational teams from partnership organisations who make up our team to realise our integration ambitions. Within these system teams, work continues under each of these long-term priorities.
- Updates and items for decision are brought to the Executive Committee as required. To understand progress and outcomes a quarterly update against each priority will be provided to the YHCP by system teams. An annual report will also be produced summarising progress and a forward look for the partnership.
- The Place Plan is underpinned by a series of key enablers: citizen engagement and communications, quality, digital, workforce and the Population Health Hub.

Health inequalities projects

- In February 2023 the YHCP Executive Committee agreed a series of Health Inequalities projects following a process to identify schemes that reduce unwarranted variation in access to care, quality of care, or health outcomes, and that focus on York's Core20PLUS5 populations. These schemes are funded by the ICB's health inequalities programme.
- The schemes agreed by the Executive Committee are:
    - Bolstering the Ways to Wellbeing small grants programme led by York CVS

- Expansion of community-based blood pressure monitoring
- York's first Health Mela September 2023
- GP outreach for individuals attending the Women's Wellbeing centre
- Recreational activities fund for asylum seekers with added health awareness sessions
- Maternal and child nutrition BFI accreditation
- York Ending Stigma campaign
- CYP asthma, implementing the Asthma Friendly Schools programme in York
- Family and schools link worker to support Children & Young People with anxiety related school absence

The projects are in progress and an update will be provided to the HWB in future briefings.

Work of the York Population Health Hub

As a key enabler of the YHCP, the York Population Health Hub continues to bring together partners to enable, analyse and undertake population health management approaches to provide a clearer picture of the health of the population and the inequalities people face across York place.

Cost of Living data pack

As part of work to understand our population and inform service delivery the Hub is updating the Cost of Living data pack produced in 2022 (Cost-of-Living Crisis in York: Understanding and Reducing the Health Impacts data pack). This update aims to demonstrate the impact of the Cost-of-Living crisis on York's communities during 2023. We will provide an update on the pack later in 2023.

Population projections to inform CYC's Local Development Plan

Informed by discussions at the Executive Committee around the New Local Plan, the York Population Health Hub has undertaken analysis on population projections to understand the impact of population growth on the utilisation of health and care services. This work is being used to support estates conversations between the Local Authority, health and care services and the New Local Plan developers to ensure that future

developments include plans around increasing health and care infrastructure to support population increases.

Resilience Planning

The YHCP have committed to producing a Partnership Resilience Plan. We want to ensure our population is kept well throughout the year, and that when people do need to access health and care services, they can access care in the right place and at the right time. The plan will focus on the resilience of health, care and VCSE services throughout the year, and has an initial focus on winter 2023.

Integrated Communications Group

Led by Healthwatch, the YHCP has also established an Integrated Communications group to align and strengthen our communications offer for the public. This group is also looking at how we can engage with communities in partnership to gain deeper insights into our population. As part of our partnership resilience planning an integrated communications plan is being developed to align messaging and communicate our offer clearly to the public.

4. **Update on Humber and North Yorkshire ICBs Joint Forward Plan**

- Integrated Care Boards with their Partners have a statutory duty to prepare a 5-year Joint Forward Plan (JFP). The purpose of a JFP is to describe how the health and care system will arrange and/or provide NHS services to meet their populations needs.
- This section provides an update on the Humber and North Yorkshire ICB JFP. The draft plan was presented at the March HWB to provide partners with an opportunity to be involved in production and feedback has been considered.

<u>Summary of the JFP</u>

- The Humber and North Yorkshire JFP seeks to bring together in one place how all parts of our ICB are working together with partners to deliver our ambitions and commitments to meet the needs of local populations.
- Our plan is being published as a working draft which will continue to develop as we develop more insights into the priorities of our populations.

- A very early draft of the plan was presented to the HWB in March 2023 by the NHS Place Director, and feedback about structure, and content was subsequently shared to be incorporated into the plan.
- The approach in HNY has been to build the plan 'from the ground up'. This means that we take used existing planning and engagement activities at place and across the ICB rather than seeking to duplicate.
- The plan sets out broad delivery of the vision over the next 5 years while providing some tangible milestones for delivery in the next 12 months so that we can measure our progress.
- The plan has been published on the ICB website and is available here.

Key points for consideration

- The plan summarises the plans and priorities outlined in Joint Local Health and Wellbeing plans to set out the stall across the whole ICB. It demonstrates how together we will deliver the strategic vision set out in HNY's Integrated Care Partnership Health and Care strategy (Start Well, Live Well, Age Well, and Die Well).
- The work happening in York Place is referenced in the JFP in multiple sections:
  - **Place priorities section:**
    - The York Place page reflects our vision outlined in the HWB strategy and our Place priorities highlighted previously in this report (see section 3).
    - The North Yorkshire page references the work underway on the redesign of urgent and emergency care across both Places.
  - **Sector Collaboratives section:**
    - Summarising plans that bring together NHS providers together across the ICS, working with clinical networks, alliances, and other partners, to benefit from working at scale. The plans demonstrate how the collaboratives will deliver ICB and local priorities to strengthen services, to improve the care and support available across organisations.

- **ICS wide Programmes section:**
  - Urgent and Emergency Care: Programme working in partnership to provide patients with safe, effective, and easily accessible UEC services, with limited variation and as standardised as possible, whilst recognising the needs of our diverse populations in each Place.
  - Population health prevention and health inequalities: Programme to support people to start well, live well and age well by ensuring that people feel included and know what to do if they need help. The Programme has six strategic priorities that will deliver ICS wide and Place based work to support the switch to prevention and focus on population health.

Next steps

The YHCP continues to develop and mature partnership arrangements in preparation for delivery of integration priorities in York.

Recommendation:

The Health and Well Being Board is asked:

i. To receive the Joint Forward Plan and provide any feedback on the approach that can support the ongoing development of the planning process for future iterations.

ii. To note the content of the report and progress made.

Reason: To keep the Health and Wellbeing Board up to date with the work of the York Health and Care Partnership.

Contact Details

Author: Anna Basilico, Head of Population Health and Partnerships, Humber, and North Yorkshire ICB (York Place)
a.basilico@nhs.net

Chief Officer Responsible for the report:
Sarah Coltman-Lovell, NHS Place Director

Ian Floyd, Chief Operating Officer CYC and York Place Lead

Report Approved ✓ **Date** 04/07/23

Wards Affected: **All** ✓

Annexes

Annexes A – G: YHCP minutes December 2022 – June 2023
Annex H: York Health and Care Prospectus
Annex I: Humber and North Yorkshire ICB Joint Forward Plan

Annex A

York Health and Care Partnership

Monday 19 December 2022, 12:30 - 15:00

Severus Meeting Room; First Floor, West Offices

Chair: Ian Floyd

Minutes – draft

Present		
Ian Floyd (Chair)	Chief Operating Officer	City of York Council (CYC)
Simon Morritt	Chief Executive	Y&STHFT
Professor Karen Bryan	Vice Chancellor	York St John University (representing higher education)
Simon Bell	Finance Director	York Place: Humber and North Yorkshire Integrated Care System (H&NY ICS)
Sarah Coltman-Lovell	York Place Director	York Place H&NY ICS
Alison Semmence	Chief Executive	York Centre for Voluntary Services (CVS)
Cllr. Nigel Ayre	Executive Member for Finance and Major Projects	CYC
Professor Mike Holmes	Chair	Nimbuscare
Present via MS Teams		
Jamaila Hussain	Corporate Director of Adult Service and Integration	CYC
Michelle Carrington	Executive Director for Quality & Nursing	York Place H&NY ICS
Zoe Campbell	Managing Director	Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)
Sharon Stoltz	Director of Public Health	CYC

Rebecca Field	Joint Chair of York Health and Care Collaborative	York Medical Group
Stephanie Porter	Interim Director of Primary Care	York Place H&NY ICS
In Attendance		
Peter Roderick	Consultant in Public Health	York Place H&NY ICS/CYC
Phillip Truby	Public Health Specialist Practitioner Advanced	CYC
Hannah Taylor	Team Administrator	York Place H&NY ICS
In Attendance via MT		
Gary Young	Lead Officer Primary Care	York Place H&NY ICS
Abigail Combes	Head of Legal and Regulatory functions	York Place H&NY ICS
Doug Flockhart	Head of Performance and Programme Delivery (Mental Health and Learning Disabilities)	Humber and North Yorkshire Health and Care Partnership
Anna Basilico	Senior Programme Manager	York Place H&NY ICS
Michal Janik	Project Support Officer	York Place H&NY ICS
Apologies		
Bryn Roberts	Director of Governance and Monitoring	CYC
Gail Brown	CEO	York Schools & Academies Board
Sian Balsom	Manager	York Healthwatch
Emma Johnson	Chief Executive	St. Leonards Hospice

Item	Title	Led by
1	**Welcome and apologies for absence** The Chair welcomed everyone to the meeting and noted the apologies. The Chair was pleased to welcome and introduce Sarah Coltman-Lovell, the recently appointed Place Director for York from 19 December 2022. The minutes of the meeting held on 28.11.2022 were reviewed and there were no matters arising from the last set of minutes and the Executive Committee.	Chair

	• Declarations of interest No declaration of interest reported.	
2	**York Population Health Hub** Phillip Truby and Anna Basilico delivered a presentation on the York Population Health Hub's (PHH) purpose, achievements and what it can offer to support the delivery of YHCP priorities. The Hub is a multi-organisation group which brings together colleagues from the local authority, health, public health, and business intelligence to enable, analyse and undertake population health management approaches in York. PHH uses a tool called Population Health Management, which applies quality improvement methods to whole populations of people rather than individuals. Data packs exploring health inequalities in York that have been produced through the hub are available publicly from https://www.healthyork.org/population-health-hub.aspx The PHH is a resource for the system and Partners were encouraged to approach PHH for support when planning and designing services. The PHH tools were recognised as useful resources to support commissioning services for York population when planning, for example the York winter plan for 2023. It was pointed out that one of the PHH data packs on cost of living shared with GP practices require admin support to contact vulnerable people to offer support. It was brough to partner attention that currently GP practices are under pressure for admin support. When implementing population health management approaches partners should be aware of the current demand and pressure on services. The presentation was positively received by partners who were impressed by the work of the Hub and committed to become champions of PHH work. Partners positively acknowledged the examples of work focusing on	Phillip Truby and Anna Basilico

	prevention and were interested to know how data packs could support clinicians and front-line staff to improve outcomes for patients. **Action 1: All partners committed to consider population health management approaches in services design and planning, reaching out to the PHH if any support is required.** It was emphasised that information governance was a main enabler to link the data between partners and there was a need for change on how data sharing agreements are being applied across partners. To improve this, it was suggested that the PHH explore working with a Caldicott Guardian to understand how these agreements can be improved. **Action 2: Peter Roderick and Anna Basilico to explore options with the Caldicott Guardian and report back to the YHCP Executive Committee.** **Action 3: York PHH to update the YHCP Executive Committee on progress twice yearly.**	
3	**Overarching priority: System pressures** Partners provided individual update on the system pressure from the summary slide with main points listed below: Emergency and activity: • It was reported that last weekend was challenging due to increase in flu and COVID cases. • The hospital was planning and preparing for the strike actions from YAS with panned care and elective cases to be reviewed daily. • Work is ongoing on recovery position and the trust was working with partners on discharge fund to access more capacity over the winter. Primary Care:	Anna Basilico/ partners

- Work is ongoing to make GP OPEL reporting more effective. There is increasing pressure on general practice, on average last week GP practices were reporting at OPEL 3, including high levels of staff sickness.

Adult social care:

- Another five agencies have joined the framework for domiciliary care to clear waiting list for reablement.
- Adult social care was reporting at OPEL3.

Quality:

- The Quality Group remit has been confirmed, focusing on initial health assessments on children entering care.
- There is a priority to focus on oral health for children and bladder and bowel pathway for children and adults.
- It was highlighted that secondary care referrals for children therapy were increasing.
- The Quality Group is looking at the quality of the discharges and learning to capture.
- The group is also supporting TEWV and the CQC action plan for YTHFT.

York CVS:

- There are more mental health-based referrals and long waiting lists being reported.
- There are also challenges trying to link patients in with specialist services-MH, Autism/ADHD, and Trauma support.

Public Health:

- School based immunisation programme are commissioned by NHS E and work is ongoing to address earlier vaccinations of children.
- Data reflects low uptake of the flu vaccine in pregnant women.
- Partners were made aware that people are deteriorating while waiting for elective or ophthalmology procedures.
- Impact of cost of living has been reported with parents not being able to afford to heat the houses, impacting children's health.

Partners comments on the system pressure report:

- Partners sought assurance from the Committee on the actions being taken. This was covered through verbal updates from partners and through the update on the winter plan provided by Michelle Carrington and Gary Young.
- Partners agreed that future iterations of the report and discussions at this meeting would focus on solutions, using resources differently and the key things partners around the table need to know to inform their organisational planning.

Partners agreed that there was a requirement for honest communication and assurance to the public on behalf of the partners on how current system challenges are being addressed and what can be achieved realistically. Partners expressed their interest in improving communication with local media to support communication with the public messaging. This will be explored further as a separate agenda item at future meeting.

Action 4: Sarah Coltman-Lovell/Anna Basilico to explore opportunities for communications teams across the YHCP to link up to provide consistent, honest messaging to the public.

- **Winter plan – update**
  Previously submitted as a Winter Plan now renamed as Urgent and Emergency plan to address urgent and emergency scheme. This plan will be submitted to ICB and presented to partners in January.

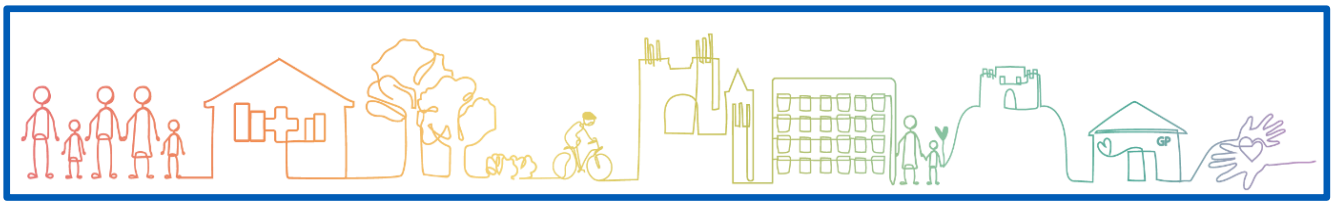
Partners were interested in a detailed update on winter plan progress on the schemes which form part of the Urgent and Emergency plan. This will be presented at the January meeting and added to the Partnership forward planner to be discussed after winter and to reassess what has been achieved and what worked well and what had the biggest impact.

Partners agreed that one of the biggest innovations is the culture and how to work as a system to create the culture. It was recommended to have dedicated time on this topic outside of the Executive Committee meeting.

	Action 5: Work on culture to be revisited outside of the Executive Committee meeting.	
4	**Partnership Priorities: Key strategic actions** Following agreement of the YHCP priorities at the September meeting it was requested that Anna Basilico brings a paper to the December meeting to outline the key strategic actions for the YHCP to undertake for each priority. Some of the key strategic actions are already being progressed within the subgroups or as part of business as usual work, and a highlight report for each sub-group will be produced quarterly and submitted to partners for assurance on progress. Partners discussed some of the emerging actions, those being: • Access to Dentistry: Partners were interested to explore possibility of establishing dental school in the region as this would provide community resource currently lacking in the system. The Director of Public Health shared that NHS England is devolving commissioning responsibilities for dentistry to ICBs. For Humber and North Yorkshire ICB, an advisory group has been established to oversee this transition. • Children and Young people Core20PLUS5: the quality group is leading on the plan for reducing health inequalities for CYP which will be brought back to the YHCP for approval. **Action 6: Public Health and Healthwatch to seek representation on the HNY advisory group for dentistry.** **Action 7: CYP quality plan for health inequalities to be discussed and approved at future YHCP meeting.**	Anna Basilico
5	**Better Care Fund Update**	Jamaila Hussain

	JH presented a paper with an update on the allocation of the Adult Social Care discharge funds. The Better Care Delivery Group leads this work to ensure that partners across the system have been involved in putting forward schemes that focus on discharge and flow. Implementation plan for schemes has been communicated, with some of the schemes staring early January. The York Health and Care Partnership were asked to note the contents of the report and the information within the attached appendices.	
6	**Mental Health, Learning Disabilities & Autism (MH & LDA) Collaborative** DF delivered a presentation on MH & LDA services in Humber and North Yorkshire including vision, strategy, and programme of work with priority workstreams. The Clinical Assembly was established across the programme to promote clinical engagement by informing clinicians of the work of the programme, sharing good practice, discussing key issues (nationally & locally), and involving clinicians in the development of the strategy. Workforce transformation and integration are taking place to deliver the MH ambition of the NHS Long Term Plan. Partners were interested to learn more specifically on how the collaborative links with York place performance and in which areas improvements could be made. **Action 8: DF to share data on York place MH & LDA performance with partners.** **Action 9: DF to check at the ICB steering groups and where York is not represented to ensure there is a representation from York.**	Doug Flockhart
7	AOB No other business was raised.	Chair

Annex B



York Health and Care Partnership

Monday 16 January 2023, 12:30 - 15:00
Severus Meeting Room; First Floor, West Offices
Chair: Ian Floyd

Present		
Ian Floyd (Chair)	Chief Operating Officer	City of York Council (CYC)
Simon Morritt	Chief Executive	Y&STHFT
Professor Karen Bryan	Vice Chancellor	York St John University (representing higher education)
Sarah Coltman-Lovell	York Place Director	York Place: Humber and North Yorkshire Integrated Care System (H&NY ICS)
Alison Semmence	Chief Executive	York Centre for Voluntary Services (CVS)
Cllr. Nigel Ayre	Executive Member for Finance and Major Projects	CYC
Professor Mike Holmes	Chair	Nimbuscare
Michelle Carrington	Executive Director for Quality & Nursing	York Place H&NY ICS
Gail Brown	CEO	York Schools & Academies Board
Martin Kelly	Corporate Director of Children and Education	CYC
Sian Balsom	Manager	York Healthwatch
Emma Johnson	Chief Executive	St. Leonards Hospice
Stephanie Porter	Interim Director of Primary Care	York Place H&NY ICS
Jamaila Hussain	Corporate Director of Adult Service and Integration	CYC
Present via MS Teams		
Simon Bell	Finance Director	York Place H&NY ICS

Sharon Stoltz	Director of Public Health	CYC
Zoe Campbell	Managing Director	Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)
In Attendance		
Anna Basilico	Senior Programme Manager	York Place H&NY ICS
Michal Janik	Project Support Officer	York Place H&NY ICS
In Attendance via MT		
Gary Young	Lead Officer Primary Care	York Place H&NY ICS
Debbie Mitchell	Chief Finance Officer	CYC
Apologies		
Rebecca Field	Joint Chair of York Health and Care Collaborative	York Medical Group

Minutes – draft

Item	Title	Led by
1	Welcome and apologies for absence The Chair welcomed everyone to the meeting and introduced new member of the partnership Martin Kelly, Corporate Director of Children and Education for City of York Council. The minutes of the meeting held on 19.12.2022 were reviewed and there were no matters arising from the last set of minutes and the Executive Committee. There were no declarations of interest in the business of the meeting.	Chair
2	**Patient story** Mike Homes started the meeting by sharing how Nimbuscare and partners are working together to meet the health and care needs of asylum seekers. Patients have been provided with good access to healthcare during their time in York, including access to a GP and referrals to specialists where required.	Mike Holmes

	Mike shared a patient story about an individual who had more than one Long Term Condition and presented with health issues on their arrival to York. Further support has been offered from Refugee Action York who welcomed the individual and other asylum seekers into the community and offered psychological and wellbeing support from the local mosque. The patient feels safe and well looked after. A discussion took place on challenges for professionals and a language barrier issue is a common theme across organisations. Partners conveyed the importance to understand the voice of vulnerable groups to empower these groups. The YHCP requested a paper to be presented back to partners on vulnerable community's needs. **Action 1: Community resilience board to provide regular updates on communities via highlight report.**	Jamaila Hussain lead
3	**Overarching priority: System pressures** • System Pressures report Following December meeting and partners feedback the format of the system pressure report has been improved with individual partners providing a summary position highlight key issues and pressure points for their organisation verbally at the meeting. Additional feedback on the format of the report was provided and partners suggested to extend time for this agenda item to encourage valuable discussion and to explore the data presented in more detail. Partners provided individual update on the system pressure from the summary slide:	Anna Basilico /partners Michelle Carrington/ Gary Young

Public Health:

- Public Health are still waiting for confirmation of the budget. Pressures remain similar to December 2022.

General Practice

- Opel levels remain high across general practice. Work is ongoing across PCNs to pool data at place, this is a positive step forward towards agreeing a dataset that accurately reflects the pressures across general practice which could also inform a routine waits recovery plan. General practice has seen an increase in number of appointments offered.

Planned Care:

- Pressure continues to increase for planned care activity, a challenging Christmas period for UEC has impacted on the number of cancelled electives. Planned industrial action (including community nursing and 111) will add to the pressure. The system has planned well for the action and is prepared, learning from other areas. Partnership working has meant that the situation has slightly recovered, although the Trust remains at Opel level 4.

Emergency Care:

- Pressures continue to increase with a significantly challenged Christmas period leading into early January. As above, this impacted on elective care with increase cancellations, but partnership working has meant the situation has slightly recovered.

Adult Social Care (ASC):

- Referrals to ASC are higher at this point in the year compared to the same time period in 2022 (52 referrals). Whilst discharges are increasing, pressure will continue to be felt in the community and care providers, so the focus needs to be on patient flow for all settings.

Quality:

- The quality group continues to meet and will hold a series of deep dives focussed on existing concerns with an output of 'I' and 'We' statements.

CVS:

- The social prescribing team report increased concerns about the cost of living, individuals reducing their prescriptions to cut costs, and a lack of transport and interpreter services. The voluntary sector report concerns about the cost-of-living crisis and energy prices.

St Leonards:

- Recruitment remains an issue. St Leonards opened additional beds over Christmas period– now 10 operational beds. Plans in place to extend this further as part of wider system response.

Following the system pressure report, discussion took place regarding funding allocation process. Partners recognised that by focusing investments on front door resources and prevention could make an impact and take pressure from Emergency Department.

Action 2: Bringing funding discussions to YHCP to strengthen partnership decision making – HNY health inequalities funding to be discussed and signed off at the February YHCP executive committee – Peter Roderick and Sharon Stoltz lead

Action 3: Primary Care leads to look at local solutions for bank holiday cover for general practice to reduce pressure on system – Mike Holmes lead

Action 4: To improve uptake of additional short-term beds at the hospice to ease discharge pressures. Emma Johnson/ Michelle Carrington lead

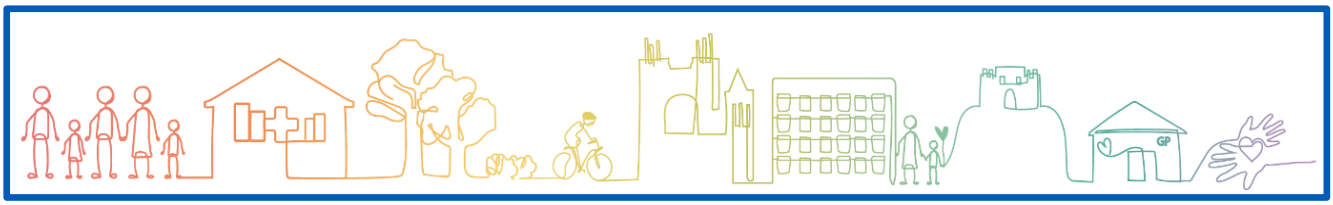
Urgent and Emergency plan

	The action plan supports YSTHFT with CQC regulatory requirements primarily impacting on delayed discharges. This is being led by Quality Improvement Group jointly chaired by ICB and NHSE and progress, outcome and risks from that work will be shared at the end of January. Discussion took place regarding discharge and current schemes being in place to support this work. Data is being collected on the number of discharges being made a day per pathway. Partners recognised that investing in community resources to look at the discharge pending would further support this work. As part of the winter plan, schemes will be evaluated and those that are not progressing alternatives are being considered and for valued schemes substructure will be put in place. **Action 5: Forward planning – the YHCP has previously committed to coordinating a York Place winter plan for 2023 - Sharon Stoltz lead** **Action 6. Work to understand how the YHCP holds itself to account for the delivery of the 2022 UEC plan -Michelle Carrington lead**	
4	**ICB delegation, Place funding, resources** Sarah Coltman-Lovell, recently appointed York Place Director, provided an update on York Place arrangement highlighting the York Health and Care Prospectus and the York Health and Wellbeing Strategy as key guiding documents to help the YHCP realise its ambitions. Sarah emphasised key points related to maturity of the partnership and vision for the next 1-5 years with ambitions on how to get there. To strengthen the YHCP's shared programme of work, partners suggested to undertake decision making in shadow form where it was in the YHCP's power to do so.	Sarah Coltman-Lovell

	In addition, partners were also interested to find out what functions are being provided across the wider footprint such as nursing and quality function that runs across North Yorkshire patch, and what delegation responsibilities leaders from each partner organisation holds. **Action 7: Future paper to be brought the YHCP outlining what we could do differently and where shared decision making could be undertaken over the next year - Ian and Sarah lead** Discussion took place on funding and resources available at system level recognising that this need to be utilised differently to deliver services on an ICB allocation given. There was a joint commitment from partners to work together on funding allocation and identifying priority schemes that would make the biggest impact.	
5	**Engagement** Sian Balsom delivered a presentation on engagement and highlighted that partnership working should promote a listening and responsive culture across the system ensuring that decisions are made close to the people and communities they serve. The discussion took place in relation to communication and engagement and partners were interested to learn what could be done at place level and what required permission from HNY ICB. A gap in a designated engagement lead was recognised in York Place, and it was reminded that resources would be allocated from the ICB to support engagement following the consultation outcome. Karen suggested that master level students could support some of the engagement work as part of their study project. Further work is needed to scope and align existing resource to increase the effectiveness of all the partners engagement activity.	Sian Balsom

	Sarah, Sian and Anna will take this forward with communication leads in HNY ICB and CYC. Partners emphasised the need for honest conversation with the public on what can be delivered within the funding available. **Action 8: Sarah, Sian and Anna will take this forward with communication leads in HNY ICB and CYC. Paper outlining plan for YHCP engagement and communications to be presented at future meeting.** **Action 9: Sarah and Karen to discuss possibility of engagement opportunities for master level students.**	
6	**Resilient Communities Board-Subgroup update** Highlight report has been submitted from Resilient Communities Board-Subgroup with brief summary of sub-group recent activities and progress for the YHCP to note. There were no specific asks of the YHCP Executive Committee at present and the next steps was to present a report to the board March/April in regard to the further direction of commissioning for services across the CVS.	Jamaila Hussain
7	**Community Health and Care-Collaborative** This item has been moved to a future agenda.	Yvonne Elliott
8	**AOB** There were no items of any other business to be discussed at this meeting.	Chair

Annex C



York Health and Care Partnership

Monday 20 February 2023, 12:30 - 15:00
Severus Meeting Room; First Floor, West Offices
Chair: Ian Floyd

Present		
Ian Floyd (Chair)	Chief Operating Officer	City of York Council (CYC)
Simon Morritt	Chief Executive	Y&STHFT
Professor Karen Bryan	Vice Chancellor	York St John University
Rebecca Field	Joint Chair of York Health and Care Collaborative	York Medical Group
Sarah Coltman-Lovell	York Place Director	York Place H&NY ICS
Alison Semmence	Chief Executive	York Centre for Voluntary Services (CVS)
Cllr. Nigel Ayre	Executive Member for Finance and Major Projects	CYC
Professor Mike Holmes	Chair	Nimbuscare
Gail Brown	CEO	York Schools & Academies Board
Martin Kelly	Corporate Director of Children and Education	CYC
Sian Balsom	Manager	York Healthwatch
Emma Johnson	Chief Executive	St. Leonards Hospice
Stephanie Porter	Interim Director of Primary Care	York Place H&NY ICS
Debbie Mitchell	Chief Finance Officer	CYC
Present via MS Teams		
Simon Bell	Finance Director	York Place H&NY ICS
Sharon Stoltz	Director of Public Health	CYC
Jamaila Hussain	Corporate Director of Adult Service and Integration	CYC
In Attendance		
Neil Ferris	Director of place	CYC
Peter Roderick	Consultant in Public Health	York Place H&NY ICS/CYC

Anne-Marie	Director of Clinical Services	St Leonards Hospice
Anna Basilico	Head of Population Health and Partnerships	York Place H&NY ICS
Hannah Taylor	Team Administrator	York Place H&NY ICS
In Attendance via MT		
Gary Young	Lead Officer Primary Care	York Place H&NY ICS
Apologies		
Michelle Carrington	Executive Director for Quality & Nursing	York Place H&NY ICS
Brian Cranna	Director of Operations and Transformation, NYY&S	Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)
Melanie Woodcock	General Manager CAMHS & LD Services	Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)

Minutes – draft

Item	Title	Led by
1	**Welcome and apologies for absence** The Chair welcomed partners to the meeting. The minutes of the meeting held on 16.01.2023 were agreed. Outstanding actions are being progressed outside of the meeting or were on the agenda for this meeting. There were no declarations of interest in the business of the meeting.	Chair
2	**Patient story** Gail Brown started the meeting by sharing a story about a child within the York area who has moved from a mainstream school to a specialist school. Due to worries about the child's health an MDT took place with the family and multi-agency professionals to assess the child's needs, with the outcome being a joint referral being made for the child to have an operation to improve their health. Worries about a decline to the child's weight were expressed and a planned intervention was put in place to improve their health. The family are grateful for the partnership working and collaboration that took place in order to meet the needs of the child and family. The Partnership discussed:	Gail Brown

	• Whether there were earlier opportunities to support the child • The need to focus on children and families living in areas of deprivation • Family Hub developments A meeting has been convened between partners to discuss a joined-up approach to supporting children, young people, and their families. It was suggested that Martin Kelly and Niall McVicar discuss family hubs at a future meeting. **Action:** feedback from the meeting about children, young people and their families, and a presentation on the family hubs, to be brought to a future meeting.	
3	**CYC Local Plan and Health opportunities** Neil Ferris presented the current housing development plans included in the CYC local plan. Neil informed Partners that the local plan is in the consultation stage, the plans will be submitted at Easter and then a response is anticipated around June 2023. The developments will see a 20% growth in York over the next 15-18 years which will mean an increase in the number of NHS patients in the area. To progress with the plans, developers are required to show that they have engaged with health care services so that the communities will have sufficient provision of services. Partners highlighted the importance of engagement in health care provision planning from both a CYC and Health perspective to ensure health and care provision is considered at each stage of the planning process. The Partnership discussed: • Affordable housing • Workforce • Inclusion of the ageing population • Early Intervention • Connecting better instead of creating new processes	Neil Ferris

	Action: Sarah Coltman-Lovell to arrange discussions across health and care and with CYC, and feedback any updates to the group.	
4	**Overarching priority: System pressures report** Due to a delay in receiving data this item was deferred. This item will now move to a quarterly update, recognising that much of the information covered in the report is picked up through other discussion items on the agenda. **Urgent and Emergency plan** Sarah provided context on the purpose of the Quality Improvement Group (QIG), why it was set up and the purpose and the slides that were distributed were shown to NHS England and CQC at their meeting the previous week to show the collaborative work being undertaken to improve. The schemes are split into three main categories avoiding complex admissions, in hospital care and transfers of care. Sarah noted that all the small things add up to help but noted challenges, for example workforce. The impact of the schemes meant that over winter York achieved a standstill position on delayed discharges despite increased demand. The focus for the year would be on developing integrated Urgent and Emergency Care plans. Work is being undertaken to think about in a York system way to forward planning to look at the totality of resource and capacity available across partners. Work is also being undertaken to review the 22/23 schemes; feedback will be used to inform planning for winter 2023.	Sarah Coltman-Lovell
5	**Humber and North Yorkshire Health Inequalities funding** *AS declared a declaration of interest for this item.* Sharon Stoltz presented a paper on Health Inequalities funding. Humber and North Yorkshire ICB received its allocation of the	Sharon Stoltz/ Peter Roderick

	national £200m NHS Health Inequalities programme funding for 2022/23.This funding is being overseen by the ICB's Population Health and Prevention Executive Committee who allocated remaining funds to Place using a Health Inequalities formula with the York being allocated £366,000. A small panel of partners from the ICB, CYC and the CVS met to discuss allocation of the funds and made proposals for the use of York's health Inequalities funding to YHCP for approval. Partners discussed the included proposals for the allocation of the Health Inequalities fund for York and agreed to fund the proposals. The Partnership would like to see evaluation of these schemes, as well as how future years potential funding might be planned. One proposal considered was for the ICB to fund advice services in GP practices delivered by Citizens Advice York, which is currently funded year on year from a limited financial inclusion grant held by CYC. The proposal was not accepted as the service requires recurrent funding. The board were supportive of the paper but agreed to hold further conversations around future planning and voluntary sector funding. **Action:** Peter Roderick to discuss CAY funding with CYC.	
6	**Summary of future plans for delegation** Sarah Coltman-Lovell presented a report in response to the January YHCP meeting where partners discussed future delegation options. The purpose of the report was to set out the proposed operating arrangements for 23/24 and development roadmap. Partners agreed with suggested recommendations and to continue with the Executive Committee in its current form in 23/24 and to contribute to development work over the next 1-5 years. The group discussed having a children and young people's existing committee as a sub-group of this work, as well as the SEND partnership. This will be discussed as part of the future agenda item on children, young people, and their families.	Sarah Coltman-Lovell

	In a discussion on making the meetings public it was decided that this would be reviewed as part of the development roadmap and would broaden in scope to include how we engage the public in our work as a Partnership.	
7	**Integrated Market Sustainability - Sub-Group Highlight Report** Jamaila Hussain provided an update on Integrated Market Sustainability - Sub-Group, highlighting a local spike in the cost of care across the sector since covid started potentially resulting in local market to be unaffordable and no capacity in the region. Further work is ongoing to set a local cost of care with Key Performance Indicators (KPIs) that reflect good quality care provision across the city. A market sustainability subgroup will ensure any future commissioning is joined up between partners. The group will also explore opportunities of creating closer integrated care across community health, primary care, and Local Authority in house services. Across the sector evidence shows care needs have increased and care providers often supporting higher health and social care needs. Despite the challenges, unlike other areas York has been able to maintain provision of care There was no specific ask of YHCP at this time. Due to winter pressure the subgroup's first meeting will be held in April once a date has been agreed she will circulate a draft Terms of Reference. The next step is to share Market Position Statement across partners. Also, series of workshops to be arranged during Q1 23/24 to start the process of setting a local cost of care. The Commissioning workshop took place on the 13th Feb. Responding to a question from Steph, Jamila informed that they are not currently looking at any new care homes in York and with the self-funder market due to change in 2025 care homes will be less able to prioritise Self-Funders over local authority funded patients. Data that had been found showed there are a lot of people in care homes in York prematurely.	Jamaila Hussain

	Sarah expressed an interest in seeing the cost of care audit so that a further conversation on what additional offers we can give to care homes could take place.	
	AOB Informing the board about the need for Foster Carers in York Martin Kelly asked the board if there were any areas with a high footfall that could display adverts for people to be Foster Carers. Members of the board were supportive and offered some of their venues, Martin informed he would circulate the materials once they had been finalised.	Chair

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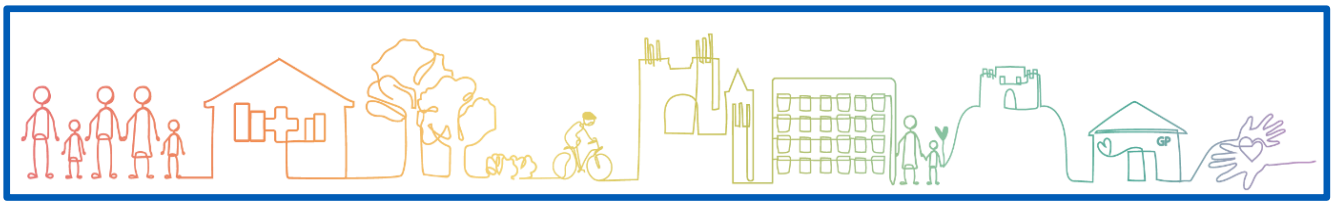
Annex D



York Health and Care Partnership

Monday 20 March 2023, 12:30 - 15:00
Severus Meeting Room; First Floor, West Offices
Chair: Ian Floyd

Present		
Ian Floyd (Chair)	Chief Operating Officer	City of York Council (CYC)
Professor Karen Bryan	Vice Chancellor	York St John University (representing higher education)
Sarah Coltman-Lovell	York Place Director	York Place H&NY ICB
Martin Kelly	Corporate Director of Children and Education	CYC
Rebecca Field	Joint Chair of York Health and Care Collaborative	York Medical Group
Sharon Stoltz	Director of Public Health	CYC
Emma Johnson	Chief Executive	St. Leonards Hospice
Helena Ebbs	Director Clinical & Professional Services	York Place H&NY ICB
Brian Cranna	Director of Operations and Transformation, NYY&S	TEWV
Cllr. Nigel Ayre	Executive Member for Finance and Major Projects	CYC
Brian Cranna	Director of Operations and Transformation, NYY&S	Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)
Sian Balsom	Manager	York Healthwatch
Present via MS Teams		
Melanie Liley (on behalf of Simon Morritt)	Interim Chief Operating Officer	Y&STHFT
Stephanie Porter	Interim Director of Primary Care	York Place H&NY ICB
Professor Mike Holmes	Chair	Nimbuscare
Jamaila Hussain	Corporate Director of Adult Service and Integration	CYC
In Attendance		

Anna Basilico	Head of Population Health and Partnerships	York Place H&NY ICB
Hannah Taylor	Team Administrator	York Place H&NY ICB
In Attendance via MT		
Apologies		
Michelle Carrington	Executive Director for Quality & Nursing	York Place H&NY ICB
Gail Brown	CEO	York Schools & Academies Board
Debbie Mitchell	Chief Finance Officer	CYC
Simon Morritt	Chief Executive	Y&STHFT
Alison Semmence	Chief Executive	York Centre for Voluntary Services (CVS)

Minutes – draft

Item	Title	Led by
1	Welcome and apologies for absence The Chair welcomed everyone to the meeting. The minutes of the meeting held on 20.02.2023 were reviewed and there were no matters arising from the last set of minutes and the Executive Committee. Councillor Ayre declared a conflict of interest that a family member had recently started working for York and Scarborough Teaching Hospital Foundation Trust.	Chair
2	**Patient story**	Emma Johnson

	Emma Johnson started the meeting by sharing a letter from a family member of an individual who received outstanding End Of Life support, expressing their thanks and gratitude for good multiorganisational partnership work and personalised care. Discussion ensued on how to embed learning from this situation and continue the strong partnership working. **Action** Jamaila to bring updates from the Integrated Dementia Strategy as an item to a future meeting.	
3	**Population Health approach to bereavement** Anna introduced the shared paper by informing that herself, Emma, and Sharon were working to create a whole city approach to bereavement as part of our work to make York a mentally healthy city and to support delivery of our Integrated Community Offer priority. In their research the data is assumed based of the death figures in the city. Negative experiences of bereavement can result in physical and mental health issues, and the York JSNA for bereavement highlighted that whilst there is a good range of support available in York and nationally, this is not sufficiently signposted or know by services. Emma Johnson explained the recommendations in the paper and outlined that should the paper be approved; St Leonards Hospice would lead the work. The work centres on establishing a bereavement alliance which would aim to improve partnership working and remove barriers. Progress on this work will be brought back to a future meeting. Discussion ensued on: • Different needs for different types of grief • Making bereavement support accessible to all • Support during end of life before individuals die • Support for children, young people and students	Anna Basilico Emma Johnson

	The board were supportive of the paper and partners committed to supporting a bereavement alliance	
4	**Humber and North Yorkshire Joint Forward Plan** Sarah Coltman-Lovell explained that the Joint Forward Plan is the delivery plan for the Integrated Care Partnerships Strategy which was published in December 2022. Places and collaboratives have been asked to input into the Joint Forward Plan and for York, the Place. Informing slide was developed from conversations Sarah has had with partners and from work that is already being completed. Sarah explained the six York Health and Care Partnership priorities and asked the board for assurance they were happy with them. The priorities align with the priorities previously agreed by the board but build on and reflect the guidance that has since been published. Discussion ensued on: • Children and Young People • A mapping exercise to ensure the Partnership is aware of the boards and sub-groups that exist, to avoid duplication • Change in some of the Language • Expanding the Prospectus so it includes our offer as a Partnership The board were supportive of the plan, but asked that some of the language be reviewed, and to see a business plan. **<u>Action</u>** Anna Basilico to reflect partner comments in the JFP. Anna Basilico will work with the York Place operational team and partners to develop a delivery plan for each of the priorities. This will be brought back to a future meeting.	Sarah Coltman-Lovell
5	**System approach to 2023 winter planning** Sharon Stoltz delivered a presentation for feedback on proposals for a system wide approach to 2023 winter planning, also considering	Sharon Stoltz

	potential heatwaves. Sharon suggested that as a Partnership, we start to plan now for Winter 2023 with input from the whole system so that a plan is complete by August, and it is clear on where funding will be spent once it is received. The proposal is to develop an overarching system resilience plan in partnership, with the right actions in place to act quickly where necessary. The York Health and Care Partnership would own the plan and use existing networks to deliver the plan, using practice and learning from the Covid-19 pandemic to ensure strong resilience planning for the future. Due to year-round demand it was asked that the name be changed to resilience planning rather than Winter planning which would also allow it to account for any adverse issues. It was agreed that resilience planning should form part of the Integrated Delivery Plans that will be developed for each of the YHCP's priorities. It was agreed for Public Health to lead on the plan, and to learn from where communication went well during covid. **Action:** Sharon Stoltz to bring back update on resilience planning to future meeting.	
6	**York Health Protection Committee (YHCP sub-group update)** Sharon informed that the first meeting would take place on the 28th March and she had received a good response for representation from different partners. The first meeting will focus on governance arrangements and the group would aim to bring together health protection to focus on the residents of York. It was asked that some of the language be reviewed in the ToRs. The board were supportive of the group.	Sharon Stoltz
	AOB There were no items of any other business to be discussed at this meeting.	Chair

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Annex E

York Health and Care Partnership

Monday 17 April 2023, 12:30 - 15:00
Severus Meeting Room; First Floor, West Offices
Chair: Ian Floyd

Present		
Ian Floyd (Chair)	Chief Operating Officer	City of York Council (CYC)
Professor Karen Bryan	Vice Chancellor	York St John University (representing higher education)
Sarah Coltman-Lovell	York Place Director	York Place, H&NY ICB
Rebecca Field	Joint Chair of York Health and Care Collaborative	York Medical Group
Sharon Stoltz	Director of Public Health	CYC
Emma Johnson	Chief Executive	St. Leonards Hospice
Brian Cranna	Director of Operations and Transformation, NYY&S	TEWV
Prof Mike Holmes	Chair	Nimbuscare
Michelle Carrington	Executive Director for Quality & Nursing	York Place, H&NY ICB
Alison Semmence	Chief Executive	York Centre for Voluntary Services (CVS)
Present via MS Teams		
Debbie Mitchell	Chief Finance Officer	CYC
Sharon Stoltz	Director of Public Health	CYC
Michael Melvin representing Jamaila Hussain	Director of Adults Safeguarding	CYC
Stephanie Porter	Deputy Director System Integration	H&NY ICB
In Attendance		
Anna Basilico	Head of Population Health and Partnerships	York Place, H&NY ICB
Hannah Taylor	Team Administrator	York Place, H&NY ICB
Alex Kilbride	Commissioning and Transformation Manager	York Place, H&NY ICB

Emma Olandj	GP Lead	Priory Medical Group
Polly McMeekin	Director of Workforce and Organisational Development	YSTHFT & Chair York and North Yorkshire workforce group
Vicky Mulvana-Tuohy	Deputy Chief AHP - Lead for AHP Professional Standards	YSTHFT
Lucy Fettes	Advanced Clinical Specialist, Community Palliative Care Therapy Team	YSTHFT
Apologies		
Jamaila Hussain	Corporate Director of Adult Service and Integration	CYC
Helena Ebbs	Director Clinical & Professional Services	York Place, H&NY ICB
Denise Nightingale	Director of Transformation (Mental Health & Complex Care)	York Place, H&NY ICB
Martin Kelly	Corporate Director of Children and Education	CYC
Mark Bradley	Director of Finance	York Place, H&NY ICB
Sian Balsom	Manager	York Healthwatch
Gail Brown	CEO	York Schools & Academies Board
Simon Morritt	Chief Executive	YSTHFT
Cllr. Nigel Ayre	Executive Member for Finance and Major Projects	CYC

Minutes – draft

Item	Title	Led by
1	**Welcome and apologies for absence** The Chair welcomed everyone to the meeting. The minutes of the meeting held on 20.03.2023 were approved. There were no declarations of interest in the business of the meeting.	Chair
2	**Partnership Comms Plan** Due to apologies this item was deferred.	Sian Balsom

3	**Rehab mapping update (including citizens story)** Vicky started by recapping her last update to the committee. Going through slides Vicky and Alex informed the committee of • Prevalence of patients not accessing services due to capacity issues with data from QOF in the City of York • Figures on patients living with frailty in the Vale of York footprint • Mapping of existing Rehab services • What Rehab should look like/what it currently feels like • Common themes across Services of barriers to accessing care and key themes and opportunities Lucy shared a positive patient story of an individual who received support from the Community Palliative Care Therapy Team who used a holistic approach to care and a crisis situation like hospital admittance was avoided. Lucy also shared that capacity issues within the team would mean that not everyone would be able to access the same level of care. Discussion ensued on: • Cost Benefit Analysis • Collaboration across providers • Increase in prevalence <u>Actions</u> • York Place team to continue to lead this integration work, and as a first step complete a Cost Impact Analysis • Looking broader at the whole rehabilitation offer to support integration for the people of York, recognising the significant capacity constraints on all of the service areas explored in the session. • Regular Updates to the Committee	Alex Kilbride / Vicky Mulvana-Tuohy/ Lucy Fettes
4	**Integrated Community Offer: Frailty SPA** Emma started by giving background information on how the Yorkshire Ambulance Service strikes allowed a more collaborative	

	way of working of services to avoid hospital admittance across the York Trust Footprint and gave a patient story as an example. Alex shared the outcomes of a workshop which had representation from organisations within the committee, recognising that work on the Vale footprint would need to be undertaken to cover the Trusts footprint. Alex also linked in the work to the strategy and the potential outcomes of the offer and shared what the next steps are over 90 days. Discussion ensued on: • No Criteria to reside • Help from Students • Pragmatism The Partnership commended this proposal as part of our Integrated Community Offer Priority, and encouraged all partners to continue to explore new ways of working and sign up to a shared agreement, deliverables and outcomes. <u>Action</u> • York Place team to continue driving forward this integration work and bring back regular updates to the YHCP. • Alex Kilbride and Michelle Carrington to have a further conversation about No Criteria to Reside and what other outcome measures would help demonstrate the impact of a Frailty SPA.	Alex Kilbride/ Emma Olandj
5	**System approach to workforce planning** Sarah started by giving context on the item, Polly followed by informing the committee about the outcomes of a Workforce Planning session that took place in Autumn 2022. The purpose of the discussion was to understand workforce plans for each partner and discuss specific issues/challenges and where we can work together to address these.	Sarah Coltman-Lovell and Polly McMeekin – group discussion

	Discussion ensued on: • International Recruitment • Retaining staff/knowledge • Cost of Living in York • Education • Workforce Issues • Volunteering opportunities • Recruitment Events • Placements for Students • Inequality in agenda for Change • Piece of work on Cultural Work • Health and Care Academy Action: It was agreed that Polly McMeekin will follow up the next steps via email to agree a few practical actions that can be taken forward by the Place Partnership in 23/24 to support recruitment and retention of workforce across York.	
	AOB There were no items of any other business.	Chair

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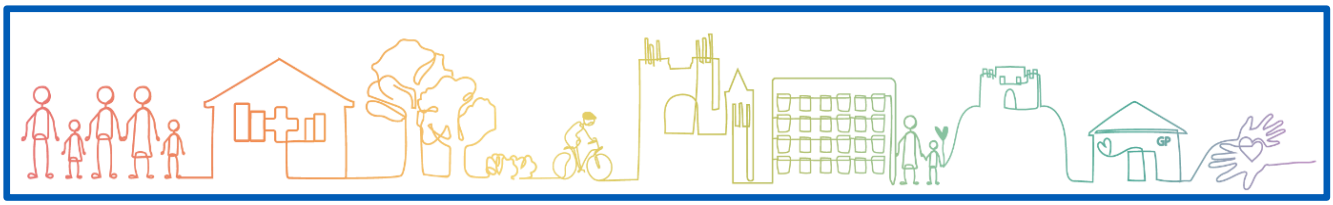
Annex F



York Health and Care Partnership

Monday 15 May 2023, 12:30 - 15:00
Severus Meeting Room; First Floor, West Offices
Chair: Ian Floyd

Present		
Ian Floyd (Chair)	Chief Operating Officer	City of York Council (CYC)
Sarah Coltman-Lovell	York Place Director	York Place, H&NY ICB
Rebecca Field	Joint Chair of York Health and Care Collaborative	York Medical Group
Emma Johnson	Chief Executive	St. Leonards Hospice
Brian Cranna	Director of Operations and Transformation, NYY&S	TEWV
Prof Mike Holmes	Chair	Nimbuscare
Alison Semmence	Chief Executive	York Centre for Voluntary Services (CVS)
Sian Balsom	Manager	York Healthwatch
Simon Morritt	Chief Executive	YSTHFT
Jamaila Hussain	Corporate Director of Adult Service and Integration	CYC
Martin Kelly	Corporate Director of Children and Education	CYC
In Attendance		
Anna Basilico	Head of Population Health and Partnerships	York Place, H&NY ICB
Hannah Taylor	Team Administrator	York Place, H&NY ICB
Apologies		
Helena Ebbs	Director Clinical & Professional Services	York Place, H&NY ICB
Denise Nightingale	Director of Transformation (Mental Health & Complex Care)	York Place, H&NY ICB
Michelle Carrington	Executive Director for Quality & Nursing	York Place, H&NY ICB
Gail Brown	CEO	York Schools & Academies Board

Professor Karen Bryan	Vice Chancellor	York St John University (representing higher education)
Sharon Stoltz	Director of Public Health	CYC
Mark Bradley	Director of Finance	York Place, H&NY ICB

Minutes – draft

Item	Title	Led by
1	**Welcome and apologies for absence** The Chair welcomed everyone to the meeting. The minutes of the meeting held on 17.04.2023 were approved. There were no declarations of interest in the business of the meeting.	Chair
2	**Poverty Truth Commission** Alison shared a video on the poverty truth commission. Discussion ensued on: • Future representation from Nimbuscare, YSTHFT and TEWV as Civic Commissioners • Links with the cost-of-living report • Young People Poverty Truth Commission • The Partnerships role in maintaining focus on those living in poverty and the specific health inequalities people in York experience. • Sharing the video at the York School Leaders Board • The importance of re-currently funding this work	Alison Semmence
3	**York Partnership Culture and Development Roadmap** Sarah started by summarising the previous work on the York Health and Care Partnerships Cultural values survey and the outcomes of the meeting. Sarah asked questions on whether the Partnership felt	Sarah Cotman-Lovell/All

	our vision was clearer, whether we to make a pledge on actions, and what action can we take personally to continue to embed the work of the partnership and create the conditions for success. Discussion ensued on: • An example of a pledge could be to use facilities offered by others in the partnership • Partnership Trust and how we can build this • Lack of knowledge and understanding about the partnership organisations • Option to focus on fewer items each meeting to execute well • Lack of visibility and understanding of the ICB across Place • Connecting the teams with similar/same roles across the partnership – walking in each other's shoes • How each leader has a responsibility to share YHCP conversations and work internally within their own organisation. <u>Action</u> • Anna/ Hannah to organise an additional meeting for the partnership to talk about their organisations, to be held at Priory Street with the potential to meet quarterly	
4	**Partnership Communications Plan** Sian gave an update on work happening on engagement within the Partnership. Sian informed the group of a meeting with comms and engagement colleagues from across the partnership. Outcomes of the meeting were: • To continue to work together regularly and feed into the head of comms network • Sian would circulate the Prospectus and Core 20plus5 documents to those who attended the comms and engagement meeting • Sharing documents with each other to circulate in their own organisations	Sian Balsom

	• Work together on an integrated communications plan for winter pressures • Creation of a campaign roadmap, covering standard comms messaging and working together on other campaigns to add in. • Comms and engagement team to meet prior to the head of comms meetings • Exploring the engagement platforms used across the partnership to understand what intelligence we have and how this can be shared across organisations. Sian noted that further work on what can be done for people who know about YHCP and the ICB already and the idea of a workshop. Suggestions of the partnership attending the Health Mela in September 2023 were discussed and whether these would be the right fit for the partnership to attend.	
5	**Updates by exception – ICS collaboratives and programmes** Sarah started by asking the committee if this item could be a standard item on the agenda for people to feedback discussions from the ICB collaboratives and programmes. Sarah and Alison gave an update on workforce, informing of a workforce event that took place in April, the 180 days challenge has now finished, and we are currently in a breakthrough stage. Sarah informed of a meeting with ICB colleagues Jayne Adamson and Jason Stamp to discuss workforce in York Place and would forward on the invite to colleagues within the partnership. <u>Action</u> • Hannah to circulate the letter from the April Workforce meeting • Sarah to forward on the York Place workforce meeting invite to colleagues	Various
	AOB	Chair

	Martin raised that he would be unable to attend the July YHCP meeting which focusses on mental health where it would have been beneficial to discuss children and young people. A separate item on children and young people, led by Martin, will be added to the agenda. Sarah raised key worker accommodation, noting that there will be an increase of 40,000 people with the new developments that are planned for York. A further meeting with Neil Ferris and health leaders is scheduled for the 31st May. Anna raised the Humber and North Yorkshire ICB Joint Forward Plan will be circulated following the meeting, the plan spans across the ICB but includes the priorities set by the York Health and Care Partnership. The Humber and North Yorkshire ICB Joint Forward Plan will be brought as an item to the June meeting for final comments. <u>Action</u> The Joint forward plan to be circulated following the meeting Ian raised the change in Admin of the political party following the local elections. <u>Action</u> Nigel Ayre to be removed from the partnership meeting invite and circulation list	

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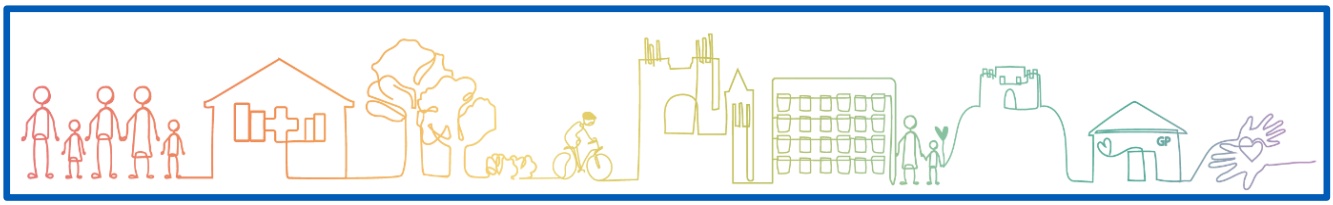
Annex G



York Health and Care Partnership

Monday 19 June 2023, 12:30 - 15:00
Severus Meeting Room; First Floor, West Offices
Chair: Ian Floyd

Present		
Ian Floyd (Chair)	Chief Operating Officer	City of York Council (CYC)
Sarah Coltman-Lovell	York Place Director	York Place, H&NY ICB
Rebecca Field	Joint Chair of York Health and Care Collaborative	York Medical Group
Zoe Campbell	Managing Director, NYY&S	TEWV
Prof Mike Holmes	Chair	Nimbuscare
Alison Semmence	Chief Executive	York Centre for Voluntary Services (CVS)
Sian Balsom	Manager	York Healthwatch
Simon Morritt	Chief Executive	YSTHFT
Stephanie Porter	Deputy Director System Integration	York Place, H&NY ICB
Jamaila Hussain	Corporate Director of Adult Service and Integration	CYC
Martin Kelly	Corporate Director of Children and Education	CYC
Cllr Claire Douglas (on behalf of Cllr Jo Coles)	Leader of the Labour Party	CYC
Debbie Mitchell	Chief Finance Officer	CYC
Gail Brown	CEO	York Schools & Academies Board
Denise Nightingale	Director of Nursing MH, CHC & Complex Care	York Place, H&NY ICB
Peter Roderick (on behalf of Sharon Stoltz)	Consultant in Public Health/ Deputy Director of Population Health	CYC/York Place, H&NY ICB
Michelle Carrington	Director of Nursing and Quality	York Place, H&NY ICB

In Attendance		
Anna Basilico	Head of Population Health and Partnerships	York Place, H&NY ICB
Hannah Taylor	Business Support Administrator	York Place, H&NY ICB
Angela Ward	Head of Children and Adolescent Mental Health Services and Adult Eating Disorder Commissioning	Humber Teaching Hospitals
Jacqui Hourigan	Designated Nurse, Safeguarding	H&NY ICB
Penny Gray	Director of Commissioning Strategy	H&NY ICB
Danielle Johnson	Director of Safeguarding	CYC
Apologies		
Helena Ebbs	Director Clinical & Professional Services	York Place, H&NY ICB
Professor Karen Bryan	Vice Chancellor	York St John University (representing higher education)
Cllr Jo Coles	Executive Member for Health, Wellbeing and Adult Social Care	CYC
Sharon Stoltz	Director of Public Health	CYC
Emma Johnson	Chief Executive	St. Leonards Hospice

Minutes – draft

Item	Title	Led by
1	**Welcome and apologies for absence** The Chair welcomed everyone to the meeting and attendee's gave a brief introduction for new members. The minutes of the meeting held on 15.05.2023 were approved. There were no declarations of interest in the business of the meeting.	Chair
2	**Introduction to Claire Douglas, leader of City of York Council**	Cllr Claire Douglas

	Claire started by explaining she was standing in for Cllr Jo Coles and introducing herself to the committee sharing her role, an overview of her career, the priorities she aims to feed through the council and what she would like to see from York Health and Care Partnership Executive Committee.	
3	**Working together for children, young people, and families** Michelle asked if the Dementia Strategy could come to the group following conversations held at the Place Quality Group the previous week. Anna Basilico will add this to the forward plan. Michelle then started by informing of the aim for there to be one Children and Young people group across the ICB and a workshop that is going to be held to look at vulnerable children. Michelle gave an overview of what life is like for a child living in York and what health inequalities our children and young people face. Danielle shared case studies of two children in York and the group discussed how as a system we could have responded differently. Danielle also shared some challenges with the committee to understand how as a system we can improve. Discussion ensued on: • Responding to crisis rather than moving the focus to prevention and early intervention • Professionally how to support people to take risk • Relationships and the importance of trusted relationships • What would have happened/be different today if we had changed the system 5 years ago • Gaps in the system • Trauma informed care • Support in schools for both children and parents • Recognising it is everyone's responsibility and come together to build a design model • Setting up a Task and Finish Group	Michelle Carrington / Martin Kelly

	Action • Anna to add in Dementia to the forward plan • Michelle Carrington and Martin Kelly to lead a Task and Finish group to look at how things could be done differently for CYP and bring back recommendations to the YHCP Executive Committee.	
4	**Humber and North Yorkshire Joint Forward Plan** Penny gave a brief overview of the Joint Forward Plan, explaining the plan would be submitted to NHS England at the end of June 2023, it would be a living document and reflect the work happening in collaboratives and places across the ICB. Discussion ensued on: • The financial deficit referred to in the Joint Forward Plan • The need to engage Local Authorities in the plan • The importance of investing in children early	Penny Gray
5	**YHCP Place Plan** Anna informed that the Place Plan for 2023/24 was built based on previous discussions held across the partnership and at YHCP meetings and the circulated document included information on the 6 York Priorities. The document describes who from our organisations are working to deliver the actions, and information to support making decisions through the YHCP executive committee, adding that an item on conflict of interest is coming to the July meeting. Answering a question on Governance Sarah replied that the subgroups will make recommendations that will be taken to the YHCP executive committee and currently people are working within their own delegated limits so decisions that are outside of this will be aligned and go through relevant organisation boards for decisions.	Anna Basilico

	Questions arose around whether there could be an addition of 'net zero' and 'in estates as economic anchor' could be added into priority 6. As workforce and estates are a big issue could it be focussed as a priority. <u>Action:</u> Anna will update the Place Plan and send to the YHCP executive committee for agreement via email. When suitable a comms document to be created to circulate	
6	**Updates by exception – ICS collaboratives and programmes** There were no updates by exception	Various
	AOB No AOB raised.	Chair

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A Health Prospectus for York 2022 and beyond

Part I: Introduction to this Prospectus

Purpose of this prospectus

This is not a strategy.

Strategies are helpful, and have their place. This, however is a deliberately short and readable 'prospectus' which has been written at the start of a new stage for York's health and care system. It describes the state of that system in 2022, the changes we are currently putting in place, and what people have told us they would like to see in future years.

> ***Prospectus*** (noun)
> a) a preliminary printed statement that describes an enterprise
> b) something (such as a statement or situation) that forecasts the course or nature of something
>
> **Merriam Webster**

This document was published in the first few months of a new organisation which plans healthcare in our region: **Humber and North Yorkshire Health and Care Partnership.**

Within this partnership, York sits as one of six 'places'. A group of leaders from has been meeting in preparation for these changes since the start of 2021 but we have only been a formal committee (the **York Health and Care Partnership**) since July 2022.

During this preparation year, we have been doing a number of things:

- focussing on improving the relationships between health and care partners
- using data to understand population health need better, with the establishment of the York 'Population Health Hub'
- collaborating on improving care
- engaging with citizens and our partners

This work has culminated in the production of this document, which is a preliminary statement that describes:

Where we are
Where we want to be
How we start the journey

How we made this prospectus

The production of this document drew on a number of opportunities for conversation in the York health and care system, and the events summarised below form the basis of the rest of this document, in its language and content.

York Big Question engagement exercise

We asked our partners in the voluntary and community sector in York to run an engagement exercise for us across winter 2021/22, which involved them hosting a conversation with people around a very simple question: ***What helps you live a happy and healthy life?*** The participants were asked to consider the question in a number of contexts: in the community they live, within health and care services, and through other city services. Additionally, when this document was finished, it was assessed by the Healthwatch York Readability panel for their view on how we have presented things.

Coproduction Workshop

In April 2022 we hosted an open-invite co-production workshop to help us write this prospectus. Participants were asked to focus on a number of areas of health: children and young people's mental health, social isolation/ connectedness, living with long term conditions, and health and care services, and asked two key questions: ***'In ten years, if nothing has really improved, describe what York looks like'***; and ***'In ten years, if things are radically different, describe what York looks like'***

Academic input

We are grateful to several senior academics within York's higher education sector for their input into the process. They talked through with us a number of international **models for health-generating city systems**, including the Marmot City approach, the WHO Healthy Cities indicators, the Preston Model (community wealth building), Doughnut Economics, and the Welsh 'Future Generations' Act.

Strategic Inquiry

The York Health and Care Partnership also held a workshop where a number of well-recognised 'strategic inquiry' questions were posed, aimed at generating meaningful, deep and challenging conversation about the issues we will need to tackle through the newly reformed health and care system. These questions were: **Where is the system now? Where does it need to be? Where are you in your own practice?**

Part II: Where are we now?

Challenges and strengths

Our work so far has highlighted a number of things to be proud of, and to build on. But it has also brought to light a number of hard and difficult realities we face in our York health and care system, which need to be acknowledged.

Strengths for health and care in York

Improved links between primary care and wider social interventions, e.g. through social prescribing	Many wonderful NHS and care **staff,** and commitment shown in e.g. the vaccination rollout	An abundance of **health assets** – green space, access to culture and heritage, community venues
An emerging aligned set of **prevention services** / practitioner networks	**Research and innovation** – the potential from clinical trials and operational insight	Use of **technology** to enable care and improve ways of getting help (but guard against digital exclusion)
The depth and togetherness of the **voluntary sector**	The power of **involvement** – seen in several 'coproduced' initiatives	Geography, in terms of our **aligned** providers, VCSE and council

Challenges for health and care in York

An overstretched, tired and burdened **workforce** where morale is low	**Demand** for healthcare seems to only ever head in one direction (upwards)	A challenging **financial** situation for all providers of care in York
The **short-term** nature of VCSE investment hinders sustainable capacity building	The long shadow and collective trauma of **COVID**	A '**crisis management**', system, not a 'preventative' system
Huge **backlogs** in care and long waits, across hospital care but also GP, community and social care.	A young **people's mental health crisis**, apparent even before the pandemic made it worse	Labyrinth **systems** – people feel they bounce from one gatekeeper to another
People often report ending up in the **wrong place** for too long, be it a hospital bed or the wrong service	**Access issues** to several services, including urgent care, primary care and dentistry	A reversal of **inequality** gains - people in poorer parts of York are dying earlier than they should

Current changes in health and care

The organisations which deliver health and care services in York are **not changing overnight**.

What is changing are the organisations which organise and plan this healthcare – essentially, those who allocate the resource and ensure the quality, safety and adequate provision of services to the whole population ('commissioning'). This is all part of a **national reorganisation** of the NHS and care.

This is not the first time these organisations have changed! As a city, York has been covered by various geographies of commissioning over the last decade:

What is different this time – and potentially a huge advantage – is that **York will have its own local body** focussing solely on the city and its needs and strengths, rather than in combination with other local areas.

Our **York Health and Care Partnership** will be a formal committee of the NHS Humber and North Yorkshire Integrated Care Board (ICB), and as such is charged with the local delivery of the four Integrated Care System goals.

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

This local group brings together senior leaders from all NHS organisations (including **GPs**, **the hospital**, and our **mental health trust**), **local government, St Leonard's Hospice, Healthwatch York,** the **education** and **higher education** sectors, to function as the ICB's decision-making body at place level for health and care.

Part III: Where do we want to be?

The following pages build on what people have described to us through the engagement exercise we have undertaken. They use the language, ideas and 'voice' of those who took part.

They tell a story, looking ahead to York's health and care system in a decade's time – 2032.

The first imagines that nothing has really improved ('the same old story')

The second imagines a radical transformation ('a better story').

2032…the same old story…

Its 2032, and York is a pleasant enough place to live. The relative affluence of our city ensures that some of the worst health outcomes seen by neighbouring northern towns (as a result of the pandemic and the cost-of-living crisis) are avoided.

The **seeds of good health**, however, are not being planted. A decade of budget constraints have meant that our local partnerships have mainly focussed on acute care and 'bailing out the boat'. Health and care services still tend to operate under a '**medical model**', placing an emphasis on procedures or packages of care which can be measured, rather than investing in the things which create good health.

We can see this most clearly in the health of our children and young adults. This is **generation COVID**. The disruptions of lockdown and the collective trauma of a pandemic meant that those learning to toddle and talk in 2020 are now starting secondary school; but we haven't proactively supported them. In addition, we've allowed increased pressures on young people, and worries such as isolation, career and housing prospects, and unemployment, to stack up. When this results in mental and physical health issues, it means more **costly interventions are needed**, with higher rates of young people accessing services.

The educational impacts are increasing inequalities in York's young adults, and with the cost of housing still a huge issue, **market forces** become destiny: York's mobile younger generation seek their future in other cities, while the less mobile stay, but struggle to find higher paying work, and to pay the bills.

Social isolation remains a big issue in the city. Parity of esteem in our system for issues like **loneliness or debt** (when A+E is full to-bursting more often than not) seems a luxury. Yet an increasing amount of healthcare demand is driven by inequalities and social factors. Fuel poverty leads to people living in colder houses increasing preventable long-term conditions. Some struggle with bills and budgeting for food, with clear impacts on physical and mental health.

Most people who are being seen by health and care services have more than one condition, but our system hasn't caught up.

The **divides** between primary and secondary care, between treatment pathways for single diseases, and between children's and adult's services, are still with us, and patients aren't getting anywhere near what we'd call a holistic or integrated service. This is true in our approach to the workforce, with the same clinical and professional **staffing structures** meaning a coherent and flexible approach to moving staff to the bit of the system which needs them is difficult.

Our work in clinical research, workforce development and innovation is still fragmented, and ad hoc; whilst we have world-class universities and colleges they are not strategically focused on local impact or really part of the partnership - so **we underplay our strengths**.

Out in the community, we haven't taken the opportunity to **involve people in services**, which (again) felt like a luxury we couldn't afford; but in fact designed out the power of people and community to make services higher quality. And our social prescribing services – while helpful, are running out of things to prescribe/refer to, with a number of key voluntary and community groups becoming unviable due to short-term contracts and lack of resilience.

2032…a better story…

Its 2032, and York is recognised as the healthiest and fairest city in the North of England. Life expectancy gaps between the richest and poorest – whilst still with us – are now **starting to close** rather than widen.

Having taken the decision to make improving health and wellbeing for all **a fundamental standard** by which we measure every decision in the city, we now only do things that support this vision, and are starting to reap the rewards.

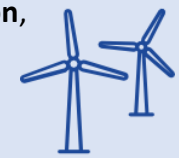
A large part of this involves a relentless shift in all areas to a **prevention and early intervention** model. At one end of the scale, communities are now defined by the depth of relationships and associations that exist, and not only do we use our health assets, but we grow them. At the other, people with long term conditions all have proactive care plans, and the most complex have a **multi-professional** team which isn't bound by disease area, sector, or the child/adult service division.

We utilised the COVID generation's experience of mental health issues and **turned it for good**, creating a more sensitive, compassionate and kinder culture and building the workforce of the future from people with lived experience. Models of community support based around **local 'hubs'** have arisen which are preventative, meaning people don't need to seek professional help so often, and can find mental wellness in connections and communities.

Children are at the centre of our city life, starting with the most vulnerable. Much better work across all partners involved in the care system, including **better transition** into adult services, means that children in care have better health outcomes, whilst the involvement of education leaders in our health partnerships mean that pioneering work is being done to raise **a healthy generation of children**, most of whom are now growing up accustomed to getting around the city using active travel methods such as walking, cycling and public transport.

Workforce difficulties are still with us, but since the introduction of a city-wide **workforce plan** and collaboration on flexible training in health and social care, we now have the right number of district nurses, carers, mental health practitioners and social workers. Our collective capability in universities and colleges has given us innovative solutions in this area, as well as creating higher-paid research and teaching jobs which boost our economy and wage growth.

In terms of our local health partnerships, York is now really starting to maximise its maturity – building on the closeness, informal and strong relationships and honest conversations needed to sort problems out quickly. Not everything is done by committee (though governance is strong and robust); our niche is to be **nimble, compact and adaptable**; we are starting to get a reputation for pioneering new models of care, and so we attract the clinical and professional leaders needed to make this a reality.



Our NHS is basically now **zero carbon**, and in fact works with the council to identify patients whose homes need insulating. Fewer people are in fuel poverty (since we have a more environmentally sustainable way of heating houses), and those struggling with debt are **quickly identified** by, for example their GP and given support. All of this is slowly reducing pressure on the NHS and social care, who have long moved from focussing on patient flow and discharge, and now **collaborate** on making care more personalised.

Part IV: How do we start the journey?

Develop our behaviours

Over this last year, the York Health and Care Partnership has agreed a Charter of Behaviours. Learning from other high performing health and care systems who have worked hard to behave as one team, we have agreed that as a set of senior leaders:

We are in it together

We agree that we will have a robust airing of views, but that once our team has reached a decision, we will all abide by that decision and support it publicly.

We will trust in people

We agree to openly discuss all matters that affect our ability to make firm decisions, including any conflicts of interest and any limits on our mandate (where we carry these from participant organisations), so that all members of our team are fully aware of any restrictions, caveats or further authority that may be required.

We will be permission-giving and empower staff

We will support our teams, and in particular professional/clinically-led service development. We will deliberately try to enable decisions to be made by 'front-line' staff by saying 'yes' to their solutions. We will promote an environment of high quality and low bureaucracy. We will recognise that Health and Care rises and falls on staff wellbeing.

We are person-centred

Recognising the diversity of our population we will develop solutions that are 'bespoke by default' focussing on understanding the needs of our residents. We will put people at the centre of decision making and be able to question where we think this is not the happening.

We will free the power of the community

People/patients will be actively involved in the system, providing feedback, supporting and leading change.

We are committed to improving population health

We recognise the significant health inequalities experienced across the city. We recognise the upmost importance of working to address these inequalities and support vulnerable individuals and populations when participating in our activities.

We will connect clinicians and professionals

We are committed to restoring the connections between clinicians and professionals from primary and secondary care, nursing and social care, and the voluntary sector. Staff are empowered to make the right decisions without bureaucracy getting in the way, and will understand the system as a whole.

Our finances will align

We will explore ways in which we can use our collective resources to the best possible effect for the population. We will strive to understand the consequences of our decisions on all partners and manage any repercussions so as not to destabilise any organisation and managing risk collectively.

Build on our framework for a health generating city

GROW
the things which keep us healthy

for example: cookery classes, the NHS procuring local goods, offering apprenticeships, more keyworker housing, capacity building in the third sector, cycling skills courses, smokefree hospitals, social prescribing, reduced air pollution

ACT
early and prevent ill health

for example: help to achieve a healthy weight, identification and brief advice for alcohol,, self-management technology, home blood pressure monitoring, peer support groups, population health management, dementia coordination, falls prevention

CARE
with compassion and quality

for example: meeting healthcheck targets, reducing elective waiting lists, supporting maternal health, preventing hospital-acquired infection, advance-care planning, timely care packages, primary care access, trauma-informed care

CONNECT
things into one York team

for example: shared care records, integrated discharge arrangements, co-location of services, locality working, multi-disciplinary working, better treatment of dual-diagnosis, personalisation, involvement of carers

Establish and mature our partnership

The following is our equivalent of a 'to do list' for our first year in operation as York' place within Humber and North Yorkshire ICS:

- Strengthen the foundations of our place partnership, including its governance
- Streamline workstreams and health sub groups in York, building a fit-for-purpose partnership model
- Support the development of a city 10 year strategy, with three key documents – the Economic Strategy, the Climate Change Strategy, and the Health and Wellbeing Strategy, at its centre.
- Lead the health and care sector response to the above strategies, including the development of action plans and associated partnership structures
- Press for a maximal model of delegated functions from Humber and North Yorkshire Integrated Care Board, to further integration plans
- Start work on joining up the health and care research and innovation potential in York, collaborating with higher education sector leaders on joint priorities e.g. workforce supply, clinical research, operational insight
- Develop our co production approach to decision-making
- Produce a realistic future workforce strategy for the city based on the concept of a York 'health and care team'
- Understand the financial challenge for York 'place' within the integrated care system, and develop plans to underpin good long term decision making
- Keep 'alliancing', including modelling the behaviours listed in this document
- Work collaboratively on a York and North Yorkshire footprint on things that make sense within the health and care system, for instance urgent and emergency care

Thank you for reading this Prospectus

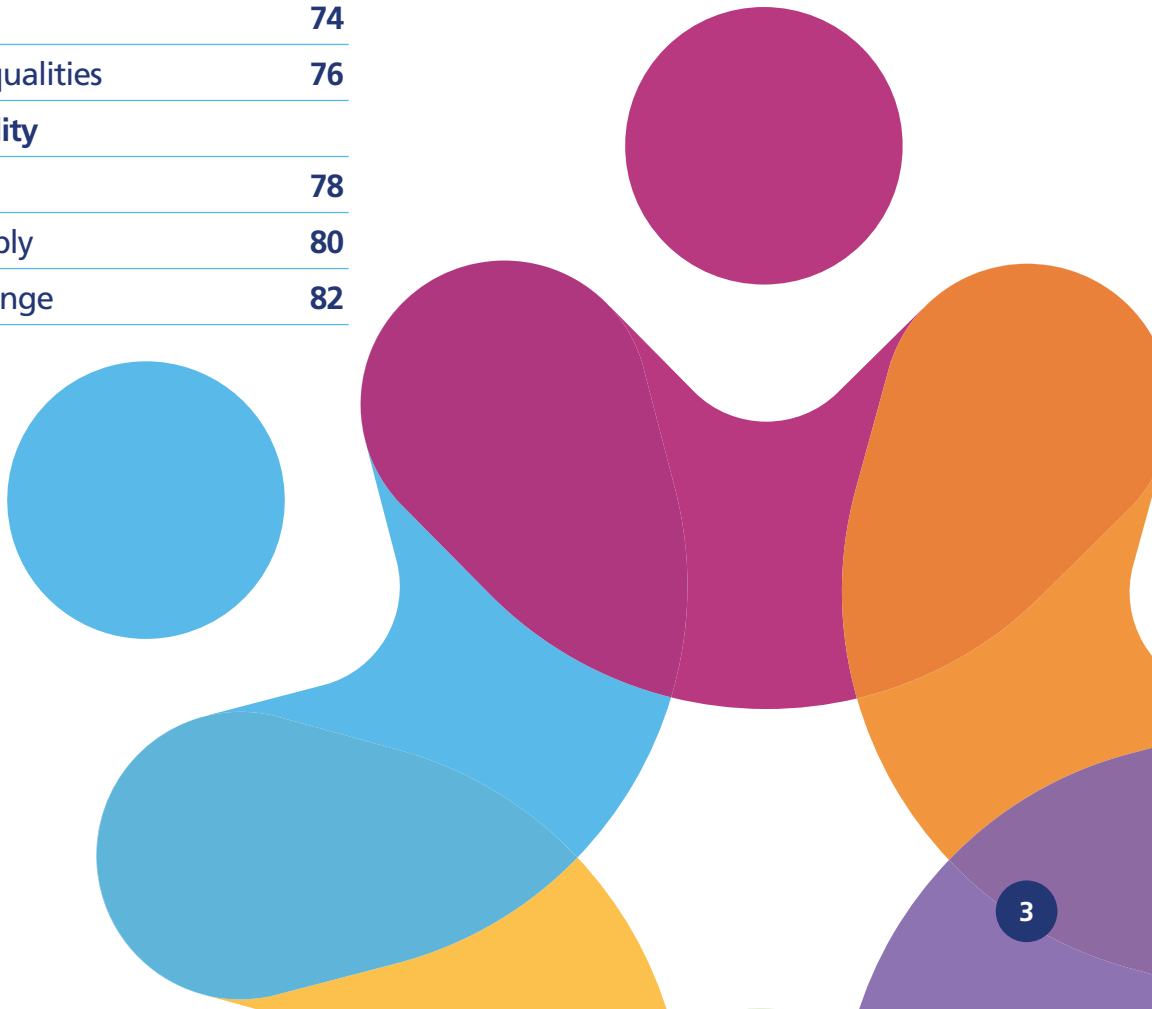
For more information on please email
peter.roderick@nhs.net

Humber and North Yorkshire
Health and Care Partnership

Joint Forward Plan

How we will deliver our strategy from 2023 - 2028

Contents



Introduction from the **ICB Chief Operating Officer and Deputy Chief Executive**

The Humber and North Yorkshire Integrated Care Board (ICB) is required to publish a Joint Forward Plan which sets out how the NHS will deliver the aims and ambitions set out in our wider system Integrated Care Strategy.

Joint Forward Plans must set out how ICBs intend to discharge their duty to have regard to the wider effect of decisions about the provision of health and care.

Our belief is that integrated care is about giving people the support they need, joined up across local councils, the NHS and other partners.

We have created the Joint Forward Plan from a 'bottom up' approach – seeking to bring together place and collaborative plans to describe how all parts of our ICB are working together with partners to deliver our ambitions through NHS commitments and to meet the needs of our local populations.

Our Joint forward plan brings into focus in one place:

- what the NHS will deliver, fully aligned to wider system partnership ambitions.
- how we are making an impact through place strategies, partnerships and plans, building on continuous engagement with our populations.
- ensuring that we are delivery focussed by including specific objectives for 2023/24.

In bringing these existing plans and strategies into one place, the ICB can hold itself to account for our actions to support system and partners strategic aims and can ensure that we understand our progress and make adjustments throughout the five years to ensure we deliver our shared vision.

We have set out the plan in two sections.

Section one will focus on integration, setting out how place and sector collaboratives will deliver the vision over the next five years and providing some tangible milestones for the next 12 months. This reflects the priorities and plans at place with health and wellbeing boards that deliver the ambition and vision of the strategy.

Section two describes how we will create the enabling conditions to achieve the vision by setting out an ICB wide overview of our structures and

ways of working to fulfil our partnership ambitions and meet legal requirements and sets out our key deliverables to achieve this in 2023/24.

The plan sets out our stall as to how the ICB will work to improve outcomes for our population, tackle health inequalities, improve productivity and make connections between health and wider issues. Including how the ICB will work with partners to address local social, environmental and economic conditions which impact on health and wellbeing.

The plan will be submitted to NHS England in June 2023 but our planning activities will continue beyond this. We will use the plan to track our progress and ensure continuous engagement through partners and with the public so that we build an ongoing five year programme to deliver our strategic aims.

This plan forms the basis of the ICB becoming a partner in the Humber and North Yorkshire System, providing transparency about how the ICB will empower local leaders to focus on improving outcomes for their populations, giving them greater control while making them more accountable for performance and spending.

This will enable us to deliver on the promise of system working, as described in the Hewitt Review of Integrated Care Systems.

- Amanda Bloor

Hewitt Review of Integrated Care Systems

Use the camera on your smartphone to scan the QR code

www.gov.uk/government/publications/the-hewitt-review-an-independent-review-of-integrated-care-systems

Introducing Humber and North Yorkshire ICB

The NHS Humber and North Yorkshire Integrated Care Board (ICB) is a statutory NHS body with those functions and duties conferred to it as set out within the Health and Care Act 2022.

The ICB operates as a joint partnership with the local authorities, with wider system partners, adopting a collective and shared approach to decision-making and facilitating mutual accountability across the Integrated Care System (ICS).

Our approach is based on the belief that we will be more successful in bringing about change if we work together.

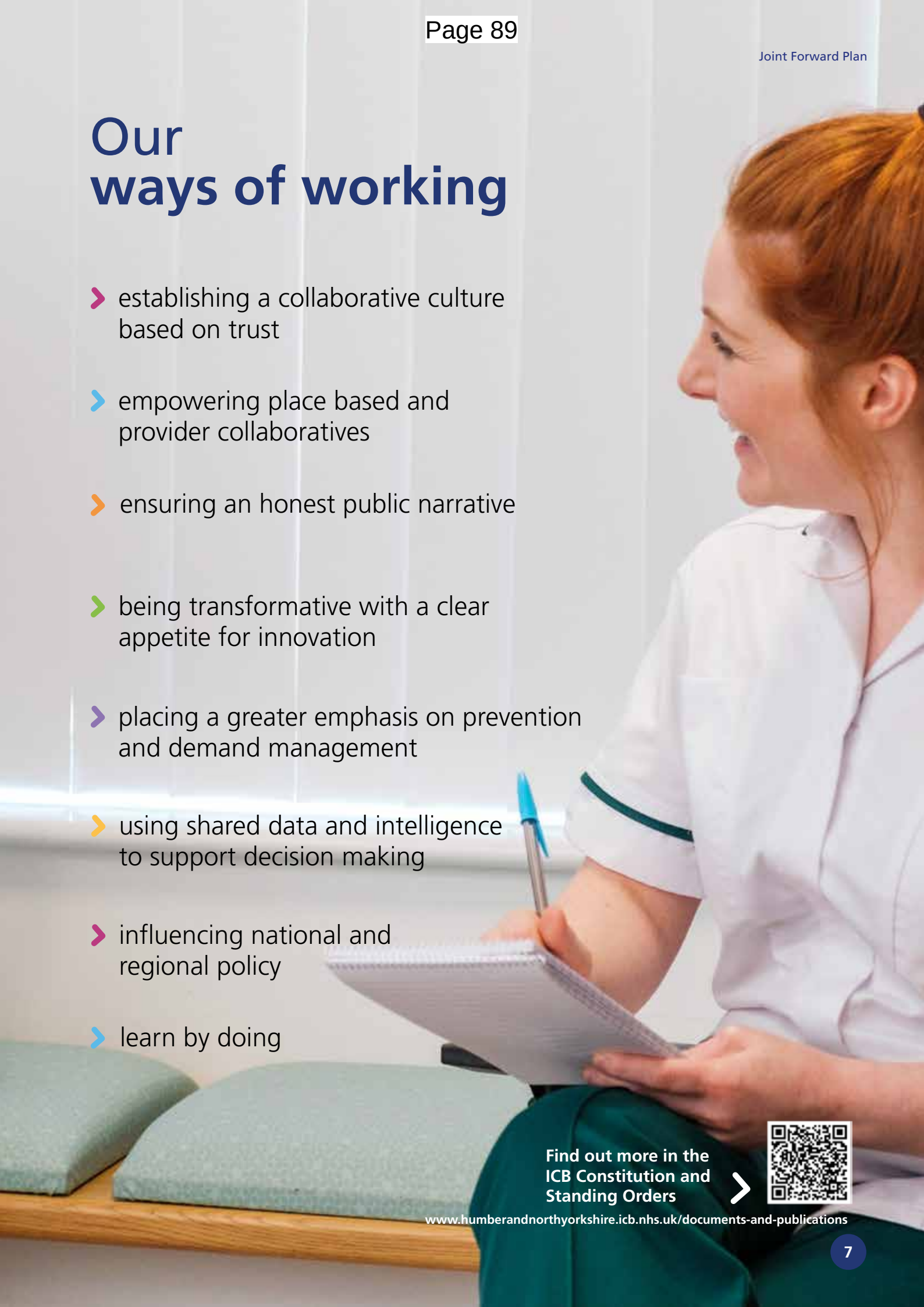
The partnership has subscribed to a principle of subsidiarity, which means that most of our focus will be on continuing our work together to improve the health and wellbeing of the local population in each of our six 'places'.

Our purpose is to improve the lives of the people who live and work in Humber and North Yorkshire. We will do this by:

- Improving outcomes
- Tackling inequalities
- Enhancing quality and productivity
- Supporting social and economic recovery

Our ways of working

- establishing a collaborative culture based on trust
- empowering place based and provider collaboratives
- ensuring an honest public narrative
- being transformative with a clear appetite for innovation
- placing a greater emphasis on prevention and demand management
- using shared data and intelligence to support decision making
- influencing national and regional policy
- learn by doing



Find out more in the ICB Constitution and Standing Orders

www.humberandnorthyorkshire.icb.nhs.uk/documents-and-publications

Our **strategy on a page**

Our ambition is:

for everyone in our population to live longer, healthier lives by narrowing the gap in healthy life expectancy between the highest and lowest levels in our communities by 2030 and increasing healthy life expectancy by five years by 2035.

To reach that ambition our **vision** is to ensure that all our people:

Start Well

We want every child to have the best start in life and enable everyone to be safe, grow and learn.

Live Well

We want to ensure the next generation are healthier than the last and have the opportunity to thrive.

Age Well

We want to ensure people live healthy and independent lives as long as possible by understanding what matters most to them.

Die Well

We want to create an environment in which people can have positive conversations about death and dying.

To deliver the ambition and vision, our **intentions** are to:

Create conditions

to

- **Think person**
- **Think family**
- **Think community**

Our partnership

We are the Humber and North Yorkshire Integrated Care Partnership part of one of 42 Integrated Care Systems (ICSs) established across England.

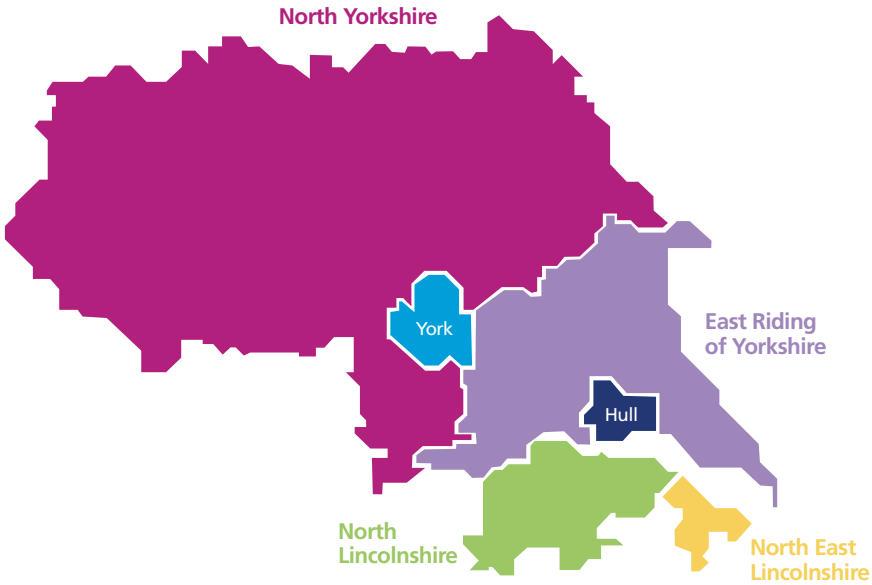
The Integrated Care Partnership (ICP) is a standalone statutory committee between Local Government and the NHS Integrated Care Board (ICB). We are responsible for developing the integrated health and care strategy to address the health, social care and public health needs of our population.

Our focus is on improving outcomes for our population, tackling health inequalities and making the connections between health and wider issues including socio-economic development, housing, employment and environment. We take a collective approach to decision-making and support mutual accountability across the Integrated Care System.

Total budget of approx. £3.5bn

1.7 million people

c.50,000 staff
across health and adult social care



175 dental practices

325 community pharmacies

162 community optometry practices

43 Primary Care Networks
(168 GP practices)

4 acute hospital trusts
(operating across 9 sites)

2 ambulance trusts

4 mental health trusts

4 community / not-for-profit providers

6 Local Authorities
(upper tier and unitary authorities)

550 care homes

180 home care companies

10 hospices

1000s of voluntary and community sector organisations

Delivering **our vision**

This section sets out how Humber and North Yorkshire ICB will work in partnership with local health and care organisations collaboratively in the interests of our population to improve health and wellbeing. Including:

- how we have developed our operating model to embed our duty of integrated working, throughout our organisation to improve quality and reduce inequalities
- outline how we will deliver improvements to realise our strategic vision and ambition, focussing on what changes will be made in 2023/24
- outline how we will deliver our population health and prevention ambitions
- set out key system developments in commissioning that will take place in 2023/24
- how we will address the particular needs of vulnerable groups as set out in guidance

Embedded in our ICB operating model is delivery at place. A key element of our delivery is through the Joint Local Health and Wellbeing (JLHW) Strategies developed at place with local authority partners. The plan includes a summary of each JLHW, setting out how each of our places will work and support delivery of these local plans, within our overarching ICB plan.

This plan aims to summarise rather than duplicate the detailed work through our places and collaboratives. It 'sets out the stall' of the ICB and its contribution as a partner to improving the health and wellbeing of our populations, encouraging transparency to enable local autonomy for delivery.

Our operating model

Our principles

The ICS is now in its first substantial year of existence after it was legally established in July 2022. As a system we want to assess our progress to date and consider how to maintain and develop our effectiveness in 2023/24. In 2023/24 we will build on these principles to:

- build on the current work in place to tackle inequalities
- accelerate our ability to deliver transformation by bringing data together
- ensure a coherent approach to quality improvement linked to performance management with clear expectations of roles and responsibilities, a culture of self reporting of problems and peer review through place and collaboratives
- balance 'designing tomorrow, delivering today' - equally keeping our focus on prevention, demand management and transformation – and being conscious and deliberate in our programmes
- widen our impact through improving population health
- support and invest in our clinical and professional leadership and organisational culture
- make sure we have a comprehensive commitment to engagement with all our partners

For more information see the ICB Functions and Decisions Map

www.humberandnorthyorkshire.icb.nhs.uk/governance

How we will deliver our plan

The aim of the Humber and North Yorkshire Operating Model is to emphasise the importance of place-based partnerships by ensuring that place and sector collaboratives are at the core of the delivery mechanism of the ICB, within an overall single operating model.

Place based leadership creates the right conditions for change, ensuring local system conversations can develop plans to address local priorities and health inequalities within the overall ICB strategy.

The role of place is to:

- develop and deliver integration and service transformation in line with the ICS Strategy and place priorities as set out in the Joint Local Health and Wellbeing Strategies
- lead and assure mutual responsibility and accountability at place for deliverables set out in the NHS plan
- deliver place efficiency plans on behalf of the ICS System

This is led by facilitating and negotiating close partnership working with local providers, local authorities, voluntary and community sector partners and populations to agree priorities within the Integrated Health and Care Strategy and the Joint Local Health and Wellbeing Strategies.

Sector collaboratives bring the provider delivery partners together to transform services at scale, doing things once to share learning and reduce variation, working closely with place partners.

The sector collaboratives are responsible for:

- delivery on key operational targets as set out in the NHS Long Term Plan and Operating Planning Guidance
- act between provider members, place, and other delivery partners to deliver transformation at scale, as part of the ICB Strategy

This matrix and collaborative approach between place and sector-based collaboratives is underpinned by the ICB, which sets the strategy, supports system wide planning and is accountable for financial and operational performance.

The purpose of our model is to support the principles of subsidiarity and delegation, ensuring that we adopt the principles of local decision making and autonomy to meet population needs while creating a whole system approach to maximise efficiencies by 'doing things once' where appropriate.

In 2022/23 there have been good examples of where the model of place led system and collaborative working has created the right strategic environment for delivery and service transformation:

- **agreeing local priorities with partners at each place, aligned to ICB priorities**
- **early engagement through place and sector collaboratives to respond to urgent care pressures and improve pathways for discharge through developing local plans for £18.1m adult and social care discharge funding**
- **developing integrated models of care with local authorities to reduce health inequalities**
- **working across place and sector collaboratives alongside local partners on the configuration of mental health services**

The York Community Mental Health Hub is a supportive environment where people can access support from the hub team – which includes a hub manager, mental health clinician, peer supporters, carer support, social worker, recovery worker and social prescriber - when they need it and have their needs met in a timely way.

The vision for the hub has been inspired by the open, community led and de-stigmatising values of the Trieste Mental Health Model in Italy.

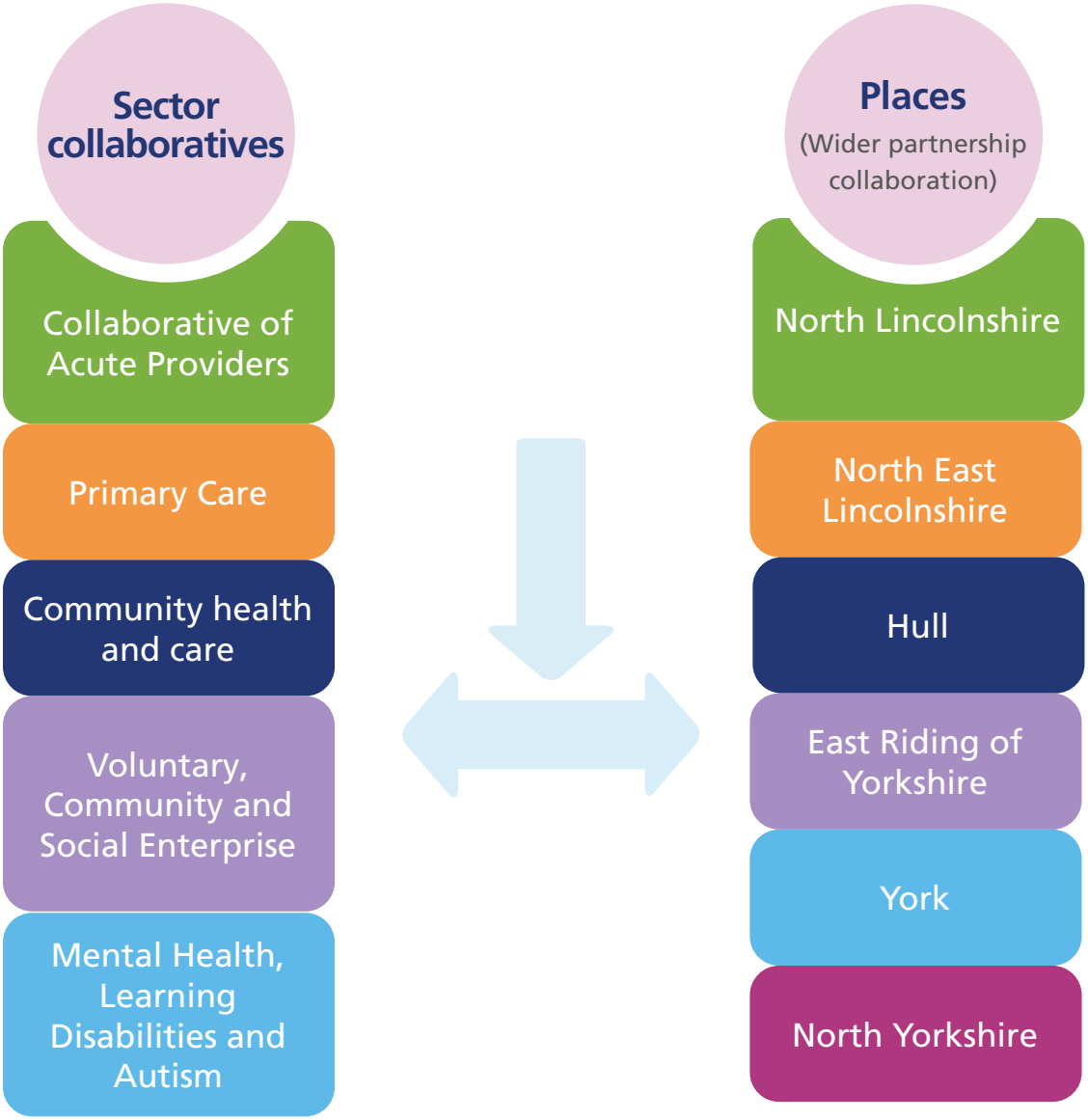
Compassionate care, strengths based and trauma informed approaches, reflection and relational activism all underpin the approach at the hub.

Our operating model

ICB single approach to planning and system accountability:

- alignment of vision and ambition to create capacity and capability for transformational change
- generating efficiencies through 'doing things once'
- assurance of system wide accountability and reporting

Delivering to local priorities and populations through:



Our operating model: **developments in 2023/24**

The ICB Scheme of Reservation and Delegation delegates to place directors:

Allocation of delegated resources to deliver the plan in each place and setting principles for how they should be allocated across services and providers.

Arrange for the provision of health services in line with allocated resources, including putting in place contracts to secure delivery of its plan and supporting providers to lead major service transformation programmes to achieve agreed outcomes.

This means that place-based leadership teams have the autonomy and flexibility to look at allocations holistically, and work with partners to agree how spending can support local priorities to address health inequalities within the overall ICB strategic approach and governance. Governance - Humber and North Yorkshire Integrated Care Board (ICB).

Throughout 2022/23, places have been engaged in discussions about local autonomy and delegation of local decision making. Three development sessions were held during 2022.

These sessions were facilitated by Capsticks with the six local authority Chief Executives, the ICB Chief Operating officer, Executive Director of Finance, Executive Director Corporate Affairs and Place Directors to review national guidance, options for delivery and local priorities. The following arrangements have been agreed for 2023/24.

Place	Intentions for 2023/24
North Lincolnshire	Delegation to continue through place director, discharged through local place committee
North East Lincolnshire	Establish a Joint Committee
Hull	Delegation to continue through place director, discharged through a local place committee
East Riding of Yorkshire	Delegation to continue through place director, discharged through a local place committee
York	Delegation to continue through place director, discharged through a local place committee
North Yorkshire	Delegation to continue through place director, discharged through a local place committee

North East Lincolnshire has a proud and lengthy history of working in an integrated way in respect of health and care for the last fifteen years as the Clinical Commissioning Group (CCG) was delegated by the local authority to commission adult social care. Over the years, through a section 75 agreement intensive collaboration has resulted in joined up services, posts and governance processes.

Our core model of care will be the Accountable Teams Model, embodying teams working together to meet the health and care needs of people, their carers and families. Rolling this model out erases the 'lines in the system' created by organisational needs and boundaries, and will be founded upon:

- one referral to the right person at the right time
- 'Accountable Care Teams' – avoiding often complicated and time-consuming transfers between services, professionals and organisations
- shared data; digitally enabled; capable and empowered staff; and tailored care
- delivering home first and virtual wards

We have already successfully delivered the Connected Health Model in cardiology, breaking down barriers between primary and secondary care to eliminate waiting lists for this specialty – we will roll this out for other pathways of care and other specialties.

Place priorities: health and wellbeing North Yorkshire

Our ambition

For all residents of North Yorkshire to have a fair chance of living a fulfilling life, free from preventable ill health, 'adding years to life and life to years'

- **think 'people':** In North Yorkshire, we will work with our communities who experience the poorest health outcomes to make sure that they can access and benefit from the services and opportunities they need
- **think 'place':** In North Yorkshire, where you live should help you stay well and happy. We want to make sure that where you live does not unfairly reduce the quality of your health or length of your life
- **think 'population health and prevention':** In North Yorkshire, we will improve the health of all our residents by prioritising interventions that will make the most difference and that make sense to do at scale.

Where we are now

- people already affected by health inequalities before the pandemic have been disproportionately affected by COVID-19, leading to even greater inequality
- over three fifths of adults are overweight or obese – similar to the national average
- healthy life expectancy (number of years lived without serious illness) for women is below the England average, and over the past nine years, has not increased
- 25% of our population is estimated to have a life-long illness
- our population is ageing – one and four people in North Yorkshire is over 65
- people who live in the wards with the highest life expectancy live 12.6 years (women) and 15.4 years (men) longer than those in the wards with the lowest life expectancy

Our priorities

A comprehensive and integrated health and social care model

A high quality care sector, with sufficient capacity to meet demand

A strong workforce

Prevention and public health: adding life to years and years to life

What we will deliver in 2023/24

We will:

- enable the four Local Care Partnerships to lead the design of the local integrated model
- in partnership with York, redesign and deliver a new single fully integrated 24/7 urgent care specification
- develop and deliver a business case for a new integrated model for intermediate care
- support discharge and flow through intermediate care with new hub and system monitoring arrangements
- develop population health management and prevention through a Primary Care Network (PCN) programme and cardiovascular dashboard
- deliver crisis response and virtual ward beds in line with 23/24 trajectories
- establish North Yorkshire VCSE assembly by Community First Yorkshire
- develop innovative models for domiciliary care, including care built on community strengths
- to further support provider sustainability, the Council will review the timescale for moving residential placements to actual cost of care
- work with care providers to implement the national charging reforms for adult social care and the NHS discharge pathway
- develop robust Standard Operating Procedures (SOPs) to maximise utilisation and flow within independent sector
- prepare proposals for transforming local authority in house domiciliary care provision
- develop more balanced/varied roles with appropriate rewards
- develop innovative approaches to recruitment and innovative workforce models
- identify opportunities for cross sector working and roles
- support international recruitment across sectors
- 12 oral health practitioners due to complete apprenticeship in August 2023 with opportunities to undertake roles in Yorkshire and Humber area
- legacy registered manager mentor to be appointed to provide support for registered managers across the North Yorkshire and York areas
- refresh the Health and Wellbeing Strategy
- expand population health management (PHM) review cycles across PCNs
- appoint a joint post between North Yorkshire Place and North Yorkshire Council to lead on health inequalities and population health
- e-cigarettes to be used as a harm reduction tool as part of the Living Well Smokefree Service
- implement Drug Treatment Plan for 23/24
- support people to maintain good mental health with timely access to effective primary, secondary and specialist services when needed
- support people to be physically active across all ages and stages of the life course
- influence through the strength of the partnership the wider determinants of health with a focus on coastal communities
- promote and invest in stronger communities and strategic commissioning of the Voluntary, Community and Social Enterprise Sector
- engage people in a dialogue about self-care, early help, loneliness and using digital tools

Place priorities: health and wellbeing York

Our vision

Over the next decade, York will become healthier, and that health will be fairer.

York Place will support delivery of the six big ambitions of our Health and Wellbeing Strategy 2022-2032:

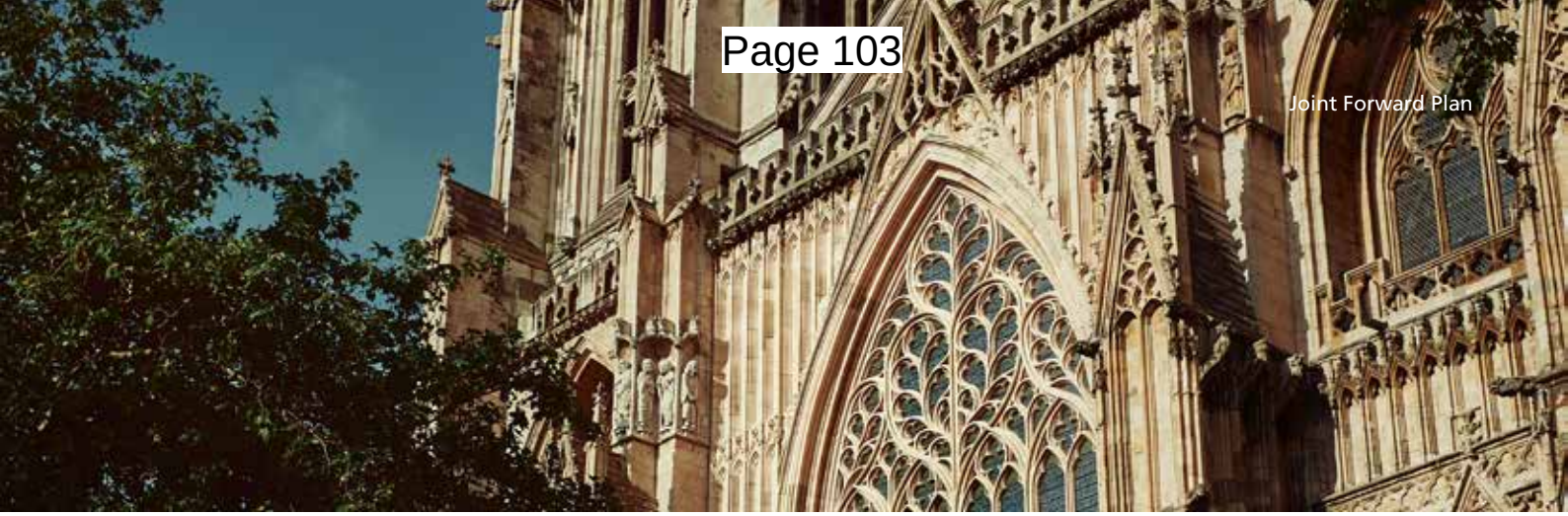
- become a health generating city
- prevent now to avoid later harm
- start good health and wellbeing young
- make good health more equal across the city
- work to make York a mentally healthy city
- build a collaborative health and care system

Where we are now

- York has an ageing and growing population, with increases in hospital care, social care and GP usage
- York's red flags are alcohol consumption, multiple complex needs, drug related deaths and student health
- one in nine people in York have more than one long-term condition, and there is an elective backlog across primary and secondary care.
- Under 18 admissions for mental health need with a high prevalence of common mental health illness, high suicide and high self harm rates
- one in ten people smoke, two in three adults are overweight or obese and one in seven live with depression
- York has a widening inequalities gap in healthy life expectancy, heath of those living with a learning disability and school readiness

What we will deliver in 2023/24

- develop an Integrated Community Frailty Single Point of Access Hub including mapping, outcomes and delivery model
- work in partnership with North Yorkshire on the redesign of urgent care, developing a single fully integrated 24/7 specification
- re-establish a clinically-led Primary/Secondary Care Interface Group to explore opportunities for shared care pathway development
- across health, social care and education we will identify the barriers to overcome through working together, we will have taken the first step, and we will have a plan for action
- acceleration of a prevention programme for long-term conditions to support delivery of the prevention actions in the York Health and Wellbeing Strategy 2022-2032 Action Plan.
- fulfil our role as an ICS to support the three city strategies, and as an anchor institution for development, housing, workforce, and supporting vulnerable groups.



Our priorities

- Strengthen York's integrated community offer
- Implement an integrated urgent and emergency care offer
- Further develop primary and secondary shared care models
- Develop a partnership based, inclusive model for children, young people and families
- Embed an Integrated Prevention and Early Intervention Model
- Drive social and economic development

What will this mean for citizens?

Strengthen York's integrated community offer

Greater access to personalised support and integrated care outside of hospital, to help people live well and independently at home for longer.

Implement an integrated urgent and emergency care offer

A safe, reliable, and resilient service where duplication is reduced, providing remote visits on a 24/7 basis to provide a better experience for patients.

Further develop primary and secondary shared care models

Shared care models between patients, specialist GPs and other specialists to deliver a personalised, seamless and holistic care experience.

Develop a partnership based, inclusive model for children, young people and families

Work in partnership for children, young people, and families to raise a healthy generation who grow into healthy and independent adults.

Embed an Integrated Prevention and Early Intervention Model

A shift to prevention and early intervention, enabling people to live healthier, longer lives, and reducing the gap in health inequalities between the most and least deprived communities in York.

Drive social and economic development

Working at the heart of communities to use and grow the assets we have, maximising our collective capability, working in partnership taking a cradle to career approach.

Place priorities: health and wellbeing Hull

Our ambition

Integration

- embed a population health approach to understanding our population across primary care, working with partners in the system i.e. local authority, VCSE sector, citizens advice, which will focus on the Core20PLUS5, all ages
- integrated pathways will be prioritised to improve benefits from services and efficient use of resources to support the improvement of patient experience
- implement Integrated Neighbourhood Teams

Primary care Priorities

- workforce
- improve primary care access
- population health & inequalities – Core20PLUS5, all ages

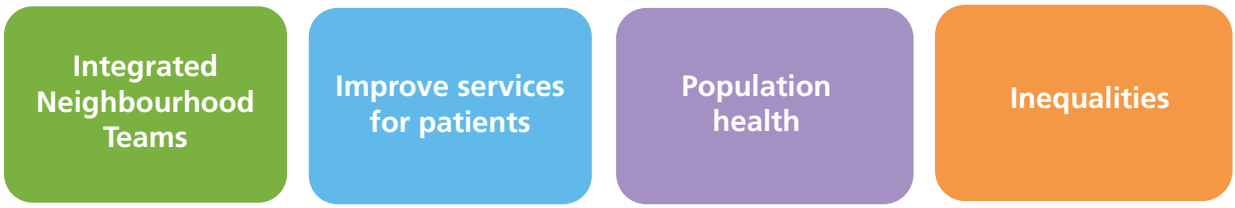
Inequalities

- supporting self care to help people live longer in good health in the community, reducing the mortality gap in Hull
- improve access to health services, integrated provision in health and social care

Where we are now

- 17% of population currently smokes – though the prevalence has generally been decreasing the rates vary widely
- for males, around 42% of the life expectancy gap between the most and least deprived wards within Hull is made up of circulatory disease and cancer
- 71% of adults are classified as overweight or obese. 28% of children in reception are overweight or obese
- 55% of adults are physically active
- 71% of people are in employment
- 47% GCSE attainment 8 score
- 33% of children are in relative low income families

Our priorities



What we will deliver in 2023/24

- roll out our project to support people in receipt of home care across the city to deliver Integrated Neighbourhood Teams
- work with community, mental health and voluntary sector organisations to deliver the Care at Home Project
- work with our priority areas across local trusts and community providers to improve access at the time of need focusing in on elective care and cancer
- continue our joint improvement plans for special educational needs and disabilities (SEND)
- deliver our system Anticipatory Care and Urgent Emergency Care Programmes to reduce admissions to hospital and improve integrated discharge processes
- ensure Hull Primary Care Networks embed a population health management approach to identify patients that may need a clinical review to support health prevention
- work across public health and with our local authority to employ a trauma informed approach to developing models for inclusion health
- focus our approach to reduce variation, with focus on Core20PLUS5, using data analysis and clinical peer review to improve care locally
- tobacco control workplace & deprived community targeted outreach
- provide primary care in children's centres

Place priorities: health and wellbeing

North East Lincolnshire

Our ambition

Our local community, health and care system is currently building on a lengthy, proud and powerful history of collaborative and integrated working ensuring our community, health and care organisations work hand in glove and this has benefitted local people for many years.

Our Health and Care Partnership enables partners to work together where a multi-agency approach is required to tackle and deliver local priorities whilst still undertaking their own functions and service delivery.

Our local community, health and care system is becoming more holistic – bringing together and delivering mental, physical and social care together for both children and adults.

As a place we will continue to work in an integrated way to deliver better outcomes for our population, linking in on a system and collaborative level, where working together in this way supports better outcomes for our population.

We will work together to reduce unfair and avoidable differences in health across the population, with a focus on reducing inequalities, and ensure that our residents are at the heart of all we do. We will come together across population groups in Accountable Care Teams using a population health approach to do this.

Where we are now

- North East Lincolnshire (NEL) has a 156,940-resident population of mostly coastal and urban communities. NEL has variation in inequalities and deprivation: 37.7% of population live in 20% most deprived areas
- in the 2021 census 43.1% of the population reported very good health compared to 48.5% nationally. 35% reported good health compared to 33.7% nationally
- NEL is in the highest 10% nationally for fuel poverty at 21%. Across the area it ranges from 7.6% in the least deprived up to 26% in the most deprived areas
- NEL has the highest premature birth rate in England and 1 in 4 children live in poverty.

Our outcomes

- Improve health outcomes and access to healthcare and reduce health inequalities
- Improve outcomes for children, young people and families
- Improve mental health outcomes
- Strengthen our local health and care workforce
- Reduce the number of people in hospital

Our key impact areas

- Primary & community care
- Children, young people & families
- Mental health
- Workforce
- Frailty

What we will deliver in 2023/24

We will:

- implement Integrated Neighbourhood Teams
- expand Connected Health Model
- produce and implement Children, Young People and Family Strategy
- deliver Best Start for Life Programme
- improve outcomes for looked after children
- co-produce and implement a Mental Health Strategy
- Children and Young People's Mental Health Transformation (eating disorders, neurodiversity, looked after children)
- develop Health and Care Partnership People Plan
- continue International Recruitment Programme
- expand Grow Our Own Programme
- develop joint and flexible posts
- establish End of Life Accountable Care Team, develop the clinical model and workforce
- continue Accelerated Home First Programme
- reduce avoidable admissions

Place priorities: health and wellbeing

North Lincolnshire

Our ambition

North Lincolnshire will be the best place for all of our residents to be safe, well, prosperous and connected; experiencing better health and wellbeing, delivered through our community first approach. People will:

- enjoy good health and wellbeing at any age and for their lifetime
- live fulfilled lives in a secure place they can call home
- have equality of opportunity to improve their health, play an active part in their community and enjoy purpose in their lives
- adult smoking rates continue to fall and were less than the England average in both 2020and 2021. We will study this reduction and ensure that the pattern continues

Where we are now

- 4.2% adults have coronary heart disease compared to England average of 3%
- recorded prevalence of depression is 14.3% compared with England average of 12.3%
- the local population of over 65s is expected to grow by a further 30% by 2042
- adult smoking rates have dropped from 17.8% in 2019 to 12.3% in 2021
- 72% of the population were overweight or obsese in 2019/20 up from 67% in 2015/16
- 16.9% of women smoking at the time of giving birth compared to England average of 9.1%

Our priorities

Mental health and wellbeing will thread through all that we do, across all ages

Innovation will be supported including digital tools that enable individuals to maximise health and wellbeing

Asset based community development will identify & work with the strengths of our communities to level up North Lincolnshire

The health inequalities gap will reduce across our wards

Healthy life expectancy will improve

Access to health and care takes account of rural challenges

The integrated practise model will be person centred

People with long term conditions will experience proportionately good health

There will be a single workforce strategy covering leadership and management, recruitment and retention, reward and recognition, career pathways and talent development

What we will deliver in 2023/24

We will:

- ensure our plans reflect the voice of our communities by working with our Experts Together Partnership and Children's Voice Partnership
- embed a population health management approach in all service developments to tackle health inequalities and improve outcomes for those most disadvantaged
- develop our workforce to support delivery of improved outcomes through integration
- develop and implement the Scunthorpe South Integrated Neighbourhood Team, focusing on our most vulnerable, high risk populations, and share best practice with other neighbourhoods
- delivery of an Integrated Urgent Care Model, including an integrated health and care single point of access and utilising our Home First Model, supporting people in the community, or where hospital admission is required, supporting them at home and maximising recovery
- develop our local provider market to support best value provision of in area care for our population with particular focus on continuing health care and mental health and learning disability
- deliver a Community Diagnostic Hub to stream planned diagnostics to a community facility to enable delivery of diagnostic targets
- embed our Local Frailty Model to reduce hospital admissions through proactive care and community delivered care, maximising independence
- deliver a plan for improved primary care access including plans for better management of capacity, estate and digital
- deliver the Connected Health Network Approach to outpatient transformation to reduce hospital outpatient referrals and follow ups
- development of sustainable neurodiversity pathway for children and young people including pre and post diagnosis support
- identify prevention opportunities to support demand management, including delivery of cardio-vascular disease prevention programme
- develop and implement our clinical delivery model for palliative and end of life care, with a focus on early identification and utilisation of Electronic Palliative Care Co-ordination System and ReSPECT in line with the Northern Lincolnshire Palliative End of Life Care Strategy

Place priorities: health and wellbeing
East Riding of Yorkshire

Our ambition

An East Riding where all residents are supported to enjoy their maximum potential for health, wellbeing and participation throughout their lives:

- children and young people enjoy good health and wellbeing
- working age adults reduce their risk of ill health
- residents achieve healthy, independent ageing
- health inequalities are reduced

Where we are now

- people in East Riding are dying years earlier than they should
- we don't have the things we need like warm homes and healthy food – we are worrying about making ends meet
- this can result in increased stress, high blood pressure and a weaker immune system
- this doesn't impact on people equally

Our priorities

Taking a population health approach

Joining up assets in the community

Avoiding dependency and reducing escalation

Accessing health and care services in a timely manner

Raising aspirations

Our population health approach has resulted in a proposed set of multi-year programmes that are based around improving the health of the population, reducing inequalities and ensuring access to high quality services.

- rural and coastal communities
- Bridlington place based programme
- adult emotional health and wellbeing
- children and young people
- workforce challenges
- communications, engagement and insight development
- rehabilitation and intermediate care
- Integrated Neighbourhood Teams
- inclusion groups

What we will deliver in 2023/24

We will:

- establish three test and learn sites for Integrated Neighbourhood Teams in Driffield, Goole and Holderness
- understand more about how to reduce inequalities in health outcomes for people living in our rural and coastal communities through a rapid health and social care needs assessment and working with partners to uncover current challenges and priorities to develop and deliver a partnership action plan
- develop our programme for Bridlington place focusing on key areas including education, health and care, transport, employment and housing and agree our immediate priorities
- develop and implement a graduated response to children and young people's emotional health and wellbeing needs. Incorporating a response to Core20PLUS5
- align our East Riding of Yorkshire workforce plans to population health needs and develop work experience placements across health and care for GCSE and A-level students
- understand capacity and demand across rehabilitation and intermediate care and explore commercial options to bring different services together under the banner of maximising independence to confirm the ambition for all pathway 1 discharges to be with 'intermediate care'.

Community Health and Care Collaborative (CHCC)

Strategic ambition

To deliver person centred care closer to home wherever possible, through a shared sense of ambition thus creating a common narrative in relation to the expectations of "integration." That treats all with the same equity and values the contribution others can bring to collective working we aspire to, in a partnership and in integrated way to deliver a true Primary Health Care Approach and improves population health care outcomes and addresses inequalities.

The CHCC brings together system leaders across the Integrated Care System together to facilitate and promote collaboration through giving visibility to inequalities and variation in order that we can address this via adopting a system approach to the redesign of specific pathways of care to support care closer to home.

The core purpose of the collaborative is to support large scale system transformational at pace with a specific focus on:

- alternative community pathways that avoid admission to hospital via the development of self referral pathways and alternative pathways in the community
- support the wider elective recovery agenda by having a clear focus on discharge transformation that demonstrates consistent reduction in those patients that no longer need to be in hospital (improving discharge, reducing 'no criteria to reside' and length of stay)
- embed digital innovation to support admission avoidance and improve discharge by adopting a system wide approach to digital transformation (Optica, wider remote monitoring and virtual ward expansion)
- increase system-wide visibility to the community resources that we have and how we are using them and how we reconfigure these resources to deliver our system efficiency ambitions
- support the statutory ICB responsibility to deliver all age palliative end of life care aligned to the National Ambitions Framework and service specification through co-production with people with lived experience
- support wider system learning and education – do things once and do it well to improve the quality of care and services that we provide

Our priorities

Embed alternative community pathways to avoid admissions to hospital

Improve patient flow with a focus on discharge to support wider elective recovery

Embed digital innovations to support admission avoidance, improve discharge and support digital pathways of care

Increase system-wide understanding of wider community resources

What we will deliver in 2023/24

We will:

- increase the number of crisis first care contacts to reduce admissions to hospital
- better understand the value of virtual wards to help inform utilisation
- complete system-wide programme of support for a new model of intermediate care to support discharge and increase bed capacity through reducing 'no criteria to reside'
- reduce unnecessary admissions and conveyance to Emergency Departments through understanding alternative pathways that would support wider admission avoidance
- improve discharge pathways to reduce the number of bed days lost and improve patient flow
- increase the use of rehabilitation and reablement and support at home for palliative care
- roll-out OPTICA and virtual ward automation digital applications to support urgent and emergency care bed occupancy
- utilise remote monitoring funding to purchase and deploy equipment in the pathways and places most challenged
- improve data quality and implement faster data flows in community to support admission avoidance
- complete system stock take of palliative and end of life care to inform ICB statutory responsibility to delivery against national strategy
- complete waiting list audit to ensure we give visibility to total waiting list to support a reduction in the overall waiting list
- provide system wide support to clinical networks (diabetes, stroke & respiratory) to ensure we support a reduction in inequalities and improve health outcomes

Community Health and Care Collaborative:

Palliative and End of Life Care

Strategic ambition

Our strategic ambition is to ensure we have a clear strategy across Humber and North Yorkshire where by we are clear as to the equitable access to services irrespective of age or geography , we address unwarranted variation and promote equity of access to Palliative and End of Life Services. We create an environment where people can have positive conversations about death and dying, ensuring we understand their end of life wishes, and people can make choices which are known, respected and can be delivered.

The Palliative and End of Live Care Programme aims to:

- work to ensure that there is secure and equitable provision of care, for all ages, across Humber and North Yorkshire to deliver specialist palliative care services and access to information
- ensure access to general medical and nursing services out of hours and rapid response to maintain continuity of care and thereby supporting patient's preferences and choice
- complete an equalities and health inequalities impact assessment and action plan focussed on palliative and end of life care

The ICB has completed a stock take and has identified seven priorities to take forward into ICB strategy and delivery plans:

- system-wide variation
- need for standardisation
- ensure children and young people's palliative and end of life care needs are integrated within the strategy
- ensure we discharge our statutory duties and satisfy the CQC single assessment inspection framework due to be launched in late 2023
- develop our strategic ambition
- revise our governance structure to demonstrate how we are discharging our responsibilities
- complete an ICB workforce assessment to identify and address any potential gaps and variation

What we will deliver in 2023/24

We will:

Take forward the priorities identified in the stocktake against the national ambitions framework in order to understand the gaps against the six ambitions:

- each person is seen as an individual
- each person gets fair access to care
- maximising comfort and wellbeing
- care is co-ordinated
- all staff are prepared to care
- each community is prepared to help

Use the outputs from the Ambitions stocktake to inform:

- ICB All Age Palliative End of Life Strategy
- work with our six places on core delivery plans
- align our system governance to give oversight and assurance as to the progress we are making

Voluntary, Community and Social Enterprise (VCSE) Collaborative

Strategic ambition

The Collaborative will work strategically with VCSE organisations to enable them to support the ICS Strategy by helping people to stay active and keep healthy, to feel included and to feel on top of their condition and know what to do if they need help.

The VCSE sector is a huge asset, covering nearly 15,000 organisations across Humber and North Yorkshire and over 23,000 full time equivalent employees. The sector overall is estimated to be worth £4.2bn combined social and economic value. These organisations support and work with individuals and communities largely around supporting health and wellbeing.

The VCSE sector collaborative provides a strategic group that engages and facilitates the engagement of the ICS with the VCSE sector.

The VCSE sector collaborative has six representatives linking into each ICB place. They are tasked with understanding their place and VCSE sector within it.

Each place representative holds a VCSE place based assembly which is a collective of VCSE organisations and provides a mechanism to speak to the sector as one voice per place. They are designed as a two way mechanism – ensuring that the VCSE, place and system are connected.

The sector collaborative also supports co-ordination of health messages and captures work, impact and thoughts of the VCSE sector to influence planning decisions.

As a collaborative our ambition is to:

- promote greater understanding of the VCSE sector – knowing itself better and ensuring that the ICS is better able to work with us effectively
- ensure that the VCSE sector is a strategic and equal partner, involved in planning and design as well as delivery
- advocate for increased investment and long term contracts to deliver on health agendas and support sustainability within the sector
- support greater links to key communities, giving people and communities a voice to work with based on their needs and wants
- work with key partners to improve outcomes and address health inequalities through delivery by shaping service design and representing peoples voice
- support and contribute to the delivery of operational priorities within the NHS England Long Term Plan and other operational and ICB priorities

Our priorities

- **Support the approach to engagement and involvement across the ICB**
- **Reduce inequalities**
- **Increase the voice of patients and the public**
- **Support wider system development**

What we will deliver in 2023/24

We will:

- increase numbers of organisation engaged, increasing levels of diversity
- track the reach of communications and public engagement
- through the collaborative, support co-design within communities to ensure a diverse perspective on development and planning
- work with partner organisations to get closer to people suffering from health inequalities
- work through VCSE organisations to support more people and communities directly, to increase digital access to healthcare and support the development and delivery of a digital strategy
- work through VCSE organisations to engage with people in coastal areas to understand their specific health and wellbeing needs
- increase utilisation of the VCSE sector to promote, engage and advocate for people's voice
- explore ways for the VCSE sector to engage in the design of services, supporting collaborative working driven by the patient voice
- support greater understanding of communities across HNY and what matters to them
- influence and shape future investment in the VCSE sector to increase sustainability
- ensure that the wider determinants of health and wellbeing are considered in ICB planning and delivery
- develop a consistent approach to the management, recruitment and development of volunteers

Primary Care Collaborative

Strategic ambition

We will ensure people can live well and age well by making sure that people get the care that they need and don't get passed back and forth and that people only need to go into hospital when absolutely necessary.

People will feel on top of their condition and know what to do if they need help. Our investment in primary care workforce will support meaningful employment. We will invest in health and wellbeing programmes and so that people can stay active and keep healthy.

What we will deliver in 2023/24

We will:

Increase access to services

- we will focus on digital inclusion in collaboration with the voluntary sector and promote the benefits of the NHS app increasing further from 51% of the eligible population registering for the app
- make it easier for people to contact a GP practice so that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
- we will increase access to primary care by providing additional appointments and increasing the number of appointments available
- we will continue to increase access to dental services with continued investment through procurements and flexible commissioning models

Develop our workforce

- we will continue to share best practice across our ICB through a range of forums, showcase events, videos and case studies

We will invest in our workforce:

- in 23/24 we will offer every newly qualified GP and practice nurse access to our Fellowship Programme
- we will fully utilise our Additional Roles Reimbursement Scheme (ARRS) budget recruiting an additional 217 individuals across our Primary Care Networks (PCNs)

Promote health and wellbeing and reduce health inequalities

- we will continue to develop our Core20PLUS5 Programme with our Core20PLUS Ambassadors
- we will continue to develop our Neighbourhood Teams
- we will continue to invest in health and wellbeing programmes

Primary Care Access Recovery Plan

The demands on general practice have never been greater, with record numbers of appointments being delivered.

Supported by investment, we will focus on delivering the plan that responds to patient feedback and sets out measures that will make a difference now to staff and patients, focusing efforts on taking pressure off teams, and supporting general practice to manage the 8am rush, and restore patient satisfaction with improved experience of access.

Working across our six places we will support practices and primary care networks to deliver on the requirements of the 2023/24 GP contract.

We will continue to work with our community pharmacy colleagues to expand their vital role by consulting on a Pharmacy First Service. We will embed the oral contraception and blood pressure services along side the Pharmacy First Service.

Mental Health, Learning Disability and Autism Collaborative

Strategic ambition

We will ensure that people can get the help they need when they are struggling, know what to do if they need help and can get the care they need when they need it. We will support people to age well and to get advice and support for their health at home or nearby through diagnostic pathways for dementia.

The Humber and North Yorkshire Mental Health, Learning Disabilities and Autism Collaborative is comprised of health and care partners, including (VCSE and third sector) responsible for the commissioning and delivery of mental health, learning disability and autism services across our ICB footprint.

The Collaborative has been in existence for five years, initially as a partnership aiming to improve services and then developing into more formal arrangements with a nominated lead provider (Humber Teaching NHS Foundation Trust).

We have worked closely with local places and providers throughout the existence of the collaborative and have developed strong working relationships that promote transparency despite the challenging wider financial and service delivery environment.

The Collaborative works with partners to collectively:

- lead on system-wide transformation programmes
- improve quality and safety
- monitor performance
- enhance partnership working including establishing robust links with colleagues across the local authority, VCSE sector, primary and secondary care.
- share best practice
- deliver value for money by achieving economies of scale
- jointly bid for ICB level funding to enhance the delivery of ICB objectives

Through 2023/24 we will build on our existing track record to expand the level and visibility of co-production and engagement across all elements of our programme and work with system partners to join up engagement processes that may currently be happening in other parts of the system.

Our priorities

Community mental health transformation

Children and young people's mental health

Urgent and emergency care mental health

Perinatal mental health

Dementia care

What we will deliver in 2023/24

We will:

- develop a three-year plan for our inpatient services across mental health, learning disabilities and autism. This will focus on quality, we will also review the resource available to the system and configure services to deliver the best possible outcomes for patients
- develop working arrangements with our transforming care partnerships to deliver key priorities across learning disabilities and autism such as, roll out of the Oliver McGowan training, the national inpatient review and delivery of learning disability annual health checks
- in 2022/23 we made significant progress in delivering annual health checks for people with serious mental illness (SMI), we will bolster this in 2023/24 and ensure the improvement is sustained for the coming years
- building on the success of the early implementer site for community mental health transformation across Hull and the East Riding of Yorkshire, we will continue to increase access to mental health support in the community including early intervention in psychosis (EIP) and individual placement support (IPS – employment support)
- we will build on the work being done by our Trauma Informed Care Programme to provide early intervention and prevention support to vulnerable children and young people, with a particular focus on those at risk of entering the Youth Justice System
- for people in mental health crisis, we will expand the use of mental health response vehicles following successful implementation on our patch via the Yorkshire Ambulance Service (YAS)
- working with the Maternity Programme, support perinatal mental health enabling improved access and increased offer of psychological interventions
- we will focus on levelling up delivery against the dementia diagnosis targets across the Humber and North Yorms ICB patch, so that resource is directed to places where the biggest improvements are needed

Collaboration of Acute Providers (CAP)

Strategic ambition

We will ensure people to get the care they need, when they need it, and not get passed back and forth or forgotten about.

The collaborative is focussed on 'at-scale' programmes covering more than one acute trust.

The trusts that make up the collaborative are:

- Harrogate and District NHS Foundation Trust
- Hull University Teaching Hospitals NHS Trust
- Northern Lincolnshire and Goole NHS Foundation Trust
- York and Scarborough Teaching Hospitals NHS Foundation Trust

The main purpose of the Collaborative is to use our collective expertise and resources to ensure that our people have timely access to the same standard of acute care and are supported to achieve their best health.

Our vision and aims

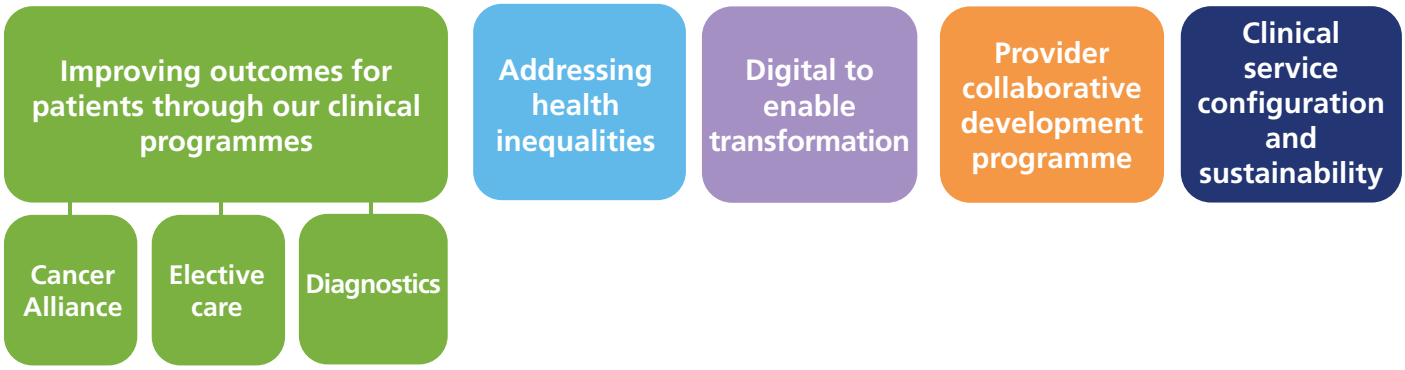
Ensure quality and safety: to collectively deliver the highest quality hospital services across our four trusts, focused on the patient and reducing unwarranted variation, so all patients across Humber and North Yorkshire can access the same high quality levels of care, wherever they live.

Transformation and innovation: to transform services to ensure the safest, most effective and most efficient care within the resources available.

Collaboration and partnership: to be excellent partners in our health and care systems and to work together where collaboration will bring benefit to patients, staff or the best use of resources.

Social responsibility: to play our full part in reducing health inequalities within Humber and North Yorkshire and to optimise our impact as anchor institutions.

Our priorities



What we will deliver in 2023/24

We will:

- support awareness and diagnosis – targeting the 20% most deprived areas
- improve treatment pathways – including stocktake of non-surgical oncology
- improve diagnostics for cancer focusing on liver surveillance and cytosponge delivery
- increase uptake and expansion of the Lung Health Check Programme
- deliver our Living with and Beyond Cancer Programme
- support 65 week delivery target through maximising capacity and utilising mutual aid
- support waiting list reduction by reducing the number of follow ups without a procedure
- optimise productivity through collectively utilising capacity
- plan, develop and implement the community diagnostic model with a target of 3% DNA for endoscopy and physiology
- agree utilisation improvement targets across modalities
- improve data quality and reporting on health inequalities to support the development of a health inequalities plan across acute care
- implement prioritisation of people with learning disabilities on the waiting list
- Electronic Patient Record Programme to support digital modernisation
- develop the peri-operative business case
- recruitment and retention, leadership and capacity, physical and mental wellbeing, learning and continuous improvement, staff experience, quality, diversity and inclusion
- planning, delivering and transforming services together under the Planned Care Strategy
- work with clinical networks to share best practice and reduce unwarranted variation
- work together to ensure clinical sustainability of fragile services

Patient initiated follow ups (PIFU) and virtual consultations are a key focus for the delivery of outpatient appointments in alternative ways. We have recognised that a personalised care approach and shared decision making are key enablers for wide spread adoption. However we realised that there was a lack of clear patient focused information that we could utilise, so we set about devising our own.

The Humber and North Yorkshire Personalised Care Group discussed options and felt that short animations would be the way forward. These could be used to support and empower patients and clinicians by explaining what these alternative ways of receiving their care are.

They could be reflected on provider websites and other social media platforms as well as potentially used in a clinic setting.

We commissioned help to create two patient animations. Storyboards were drawn up and once finalised the animations were created.

Animations went live at the end of July 2022 and are available on Humber & North Yorkshire Health & Care Partnership YouTube.

We have received a lot of national and regional interest and received many compliments. The group will continue to widen adoption of the videos and continue to engage with patients.

Urgent & Emergency Care (UEC) ICS-wide Programme

Strategic ambition

To provide patients with safe, effective and easily accessible UEC services, with limited variation and as standardised as possible, whilst recognising the needs of our diverse population.

Each Place within HNY has developed their own UEC Improvement Plans based on local pressures, the national recovery plan and recognised good practice.

Identifying areas of commonality, and opportunities to deliver at scale, the UEC Programme has selected three key priorities from these plans to deliver across the system, providing support and best practice to delivery.

These three priorities have the scope to have the biggest impact on UEC quality and performance, improving patient outcomes and experience of care.

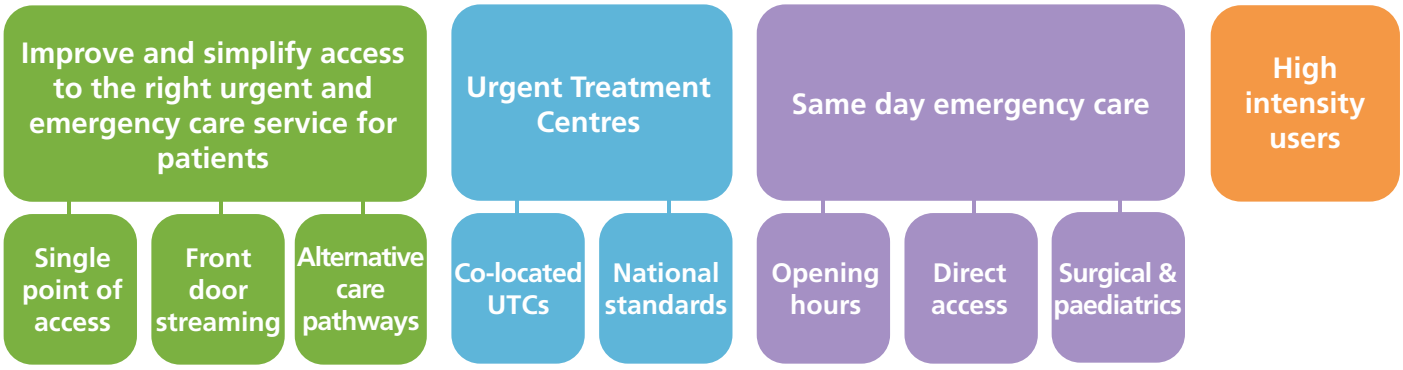
NHS 111

We know we have many entry points to the Unplanned Care System which can lead to confusion. Often the public access the service that they are familiar with which may not be the service that could be most appropriately meets their needs. NHS 111 should be instrumental in signposting and helping the public navigate the right service to minimise any delay.

We will ensure there is continuous improvement to the Directory of Services and ensure NHS 111 has the right access points to ensure patients receive the right care in the right setting.

We will work with Yorkshire Ambulance Service, the regional provider of NHS 111 to maximise integration with urgent care services and directing patients to the right service or care advice across Humber and North Yorkshire.

Our priorities



What we will deliver in 2023/24

We will:

- reduce unheralded walk-in patients to Emergency Departments
- reduce the number of ambulance conveyances, both to Emergency Departments and other hospital settings
- increase the number of alternative care pathways available to patients which avoid Emergency Department and hospital
- support improved CAT 2 response times by reducing conveyances to hospital
- improve ambulance handover times within Emergency Departments
- reduce overcrowding in Emergency Departments
- support the reduction in >12 hour waits in department
- undertake a full review of all Urgent Treatment Centres across HNY – co-located and standalone
- improve type three performance reporting and subsequent overall four hour standard
- support reduction in Emergency Department crowding and time in department
- ensure Urgent Treatment Centres are compliant with national standards, improving patient awareness, and understanding of the Urgent Treatment Centre offer, along with consistent access to care
- increase direct conveyance to Urgent Treatment Centres, supporting reduction in ambulance handover times and CAT2 response
- ensure minimum opening hours of 12 hours a day, seven days a week
- align same day emergency care opening times to Emergency Department peak demand times
- increase direct access to same day emergency care for 111, 999, crews on scenes and GPs, without the need for Emergency Department assessment first
- implement referral based on exclusion criteria to maximise same day emergency care opportunities
- increase 0 day lengths of stay
- reduce Emergency Department crowding and wait times – improving 4-hour standard
- co-ordinate an Integrated High Intensity User Programme across the ICS
- reduce number of patients classed as high intensity users
- reduce reattendance rates

Population health prevention and health inequalities

Strategic ambition

We will help people to start well, live well and age well by ensuring that people feel included and know what to do if they need help. We will deliver this through six workstreams.

2022/23 has been a moment for the committee to identify its shared priorities, establish ways of working that create connections across the system, and begin delivering ambitious programmes that maximise the opportunities of our Integrated Care System. Going forward into 2023/24, the Committee plans to accelerate these programmes.

Our priorities

Core20PLUS5 adults

- co-ordinate and oversee delivery of the system's approach to Core20PLUS5

Core20PLUS5 children

- link with system partners to reduce healthcare inequalities for children and young people

Prevention and risk factors

- oversee the ICB delivery of long term plan priorities of:
  - alcohol
  - tobacco
  - obestiy

Public health functions

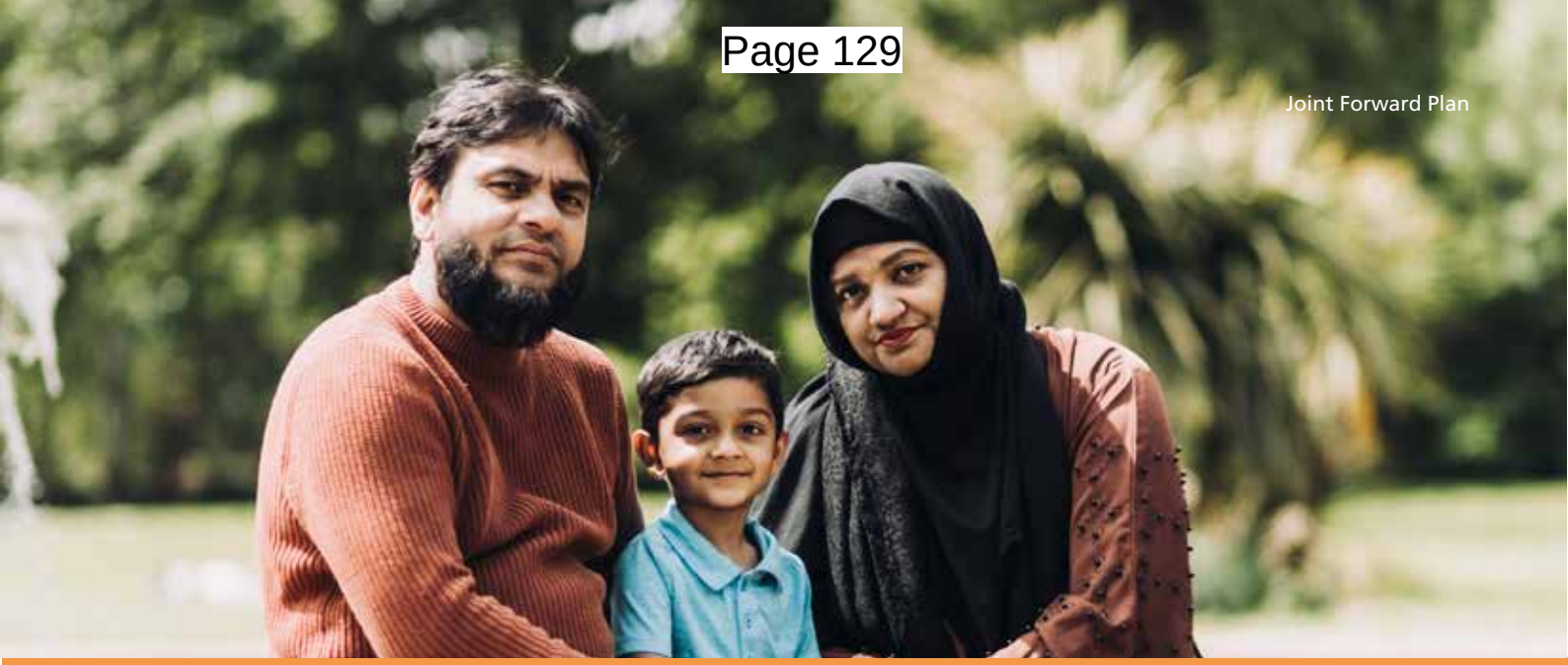
- oversee the winter vaccination programme and support the transition of public health commissioning

Population health intelligence

- oversee the implementation of Population Health Management (PHM) tools

ICP building blocks

- support the ICP to carry out its function to improve population health and reduce inequalities



What we will deliver in 2023/24

We will:

- embed Core20PLUS5 into the work of Integrated Neighbourhood Teams, starting in our coastal areas
- develop our approach to addressing multi-morbidity starting with our cardiovascular disease prevention and detection plan
- continue our approach to address asylum seeker health needs
- scope out an inclusion health service that reaches all parts of the system
- trial the risk stratification tool to identify areas of action for children and young people with asthma
- use a data driven approach to identify inequalities in access and experience of children and young people in mental health services
- build on the success of our Joint Winter Vaccination Board to address health inequalities and make every contact count
- roll out the spring COVID booster campaign and plan for an anticipated COVID autumn booster campaign
- provide the tools at local level to improve population health and reduce variation through continuing our two year programme to roll out PHM support across primary care networks and place leaders
- stand up a robust measurement and evaluation framework with a focus on Core20PLUS5
- establish an Integration Needs Assessment Steering Group to make recommendations on where further integration should take place
- develop a strategy to address health disparities in coastal and port communities where we have some of our most significant health inequalities
- Introduce health inequalities fellowship opportunities for health and care staff in HNY

Develop HNY Centre of Excellence in Tobacco Control In 2023/24 we will:

- invest in lung health checks
- embed tobacco control in nursing and midwifery
- support investment at place including local authorities to target inequalities
- develop strategies that focus on prevention for people with one long term condition from developing other conditions
- increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
- increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20% on lipid lowering therapies to 60%

Population health and prevention: **tobacco control**

Humber and North Yorkshire ICB recognises tobacco use as the single largest preventable cause of ill health, responsible for half of the difference in life expectancy between the least and most deprived. Our efforts to tackle this burden of ill health are twofold.

Firstly, through our successful Treating Tobacco Dependency Programme we are embedding smoking cessation into maternity, acute and mental health pathways in the region, as well as into lung health Checks. So far, from September 2022 – May 2023 1126 patients have received an intervention, and of the 549 outcomes that are due, 245 (45%) have been quits. In 2023/24 we will continue to support trusts with the rollout of the NHS Long Term Plan and embed tobacco dependency treatment into lung health checks in North Lincolnshire and North East Lincolnshire.

Secondly, financial resource has been secured for the establishment of a comprehensive tobacco control programme – the Centre for Excellence in Tobacco Control. The programme will deliver:

Co-ordination across the ICB

- well-funded regional communications and mass media campaigns
- illicit tobacco leadership
- a strong HNY voice to lobby and advocate on behalf of effective national policy
- policy expertise/data intelligence e.g. vaping
- research and evaluation
- long-term leadership and quality improvement for NHS tobacco dependency treatment services

System investment

- lung health checks
- sector-specific support e.g. primary care and community pharmacy
- systematic approach to work within social care and housing services
- embedding tobacco control in nursing, midwifery and undergraduate/ postgraduate medical information

Place-based investment

- supporting local stop smoking services to provide NICE-standard services including e-cigarettes
- investment in financial incentives for pregnant smokers
- funded very brief advice (VBA) resources and training capacity
- funding for local authorities to target inequalities

The tobacco control leadership will be through experienced specialised programme lead and team, supporting tobacco alliances and leadership quality improvement of NHS stop smoking services, leading communications across Humber and North Yorkshire.

The communications vision is to ensure strong coherent messages that prompts more quit attempts and connects smokers with effective support and/or quit aids.

What we will deliver in 2023/24

We will:

- continue roll out of embedded smoking cessation in lung health checks and launch the programme in North Lincolnshire and North East Lincolnshire
- launch our media and communications campaign
- expand the current programme core team so that we can launch the full model for the start of 2024/25

Cardiovascular disease (CVD) disproportionately impacts on our most deprived populations and is a driver of inequalities in mortality at ICB level. Opportunities to influence CVD risk range across the life-course, from pre-conception and antenatal factors through to end-of-life considerations. In Humber and North Yorkshire we will optimise the whole system working through the ICB in our approach to cardio-vascular prevention and detection.

Preconception and antenatal approaches will require working across the Partnership and into the Local Maternity and Neonatal Service, and the Maternal Medicine Network to tackle intrauterine risk factors like maternal smoking.

There will also be partnership working with local authority teams in relation to childhood, adolescent, and adult risk factors like physical inactivity, unhealthy weight, and opportunities to better identify CVD risk using NHS Health Checks.

NHS providers across secondary, and the breadth of primary care will continue to accelerate the identification and optimal management of significant, cross-cutting risk factors like high blood pressure and high lipids, in addition to identifying individuals who may have undiagnosed familial hypercholesterolaemia and treat them to effectively negate the increased risk of developing CVD that their genetics adds.

Primary, secondary, and community care will also work together to ensure appropriate and equitable access to cardiac and stroke rehabilitation and ultimately person-centred advanced care planning.

All of this is being developed and delivered at places and neighbourhoods, looking through an inequalities lens using the Core20PLUS5 approach, utilising a population health management approach and underlying principles.

Personalised Care

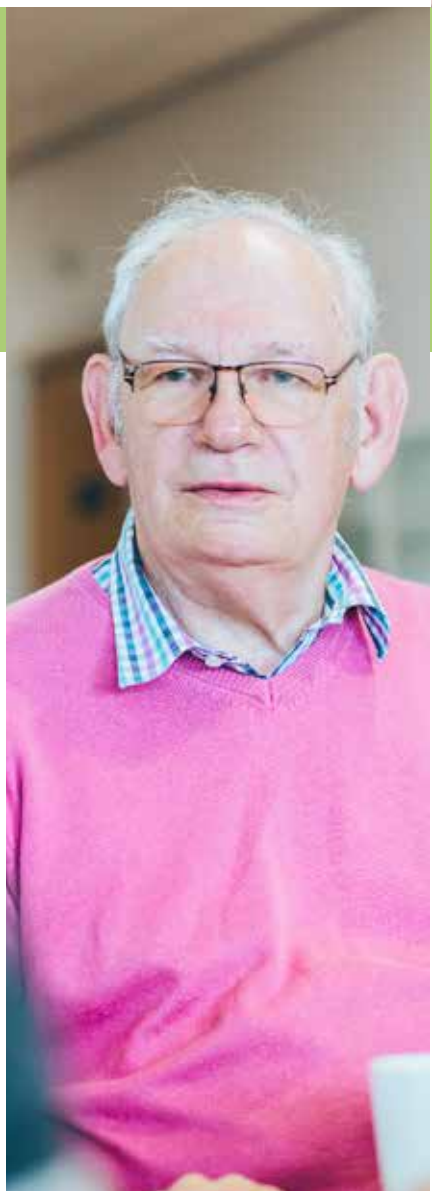
The comprehensive model of personalised care helps to establish a whole-population approach to supporting people of all ages and their carers to manage their physical and mental health and wellbeing, build community resilience, and make informed decisions and choices when their health changes.

In Humber and North Yorkshire we have established our system approach to personalised care. Personalised care is much more than patient experience, it is an holistic approach that is integral to our approach to population health and reducing health inequalities as it starts from a position of talking to the individual and finding out what matters to them, their immediate family circumstances and the support they get or could receive from their wider community – enabling us to Think Person, Think Family, Think Community.

We aim to embed and enable the principles of personalised care across our programmes. For example, the Population Health and Prevention Programme has endorsed a principle of personalised care in the commissioning of inclusion health services.

Case Study

Creation of Rural East Riding and North Yorkshire community based 'micro support' businesses/social enterprises which will deliver local personalised care including: home care and day services, increasing access to appropriate, responsive and quality personal support, developing local business opportunities and reducing staff travel time and related carbon emissions.



Partners

- working in partnership with Carers Plus Yorkshire in North Yorkshire and Yorkshire in Business in East Riding who are hosting the co-ordinator roles in each area

Current project status

- marketing material in place including logo, Facebook page and website under construction
- introduction pack developed including Quality Standard, basic policies and procedures and guidelines

North Yorkshire Area (co-ordinator appointed January 2023)

- regular steering group meetings (seven members) overseeing progress
- monthly meeting for new and existing Micro Providers (12) in Hunmanby and Filey

East Riding of Yorkshire area (co-ordinator appointed May 2023)

- establishing local contacts, existing businesses and drop in places
- six expressed interest in becoming Micro Providers
- contacting potential steering group members

What we will deliver in 2023/24

We will:

Embed a personalised care ethos

- training and development

Connect with thriving communities

- community based micro support
- digital health hubs
- social prescribing & supported self management
- early Intervention at the Ironstone Community Hub
- children & young people social prescribing - SEND & PHBs / care leavers / York extension
- Community Support Organisation (CSO) capacity to support frail individuals
- proactive social prescribing in York
- Brain Health Café in York
- Scarborough children and young people's social prescribing – Social, Emotional and Mental Health (SEMH)

Enrich personalised care approached across health and care

- maternity
- Local Maternity and Neonatal Systems (LMNS) Gestational Diabetes Pilot
- hospital discharge (oalliative & end of life personalised care & support planning)
- waiting well - HUTH – social prescribing / obesity
- palliative care – care planning
- VCS – PHB knowledge and understanding
- Personalised Joint Care and Support Planning Toolset for Learning Disability - integrating health and care

Addressing the particular needs of **children and young people**

Strategic ambition

The vision for all our Children & Young People is to start well, enabling them to live and age well and if their life is shortened, to end their life well.

The Children & Young People's Alliance meets every two months and membership comprises of multiple stakeholders across the ICS. The alliance oversees the delivery of the service innovation and improvement described in the NHS Long Term Plan and the Children and Young People National Transformation Programme with a specific focus on integration and long-term conditions such as asthma, diabetes and epilepsy.

Population health data and analysis combines feedback with each of our six places across our footprint to inform the strategies required.

This includes addressing health inequalities and inequalities, an example of which is the diabetes poverty proofing projects underway in two of the most deprived areas in Humber and North Yorkshire, the learning from which will be utilised system wide.

Our child voice strategy

The ICB-wide Children and Young People's Engagement and Co-production Strategy will support work to develop and deliver a consistent and effective voice and influence for children and young people across the ICB and ensure those involved are representative of our diverse communities. This will be in place by autumn of 2023.

Children and young people's Core20PLUS5

Humber and North Yorkshire is in the process of including an Lower Super Output Area approach into the Indices of Multiple Deprivation data to ensure pockets of deprivation in more affluent local authorities are also included in projects. We will also look at wider data associated with risk linked to the Public Health Fingertips data, as well as other sources e.g., Joint Strategic Needs Assessments.

Vulnerable children and young people are being identified as part of all workstreams, with particular focus on those with increased risk including those with protected characteristics.

These include ethnic minority communities, inclusion health groups, people with learning disabilities and autistic people, coastal communities with pockets of deprivation hidden amongst relative affluence and protected characteristic groups.

Specific consideration should be given to the inclusion of young carers, looked after children/ care leavers, those in contact with the justice system and LGBT+ people. Learning disability and autism, special educational needs and disabilities (SEND) and children with complex needs and/or disabilities and impact on 'was not brought' rates.

Our priorities

- Diabetes
- Epilepsy
- Asthma
- Mental health, learning disability and/or autism - delivered with the sector collaborative

What we will deliver in 2023/24

We will:

- improve access to digital technology to manage diabetes
- roll out to all places the Diabetes Poverty Proofing Project
- benchmark services against core standards for children with epilepsy to identify priority areas for improvement
- deliver and evaluate our pilot programme with specialised nurse practitioners for children and young people with asthma
- embed a pathway between primary and secondary care to deliver national asthma standards
- increase access to dental services and improve oral health
- develop an ICS strategy for palliative and end of life care
- develop our programme for early support and intervention
- use data tracking and local feedback to identify areas of concern and risks for urgent and emergency care attendances
- develop a joint strategy including personalisation planning
- improve access to mental health support for children and young people
- support perinatal mental health enabling improved access and increased offer of psychological interventions
- reduce reliance on inpatient care so that by March 2024 no more than 12 – 15 under 18s with a learning disability and/or autism per million are cared for in an inpatient setting
- with the Mental Health, Learning Disability and Autism Collaborative ensure that 75% of people aged over 14 on GP learning disability registers receive an annual health check and action plan

Addressing the particular needs of **perinatal and neonatal care**

Strategic ambition

To ensure that it is easy for parents to get the care and support they need for their children and has the care and support they need.

The Local Maternity and Neonatal System (LMNS), co-produced with service users is: **'for maternity and neonatal services in Humber and North Yorkshire to be kind as well as safe for all, by supporting and enabling our teams to consistently provide personalised, supportive and informed care, with empathy, understanding and compassion'.**

The LMNS works across maternity and neonatal providers to support the various workstreams going on at place and combine those required regionally and nationally to reduce duplication and improve consistency. From the three-year plan:

- listening to women and families with compassion which promotes safer care
- supporting our workforce to develop their skills and capacity to provide high-quality care
- developing and sustaining a culture of safety to benefit everyone
- meeting and improving standards and structures that underpin our national ambition

Locally we also prioritise prevention and population health; reducing inequalities across our communities and ensuring underrepresented groups have a voice.

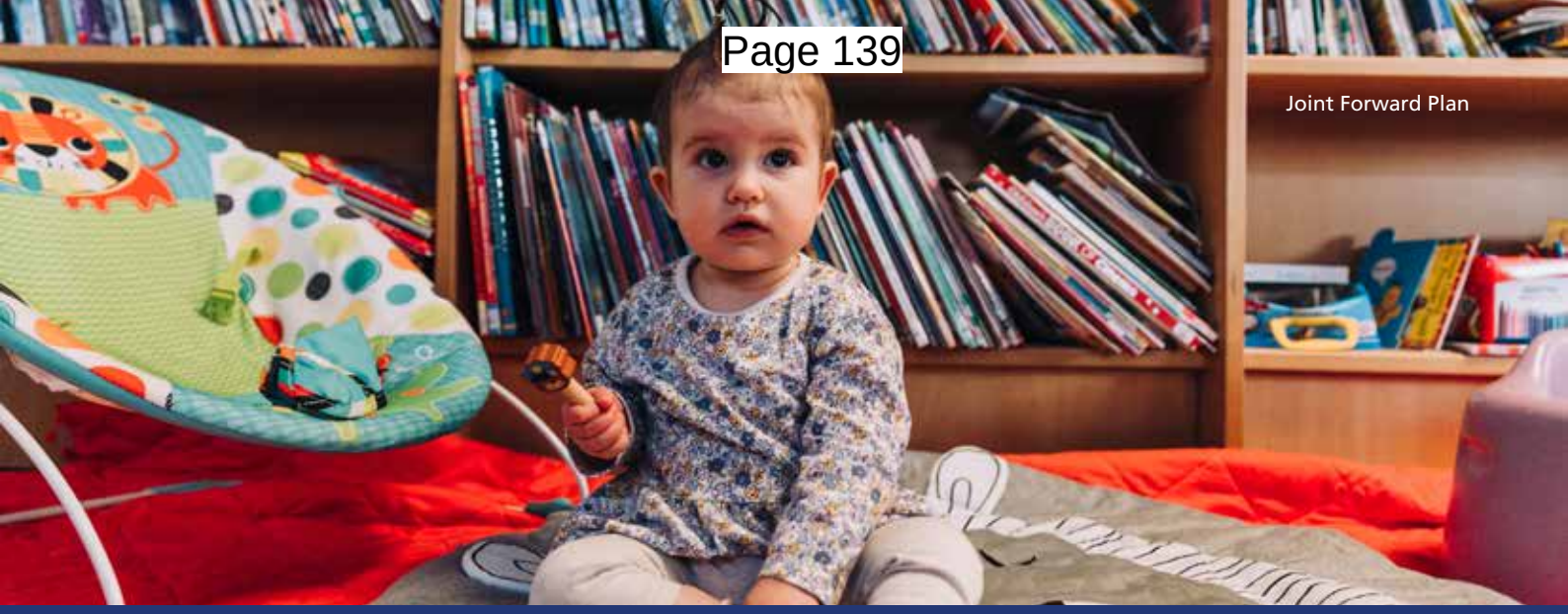
Core20PLUS5 Adult

Inclusive of Maternity Continuity of Carer; evidence based to describe better outcomes particularly in perinatal mental health and safe birthing.

Currently targets are paused nationally; we have teams in North East Lincolnshire and plans to reinstate teams in other areas. Focus on equity of provision means teams planned for more deprived areas and in groups such as younger parents, LGBT+ families, those with disability etc.

Maternity Voices Partnership

The Maternity Voices Partnership local groups are looking to expand in 23/24 to reflect their increased workload; more capacity and resources are required across Humber and North Yorkshire and particularly in areas of pressure including some parts of our cities and coastal communities. We will also be reviewing the scope of these groups around covering Neonatal family engagement and ensuring accessibility to best care.



Our priorities

Safety and quality

Choise and personalisation

Enablers (prevention and workforce)

Digital

What we will deliver in 2023/24

In 23/24 we will:

- second round of Ockenden/East Kent Peer Review visits; evidence safe, high quality care
- support for CNST adherence, including working alongside providers to achieve Saving Babies Lives v3 – new update includes support for gestational diabetes
- implementation of three year plan priorities including new Pelvic Health Services
- continue improvement against BAPM7 neonatal standards/pre-term birth support
- ensure Continuity of Carer Teams are supported and developed in deprived areas
- continue provision of 'Ask A Midwife' service, LMNS birth plans and supplementary sheets, unit videos, translation & interpretation support, surrogacy guidance etc.
- support LMNS equity & equality and cultural diversity lead work to ensure equity
- continue research work with University of Hull into alcohol support in pregnancy
- work with the Tobacco Control Team to implement a universal incentive scheme
- commence the pilot of heathy weight, diet and exercise support before LMNS rollout
- continue to support recruitment and retention leads in Trusts, maintain links with HEI training, progress international recruitment to maintain required staffing levels
- develop strategy with the Humber and North Yorkshire Midwifery Workforce Supply Planner and HEE
- implement the Maternity Support Worker Scheme to ensure consistent competencies
- support perinatal and maternal mental health schemes enabling improved access
- complete implementation of BadgerNet single maternity IT system across Humber and North Yorkshire
- ensure Yorkshire & Humber Care Record embedded for contextual launch
- review SI/Quality/Performance reporting for true data comparison and learning
- scope e-red book provision with partners

Addressing the needs of victims of abuse

The ICB will undertake duties in relation to serious violence as a specified authority and work with other specified authorities to prevent and reduce serious violence including sexual violence and domestic abuse.

- completion of a serious violence needs assessment
- developing a partnership response strategy setting out how serious violence will be addressed
- producing a local delivery plan to tackle serious violence with a focus on high impact actions
- coordinating a project to develop a comprehensive baseline assessment of current data sharing between authorities and identify how improvements in access to data would support reduction in serious violence
- development of a mutually agreed definition of serious violence.
- delivery of trauma informed training to key members of the workforce.

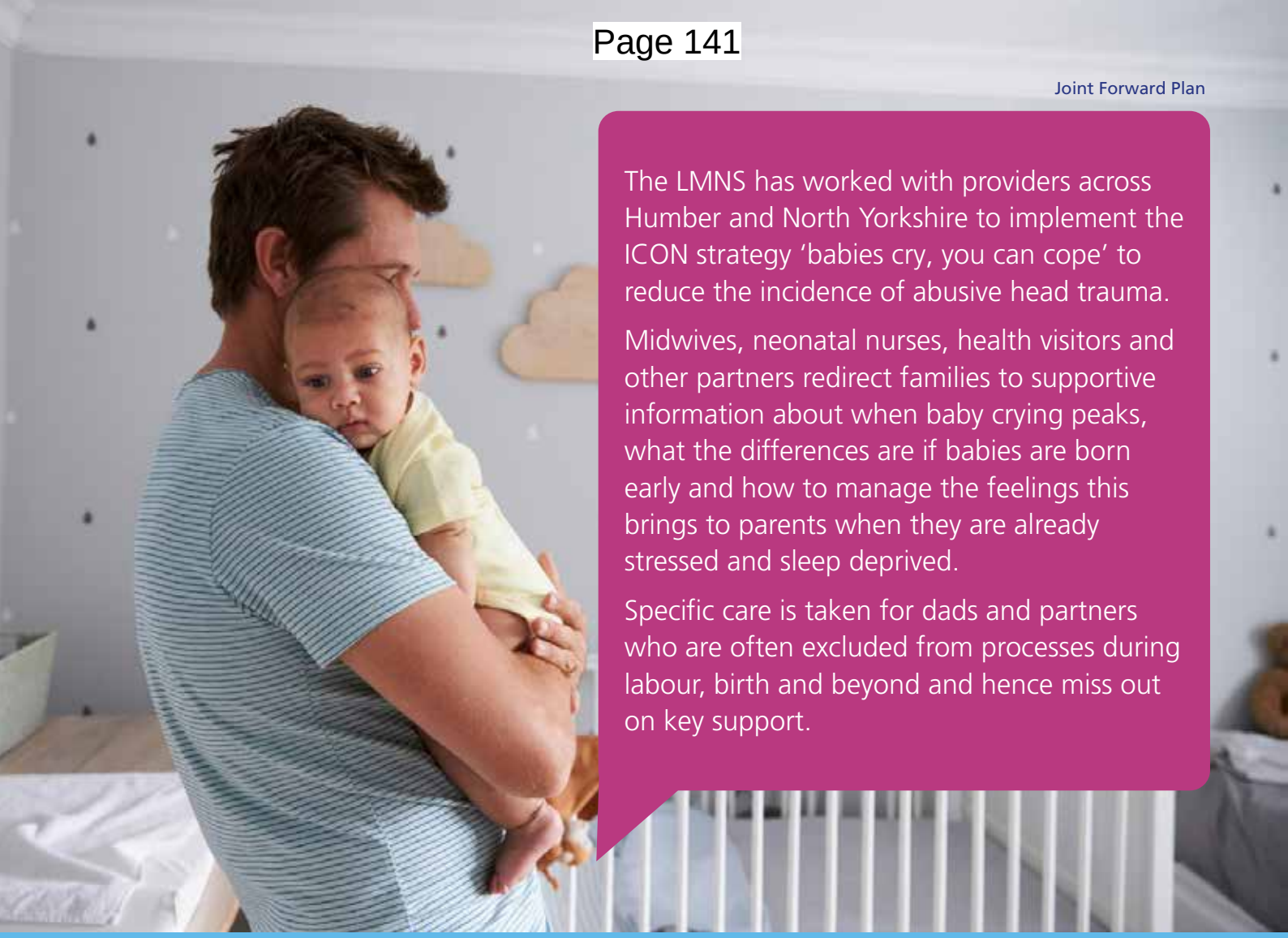
We will work with statutory safeguarding partners to:

- respond to the findings of the national Audit of Domestic Abuse Support in Healthcare Settings
- map models of intervention for domestic abuse across the ICB to adopt and spread best practice
- strengthen existing ICB wide governance and strategic processes in relation to domestic abuse
- working with statutory safeguarding partners at place to further develop pathways for non-fatal strangulation, honour and faith-based abuse, FGM and forced marriage
- respond to children as victims of domestic abuse through early intervention programmes of work with families who are experiencing low levels of domestic abuse to prevent escalation such a PITSTOP
- ensure meaningful data collection from within the NHS contributes to develop a better system-wide understanding of domestic abuse

The ICB will support our staff to discharge their duty to safeguard children and vulnerable adults by:

- developing an ICB wide learning culture through which recommendations from national and local statutory reviews including Domestic Homicide Reviews are utilised to improve practice
- ensuring safeguarding training is of a high quality, and enables staff to recognise and respond to signs of abuse, including domestic abuse and sexual violence, in a timely fashion
- supporting staff who are victims of domestic abuse, and ensure managers and HR teams are equipped with the skills and knowledge to offer the right support when staff disclose abuse

We will publish our Serious Violence Strategy for each local government area by 31 January 2024.



The LMNS has worked with providers across Humber and North Yorkshire to implement the ICON strategy 'babies cry, you can cope' to reduce the incidence of abusive head trauma.

Midwives, neonatal nurses, health visitors and other partners redirect families to supportive information about when baby crying peaks, what the differences are if babies are born early and how to manage the feelings this brings to parents when they are already stressed and sleep deprived.

Specific care is taken for dads and partners who are often excluded from processes during labour, birth and beyond and hence miss out on key support.

In North East Lincolnshire we have maintained an active partnership with the local authority and a range of other stakeholders in respect of domestic abuse and sexual violence for the last decade and have contributed to the cost of services addressing the needs of victims and perpetrators over the years.

We have made a recurrent financial contribution to local services for the last three financial years and this will continue.

We co-produced the North East Lincolnshire Domestic Abuse Strategy with the local authority and all local stakeholders during 2020.

The strategy considers female genital mutilation, so called honour based violence and forced marriage. We are currently working with the local authority to design and implement a commissioning process for local services mandated under the Domestic Abuse Act 2021 which will focus on:

- refuge accommodation
- safe dispersed accommodation
- community outreach support
- Sanctuary Scheme
- MARAC co-ordination
- specialist support for children and young people affected by domestic abuse

New commissioned services will be operational in August 2023 and will deliver a range of outcomes associated with the Domestic Abuse Act. These outcomes focus on the recovery journey for victims/survivors and optimising their resilience and ability to live independently free from violence and abuse.

The overall long term outcome we intend to achieve with this work is the reduction in prevalence of domestic abuse and the reduction of children in care as a result of domestic abuse and sexual violence.

System developments

Delivering today to **transform tomorrow**

Listening to patients' experiences of their care – and to the views of the NHS staff who provide it – plays a crucial part in delivering services that are safe, effective and continuously improving.

Humber and North Yorkshire ICB has a statutory obligation to involve patients and the public in decision making and service development. There are clear standards for public engagement to shape decisions, monitor quality and to set priorities. By giving everyone an equal voice, listening to people who use services and empowering them to be part of the design and decision making about service we become aware of ideas and aspects of service that may not have been considered, enabling us to make positive change.

Insight does not come from a single source: from a single survey, patient story, focus group or public meeting. It's about using a combination of sources to understand a number of different issues and then to ask: "How do we use what we've found out – positive and negative – to improve the quality of every patient's experience?"

Insight can tell us things that other performance data cannot, particularly about how people feel about hugely important issues such as dignity, compassion and respect. We will use continuous engagement models to inform the generation strategic direction as well as specific plans.

We will link with our wider partners to ensure that the collective insight gathered by all organisations is shared, analysed and utilised effectively to build up a full system picture.

All the data and insight we gather and collate will inform future iterations of the Joint forward Plan and other strategies for service delivery. It will also be used to steer our marketing and campaign messaging to ensure our communication resonates with the various audiences it is intended to support. We will support asset-based community development approaches, working with partners (e.g. public health, community teams in local authorities etc.) to help to activate individuals and communities to tackle barriers to good health and wellbeing.

In 2023/24 we will undertake a programme of patient and staff insights gathering activities to inform a long term transformative approach to how people think about their health and access to health services. We will focus on three priority areas of our strategy:

- making sure that people know what to do to stay healthy
- that people get the care that they need and don't get passed back and forth or get forgotten
- that people only go into hospital – as an outpatient or inpatient – when it is absolutely necessary

This will inform our longer term approach by understanding our populations, experiences, outcomes and needs. This means that we will be able to embed radical change, to better manage rising demand for elective care and improve patients experience and access to care when they need it.

We will launch our programme of work during the first week in July when the NHS celebrates its 75th birthday. This activity will build on initial work undertaken to inform the development of our ICB Engagement Strategy.

Developing our operating model

System wide priorities - doing things once

Integration

Work across the ICB system and at place to develop and deliver an integrated model of care to ensure that:

- people know what to do to stay healthy
- people get the care they need and don't get passed back and forth or get forgotten
- people only go into hospital when it is necessary and only for as long as medically needed
- delivery plans for each place should support the work of the sector collaboratives to reduce follow ups, improve patient flow and address discharge challenges focusing on no criteria to reside/lengths of stay

Quality, Efficiency and Productivity Programme

Humber and North Yorkshire Quality Efficiency and Productivity Programme has identified five priority areas to be delivered across the system via the place and collaborative teams, these are:

1. reducing unwarranted variation
2. follow up reduction (including patient initiated follow up)
3. prescribing
4. no criteria to reside (reducing average length of stay universally)
5. continuing health care and Section 117

The programme will realise the scope, scale of system opportunity, impact on quality,

efficiency and productivity by:

- aligning costs to strategy: differentiate the strategically-critical 'good costs' i.e. waiting list reduction / targeted health inequalities funds from the non-essential 'bad costs' i.e. pay growth/contracting costs/locum costs
- harnessing the value of the ICS operating model: do once where makes sense (not just replicating the commissioner provider split at six places)/act as a system facilitator/deliver service transformation through a) place (with local authorities, primary care and social care and community) b) sector collaboratives
- aiming high: use technology, innovation and new ways of working to radically reduce and streamline the cost base/increase capacity i.e. out-patient follow up/addressing clinical variation/one workforce
- setting direction and showing leadership: deliver cost reduction as part of a strategic, business transformation programme = Humber and North Yorkshire Quality Efficiency Productivity Programme
- creating a culture of continuous improvement for our staff: '100 ways ' – no stone unturned, improving efficiency and reducing costs, encourage calculated risk, no blame culture

Acute and planned care

Humber Acute Services Review

The Humber Acute Services Programme is about finding the best way to organise our hospital services so we can deliver better care in the future. This can address the challenges we face of:

- shortages and skills gaps in our workforce
- services not meeting clinical and waiting time standards
- buildings, equipment and digital infrastructure not being up to scratch

In 2022 we involved clinical teams, patients and the public to design and evaluate different solutions.

In 2023/24 we will develop a set of proposals to consult with the public on. The decision on which model of care to implement will only be taken after consultation for implementation from 2024 – 2030.

For more information visit our website.

Use the camera on your smartphone to scan the QR code

www.humberandnorthyorkshire.org.uk/our-work/humber-acute-services-review

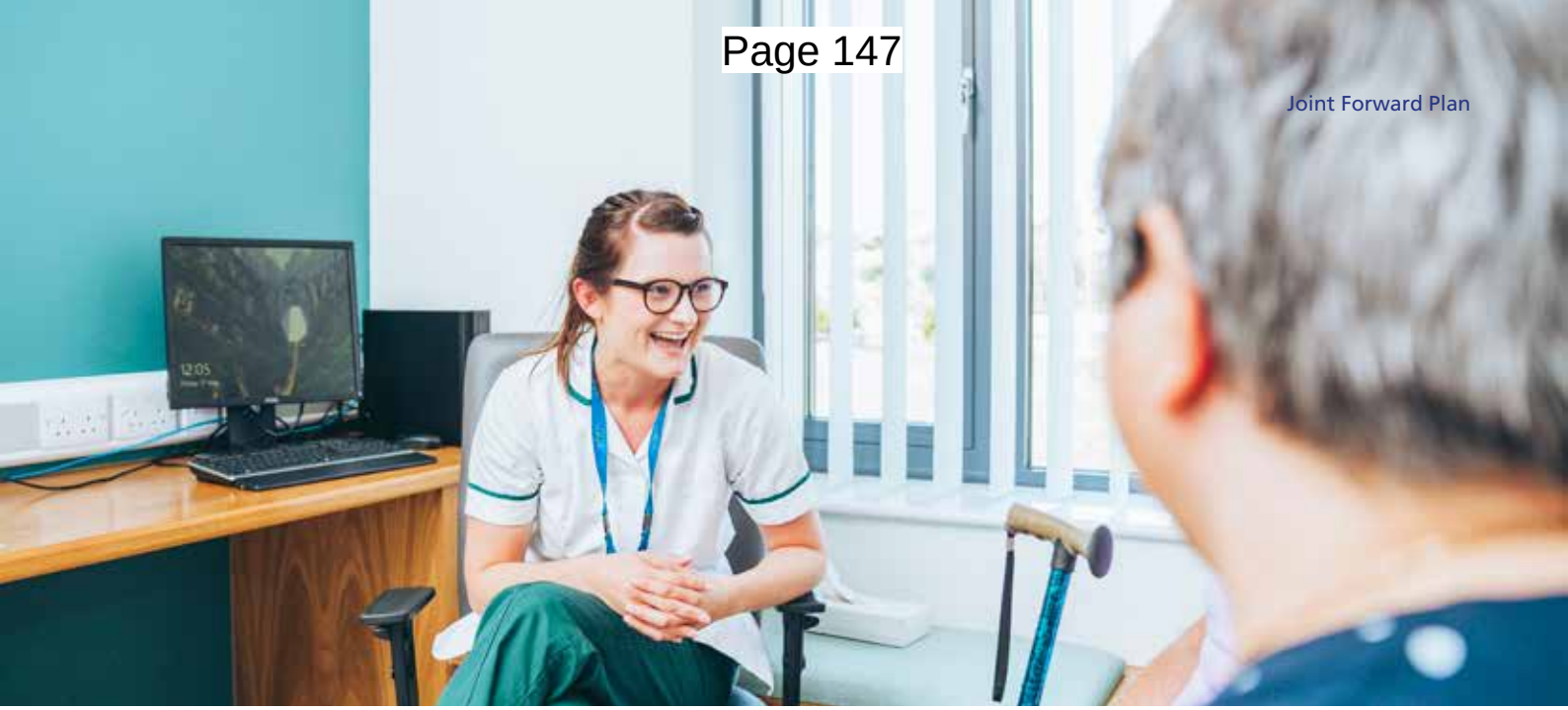
Community Diagnostics Centres

The National Policy for Community Diagnostic Centres will enable investment to increase diagnostic capacity and reduce elective – especially cancer – waiting list times, reduce health inequalities and deliver a better more personalised experience for patients. This will be delivered through a 'hub and spoke' model.

In Humber and North Yorkshire demand is expected to increase significantly over the next 10 years and so we need to develop our diagnostic service at scale and over an extended period and we will need to maximise the use of national funding.

In 2023/24 we will:

- submit business cases for our hub and spoke model for the ICB and
- implement the Scunthorpe Community Diagnostic Hub, approved by NHS England in March 2023 to be operational on 1st April 2024



Plannced care five year strategy approach

Through the Collaborative of Acute Providers (CAP) partners will develop a planned care strategy during 2023/24. The strategy will aim to:

- improve access and patient health outcomes
- refocus planned care services with a focus on productive, efficient models
- build an ICS model that is able to meet the demand of the population
- address health inequalities and reduce variation
- improve system resilience
- improve system working
- build on digitally enabled care solutions
- based on place wherever possible
- ensure compliance with national policy and guidance

Our future models will consider how to maximise existing dedicated elective facilities and develop high volume, low complexity (day case) hubs and specialist inpatient elective hub(s). This will help us to deliver what patients and the public have told us is most important to them – being seen and treated as quickly as possible.

In 2023/24 we will undertake detailed modelling and engagement to build the case for change.

We expect the programme will be over five years starting in 2023/24.

Pharmacy, optometry and dental services

In April 2023 commissioning of pharmacy, optometry and dental services was delegated from NHS England to ICBs. Delegation provides an opportunity to support increased autonomy at a local system level, backed up by appropriate regional and national support, which can improve access to services and improve health outcomes.

Dental health inequalities

In Humber and North Yorkshire there are approximately 170 general dental service providers for our population.

Oral health inequalities exist in:

- those in the most deprived areas experience poorer oral health across all age groups
- vulnerable children known to the social care system, individuals with severe physical and/or learning disabilities, those with poor mental health, older adults, homeless, asylum seekers, refugees and migrants

Data and evidence surrounding oral health inequalities is variable and complex, but we know that they also exist in relation to oral cancer as well as in vulnerable groups with long-standing medical conditions, substance misuse, prisoners/prison leavers and Gypsy, Roma and Traveller communities.

What we will deliver in 2023/24

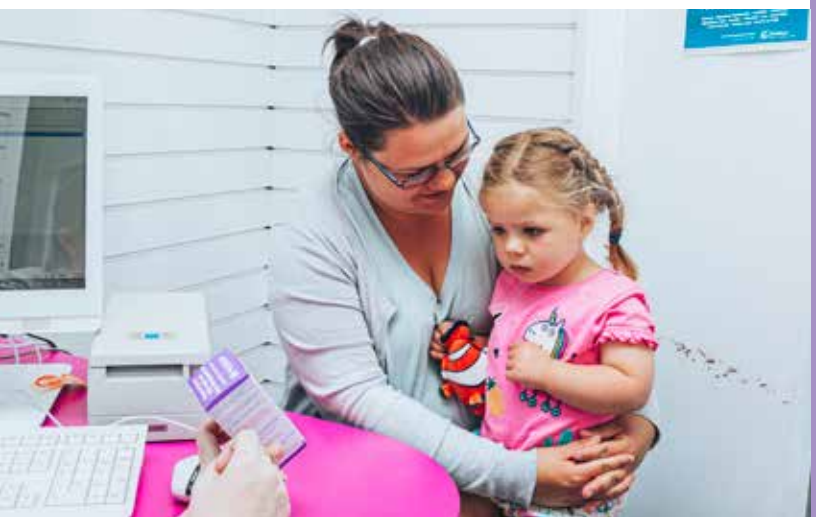
- understanding current services, effectiveness and risks
- improving access
- prevention with a focus on 2-11 year olds, residents of care homes and inclusion health services
- using data and clinical input to prioritise actions
- focus on workforce - both recruitment and retention
- we will continue to work with our community pharmacy and optometrists to maximise the skills and capacity to support our patients in accessing care close to home

Public health commissioning: screening and immunisation

Commissioning will be central to the NHS meeting the challenges it faces today and in the future, and in ensuring that the NHS delivers the triple aim of improved population health, quality of care and cost-control. In order to deliver the triple aim, commissioning will need to continue to develop as it has since its inception.

There will be a need for commissioners to work more closely together, aligning their objectives with providers and taking a more strategic, place-based approach to commissioning. Integrated Care Systems will all play key roles working with NHS England commissioners to secure the benefit of working together across a system to deliver for patients. Specifically, improving quality of care, reducing inequalities across communities and delivering best value.

For NHS public health functions (screening (cancer and non-cancer), immunisations including COVID-19 and flu, and Child Health Information Systems) commissioning responsibility will remain with NHS England. We still have detailed work to do due to the complexity of the services commissioned by NHS England for screening and immunisation pathways. Over the course of 2023/24 national and regional NHS England teams will support progress towards joint working.



What we will deliver in 2023/24

In 2023/24 in Humber and North Yorkshire NHS England regional commissioners and the ICB will work together to:

- align the Yorkshire and Humber Screening and Immunisation Health Inequalities Action Plan with ICB priorities
- respond to anticipated national strategies for screening and immunisation for the ICB
- work in partnership to deliver the programme for bowel cancer screening

Specialised commissioning

In Yorkshire and Humber we have a long history of working collaboratively with NHS England commissioners to improve clinical pathways.

In 2022 NHS England set out its ambition of giving responsibility for managing local population health needs, tackling inequalities and addressing fragmented pathways of care through enabling delegation to ICBs of specialised commissioning. The aim is that by giving ICBs responsibility for a broader range of functions, we will be able to design services and pathways of care that better meet local priorities.

We will have greater flexibility to integrate services across care pathways, ensuring continuity for patients and improved health outcomes for the population.

In April 2023 a joint committee was formed between the three Yorkshire and Humber ICBs and NHS England. The role of the committee is to oversee the delegation of the approximately 60 specialised services to ICBs from NHS England by April 2024.

What we will deliver in 2023/24

We will:

In preparation for the full delegation of services NHS England and Yorkshire and Humber ICBs will jointly work to identify priority clinical pathways to test out new ways of working in partnership across the system so that we can secure the benefit of working together for patients. The aim is to improve the quality of care, reduce inequalities across communities and deliver best value.

Healthy childhood

Neonatal care – to work with the Yorkshire and Humber Neonatal Operational Delivery Network and Local Maternity and Neonatal Networks (LMNS) to deliver the five-year plans for the implementation of the national Neonatal Critical Care Review to reduce neonatal mortality.

Cardiovascular

Mechanical thrombectomy for stroke - to improve access to mechanical thrombectomy across the region by optimising the use of current in-hours services.

Renal Dialysis - working through the Yorkshire and Humber Renal Network actively reduce the need for renal dialysis by actively focussing on interventional and alternative treatments.

Cancer

Radiotherapy and chemotherapy - to work with providers of paediatric radiotherapy, chemotherapy, oncology services, and cancer alliances to develop new and sustainable service models.

Other

Adult critical care - develop an Adult Critical Care Transfer Service that will support best use of critical care capacity across Yorkshire and the Humber.

Measurable outcomes:

- number of patients accessing thrombectomy service
- stillbirth and neonatal mortality rate
- cancer five year survival rates
- reduced rate of growth in new referrals to renal dialysis units

Mitigating climate change

Acting on the climate crisis is a clear, yet still neglected, priority for public health. There is now a large body of work making a clear link between climate change and health.

The impacts of climate change on health can be direct - relating primarily to changes in the frequency of extreme weather (such as heatwaves, drought, fires, floods, or storms) - and indirect, through changes on ecosystems (for example, water-borne diseases, and air pollution) and through effects mediated by human systems (such as occupational impacts, undernutrition, mental health, but also migration and conflict).

In 2023/24 we will work across our system partners to embed our sustainability impact assessment across new policy areas and developments.

Integrated system social care strategic leadership forum

The strategic forum has been established to provide a platform where leaders across health and social care and the wider integrated care system can come together to focus on common priorities, sharing insight and intelligence and collectively identify opportunities for improvement and wider system collaboration.

The particular focus is to strengthen the opportunity for senior ICB leaders and directors of adult social care to come together to discuss system-wide issues and challenges with a view to supporting a collaborative approach and collective solutions. The aim is to supplement and strengthen both discussions and actions across the wider ICS geographical footprint.

In 2023/24 the forum will develop an agreed action plan aligned to health and care integration.

The focus will be on the following core areas:

Workforce

- retaining the social care workforce - cost of living crisis
- profile of the sector - changing the narrative
- parity for the social care work force
- link with wider workforce development and new roles e.g. AHP/ARSS - others

Sustainability of the care sector and engagement

- fair cost of care uplifts
- care fee uplifts
- significant inflationary pressures on the sector- energy and fuel
- care provider failure and withdrawals from the market increasing

Sufficiency and sustainability of prevention strategies

- wider focus on prevention and waiting well via a whole system approach
- Winter capacity issues - short term fixes not sustainable and opportunities missed
- short term/non recurrent funding versus long term funding needed for the sector
- equitable distribution of funds/grants
- understand and agree how mutual assurance frameworks need to align

Creating the conditions for delivery

Our ICS strategy sets out how we will create the conditions to enable and empower our people, communities and organisations to achieve change. This section of the Joint Forward Plan sets out how the ICB will create these conditions in how we work within our organisation and with our partners to embed this way of working in everything we do, and to meet our statutory requirements and obligations.

In this section we will set out:

- how we will work to improve the quality of services provided
- how we will make plans to improve the efficiency and sustainability of use of resources
- how we will create an enabling structure to provide transparency and to meet our statutory obligations
- how the ICB will support wider social and economic development as a system partner

Nursing and Quality **delivering our duty to improve quality**

The ICB Quality Committee is established in line with national guidance including key senior leadership members across the system. The Quality Committee is an executive committee of the ICB board. Each place has established quality place groups and operate in accordance with the ICB Quality Assurance Framework.

In 2023/24 we will:

- continue to implement our system approach to quality management in accordance with National Quality Board Guidance including managing performance as set out in the guidance. Quality Risk Response and Escalation in ICSs; Guidance on System Quality Groups
- establish the ICB virtual safeguarding hub, to co-ordinate functions to support delivery, provide mutual aid and deliver programmes of work at scale to articulate best clinical practice in safeguarding.

Our ambitions include:

- delivering safe, personal, kind, professional and high-quality maternity care. improving the lives of children, young people and adults with learning disabilities and or autism who display behaviours that challenge.
- supporting people to live well by greater working together across health and care to address determinants of health and ill health
- ensuring people age well by improving NHS care in care homes focusing on infection control, hydration, tissue viability and medication management
- ensuring people end their lives well by ensuring a consistent and comprehensive implementation of the national framework for Ambitions for Palliative and End of Live Care.

Priorities for 2023/24

Creating constant quality and improvement opportunities – championing a culture of curiosity, ensuring quality is everyone's responsibility and striving to be better
Continue to develop and embed the strategic quality governance arrangements for example Place Quality Group and the Quality Committee (Board Assurance Framework)

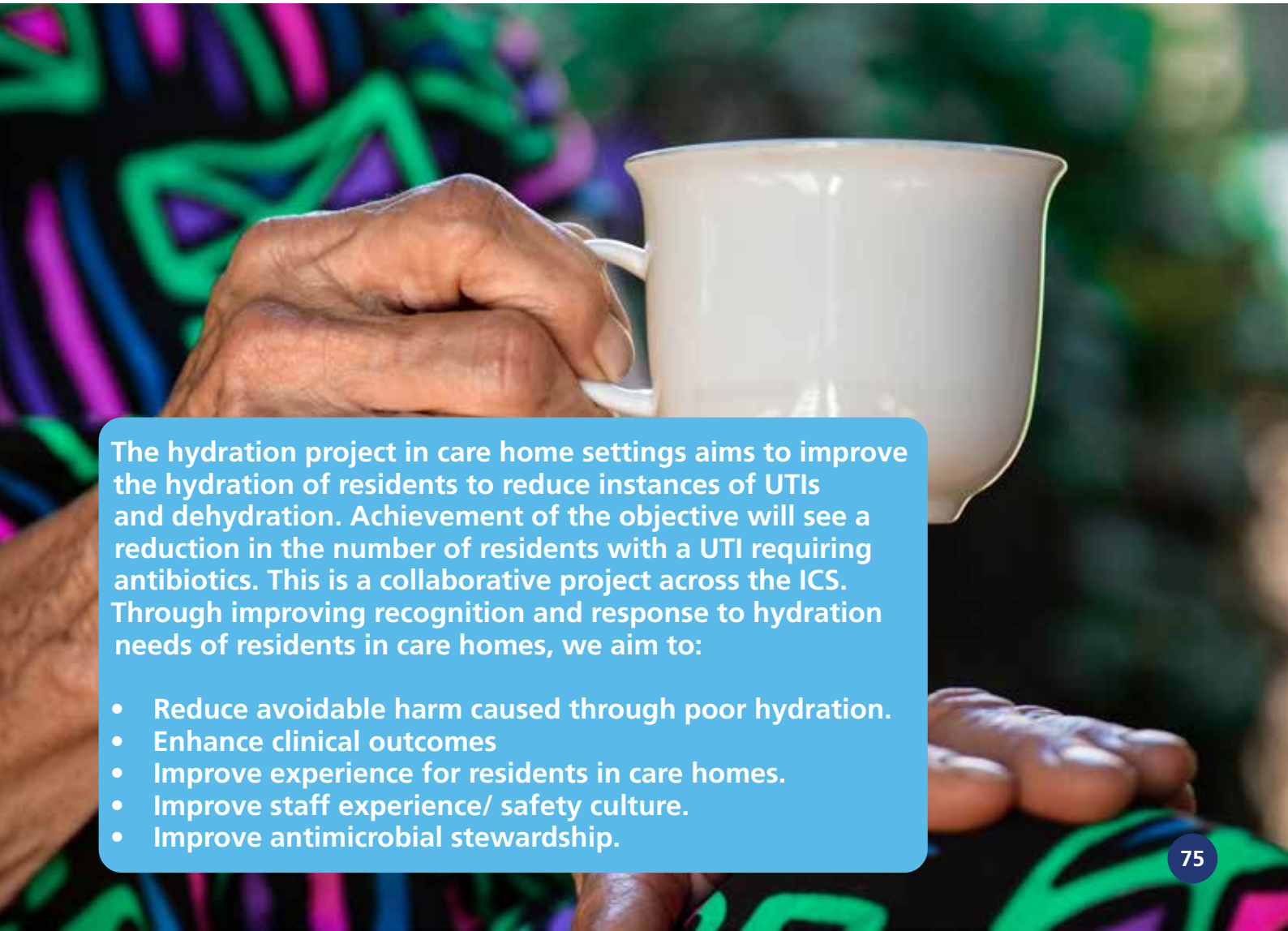
Embed the operational quality systems
To include the range of statutory and regulatory responsibilities

Safeguarding
Provide assurance of system arrangements

Further develop the safety insight involvement and improvement
In particular the patient safety incident response framework and learning from the patient safety events (LPSE)

Service user experience
To develop a focus on service user experience, including better use of insight and feedback

Trust
Building trust across the system to support mutual accountability and mutual responsibility



The hydration project in care home settings aims to improve the hydration of residents to reduce instances of UTIs and dehydration. Achievement of the objective will see a reduction in the number of residents with a UTI requiring antibiotics. This is a collaborative project across the ICS. Through improving recognition and response to hydration needs of residents in care homes, we aim to:

- **Reduce avoidable harm caused through poor hydration.**
- **Enhance clinical outcomes**
- **Improve experience for residents in care homes.**
- **Improve staff experience/ safety culture.**
- **Improve antimicrobial stewardship.**

Quality: **reducing inequalities**

The Population Health and Prevention Executive Committee oversees the ICB's ambition to improve outcomes in population health and healthcare. It is a partnership between the six local authorities, the ICB, and providers.

The Population Health and Prevention Executive Committee oversees the ICB's ambition to improve outcomes in population health and healthcare. It is a partnership between the six local authorities, the ICB, and providers. The plans reflect with those partners and, in instances with those who have lived experience of needs the committee is planning to address. The committee's membership reflects the operating model of the ICB. Its executive lead is Amanda Bloor (Deputy Chief Executive and Chief Operating Officer of the ICB) and it is co-chaired by Louise Wallace (Director of Public Health for North Yorkshire) and Julia Weldon (Director of Public Health for Hull City Council). The committee will support the ICP to carry out its function to improve population health and reduce inequalities in healthy life expectancy.

We will do this by:

- providing population health and prevention leadership and oversight to support the vision of helping the population to "start well, live well, age well and end life well"
- influencing decision making, at scale, and supporting place-based delivery to improve population health, tackle health inequalities and prevention
- ensuring the approach to population health management is front and centre of the work of the Humber and North Yorkshire Health and Care Partnership and is embedded within programmes and workstreams.
- ensuring the effective delivery of key programmes to reduce and address health inequalities across the system

2022/23 has been a moment for the committee to identify its shared priorities, establish ways of working that create connections across the system, and begin delivering ambitious programmes that maximise the opportunities of our integrated care system. We have seen places, providers and collaboratives enhance their individual and collective responsibilities towards health inequalities via resources, governance and actions. Going forward into 2023/24, the committee plans to accelerate these programmes and seek further alignment to the newly developed Integrated Care Strategy.

Priorities for 2023/24

Inclusion health
Fully scope out inclusion health service that reaches all parts of the system

Measurement
Stand up a robust measurement and evaluation framework against the committee's programmes, with a focus on Core20PLUS5

Major conditions
Develop strategies that focus on preventing people with one long term condition from develop their 2nd, 3rd and 4th condition

Education and training
Introduce health inequalities opportunities to health and care staff and co-ordinate public health training opportunities in the ICB for junior doctors and registrars so that we can upskill the next generation of the health and care workforce with expertise to deliver integrated care that maximises healthy lives

Finance
Establish an expert finance sub-group that will make recommendations to the ICB on the allocation of resources that address population health, prevention and health inequalities

Health inequalities funding

Using the NHS England ICB Place Based Allocation Tool, each of the six individual places were grouped at GP practice level to determine their Relative Need Indexes and associated population sizes. This was done at GP level because some of the places are not coterminous with their local authorities. Combining these to ICB level gave a relative percentage of the ICB's Weighted Health Inequalities Population attributable to each place which was then used as the basis for the allocation.

Humber and North Yorkshire has developed a number of schemes in 22/23 in collaboration with local authority partners which are approved and via the committee and have a quantifiable allocation and measurable impact:

- expanded Tobacco Control and Dependency Treatment Programme
- perinatal weight management project trial
- programme management support to coordinate the CVD prevention pathway
- addressing premature births through a Maternal Wellbeing Programme
- care and support for victims/survivors of domestic abuse
- inclusion health - weight management
- GP Drop-in Service in Rainbow Children's Centre
- family and school links project: support with anxiety related school absence
- GP outreach Urgent Care/Dental Care Service for sex workers
- Cultural Community Café and recreation facilities for asylum seekers – adults and children

Efficiency and sustainability: **financial duties**

The system faces a significant underlying financial pressure as we move into 2023/24 and beyond.

Humber and North Yorkshire ICB has a brought forward cumulative deficit of £96m and under the current guidelines subject to delivering financial balance in 2022/23 and 2023/24 this deficit will be written off.

The financial regime that has been in place during the COVID pandemic has increased the cost base of the organisations within the Humber and North Yorkshire area.

Whilst there is a clear ambition and move towards establishing system financial control there remains organisation statutory financial duties that do not always enable a "system first" approach.

Provision continues to be significantly fragmented which can make delivering efficient and effective end to end pathways challenging.

Fair, equitable and realistic financial targets should be established.

The architecture that has been created through the Health and Social Care Act 2022 is described as permissive and therefore there is an opportunity to design the rules to fit the requirements of Humber and North Yorkshire for 2023/24 and beyond.

Guiding principles:

- enable the ICS including its constituent organisations to deliver operational and strategic goals
- enable the system to deliver on the triple aim of improving population health, improving the quality of services and improving value for the system
- ensure that each organisation is not financially disadvantaged at the expense of another (equity)
- deliver financial balance at organisation and system level
- incorporate learning from last year's process
- aim to live within our means - recognise the constraints in which we operate and don't have unrealistic expectations
- we have collective ownership of the challenge and will work collaboratively to problem solve
- seek to align plans with agreed assumptions as early as possible including revenue, capital activity and workforce
- keep it simple as much as possible – avoid protracted bidding processes – be pragmatic
- open book and transparent
- open to constructive challenge
- seek optimum solution for the ICS – recognising this may create issues at an organisation/place level – but have confidence this will be recognised as part of the planning process
- seek to agree a Financial Risk Management Strategy as early as possible
- develop and adopt a sustainability impact assessment for any new investments or financial decisions
- develop efficiency and productivity plans at organisation, place and system
- be prepared to test the efficacy and efficiency of existing investments and make disinvestment recommendations

Our approach to financial planning

Short term

- quantify our gaps quickly
- explore rapidly in year opportunities
- keep it simple and realistic
- establish our process with place and collaboratives as our prime planning route
- fully exploit the digital agenda
- ensure system rigour
- develop a system lens to demand management

Beyond one year

- describe our three year position and stick to it
- identify our key areas of fragility
- align national and local planning parametres
- keep a strategic focus on capital planning

Our priorities

Embed the ICB approach to driving value and eradicating waste

Develop our systematic approach to planning, ensuring system accountability and transparency

Publish our Joint Capital Resource Plan

What we will deliver in 2023/24

- **align costs to strategy:** differentiate the strategically-critical 'good costs' i.e. waiting list reduction / targeted health inequalities funds from the non-essential 'bad costs' i.e. pay growth/contracting costs/locum costs
- **harness the value of the ICS operating model:** do once where makes sense (not just replicating the commissioner provider split at six places)/act as a system facilitator/deliver service transformation through
  a) place (with local authorities, primary care, social care and community)
  b) sector collaboratives
- **aim high:** use technology, innovation and new ways of working to radically reduce and streamline the cost base/increase capacity i.e. out-patient follow up/addressing clinical variation/one workforce and continued investment in renewable energy
- **set direction and show leadership:** deliver cost reduction as part of a strategic, business transformation programme = HNY Quality Efficiency Productivity Programme
- **create a culture of continuous improvement for our staff:** '100 ways' – no stone unturned, improving efficiency and reducing costs, encourage calculated risk, no blame culture
- establish system wide ICB planning meetings to hold ourselves to account and embed our core principles to planning and accountability

In line with NHS England guidance we will develop and publish a narrative explanation on the full 12 months period from April 2022 to March 2023 making sure that we embed our principles of:

- decisions taken closer to the communities they affect are likely to lead to better outcomes
- collaboration between partners in a place across health, care services, public health, and voluntary sector can overcome competing objectives and separate funding flows to help address health inequalities, improve outcomes, and deliver joined-up, efficient services for people
- collaboration between providers (ambulance, hospital, and mental health) across larger geographic footprints is likely to be more effective than competition in sustaining high quality care, tackling unequal access to services, and enhancing productivity

Efficiency and sustainability: **procurement and supply**

The ICB will generate system efficiencies through 'doing things once' to maximise efficiency and ensuring aggregation of spend, demonstrating best value.

Three acute trusts within the ICB have appointed a single Director of Procurement who has presented a business case for a centralised procurement function delivering services on behalf of all three trusts (note: Harrogate is aligned to West Yorkshire ICB for procurement). This business case was approved by all three Trust Boards in February 2023.

The business case included a single governance structure and standard set of SFIs relating to procurement and contracting which was accepted by each Board. The proposed governance structure aligns to the Public Contract Regulations 2015 as well as other horizontal policy requirements such as Greener NHS Sustainable Procurement Programme and tackling modern slavery within government supply chains. As part of the business case specific resource within procurement has been approved for governance & assurance and sustainability & social value.

A key facet of the business case is to move beyond cost-down and to incentivise procurement to deliver value across the organisation. A new savings policy has been developed which encourages procurement to think beyond, and count the benefit of, wider value to the system such as how procurement decisions can reduce a patient's length of stay, improve theatre efficiency or reduce cost within the community.

A three-year Procurement Strategy has been developed and approved by the Trust Boards which seeks to:

- support the aims and vision of the ICS and collaborative members
- create a single procurement function which will help support the sustainable provision of clinical and non-clinical services
- establish the collaborative as a centre of procurement and commercial excellence which provides procurement and commercial services to its member organisations
- support supplier rationalisation and cost savings
- ensure standardised robust product selection and range management practices are in place
- ensure that policies, practices and procedures are standardised and provide for the effective provision of procurement to the collaborative trusts
- ensure innovative and robust Supplier Relationship Management (SRM)
- develop P2P e-commerce processes and systems to ensure smooth and efficient processing for all purchasing requirements
- enable effective partnering with senior stakeholders, internal customers and suppliers;
- ensure all staff are given the opportunity to develop their potential.

Aims and objectives of the procurement transformation programme

- embed robust procurement and contracting governance and decision making in accordance with the ICB's governance framework through supporting individuals and teams across the ICB to understand processes and know how to access support from the Procurement and Contracting Team
- transform how the Procurement and Contracting Team operates to improve efficiency and reduce duplication while maintaining strategic support for places
- establish a roadmap for the rationalisation of ICB contracts to improve consistency and maximise the efficiency of contract management
- deliver an effective procurement plan for the ICB which balances procurement regulations, legislation and assessed risks
- develop an ICB Contract Management Framework of standardised approach and procedures
- complete the implementation of the single ICB e-contract register

Our priority

Standardise procurement data and systems

What we will deliver in 2023/24

- develop a single contract database which ensures all contracts are visible in one place and informs the collaborative annual work plan
- implement a single procurement catalogue to standardise pricing and maximise volume across the trusts
- implement a single procure-to-pay system which will provide greater visibility of what is being procured, from whom and for how much. This will help identify opportunities for product standardisation balancing financial benefit, patient safety and supply chain resilience
- ensure a single inventory management system linked to Scan-for-Safety allowing the collaborative to track products across the trusts and better manage stockholding

Efficiency and sustainability: **duty as to climate change**

The Health and Care Act 2022, the legislation that bought about Integrated Care Boards (ICB) also enshrined in law a commitment by the NHS in England to consider climate change in all decisions.

At Humber and North Yorkshire ICB, we not only recognise our legislative commitments to climate change but aspire to move faster and further becoming recognised as national leaders in responding to the climate emergency through increased mitigation, investment and at the same time ensuring a just and inclusive transition – ensuring on one is left behind.

Our HNY response to the challenges of climate change will be set out in the ICS Green Plan and overseen at the highest level of organisation with an ICB board level Senior Responsible Officer (SRO) for Sustainability. Providing system leadership, working with partners across our communities our work on sustainability will mirror the commitments of the wider Yorkshire and Humber Climate Change Commission in the effective delivery of:

1) **net-zero** – reducing greenhouse gas emissions

2) **climate resilience (adaptation)** – resilient healthcare in the face of a changing climate

3) **nature and biodiversity** – supporting ecosystem recovery

4) **just and inclusive transition** – transitioning to a net-zero carbon economy in a way that is fair and equitable for all

Humber and North Yorkshire will establish dedicated functions and identify required resources commensurate with the scale of the challenge of discharging our duty to climate change in line with local priorities and arrangements.

The ambitions articulated in the ICS Green Plan, a system-wide delivery plan to cut emissions, adapt to a changing climate, increase biodiversity and ensure a just transition.

A three-year strategy based on the aspirations set out in "Delivering a Net-Zero National Health Service" sees our response to climate change woven into all aspect of our ICS ways of working.

In 2023/24 we will continue focus on Green Plans to reduce environmental impact focusing on our priority areas.

Our priorities

Our deliverables

Data and performance

- establish metrics linked to the Greener NHS Dashboard to monitor key performance of the ICS commitments to climate change
- develop a carbon footprint dashboard to establish the carbon account of the ICB

Digital enablers

Digital initiatives can play a key role in supporting a net-zero economy by increasing efficiency, reducing waste, and optimising energy usage including:

- digital supply chain management - procurement of low energy equipment
- research and implementation of "power down" software
- energy-efficient data centres

Estates

There are a number of estate initiatives that will be built into our estates strategy for primary, secondary, tertiary and community care to support the transition to net-zero including:

- costed plans to decarbonise the estate
- increase building energy efficiency
- on-site generation of renewable energy and heat
- optimising building usage

Travel and transport

- collaboration with partners to support modal shift initiatives to public transport and active travel alternatives for staff and patients including walking and cycling
- support the transition to electric vehicles including through staff benefit schemes
- transition of owned and leased fleet to ultra low and zero emission vehicles

Procurement and supply

From April 2023 all contracts above £5m per annum the NHS will require supplies to publish a Carbon Reduction Plan. From April 2024 the NHS will extend this requirement to cover all procurement. More information can be found at the Net Zero Supplier Roadmap, scan the QR code below to view the roadmap.

www.england.nhs.uk/green-ernhs/get-involved/suppliers/

Medicines

- decommission desflurane completely given the availability of clinically safe, more environmentally friendly, and cost-effective alternatives
- reduce carbon footprint of inhaler prescribing
- reduce emissions from nitrous oxide and mixed nitrous oxide products in manifold cylinders

Creating an enabling infrastructure: **promoting involvement**

By giving everyone an equal voice, listening to people who use services and empowering them to be part of the design and decision making about services we become aware of ideas and aspects of service that may not have been considered, enabling us to make positive change.

Although we have a legal duty to involve people, we believe local people know their communities best, building relationships and trust by making sure everyone has a voice and that decision making is underpinned by robust evidence, we can make sure that services meet the needs of the local community. Creating opportunities for patients and the public to be involved and contribute, by sharing power and co-producing services and solutions.

The Integrated Care Board has a legal duty to involve patients and the public in decision making and service development. There are clear standards for public engagement to shape decisions, monitor quality and to set priorities. These come from a number of sources, including:

- legislation
- the NHS Constitution
- existing national guidance
- Integrated Care System (ICS) Guidance

Our co-produced vision for engagement, aligns with the principles described in 'Building strong integrated care systems everywhere', and describes what engagement and involvement is and how we will achieve it.

Building on the best practice already in place across our six places we will:

Be visible honest and open

Be flexible and dynamic

Be inclusive and accessible, seeking voices of the seldom heard

Listen to communities and value contributions

Learn from each other and feedback

Involve people in being part of the solution

Build on trust and ongoing relationships

Find out more about our engagement work

Use the camera on your smartphone to scan the QR code

www.humberandnorthy-orkshire.org.uk/our-work/get-involved

Creating an enabling infrastructure: **involving patients and patient choice**

Humber and North Yorkshire Health and Care Partnership recognise that there is a part for us all to play in looking after our health and the health of those around us.

On 1st April 2023 a new website was launched by the NHS in Humber and North Yorkshire to help people start well, live well and age well. Here you can find all the information you need to help live a more healthy and active life whilst learning about the health services in your area.

Let's Get Better brings together lots of health and wellbeing information to support people throughout their lives and helps people choose well and get the care they need when they're unwell.

The Let's Get Talking blog celebrates the people, places and potential that our area has to offer.

The programme is supported by social and digital media, print and online partnerships and health advice videos. Further development is planned including enhancing local content and increasing information on commissioned services, voluntary and community sector and community support in each area, plus specific LGBT+ health information and advice and enhanced accessibility.

Visit Let's Get Better for more information www.letsgetbetter.co.uk

Patient Engagement Portals

An NHS Patient Engagement Portal is a digital platform that allows patients to access their healthcare information, communicate with healthcare providers and manage their health in a more convenient and efficient manner.

For patients this will mean a more consistent experience that improves access, visibility and control for patients on elective care pathways.

It will enable a single point of entry digital 'front door' to NHS services through the NHS App.

In 2023/24 the ICB has been successful in securing funding which will extend the coverage and expand the functionality and impact of Patient Portals.

Involvement case studies

Customising engagement to make it relevant

In 2021 engagement took place with children and young people across the Humber to hear what they liked and didn't like about coming into hospital and what was most important to them when receiving care or treatment to help them feel better quickly.

To undertake this engagement effectively and ensure young people could respond in a way that was meaningful to them, a child-friendly approach was developed in partnership with play specialists, patient experience leads and paediatric clinical leads within the two hospital trusts.

For young children (0-10 years) a fun activity booklet was developed featuring drawings, matching activities and space to write or leave comments. For older children/young people (11-18 years) a bespoke questionnaire was produced with simplified questions and open space to provide free text or drawings. This booklet was also available to complete online and a URL and QR code was provided to participants. Participation was incentivised with a prize giveaway and parental consent was built into the survey design.

Maternity Voices Partnerships

The Local Maternity and Neonatal System (LMNS) works very closely with Maternity Voices Partnerships (MVPs) based in each place and with a coordinating lead to link into regional and national initiatives.

The MVPs host regular meetings, engage through social media, oversee production of guidance and processes, and support the oversight and assurance processes of the LMNS within their local hospitals to ensure families needs are met.

They also have a cultural diversity lead across Humber and North Yorkshire who supports linkages into different community, faith, racial, LGBT+ and other minority groups to ensure they are effectively represented in these discussions.

The Mental Health Learning Disability and autism sector collaborative

We have a strong track record of engaging with the public in development of the collaborative's priority programmes and we have some excellent examples of where this has been done effectively.

As part of our children and young people's mental health programme we have held extensive engagement with children and young people, particularly in relation to the delivery the trauma informed care programme.

- we have a dedicated co-production and engagement lead, who has ensured that we are working collaboratively with the children and young people we are supporting to recognise their needs and thoughts on what will work best to support them. Service developments and strategic plans alike will be demonstrably co-produced
- collaborative led engagement processes that will, by default, be arranged and delivered across health and care boundaries (local authority, primary care, VCSE etc)
- people with lived experience will be represented across our collaborative programme, it's key priority workstreams and programme governance.

Creating an enabling infrastructure: **appropriate advice**

Clinical and care professionals are the cornerstone of the ICB - a key enabler in delivering the ambitions of the Joint Forward Plan. The ICB has a model of clinical place directors, who have a dual role to provide leadership within their respective places and operate strategically across the ICB.

Each clinical place director collaborates with a virtual team of clinical and care professionals within their respective places. They provide expert clinical advice and facilitate the culture change needed to deliver fully integrated care, across programmes, places, networks and collaboratives.

Alongside this, leading clinical and care professionals from across ICB geographies coalesce on a weekly basis to learn, share and develop clinically led solutions to the various systemic issues facing the ICB.
A core purpose and ambition of the directorate is to drive and facilitate culture change through clinical and professional leadership, at all layers of our complex system.

We will do this through:

Clinical effectiveness

Developing improved clinical pathways and policies to reduce unwarranted variation, improve quality and reduce inequalities

Digital

Developing the digital strategy and vision to address digital exclusion, develop shared records and support business intelligence

Research and innovation

Growing our knowledge and capacity to scale up innovation

Medicines optimisation

Ensuring the most effective, appropriate, safe and sustainable use of medicines

Our priorities

Take forward and agree a way forward for a digital solution to better pathway standardisation to reduce unwarranted variation and support system transformation for patients

Develop clinical leadership to champion and embed clinical transformation within place, collaboratives, and system partners

Develop a structure for clinical networks operating in the ICB which will provide visibility of work and enable the ICB to drive effectiveness and efficiency through agreed network work programmes

Embed streamlined clinical decision making processes for the harmonisation of existing and introduction of new clinical policies

Creating an enabling infrastructure: **Innovation, Research and Improvement (IRIS)**

Vision

Support and grow an exemplar system that enables and facilitates research, innovation and improvement to realise the HNY ICP ambition for everyone in our population to liver longer healthier lives.

Mission

Innovation, research and improvement are critical elements of a thriving health and care system. IRIS will be the front door into, and out of, the Humber and North Yorkshire system for innovation, research and improvement. The virtual hub will connect partners across our system to maximise our assets and resources.

What will IRIS do to realises its mission and vision?

Single front door

- for industry, life sciences sector, arms length bodies, academia
- facilitate rapid adoption, spread, scaling up of innovation and best practise

Virtual hub for stakeholders

- harness existing networks, activity, and resources to create a joined-up system that encourages, promotes and enables research, innovation and improvement
- match making function to facilitate new collaborations

Demand signalling

- communicating ICS priorities and 'grand challenges' to researchers and innovators

Culture change

- education, training and upskilling the workforce to provide colleagues with the knowledge and tools that they need to embed research, innovation, and improvement
- promoting research in primary, secondary and social care

A data driven and evidence-based system will enable:

- cultural change and staff empowerment – those who do the work know the solutions
- better outcomes for people
- standardisation of systems and processes
- recruitment and retention of talent
- better use of resources

What will success look like?

- grow local healthcare innovation knowledge and capacity
- support local healthcare innovator and economic development
- fixing our local healthcare 'grand challenges'
- scaling up any local fixes beyond HNY ICS
- be an exemplar health and social care system for research, innovation and improvement

What we will deliver in 2023/24

Launch a support a programme of organisation development linked to our priorities:

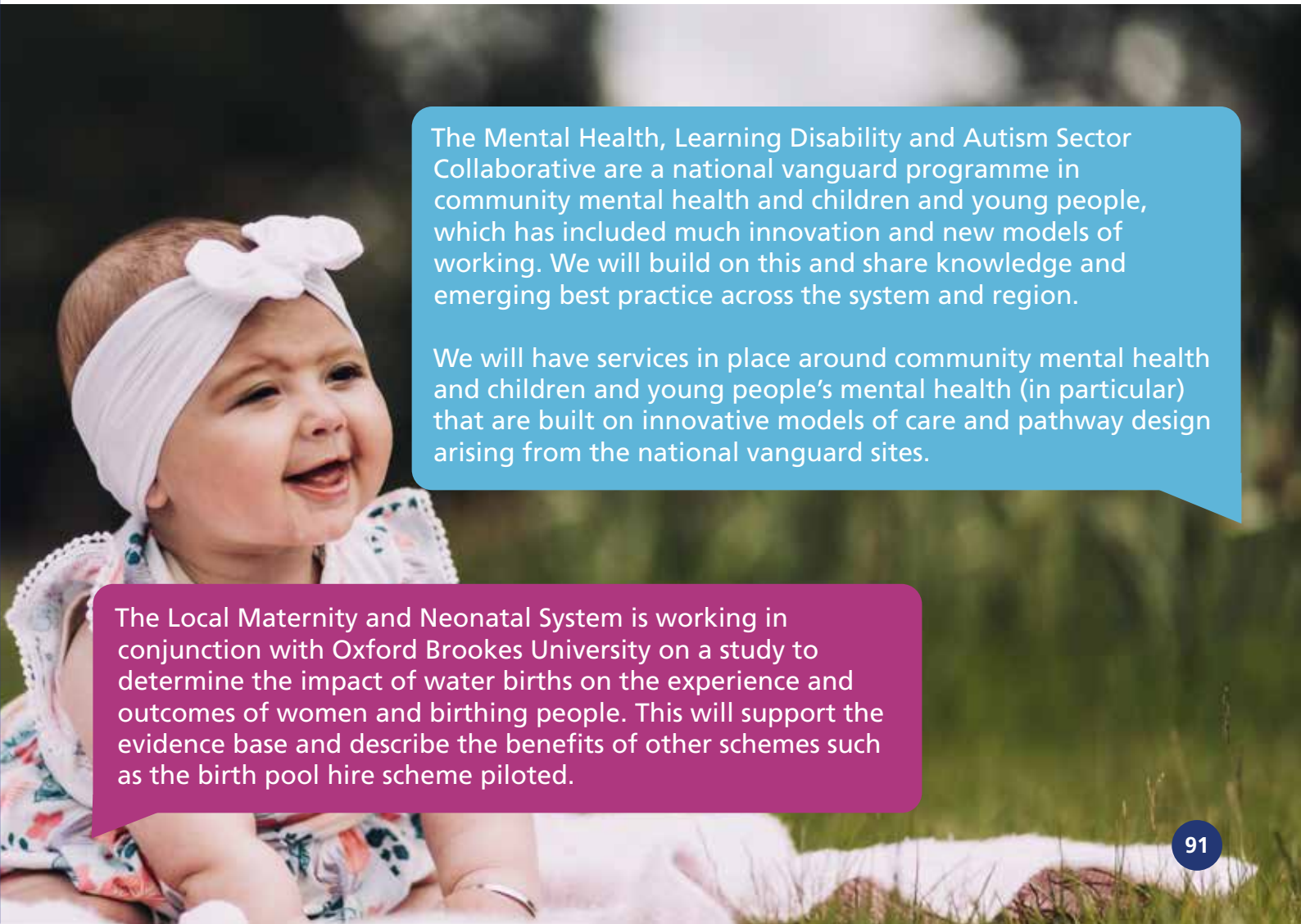
- host a launch event and support ongoing engagement and relationship building
- identify two ICP 'grand challenges' for IRIS to drive activity toward
- create the ICP strategy for research, innovation and improvement
- perform a comprehensive stocktake of what resources exists in the system and develop a plan for how best to deploy them
- create new partnerships with education and industry particularly around big data and data analytics

Create the right decision making structures to support innovation, research and improvement

- identify and agree the governance for IRIS
- primary care research and development function sits within IRIS
- identify a Senior Responsible Owner within the ICB to champion and lead the programme
- build capacity within the team

Adopt NHS impact to create the culture and conditions for continuous improvement across the ICS

- engage with NHSE on the adoption of NHS impact
- learn lessons internally and from other peer ICBs
- engage with global leading vendors to identify opportunities for clinical and operational improvement and sustainable change



The Mental Health, Learning Disability and Autism Sector Collaborative are a national vanguard programme in community mental health and children and young people, which has included much innovation and new models of working. We will build on this and share knowledge and emerging best practice across the system and region.

We will have services in place around community mental health and children and young people's mental health (in particular) that are built on innovative models of care and pathway design arising from the national vanguard sites.

The Local Maternity and Neonatal System is working in conjunction with Oxford Brookes University on a study to determine the impact of water births on the experience and outcomes of women and birthing people. This will support the evidence base and describe the benefits of other schemes such as the birth pool hire scheme piloted.

Creating an enabling infrastructure: **our digital strategy**

Vision

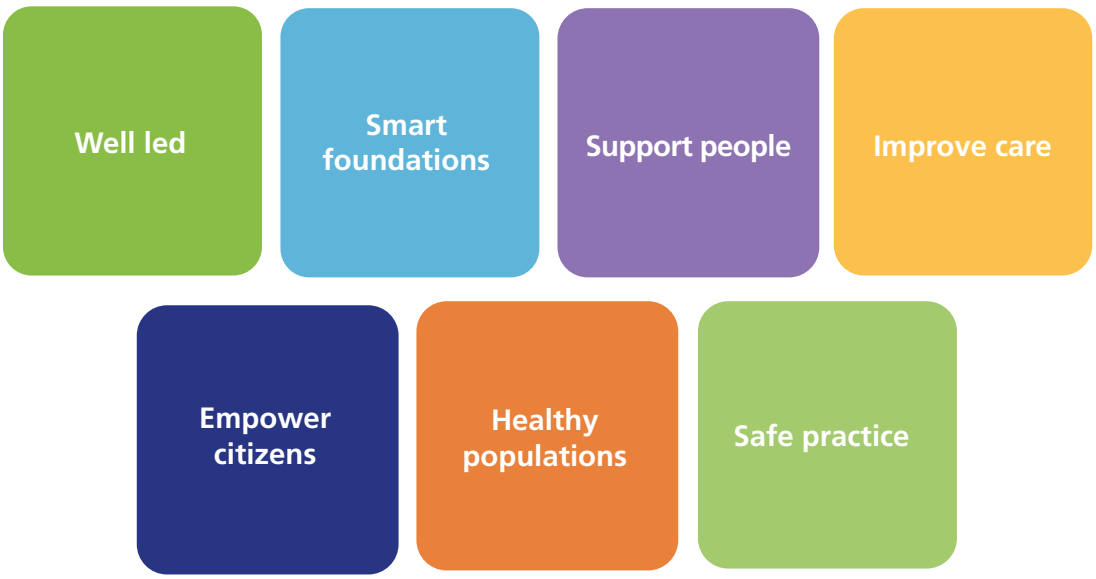
Our digital vision is 'to deliver digital and information services and solutions that enable citizens to Start well, Live well, Age well and End their lives well.'

Humber and North Yorkshire Health and Care Partnership will embed digital transformation as an integral part of our clinical, business and population health strategies.

We will

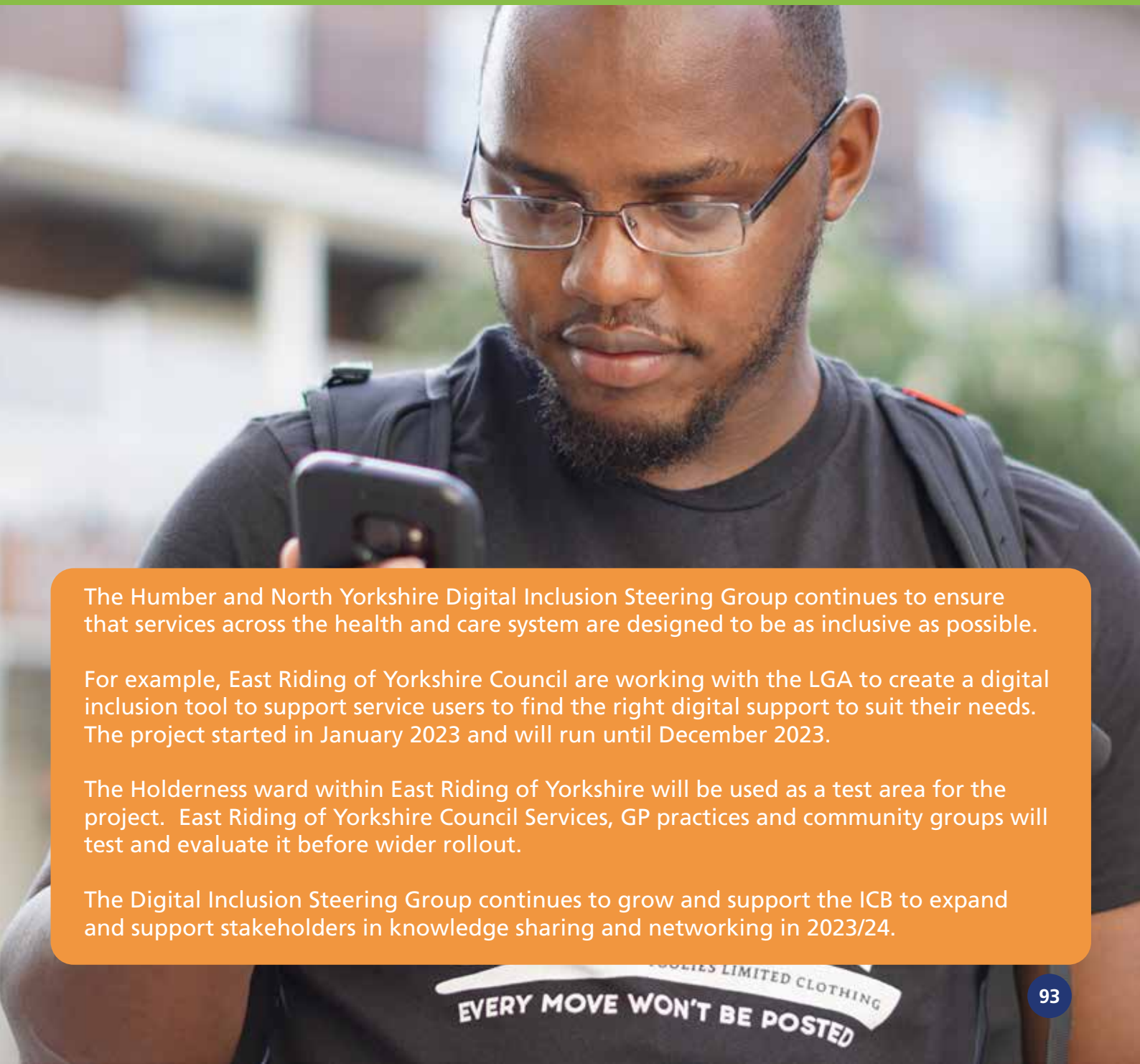
- Use digital to improve the way services are designed, delivered and managed in an integrated way, with a clear focus on the individual and their experience, and where health and care professionals can make the best decisions because they have the information they need at the point of car when they need it
- Optimise the value of data to create intelligence to be used routinely to improve patient safety, delivery better health outcomes and tackle inequalities
- Nurture a thriving digital health and care ecosystem, supporting research and innovation, developing skills and capabilities and recognised internally as an exemplar of innovation and digitisation

Our priorities



What we will deliver in 2023/24

- development of a unified approach to digital based on a distributed leadership model with the intention of a refreshed system wide approach
- continue to deploy the Yorkshire and Humber Care Record across all areas of health and social care
- collaborate to rationalise and develop our electronic patient record systems, delivering the required elements of the programme
- continue to implement the actions set out in the Digital Inclusion Strategy and Plan
- develop and implement a self-sustaining, system-wide, multi-disciplinary data and analytical collaborative model – that produces high-quality, locally-relevant intelligence to enable leaders at all levels to make decisions informed by evidence



The Humber and North Yorkshire Digital Inclusion Steering Group continues to ensure that services across the health and care system are designed to be as inclusive as possible.

For example, East Riding of Yorkshire Council are working with the LGA to create a digital inclusion tool to support service users to find the right digital support to suit their needs. The project started in January 2023 and will run until December 2023.

The Holderness ward within East Riding of Yorkshire will be used as a test area for the project. East Riding of Yorkshire Council Services, GP practices and community groups will test and evaluate it before wider rollout.

The Digital Inclusion Steering Group continues to grow and support the ICB to expand and support stakeholders in knowledge sharing and networking in 2023/24.

Creating an enabling infrastructure: **our people strategy**

Our People Strategy

Be the best place to work

- supporting staff health and wellbeing
- supporting inclusion and belonging

Grow and train our workforce

- growing the workforce of the future and ensuring adequate workforce supply
- educating, training and developing people and managing talent

Demonstrate system leadership

- valuing and supporting leadership at all levels
- supporting system design and development

Our priorities

- **Inclusive health and care careers**
- **Flexible workforce: agency and bank**
- **Leadership, talent and succession**
- **Stay and thrive: retaining our staff**
- **OD lab for system effectiveness**

Our Workforce Transformation Programme

We will deliver our strategy through an iterative transformation programme delivered in phases to enable sustainable workforce transformation and drive system development. Our innovative methodology for workforce transformation is built on distributed leadership and open participation.

Case study: 180 Days of Action on Workforce Sept 2022 – March 2023

Read about the success of the first phase of our transformation programme – 180 Days of Action on Workforce - in our 180 Days storybook and watch our 180 Days partnership film to hear about how our innovative approach to change design and leadership is changing the way partners work together.

What we will deliver in 2023/24

Inclusive health and care careers

- careers support menu in deprived schools
- work experience placements bank, employer toolkit and virtual offer
- disability confident
- veterans

Flexible workforce: agency and bank

- design Humber and North Yorkshire (HNY) system collaborative bank
- deliver 23/24 NHS England bank and agency objectives
- create HNY bank and agency dashboard

Leadership, talent and succession

- create best practice programmes for leaders at all levels
- explore common induction

BREAKTHROUGH HNY

Our Workforce Transformation Programme 2023/24

Our People Strategy sets out a long-term architecture for the people challenge and explains how our leadership community is organising its collaborative thinking and planning around people and workforce.

Our System Workforce Board and its committees will oversee the development and implementation of medium-term strategic plans, ensuring partners from all sectors are involved and share control.

Embrace new ways of working

- all sectors workforce transformation including VCSE
- carers and volunteers

Building strong foundations

- transforming people services and supporting the people profession
- leading co-ordinated workforce planning using analysis and intelligence

Care at home workforce redesign

Children and young people's workforce redesign

Oral health workforce redesign

Volunteers at the heart of the system

Enabling colleague movement

One system, recruiting together

- deliver career progression curriculum
- work with region 4+1 on senior level talent

Stay and thrive: retaining our talent

- co-design and launch flexible working strategies
- new starter attrition prevention tools
- exit intelligence
- stay conversations

OD lab for system effectiveness

- create cutting edge OD toolkit to support system effectiveness, involving and developing place, collaborative and function leaders and teams

Care at home workforce redesign

- map VCSE care at home workforce at place
- streamline care at home roles
- amplify direct care provider voice
- care at home digital vision

Children and young people's workforce redesign

- to be developed with directors of children's services

Oral health workforce redesign

- to be developed with dental commissioners and profession leaders

Volunteers at the heart of the system

- apply 180 Days research findings
- design and progress HNY volunteer hub
- research volunteering in social care

Enabling colleague movement

- define and negotiate portability agreement and process
- employee passports

One stystem, recruiting together

- HNY attraction campaign and front door
- shared recruitment charter and principles
- pilot joint recruitment campaign and recruitment innovation

Creating an enabling infrastructure: **supporting wider social and economic development**

We share the responsibility for improving health with our people who live and work in Humber and North Yorkshire. As organisations we have extensive assets at our disposal and using our collective power and influence we can use these to put in place building blocks for health (see diagram below). These building blocks are the underlying circumstances that affect the health, lives and life chances of our people. Improving these underlying circumstances has a direct impact on the people's health and provide opportunities for our populations to thrive.

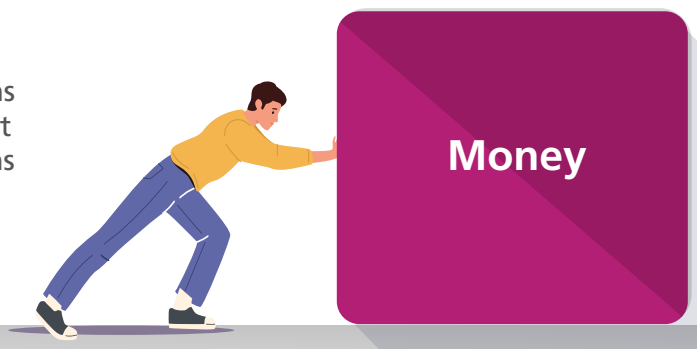
Utilising our partnerships and our history of working with our communities, we will look to optimise the arrangements to impact positively on our communities and support through our actions addressing the gaps in the building blocks of health, to deliver the aims and aspirations for better health and improved lives for our people and communities.

As the organisations that are one of, if not the biggest employers, in each of our six Places, we are committed to positively contributing to making a difference for local people by:

- Seeking to enable local economic growth by buying local and supporting the creation of a strong infrastructure that attracts and builds businesses in our area
- Creating greater access to work by growing the workforce of the future and providing opportunities for people to develop their skills and giving our people a purpose
- Reducing our environmental impact and making our contribution to the Net Zero Climate targets.

What we will deliver in 2023/24

- establish a health and care anchor network that can co-ordinate and motivate the strategic approach
- understand the health and care system collective strengths and areas for collaboration through a baseline assessment of anchor activity
- develop shared ambition and co-ordinated plans for each of the anchor pillars with measurement that demonstrates health and care organisations social value



Case study

In North East Lincolnshire we recognise the important part we have to play in supporting wider social and economic development in the borough and we are utilising our partnerships and long history of integrated working to optimise the arrangements to impact positively on our communities.

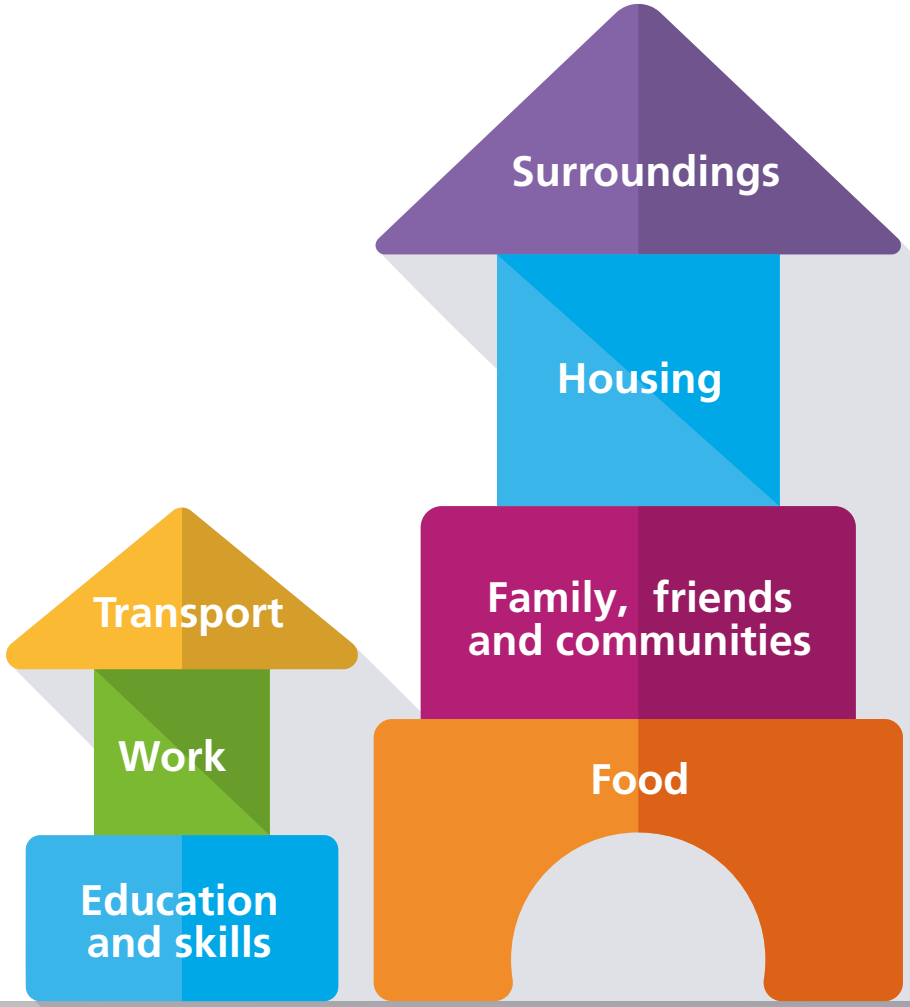
One of our key priorities is workforce development and this is being facilitated through the North East Lincolnshire Health and Care Partnership and involves partners from across health and care.

Its broad aim is to ensure a thriving workforce in health and care locally. It has a focus on development of local talent through engagement with further and higher education institutions and bringing together the potential health and care employers with local curricula in order to help shape the workforce for the future.

In addition to this the workforce group will:

- develop a joint approach to international recruitment focused on nursing and medical staff - specific focus on supporting refugees in 2022/23 to gain meaningful employment in health and care
- join up activity across partner organisations in initiatives with schools to support increased capacity and impact
- develop joint or flexible posts and posts which offer a career development pathway between partners and across health and social care

We are conscious that our ability to influence the local community extends beyond workforce and we are actively undertaking a review of estates and facilities alongside partners to ensure we are optimising our physical estate and promoting environmental sustainability within this.



Credit: Health Foundation

Appendix

Appendix A:
What will success look like

How we will know we've succeeded

Start Well

Strategic outcomes	JFP Outputs	Operational plan deliverables
I am safe. My family has what they need to look after me	Complete a serious violence needs assessment and develop a partnership response strategy Respond to the findings of the national audit of domestic abuse support in healthcare settings Map models of intervention for domestic abuse and adopt and spread best practice develop pathways for non-fatal strangulation, honour and faith-based abuse FGM and forced marriage Respond to children who are experiencing low levels of domestic abuse Ensure meaningful data collection to contribute to developing a better system understanding of domestic abuse Develop an ICB wide learning culture and ensure safeguarding training is of a high quality	
I know what I can do to stay healthy	Pilot health weight, diet and exercise support before LMNS roll out Develop our programme for early support and intervention	
My Mental health matters and I can get help when I'm struggling	Build on Trauma Informed Care Programme to provide early intervention and prevention to support vulnerable children and young people Support perinatal mental health enabling improved access and increased offer of psychological interventions Improve access to mental health support for children and young people	Improve access to mental health support for CYP in line with the national ambition Improve access to perinatal mental health services

Strategic outcomes	JFP Outputs	Operational plan deliverables
My Mental health matters and I can get help when I'm struggling	Support perinatal mental health enabling improved access and increased offer of psychological interventions Reduce reliance on inpatient care so that by March 2024 no more than 12-15 under 18s with a learning disability and/ or autism per million are cared for in an inpatient setting Ensure that 75% of people aged over 14 on a GP learning disability register receive an annual health check and action plan	
There are exciting career opportunities for me	Introduce health inequalities opportunities for health and care staff in HNY	
It is easy for me to get the support I need for my child	2nd round of Ockenden peer review visits - evidence of safe, high quality care CNST adherence including working to achieve Saving Babies Lives and support for gestational diabetes Implementation of 3 year plan including new Pelvic Health services Continue improvement against BAPM neonatal standards pre-term birth support Continue research work with University of Hull research work into alcohol in pregnancy Support LMNS equality and diversity programme to ensure equity Continue to support recruitment and retention in trusts to maintain required staffing levels for maternity services Develop strategy with HNY wider workforce supply planner Implement maternity support worker scheme to ensure consistent competencies Complete implementation of BadgerNet single maternity IT system Ensure Yorkshire and Humber Care Record embedded for contextual launch Review SI and quality performance for true data comparison and learning	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury Increase fill rates against funded establishment for maternity staff

Strategic outcomes	JFP Outputs	Operational plan deliverables
It is easy for me to get the support I need for my child	Scope e-red book provision with partners Use a data driving approach to identify inequalities in access and experience for children and young people in mental health services Trial the risk stratification tool for action for children and young people with asthma Improve access to digital technology to manage diabetes Roll out to all places the diabetes poverty proofing project Benchmark services against core standards for children with epilepsy to identify priority areas for improvement Deliver and evaluate our pilot programme with specialised nurse practitioners for children and young people with asthma Embed a pathway between primary and secondary care to delivery national asthma standards Increase access to dental services and improve oral health Use data tracking and local feedback to identify areas of concern and risks for urgent and emergency care attendances Develop a joint strategy including personalisation planning Ensure Continuity of Carer teams are supported and developed in deprived areas Continue provision of 'Ask a Midwife' service including birth plans, translation and interpretation support, surrogacy guidance	

Live Well

Strategic outcomes	JFP Outputs	Operational plan deliverables
I am on top of my condition and I know what to do if I need help	Improve diagnostics for cancer - focussing on liver surveillance and cytosponge delivery	Meet the cancer faster diagnosis standard by March 2024
	Support awareness and diagnosis of cancer - targeting the 20% most deprived areas	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the early diagnosis ambition by 2028
	Deliver our programme of Living with and beyond cancer	
	Build on the early implementer site for Community Mental Health Transformation to continue to increase access to mental health support in the community	Increase the number of adults and older adults accessing IAPT treatment
	Develop a 3 year plan for inpatient services across Mental Health, Learning Disabilities and Autism	Achieve a 5% on year increase in the number of adults and older adults supported by community mental health services
	Develop working arrangements with transforming care partnerships to deliver key priorities across learning disabilities and autism	Work on eliminating inappropriate adult acute out of area placements
	For people in MH crisis expand the use of MH response vehicles following successful implementation on our patch via the Yorkshire Ambulance Service (YAS)	Reduce reliance on inpatient care, while improving the quality of inpatient care for adults with a learning disability and/or who are autistic
	Ensure sustained improvement for the delivery of annual health checks for people with serious mental illness	Ensure 75% of people aged over 14 on GP learning disability registered receive an annual health check and health action plan by March 2024
	Work with maternity programme to support perinatal mental health enabling improved access an increased offer of psychological interventions	
	Continue to invest in Health and Wellbeing programmes	

Strategic outcomes	JFP Outputs	Operational plan deliverables
I am on top of my condition and I know what to do if I need help	Work with partner organisations to get closer to people suffering from health inequalities Support more people and communities directly to increase digital access and support a digital strategy Develop approach to addressing multi-morbidity starting with our cardiovascular disease detection and prevention plan Develop strategies that focus on prevention for people with 1 long term health condition Support investment at place including local authorities to target inequalities Increase percentage of patients with hypertension treated to NICE guidance Increase percentage of patients aged between 25 and 84 years old with a CVD risk score greater than 20% on lipid lowering therapies Address health inequalities and make every contact count through our Winter Vaccination Board Roll out the spring COVID booster campaign and plan for an anticipated COVID autumn booster campaign	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024 Increase number of patients on lipid lowering therapies
I get the care I need and don't get passed back and forth or get forgotten on a waiting list	Planning, delivering and transforming services together with the planned care strategy Work with clinical networks to share best practice and reduce unwarranted variation The electronic patient record programme to support digital modernisation Work together to ensure the clinical sustainability of fragile services Implementation of prioritisation of people with learning disabilities on the waiting list Improve treatment pathways including a stocktake of non-surgical oncology Increase uptake and expansion of the Lung Health Checks programme	Continue to reduce the number of patients waiting over 62 days

Strategic outcomes	JFP Outputs	Operational plan deliverables
I get the care I need and don't get passed back and forth or get forgotten on a waiting list	Support the 65 week delivery target through maximising capacity and utilising mutual aid	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
	Support waiting list reduction by reducing the number of follow ups without a procedure	
	Optimise productivity through collectively utilising capacity	Deliver the system specific activity target
	Plan, develop and implement the community diagnostic model with a target of 3% DNA for endoscopy and physiology	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 Ambition of 95%
	Agree utilisation improvement targets across modalities	Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and a the diagnostic waiting time ambition
	Continue development of our neighbourhood teams	
	Utilise our Additional Roles Reimbursement Scheme to recruit an additional 217 individuals across Primary Care Networks	Continue to recruit ARRS roles by the end of March 2024
	Make it easier for people to contact a GP practice so that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently as assessed the same or next day according to clinical need	Make it easier for people to contact a GP practice Continue the trajectory to deliver more appointments in general practice by March 2024
	Increase access to primary care by providing additional appointments and increasing the number of appointments available	Continue the trajectory to deliver more appointments in general practice by March 2024
	Increase access to dental services with continued investment through procurements and flexible commissioning models	Recover dental activity improving units of dental activity towards pre-pandemic levels
	Continue to share best practice through a range of forums, showcase events, videos and case studies	
	Explore ways for the VCSE sector to engage in the design of services	
	Reduce unheralded walking patients to Emergency Departments	Improve A&E waiting times by March 2024
	Reduce the number of hospital conveyances, both to Emergency Departments and other hospital settings	Improve CAT 2 response times across 2023/24
	Support improved CAT 2 response times by reducing conveyances to hospital	Improve CAT 2 response times across 2023/24

Strategic outcomes	JFP Outputs	Operational plan deliverables
I get the care I need and don't get passed back and forth or get forgotten on a waiting list	Improve ambulance handover times within emergency departments	Improve CAT 2 response times across 2023/24
	Reduce overcrowding in Emergency Departments	Improve A&E waiting times by March 2024
	Support the reduction in >12 hour waits in emergency departments	Improve A&E waiting times by March 2024
	Undertake a full review of all urgent treatment centres	
	Improve type 3 performance reported and subsequent overall 4 hour standard support reduction in emergency department crowding and time in department	Improve A&E waiting times by March 2024
	Ensure urgent treatment centres are compliant with national standards	
	Increase direct conveyance to urgent treatment centres supporting reduction in ambulance handover times and CAT 2 response	Improve CAT 2 response times across 2023/24
	Minimum opening hours of 12 hours a day 7 days a week to support same day emergency care	
	Align same day emergency care opening times to peak demand times	Improve A%E waiting times by March 2024
	Increase direct access to same day emergency care for 111, 999, crews on scenes and GPs without the need for ED assessment first	Reduce adult general and acute bed occupancy
	Implement referral based on exclusion criteria to maximise same day emergency care opportunities	Improve A&E waiting times by March 2024
	Increase 0 day lengths of stay	Improve A&E waiting times by March 2024
	Reduce emergency department crowding and wait times - improving 4-hour standard	Reduce adult general and acute bed occupancy
	Co-ordinate an integrated high intensity user programme across the ICS	Improve A&E waiting times by March 2024
	Reduce the number of patients classed as high intensity users	Reduce adult general and acute bed occupancy
	Reduce re-attendance rates	
	Increase the number of alternative care pathways available to patients which avoid emergency department and hospital	

Strategic outcomes	JFP Outputs	Operational plan deliverables
I get the care I need and don't get passed back and forth or get forgotten on a waiting list	Develop the peri-operative business case Submit business cases for the hub and spoke model for Community Diagnostic Centres Implement the Scunthorpe Community Diagnostic hub Undertake detailed modelling and engagement on our planned care 5 year strategy and approach Consult on a set of proposals for the Humber Acute Services Review Understand current services, effectiveness and risks for pharmacy, optometry and dental services Align the Yorkshire and Humber screening and immunisation health inequalities action plan with ICB priorities Work on identified clinical pathways to test out new ways of working for specialised services	
I feel included - I have a place to belong	Improve data quality and reporting on health inequalities and develop a health inequalities plan across acute care Continue to develop our Core20PLUS5 ambassadors to promote health and wellbeing and reduce inequalities Focus on digital inclusion, increasing the number of eligible population registering for the NHS App Continue to embed a personalised care ethos Connect with thriving communities through personalised care Enrich personalised care approaches across health and care Increase the numbers of organisations engaged, increasing levels of diversity Track the reach of communications and public engagement Support co-design within communities to ensure a diverse perspective on development and planning	

Strategic outcomes	JFP Outputs	Operational plan deliverables
I feel included - I have a place to belong	Work through VCSE organisations to engage with people in coastal communities to understand their specific health and wellbeing needs	
	Increase utilisation of the VCSE sector to promote, engage and advocate for peoples' voice	Continue to address health inequalities and deliver on the Core20PLUS5 approach
	Support greater understanding of communities across HNY and what matters to them	Continue to address health inequalities and deliver on the Core20PLUS5 approach
	Embed Core20PLUS5 into integrated neighbourhood teams, starting in our coastal areas	Continue to address health inequalities and deliver on the Core20PLUS5 approach
	Address asylum seeker health needs	
	Scope out an inclusion health service that reaches all parts of the system	
	Provide tools to improve population health and reduce variation through roll out of PHM support across primary care networks	
	Integration Needs Assessment to make recommendations of where further integration should take place	
	Develop strategy to address health inequalities in coastal and port communities	Continue to address health inequalities and deliver on the Core20PLUS5 approach
I find ways to stay active and keep health that work for me	Utilise our Additional Roles Reimbursement Scheme to recruit an additional 217 individuals across Primary Care Networks	
	Develop a consistent approach to the management, recruitment and development of volunteers	
	Ensure that the wider determinants of ill health are considered in ICB planning	
	Influence and shape future investment in the VCSE sector to increase sustainability	

Strategic outcomes	JFP Outputs	Operational plan deliverables
I quit smoking and I feel great	Implement a universal incentive scheme for tobacco control for smoking in pregnancy Invest in lung health checks Embed tobacco control in nursing and midwifery Launch media and communications campaign for tobacco control Prepare for the launch of the full model for tobacco control in 2024/25	
I have meaningful employment despite the barriers I face	Provider collaborative development programme for staff health and wellbeing, diversity and inclusion Offer every newly qualified GP and Practice Nurse access to our fellowship programme	

Age Well

Strategic outcomes	JFP Outputs	Operational plan deliverables
I only go into hospital If its absolutely necessary	Reduce unnecessary admissions and conveyance to Emergency Departments through understanding alternative pathways that would support wider admission avoidance Improve data quality and implement faster data flows in community to support admission avoidance Complete waiting list audit to ensure we give visibility to the total waiting list and support a reduction in the overall waiting list Provide system wide support to clinical networks to support a reduction in inequalities and improve health outcomes Utilise our Additional Roles Reimbursement Scheme to recruit an additional 217 individuals across Primary Care Networks	Continue to recruit ARRS roles by the end of March 2024

Strategic outcomes	JFP Outputs	Operational plan deliverables
I only go into hospital If its absolutely necessary	Make it easier for people to contact a GP practice so that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently as assessed the same or next day according to clinical need Increase access to primary care by providing additional appointments and increasing the number of appointments available Continue development of our neighbourhood teams	
I can get advice and support for my health at home or nearby	Increase the number of crisis first care contacts to reduce admissions to hospital Increase the number of crisis first care contacts to reduce admissions to hospital Better understand the value of virtual wards to help inform their utilisation	Consistently meet or exceed the 70% 2 hour urgent community response standard Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
I can get advice and support for my health at home or nearby	Complete system wide programme of support for a new model of intermediate care to support discharge and increase bed capacity through reducing 'no criteria to reside' Improve discharge pathways to reduce the number of bed days lost and improve patient flow Roll out OPTICA and virtual ward automation digital applications to support urgent and emergency care bed occupancy	

Strategic outcomes	JFP Outputs	Operational plan deliverables
I can get advice and support for my health at home or nearby	Utilise remote monitoring funding to purchase and deploy equipment in the pathways and places most challenged Focus on levelling up delivery against the dementia diagnosis targets across HNY so that resource is directed to places where the biggest improvements are needed	Recover the dementia diagnosis rate to 66.7%
I am as active as I can be	Continue to invest in Health and Wellbeing Programmes in Primary Care	
My wishes are known and respected	Increase the use of rehabilitation and reablement and support at home for palliative care	
We are able to talk confidently with patients about their end of life wishes	Develop an ICS strategy for palliative and end of life care for children and young people	
My wishes are known and respected	Develop the ICB strategy and delivery plan, responding to the priorities identified in the stocktake	

Humber and North Yorkshire
Health and Care Partnership

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Health and Wellbeing Board **25 July 2023**

Report of the Acting Director of Public Health and the NHS Place Director for York, York Health and Care Partnership

Discussion Paper: Review/Reset of York's Health and Wellbeing Board (HWBB)

Summary

1. Over the past 18 months there have been many changes within the health and social care system; including the abolition of Clinical Commissioning Groups (CCGs) and the introduction of Integrated Care Boards (ICBs) and associated Place Executive Committees Additionally, the Health and Wellbeing Board have approved a new 10-year Joint Local Health and Wellbeing Strategy and delivery action plan.
2. These provide the HWBB with an opportunity to review how it might want to operate during the coming years.
3. As a reminder, this report sets out the statutory functions of the HWBB as well as its status within the new NHS arrangements. However, this is predominantly a discussion paper for HWBB members to consider a variety of ideas to shape the HWBB going forward. The intention is to use the discussion to revise the HWBB Terms of Reference and present these at the September meeting of the board for approval before they are submitted to Full Council for inclusion within the local authority's constitution.

Background

4. Health and Wellbeing Boards have been a key mechanism for driving joined up working at a local level since they were established in 2013. The Health and Social Care Act 2022 abolished CCGs and replaced them with Integrated Care Boards which cover a larger geographic area; these take on the commissioning functions of the CCGs. Each area within an ICB has its own 'place' Executive Committee (in York this is the 'York Health and Care Partnership Executive Committee (shadow)') and the HWBB receives regular updates from them.
5. The Health and Social Care Act 2022 did not change the statutory duties of the HWBB as set out by the 2012 Act but established new

NHS bodies known as ICBs and required the creation of Integrated Care Partnerships (ICPs) in each local system.

6. HWBBs continue to be responsible for:

   - Assessing the health and wellbeing needs of their population and publishing a Joint Strategic Needs Assessment (JSNA)
   - Publishing a Joint Local Health and Wellbeing Strategy (JLHWS) which sets out the priorities for improving the health and wellbeing of its local population and how the identified needs will be addressed, including addressing health inequalities, and which reflects the evidence of the JSNA
   - The JLHWS should directly inform the development of joint commissioning arrangements at place level and the co-ordination of NHS and local authority commissioning, including Better Care Fund plans
   - Each HWBB also has a separate duty to develop a Pharmaceutical Needs Assessment (PNA) for their area

7. HWBBs remain a formal statutory committee of the local authority, and will continue to provide a forum where political, clinical, professional and community leaders from across the health and social care system come together to improve the health and wellbeing of their local population and reduce health inequalities. The core statutory membership of HWBBs is unchanged other than requiring a representative from ICBs, rather than CCGs. Given the greater number and organisation of functions aligned to ICBs compared to CCGs there may be cause to expand ICB membership beyond one member representative. HWBBs can continue at their discretion, to invite other organisations to join the HWBB.

8. Considering the above the HWBB are provided with an opportunity to discuss and shape the work and direction of the HWBB going forward. Some areas for discussion are highlighted below.

Working better together as a system

What does the guidance say?

9. Both local authorities and ICBs must have regard to the relevant JSNAs and JLHWSs so far as they are relevant when exercising their functions. NHS England must have regard to these documents so far as relevant, in exercising any functions in arranging for provision of health services in relation to the geographical area of a responsible local authority.

10. Health and Wellbeing Board guidance released in November 2022 by the Department of Health and Social Care supports ICB and ICP

leaders, local authorities and Health and Wellbeing Boards to understand how they should work together to ensure effective system and place-based working, following the principle of subsidiarity. It sets out the expectation that all partners (HWBBs, ICBs and ICPs) adopt a set of principles in developing relationships, including:

- Building from the bottom up
- Following the principles of subsidiarity
- Having clear governance, with clarity at all times on which statutory duties are being discharged
- Ensuring that leadership is collaborative
- Avoiding duplication of existing governance mechanisms
- Being led by a focus on population health and health inequalities

11. ICB and ICP leaders, informed by people in their local communities, need to have regard for and build on the work of the HWBB to maximise the value of collaboration and integration.

What are the system arrangements?

12. Within the Humber and North Yorkshire ICB there are six Places, one of which is York. ICB teams work with partners at place to support the integration of services and improved outcomes, working alongside the six Health and Wellbeing Boards. NHS provider organisations remain separate statutory bodies and retain their current structures and governance and work collaboratively with partners at place. As part of these local place arrangements, groups of GP practices, known as Primary Care Networks, work together as well as with the other providers to focus on planning and delivering services to meet local patient health and care needs. Please see 'Working better together as a system' in annex A for further details of the ICB's operating arrangements.
13. In York Place we have the York Health and Care Partnership Executive Committee (shadow) which is the delivery arm of the HWB strategy and the ICP strategy in York. It also has its own Place Plan (aligned to the JLHWS) which it shares with the Health and Wellbeing Board.
14. HWBBs will continue the relationships they had with CCGs with ICBs, and this includes receiving the York Place Plan and ICB Joint Forward Plan for discussion.
15. **Joint Forward Plans:** Before the start of each financial year an ICB, with its partner NHS Trusts must prepare a 5-year Joint Forward Plan, to be refreshed each year. ICBs must involve HWBBs as follows:

- Joint Forward Plans (JFPs) for the ICB and its partner NHS trusts must set out any steps that the ICB proposes to take to implement Joint Local Health and Wellbeing Strategies
- ICBs and their partner NHS trusts must involve each relevant HWBB in preparing or revising their forward plans
- In particular, the HWBB must be provided with a draft of the JFP, and the ICB must consult with the HWBB on whether the draft takes proper account of its Joint Local Health and Wellbeing Strategy
- Following consultation, any HWBB within the ICB's area has the right to respond to the ICB and may give its opinion to NHS England
- Within the ICB's JFP, it must include a statement from the HWBB as to whether the JLHWS has been taken proper account of within the JFP

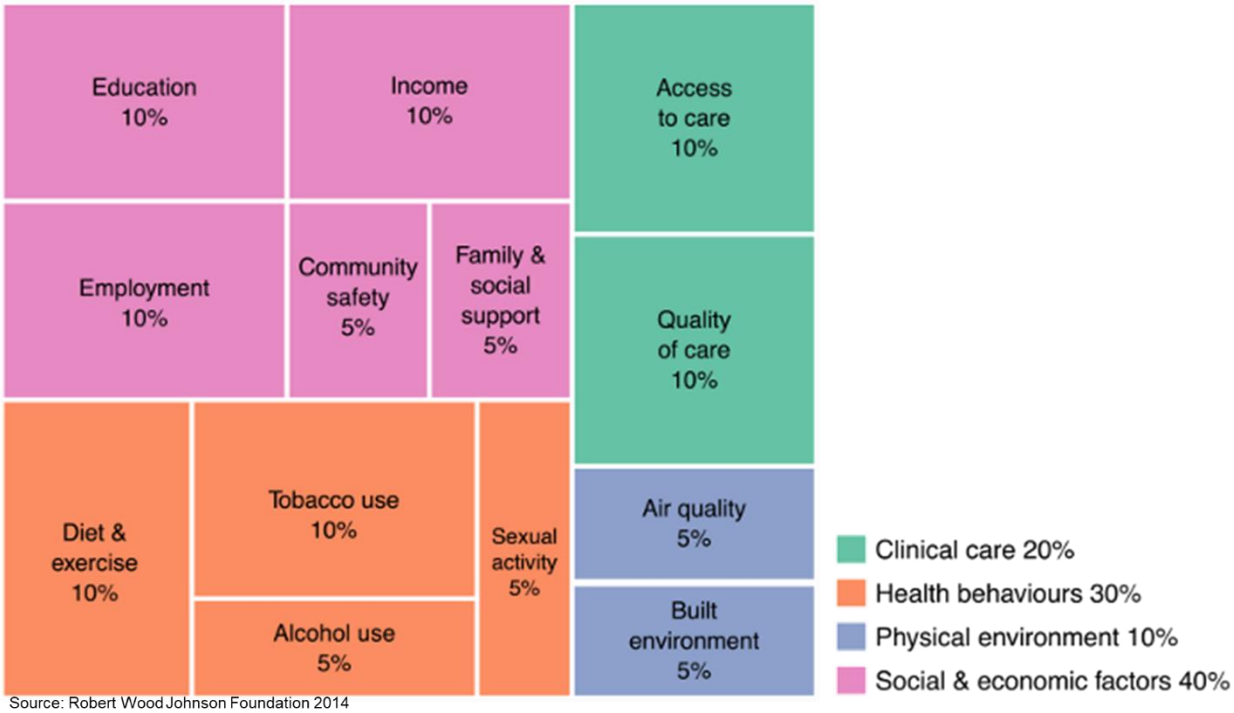
16. **Annual Reports**: ICBs are required as part of their annual report to review any steps they have taken to implement the JLHWS. In preparing this review the ICB must consult the HWBB.
17. **Performance Assessments**: in undertaking its annual performance assessment of an ICB, NHS England must include an assessment of how well the ICB has met the duty to have regard to the relevant JSNAs and JLHWSs within its area. In conducting the performance assessment, NHS England must consult each relevant HWBB for their views on the ICB's contribution to the delivery of any JLHWS to which it is required to have regard.
18. **Integrated Care Strategies**: All HWBBs within an ICB area should be involved in the preparation of system-wide integrated care strategies that will tackle some of the challenges that are best dealt with at a system level (for example, workforce planning)
19. It is recommended that the paragraphs above are reflected in a revised Terms of Reference for the HWBB; to be presented to the Board in September 2023.
20. Additionally, there are several sub-groups within the ICB both at regional and place level (e.g., the Place System Quality Group). HWBB may wish to discuss what, if any, relationship/input they need to have with these.

Membership

21. In legislation the membership of the HWBB must include at least one councillor of the local authority, the Director of Public Health for the local area, the director of adult social services for the local authority, the director of children's services for the local authority, a representative for the local Healthwatch, a representative of the ICB and such other persons, or representatives as the local authority thinks appropriate

22. The current membership of the HWBB has been broadened and comprises four elected members, the Director of Public Health for York, the Corporate Director of Adults and Integration at City of York Council, the Corporate Director of Children and Education at City of York Council; Humber and North Yorkshire Health and Care Partnership, NHS England and Improvement; Healthwatch York; York and Scarborough Teaching Hospitals NHS foundation Trust; Tees, Esk and Wear Valleys NHS Foundation Trust; York CVS; North Yorkshire Police; Independent Care Group; York Health and Care Collaborative.

23. Having the right people around the HWBB will assist with the delivery of the priorities within the Joint Local Health and Wellbeing Strategy 2022-32 and our local vision to make York a healthier and fairer city. HWBB may also want to consider whether they would wish to adjust the content of their agendas (see section later in the report) as well as the weight of the HWBB membership to better reflect a focus on the wider determinants of health. These are described in the diagram below:



Source: Robert Wood Johnson Foundation 2014

24. Acknowledging the number of representatives already around the HWBB table, members of the HWBB are encouraged to discuss their membership and reflect on whether this should be changed and/or broadened to better reflect the wider determinants of health and the new strategy's overarching goal to reduce the gap in healthy life expectancy between the richest and poorest communities in York. A wider membership could strengthen the existing partnership arrangements and lead to a wider range of contacts with York's population. This could include representatives from housing, fire and rescue service, economy (local business), community pharmacy, higher education and other service areas and organisations that the HWBB may feel are required.

25. In the current Terms of Reference, the vice-chair of the HWBB was the chair of the now abolished CCG. HWBB members may want to consider whether this role should pass to the representative of the ICB or whether different arrangements should be introduced.

Sub-structure

26. The Health and Wellbeing Board currently has several sub-groups that sit beneath it. These groups were established to deliver on the previous Joint Health and Wellbeing Strategy but have morphed and developed over time with some now working to a much wider and more flexible remit.

27. It would be timely to review the Board's current sub-structure in terms of where these groups should sit going forward and whether they still need to be sub-groups of the HWBB.

28. **Mental Health Partnership**: this is a well-attended and strong partnership that has been leading on the Connecting Our City project and on mental health transformation within the city. The partnership has been intrinsic in advising how community transformation monies are spent across the system and have been key in establishing a mental health hub within the city. To strengthen the role of the partnership and allow for them to both further develop the mental health hub model and have a stronger mandate around the spending of community transformation monies across the system HWBB are asked to consider transferring this group to sit beneath the York Health and Care Partnership Executive Committee (shadow) as the transformation funds flow down from NHS England through the wider system.

29. HWBB would still have a strong relationship with the partnership and receive an annual update on their work; specifically, around how the partnership has worked to deliver the mental health focused priorities within the new Joint Local Health and Wellbeing Strategy.

30. The Terms of Reference for this group will need to be reviewed to reflect the NHS Reforms, the Connecting Our City project work, the Community Mental Health Transformation Fund and any new reporting arrangements that are agreed.

31. **Ageing Well Partnership**: This is a strong and active partnership that HWBB originally created to lead on the Age Friendly City work and to be part of developing a Dementia Strategy for the city. This work continues and the HWBB receive updates on both these pieces of work at least once a year. Consideration needs to be given as to whether this partnership needs to be a formal sub-group of the HWBB or whether it could continue in a more flexible way with its governance aligned elsewhere. HWBB could still ask for annual reports from the group should they wish to do so. Again, it would be timely to request a review of its Terms of Reference.

32. **Children and Young People's Health and Wellbeing Programme:** this sub-group was created to specifically focus on children and young people's health, including maternal health. It is also the overseer of the development of a new Children and Young People's Plan for the city. There is work going on, led by the York Health and Care Partnership, to map the groups/committees that have children and young people as part of their remit. Considering this it is suggested that this group is temporarily suspended to ensure that there isn't any duplication of work across groups. Once this piece of work has been completed a decision can be made on whether this group should remain a sub-group of the HWBB, be disbanded, aligned to another board, or be re-constituted with a more specific remit.

33. **York Health and Care Collaborative**: this group have been reporting to the HWBB as a sub-group for several years. It is suggested that this group continues to report to the Health and Wellbeing Board.

34. **The Population Health Hub** also reports to the HWBB and has delegated responsibility for producing a JSNA and keeping this up to date on behalf of the HWBB. It is suggested that this arrangement remains the same with the group providing the HWBB with an annual update on their work in January of each year.

35. There are many other groups within the city focused on specific themes and/or service provision. Some of these will have mention of the HWBB in their Terms of Reference and may request to bring update/progress reports to the HWBB.

Agenda Management

36. The HWBB has a broad focus of work, a new 10-year Joint Local Health and Wellbeing Strategy and a live action plan to deliver this. There is also a commitment to reduce health inequalities in the city. HWBB are asked to consider the make-up of future agendas to be responsive to this and to the recent NHS Reforms. One suggestion would be to split agendas into thirds as follows:

    - 1/3 Integration and determinants of health attributable to health and social care services (to include, but not restricted to, reports from the York Health and Care Partnership Executive Committee (shadow), Humber and North Yorkshire Integrated Care Board functions that the HWBB determine to have sight of; Better Care Fund; some Healthwatch York reports)
    - 1/3 Wider Determinants of Health (such as education, housing, employment, social isolation, poverty) (to include, but not restricted to, the Joint Local Health and Wellbeing Strategy action plan to assure the HWBB that the strategy is being delivered and making a difference, some Healthwatch York reports, and discussion about specific topics that impact health).
    - 1/3 Future Focus & Partnerships (this could include updates from any partnerships that have a relationship with the HWBB such as the Ageing Well Partnership. This section would also afford the HWBB the space to discuss broader plans to meet longer term local health challenges (3 years +) which require consideration of health and care as well as social and economic factors, for example workforce and estates planning and the role of digital and technological innovation.

Governance

37. The current Terms of Reference for the HWBB do not give any guidance on voting. HWBB are asked to discuss whether they wish to include anything on voting within a revised Terms of Reference (ToR). Many HWBBs do have something about this in their ToR and this can range from all members of the Board being entitled to vote with decisions being taken by the majority vote (chair having the casting vote) to only statutory members of the HWBB being able to vote. HWBB are asked to provide a view on whether they would like to include this in their revised Terms of Reference.

Consultation

38. This is a discussion document and thus the HWBB are being consulted on a variety of issues related to the Board's work.

Options

39. This is a discussion report and contains ideas and pointers rather than specific options. For ease of reference, and to recap, HWBB are asked to focus their discussion on the following:

    a. Discuss whether they are happy for the information in paragraphs **4-20** to be distilled and reflected in a revised Terms of Reference for the HWBB. This information covers the statutory functions of the HWBB and the ICB and ICP documentation they need to have regard to. HWBB are also asked to highlight anything they think might be missing from the information contained within these paragraphs

    b. Provide their thoughts on the membership of the HWBB including whether they wish to identify a named vice-chair **(paragraphs 21-25 refer)**

    c. Consider and discuss the sub-structure arrangements, if any, for the HWBB and whether some of the current partnerships need to realign to the York Health and Care Partnership Executive Committee (shadow) **(paragraphs 26 to 35 refer**)

    d. Discuss how they would like to manage agenda items at future meetings **(paragraph 36 refers)**

    e. Consider whether they wish to include voting arrangements within their Terms of Reference **(paragraph 37 refers)**

Council Plan and other strategic plans

40. Maintaining an appropriate decision-making function and reviewing how the Board operates, contributes to the Council delivering its core priorities set out in the current Council Plan. It also ensures the Board is effectively aligned to the new NHS arrangements. Updating the Board's terms of reference ensures that partnership working is central to all organisations represented at the HWBB.

Implications

41. The Council is statutorily obliged to appoint a Health & Wellbeing Board and its terms of reference should be approved by the Council, given that the Board acts as a Committee of the Council. Following any review of, or proposed alteration to, the terms of reference by the

Board, it is therefore appropriate for any changes to be referred to Full Council for ratification.

42. The HWBB has no decision-making responsibilities for service provision or finance. There are no known implications in this report in relation to the following:

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

Risk Management

43. In compliance with the Council's risk management strategy, the only risks associated with the recommendations in this report are that the Council would fail in its statutory obligation if the terms of reference were not reviewed, updated, and confirmed. Additionally, if the HWBB does not deliver against the ambitions and goals in its Joint Local Health and Wellbeing Strategy the overarching goal of reducing the gap in healthy life expectancy between the richest and poorest communities in York might not be met.

Recommendations

i. The HWBB are asked to discuss the themes highlighted in this report with specific reference to the summary set out in paragraph 39 of this report.

ii. Following on from this that any changes to the Board's Terms of Reference be brought back to the September meeting of the HWBB for approval before being referred to Full Council for approval.

iii. For the Monitoring Officer to ensure that the Council's Constitution is updated to incorporate any revisions to the Terms of Reference once they have been agreed by the HWBB and by Full Council.

Reason: In order to ensure that the Health and Wellbeing Board continues to undertake its statutory functions appropriately and effectively and continues to strengthen local partnership arrangements.

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Chief Officer Responsible for the report:

Peter Roderick
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Sarah Coltman-Lovell
NHS Place Director for York
York Health and Care Partnership

Report Approved ✓ **Date** 30/06/23

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers
Joint Local Health and Wellbeing Strategy

Annexes
Annex A: Working Better Together as a System

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Humber and North Yorkshire
Health and Care Partnership

NHS

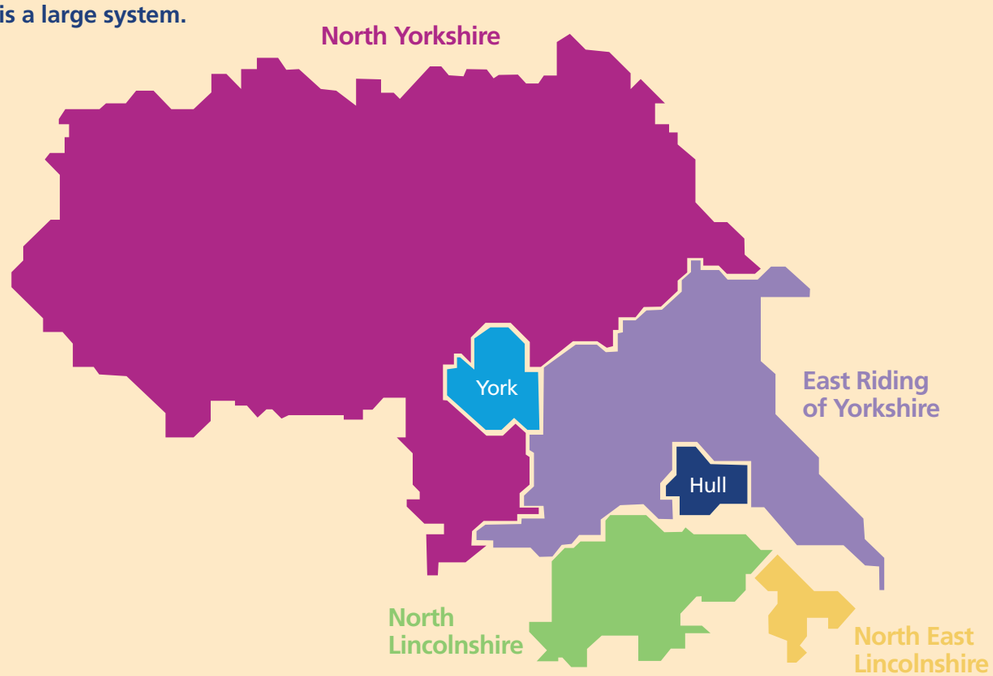
Working better together
as a system

Thank you for making time to read this at-a-glance guide to our Integrated Care System Operating Framework and our governance structures: Its deliberately brief, its deliberately straightforward. Its purpose is to provide an insight into how our integrated care system seeks to bring together all partners and stakeholders in the joint ambition of improving the health, care and wellbeing of our population. At the end, we provide you with 10 simple ways of checking that our ICS is delivering its operating model and governance framework effectively.

Sue Symington
Chair

Our **partnership**

By working as a system, we mean bringing together all of the resources in Humber and North Yorkshire, together, to best serve our population. This is a complex challenge, because ours is a large system.



6 local authorities

550 care homes

Population of 1.7 million people

c. 4000 square miles
185 miles of coast

7 NHS Trusts

42 Primary Care Networks

1,000's of volunteers

50,000 staff

A budget of £3.5 million

Our complex **challenges**

The challenges our system faces are significant.

20% of children live in low-income families

16% of adults have high blood pressure

1 in 8 people smoke

27,160 GP appointments every week

8 children in 1,000 in our system live in care

48,655 people receiving mental health services*

*February 2023

76.6% of adults are employed

185,507 people waiting for hospital appointments**

31% of people over 65 live alone

**May 2023

Our ambition is for everyone in our population to live longer, healthier lives by narrowing the gap in healthy life expectancy between the highest and the lowest levels in our communities by 2030 and increasing healthy life expectancy by five years by 2035.

To reach that ambition our vision is to ensure that all of our people:

Start Well
We want every child to have the best start in life and enable everyone to be safe, grow and learn.

Live Well
We want to ensure the next generation are healthier than the last and have the opportunity to thrive.

Age Well
We want to ensure people live healthy and independent lives as long as possible by understanding what matters most to them.

Die Well
We want to create an environment in which people can have positive conversations about death and dying.

Our **operating arrangements**

To work together effectively, to seek solutions to the challenges we face and to meet our ambitions for our population, it is important that we organise our partnership, its governance and its accountabilities in a way which is accessible, easy to understand and that reduces bureaucracy. The following describes the four core elements of an Integrated Care System.

Places

Our places connect local authorities, the NHS and providers of health and care. We have six places: North Yorkshire, York, Hull, the East Riding, North Lincolnshire and North East Lincolnshire. ICB teams work with partners at place to support the integration of services and improved outcomes, working alongside the six Health and Wellbeing Boards. NHS provider organisations remain separate statutory bodies and retain their current structures and governance and work collaboratively with partners at place. As part of these local place arrangements, groups of GP practices, known as Primary Care Networks, work together as well as with the other providers to focus on planning and delivering services to meet local patient health and care needs.

Integrated Care Board

The Integrated Care Board is directly accountable for NHS expenditure and performance within the system, as it relates to the Integrated Care Strategy and delivery plans. As a minimum, the ICB board must include a chair and two non-executives, the ICB chief executive and clinical and professional leaders, and representatives from NHS trusts, primary care and local authorities. The ICB board includes two statutory committees; Audit and Remuneration. Other committees focus on oversight and assurance and provide the board with assurance on the delivery of key priorities including system quality and finance.

Integrated Care Partnership

The Integrated Care Partnership is a statutory committee which connects the ICB and Local Government. It has developed an Integrated Care Strategy which addresses the health, social care and public health needs of our system. The membership and detailed functions of the ICP is decided by its partner members. The ICP focuses on the connections between health and the wider determinants of health, including socio-economic development, employment and environment. Partners adopt a collective approach to decision-making and support mutual accountability across the ICS.

Sector Collaboratives

Our five Sector Collaboratives ensure each health and care provider is part of a larger grouping which seeks to deliver the strategic priorities for their sector together and includes primary care, acute care, mental health, community care and voluntary and third sector activity. Members of the collaborative agree together how this contribution will be achieved in line with the overall Integrated Care Strategy and delivery plans.

Functions and decisions map

Integrated Care Partnership (ICP)

Key role and responsibilities are to:

- Develop and agree an **integrated care strategy** across Humber and North Yorkshire
- Make recommendations to the ICB on delivery of integrated care strategy
- Have **oversight** of delivery of the integrated care strategy
- Work effectively, collaboratively with partners and to have **shared accountability**.
- **Membership:** ICB Independent Chair, representatives from the ICB, local authorities, Healthwatch, and other partner organisations.

Strategy ⟷

Health and Wellbeing Boards (HWBB)

Key role and responsibilities are to:

- Agree the **Joint Strategic Needs Assessment** and the Joint Health and Wellbeing Strategy for their Place
- Encourage the organisations that are responsible for commissioning health or social care services to work together and to work closely with the Board

A partnership between each local authority and Place: York, East Riding, Hull, North Lincs, North East Lincs and North Yorkshire.

Strategy ↓

Integrated Care Board (ICB)

Key role and responsibilities are to:

- Develop and agree a **5 year delivery plan** that reflect the integrated care strategy
- Discharge the functions of an ICB including the accountability for **NHS spend and performance**
- Hold the executive to account for financial and operational objectives delivery
- Create an environment and conditions for **effective partnership working**

Membership: Independent chair, chief executive, executive directors, non-executive directors, and members selected from nominations made by trusts, local authorities and general practice, VCSE and HealthWatch.

Delegation ⟶

Accountability ⟵

Strategy ↓

Place Arrangements

Key Role and Responsibilities are to:

- Deliver integration and service transformation in line with Place priorities and as required to deliver outcomes for the population
- Address health inequalities at a Place level

Membership: Place chief executive lead, NHS Place based directors, NHS, public health, social care, local health and care providers, VCSE and HealthWatch.

Delegation ↓ **Assurance** ↑ **Agreements** ↕

Integrated Care Board Committees

Provide the Integrated Care Board with assurance about specific functions e.g. audit, risk, remuneration, quality, performance, finance.

Delegation ↓ **Assurance** ↑ **Agreements** ↕

Place committees (as required)

Provide the Place Committee with assurance about place delegated functions e.g. quality, finance if required.

Sector Collaboratives

Sector Collaboratives will deliver key responsibilities agreed with the ICB where it makes sense to work together across Humber and North Yorkshire to meet the needs of the population.

Provider Partnerships

Provider Partnerships will collaborate to deliver plans that transform services to meet the needs of the population in a specific place.

A strong system **working well**

The ultimate success of our Integrated Care System will be our population starting life well, living life well, ageing well and dying well.

To achieve this, we must have a system that works well. This document has sought to capture the ways in which we will formally arrange our governance to best serve our population and their care.

Here are 10 ways you can check that we have strong system which is working well

	ICB and ICP performance is reviewed annually and shared openly
	ICS progress in achieving strategy ambitions is measurable and shared openly
	The voice of lived experience is listened to and taken into account
	Joint working between all partners is evident and demonstrable
	Partnerships with business and organisations outside of health and social care, thrive and seek to improve the health of the population
	Learning and research is shared widely – both nationally and locally
	Activities are managed and delivered within the budgets allocated
	Decisions are made at the appropriate level – including across the whole system and specifically at place.
	A diary of governance meetings planned 18 months in advance
	Papers and minutes of public meetings are available on the website in a timely way and public meetings are also live streamed

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Publication date: June 2023

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Health and Wellbeing Board 25 July 2023
Report of the Manager, Healthwatch York

Healthwatch York Report: Breaking Point: A recent history of mental health crisis care

Summary

1. This report is for the attention and action of Board members, sharing a report from Healthwatch York which shares local experiences of seeking support for a mental health crisis in the city.

Background

2. Healthwatch York provides information and advice about health and care services, signposts people to support, and listens to their experiences when accessing health and care services. Whilst looking at people's experiences of urgent care, we recorded a number of stories relating to poor experiences of mental health crisis support. We began work to explore these experiences further. We worked with staff working in and alongside crisis care services to understand their views on support available.

3. We also worked with partner organisations York Mind and York Carers Centre, to reach out to and record the experiences of people with lived experience of mental ill-health and those caring for them.

4. We appreciate this has been a very difficult time for everyone working in health and social care. We aimed to produce a report that acknowledges the difficult national picture with regards to crisis care and to highlight the concerns being reported to us. We have shared this report to encourage further discussion of these challenges and consideration of ways we can collectively address them.

Main/Key Issues to be considered

Consultation

5. In producing this report, we held 1-2-1 interviews with people working in the local health and care system, people with experience of crisis care services, and carers supporting people who had experience of mental health crisis.

Options

6. There are two sets of recommendations within this report set out on pages 100-102. These are participant recommendations based on local experiences alongside further recommendations based on everything that was shared with Healthwatch York in developing the report. These recommendations are:

   i. Increased provision of preventative care so that fewer people end up in crisis in the first place

   ii. Lower level support: decrease the threshold for support so that people don't have to end up in crisis before they get support

   iii. Improved follow up after discharge or after calling the crisis line so that crisis is not a revolving door and people do not repeatedly find themselves in crisis

   iv. Strengthening the crisis line alongside promoting the second line for those who need support but are not in crisis

   v. Clarify what constitutes 'crisis' for both service users and professionals

   vi. Reinstate and strengthen the Mental Health Crisis Care Concordat to clarify care pathways, provide clear minimum performance standards for all those working in services, and make sure members of the public can access the right help and support at the right time delivered by appropriately trained professionals.

   vii. Review existing resources, support services and gaps in the pathway and identify the most effective ways to deliver support and fill gaps, including those best provided by the VCSE sector.

   viii. Restructure approaches to coproduction to make sure everyone's views and experiences are heard and influence service design and delivery. This must include working with external partners to facilitate involvement for those who cannot engage directly. Consideration must be made of the resource implications for VCSE organisations to make this possible.

ix. Learn from schemes improving people's experiences of crisis response / changing the system to identify ways to invest in and maintain those that work (for example, the positive feedback about police street support).

x. Make sure workforce plans reflect the specific challenges for attracting health and care staff to York (including lack of affordable housing, transport). Work together locally to learn from historical examples such as the Rowntree Housing model and how these fits with Local Plans.

xi. Embed a compassionate culture towards all people experiencing mental ill health.

Implications

7. There are no specialist implications from this report.

- **Financial**

There are no financial implications in this report.

- **Human Resources (HR)**

There are no HR implications in this report.

- **Equalities**

There are no equalities implications in this report.

- **Legal**

There are no legal implications in this report.

- **Crime and Disorder**

There are no crime and disorder implications in this report.

- **Information Technology (IT)**

There are no IT implications in this report.

- **Property**

There are no property implications in this report.

- **Other**

There are no other implications in this report.

Risk Management

8. There are no risks associated with this report.

Recommendations

9. The Health and Wellbeing Board are asked to:

   i. Receive Healthwatch York's report, Breaking Point: A recent history of mental health crisis care.

   ii. Confirm how they wish to be informed on progress against the recommendations within the report.

Reason: To keep up to date with the work of Healthwatch York, be aware of what members of the public are telling us and identify the best route for the development of partnership improvement plans.

Contact Details

Author:	**Chief Officer Responsible for the report:**
Siân Balsom Manager Healthwatch York 01904 621133	Siân Balsom Manager Healthwatch York 01904 621133

Report Approved	✓	**Date**	12/07/23

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:

Annex A – Breaking Point: A recent history of mental health crisis care
Breaking-Point-Mental-Health-Crisis-Care-June-2023-updated.pdf (healthwatchyork.co.uk)

Breaking Point

A recent history of mental health crisis care in York
June 2023

healthwatch York

Contents

Content warning: This report contains information that you may find distressing including repeated reference to mental ill-health, distress, suicide and suicide attempts, mental health stigma, self-harm and self-injury. We portray the subject of mental health crisis care from personal experiences with the purpose of creating positive change. Please be mindful of your own wellbeing in deciding whether to continue reading this report.

For further information on advice and support available in York please refer to our Mental Health and Wellbeing Guide[1]

1 https://www.healthwatchyork.co.uk/wp-content/uploads/2023/04/MHWguide_Final-draft_pr01-1.pdf

Acknowledgements

Thank you to everyone who took time to be interviewed or join a workshop and to all the people who have helped to develop this report.

Thank you to the organisations who gave permission to offer staff time including York CVS, York Mind, York Carers Centre, Tees Esk and Wear Valleys NHS Foundation Trust (TEWV), City of York Council (CYC), York & Scarborough Hospital NHS Foundation Trust (YSHNFT) and Changing Lives.

Thank you to the front-line mental health workers and the carers of people who have experienced mental health crisis care. And especial thanks to all the people with direct lived experience of mental health crisis care in the city who summoned the strength to recount their stories in hope of a better future for others. We hope this report does justice to your truth.

Cover image by Nik on unsplash

Introduction

This work aimed to capture the views and experiences of mental health crisis care from staff, patients and carers. By forming an understanding of the services in York for adults experiencing mental health crises, we aimed to identify ways to improve local services and support. Mental health is a key issue nationally and locally and there is a growing awareness that it is an area that needs urgent action. It is a priority for Healthwatch York and this project was carried out in the light of information already available, including our previous research and insights gained from feedback about the challenges faced by people when experiencing a mental health crisis.

The National Picture

There has been a problem in mental health crisis care across the country for at least the last ten years, despite commitments being made both nationally and locally. A Mind report from 2011[2] highlighted the importance of treating service users with respect, courtesy, and kindness, and creating a culture of service, hospitality, and safety in mental health crisis care. The report recommended that acute and crisis mental healthcare services should learn from the examples of good practice that can be found across the system especially in voluntary services and private providers. They found a lack of humanity and individuality in mental health crisis care. They recommended that individuals' definitions of what constitutes a crisis should be respected. They also suggested, based on examples of good practice, the use of nurse-led teams and of peer support from those with experience of mental ill health.

In a 2012 publication[3] Mind looked at crisis care statistics and reached the conclusion that crisis services failed to support thousands of people every year. The report looked at information obtained via Freedom of

[2] https://www.mind.org.uk/media-a/4377/listening_to_experience_web.pdf
[3] https://www.mind.org.uk/news-campaigns/news/mental-health-crisis-care-services-under-resourced-understaffed-and-overstretched/

Information requests to mental health trusts which revealed that services were 'under-resourced, understaffed and overstretched'.

- Services were understaffed: four in ten mental health trusts (41 per cent) had staffing levels well below established benchmarks.
- People were not getting the help they need: there was huge variation in the numbers of people accessing crisis care services and one in five people (18 per cent) who came into contact with NHS services in crisis was not assessed at all. Only 14 percent of people said that, overall, they felt they had all the support they needed when in crisis.
- People weren't assessed quickly enough: only a third (33 per cent) of respondents who came into contact with NHS services when in crisis were assessed within four hours, as recommended by the National Institute for Health and Clinical Excellence (NICE).
- Services were not available all the time: one in ten (10 per cent) of crisis teams failed to operate 24-hour, seven-day-a-week services, despite recommendations by NICE.
- People could not contact crisis teams directly: only half (56 per cent) of crisis teams accepted self-referrals from known services users and just one in five (21 per cent) from service users who weren't already known to them. This was despite NICE guidance that crisis teams should offer self-referral as an alternative to emergency services.
- Fewer than a third (29 per cent) said they felt that all staff treated them 'with respect and dignity'.

This report painted a picture of inadequate mental health crisis care and demonstrated that those who suffer from mental health crises were being failed nationally.

The evidence from 2012 furthered the points made the previous year, that increased dignity and respect were needed alongside a culture change to one of kindness and hospitality. The lack of self-referral ability demonstrated that crisis services failed to accept and take into account individual definitions of what constitutes a mental health crisis.

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. Its role is to monitor, inspect and regulate services, including mental health services. CQC was asked by the government to try and better understand the perspectives of people who experienced a mental health crisis. The resulting report, 'Right Here Right Now'[4], published in 2015, detailed experiences of help, care and support during a mental health crisis. The review looked at the views of people who experienced a mental health crisis and the response they received. CQC wanted to understand whether people were being offered the right care at the right time, and if they were being given the information they needed. They also wanted to find out about the attitudes of those providing help, care and support. To produce the report CQC undertook:

- a national data review, 2011 to 2014
- a call for evidence in 2014 generating more than 1,750 responses
- a survey and mapping of health-based places of safety
- gathering information from local area inspections

The CQC review paid particular attention to cases of self-harm and to those detained under Section 136 of the Mental Health Act. It looked at their experiences of help, care and support from GPs, specialist mental health services and accident and emergency (A&E). People were asked whether they felt listened to and taken seriously, whether they were treated with warmth and compassion, and whether they felt judged. CQC found that, although there were examples of good practice, many people experienced problems getting help when they needed it, and found that healthcare professionals sometimes lacked compassion and warmth. Variation in responses was not just related to the local area but what part of the system people came into contact with. GPs and voluntary services scored well, but fewer than four in 10 respondents were positive about their experiences in A&E. Feedback also highlighted poor staff attitudes to injuries caused by self-harm. Other findings included:

[4] https://www.cqc.org.uk/publications/major-report/right-here-right-now-mental-health-crisis-care-review

- Many people went to see their local GP first when they were having a mental health crisis. 60% of people who visited their GP were satisfied with the experience.
- Most people reported that they came into contact with at least three different services when they had a mental health crisis. 12% said that they had come into contact with between six and ten services, indicating a need for better collaboration between services.
- People wanted to be involved more in their own care.
- The use of police cells as a 'place of safety' for people in crisis had fallen, but people under 18 can have problems accessing suitable places of safety.

GPs, ambulance services and police were seen as caring and empathetic. The voluntary sector and charities were also viewed as being more supportive. However, people's experiences in both A&E and specialist services were clearly inadequate. A&E had the lowest score of any service with only 36% of people saying they felt respected. Responses relating to self-harm were largely negative, with gaps in the service at times of high incidence (i.e. 11pm – 5am). The frequency of use of A&E for mental health was seen as an indicator that the system was not working at local levels. Irrespective of location or which services people came into contact with, only 56% said that the care they received helped, or was partially helpful in resolving their crisis.

In conclusion, CQC found that people often had poor experiences of mental health support and there was considerable variation across England. Although attitudes had improved there was still a long way to go until people experiencing a mental health crisis received the same sort of response as those experiencing a physical health emergency.

As a result of the CQC report, the Crisis Care Concordat was introduced in 2014[5]. This is a national agreement pledging to work together better to make sure that people receive the help they need when they are experiencing a mental health crisis and to improve the system of care

[5] https://www.crisiscareconcordat.org.uk/

which supports them. Its main focus is the response to crises, but there is some emphasis upon prevention and aftercare. CQC hoped that the Concordat would be a driver in improving practice and that local Crisis Care Concordat groups could have a major role in making sure that pathways for crisis care provide the right care to people in crisis when they need it.

In 2014, services involved in the care and support of people in crisis, including TEWV (Tees, Esk and Wear Valleys NHS Foundation Trust, which provides mental health services in York), North Yorkshire Police, Police and Crime Commissioner North Yorkshire, Vale of York Clinical Commissioning Group, York and Scarborough Teaching Hospitals NHS Foundation Trust, Yorkshire Ambulance Service NHS Trust and City of York Council signed the Crisis Care Concordat. The statement committed the organisations to working together to prevent potential and future crises. It defined a mental health crisis as:

"When people of all ages with mental health problems urgently need help because of their suicidal behaviour, panic attacks or extreme anxiety, psychotic episodes, or behaviour that seems out of control or irrational and likely to put the person (or other people) in danger."

The Concordat also included a clause detailing a 'parity of esteem', this is when mental health is valued equally with physical health:

"If people become mentally unwell, the services they use will assess and treat mental health disorders or conditions on a par with physical illnesses."

It focused on four main areas:

- Access to support before crisis point, ensuring that people can access 24-hour support and are taken seriously when they ask for help.
- Urgent and emergency access to crisis care, ensuring that mental health crises are treated with the same level of urgency as a physical health emergency.

- Quality of treatment and care when in crisis, so that those in crisis are treated with dignity and respect, receive consistent care and are kept well informed about their rights and the care they are receiving.
- Recovery and staying well, so that those who have experienced a mental health crisis are referred to appropriate services to prevent future crises.

By acknowledging that there was a problem and pledging to address this, services seemed to make a move towards positive change. However, our findings suggest that since the introduction of the Concordat, limited progress appears to have been made.

The Independent Mental Health Taskforce[6] published its 'Five Year Forward View for Mental Health' in 2016, clearly setting out the strategies for "improving availability of care and treatment for people with mental health problems; to improve their outcomes and wellbeing but also to tackle the wider costs of mental ill health to the health service and society as a whole".

In 2020 the Royal College of Psychiatrists reported that two-fifths of patients who were waiting for mental health treatment had had to resort to crisis services, with one in nine resorting to A&E[7]. The article showed the damaging consequences of long waiting times for mental health treatment; people had to wait so long for treatment that they reached crises that could have been prevented if they had been seen sooner by non-emergency services. The report found that people living with severe mental illness were left waiting for treatment for up to two years. It also gave the example of one man who waited four years for treatment after attempting to take his own life.

In summary, the report found that NHS mental health services were failing to address preventable crises and forced people to resort to emergency and crisis services. This is in discrepancy with the 2014 Concordat, which pledged to ensure that people can access support before a crisis. The

[6] https://www.england.nhs.uk/mental-health/taskforce/

[7] https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2020/10/06/two-fifths-of-patients-waiting-for-mental-health-treatment-forced-to-resort-to-emergency-or-crisis-services

article attributed this to inadequate staffing in the mental health workforce.

Although the report is from 2020, it strongly echoes the understaffed crisis care service of the 2012 Mind report[8]; it seems that despite the government and services committing to improvement, the system continues to fail to meet the needs of many people experiencing mental health crises.

In 2023, the BBC released an article on mental health crisis services' national failure to answer suicide calls[9]. Their research showed that one in five calls to NHS helplines were going unanswered. The BBC argued that this was resulting in increased pressure on A&E, a service already under extreme pressure.

The BBC article suggested that the issue stemmed from a lack of provision in wider mental health services, resulting in increased numbers of people reaching crisis point. As well as this, it argued that understaffing and lack of training meant that crisis line responders were unable to provide adequate levels of advice and referrals. The article also referenced coroners' Prevention of Future Deaths reports which indicated an understaffed service unable to effectively assess patient risk.

It is clear that, nationally, mental health crisis care services are struggling to meet the needs of those who use their services. However, that does not mean that it is impossible to provide good mental health crisis care. There are a lot of examples of good care across the country and, as Mind suggested in 2011[10], it is important to learn from them.

The government's plans for reform

The government commissioned an independent review of the Mental Health Act, chaired by Sir Simon Wessely. The resulting report was published in 2018[11].

[8] https://www.mind.org.uk/media-a/4372/commissioningexcellence_web-version-2.pdf
[9] https://www.bbc.co.uk/news/uk-64235372
[10] https://www.mind.org.uk/media-a/4377/listening_to_experience_web.pdf
[11] https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review

The government consulted on a range of reforms, taking account of the independent review. 'Reforming the Mental Health Act: Government response to consultation',[12] published in 2021, set out the government's plans in detail. The government intends to reduce the over-reliance on police in mental health crisis care. Under the current Mental Health Act, clinicians in A&E have no power to detain. This means they are being forced to involve the police in mental health care. The government believes that the solution is not just to extend these powers to A&E (although short-term emergency detention powers in A&E are an option), but also to address the problem at its source. It suggests that improving access to crisis services would reduce the numbers of people using A&E services.

The government also proposes increasing patient choice and autonomy, including for patients under the age of 16. New 'Advance Choice Documents' would give patients the opportunity for meaningful input about their treatment preferences. Patients would create these documents with the support of independent advocates when they are well, so that they can have some say in their own care. Patients will also be given the opportunity to name a Nominated Person so that this duty does not automatically fall to the nearest relative. The government also proposes that the statutory right to an advocate be extended to all inpatients, including voluntary inpatients.

To increase patient autonomy for children, the government proposes the introduction of a statutory capacity test for children. To further protect children, it recommends stronger requirements to make sure children are not placed in adult or out of area wards.

The government acknowledges that there are racial inequalities within mental health services and deems them to be unacceptable. To tackle the inequalities, it recommends that every health organisation is required to have a nominated person responsible for overseeing policies aimed at

[12] https://www.gov.uk/government/consultations/reforming-the-mental-health-act

addressing racial inequalities. As well as this, they recommend the introduction of a statutory right to culturally appropriate advocacy.

Additionally, the government recommends that Community Treatment Orders (CTOs) are abolished. These are an alternative to inpatient care, whereby a patient has compulsory treatment in the community rather than being detained. It was found that CTOs were used disproportionately for BaME patients and that there was insufficient evidence to demonstrate their benefit.

Next, the government recommends that there should be clear and evidenced grounds for detention under the Mental Health Act rather than the abstract risk-based justification that is currently used. It also recommends the removal of learning disabilities and autism as grounds for detention.

To make sure meaningful change is made, the government recommends the introduction of a Mental Health Commissioner to oversee the reforms and tackle racial inequalities. The government will publish a plan of how it will resource and implement changes.

The government has published a draft Mental Health Bill[13] to give effect to some of these reforms. However, the Bill will not be the only change made; it will be a part of an ongoing process to improve mental health services nationally.

Good practice

Across the country there are many examples of good care and, as was suggested by Mind over ten years ago, it is important to learn from these to make sure everyone who is in a mental health crisis receives good care. Below are some examples of good practice in mental health crisis care across the country.

[13] https://www.gov.uk/government/publications/draft-mental-health-bill-2022

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust is rated overall as outstanding by the CQC[14]. The chair of the government's independent review of the Mental Health Act, Sir Simon Wessely, referenced the Trust's street triage team as an example of good practice[15]. The street triage initiative ensures that those who are taken to a place of safety under a Section 136 are treated with understanding and helps to avoid preventable detentions under the Act. Mental health nurses are present in all custody suites and dedicated officers work within local hospitals, ensuring effective collaboration between the police and mental health services. All agencies involved in mental health crisis care are provided with specialist training to ensure people experiencing a crisis are treated in a caring and effective manner. This approach is a positive step towards removing the stigma around mental health issues by ensuring that all services, including the police, understand the needs of those in a mental health crisis. The initiative is commended and said to have reduced the number of people detained under the Mental Health Act as people with mental ill health can be signposted to the appropriate services rather than being unnecessarily detained.

East London NHS Foundation Trust is also rated overall outstanding by the CQC[16]. It is running a Community Mental Health Transformation Programme[17] which has been awarded the Quality Improvement and Service Transformation Award at the Positive Practice in Mental Health Awards 2021. The programme blends services across primary and secondary care and services provided by third sector organisations to prevent silo working and foster collaboration. This makes sure there is provision for those at risk of being left behind by the system, particularly those who do not require high level interventions from secondary care, but who still require support. By breaking down the barriers between services, people will be able to access the support that they need as soon as they

[14] https://www.cqc.org.uk/provider/RX4

[15] https://www.cntw.nhs.uk/news/ntw-and-northumbria-police-recognised-for-street-triage-team-work/

[16] https://www.cqc.org.uk/provider/RWK/inspection-summary#mhcrisis

[17] https://www.elft.nhs.uk/information-about-elft/community-mental-health-transformation-programme

need it. This will prevent further deterioration of individuals' mental health and reduce the need for crisis services. This programme has been developed based on feedback from GPs, carers, and service users to make sure no one falls between the gaps between service boundaries. This programme not only works alongside third sector organisations, but provides funding for them, ensuring needs of service users are met effectively and no one gets left behind.

Bradford District Care NHS Foundation Trust is also highly rated[18]. Bradford's First Response initiative[19] enables the provision of a joined-up service across different mental health care providers, the police and the voluntary sector enabling them to provide people with support early on, to prevent crises. This approach has reduced the number of people sectioned under the Mental Health Act and reduced demands on A&E. The first response service allows people to self-refer into psychological therapy for support and those who require more support are seen within an hour by a more advanced practitioner. In a similar way to the East London initiative above, Bradford has placed mental health staff in police control rooms, custody suites and A&E departments. The initiative also aims to work collaboratively across police and community services to prevent crises and ensure that those who are in crisis get the right support. Those who experience a mental health crisis, can access an in-depth leaflet outlining[20].

The South West Zero Suicide Collaborative deems even one suicide to be too many[21]. Rather than dismissing suicides as an unfortunate inevitability of mental ill health, it is committed to the idea of zero suicides. This project works in line with the framework set out by the government's National

[18] https://www.cqc.org.uk/provider/TAD

[19] https://www.bdct.nhs.uk/services/first-response/

[20] https://www.bdct.nhs.uk/wp-content/uploads/2016/12/First-Response-concertina-leaflet-new-freephone-number.pdf

[21] https://www.england.nhs.uk/mental-health/case-studies/archived-mental-health-case-studies/zero-suicide/

Suicide Prevention Strategy. It works on initiatives to reach at-risk groups, for example reaching and supporting men through local pubs.

The Trusts with the highest CQC ratings and those commended for good practice are committed to providing joined up care and collaborating across different service providers. An emphasis on prevention and collaboration is evident throughout these initiatives. They all encourage services to work together to ensure that people are supported by the right service early to prevent as many people as possible from reaching the point of crisis. There is also a strong emphasis on working alongside community services provided by voluntary sector organisations; not just referring to them but also providing funding and resources. These good practice examples promote an understanding of a safe response to crises and ensure that those who are in crisis, and their carers, are kept informed and treated with understanding by fully trained members of staff.

Impact of the pandemic on mental health crisis services

According to the CQC (2022)[22], the pandemic caused a reduction in low-level community mental health services, which can reduce the likelihood of people reaching crisis point. The CQC is concerned that this reduction in community services has contributed to the increase in people being detained under the Mental Health Act (there was a 4.5% increase in detentions in 2020/21) and increased pressure on mental health crisis services. Whilst some of these community services have now started to rebuild after the pandemic, others are struggling to recover due to staff shortages and burnout is is likely to be increasing the number of people reaching crisis, but the pandemic also has had a significant impact on individuals' mental health due to the loneliness and isolation that resulted from lock downs and restrictions. In 2021 Mind released a report[23] based on a survey which asked 12,000 people how the pandemic had impacted their

[22] https://www.cqc.org.uk/news/releases/effects-pandemic-continue-add-pressures-mental-health-services-worsening-access-care

[23] https://www.mind.org.uk/media/8962/the-consequences-of-coronavirus-for-mental-health-final-report.pdf

mental health. It found that those who already had a mental health issue had been the most affected, and many of them had experienced increased severity of issues. It also found that since the pandemic, young people are more likely to be unable to cope with their mental health issues and are more likely to use coping mechanisms, such as self-harm, than adults. Undoubtedly this has had an impact on crisis services as it has likely caused increased demand for an already overstretched service.

The Regional Picture

Since 2015, the Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) has been the Mental Health & Learning Disability NHS Trust for County Durham and Darlington, Teesside, North Yorkshire, York and Selby. TEWV has been under pressure for various reasons over the last few years. It has been criticised for a lack of effective risk management[24] and for a dismissive[25] and uncompassionate[26] culture. It has also received multiple calls for public enquiries. It is important to note, however, that the focus of criticism has been on areas outside York.

One of the fiercest criticisms of TEWV was set out in a report by academics from the University of Central Lancashire and the University of Leeds in 2022[27]. The authors, Langley and Price, identified that the same themes consistently emerged from coroners' reports and articles surrounding the deaths of 85 people who had used TEWV's services. The authors found that TEWV had repeatedly apologised for these mistakes and claimed that changes would be made, yet mistakes had continued.

[24] https://www.bbc.co.uk/news/uk-england-tees-56529121

[25] https://www.tewv.nhs.uk/content/uploads/2023/03/Independent-Review-of-Governance-at-TEWV-March-2023.pdf

[26] https://www.mind.org.uk/news-campaigns/news/mind-comments-on-west-lane-hospital-report-detailing-repeated-failings/

[27] https://www.researchgate.net/publication/360939741_Death_By_A_Thousand_Cuts_Report_into_the_Tees_Esk_and_Wear_Valleys_NHS_Foundation_Trust_BPD_Protocol (Langley and Price 2022)

Langley and Price were especially critical of TEWV's Borderline Personality Disorder Protocol (BPD+)[28]. This was replaced in April 2021 by a new Harm Minimisation Clinical Risk Assessment Policy[29]. This stresses that 'positive risk taking' should not be used to deny people the care they need and that its use should be focussed on the person's wellbeing rather than the service's priorities. This new policy also emphasises that when 'positive risk taking' is used, it must be with the consent of the patient and risks should only be made in a collaborative manner.

Langley and Price found a recurrent theme in feedback on TEWV's services was that people were being refused care due to the assumption that they had the mental capacity to ask for it. Repeatedly people were told by mental health crisis services across TEWV that they had the mental capacity to ask for help, so did not actually need it.

In two reports to prevent future deaths from 2022[30], TEWV was criticised for its lack of understanding of autistic people. In both reports the death of the individuals was (at least in part) put down to a lack of suitable provision. The reports highlighted a need for increased holistic working and not to separate autism and mental health needs.
"Her death was contributed to by the actions and inactions of the mental health clinicians entrusted to keep her safe within a care system that was underdeveloped to manage an autistic individual with complex needs."

"Mr McLellan's distress and stressors before his death included his feelings that he was not getting what he saw to be the right help and that he would not lose his feelings of helplessness such that he took his own life."

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28 https://www.whatdotheyknow.com/request/672014/response/1633272/attach/2/BPD%20Protocol%202014.docx?cookie_passthrough=1

29 https://www.tewv.nhs.uk/content/uploads/2021/12/Harm-Minimisation-Clinical-Risk-Assessment-and-Management-Policy.pdf

30 https://www.judiciary.uk/wp-content/uploads/2022/04/Zoe-Zaremba-Prevention-of-future-deaths-report-2022-0117_Published.pdf
https://www.judiciary.uk/wp-content/uploads/2022/09/Antony-McLellan-prevention-of-future-deaths-report-2022-0207_Published.pdf

Both reports recommended that TEWV drastically improve its provision for autistic individuals with mental health needs.

The coroners' reports highlighted the stories of individuals who have died because of this lack of provision. However, they also acknowledged that this was a wider issue than just TEWV: "*statistical evidence indicated that autistic individuals are more at risk of suicide than those with no neurodevelopmental condition, and females at greater risk than their male counterparts.*"

Also in 2022, local councillors in Stockton called for a public inquiry into TEWV[31], citing accounts from staff and patients who felt they had been failed by TEWV. One patient's account said that TEWV had left them feeling "chronically suicidal".

Families of three young women, who died during or after being in the care of West Lane Hospital, added their voices to the call for a public inquiry into TEWV[32]. The families attributed the deaths to failures on the part of the hospital. David Moore, whose daughter died under the care of TEWV, said that the care was "substandard" and lacked compassion.

While a full public inquiry into TEWV did not go ahead, an independent investigation into the state of TEWV's West Lane Hospital in Middlesbrough (now closed) was conducted after the deaths of Christie Harnett[33] and Nadia Sharif[34], who were both 17, and Emily Moore[35], 18, who took their lives in an eight-month period in 2019 and 2020 while under the care of the

[31] https://www.thenorthernecho.co.uk/news/19934620.tewv-trust-chief-faces-stark-accounts-let-down-staff-patients/

[32] https://www.bbc.co.uk/news/uk-england-tees-60569467

[33] An-independent-investigation-into-the-care-and-treatment-of-Christie-in-West-Lane-Hospital-by-Tees-Esk-and-Wear-Valleys-NHS-Foundation-Trust.pdf (tewv.nhs.uk)

[34] https://www.tewv.nhs.uk/content/uploads/2022/11/An-independent-investigation-into-the-care-and-treatment-of-Nadia-in-West-Lane-Hospital-by-Tees-Esk-and-Wear-Valleys-NHS-Foundation-Trust.pdf

[35] https://www.tewv.nhs.uk/content/uploads/2022/11/TEWV-response-to-NHS-England-independent-investigation-Emily-Moore.pdf

hospital. The report, published in March 2023[36], found that conditions at the hospital were "chaotic and unsafe".[37]

The report found significant staffing issues at West Lane Hospital, including a lack of relevantly and adequately trained staff, low staffing levels, often due to staff ill-health, and an over-reliance on agency staff resulting in a lack of continuity of care and increased stress on the young people in their care. The report cites staff attitudes as a theme from service user feedback and found that patients felt staff were judgemental and dismissive.

Moreover, the report raised inadequate risk management, a lack of safe practices within West Lane Hospital and a failure to learn meaningful lessons from mistakes. Culture and effective management are also raised as issues with suggestions that the TEWV area is too big to manage effectively. (On this last point, TEWV had already responded by carrying out an organisational restructure in March 2021 resulting in the creation of two care groups: Durham Tees Valley and North Yorkshire and York.

The report made a number of recommendations, including:

- complaints and feedback from service users and parents are taken more seriously
- decision making is evidenced and traceable
- oversight at a strategic level is increased
- Duty of Candour is consistently applied
- transitions are more effectively managed
- TEWV must make sure initiatives are being implemented effectively
- risk management is improved
- there is increased clarity of the role of high-level management
- safeguarding is improved.

[36] https://www.tewv.nhs.uk/content/uploads/2023/03/Independent-Review-of-Governance-at-TEWV-March-2023.pdf
[37] https://www.bbc.co.uk/news/uk-england-tees-65013550 21 March 2023

In March 2023, TEWV provided a public statement[38] following the production of the report and recommendations:

"....Our three big strategic goals in Our Journey to Change, which was launched in March 2021, confirm our commitment to listen to and act on the voices of our service users, their families and their carers, as well as to our staff and our partners. We use the term co-creation to describe that ambition. This helps us provide a better experience of high-quality, effective, and safe care to the people who use our services, offering clinical care that is person-centred, timely, compassionate, and kind. All of this is underpinned by our values of respect, responsibility and compassion, which are at the heart of everything we do.

We have employed two lived experience directors who bring their own knowledge, understanding and compassion to the strategic leadership of the Trust, to make sure that experienced voices are heard at all levels of the organisation, and that shared decision making is modelled from ward to Board. We now employ 28 peer support workers too.

These roles were developed as part of a wholesale organisational restructure which was put in place from April 2022, following a governance review in early 2021. Our new structure:

- *simplifies the governance processes – giving nurses more time to care, supporting clinical teams to make decisions with the people they care for and making it easier for everyone to understand their role and responsibilities,*
- *strengthens reporting from teams through our two care groups directly to the Board,*
- *embeds increased line of sight from ward to Board.*

This is all part of the journey the Trust is on to completely transform the services it provides, in parallel to our organisation-wide culture change

[38] https://www.tewv.nhs.uk/about/publications/independent-investigation-camhs-west-lane-hospital/#tewv-response-to-the-report

programme. We are seeing positive results with the most recent NHS staff survey showing we are the most improved mental health trust in England."

The various reports outlined above build a picture of a mental health service under severe pressure and of a Trust struggling to meet the needs of many of its patients.

The Local Picture

This period has been a time of significant change for mental health care provision in York:

- Bootham Park Hospital closed at short notice, following an unannounced CQC inspection in September 2015.
- The Retreat Hospital, which promoted 'moral treatment' based on 'humane and kindly psychological treatment' from 1796, closed in-patient services on 31 December 2018.
- The Haven, a telephone response and evening service for people to access seven days a week as an alternative to crisis care, opened in 2018.
- Foss Park Hospital, a purpose-built 72-bed hospital for people with mental health problems and dementia, opened in York in April 2020.

In 2021 the CQC carried out inspections on mental health hospitals under TEWV[39]. The inspections of the acute wards for adults of working age and psychiatric intensive care units were across the whole Trust area. They were rated inadequate for both 'safe' and 'well-led'. The inspections found that staff failed to manage and assess risks, resulting in patients being put at risk. A re-inspection in May 2021 took place over nine wards, including Ebor and Minster wards at Foss Park Hospital. The subsequent report[40] gave the rating 'requires improvement' and the CQC 'no longer had significant concerns relating to risk management of service users'. It was noted at a meeting of the City of York Council scrutiny committee on 2

[39] https://api.cqc.org.uk/public/v1/reports/ebdb75c1-e25b-44d4-a705-e3b772b7ad09?20210326010509
[40] https://api.cqc.org.uk/public/v1/reports/5f374c9c-17a7-43c1-9824-00d1df43813e?20221129062700

November 2021[41] that TEWV had committed an extra £5.4m and that North Yorkshire, including Foss Park, would use its allocation for extra staffing for inpatient wards and to secure additional administrative support, increase nursing capacity and support practice development. Four consultants were reported to have been recruited to address some of the challenges within the services and a new bed management system had been introduced.

According to the York Health and Wellbeing Joint Strategic Needs Assessment (updated in May 2023)[42], the suicide rate in York is currently in line with the national average but has been high in recent years. The rate in York is higher than many of York's statistical neighbours for both men and women. Self-harm is also identified as an area requiring improvement. The rates of York residents admitted to hospital for injuries relating to self-harm is higher than most of its statistical neighbours. The rates are particularly high for self-harm admissions in young people aged 10-24, but most notably in those under the age of 20. A high suicide rate and high rates of self-harm can be seen as an indicator of unmanaged serious mental illness and mental distress; however, it is important to note that these statistics do not show the proportion of people who present to any particular service.

People in York reporting high levels of anxiety is similar to the national and regional average. However, people in York were more likely to report high anxiety than the majority of York's statistical neighbours. Over the last five years the national trend has been stable, and York's data has either been similar to or slightly higher than the national picture.

What did we do?

In order to help shape, challenge and improve local health and social care services, Healthwatch York routinely gathers the views and experiences of people who use them. In May 2022 we focused on reaching out to adults

[41] https://democracy.york.gov.uk/mgAi.aspx?ID=60543
[42] https://www.healthyork.org/mental-health.aspx

who have experienced mental health crises, their carers, and front line mental health workers.

Qualitative research techniques were used for this report, which allowed people (including those with lived experience of the crisis care service) to tell us their stories. We acknowledge that in a service context of 15,000 contacts a year in the York and Selby Crisis Team (which excludes the assessments of acute hospital liaison in York District Hospital) the number of comments and the range of participants was narrow, and as a result some service areas have a low level of response. Nonetheless, qualitative analysis allowed us to capture the stories of people with all of the human subtlety, detail and complexity, uncovering topics that otherwise could have been missed by a quantitative approach. Whilst the limitations of this report are not insignificant, we have confidence in its results because we were able to achieve saturation within the data (the point at which no new information is gained from further data collection) and because findings were corroborated by data collected from different people over different times.

In total, we conducted 29 in-depth semi-structured interviews collecting 59,611 words and 410 specific statements about mental health crisis care: 55 positive (13%) 320 negative (78%) and 35 ideas (9%). We held five workshops, including with the TEWV crisis team, Acute Hospital Liaison Mental Health Team, York Carers Centre, a 'drop-in' style workshop and a York voICeS meeting to review the data gathered, inviting participants to comment on the emerging themes. In total we spoke to 67 People - 43 staff (seven male and 36 female) / 15 carers (one male and 14 female) / nine lived experience (three male and six female).

Key findings from our work

- Mental health services are under severe pressure throughout England, and have been for a long time
- TEWV (specifically) has faced major problems with some of its services, particularly in Middlesbrough
- The people we talked to for this research told us it is hard, sometimes impossible, to access help when it is most needed
- Some of the problems stem from under-funding, but others appear to be cultural - poor training, poor communications, poor attitudes
- Despite their own negative experiences many participants recognised that there is a system issue rather than an issue with individual staff members. It's important to recognise that staff members are under significant pressure and require more support and training to provide the best possible care for those in crisis
- There is no doubt that our current system is letting people down, to the point where people have died
- Without urgent action, we will continue to fail some of our most vulnerable people
- The people we talked to made recommendations for improvement, specifically an increase in lower level support and preventative care, follow up care to keep people well following a crisis, and clarity on what a crisis is (see page 104 for these recommendations in full)

Our findings in more detail

Accident and Emergency Department (A&E)

There were 15 statements from participants recounting their experiences of A&E including substance misuse, self-harm, anxiety and depression, suicidal thoughts and suicide attempts.
There seems to be a lack of understanding of mental health issues in A&E or the capacity to deal with them. We found people being discharged with their physical health issues treated, but without adequate treatment for their mental health concern. For example, we heard from people who had been admitted to A&E after self-harming but were essentially 'patched up' and discharged without any care relating to their mental health issues.

We found inconsistent and sometimes judgmental attitudes from healthcare providers, inadequate follow-up care, lack of communication and coordination between different healthcare teams, and dangerous assumptions made about patients' situations.

A carer also raised concerns about the lack of advice or instructions given to patients and their families when discharged from A&E after a mental health crisis. Some participants shared positive experiences with healthcare providers who showed understanding and were able to refer them to appropriate services.

"When she did eventually get through to the crisis team they took her into hospital to treat her physical condition, but in terms of her mental health, she was just discharged and they gave her a couple of numbers that were community based mental health support."

"Some doctors in A&E have been amazing with me, others have basically looked at me like a time-waster I suppose because things are 'self-inflicted'. It is very variable, I think it is the luck of the draw sometimes, unfortunately."

"When I presented at A&E, people would look at me and judge the situation rather than the individual. I've often had 'sort yourself out, you've had too much to drink, go and sleep it off and you'll be fine tomorrow'. They didn't ask that second question because I was desperate for someone to ask just that second question: 'are you actually ok?'"

"Discharge from A&E is one of our biggest sources of referral. We've worked with the liaison team for long enough that they have quite a good awareness of what homeless services are about. They are quite good at referring people who don't have anywhere to go, because a lot of the time people are going in with anxiety and depression and suicidal thoughts, but when they dig into it, it can often be around social stressors, not having anywhere to live and things like that. They are one of the better teams at the hospital at referring people."

"Improved training for A&E support is required; people are often not seen by the duty psych when they should and there is a lack of follow up. Police have arrested me to force me to go to A&E, to then be asked by liaison 'why are you here?' No one seems to know the process or who's job includes what, there is very little liaison or communication"

"Some people go to A&E because they are not safe and need to get admitted, but obviously there are pressures around beds. A few years ago when Bootham closed, we had everybody sent to Middlesbrough. They would stay in Middlesbrough for a day and be discharged, but the information wouldn't always come with them. If you are in crisis the last thing you want to do is be sent 100 miles across the country."

"So, I think initially he went to A&E and said 'look, all I need is just some diazepam right now', but they looked at his records and it's the GP's fault because she'd coded it somehow so it came up that he had drug issues. It wasn't down to the GP, but whatever he said to both A&E and crisis they just wouldn't listen to him. So they were making all sorts of assumptions without even trying to talk to a GP to see if this is the case, and that's what I

feel all the time, they are making these very dangerous assumptions about people's situations."

"And we've had carers say to us that they just don't ring the crisis team anymore and they end up ringing other emergency services or going to A&E which isn't appropriate, or police get involved, it's not a crime if someone is poorly, they need mental health help."

"Unfortunately, everything started to unravel again. I was self-harming a lot and I was overdosing a lot, but just as a form of self-harm and I was turning up to A&E and literally patched up and that was it. I was talking about trackers in my skin, which, you know, probably should have been a red flag."

"A carer raised a concern about something that happened five or six years ago when being discharged from A&E after her daughter's suicide attemp. Because her daughter was over 18 and it was classed as a mental health issue they weren't given any advice or instructions (in the way you might expect if someone had broken their leg or a similar non-mental health discharge) or any helpful/useful information that you would normally expect when taking someone home from A&E (e.g. take paracetamol for any pain, rest etc.). No information was shared with them of the details of what had happened, so I think she felt they weren't very well equipped."

"The police will take people experiencing crisis, who they suspect may be homeless, straight to A&E. They take a lot of people to A&E and leave them there and they just don't know what to do with them."

Addiction

There were 11 statements from participants recounting their experiences of addiction including substance misuse and mental health issues.
We found evidence of a lack of understanding and support for individuals who have both addiction and mental health issues (dual diagnosis). The system is difficult to navigate, and there are disparities in treatment options for addiction. It seems that some service providers hold

misconceptions about addiction and may blame individuals for their problems, making it difficult for them to seek help. This can lead to a cycle of shame, self-hate and hopelessness. Additionally, there are challenges in dealing with people under the influence of drugs or alcohol; mental health assessments may not be possible at such times, and addiction services may struggle to engage with individuals who have poor mental health. This can create a 'chicken-and-egg' situation where people are unable to get the help they need.

Overall, it's clear that there is a need for more integrated and holistic approaches to treating addiction and mental health issues. Service providers need to have a better understanding of these issues and work together to provide comprehensive care and support for those who are experiencing them.

"I cannot understand how you can have mental health and addiction in different arenas as they are so connected. To separate those things to me just shows a fundamental lack of understanding of addiction, and addiction causes a lot of mental health issues. They are made separate when they should be one, it's never going to be possible to treat somebody with addiction if you separate those two things."

"It's 'a weakness' or it's 'about willpower' which is not the case, but it is framed like that. Sometimes you have an insight into systems where substance abuse is prevalent, but there is a lack of understanding which is extremely frustrating; 'stop doing that thing and you might receive some help' is the narrative."

"I have been through treatment myself and I haven't picked up a substance since I've been to Oaktrees so I am really grateful for it. I think the help is there, but I think York needs some more of it."

"There are disparities in treatment options for addiction as well, so sometimes it feels like you've got to navigate the different types of therapy."

"The idea that an addict can simply reduce the abuse of a substance by keeping a diary or simply stopping is counterproductive, it doesn't work; 'why don't you go home and just lie about how much you drink?'"

"A couple of years ago now I went to hospital with a friend who was a drinker who was having a seizure. One of the liver consultants came out and said to her 'I'm really disappointed in you, you're back here again'. I could see instantly in her face the impact that one sentence had on her. She's dead now, but I remember that, and I remember seeing her face and the brutality of that statement, when she had come for help. I think she left a couple of days later, she just couldn't cope with being spoken to like that, she was full of enough shame and self-hate to be told again 'what a naughty girl she'd been'. It was shocking and these are people who are 'experts'. It made me think that there might be a clinical approach to treating the symptoms but in terms of emotional or mental or psychological it seems to be really missing."

"You've got to jump through hoops and for somebody who's maybe drinking a lot, it is very difficult. They are set up to fail, and then they reach crisis point and they go back to A&E and it's just the same cycle; it's really frustrating."

"We get issues around dual diagnosis, so people who are under the influence of drink or drugs, we don't always get the most holistic response from crisis contacts."

"In general, one of the big obstacles does seem to be dual diagnosis. We've gone in phases with dual diagnosis over the years and I've been working with homeless people for 20 years now. We've had several phases where we've had a real effort to do dual diagnosis, and not to gate-keep people with substance abuse issues particularly. Of late there is quite a lot of gatekeeping around substance use whether it's alcohol or substances. I've been in several multi-agency meetings about people who are very chaotic and quite high risk where the mental health input has been; 'well they're

drunk all the time so we can't do anything, so we're closing them. It has not always felt particularly supportive for workers within homeless services."

"I do understand that it is difficult to diagnose someone's mental health when they are under the influence, of course it is, but addiction is a recognised mental health condition. It feels like an excuse not to deal with that extra level of complexity. 'I can't assess this at this point, but when is the best time of day to see you so that I can?' should be the response, not I'm sorry when you've stopped taking drink and drugs and when you've stopped using amphetamines, that's when we'll do an assessment. Also substance abuse services really struggle to engage with a person because their mental health is so bad. But how am I supposed to stop using drugs when my mental health is so bad? It is chicken and egg."

"My son self-medicates with alcohol, but services will not attend if he is drinking. However, his drinking is because of his mental health, so he ends up in a full crisis as he has no help/support."

"I am fully aware of the constraints mental health services have, but there needs to be great improvements on dual diagnosis support for those people accessing substance services as it tends that we are the service that ends of having to lone work the people with mental health /substance misuse and we are not mental health trained. Regularly when a person who has been with mental health services accesses us, we see mental health services back off, this should not be the case so any report that can try and influence a more joined up approach I am happy with."

Communication

There were eight statements from participants recounting their experiences of poor communication between different services.

There appears to be a lack of communication and collaboration between various services and teams involved in mental health care. This can lead to a fragmented approach to treatment, where individuals' issues are not seen as a whole and are instead treated separately. This problem seems

to be prevalent across primary, secondary, community and statutory services.

The lack of communication is also hindering the implementation of strategic plans and initiatives. There seems to be a disconnect between what is being discussed at a strategic level and what is happening at an operational level; the clinicians and operational staff may not be aware of the strategic plans, which can lead to confusion and lack of 'buy-in' from staff.

Additionally, a lack of communication can lead to delays in accessing services, which can be detrimental to individuals' mental health. The longer the wait time, the more likely it is for individuals to lose faith in the process and not seek help when they need it. It is important to recognise that mental health care is not just the responsibility of specialists as 'experts', but everyone's business. It is crucial to involve people in the community who see individuals day-to-day and can provide support and conversations, especially when specialist services are under-resourced and cannot provide timely care.

"Lack of communication between services; especially primary and secondary care services."

"No communication between the Community Mental Health Team (CMHT), police and the hospital."

"There's no communication from the crisis team to other teams e.g. CMHT."

"There is a huge gap basically working with somebody who presents; they go to the crisis team then they might go to A&E and be seen by the team there. Then they are 'not at immediate risk' and referred back into the community and it just seems to be a gap and a breakdown in communication."

"There's a lot of people who have just lost faith in the process and the services. They've been through them so many times waiting for an

assessment and jumping through hoops that they just won't go near them even though they're really unwell. I think that is really problematic because we need all of those different aspects, that sort of social aspect, the friendships, the community support to work alongside and complement specialist services when people really need that. But we're not quite there with that. At a strategic level there's lots of noise, positive noise about getting there and that is what we want to achieve. We need to get staff at an operational level to get on board with that or it's never going to happen."

"I always raise the question that I don't know how aware a lot of the clinicians who are on the ground in these teams are of the work that is going on at a strategic level in TEWV. I think there's a real disconnect between that strategic level and the senior managers and the operational staff because you talk to them about connecting our city and they're like 'what's that'?"

"Complaints via PALS go nowhere because notes don't reflect that."

"It's those people in communities that will be having those conversations that make such a difference, they see people day to day. I always reflect to clinicians that they can sometimes have professional snobbery that 'we're the experts', 'we should be having these conversations'. Actually, it's everybody's business. There's a real danger in that narrative of 'we're the specialists, leave it up to us', especially since they are so under-resourced. It's like I'd love to leave it up to you, but you can't see that person until three months' time, so I think someone else should be having a conversation with them in the meantime."

Community Support

There were 16 statements from participants recounting their experiences of community support.

We found that community support services (including voluntary and community organisations and Local Area Coordinators (LACs) based at York City Council are highly valued by individuals who are struggling with

their mental health. These services are sometimes seen as understanding and relatable, as they are often run by individuals with 'lived experience' of mental health issues. The support provided by community services can play a key role in preventing people from reaching crisis point, and can also be vital in supporting people's recovery.

However, it can be challenging for individuals to know what support services are available to them, and this is where the support of social prescribers and Local Area Coordinators can be invaluable. These professionals can help individuals access the support they need before they reach crisis point, and can provide guidance on available services.

Connecting people with similar experiences also appears helpful in supporting good mental health, as it allows individuals to feel less alone and more understood. Stigma around mental health is still present, and this can make it difficult for individuals to seek help or talk openly about their experiences. However, the conversation around mental health is improving, and the work of community support services is helping to break down some of these barriers.

Different individuals will have different preferences when it comes to the types of support they need, and community support services should aim to provide a variety of different options. Some individuals may prefer more mental health-focused groups, while others may prefer more general support. The important thing is that individuals feel empowered to access the support that is most helpful for them.

Finally, it's clear that community support services can be very effective when they are delivered by individuals who have lived experience of mental health challenges. These individuals are often best placed to understand the needs of those they are supporting, and can provide a level of empathy and understanding that is difficult to replicate otherwise.

"It could be something that could be referred to as 'pathway to recovery' or somebody else in the voluntary sector, but actually in the meantime they

don't require crisis support. It's just that they need to hear a friendly voice, just somebody to talk to relieve that anxiety a little bit."

"There are other things we can put in place to stop, or at least reduce the risk of that crisis happening. Working as holistically as possible using the voluntary and charitable sector to do that."

"Quite often it is just knowing what's out there, quite often there are crisis support services, but they don't call themselves that, but they do provide that."

"What is on offer for people who aren't under a Community Mental Health Team to receive support before they reach crisis point?"

"...and LACs have flexibility, they are part of the system that seems to be able to work round it and they have the freedom to do that, so they are able to find ways that other parts of the system can't."

"Community support seems fundamental in a lot of people's recoveries. I've heard so many stories where it has been a community-based organisation, a charity or a couple of individuals who seem pivotal in them starting to get better."

"It is all about connection and connecting people seems fundamental, hopefully like-minded people and potentially people who have been through very similar experiences to you. Any sustainability in good mental health seems to be about getting that interaction with a specialist and also wider interaction."

"To some extent we've got a network of community hubs across the city. A lot of the LACS are involved in those. They're similar sorts of spaces. We find that what you need is a variety of spaces. Some people are keen to go to something that is really focussed on mental health and have those really focussed conversations. Some people who've had a lifetime of dealing with their mental health, they specifically say to us; 'I don't want any

mental health groups', 'I don't want anything to do with Mind'; they want something more general."

"Changing Lives is very much 'on the ground' and they get it, because a lot of them have been there and that's very similar with us, the majority of us with personal lived experience and still living with experience. Some of the best practitioners, they know and they get it."

"Voluntary services are available and stuff like that, I can't keep up with what's happening. The fact that social prescribers work locally, have knowledge of the local area, and what's available for people is just fantastic."

"They [York Mind] seem to take people seriously, they listen to people, didn't talk over you. Everyone was like, actually communicating, not treating us like, 'it's for young people' but they weren't doing the 'baby talking thing'. Really, they were just treating us like people and not like a problem."

Crisis After Care

There were 94 statements from participants recounting their experiences of the 'crisis after care' (i.e. after the initial traumatic crisis event and the first few steps along the path to recovery).

There are many problems with the mental health crisis after care that make it difficult for people to access appropriate support. One issue is the lack of clarity around when it is appropriate to call the crisis team, which may lead to inappropriate calls and a strain on resources. Another problem is that there is a lack of support available for those who are not yet in crisis, which means that people often call the crisis line when they need a lower level of support.

People also feel that the crisis after care is disjointed and inflexible, and that there is a lack of understanding that recovery is not a linear process. This can result in people being discharged too soon without adequate

support. There is also a feeling that the after care is not designed to meet the complex needs of homeless people.

In addition, there is a sense that people with a personality disorder diagnosis may be prevented from accessing appropriate support, and that the crisis aftercare is difficult to navigate. People may feel like they have to 'play the system' in order to get the help they need, which can be a barrier for those who are already unwell.

There is often a lack of sustainability in the support provided after the first point of contact, and people may be discharged from services when they are not yet fully recovered. This can lead to a rapid decline in their mental health and a need for further crisis care.

To improve mental health crisis after care, it may be necessary to provide more support for people who are not yet in crisis and to ensure that the crisis after care is more flexible and responsive to the complex needs of individuals. There may also be a need to address issues around 'gatekeeping' (withholding services) and to make crisis after care easier to navigate for those who need support. Finally, there is a need to ensure that support is sustainable and that people are not discharged too soon (from both Acute Hospital Liaison and Crisis Team) without adequate support.

We found that it was sometimes difficult for homeless people with mental health problems to access support when they need it. Some of these issues include a lack of follow-up after initial assessments, the complexity of problems faced by homeless individuals, digital exclusion, the need for face-to-face interventions, a lack of personal contact, and poor communication between different teams. This highlights the importance of improving communication between teams and working together to provide support to vulnerable individuals. It also emphasises the need for more personal contact and face-to-face interventions, as well as the need to address issues such as digital exclusion and day-to-day struggles faced by homeless people.

There are particular issues of concern for people experiencing personality disorders or complex Post Traumatic Stress Disorder (PTSD). It appears that some individuals are struggling to access appropriate support and are being passed between different services without receiving effective treatment. The availability of specialist services such as psychotherapy is also raised as a concern.

Some people are having trouble accessing the care they need, and there is a perception that the access team is acting as a 'gatekeeper' and preventing many from getting through to the Community Mental Health Team. Those who do receive care are sometimes not given enough sessions or coping strategies to deal with their issues. Discharge from care can be a difficult and abrupt process, with people being sent back out into the community without adequate support.

Referrals are not always met, crisis plans are sometimes ineffective, and communication is sometimes poor. Misdiagnosis and lack of continuity of care also appear to be issues. However, there are some friendly and helpful staff within the system.

Theme A: immediate post-crisis support

"In fact they <the Crisis Team> did come round one night and sat with her for a few hours, and she did get some support at that point, but that has dwindled and it's always a kind of one-off interaction, whilst at that moment in time it might be helpful because actually you are soothed because there is someone else in the room who knows what they are talking about and that is great, but as soon as they have gone and you are in that state, you know, the descent is rapid."

"It is the sustainability of help after the first point of contact which again seems to be missing."

"She was in absolute crisis. Picking up the phone to speak to people and arrange an appointment was really not the place that she was in at that point. Really, she was absolutely desperate to be sectioned, she just wanted to be somewhere else, but it wasn't going to happen. And I've

heard that too many times in terms of that one point of access crisis support."

Theme B: navigating longer-term support for after crisis care

"People talk about playing the system, and I absolutely see why. I think it is sinister because sometimes it makes recipients of services manipulative, not because they are inherently manipulative people, but because they want help, and if you don't know how to do that you tend to lose."

"I know people who have downright lied, by saying that they have reached this level of mental health crisis, and perhaps they haven't, or those suicidal thoughts aren't as prevalent. It seems to be an exaggeration of your symptoms, because they have the awareness that if they say they are feeling alright today, that is the end of that."

"Recovering from a mental health issue is never a linear process, but it seems to be framed or guided by the fact that a person gets better and better and better, but they don't necessarily. It is that lack of sustainability in help, or even the flexibility, without having to go through the whole formal process again of engaging, criteria meeting (I'm sorry you've already had your time)."

"In the community because they're struggling, people might not answer their phones or might not feel able to open letters so then they are discharged from the community team because they have not responded."

"To have more support for people during the day would be amazing; like a network of places that people could go."

"I really had to hit a crisis later on, becoming severely depressed, going into hospital and the experience in hospital wasn't really positive because it didn't impact on the severe depression, but I did get referred to an anxiety disorders unit, it took a year, but that was really helpful. But I had to hit that crisis before I got that help."

"It is all very well and good encouraging us to speak up and ask for help, but is the help there?"

"I think there is a problem with the system where we have to follow and chase things up when we are very unwell."

"I slowly saw that shift when they started to introduce the access to mental well-being team, almost the 'gate-keepers'; we often called them the 'gate-keepers' to mental health services and TEWV."

"So, the access team came in and then the crisis team alongside them, even though there had been crisis support home based treatment and things like that prior, it felt very much as if some process had been put in to stop people getting to the support that they needed."

"I know people who have contacted the crisis team to be told that their issues are 'not mental health', it's not something they can deal with. So we are working with a lot of people who have relationship difficulties, job losses through Covid, health issues, all sorts of things, and that impacts on their mental health to the point that they are maybe feeling suicidal to be then told by the crisis team that their issues are 'relational' or 'economic', so it's not their mental health, so they <the crisis team> are not there to help. Sometimes they are told IDAS will pick that up, or KYRA women's service will pick that up, so they seem to be very good at signposting back out into the community when you have people that are really on the edge."

"It would be good to have something for people that are in crisis that need that kind of emotional empathetic support from a professional that has time and can have a look at their staying well plan and their crisis plan and things, and talk them through it. But just to have that much more time."

"I think there can sometimes be a bit of a disconnect between somebody going to the hospital, seeing somebody, they don't need an admission, they've maybe been referred on to Huntington House or something like that, but then that follow up doesn't always seem to happen for people."

“For a lot of those clients, their lives are very day-to-day and things have to be tangible. If somebody actually opens up and expresses that they are in a mental health crisis in the middle of the night, if it’s 10 days before somebody trained in mental health care can speak to them about that, apart from somebody on the phone in the middle of the night (the crisis team) often by that point, not that they are not still in crisis, but they maybe don’t feel like anybody has responded.”

"Yeah, just none of it really makes sense. I mean, like xxx has just said, all this lady is wanting is to sit down with somebody wants to start PTSD therapy, and have a conversation about how she copes with the triggers, the system will have to adapt, because we'll keep fighting on behalf of people. And it will be the same, it will be another person saying no. And all these organisations start fighting on behalf of people, then the system, surely get tired of all these fights and will have to do something eventually. I suppose this is one sort of approach, as well as writing reports and saying, What are you doing? Where's the resource for this? And this and this, and this?"

“In terms of the crisis care pathway there is still a lot of work to be done around connecting all the different teams up. There is almost this quite negative culture of kind of handing off between the teams rather than a kind of fluid working alongside each other and working together and we find that as Local Area Coordinators. Some of the introductions that come through to us almost feel like a dump and run.”

“But I do find, particularly I think between the CMHTs and the crisis team, there often seems to be quite a fractious relationship. This kind of sense that it’s not my problem, go and talk to this person. It becomes really frustrating for us because we spend a lot of time on the phone, waiting to get through to somebody and then being told it’s not my issue, you need to go and ring someone else over there. And if that’s frustrating for us, I can’t imagine how frustrating that is for someone who’s experiencing a mental health crisis. So, it does feel like there’s a lot of work to be done about getting those teams to work together.”

"But then again, saying that, there are these odd cases where clinicians will go out of their way. I think it's important not to lose those examples because they are under so much pressure and I imagine that it feels like quite a thankless task."

"You get people that are sort of stuck in the assessment process. I was supporting somebody, a woman who was pregnant, who became really unwell with her mental health quite quickly and in pregnancy that can be really kind of catastrophic, women can end up experiencing psychosis and their mental health can deteriorate quite rapidly. I was really concerned about her, she was saying that she was really suicidal. She had already been referred to the perinatal mental health team by a midwife. So, I rang the perinatal team, knowing this, and said 'I'm really worried about her, I've just got off the phone to her' and they said 'oh well actually she's not on our system' and I said 'well I know she's been referred'. And they sort of broke glass on their system to see that she was still with the access team and waiting assessment with the access team. I said 'considering the situation she's in, is there any chance that somebody could give her a ring', 'oh no no it's not with us, you need to go and ring the access team, she's got an assessment on Friday could she not wait until then'. I said that she can't. So then it was 'well you need to ring the crisis team'. And that was quite a difficult conversation because I said 'she's pregnant so she's gonna come through to you after this assessment with the access team, you know that could we instead of passing it around all these different teams could we not jump a step and have one of your practitioners give her a ring and have a chat with her'. It was just a very hard 'no, no we can't because of the bureaucracy'. Situations like that are very hard and it doesn't feel very human and it doesn't feel very compassionate. Some of the clinicians are a bit process driven. If that practitioner that I spoke to really wanted to, she could've just picked up the phone and had a conversation with this lady. I don't think any managers anywhere in TEWV would've said 'oh you shouldn't have done that because it's not with your team yet.'"

“There have been some positives under TEWV in that the access team, they’ve done a lot of work into trying to make the referrals into the access team much more accessible.”

“That’s [community mental health transformation] working alright, there's been some really positive things from carers saying it’s made a huge difference to the people that they care for having had previous admissions and now following a recent admission, having a social prescriber involved for example to help someone go, there's no use having a list of places to go if you're really vulnerable and you’ve just come out of Foss Park. To walk through the door of an organisation and say that I need some support, it's really difficult.”

"Used to be Dialectical Behaviour Therapy and Psychotherapy, for people that have complex mental health conditions. But there's not even any access to that anymore."

“I don't want a group that is talking or helping me manage my emotions, I need to find coping strategies to deal with the flashbacks that I am having about things that's happened and nobody could offer that support.”

"So, people are at the moment jumping through loads of hoops to just basically pass the buck to you. The particular patient I worked with was quite upset about the fact that she had the access team appointment. They said the only thing we can offer you is an appointment with IAPT. They booked that appointment knowing that IAPT could not work with her because of her complex background.”

"xxx is really anxious about situations and has lots of sort of difficult thoughts to the point where she got really frightened about crossing the road because of OCD. If she crossed the road at a certain place, something bad was going to happen. And she was told by IAPT, 'that's not something we can help you with'. And again, directed to York St. John Counselling and Mental Health Clinic; redirected there to the trainees, basically, yeah, so that is kind of where it just seems to be happening. So,

we are at a meeting at the GP surgeries, and I flagged it up there, which was quite a shock to quite a few of the GPS, because they're assuming they're passing people on to certain services, which is maybe not correct. And the same with the access team, they feel that if they pass them people to the access team, they're gonna get some form of mental health support, but people are just getting passed back out again to Kyra, York St John, Mind, etc."

"Have discharge be less of a cliff edge."

"Services are discharging patients for being 'too high risk'; it makes zero sense. Who is the person that is the perfect level of complex and risky and what is actually offered to that person?"

"Discharged because 'too complex'."

"Suicidal plans and liaison – holds the door open to go and kill herself."

"Professionals meeting – no input."

"Not informed of own care pathway."

"Lack of continuity of care."

"Fed up of being treated like shit."

"Some friendly and helpful staff."

Theme C: navigating crisis after care for Post Traumatic Stress Disorder (PTSD)

"Had a couple of people that I'm working with who have a complex PTSD diagnosis and really struggling to get any of support. I've got two patients both very similar in presentation in that they have a complex PTSD diagnosis. They've had a history of some form of either sexual or domestic abuse in the past with lots of flashbacks, symptoms of PTSD, both of them try to access support. So, they're referred to the access team by the GP,

seen by the access team and basically kicked back out into the world, back out into third sector organisations. So, to Survive and IDAS. So, a lot of pressure was being put on those services. Both of them have seen these different services, and the services helped within their remit with the situation. So, it might have been a sexual incident or what have you, but we're not able to deal with a longer-term PTSD diagnosis and managing the kind of flashbacks and all the experiences."

"GP surgeries were left with two patients really struggling with their mental health, came through social prescribing one of them has gone down the route of putting in a formal NHS complaint, to say that they're not getting the support they need with their PTSD, the other one decided to put in an informal kind of complaint. Both were then seen again, given another assessment by access, both seen by the same clinician. I was at both the meetings with the patients. One of them's been referred through to CMHT support and he's now getting some one-to-one work around trauma and managing how to deal with flashbacks and coping strategies. The other one was denied access to CMHT and it's been passed through and was told; 'oh, we'll make a referral for you to IAPT'. So they've gone to IAPT, been assessed and given a statement to say that they only work with people who have single incident trauma and the staff there are not trained or funded to provide support to people with complex PTSD. So, they've signposted them to the counselling for mental health clinic at York St John."

"The access team is saying that they don't do trauma-based interventions, so who does? The amount of people that are coming through social prescribing at the moment who have complex PTSD or a form of trauma on their medical records, and they can't actually access anything. When it was the previous Trust in York, you had things like St. Andrews, you had The Retreat, which I know that was private, but you had The Retreat communities, you also had access to psychotherapists, and whereas I have to say, they don't have psychotherapists. So, what do they actually offer? It just feels like it's just got smaller the provision, but the GPs are

referring and signposting people through to IAPT because they are under the illusion that the services are available."

"People are sort of now seeing the access team are like the gatekeepers. So, it's like the access team will either give you permission to go into the CMHT or they won't and it doesn't seem to be that many people getting through to the CMHT. I've got a lady that I'm working with who has PTSD from different things, she's now self-harming, and she's been given six sessions with a psychologist at CMHT, but she's not been given any coping strategies to deal with some of the things that she has, and it's literally six sessions. You have six sessions, and then you're out; 'you'll be better by then'."

Theme D: The Haven

"We've had a few people present at the Haven and again I think there is that confusion about 'what can the Haven do?' Often people view it as a crisis service that you can go to, but that is actually not necessarily what it is supposed to be or is geared up to be, I think there is some confusion around that for people when they are looking for some support. It's a great thing for the crisis team, but again you are talking to somebody over the phone and it's not having somebody tangible who you can actually talk to and feel some kind of comfort from which is why some people still go to A&E."

"Going to the Haven I've had mixed messages where some people have had one-to-one, so they sat in a room with somebody and had some proper one-to-one time and others where they have just been invited to have a cup of tea and almost sort of just sit there in that space, but they have gone with that expectation that they'll get to chat to someone, but been told 'no', it's more of a sort of safe space to be if you're not feeling great. And then you've had other people who have had an intervention, so again it's really mixed as to what they do and where people go if they are in crisis."

Theme E: navigating crisis after care for people with personality disorders

"You have a PD… what do you expect."

"The attitude and stigma within services towards PD patients is awful. This is even worse when it's a misdiagnosis and is used to justify poor treatment or lack of input."

Crisis Line (Staff)

There were 12 statements from participants recounting their experiences of the staff crisis line (i.e. the alternative to the public crisis line telephone number offered to staff).

Some mental health professionals find that they cannot get through to the crisis team using the public line but can get through quickly using an additional internal 'staff' line. However, not all professionals are aware of this staff number and others who are aware of it do not find it to be any more responsive than the public line.

Some professionals have had positive experiences with the staff crisis line, reporting good support and successful outcomes for their patients. However, others have expressed frustration and concern when they are unable to get through to the crisis team and must deal with patients in crisis on their own.

Overall, it seems that there are both positive and negative experiences with accessing the crisis team on the staff number, and that there may be some variability in responsiveness depending on the specific circumstances and individuals involved.

"There is a different number for professionals and that is the one funnily enough that I did use last week and I got straight through."

"I had tried the public line first for half an hour with no answer, then used the staff line and got straight through."

"They <the crisis team> are very hard to get hold of even with professional numbers, it is very hit and miss."

"That was the professional line I used, but I wasn't working in a mental health team then and other workers I was working with weren't aware of the professional line."

"There is a staff line. I got it as NHS staff, but it is not publicised because it would be inundated. I have used the professionals line all the time and I get straight through and they do an assessment. I used it last week, it is regular."

"In my experience people have been referred on or discharged if it's not a crisis, but to cover my back I would always phone them first."

"I've had a couple of members of the team saying it's difficult to get through to the crisis line. Even on the 'workers' line."

"We have heard some really positive experiences as well, and heard from some people that when they have got through and spoken to somebody they've got some really good support and it has really helped. I'm thinking of one case in particular and it was an older lady and the LAC said that the support from the crisis team when they came out was brilliant. She was experiencing psychosis and was acutely unwell and she was adamant that she didn't really need much support from mental health services, but they managed to work with her to get her to agree to a voluntary admission to hospital rather than having to go down the route of sectioning first which is always much better."

"We've got the staff number for the crisis line and email addresses for some of the practitioners as well, so with all those different options and ways of getting in touch we can usually get in touch with someone quite quickly if we need to."

"We sometimes struggle to get through on the crisis line and we have the staff number."

"It's very frustrating when you're concerned about someone you're sitting with and you can't get through to them <the crisis team>. As soon as you get through and as soon as you've got that progress, you're relieved that you know someone else is dealing with it and you can hand it over to them, but when you can't get through to the service and you've got a busy clinic and you're trying to see other people at the same time. Reassuring this patient that help is on the way and trying to keep the patient in the surgery is often hard because of the concerns of what they're going to do to themselves or others. It does impact on you psychologically, how you deal with your next patient or the patient afterwards."

"That was properly scary, you know, something you dread most as a therapist. I wouldn't trust anybody who said that was easy to deal with; there and then to try to contact the crisis team and couldn't, it was so hard to do something, I literally couldn't get through. No, I just couldn't get through."

Crisis Line (Public)

There were 71 statements from participants recounting their experiences of the public crisis line (i.e. the alternative public crisis line telephone number).

Many people in crisis experience long waiting times and inadequate responses when calling crisis lines. People report having to ring many times and sometimes waiting for hours before the crisis team answers. This can have serious consequences for people's mental health; it is important that they receive timely and compassionate support. It is extremely concerning to hear that people who are feeling suicidal are being told that they have 'capacity' and can choose to proceed with their plans 'if they choose to'.

It is clear that there are issues with the crisis lines in some areas, and it is important for these issues to be addressed. Providing adequate resources and training for mental health professionals who work on these phone lines is essential, as is ensuring that these lines are adequately staffed to meet the needs of the community. There is a recognition that crisis line staff are under a lot of stress and may not be adequately trained to handle the demands of the job. It is important that people who are experiencing mental health crises are heard and receive the support they need.

Our research found many concerns about crisis lines including: unhelpful advice, long wait times, and a lack of warmth or empathy from the crisis line staff. People also seem to have different ideas about what the crisis line is for, and some feel that the service is not working for them in their time of need. Some individuals report feeling unsupported and abandoned after reaching out to the crisis line multiple times without getting the help they need. Additionally, making sure that people are aware of alternative resources such as Samaritans and ChildLine can be helpful in providing additional support.

"One person tried to ring the crisis line 36 times about eight months ago. She tried to ring over the weekend and wasn't able to get through."

"I've had experience only on two occasions where I've tried to ring the crisis team and they haven't come through."

"In an ideal world you'd like to have that support for everyone all of the time when someone is in crisis. Just a simple phone call with someone there to support you and they can do it effectively."

"There are stories of people that we've worked with who have phoned 70 times in one night and you're thinking, well what happens?"

"Neither worker had referred people to the Samaritans line, it is a third sector entity."

"I have had success of calling the public number in the past."

"I have heard that the crisis care line does not get picked up, and not just in York, e.g. Lancashire doesn't answer, so it is just a nationwide problem."

"There was a lady I was talking to and she was in an absolutely awful place and she called me up one night and she had overdosed and she had self-harmed and the first time she tried to ring the crisis team no-one picked up."

"Not getting through to the crisis line is a disaster. It is hard for the person making the call…if you've got to that point in life where you think 'this is it' and have had the courage to pick the phone up in absolute desperation and not get through; the knock-on effects of that are disastrous."

"It just seems that they've gone through to the crisis team and unless they are actually well, it's really difficult I know, that everybody is really stretching under pressure but I know that the teams sometimes have phoned and get quite curt answers."

"It could be that somebody is presenting over and over in a crisis but the crisis team is so used to that person that they say 'well no, we're not going to do anything'."

"It isn't acceptable to have a crisis line that isn't answered."

"The crisis line is advertised as 24/7 but it doesn't get answered. It's wrong to offer crisis help and not answer the phone to somebody who is in crisis, whether that's staff or not, they've still got to provide a service."

"I had mixed experiences of people accessing crisis. A lot of people had to access the mental health support line which was Council run rather than access the crisis service line and I think a lot of people found that really beneficial and helpful, but that has obviously disappeared so the only route now is via the crisis service and there doesn't seem to be much

'joined-upness' between the crisis service, the access team and the other services like IAPT etc."

"I've had quite a few people say that they call the Samaritans rather than the crisis team. One gentleman who I've been working with recently said he felt really patronised when he got off the call because they were questioning the fact that he should change his thought processes about things then everything would be ok. He almost felt like he'd been analysed on a call, but then not given any help at the end of it and ended up having to ring the ambulance because he was feeling like he was suicidal."

"We've a had a few people say they've had to ring and ring and ring <the crisis line> and not get through, but it sounds like some of the ones I'm speaking to have managed to get hold of somebody and talk to somebody; it's just that what they're left with at the end of it does feel like anything tangible. So, it's something about 'how do they deem something to be a crisis?' and 'what is their role in support?'".

"A lot of patients feel like if they're ringing them they are in desperate need for something, and they are not getting anything but a chat."

"When someone is ringing in a crisis I suppose their expectation is that someone is going to help, then they are asked lots and lots of questions and sometimes those questions have got no relevance to that person."

"What is the person's expectation on the end and actually what is this service going to offer and that is why quite a few people are just calling the Samaritans, but there isn't a proactiveness with that, no one is going to say right we're gonna call an ambulance or get you the help you need."

"I think one of the issues is when we lost the mental health support line, because I only really heard good things from patients when they were being supported over the mental health support line. It had more of an empathetic approach."

"It became worse (being on hold or in a queue) when they changed the crisis number to this one that covered the area because it used to be just York and you used to ring York's direct crisis team, and I don't think, well I haven't heard of having to be in a queue. It seems to be much more when they changed to this number that covers the whole of TEWV."

"If somebody tried to ring and couldn't get through, put the phone down and ended up that they did end their own life, couldn't that be investigated in a coroner's court? Would they be able to identify; 'well actually they tried to get through to the crisis line?'"

"I spoke to a couple of my colleagues before I saw you and one was saying about a recent incident where somebody was supported to ring the crisis team during the night and it took about 40 minutes to get somebody on the phone to that person."

"My son has given up and doesn't ring the crisis team anymore. He just calls the police or an ambulance."

"There is quite a lot of feedback coming through around people trying to contact the crisis team because they have got that new number now. On the face of it that's a really positive thing because they are offering that kind of general mental health support. I remember with the crisis line when you had to be with secondary care services or a professional had to ring on your behalf, so they have opened it up and made it much more accessible and taken away a lot of the exclusion criteria, but they haven't necessarily got the staffing to support that, so we are hearing a lot from people who are struggling to get through."

"People are ringing multiple times or are waiting a long time to get through because I think if you can hang on you will get through eventually, but it's quite a long wait."

"We have had a couple of horrendous experiences with the crisis line a few years back where there was absolutely nothing on offer."

"Even if my daughter had a knife to my throat, I don't think I'd ever ring them."

"They reckon 10% of people who ring are in genuine crisis and therefore 90% could be accommodated in a much less acute fashion."

"We've had cases where the person is locked in a room, throwing chairs at an elderly parent, an absolute desperation kind of state and then they've phoned the crisis team and been told to tell them to have a bath."

"It's a simple thing, by saying recruit more staff. There's a limit to how that can be achieved but it would be good to know there'll be a response when we call that number. The staff I have always spoken to are well trained, really helpful and no hesitation, I haven't got any concerns about their ability to do their job. It's just having the numbers to do it but I don't know how they would do that, it's not a bottomless pit."

"All I remember is the fact that every single call to the crisis team has been the same level of patronising. There's sometimes where I'll go to the crisis team and I'll leave in more of a crisis than I was in already. I don't know how to explain this, there's a lot of times where they'll make you feel guilty for being on the phone with them."

"Even when I was under CAMHS, I was aware of the crisis line but I'd use ChildLine because they felt a lot less shitty."

"It feels like they're trying to get you off the phone as soon as possible so they can seem like they're doing a good job and they're not, they're doing an absolute shit job because you get better help from an AI generated script because that's all they do because an AI generated script wouldn't have, and this is no hate to them as people, they're dealing with young people who are calling you because they are dealing with suicidal thoughts or are a danger to themselves or others. An AI wouldn't have the same levels of bitchiness when you're like 'hey here are my problems' and

an AI wouldn't turn around and say 'why are you telling me this, what the hell do you expect me to do?'"

"I struggle with picking up cues, subtlety, I'm absolute shit at it all, but even I can tell that they're not happy to be there, they wish they could be somewhere else, and when you're sat there at your lowest point thinking everyone hates me, they are better off without me and someone on the phone that you're calling because you're thinking that is basically confirming that."

"One of my friends had it where they were talking to the person about it, they'd gone through 'three steps thing' and they were turning round and going to them, I've had people saying this to me before; 'it's not helpful can you give me some actual advice?', the person basically turned around and went; 'I don't appreciate your attitude I'm hanging up for my sake', after my friend had basically said 'I'm calling you because this is my last option before I try and kill myself.'"

"It's just an endless cycle of just, you speak to them once, you realise they're useless, you speak to them a second time, you realise they're more useless, you speak to them a third time, you're wondering why the hell you're still calling, you speak to them any time after that and you must be desperate as anything to have any help."

"They don't ask 'are you safe?', 'are you a danger to yourself?', which is an important question because if someone's sat there going 'hey I want to kill myself' your first response should be, 'okay are you safe?', 'do you need immediate 999?', 'do you need someone to come to your house to do a welfare check'?'. They don't do anything like that, just; 'have you tried having a cup of tea?'"

"I have reached a new low every time, to reach out to them and every time I've just been let down more and more."

“For me if I’ve got a whole set of skills behind me from being able to de-escalate and support you, so when we phone the crisis team, it's not willy-nilly because I’ve absolutely run out of all those techniques and I remember the first time I phoned up and it was; ‘this is the state we’re in we’ve done this, this, this’, and she was like ‘yeah you’ve been through everything we’d suggest, there’s nothing else you can do’. And in some ways it was reassuring, because I knew I’d done everything I should’ve done but then you also think, but what am I gonna do now, because I’m still in crisis.”

“And especially when people themselves are ringing and not being able to get through, it's just so off putting that they're in a point of really of desperation. And he just further added to that sense of abandon that no one else cares, by the fact that the crisis team isn't picking up. Also, as well, I think it's something about the way, the way they actually come across on the phone. This sounds horrible, because I know that they're under a lot of pressure. You know, from one sense, I can understand it, but they're very, there's no warmth, well, there's a lack of warmth, when they are on the phone. It's very clinical.”

“If somebody is in crisis, the closing and then it should be literally three or five rings and someone picks up, not 45 minutes.”

"Well, one of the things that came up with the name crisis is really quite misleading. It's not working for someone in immediate crisis. So, it's very hard to find what you say when you use the crisis line."

"It's a funny service of crisis line, it's not really what it purports to be, people are trying their best but it's, it's really a shame."

“I did start using a crisis line and they were just so unhelpful. They kept telling me I had capacity and it was my choice and stuff like that. Which I suppose is useful to some people because it makes them feel like they've got autonomy, but to me it was not useful. No.”

"I sometimes go non-verbal and a crisis line was useless to me."

"I spoke to someone a couple of weeks ago…the irony, I suppose irony of ironies was she'd rung them in extremis. She was young, really young and she was so angry with them, that she put the phone down and didn't do the things she was going to do out of sheer anger, it's a strange model, isn't it? I've heard recently people ringing up and being on hold for like half an hour. When you're in crisis, half an hour is bloody long."

"The overwhelming demand seems to be now, I'm not being completely nasty to the crisis line, I think that maybe they're not trained very well and they are definitely under a lot of stress at the moment, but so is the rest of you know, the health service."

"So, you've got different definitions of what the line is for."

"Neither of my daughters will speak to the crisis team anymore - they're placed on hold/automated messages to call back later and if on odd occasions you get through the advice is useless. You don't get through to York and don't seem to be able to access notes/care plans (like they should be able to). So, advice is quite general e.g. distract self, warm drink, go to bed. So, they don't ring, they don't see the point and think 'why bother'."

"My son has called me crying saying he has been trying for two hours to get through to the crisis team."

"Carer 1 - doesn't ring the crisis team because you can be on hold for two hours - she rings 999 or ambulance instead. Carer 2 - similar feedback - doesn't call."

"Shared an experience about five years ago when she felt her daughter was unsafe and contacted the crisis team on Friday evening, but because her daughter was already under the care of an early intervention team she was told she had to wait till Tuesday to speak to someone from that

team. The next night she called again but she couldn't understand what the person who answered the phone was saying, and he kept getting details wrong like her name, address etc. Because he repeatedly got the details wrong, she gave up and put the phone down."

"The phone line is not accessible to all and some of the advice is not applicable due to physical disabilities."

"If my son couldn't get through, he would take it personally/ become paranoid, so it is important that someone answers."

"It's a load of shit."

"Advice given is not appropriate to a person's needs. People can be suicidal and told to go have a hot bath or a cup of tea."

"If I really wanted to kill myself, I'd try harder" - hanging up on them."

"You have no reason to want to kill yourself, at least you're not in a war zone and dodging bombs."

"It's your choice if you want to kill yourself."

"You're not at risk of suicide else you'd be dead."

"Four hours and then hung up."

Crisis Team

There were 72 statements from participants recounting their experiences of the crisis line accessed directly by the public.

We found that the crisis team can be both helpful and ineffective, depending on individual experiences. Some people have had positive experiences, where they received quick and appropriate support, leading to successful outcomes. However, others have had negative experiences

where they feel invalidated and rejected, and some have even ended up feeling worse after contacting the crisis team. There is a lack of clarity on what constitutes a mental health crisis, and there is a need for better follow-up after contact with the crisis team.

Some participants felt that the crisis team was understaffed and overwhelmed by the demand for mental health services, particularly during and after the pandemic. They suggest that there needs to be a shift in the demand for services to lower-level services, so that acute services can do a better job.

Others have expressed frustration with the way that personality disorders are perceived and treated by mental health services. There are concerns that people with personality disorders are being dismissed rather than being given the support they need.

Additionally, there have been concerns about the crisis team's ability to deal with complex diagnoses. Overall, it seems that there is a need for more clarity and consistency in how crisis teams are staffed and operated, as well as better communication with patients and their care-givers about what services are available and how to access them.

"Crisis care is always in crisis."

"I contacted the crisis team who did respond very well and responded very quickly, within an hour a doctor had come, then we did involve the police, and it went very well, within a couple of hours."

"He was then escorted informally by police, he was then assessed and has had treatment now, so that is a good story of this service working well. He is actually being discharged this week, he is a lot more well than he was when he came in here."

"I have seen first hand the crisis team work and the way it is set up is fantastic and they really do their best, but it's not infinite the amount of people that work within it or the capacity that they have."

"We then called the crisis team and said could you go in and check on this lady and I was quite surprised when they did pick up because I thought nothing was going to happen. But they were there when I turned up and they were offering crisis support and I was able to work with them because I knew the lady quite well, to see if she would agree with a formal admission. So that was a good response from them, very quick."

"Going to the crisis team is not part of a normal induction process, it was a one off for the student placement, but it was a useful experience for her seeing it from that side. Our induction to what it is was all through word of mouth and experience on the job. We'd like to know too…"

"We need to know, what does 'crisis' mean?"

"It <crisis care> is in a dire place."

"We've asked the crisis team to come to us at two team meetings, so that we know more and can define crisis more clearly and understand this service."

"People are often left feeling much worse after their experience with the crisis team. The onus is put on the person to sort themselves out and they're not feeling well. There is a gap, something isn't right."
"But we have had the odd positive but sometimes we've also been fobbed off there's no other way of really describing it."

"The crisis team were really helpful, they referred me on to the access team. They <the access team> introduced me to a department that I hadn't heard of before; the department for psychiatric medicine and by speaking to my GP practice, they are working on getting me a referral via the access team to this new department. So, in my personal experience I've had really good mental health support from the NHS."

"She has been passed to places like Survive and IDAS who can help with certain elements, but they are not here to offer long term support around PTSD. So she's actually been ringing the crisis team on a regular basis and they have told her more about what is in her medical notes, what agreements have been made and what the criteria are that other services haven't told her, so she has just had a letter that says 'you can't have this, you don't meet that.' Whereas crisis have actually explained to her why she doesn't meet that criteria. She is my first in a very long time that has had a really positive input and said that she'd spoken to the same people which felt quite comforting."

"For patients with a personality disorder there would be a less empathetic response from crisis team. So much so that I think some patients would stop using it."

"I guess the crisis team, well I know from working at TEWV as well, is grossly understaffed, and there is such a lot of pressure on the staff because it is so understaffed and there is such a lot of sickness as well, people off long term with stress and things, so that puts more pressure on. So, it seems the crisis team are very much assessing risk and directing from there, it doesn't sound like the kind of support that patients are describing that they got is very therapeutic, it seems more kind of risk assessment."

"I would have said before the pandemic I would probably have seen more follow up from crisis contacts."

"We frequently ask questions and what we'd really like to do is a question on, 'what is a crisis, what deems a mental health crisis?' and 'what does the crisis service do?'"

"We have quite a close relationship with the crisis team, we have our clinical supervision through one of the advanced practitioners on the crisis team and we have quite strong links with xxxxx who comes to our

practitioners' forum and he maintains a directory of online mental health resources which xxx shares with us and is now on Live Well York."

"We can see how much pressure that team has been under and we have quite a lot of empathy for that because the demand around mental health during the pandemic and post pandemic, the impact on people's mental health has been phenomenal and the demands that services and everyone finds themselves under has been really, really tough and I know that TEWV has got a bit of a staffing crisis, they've got lots of vacancies that they are struggling to fill, it's just such a challenging sector to work in at the moment and they've had so many people off sick with stress."

"We very much advocate for people in communities and where there are bad experiences and people have been struggling to get through, that's really awful, but I think you need to balance that with the pressure that staff are under, because they are people as well."

"The crisis team feel that 90% of the calls are not a real crisis. There should be triage and another service for people who feel lonely. The reality is that there is crisis care or A&E, there is nothing in between. The demand needs to be shifted to a lower-level service so that the acute service can do a better job."

"As a service who receives referrals from people still in crisis post-NHS emergency support, we are for low-mid level support run by volunteers and overrun with referrals with PTSD/EDs/attachment disorders/multiple suicide attempts/long term self-harm. Passing these people onto our services is inappropriate and potentially harmful for those clients; voluntary support needs to be preventative, not a sticking plaster."

"I've never heard one positive thing said to me about the crisis service."

"...as a member of staff and part of the mental health community in York and supporting friends and family, I am just appalled."

"There seems to have been nationally this whole shift around people with personality disorders; 'it's behavioural, they just need to knock it off'. I've been told things like I had a professional tell me when I had a client ring me up and it was a Friday and she was really distressed, 'I don't want to be here any more', 'I can't do this', 'I just want to die' and when I got in touch with mental health services they were like; 'she's just being emotionally abusive', 'that's awful what she's just done to you', 'if I was you I'd turn your phone off, pour a glass of wine and ignore her'. That was CMHT and the crisis team that said that."

"I think there is a very common theme along the same lines that people go to the crisis team feeling suicidal and that not seeming to trigger any sort of response whatsoever. Almost like 'well that's how it is', 'it's behavioural', 'they are choosing to do it'."

"Many of my clients that come to me, as you'd expect with NHS complaints, it's about not being able to access mental health services. Generally people <are> feeling very let down by mental health services in York and often before they get to me, they will have got to a crisis point and contacted the crisis team and basically not been given any support, generally <this> is really common thing. I get people saying to me over and over again different people saying, 'I will never ring them up ever again' and actually they felt worse because they contacted the crisis team because on top of their own crisis they are then being treated in such a way by the team that makes them actually feel worse, invalidated."
"When I call <the crisis line> sometimes I get through, I phoned them 37 times until somebody answered the phone. My friend is coming off antidepressants, when you come off it, it's like coming off an opiate, so it's full on, you vomit. She's never been aggressive in her life, she'd grabbed her counsellor by the throat, she was in a mess. So, she rang them 37 times, finally got through and explained the situation and they were like right I'm going to check this and get back to you within the hour. An hour and a half passed, <person 1 - that's a very common theme, they say they'll do

something and then it not happening> nobody rang back and my friend was escalating, so I rang back again 17 times (it's funny how I remember) and I got through and explained who I was and they had no record of my previous call. At this point my friend was just broken and couldn't take any more, she wanted to rip her own skin off, she went into the other room and … ended up in intensive care. That's the crisis team."

"Some of my clients will try A&E and feel rejected by A&E and not getting any support there and then they'll try the crisis team and the same thing happens with the crisis team, so that's quite a common thing for my clients; to try one and then try the other and just then where do they go after that? I had one client who would threaten to throw himself under a train because that was the only way, then the police would get involved, but at least somebody was reacting. That's how bad people can feel, like 'what do I do now?'"

"People feel they have no choice but to do something that forces professionals to look at them. It's desperation."

"I've lost clients. Xxxx died in from drug induced psychosis. I attended the inquest and was involved in the whole situation. He moved back to York <from London> and he really struggled, so he started drinking and had a bit of a problem with drink for a long time. He went off to xxxxx and by Monday he had completely lost his mind. Every single day at least three times a day until Friday he came into contact with the crisis team, he was going in and out of the police station, in A&E, the crisis team were going out and seeing him. He was running round York 'they're gonna kill me, they're gonna kill me'. They're going to put me into three pieces and chop me up. <He was> turning all the phones off 'they're listening, they're watching. They're coming, they're coming.' On Wednesday he begged the crisis team, I don't know if it was a moment of insight or what, he begged them; 'take me to hospital, I'm begging you, I'm begging you'. They gave him a 30% chance of killing himself, I don't know how you make that sum, and wouldn't admit him. They said he didn't need admitting. He needed to come down off the

drugs, but he hadn't actually taken any more drugs. They call it first episode, second episode, when you get to third episode they'll then look at sending you. By Thursday he'd given up, decided he wanted to take back control, he didn't want to be chopped into pieces, so his only choice was to xxxxxx. So, he took xxxx on Friday night and didn't expect to wake up, he was very surprised when he did. So he took xxxxx on Saturday morning and then crisis team turned up about lunch-time, and he was like 'it's all right now they're not coming for me, I've taken xxxxx, so I'll be dead shortly. Then they were like 'oh no, quick get him to the ambulance' and off they went and they were obviously trying to put drips, but he said 'oh no, no, you can't don't treat me, because if you treat me then they're going to come and I'll be chopped into three pieces. So, they had to sedate him and he was in a coma for 11 days and he spent his 37th birthday on a mortuary slab. They carried him to xxxxxx in a box; a year later on his birthday, scattered him on xxxxxx. We were at the inquest and the coroner was saying; 'why did you not intervene?' He begged you."

"Within mental health crisis services in York the fact that you are suicidal just doesn't seem to make a difference to the care. It's just like Russian Roulette. One of the things I've been really shocked by is that a client comes to you and says, I told them that I feel suicidal and still they are not offering any mental health support, so how bad does it have to get, can it get worse?"

"Clients who often end up in forensic hospitals, frequently have been in crisis, without intervention, despite asking repeatedly for help, and then feel they have to escalate to force reaction from emergency services, including eliciting "suicide by police" which leads to them being charged with an offence instead of receiving mental health crisis care they need."

"There was a point when he was convinced his neighbours either side were plotting to kill him and were talking about him and he was very, very afraid and very frightened. So, he's got an axe and then he was like, I've got this axe and he was crying down the phone; 'I don't want to hurt anybody', 'I'm

*not a bad person', 'I don't want to burn in hell', 'I'm so afraid, and they're plotting, they're gonna kill me'. Do you know what crisis team did? Absolutely f*** all. These neighbours had no clue, he was sat in that flat with an axe. Could you imagine that you were living in that flat and you had no idea that there was a man upstairs <with an axe> and he was ringing us, he was ringing crisis team, he was ringing the police, he was ringing ambulances, but guess what one of his diagnoses is? Personality disorder, so they won't <intervene>, oh 'this is what he does'."*

"Another thing is that crisis team agreeing to do something like call the person back or arranging stuff and then it just doesn't happen, so that's really common, and obviously you're at the point when you needed to ring the crisis team that is huge if someone has agreed to do something and it doesn't happen. That has a big impact on my clients. You have to be really, really desperate to get to that point and just being turned down or things being agreed and then not happening is the nail in the coffin."

"I am aware that a lot of people ring the crisis team when they're not in crisis and I think that's because of lack of other services like the preventative stuff that's really struggling so I know that it's really difficult for the crisis team to judge who is really in a crisis and who isn't. But I think that if you have a carer who's saying I've tried all these things and we are at this stage, that carer is also in a crisis, not just the person that they are caring for, it's the carer too that's also in a crisis. That's really demeaning to suggest things like go for a walk or have a bath which are really not helpful at that stage."

"In fact, we've had a couple of really positive ones, so we've had someone in complete and utter crisis and we've phoned the crisis team because they'd tried and not managed to get what she needed. The person we spoke to was brilliant and really good, they said we'll take this off you which is what we needed, we needed them to say we've got this now because it was far, far beyond really complex. And that was really positive, so we have had good experiences."

“So, we have major frustrations getting through to the crisis team when we have managed to identify a patient who is at risk and they become active in a patient’s life. Fantastic service, it’s just that initiation and getting the patient known to them but we have problems initially.”

“I’d rather just internalise it then have someone guilt trip me, tell me that I’m over exaggerating, that my issues are just on me, basically ‘it's your problem, you deal with it, I couldn’t give a shit, I don’t get paid enough to deal with you.’”

“I don’t think there’s actually anything positive that I have ever experienced with the crisis team besides, they’re funny to laugh at.”

“Whenever I’ve called, they’ve always been like, “is there someone else we can talk to?” basically. That always seems like they genuinely don’t wanna talk to me, they’re happy to talk to anyone else, except me.”

“And actually, it ends up being more unhelpful to individuals than helpful.”

“It's almost as if when you ring them from the point of contact, they're trying to get you off the phone, and they're trying to push responsibility back.”

“I'm not gonna say it's getting worse, because I don't think I've got actual evidence for that. But it's definitely not getting better.”

“It's the elephant in the room that they haven't got the resources that they need to deliver the service that's needed. And it does put pressure on the staff. Actually, what they do need is an investment, so that they've got the team to be able to do the job and their staff are not getting burnt out.”

"If it's not going to be a crisis service, then it needs to be more clearly communicated what it is."

"The underlying sense that I got was that they're very aware of the weaknesses, but don't have, or aren't granted enough resource by the top level to do it."

"With the crisis team we're still getting issues around people. I'm still getting it all the time, I just put this call in to the crisis team because they don't have a phone to register. Even though I'm working within xxx, she really tries to ring a care coordinator at Huntington House. Nobody ever gets back to her until about two or three days later, by which time she's potentially self-harmed because she's not got through to the right person."

"Sometimes they (crisis team) have been great, when I (carer) have spoken to them when there has been an issue or I've needed advice."

"They didn't seem to have the power to do anything or stop it going further (crisis team)."

"My daughter was becoming unwell and the care coordinator asked for CBT but they refused and then things went downhill so then a social worker, crisis team, consultant came - crisis team said she argued for my daughter to stay at home. But we were past that point and she was detained under section 2 of the Mental Health Act."

"There have been times when they were needed but they weren't able to step in (crisis team)."

"I am not quite sure what their role is (crisis team)."

"Carer - hadn't contacted the crisis team but was put off from making contact because of the bad things she has heard about them and worried what would happen if she did contact them."

"A service sitting beneath the crisis team would be good - something more preventative (to stop things reaching crisis). xxxx from First Contact talked about the Durham model where there was a listening service which acted as a sort of triage to filter out those who needed to talk from those who were in crisis."

"The length of time it took to process the paperwork for a crisis call, if unknown to TEWV."

"There are certain complex diagnoses that services seem either to not understand or are scared of, so you get offered nothing at all – even crisis services when in actual crisis."

"What is the definition of 'crisis'? Lack of clarity of stages..."

"Support isn't what we thought it was going to be..."

"Initial contact with crisis team and liaison team was okay – respectful."

"Told police to leave her alone to kill herself - 'she won't succeed so leave her to it' - at least four times."

"Crisis don't offer solutions."

"I don't call the crisis team, I avoid the crisis team."

Criteria Threshold

There were 24 statements from participants recounting their experiences of reaching, or failing to reach different 'thresholds' for treatment.
We found that people who are in crisis are often being turned away by mental health services because they do not meet the criteria threshold for support. The threshold for what is considered a crisis is described by many participants as being very high, which means that even people who are feeling suicidal may not be considered unwell enough to receive support.

This situation is problematic both for the individual and the system as a whole, because it means that people who are turned away may become more unwell in the future, which could be prevented by lowering the threshold for support. We also found that it can be difficult for professionals to judge whether someone is in crisis, and that families and carers feel better placed to recognise the warning signs.

The criteria threshold is not always clear or consistent across different services, which can make it difficult for people to know where to turn for help; some people may be denied support even when they are in genuine need, while others may be able to access support for relatively minor issues.

The text highlights the need for mental health services to be more flexible and responsive to the needs of people who are experiencing a crisis, rather than relying on rigid criteria thresholds that may not reflect the complexity of people's experiences.

"In terms of crisis care. Lots of people are waiting on mental health support, they haven't met the criteria for mental health support."

"A lot of people have asked for referrals and for whatever reason the criteria isn't met."

"It all seems to be about criteria; what is your criteria to access this service, what is your criteria to access the community mental health team, and that bar seems to have got higher going back to how it has changed with the Trust."

"It can be a bit hit and miss, because people are in crisis, or feel that they are in crisis, quite often it is not the same thing."

"It is difficult as a professional to make a judgement as to whether someone is in crisis."

"Families and carers know the warning signs so we should be listened to."

"Boy, have I had to become very unwell to get some support."

"I mean I haven't seen the bit of paper with the criteria as to how you access it, but I did speak to a LAC about criteria and they were telling me how ludicrous it is."

"In terms of crisis care. Lots of people are waiting on mental health support, they haven't met the criteria for mental health support. Someone told me it was 18 weeks before they can get onto the first rung of potential mental health support, which is far too long if you're struggling."

"What I'm hearing from patients now is that they feel as if they go somewhere the door is shut, but there isn't a 'joined-upness' which says 'you can go to this service'. Each of them have their own criteria for when they'll help somebody, so it feels like if you don't get through that one you have to try another route and another route."

"I had my first positive chat with somebody about the crisis team yesterday. Somebody with complex PTSD is not able to access therapy support via TEWV, apparently they have been told that TEWV no longer offer that level of support, but they do offer it if you can get into the CMHT, so if you can meet the criteria for CMHT then they might give you some support around trauma, but if you don't meet the threshold, and this lady has been told that she doesn't, then you can't access any trauma support."

"That lady who I mentioned who had had a good experience of crisis; she is at the point of wanting to make a complaint to TEWV because she's been diagnosed with complex PTSD, had a long history of domestic violence and other kinds of abuse in her life and she's having flashbacks, panic attacks, on a daily basis. She knows somebody from going to a kind of drop-in support place who had also been diagnosed with complex PTSD who has far, far fewer symptoms and is on far less medication, but is accessing the

Community Mental Health Team support, she has a psychiatrist a CPN who visits her. This lady has been told she doesn't meet the criteria for the Community Mental Health Team, so how....if you know people who are still working with those teams and now they are not able to even get through the door."

"Certainly even from the GP's perspective, this particular GP who is working with this lady is really trying to push the doors down, she keeps going back and saying you've referred her to IDAS, but IDAS has said they can only do this, so they are not able to give that level of input that she needs. You've now told us she needs to go to Survive, so she's going to Survive, so if Survive turn round and say 'we've done what we can do', where does she go? But the letter said that she doesn't meet the criteria for CMHT and that is where she might be able to get some trauma support, so she is just in crisis on a day-to-day basis. Luckily her crisis team experience had been positive, because there is somebody picking the phone up helping her to de-escalate when she's going into a complete state and trying to help reduce that, but they are still not giving her any input. So she's just in a crisis situation all the time, she is ringing the crisis team every day pretty much and having that contract, but she still doesn't meet that criteria, so it's hard to know what that criteria is; is it that somebody is presenting at A&E a lot, is accessing GPs a lot, or not, it seems really difficult."

"If a patient has a crisis outside of CMHT hours at weekends then they phone the crisis team, or if you were really concerned about a patient over the weekend you might put in a referral to the crisis team to see if they'd do a home visit to check their safety and support. Over time I found that the level of risk for the crisis team to actually accept a referral was rising and rising. For someone to get support from a CMHT they are raising the bar and for somebody to be admitted to hospital the bar is being raised again. This started happening about three years ago."

"One of my clients, I'd been working with her for a long time. She was 13 when she first started being unwell, she was adopted, <there was> abuse, a difficult start to life. She was at CAMHS and she had literally, like chicken

scratches, she said 'and I've done that to my arm'. They were superficial, she'd hear the doctor and her mum talking saying; 'I wouldn't worry about them, nothing more than superficial scratches'. Nothing to worry about. So, she went 'superficial, nothing to worry about, I'll show you'. This girl now is in her 30s, and has experienced an escalation to life threatening extremes of self-harm."

"He's like been in Huntington house, I've been involved, but on Friday he wouldn't leave the flat, paranoid psychosis, thought that York was full of demons and ghosts so won't go outside. Also thinks that he's going to die and he's going to burn in the middle of the sun and also that children were going past his window shouting "you're gonna burn in the sun". He told his sister to read the book of Revelation. So, she phoned the crisis team on Friday, they spoke to him and because he wasn't voicing active suicidal ideas, they said he was okay."

"Some of the carers are in their 70s, 80s, they're worrying about what happens when they're no longer here but when they are here, they're banging on the door asking what we do when I'm in a crisis. You know, I'm looking after someone 24/7 and no one's helping, no one's even listening and telling me what to do if things go completely wrong, what is gonna happen when they die."

"Not if you've attempted once but if you've attempted three times then you can reach out for help. But if you die on the third time, not their problem."

"People with mental health difficulties, particularly if there's risk involved, can end up slipping through the cracks where they're not severe enough for some services, and sometimes you're the only person who is going to see them who's going to check in on them, even though you shouldn't, and even though you're not a mental health professional, when you're made to feel like you're the only person in the service looking out for them, it's very hard to disengage, even if you're not the most appropriate person, because at least you're someone. Yeah. It's really hard. And we're all having to work on our own boundaries of that and how we handle it."

"Xxx is bi-polar and she'd come out of an appointment just really frustrated and she'd be like; what do I have to do? I wonder if I get up and wrap the phone wire round his neck."

"It's a gatekeeping place, the same as IAPT even going on the form to fill in the online referral form for IAPT which is now the go-to, you've got to do that. The minute you start to say you have self-harming tendencies or you drink alcohol to excess it's 'no, no, no, not suitable for IAPT'. But then you get somebody like this lady who gets through all of that and they turn round and say we don't offer specialist trauma support, you need to go to CMHT, so you go back to your GP from IAPT, GP then refers to CMHT; no you don't meet our criteria, back out again to the access team, 'oh we're going to give you a five week managing emotions course'; she goes on a five week managing emotions course and it doesn't deal with any of the PTSD and trauma, but helps in some ways with understanding emotions. So 'we've done our bit, we can't do any more', so you're back out again. And that person is just…it's that revolving door thing again. So, she's not going into hospital all the time, like when I first started working in advocacy, it was a boomerang in and out of Bootham. So now it's a boomerang around these services to try and get anywhere and that's the difficult bit."

Foss Park Hospital

There were 11 statements from participants recounting their experiences of Foss Park Hospital. Foss Park Hospital is a purpose-built, 72-bed hospital for people with mental health problems and dementia, it opened in York in April 2020.

We found that Foss Park Hospital has been the site of several disturbing incidents involving patients with mental health issues. The hospital appears to have long waiting times for patients and discharges that may have been premature.

The first story mentioned is about a young woman who attempted suicide and was admitted to Foss Park only to be discharged and attempt suicide again. When the police found her, there were no ambulances available to

transport her, so she had to wait in a police van for hours before being seen by a paramedic. Another young girl who was discharged from Foss Park completed suicide shortly after leaving the hospital.

Some patients appear to have been neglected after being discharged from Foss Park.

Overall, these stories paint a picture of a hospital that has struggled to meet the needs of some patients and has failed in some circumstances to provide adequate care to people with acute mental health needs.

It is important to note that some of the cases detailed below are from the perspective of staff and reflect their perspective concerning particular incidents. Healthwatch York does not have the individual's perspective, but the statements below reflect the concerns of workers within the local system. Some of the incidents described have been the subject of subsequent in-depth investigations by multiple agencies at various levels.

"There was a girl and something really awful had happened to her, she made a massive suicide attempt and got admitted to Foss Park. She'd had to wait four and a half hours in a police van. Also, she was detained but they kept letting her out on unescorted S.17 leave. That situation repeated over the course of a week, with police bringing her back each day after they let her out unescorted from the ward."

"A young girl discharged from Foss Park got on the bus outside Foss Park....(went by bus to place where attempted to take her own life)....she died."

"I am currently at war, right now, for yet another unsafe discharge out of Foss Park. It's just relentless."

"There was a lady <with a> learning disability, mental health issues, she was outside the <shop> in <location in York> for a fortnight after being discharged from A&E, been in Foss Park for a while, they couldn't find a placement for her. They discharged her out of Foss Park, then she was in A&E then I was on the phone to hospital liaison as they tipped her out of a

wheelchair into the street. She then spent two weeks on the floor outside the xxxx in xxxx. For some reason the bottom half of her was completely naked, we are unclear why. She had ulcers on her legs, by the time we got her off the floor she had maggots crawling in her legs. We thought she was going to lose her legs. We had to use a guardianship order to be allowed to drag her off the floor. She was covered in urine, she was covered in faeces, her bank cards had been taken, jewellery had been taken, she told me that somebody had injected her with a drug, and a drug was found in her system, she is not a substance abuser. This lady required a specialist placement, but due to delays in finding/securing this for her, as she was informal, staff would allow her out unescorted, despite her vulnerabilities, and she'd disappear for a couple of days and turn up in A&E. This was happening repeatedly. This lady had a diagnosed personality disorder, as a result, it was felt her presentation was behavioural and she was discharged from Foss Park. Whilst in A&E, she began shouting and swearing, so was told to leave and present as homeless at West Offices. "She could have lost both her legs. She is now in a place where, she's very traumatised by what has gone on, she is very mistrustful, very frightened, but she is now doing quite well. It's scary, really scary. Whenever I do this job, I always think; 'that could be me' it is sheer chance, sheer luck. There is real compassion fatigue out there; but what would you do if that was your mother?"

Funding and resources

There were five statements from participants describing their views on a lack of funding and resources within mental health services locally. Funding is a significant issue in the provision of mental health services, particularly crisis support. Lack of funding and challenges in staff recruitment mean that the crisis service is struggling to cope with demand, which puts pressure on other services such as A&E and voluntary community support groups. The cuts to funding over the past decade have been described as 'shocking', and there is a perception that mental health has been neglected in favour of physical health during the pandemic. The lack of funding has also been blamed for inappropriate

referrals and limitations on the work of charities. There is a sense that more funding is needed to provide additional beds and support, and that mental health services require more attention from policymakers.

"A lot of it is about provision and about where the funding is and where it isn't, because everyone has got a huge case load."

"It's funding and the last 10-years of cuts have been shocking."

"More beds needed, if there were more beds this would take pressure off crisis and A&E."

"Funding, or lack of, seems to be used as an excuse to offer nothing."

"We're never going to have enough crisis support, particularly in the last two years, when most of the funding has gone on the physical health and quite rightly so in the pandemic, but now we are realising mental health has been bubbling away in the background, I think that there is an assumption that people are back to normal now, but they are not."

Mental Health Services

There were 19 statements from participants describing their views on broader mental health service issues.
The current mental health system is struggling to cope with the demand for services, and there is a lack of preventative services and referral options for professionals. This often leads to people seeking help in A&E or relying on voluntary organisations, which are also facing increased demand. People are calling for a mental health service that is more holistic, similar to the Trieste model. There are also concerns about the lack of services for children, autistic people, and older people.

Many believe that mental health is not given enough priority compared to physical health, and there is a need for better training for professionals to assess and refer mental health patients. There are some positive examples, such as the Papyrus service in the UK and the preventative

approach taken in Scotland. Some suggest that the entire system needs to be overhauled to reduce stigma and improve communication.

"If you look at the Trieste model, which is something that York is trying to bring in, it is that open access to mental health services at the point that the individual thinks that they need it."

"I mean the mental health system is in a mess isn't it?"

"There are many people in absolute crisis with their mental health."

"We do get lots of carers ringing us after they've tried the crisis team and after they've tried lots of others, they've tried GPs, they've tried the crisis team, they've tried the mental health services. Then they ring us, but we are not mental health specialists, we do not know the answer, but we end up dealing with a lot of issues that are far beyond what we should be doing as a voluntary organisation."

"We have very few places to refer them to, we have very little in bed situations in York, we have absolutely very few services for people with eating disorders for example or you know psychosis and things like that."

"I think closing some of the services in York has been particularly detrimental to people. We just don't have that place of safety to refer people into. You can send them to A&E, but they are busy with other things as well as mental health. We just send anyone who's actively injuring themselves or psychosis to A&E."

"So, I think instead of triaging the patient, I think it would be better to have further training in surgeries to make sure that the quality of referrals is correct. It's time, it's a heart sink situation, we're all trained in physical health 100 times over, so if someone comes in with a pain of the stomach we're happy to assess that, we can assess that we've got our referrals we can get that sorted and we know how urgent it is, if someone's talking

about mental health, it's not a 10 minute appointment it takes us a while to dig deep enough to understand how distressed the patient is."

"And it's just like a revolving door, I think with a lot of people is the fact that they're in crisis, because there's a lot of stuff outside their control, whether it's work, housing, you know, difficult family relationships, past trauma. But when we've got them out of immediate crisis, there's no kind of, oh, but they're still in crisis. And we need to work holistically."

"I think mental health, and to be honest care for the elderly, are always bottom of the list. And it continues to be the case. And that's a fact that I think that's because they've got less of a voice and less power and they're easily ignored."

"Somebody said a whole lot of people are finding Papyrus really useful."

"Scotland's very different mental health wise anyway. I mean, it was a while ago, but it seemed like it was very aimed at preventing crisis, rather than in England, where it kind of feels like they wait as long as physically possible and then swoop in at the end."

"In Scotland, I could get treatment. In England, I can't because my BMI is not like dead."

"Scrap the entire system and start over without the intrinsic stigma and assumptions and with improved communication."

"Services for people with autism?"

Police

There were three statements from participants about the police in York. The police in York appear to be involved and well-trained in dealing with mental health crises. It's important for all frontline workers to have an understanding of mental health and be prepared to respond with flexibility and compassion. It's also encouraging to hear that the police are taking

steps to improve their skills and knowledge in this area. Collaborative approaches between different services, such as the police and mental health services, can be effective in providing better care for individuals in crisis.

In response to discussions about the publication of this report North Yorkshire Police offered the following statement to help gain context of their work in crisis care:

North Yorkshire Police, Force Control Room Mental Health Team

The team are mental health clinicians, employed by TEWV and working within the NYP control room. The team are part of the network of mental health crisis service, and work with NYP to help NYP deliver the most appropriate response to mental health crises being reported to police.

Over the last decade, it has been seen that the number of mental health crises to police have increased dramatically. One response has been 'street triage', where a mental health clinician can attend crises with police officers. There is no national model for this type of service, and its application nationally is patchy. The North Yorkshire model now has no street triage, and the clinicians in the control room attempt to meet this demand remotely – as the large geography of North Yorkshire is such a challenge to be able to attend in a timely way.

The aims of the team are to ensure that people presenting to NY Police in mental health crisis receive the most appropriate mental health response in a timely way. They also aim to minimise the number of unnecessary Section 136 MH Act detentions, and reduce mental health demand upon the police, by resolving issues or getting people to the correct place. The team work to their aims by giving advice to police and carrying out mental health triages by telephone.

"The police in York are a lot more understanding and prepared to work with staff than they were 20 years ago around things like mental health. Officers seem to have a bit better knowledge around mental health issues and tend to be a bit more prepared and flexible. They turned up in our old

hostel with an attitude that these are the worst people in the city and we're here to arrest them, or we're not coming. Whereas now they do tend to respond, it does depend upon the individual officer, but we have had one or two circumstances where we have sat down with an officer and said, 'right how can we deal with this?' to get the person the help they need."

"I'm a trainer for this thing called assisted suicide prevention; the police have been sending more people on that, because they're often the frontline for mental health increasingly, you know, think that they've always had to do that stuff. So, it seems to be as if there's a willingness or recognition to improve their own skills."

"First contact was good – police triage involvement, knew her well."

Prevention

There were five statements from participants about the role of prevention in mental health services.

Prevention has been a theme in this research and there is recognition of the importance of prevention in mental health. Early intervention and proactive support can help to prevent people from reaching crisis point and can ultimately lead to better outcomes for individuals and less strain on mental health services. However, there are also challenges around funding and resources for preventative measures, and it can be difficult to shift the focus away from crisis management towards prevention.

Nonetheless, it's encouraging to see that there is a growing awareness of the need for prevention and that there are calls for more investment in low-level support and early intervention services.

"We need things that reduce the likelihood of crisis because people don't just wake up in crisis, it's a build-up."

"Peer support is brilliant, having an avenue there that is pre-crisis, that for me is an obvious thing, be proactive and put something in pace before we get there, then we can alleviate the crisis team."

"Community support should be more preventative and less reactive."

"Going down the road of talking about prevention, and that is an arena that need to be talked about, but that seems quite unfathomably difficult as clearly the funding is problematic around the crisis point, so trying to look at trying to help someone not get to that place in the first place seems like a vastly difficult conversation."

"Preventative/low level NHS support before people's mental health deteriorates to crisis (turning young people away from CAMHS as 'not at risk' is negligent) and means more money/resources down the line."

Reduction in Services

There were three comments concerning a perceived reduction in mental health services.

This perception may result in people not being able to access the care they need. It also increases reliance on the voluntary and community sector, which may not be always be equipped to handle high-level needs.

There was also a feeling that access to emergency support and second-tier support, such as community mental health teams, trauma therapy support, and psychiatry input, have been scaled back. This may leave individuals struggling to manage their mental health conditions without the necessary support and resources.

"With Leeds and York Partnership Trust there seemed to be much more access to crisis support and mental health support in general, even though at that point people said there wasn't enough mental health support. When we're looking at what we've got now, compared to what we had, you can really see that difference in the access to emergency support and also the access to 'second tier' support; access to the

community mental health team, trauma therapy support, psychiatry input, so it's really scaled back."

"I started working with xxxx in 2005 and at that time the access in the 'in' to mental health services seemed to be more there, you had Bootham, I know people had issues with Bootham Hospital, but the services were all there in one place and it felt more accessible."

"Now it is resulting in people needing to complain, making an NHS complaint because they are not getting any help. I think that people thought when TEWV came in that they are supposed to be a mental health trust and obviously you've got projects all over in the North East, so people thought that they would be coming in and improving what was already there rather than stripping it back. It does seem to push a lot of pressure onto the charity sector."

Staff

There were seven comments concerning mental health staff.

Despite negative experiences with mental health crisis care shared as part of this research, many of the participants recognised that there is more of a system issue rather than an issue with individual staff members. It's important to recognise that staff members are under significant pressure and require more support and training to provide the best possible care for those in crisis.

Some healthcare professionals who do not work in the crisis team also feel they need more training in knowing where to send people when they are in crisis. This highlights the need for a comprehensive approach to mental health training that extends beyond crisis care teams to all healthcare professionals.

Many individuals working in the system go above and beyond to provide support to those in crisis. However, some feel that the level of support for

workers is very low, and more support is needed to prevent burnout and ensure staff can provide the best possible care.

Some felt that there were not enough trained people to deal with mental health issues and that there is a lack of support for individuals who need it. This highlights problems around recruitment and the need for increased resources and funding to address the mental health crisis and ensure that individuals can receive the care and support they need when they need it.

"The majority of feedback that I have had about individuals within the system has been amazing, some of the examples I've heard of how support workers are absolutely… they have done everything and put aside their own time to help people has been extraordinary, so it feels like such systems are full of wonderful human beings, but as soon as you look at it from a system level it becomes problematic. It is almost like you want to say to people, please don't take this personally, this is the system's problem not you, you are awesome."

"I've probably had as many tears from people working within the system as I have from people trying to access the system. I think the level of support for workers is very low, so sometimes there is peer support and sometimes a telephone line and occasionally people have access to professional support for an hour or so, but generally the support is very low."

"The root of the problem is that there are not enough trained people to deal with this. There is a public narrative around talking more about mental health, which is a good thing, but there is nothing to support people when they do."

"We had a case here; he said: 'this is my last day here and if I don't get help this is what I'm going to do' and for somebody who's not trained or not clinical to make that decision is very difficult. More training or more intermediate support would have been much better."

"It's difficult with the social prescribing because we are supposed to be working with people with mild to moderate mental health problems, but there are people coming through that are more severe and I'm finding that, even though it's not part of the role, I am having to draw on some of my mental health nurse training, un-officially really. I think I would struggle a lot more if I hadn't had that training, I really would, so I feel for people on the social prescribing team who haven't had a lot of mental health training."

"A lot of pressure on staff and we could earn more without this stress."

"We're all concerned, you've always had that case where it was a patient that you didn't think was severe or something like that but, ultimately, we did something and we've all had that situation where you've got someone sitting there going 'oh we'll be alright' and then a few days later you hear that they've, you know. So, I think it's also that fear and how comfortable you are at saying, well off you go now."

TEWV

There were 13 comments concerning mental health staff.

TEWV (Tees, Esk and Wear Valleys NHS Foundation Trust) was criticised by many participants for becoming less person-centred and overly focused on discharge and processes, often making assumptions about patients that limit access to support.

Some staff members have also expressed frustration with TEWV's standardised and model line approach, which they feel limits their creativity in working with patients. Some patients have been hopeful for change but remain sceptical, citing broken promises.

However, some have been optimistic about recent investments in funding for early intervention and support, which they hope will have a positive impact on reducing demand. TEWV's approach is to show patients that they have a choice in their recovery, which may be well-intentioned but

may not be suitable for all patients. Patients have expressed frustration with the difficulty of making complaints and accessing support, with some feeling that TEWV actively ignores their concerns.

"I was working with the xxxx team when TEWV took over from the Leeds and York Partnership Trust (LYPT), there were quite a lot of staff that left because they were unhappy with the changes. But it felt to me that the way TEWV worked with model lines and very systematic way of working, as a member of staff you lost that creativity that you could have with patients because everything had to be done in a certain way, it was very standardised; a certain staying 'well plan' had to be done and at each meeting in the morning you'd have to say what you did with the client the day before and how you'd moved them forward on the pathway, so it was very much about moving people forward in the process and then discharging, whereas before with LYPFT you felt like you had more creativity and more space, so you could have an appointment with somebody and the goal could be 'building therapeutic relationships', but therapeutic relations wasn't one of the processes, so it kind of, to me, it felt like that was being removed and in my nurse training the big part of mental health nurse training is that the therapeutic relationship is absolutely key, but the reality I found with TEWV is that is hard because you just don't have that time and the pressure is on targets, processes and 'moving people on'. So, it feels very different to what I thought I was signing up for when I trained to be a mental health nurse."

"One of the positive things for my team is, we've recently got some funding in from TEWV and the CCG which comes from a pot of funding called alternatives to crisis care. Where they are looking to invest in early intervention and upstream support for people, to prevent them from getting to the point where they are in crisis and keep people well. They've recognised that we work with so many people in the community, supporting them with their mental health and that has had a bit of an impact on reducing that demand. So, we've been given a little bit of funding to increase the capacity of our team. That's like really positive partnership working."

“A general theme is making a lot of assumptions about people very quickly and often that assumption means they’re not gonna give them any support. I don’t know if they work that way because they are under-resourced.”

“They don’t want people to become what they call a career patient, a revolving door patient, and this becomes their entire life. They want to show them that they can be their own heroes, they can save themselves, they do have a choice, you don’t actually have to cut your wrist, you could do something else instead, you could treat yourself with kindness, you could stop hurting yourself because you deserve better than that. The theory of it is great, it’s coming from a place of good intention, but some people with certain conditions, things like Emotional Intelligence, <without> social support, family support, some people don’t have that. There is a massive assumption there.”

“Some people might always need that support worker and that’s ok. Let’s be realistic about that and don’t pretend these people don’t exist.”

"I keep hearing things, you know, 'we're on a roadmap to improvement', but this has been almost a year of watching in quite some detail a system that feels like it's getting worse."

“I’ve had some serious situations with my son (complaint level) - when my son is in crisis, he has to come first. I don’t have time to write letters etc.”

“It's very difficult to make a complaint - I do not have time or energy due to my caring role. If I do then nothing comes of it, and the procedure doesn’t work.”

“During the day you’re supposed to ring your team’s duty worker but this is a voicemail.”

“You have capacity – it's up to you – you have choice.”

"TEWV took on care but openly actively ignored Retreat plans."

"Package of care – funded with old home team 1% and TEWV ongoing – agreed – nothing happened."

"Notes not accurate, information missing, discrepancies between experience and what's written."

The Haven

There were six comments about The Haven.

There is support for The Haven (which offers mental health support to anyone aged 16 or over in York) as it provides a valuable service that is not necessarily offered by crisis care. People feel that the Haven provides a place where they can be heard and listened to, which is not always the case with crisis care services.

The accessibility and drop-in nature of the Haven/hub model is also appreciated, as it promotes community support and a more preventative approach to mental health care, rather than a reactive one.

Some people are even suggesting that the community mental health hub model should be the way forward for mental health care services. However, there are also some concerns about whether the community mental health hub is simply filling gaps in the current system, rather than fundamentally changing it.

"The Haven provides something that crisis teams can't provide, which is both a place and people to listen, I don't think crisis is there to listen, they are there to respond."

"We've got the Haven that you can go to in the evening and we've got a 'staying safe number' so we've got Samaritans and support like that."

"Crisis team should not really be signposting to the Haven without assessing the safety of the client/patient. Haven is not designed for or have capacity for very high risk."

"The Haven/hub model was good, and this was because it was accessible and you could just drop in."

"Mental Health Hub - <we need> everyone to buy into this and TEWV to put emphasis on this being the new way forward."

"Community Mental Health Hub, what will this achieve? Is it gap filling?"

Waiting Lists

There were 11 comments about waiting lists for mental health services. The length of waiting lists for mental health services continues to be a major concern for many service users. Long waits for care discourage people from seeking help and put them at risk of reaching a point of crisis. Some service users have experienced waiting times of more than 18 weeks, and this delay in accessing care can put additional pressure on an already over-stretched system, including crisis teams, contribute to and increase mental health crises.

"The GP is often the place that people refer to, but can you get hold of a GP when you need it? Certainly not, or you can book in something in two weeks' time."

"The waiting time for mental health care through a doctor is another bit of gatekeeping."

"I've just walked in having built up the courage to ask for help and I'm told, actually you're not that important, come back three weeks on Thursday."

"Someone told me it was 18 weeks before they can get onto the first rung of potential mental health support, which is far too long if you're struggling."

"Getting some kind of aftercare from the mental health service takes 12 weeks, this seems to be a bit of a standard timeframe, but still that is not enough."

"Initially on the call <to the access team> the person said, 'it is a 20 week waiting list', but then she said 'it is urgent', and I said yes 'I think it is'. So I hung up and five minutes later I was called up by a consultant."

"Waiting lists have always been a problem, but they seem to be getting worse. Often when you need help you need it soon, not in six months or a year's time, that's no good really."

"I've certainly had; 'come back and see us in three weeks on Thursday', so is that the help? 'What do I do between now and three weeks on Thursday?' 'Well, you just have to manage', and that has been quite consistent. I might be in deeper trouble by the time I get to you, or I might not get to you because I'll think, you know, 'I've had enough'. I have actually considered taking my own life."

"I don't think that people who don't have a mental illness or condition realise how long that two or three weeks or months actually is, and very sadly some people don't make it to that time, because they make a different choice which we know very sadly does happen."

"They've been promised that they'll have an appointment within a week, but a week is a long time when you're in a mental health crisis."

"We're creating more mental health crises, the system can't cope with what we've got anyway and then we've got a backlog of waiting lists, creating even more for the crisis team which is already snowed under."

Case Studies

Case study of a person admitted to A&E in York Hospital after a suicide attempt.

My neighbour had found me and called the ambulance to get me to hospital. The usual long wait in A&E. Eventually I got seen to. While the doctor was stitching my wrists up, my hands, the crisis team turned up.

<The> attitude was that 'it's another who's tried again' - I overheard <them> talking to the nurses and the doctor stitching my arms. Then s/he went off. After a while s/he came back and shoved a leaflet in my hand and said, 'we're going to discharge you, and if you have any problems, ring the crisis line'.

It didn't matter what their personal thoughts were, they should have been more caring, not as abrupt and taken more time to see whether I was fit or not. <Assess> when can I go home, keep me for a few hours or a day. <It was> just the pure bluntness, I felt like saying 'do you treat all your patients like this?'

I had lost that much blood I could hardly walk, and I was trying to tell them I wasn't well. But that chap seemed to give me the all clear, that I was capable of managing at home. Even the taxi driver got a wheelchair for me and said; 'I want to wheel you back straight to A&E; you're not fit'.

Nothing happened <after the taxi took me home>, it was just; 'go down to your doctor and get your dressings changed the next day'. I cleaned up some of the blood as best I could and slept on the spare bed.

I rang the crisis line and tried to explain what happened. Someone was supposed to come and see me. I explained I needed someone to

come and see me as soon as possible. By dinner time they turned up. They were a right nice couple. They were doing their best to get me round but slowly I was drifting away.

Then eventually, by 9pm, an ambulance had turned up and they wheelchaired me downstairs. I told them what had happened and they said I shouldn't have been sent home. They were in two minds whether to take me to A&E or to Foss Park. This just isn't the way you want things; they swan in 'I'm from the crisis liaison team' and looked at me as if to say it was my fault because I tried to finish it.

I got to Foss Park and they put me on xxxx ward. The following day / evening, they wanted to weigh me and measure my height. I don't know how I got to the end of the corridor, but they didn't have any wheelchairs to wheel me. A hospital without wheelchairs!

I was as white as a sheet and my blood pressure was 70. On the way back, I collapsed and they called an ambulance and rushed me to A&E. I could hear the ambulance staff asking why they had let me out. They were really nice. I remember the crisis team were in and out, on the phone trying to sort things out. They were really good. I can't remember a wrong word. They were really supportive trying to find somewhere for me to go.

<I spent> three days in the hospital and then back to Foss Park.

Case Study of a person's experiences in Foss Park Hospital and another psychiatric hospital

I had an assessment and then the doctors wanted another one done, because he said, 'he might be alright to stay in the community'. I had another meeting and turned up at Foss Park just thinking it was like another one-to-one, and my mentor was there, his boss and six other people, and I wasn't kind

of prepared for it. And then it was in that meeting, it was kind of said 'I'm off to hospital'.

I remember the assessment, but the sessions I'd had before was like a one-to-one. So, I turned up and I'm like <makes surprised face>, I went to the toilet and came back out and there were even more, so it was a bit daunting really. I went out for ten minutes and basically I had a choice to go voluntary and they kind of let me go home of my own accord, so I just went to my car, they didn't really check, I could have easily gone and done something, I left and went to the car, but then because of the fact that I was going to hospital, in that moment I was quite impulsive.

Well, I left and went home, it was a bit of a rush around and said, look, we'll come and check on you. And then it could be tomorrow. It could possibly be Scarborough or whatever, shouldn't be far away. Then on Saturday morning they rang and the woman said 'you're off to xxxx' <a city over 200 miles away>. I got picked up at 12 and taken <there>.

I was in xxxx for three and a half, four weeks and then I got moved back to York for like a week and a half and then I had two sessions with the home-based treatment team and then back to the community team. Then they sent me to the early intervention and psychosis team. And then they've just sent me back last week to the community team again. So, it's like change of a lot of personnel.

The whole hospitals palaver was quite weird, because it didn't really get explained. So for example, when I got to xxxx, they took all my bags sat me in a room, and it was all because it was the weekend, I literally got left in my same clothes and they said we're leaving your jogging bottoms with string in it, you can have your phone, but no one explains anything. I hadn't even been given a toothbrush. It was a good 24 hours after that I actually got my belongings back, because obviously they note everything down that you've got belongings wise.

I kind of just stood in that in a kind of communal kitchen area where you learn a lot more stuff. It's like being in prison you just kind of pick up on the routine and what you can and can't do, but it's not explained. And then I came to York and York was completely different. I was allowed my razor, my charger and stuff like that. It's odd because you go and sit outside and then staff will come and bug you, for like, 'why are you sat there? Come inside', but then they wouldn't do that if you're just sat your room. So, it's a bit like 'I can't do right or wrong' sometimes. I think a lot of it is just explaining, it's like moving teams and stuff, it isn't really explained what's happening.

I got transferred back to York and it was completely different because the rules were different. I got a leaflet at least when I got into York. But then it felt weird trying to sign out and stuff because again, it was different because you got a strip search every time, but in York it was a bit like they just let you in. I could have brought something in to be honest. I sat in my room, but a lot of people, it put them on edge and seemed a bit more erratic when I got to the York, and one time some lad had a fight and ran off and come back with some sort of wood. I could have easily snuck something in as a protective weapon if I felt that way, not that I would. It seemed extreme at the time in xxxx, like the whole like checking, but you could see when you got to York it's for the right reason.

Case study of a family's experience of crisis support

Woman raised concerns about failure to provide care for people with autism. Son has twice had an autism diagnosis. The family had to pay to go through Tuke Centre diagnosis after initial diagnosis from Sheffield was taken off him. He was in Willow Tree House in Haxby before the pandemic. Family were told he needed to be discharged to home during the pandemic. Family

were assured care would be put in place, but essentially no care was provided.

Autism Plus were meant to be involved so he could live in the community. There was no care plan in place, no structure, no meaningful activities, no routine. Son relies on structure to get through the day and manage anxiety. Did get him independent housing, but still no care - two years four months without real support. Son believed someone was going to kill him. Family believe this is all linked to his anxiety.

He ran away, got on a bus then a train. Family kept calling, eventually tracked him to a nearby town. Police kept an eye out, but family had to pay for a taxi at 3am to fetch him home. Called crisis team, they said they'd see him in a few days. He ran away again twice in that time. Family by now gravely concerned. Took him to Foss Park for help. He didn't want to go in, so TEWV contacted police for assistance. Three cars turned up with lights flashing. Son screaming as carried in. Family feel this was more traumatic than needed to be.

Still no structure on ward. Family felt the ward was not a sensory sensitive environment. Local authority now saying he doesn't need night care when he's discharged. But he doesn't take his medication if someone doesn't tell him to before bed. He has run away three times and is in a worse place than ever. Family feel no-one listens until there is a carer breakdown, they are otherwise expected to just keep it all going. No one is involving them.

Family has a Health and Wellbeing Power of Attorney in place, but TEWV staff keep discussing whether he has capacity, and not involving the family in discussions. Invited them to a meeting that started at 11am, family brought in at 11.30am but no one would tell them what was decided and the meeting was over. Family feel that "autistic people should not be in hospital"; that "there is no autism service in York"; and

that when it comes to crisis care "nothing happens till you get the police involved." They also feel "there is no integration - the local authority let things get bad enough for health to pick up the problem and the tab."

Case study of seeking help from the Crisis Team in York

In early 2022 he went into crisis in York. The crisis team came round, and he had an assessment with a psychiatrist. In the next few days he had multiple visits from the crisis team but did not find them to be very useful. The crisis team was not able to deal with the fact that he was also physically disabled. Being in mental health crisis pushes him into physical health crisis due to increased stress on the system. But the crisis team's response to him being in bed wanting to hurt himself was to tell him to get up and go for a walk. Their response to him saying that he was not capable of this was "Oh well now you're just being difficult."

The psychiatrist came back a few days later with a completely changed manner. The psychiatrist told him that he was a drug addict and that he had a personality disorder – neither of which were true. The psychiatrist claimed that he was addicted to diazepam which he had been put on whilst hospitalised in xxxx and he had never used it outside of what he had been prescribed. However, the psychiatrist claimed that since he had been on it for a year, he must be addicted despite him not displaying any signs of dependency. The psychiatrist also claimed that he had emotionally unstable personality disorder because he had self-harmed since childhood – which he hadn't.

Psychiatrist informed him that he would be taken off diazepam in two weeks despite guidance saying that if you have been on diazepam for over a year you should be taken off slowly.

He has PTSD from a previous situation where he couldn't get emergency treatment that he needed when he was very ill – this situation was identical as he was in a life-threatening situation and being refused medical care.

The psychiatrist then told him that he did not have PTSD.

"I just felt like I'd been run over by a train."

Psychiatrist didn't listen to him or his parents when they told him that he didn't have emotionally unstable personality disorder.

After that he stopped eating and drinking - "I was just broken."

Crisis team didn't believe that he wasn't eating or drinking they thought he was just after attention.

xxxx from the crisis team was kind and was able to get him to drink something.

Crisis team was a culture shock from xxxx as they treated him without empathy or professionality; they did not seem to know what they were doing.

He feels like the personality disorder is to deny him help; he requested a second opinion and was told he would get one at CMHT.

He also went to the psychiatrist to try and convince him with reasons that he did not fit the criteria for PD – the psychiatrist said that he would withdraw the diagnosis but a year later he requested to see his medical notes which say that the psychiatrist only said that he would withdraw the diagnosis to preserve the therapeutic relationship and all subsequent interactions with the crisis team still included the PD diagnosis.

In Autumn 2022 things got bad again and his care coordinator referred him to the crisis team, but the crisis team just thought that he was after drugs and attention.

CMHT did not work with the PD and drug addiction diagnoses; they use the correct diagnoses of PTSD and autism.

CMHT recommended a couple of days of diazepam but the crisis team refused as they believed that he was a drug addict – this triggered a sever dissociative episode.

This led to attempting xxxxxx, he was helped passers-by; they gave him a lift to A&E.

Psychiatric liaison in A&E made his father leave the room against his wishes and then told him that he was just after drugs and that there was nothing wrong with him. The psychiatric liaison didn't ask what happened or how he was.

The psychiatric liaison had security escort him out without warning – this made him extremely distressed and A&E doctors were confused about why liaison had left.

Chucked out onto the street and his father took him home in a taxi.

The next day he told his parents that he was planning on killing himself and that there was no point in contacting the crisis team as they wouldn't believe them. He didn't kill himself at the weekend and on the Monday his parents were able to get in touch with his care coordinator and he was voluntarily admitted to Foss Park.

Foss Park was good until they accessed the notes which had his PD diagnosis – psychiatrist's notes from Foss Park said that the hospitalisation would not help; this was before s/he had even met him.

He discharged himself from Foss Park after one week – they ignored his physical disability and said he was a drug addict.

He needed diazepam which his GP had given him for emergencies to help with physical pain caused by phycological stress. Foss Park said he could only use it for one day even though when you reduce diazepam when in crisis he becomes physically very ill.

Three days later he couldn't get out of bed so he could not eat for two days until a healthcare assistant came with some stew.

Healthcare assistant told him to talk to the nurses as he wanted to kill himself, but the nurses told him he was just a drug addict.

This led him to throw his bowl out of the door which ended up shattering windows; then he went "to pieces" and huddled in his bathroom but he was told that the doctors had said not to give him anything because he is an addict and just wants attention, so they left him in the dark and screaming and nobody came. He still can't sleep with the lights off.

Very few staff there the next day as it was the Queen's funeral, and he was easily able to discharge himself and the doctor said there were no concerns with very few questions asked.

His friend kept him alive until the arrival of the CMHT care coordinator.

In early 2023 – care coordinator set up a crisis plan that did not involve the crisis team – CMHT psychiatrist tested him formally for substance dependency and he did not meet the criteria – notes now say that he

used to be an addict even though he never has but the new psychiatrist cannot change anything retrospectively.

CMHT has never gone down the PD or addict line but have also never given treatment for PTSD – psychologist for PTSD left and there has been no replacement.

Crisis plan without crisis team was set up which included an emergency drug kit and the Haven, but the GP refused to prescribe this emergency kit. The emergency kit including the Haven had been set up by his care coordinator who subsequently left and the new one did not seem to care.

A bad appointment with CMHT where he was told that he would not get emergency kit or PTSD psychologist led to a dissociative state – he tried to leave the building but didn't manage and ended up throwing chairs around reception – care coordinator told him just to get out despite knowing that this was a PTSD trigger which mean that he "lost the plot entirely".

CMHT staff called the police, and the police were brilliant – "they were absolutely fantastic; I cannot speak highly enough of them. The police know that you cannot rely on the crisis team." Staff at CMHT were useless at de-escalating his crisis, they just stood around.

The police knew exactly what to do, they told him they wouldn't leave him and sat in the van and listened to him. They told CMHT to do their jobs and helped mediate.

With mediation by police, the CMHT manager then agreed to contact the GP to try and sort out emergency meds kit and to try and sort out the replacement psychologist.

He felt that it was hopeless and no one would help him because they just think he's an attention seeking drug addict, so he made plans to attempt suicide. He texted his friend to say goodbye and fortunately they worked out where he would be. A police search party was sent out and he was found in Whitby.

He was taken to Scarborough Hospital – the crisis team there was amazing and really compassionate. They understood that he was going through a terrible time; the policeman who found him in Whitby was also amazing.

Everyone at Scarborough was amazing until he spoke to a psychiatrist who had seen his notes. This psychiatrist told him to go home as he was low risk but the rest of the staff did not think he was safe to drive so they put him in a taxi.

York crisis team aren't providing a crisis service they are making crises worse; he has not been able to work since his first interaction with the crisis team.

Participant recommendations

During the interviews participants identified how the system could work better for them. This included:

Recommendation	Made to
Increased provision of preventative care so that fewer people end up in crisis in the first place	York Health and Care Partnership / York Health and Wellbeing Board
Lower level support; decrease the threshold for support so that people don't have to end up in crisis before they get support	York Health and Care Partnership / Tees Esk and Wear Valleys NHS Foundation Trust
Improved follow up after discharge or after calling the crisis line so that crisis is not a revolving door and people do not repeatedly find themselves in crisis	Tees Esk and Wear Valleys NHS Foundation Trust
Strengthening the crisis line alongside promoting the second line for those who need support but are not in crisis	York Health and Care Partnership / Tees Esk and Wear Valleys NHS Foundation Trust
Clarify what constitutes 'crisis' for both service users and professionals.	Tees Esk and Wear Valleys NHS Foundation Trust

Recommendations

Recommendation	Made to
Reinstate and strengthen the Mental Health Crisis Care Concordat to clarify care pathways, provide clear minimum performance standards for all those working in services, and make sure members of the public can access the right help and support at the right time delivered by appropriately trained professionals.	NYP, TEWV, CYC, Y&SHNHSFT, voluntary sector partners, YAS
Review existing resources, support services and gaps in the pathway and identify the most effective ways to deliver support and fill gaps, including those best provided by the VCSE sector.	YHCP, TEWV, CYC
Restructure approaches to coproduction to make sure everyone's views and experiences are heard and influence service design and delivery. This must include working with external partners to facilitate involvement for those who cannot engage directly. Consideration must be made of the resource implications for VCSE organisations to make this possible.	TEWV
Learn from schemes improving people's experiences of crisis response / changing the system to identify ways to invest in and maintain those that work (for example, the positive feedback about police street support).	YHCPEC / MHCCC
Make sure workforce plans reflect the specific challenges for attracting health and care staff to York (including lack of affordable housing, transport). Work together locally to learn from historical examples such as the Rowntree Housing model and how this fits with Local Plans.	HNY ICB

Embed a compassionate culture towards all people experiencing mental ill health.	YHCPEC / YHWB

Initial response from TEWV

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

It's incredibly important that we listen and act upon people's experiences. This will help us, along with our partners, to drive forward improvements and make sure that everyone receives safe and kind care.

In common with elsewhere in the UK, there continues to be an unprecedented demand for mental health services. In 2021/22 we received 267,150 calls to our crisis lines across our trust geography, which was a 12.5% increase on the previous year.

We're absolutely committed to providing a better experience for people in our care and there is a great deal of work underway to improve crisis services, as well as preventative care in York.

This includes:

· Our crisis response and home treatment team in City of York and Selby which supports people to continue to live at home in their local communities. The team also help people during times of crisis to keep them safe. They are available 24 hours a day, 7 days a week.

· First contact mental health workers, introduced through the Community Mental Health Transformation programme, to support people in the community. This is part of primary care, proving early mental health support to reduce need for crisis or secondary care.

· The launch of mental health hubs in City of York and North Yorkshire, the first of which is now open in Clarence Street, York. This has been done in partnership and provides a range of social and health support to in a local accessible hub which is easily accessible and provides ongoing support when people need it.

· Mental health team presence within the police force control room supporting an increased number of frontline police officers where there is a mental health need.

· Working in partnership with the third sector we've increased telephone response to the all age mental health support and crisis line. This has resulted in a wider range of support and increased response rate to people across City of York and North Yorkshire.

· Joint working with City of York Council to support the homeless and the provision of bespoke mental health housing.

Whilst we know there is more to do, we have continued to make significant progress and over the last year we have put patients, carers and families at the heart of the way we plan and deliver care.

Conclusion

Our aim in doing this work was threefold:

1. To provide a voice to those who feel unheard in the current system.
2. To understand what crisis care can feel like for those individuals as well as the carers and organisations who try to help them.
3. To identify what people think would improve the support available.

This is not an easy report to read, and in truth has not been an easy report to write. We have, throughout, been mindful of the need to honour the experiences of those who trusted us to hear them. Some of these experiences are historical, but it is clear through our conversations that these poor experiences live long in the memory.

We subtitled this report 'a recent history' very deliberately. Because we want to help play a role in shaping the future, we believe that the best way to do that is in partnership with those experiencing mental ill-health and the system that is trying to help them. Our experience in peer research has reminded us that before you can start to work together on what comes next, you need to capture the experiences people live through – in essence, people need to get this stuff off their chests, and feel listened to and validated when they do. We hope this report can help capture their truth, and allow us all to draw a line under what has happened and begin to focus on what comes next. We are committed to helping make that happen.

No one individual or organisation can make that change. This has to be a partnership effort. Those responsible for buying health and care services must continue to invest in the transformation of community mental health services. Those helping plan our future workforce must address the challenges that stop people wanting to work in health

and social care. Those delivering services must work together to make sure people can access the right help at the right time.

There are many seeds of hope for a better future in York. The Connecting our City project has given us a shared vision for community mental health services. Coproduction has been an underpinning principle of all Connecting our City work. Inspired by Trieste's model, we are working to create a new approach here in our city. This includes:

- the introduction of new support services for people with eating disorders
- better multi agency support planning on leaving Foss Park hospital through Pathway to Support
- the creation of community mental health hubs with multiple partners providing a range of support.

Our major provider of statutory mental health services, TEWV, has also been working on its own transformation, with significant changes to its senior leadership and a commitment to a 'journey to change' and investment in increasing the role and understanding of lived experience within the organisation. TEWV has already identified significant areas for improvement including in crisis care.

In Primary Care, we are seeing an increase in mental health support roles. These aim to provide earlier access to help and prevent people's mental health deteriorating, as well as providing support for those being discharged from mental health hospitals.

There are renewed commitments to improving mental health within York's refreshed Joint Health and Well-being Strategy and from York Health and Care Partnership.

We understand how difficult this report is to read, and we are mindful of the impact on existing staff, and the potential impact on those who may be considering a health and care role. We must say again thank you to all those working in services who worked with us on the report. Making life harder for anyone working in services is not our intention. We want to say very clearly that we do not believe this report highlights a people problem, but a system issue. One quote from our report sums this up best:

"The majority of feedback that I have had about individuals within the system has been amazing, some of the examples I've heard about support workers are absolutely incredible…. They have done everything and put aside their own time to help people. It has been extraordinary, so it feels like such systems are full of wonderful human beings. But as soon as you look at it from a system level it becomes problematic. It is almost like you want to say to people, please don't take this personally, this is the system's problem not you, you are presumably awesome"

We hope that this report can be a further catalyst for the partnership work to improve mental health support in the city.

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Health and Wellbeing Board 25 July 2023
Report of the Manager, Healthwatch York

Healthwatch York Report: Health and the Cost of Living in York

Summary

1. This report is for the attention and action of Board members, sharing a report from Healthwatch York which looks at the results of the second Healthwatch York survey exploring the health impacts of the rising cost of living.

Background

2. Healthwatch York provides information and advice about health and care services, signposts people to support, and listens to their experiences when accessing health and care services. Recently there has been an increase in mentions of the cost of living when discussing health and care concerns. Having completed one survey before Christmas, we wanted to maintain our understanding of the issues being experienced.

3. We developed a survey and reached out through our local engagement activities and our partner organisations to share the survey widely. We would like to thank Kate Pickett from University of York for her support with the survey questions to maximise our learning potential.

4. We produced a report highlighting the day-to-day impact on local people's health and wellbeing as a direct result of rising living costs. We have shared this report to encourage further discussion of these challenges and consideration of ways we can collectively address them. We acknowledge the significant partnership work already underway to provide help, advice, and information to those most directly affected. This partnership work is being coordinated and supported by City of York Council.

Main/Key Issues to be considered

5. Our report's key findings are:

- The increasing cost of living is having a detrimental effect on York residents' physical and mental health
- York residents are deeply concerned about being able to keep themselves and their families warm
- People are having to skip meals and/or relying on foodbanks - irrespective of what ward they live in
- Residents are reducing their consumption of healthy foods due to rising costs
- Those whose answers indicate they are depressed and/or clinically anxious are disproportionately impacted
- Rising costs are beginning to have an impact in households that had previously reported as managing
- York residents are adapting by changing their spending and living habits, dipping into their savings, and increasing their borrowing
- Feelings of isolation are increased by not being able to afford associated costs with socialising such as transport

Consultation

6. In producing this report, we consulted the public through a short, simple survey and compared them with our previous survey results. We also used the experiences people shared with us.

Options

7. There are recommendations on page 36 of the report, namely:

i. Consider ways of measuring and monitoring the health impacts of cost of living rises across the York population, for example monitoring over time the levels of people admitted to hospital who are malnourished

ii. Consider ways of making sure everyone has access to advice and information, not just those living in known areas of deprivation in the city. This must include access for those in the outer villages and those experiencing digital exclusion

iii. Consider the findings from the pilot of heating help for those with long term health conditions in Gloucester, and whether opportunity exists locally to support those most at risk through winter pressures funding York Health and Care Partnership Continue to make strong representations to challenge the perceptions of York as an affluent city and speak out for our residents who are currently struggling. This must include making sure colleagues across the wider Integrated Care System are fully sighted on the particular issues York residents are experiencing

iv. Collectively recommit to the council motion to recognise socio economic status

Implications

8. There are no specialist implications from this report.

- **Financial**

There are no financial implications in this report.

- **Human Resources (HR)**

There are no HR implications in this report.

- **Equalities**

There are no equalities implications in this report.

- **Legal**

There are no legal implications in this report.

- **Crime and Disorder**

There are no crime and disorder implications in this report.

- **Information Technology (IT)**

There are no IT implications in this report.

- **Property**

There are no property implications in this report.

- **Other**

There are no other implications in this report.

Risk Management

9. There are no risks associated with this report.

Recommendations

10. The Health and Wellbeing Board are asked to:

    i. Receive Healthwatch York's report, Health and the Cost of Living in York.

    ii. Request responses to the recommendations from the bodies named within the report.

Reason: To keep up to date with the work of Healthwatch York, be aware of what members of the public are telling us and respond to the issues raised.

Contact Details

Author:	**Chief Officer Responsible for the report:**
Siân Balsom Manager Healthwatch York 01904 621133	Siân Balsom Manager Healthwatch York 01904 621133

Report Approved ✓ **Date** 12/07/23

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:
Annex A – https://www.healthwatchyork.co.uk/wp-content/uploads/2023/06/Health-and-the-Cost-of-Living-in-York-May-2023.pdf

Health and the cost of living in York

May 2023

healthwatch York

Contents

Content warning: Contains reference to mental ill-health, self harm, distress

Acknowledgements

In this second cost of living report once again most of the content is the responses people gave to our survey. We want to thank every single person who took the time to complete it.

This report is, as before, an uncomfortable read. But we make no apology for sharing so many of the responses. Words have power – the reality of people's lives help strengthen our determination to make changes.

All people deserve to be heard. Thank you for taking the time to listen.

Cover image from Towfiqu barbhuiya on unsplash

Background

In December 2022 we released the findings of our first cost of living survey which we ran between 6 October and 5 November.

To gain an ongoing perspective into the impact of the rising cost of living, we ran a second survey between 10 February and 17 March. We received 200 responses from across York.

This report outlines the findings of our second survey, with a brief comparison between the findings of the two surveys.

National picture

New Samaritans figures reveal rising impact of financial worries on mental health [1]

The Samaritans released a statement ahead of the budget in March 2023 which called on the government to invest in suicide prevention and mental health support.

The statement highlighted that the Samaritans had seen the impact of the rise in cost-of-living on people calling their service. The report cites an increase in the percentage of first-time callers who were concerned about finance and unemployment in January 2023. These numbers only continued to rise in February with 400 calls a day related to finance and unemployment in February 2023.

[1] https://www.samaritans.org/news/new-samaritans-figures-reveal-rising-impact-of-financial-worries-on-mental-health/

Cost of living a 'second health emergency' after Covid-19 | ADPH[2]

The Association of Directors of Public Health have published their annual report which warns of the health consequences of the increased cost of food and energy.

The report shows that those already struggling are most affected by the increase in living costs. In addition, rising living costs have also affected those who previously reported to be managing financially. This is a trend also seen here across our two surveys.

The report raised the concern that the rising costs will only widen the existing health inequalities and highlighted the strong link between economic prosperity and health.

The report gives recommendations that increased public health work is necessary to reduce these inequalities. The report also acknowledges the excellent response from the voluntary, community and social enterprise (VCSE) sector.

Cost of living: People are increasingly avoiding NHS appointments and prescriptions | Healthwatch[3]

Healthwatch England have found that the rise in the cost-of-living has impacted access to health and care services. People were increasingly struggling to afford the associated costs of health and care appointments such as; transport costs, internet and phone costs. This results in missed appointments. Their polls also show that increasingly, people are avoiding taking medications (over the counter and prescriptions) due to cost.

[2] https://www.adph.org.uk/2023/03/cost-of-living-a-second-health-emergency-after-covid-19/

[3] https://www.healthwatch.co.uk/news/2023-01-09/cost-living-people-are-increasingly-avoiding-nhs-appointments-and-prescriptions

The report reflects on gender disparities; with more women reporting they are unable to afford to heat their homes and turn on essential appliances, than men. Similarly, there had been a significant impact on mental health, especially for women.

Findings also show that increasingly, people are unable to afford healthy foods and are having to skip meals and an increased impact on physical health as a result of the rising costs. These findings reflect our own.

Local Picture

Out of pocket: the places at the sharp end of the cost of living crisis | Centre for Cities[4]

According to a centre for cities publication, York residents are on average £116 a month poorer than they were a year ago. This is due to 10.6% inflation and –4.2% wage rise between January 2022 and January 2023.

The cost of living crisis impact on York revealed | YorkMix[5]

In November 2022, York Mix cites that 14,700 households in York are expected to experience poverty this year taken from the latest estimates presented at the York Cost of Living Summit. They argued that this was due to a combination of low pay and high costs of energy and food. The article claims that decreases in funding from central government to local government has left York with a significant gap in funding meaning that people in York have been left without enough money.

COTN-APPG.pdf (thenhsa.co.uk) [6]

University of York researchers co-authored this report which found that children in the North of England are most vulnerable to the effects of the

[4] https://www.centreforcities.org/publication/out-of-pocket-the-cost-of-living-crisis/
[5] https://yorkmix.com/the-cost-of-living-crisis-impact-on-york-revealed/
[6] https://www.thenhsa.co.uk/app/uploads/2023/01/COTN-APPG.pdf

rising cost-of-living. The report warned of a public health crisis which will disproportionately affect the North of England.

The report found that families in the North are more likely to live in damp homes than the rest of England, even before the increased cost of living. Children in the North are also more likely to be living in food insecure homes.

The report also highlights the social and mental health implications of the rising cost of living on young people such as increased stress and feelings of guilt. Additionally, children and young people from low-income families are less likely to be able to afford extra resources to learn and join in with friends.

Key Findings

A summary of our findings:

- The increasing cost of living is having a detrimental effect on York residents' physical and mental health
- York residents are deeply concerned about being able to keep themselves and their families warm
- People are having to skip meals and/or relying on foodbanks - irrespective of what ward they live in
- Residents are reducing their consumption of healthy foods due to rising costs
- Those whose answers indicate they are depressed and/or clinically anxious are disproportionately impacted
- Rising costs are beginning to have an impact in households that had previously reported as managing
- York residents are adapting by changing their spending and living habits, dipping into their savings, and increasing their borrowing
- Feelings of isolation are increased by not being able to afford associated costs with socialising such as transport

Comparison: December 2022 vs March 2023

There are shared themes between our March 2023 survey and December 2022 survey. Most notably, feelings of isolation due to reduced socialisation and struggling to afford food; particularly healthy and specialist foods.

Both surveys found that respondents were struggling to heat their homes. This second survey found that as well as the worsening of existing conditions, not being able to heat homes over winter has resulted in damp and mould in people's homes. This can worsen existing health conditions as well as bringing on health conditions.

The first survey found that there had been an increase in feelings of anxiety around money. In this survey we used the GAD-2 and PHQ-2 (see appendix 2) measures of anxiety and depression. This second report shows that those measuring as having depression and/or anxiety had been disproportionately affected by the rising cost of living.

The March 2023 survey indicates that respondents are less likely to consider themselves to have been impacted by the rise in cost of living (85%) than December 2022 (88.44%). However, responses show that individuals are changing their habits to adapt.

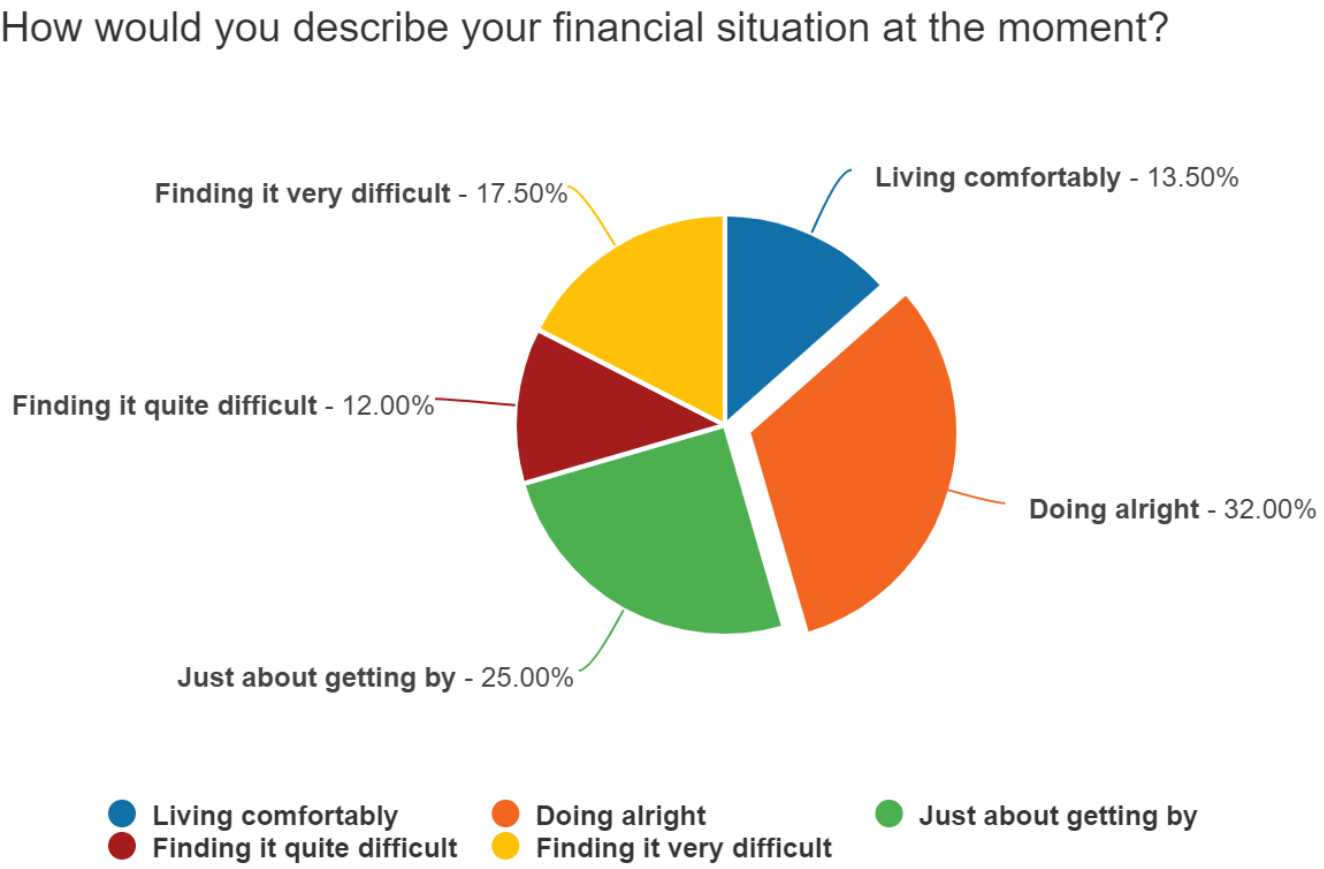
Additionally, in the December 2022 survey, 69.54% of respondents told us that their health had been affected by the cost of living compared to just 54.5% of respondents in March 2023. This is perhaps indicative of a trend towards acceptance or even apathy towards the effects of the rising costs.

Within the March 2023 survey, many respondents identified themselves to be financially secure despite having to cut back on basic necessities such as food and warmth. Again, this suggests increased acceptance of, or possibly resignation to, the challenges of living with less.

Our Findings

Q1: How would you describe your financial situation at the moment?

200 responses



70.5% of respondents reported being financially secure. 29.5% of respondents reported being financially insecure (see appendix 1).

Of the people who told us that they are living comfortably, 85.2% said that their health was 'good' or 'very good'. In contrast, of those who told us they were finding their financial situation 'very difficult', only 28.6% described their health as 'good', and none as 'very good'. 45.7% of those finding it 'very difficult' described their health to be 'bad' or 'very bad'.

Some respondents gave additional context. The additional comments tell us that people are struggling to afford what they used to. They are being forced to spend their savings to cover bills and other essential items. Many cannot afford additional expenses and to socialise anymore which is

having a negative impact on their mental health. People reported feeling guilty about this.

Of those who reported to be managing the increased living costs, many were concerned that their savings won't last or that the situation will get worse.

Can meet bills but not a spare penny. So bad for mental health as there is no pleasure. Spend so much time feeling guilty that I cannot do more with my family.

Comments reflecting key themes:

"I am finding it very difficult to manage as a single mum with a mortgage and having returned to education 3.5 years ago. I am on the last 3 months of my course and struggling to make ends meet to continue."

"Always overdrawn. Missing out meals and limiting heating. Cannot claim extra as I do not receive identified benefits."

"We are alright compared to a lot of people who are suffering but we've definitely taken a huge hit in terms of bills."

"We are only able to manage because I have taken on some exam work, having retired due to burn out and poor physical health before the pandemic. However, we are existing rather than enjoying life. I worked all my adult life and then found that my state pension would not be available for six extra years."

"A few years ago, we were able to have money left at the end of each month to add to savings. Now this is not the case and have to be very mindful to bring everything in budget to ensure [we] do not go

overdrawn. Also constantly trying to look at ways to save on outgoings and any social expenditures have stopped"

"Cannot afford enough food or transport. Unable to save despite working."

"We have been able to ride the incredible hikes in food and energy but I'm not sure we'll manage a holiday this year which is a shame as due to covid it's been a while since we've had one and it really boosts your mood and gives you something to look forward to. But we do have enough and know we are very blessed to be able to be managing. The rise in food prices has made me very aware of shopping and what I am buying."

"Our money doesn't go as far as it used to, we've taken action to reduce costs and make our money work even harder, but it's so difficult at the moment."

"I am ok at the moment because of savings but they will only last so long!"

"Like many people just now, I am concerned that things may get worse before they get better"

"The cost of electricity and gas is far too much. The rising cost of food is becoming a bigger issue too."

"I find I am constantly worrying about things"

"Used to be able to save money for holidays and home improvements Now we just about manage a cheap holiday for the kids as all the bills have gone up. I am not sure what we will do when we come out of our fixed rate mortgage in two years"

Q2. Have you been affected by the rising cost of living?
198 responses

Just over 85% said that they had been affected by the rising cost of living.

Of those who felt that they were unaffected by the rising cost of living, only 30% were one or more of the following; a carer, a person who is disabled, someone with experience of mental ill health or someone who had a long-term health condition.

Additionally, 79.2% of those who had been unaffected by the rising costs told us that they had 'good' or 'very good health'.

Respondents were also asked to provide additional comments.

Many respondents told us that they are struggling with the rising costs of food. With respondents having to cut down on non-essential items, reducing their portions and not being able to afford healthy foods and foods needed for allergies/intolerances. Some have had to start using foodbanks.

The rising cost of energy means some people cannot afford to heat their homes. People are having to spend all their money on bills, mortgages and food. Because all of these have risen so much, they are finding they do not have much left afterwards.

Respondents told us that they are finding that prices are rising but their incomes are not meaning that they do not have as much disposable income as they used to.

Mortgage increases, food cost increases, energy price increases have left little income for family activities and fulfilment/self-care activities. As a result my mental health has suffered.

Comments reflecting key themes:

"I have had to use the foodbank a few times"

"cost of food and utilities - very cold flat. Not able to buy as much fresh food"

"Not eating every day"

"Everything has gone up apart from my income"

"Have only put heating on 5 times since October, checking prices of everything when shopping and only buying what's needed. Using headlights on an evening instead of putting lights on"

"Yes, both me and my partner work full time. We are just making enough money to pay our mortgage and bills. Little money left over to spend on luxuries. Worrying about debt."

"Buy less food. Smaller portions. More fillers and less protein, vegetables and fruit. Take advantage of free food nearing sell by date and delivered free. Don't have friends and family in for coffee. Grow a large percentage of my own food."

"I go to foodbanks now as food has gone up so much… nor do I often put my heating on."

"Costing a lot more to maintain our previous standard of living in retirement"

"Less disposable income higher heating bills and council tax"

"Drastically rising bills and living expenses have not been matched by a rise in wages."

"Cost of food and I have coeliac disease so the price rises mean a loaf of bread is now £3.70. I have bi polar disorder and at a low at the moment"

"Worry about type of food that can be afforded. Need a special diet but can no longer afford it"

"No money for good food living on packets of noodles. Frightened to put Gas and electric on even though I'm housebound every time my money comes in it's gone out with increase in fuel costs"

"Struggling to buy healthy foods. Having to look for cheaper brands"

"The rise in mortgage rates and energy bills"

"I have reduced spending overall in order to have enough to pay bills and buy groceries. There is no spontaneous spending or money for treats as this is being saved towards future energy bills."

Q3. This winter, are you able to keep your home warm enough?
197 responses

81 people said that they were unable to keep their home warm enough. Our data shows no discrimination between wards, suggesting that energy prices are a concern across York.

47% of those who were not able to keep their house warm enough reported themselves to be financially secure (see Q1). This suggests that

people consider themselves to be fine despite the struggle to keep their houses warm over winter.

When asked to give further comment, many respondents told us that they have been able to keep themselves warm this winter but not their houses as they have been using alternatives to heating such as; hot water bottles, blankets, jumpers and heated blankets. This has meant that people are finding increased mould and damp in their houses and that their health conditions, such as asthma, are exacerbated.

Those who are putting their heating on told us that the high prices of it is causing significant anxiety and at times making them go into further debt.

Respondents are often only heating their homes when children are home and are only heating the rooms that they are in or one room at a time. The increase in people working from home has meant a lot of people are having to spend all day in cold homes. Some people are going to bed early just to avoid feeling the cold.

It cost us approximately £900 more to heat the house. I am very worried because it looks like I will be at home next winter, in the day, I am not sure if we can afford to keep even one room warm

Comments reflecting key themes:

"Don't put heating on, have a blanket for warmth, get into bed earlier to keep warm"

"We had to buy warmer clothes"

"Can't afford to have the heating on. Been using blankets instead"

"Due to health reasons we have to keep warm so try to stay in one room where possible."

"2 of us in the household are Asthmatic and it has aggravated our health being so cold."

"I have chosen heating over eating!"

"Yes, while children are home. I don't heat the house when home alone working from home"

"On for 30 mins, down stairs. Blanket and cat to keep warm. Not on everyday and going to bed earlier than normal"

"The only time my heating has been on is absolute emergency to dry my sons school uniform & I was like a nervous wreck worrying"

"I was too anxious to leave the heating on for as long as it really needed to be on"

"We have had to ration when we use heating. We have persistent black mould in the house which the landlord will not address and this has been exacerbated by not using the heating as much during the winter months."

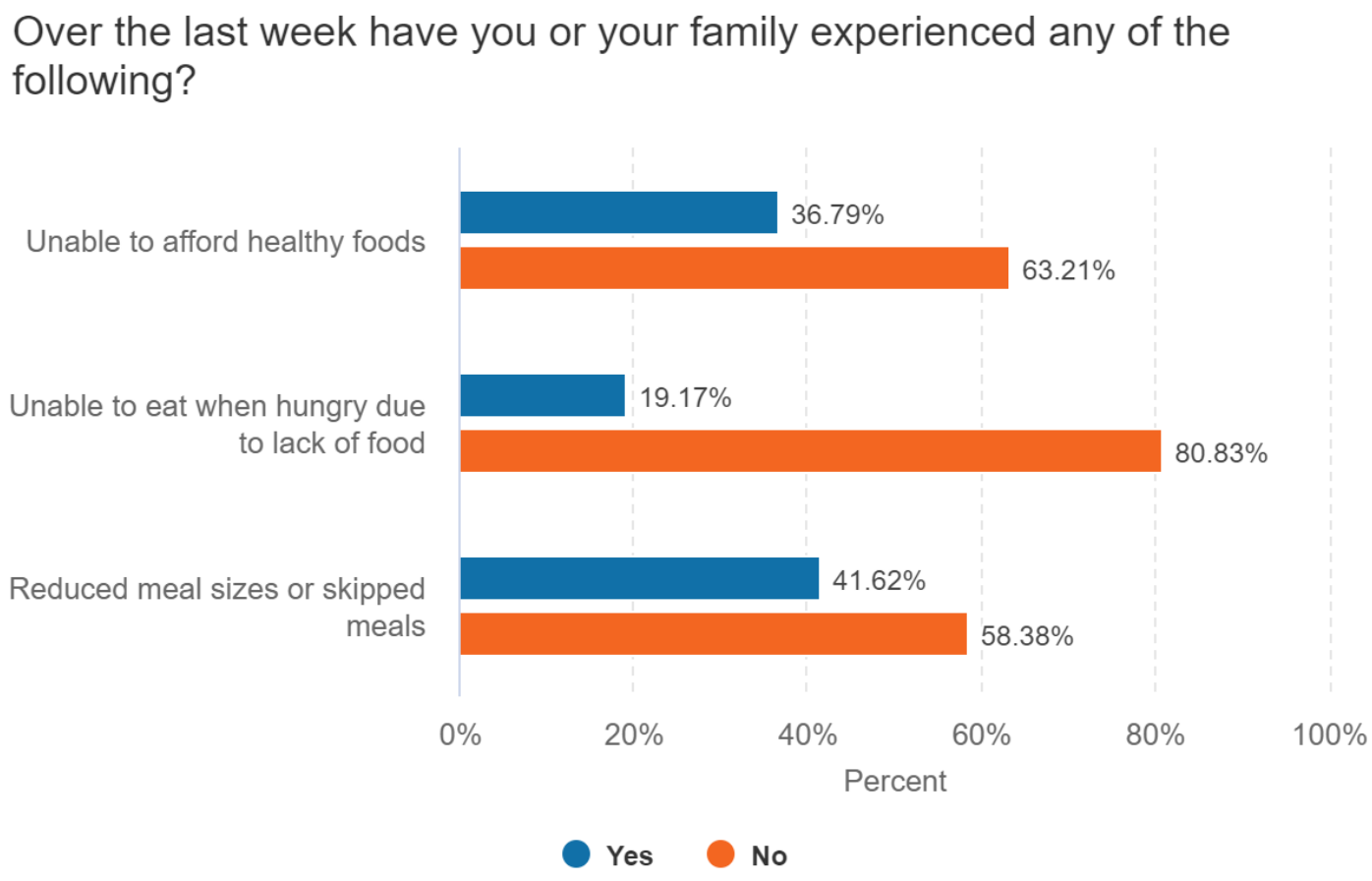
"I put on the heating on a night as we have a baby but we are extremely careful about our use and if I am alone in the house, I don't put it on and can be cold."

"It got very damp as heat was often only on for short periods. We kept warm but house was cold."

"We have bought heated blankets to avoid turning on the heating. Our house has since developed mould because of the damp."

Q4. Over the last week have you or your family experienced any of the following? (Unable to afford healthy foods, unable to eat when hungry due to lack of food and reduced meal sizes or skipped meals)

197 responses



36.8% reported they were unable to afford healthy foods.

Those who were likely to have depression (see Q7) were almost twice (1.9 times) as likely to be unable to afford healthy foods than those who were not.

19.2% were unable to eat when hungry due to lack of food.

Those who had anxiety (see Q7) were 6.6 times more likely to be unable to eat when hungry than those who did not.

These findings suggest that depression and/or anxiety is an important factor in food insecurity.

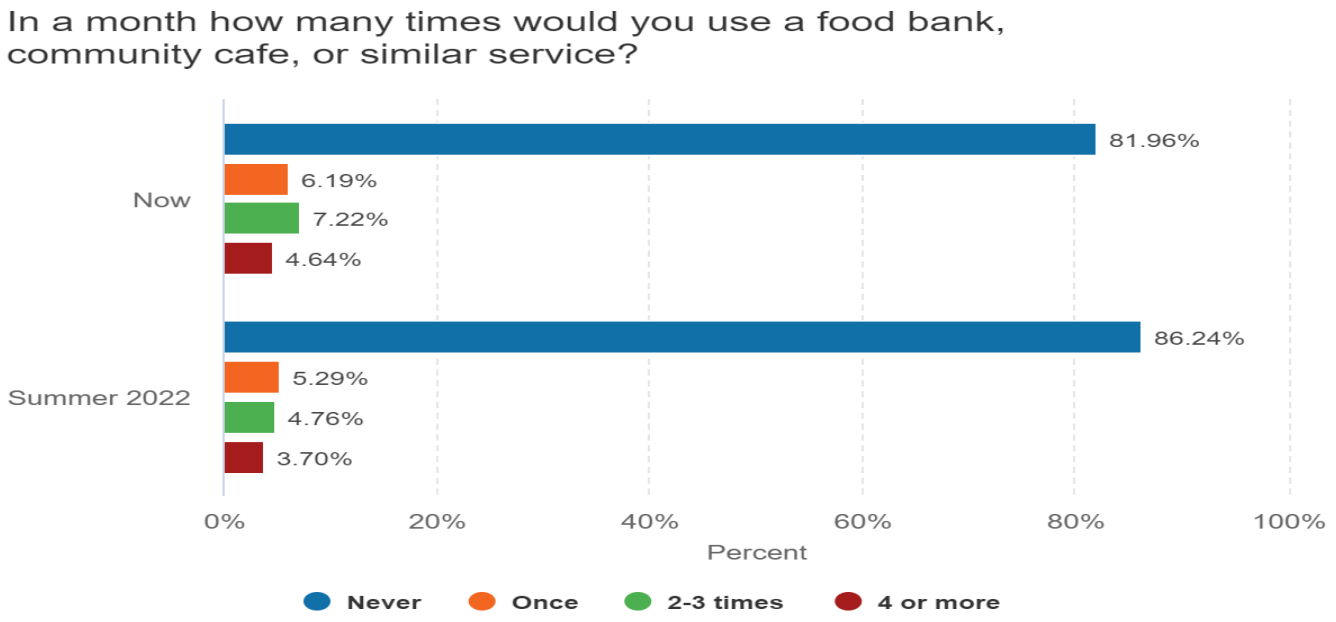
41.6% have reduced meal sizes and/or skipped meals. This group lived in a range of council wards, from some of the most affluent to some of the most deprived.

Even though people told us that they have had to skip meals or reduce meal sizes, 42.7% of these respondents identified themselves as financially secure (Q1). Again, this suggests that many people do not consider themselves to be financially struggling despite having to cut back on necessities such as food and warmth.

Q5. In a month how many times would you use a food bank, community café or similar service?

People were asked to answer this question comparing Summer 2022 and now.

195 responses



Whilst there has been only a slight increase on the overall use of foodbanks and community cafes, there has been a more notable increase in the frequency of use now compared with summer of 2022 (4.7% 2 – 3 times a month compared with 7.22%).

Disabled people appear to be more vulnerable to food poverty when compared with other groups. A disproportionate number of people who use food banks or similar services self-reported as disabled (25.7%) compared with 18.09% of our sample. Those self-reporting as disabled were more likely to have used a foodbank than not, both now and in summer 2022.

There was no notable difference in the use of food banks and community cafes across York wards.

Q6. Have changes to the cost of living affected your physical and/or mental health?
197 responses

109 people told us that changes to the cost of living had affected their physical and/or mental health.

Respondents who self- reported as financially insecure (Q1) were 2.3 times more likely to have had their health impacted by the cost of living than those who self-reported as financially secure.

In accordance with local and national findings, respondents told us that the increased cost of living has had an impact on their mental well-being. With increased levels of stress, anxiety, tension, and worry. Many respondents told us that they are constantly worried that prices will continue to increase. The stress is causing strains on relationships and for some, causing increased levels of self-harm.

Respondents have told us that they cannot afford to socialise or go on holiday anymore; this is having a detrimental impact on wellbeing due to

feelings of isolation. The increased travel costs are further exasperating this issue.

Many respondents have found that they are having to cut out healthy foods, gym memberships and self-care which is impacting on people's wellbeing and physical health. As mentioned in a previous section, the increased cost of heating your home means that a lot of people are going without or cutting back, which can impact on existing health conditions.

Lots of stress due to money worries. Impacts on sleep quality and quality of relationships with others as its all I can think about at times. Also parent guilt that I'm not or may not be able to provide.

Comments reflecting key themes:

"My husband and I argue over the heating, the cost of everything. I worry constantly, compared to lots of people I know we are ok but one small thing, and we would be in big trouble. You feel like you are constantly on the edge of losing everything."

"I can't afford my swimming exercise membership which affects my mental wellbeing and physical - I can't afford the membership and travel, one or the other, so neither sadly. Concentration levels lower due to poor diet and hunger"

"I get very tired when I'm cold. The worry has caused me a lot of stress and tension, which led to me having an accident and hurting my back"

"I seem to have picked up far more colds/infections than this time last year. Worrying about keeping the house warm is constantly on my mind."

"Stressed as cannot buy things I want/need for my son. Barely making rent. Feeling anxious and depressed a lot"

“Having the heat off has made my arthritis worse I believe. Just using blankets instead of gas central heating.”

“I feel more isolated which has affected mood”

“I am stressed all the time and feel constantly overwhelmed.”

“My circumstances right now are horrible and my already bad mental health has just got worse and worse to the point I'm self harming nearly every day”

“Making healthy food choices is more expensive, diet is important for my physical and mental health. It's stressful budgeting a low income- benefits. What's priority and what's isn't. Can I afford bus fare to socialise? Volunteer work. How will I manage electric key meter when the help vouchers run out?”

“The whole money situation has increased my anxiety and stress levels which has resulted in an increase of my self harm levels.”

“I can't cope mentally physically I'm cold all [the] time I'm tired a lot [and] I feel lethargic and sickly and get dizzy spells. I collapse when tired due to anaemia and cold doesn't help, making me weaker”

“Not sleeping properly and my son will eat all the time I don’t"

“I no longer have hobbies or trips out. The dog has to be fed before I am and the quality of our food is worse so I am often stressed. Bills are difficult to manage and I can't visit my son and daughter in Edinburgh as the travel costs too much.”

"Unable to do anything as no money to fill car up or travel. Have not been on holiday now for 4 years - unaffordable. This is impacting on my mental health as I now am starting to feel down."

"Mortgage increases, food cost increases, energy price increases have left little income for family activities and fulfilment/self-care activities. As a result, my mental health has suffered."

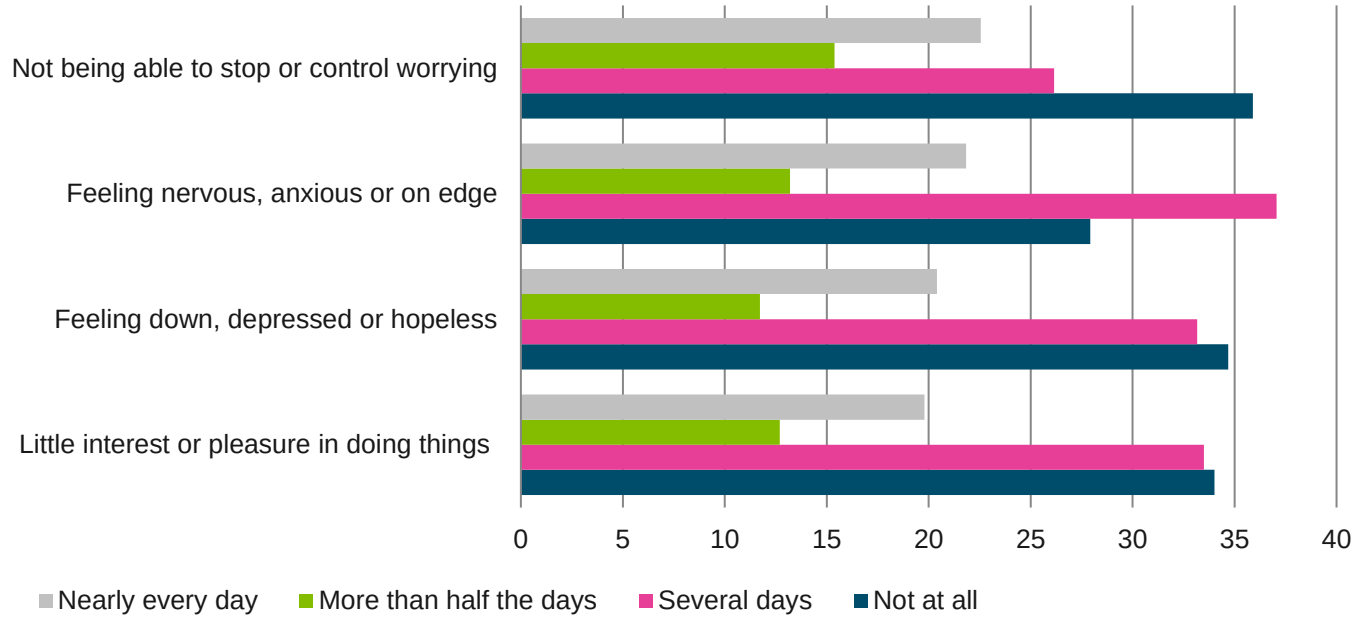
"Less money to go out and see friends. Worrying about debt. Feeling more isolated. Not looking forward to the future."

"Stopped gym membership, buying less fruit/veg not going out to meet friends so often"

Q7. Over the last two weeks, how often have you been bothered by the following? (Little interest or pleasure in doing things; feeling down depressed or hopeless; feeling nervous, anxious or on edge; not being able to stop or control worrying – answer range not at all; several days; more than half the days; nearly every day)

197 responses

Over the last 2 weeks, how often have you been bothered by the following?



Respondents told us that the rising cost of living has caused feelings of anxiety and depression. Respondents who measured as likely to have depression were twice as likely to say that their physical and/or mental health had been impacted by the rising cost of living compared with those that did not.

We used the GAD-2 (anxiety) and PHQ-2 (depression) assessment tools (see appendix 2). 36% of respondents identified as likely to be experiencing depression. 41% identified as likely to be experiencing clinically meaningful anxiety.

There appears to be a relationship between financial and food insecurity, and anxiety and depression. Respondents with clinically meaningful anxiety were 6.6 times more likely to have used a food bank in the last month. Those with depression were 5 times more likely to be financially insecure. Those with clinically meaningful anxiety were 6.5 times more likely to be financially insecure.

Everything is a worry

Comments reflecting key themes:

"Very down as can't join in with things as no spare cash. Have cut back but resent having to when I work 40 hours a week"

"I am refugee I came from Iran, I have no friends or family here life is very difficult for me"

"Thinking about the changes that will occur in the future make me feel nervous and worried. What will happen if we can't pay our bills or I can't

do that little bit of extra work. I am usually optimistic, but find it harder to sustain this attitude."

"I am self employed and it is a quiet time of year for work. Although I have savings for these times i worry in case things don't pick up"

"Trouble sleeping, stress between members of household. anxiety about bills."

"I have the responsibility of making ends meet. So, all the worry is on me!"

"I have mental health issues and find finances particularly tricky and often get worried or stressed"

"Due to redundancy I have just lost my job which has affected my mood, self esteem and confidence"

Q8. Can you share any examples of ways you are managing your living costs?
179 responses

Respondents expressed that they have to be more careful with their money than before and have to think a lot more before they spend.

The main ways in which people are changing their habits to manage their living costs are:

- Not putting their heating on
- Reducing energy consumption
- Cutting back on how much they eat and planning cheaper meals
- Socialising less
- Cutting back on non-essential expenses

In addition, respondents report budgeting, batch cooking, borrowing money, and using foodbanks and/or community cafes to cope with the costs. Respondents are also turning away from heating their homes and using other methods to stay warm such as hot water bottles and extra clothing layers/blankets.

Some have found that they are not coping at all and cannot share any ways in which they are managing their living costs.

It's well understood that skipping meals and cutting out healthy foods can have a detrimental impact on physical and mental health. Additionally, isolation caused by reduced socialisation may have long term implications for people's mental health and wellbeing.

Similarly, not heating your home over long periods of time can cause mould and damp which is especially damaging to children and those with poor health.

Having no heating. Bathing once a week only. Using cold water nearly all the time. Going to bed early. Not going out. Not driving my car. Cycling to any place needed. No take aways. Not eating out. Buying items that are reduced. Using food banks. Borrowing off family and friends.

Comments reflecting key themes:

"I think more about what I need - and sometimes, instead of 'what do I need?' it's 'what can I manage without, for now?' (I'm noticing this more when I do my on-line grocery shop, which I tend do every 3 to 4 weeks - I try to keep my budget close to the 'minimum spend', but that is getting harder week by week)"

"Using food banks. Extra layers of clothes instead of heating. Cancelling kids activities"

"By keeping the heating down as much as possible. Not planning trips away (have family abroad, and haven't been on holiday since the pandemic) Not eating out"

"foodbanks and avoiding having heat on.. trying to use car less.. less trips away or out for meals.."

"Not eating as much and being cold due to heating prices."

"not buying new clothes when required. socialising much less."

"Having to borrow money but this isn't sustainable."

"I'm not managing to cope it's stress every day and it depresses me to the point of making me sick"

"Not eating as much and being cold due to heating prices."

"Budgeting and plan"

"Using credit cards borrowing from family borrowing from employer"

"2 meals a day, washing hands in cold water, wearing clothes for longer, meal plan, using microwave, slow cooker and airfryer. Quick 2 mins showers with temp down, dish washer on twice a week"

"No activities for my child. No going out for me Eating from food banks Living on a credit card"

"Just surviving at the moment"

"Buying less food, wearing more clothes at home, switching to cheap brands for shopping"

"Turn heating on less. Don't constantly heat water, only when need to shower. Eat out less, buy less non essentials."

"Just like everyone else - not heating the house, spending less on everything. No days out with the kids. Trying to watch every penny. Shopping around for value when doing the food shop. Topping up blankets on the kids beds."

"Cut down food by eating less, turn down electricity, turn down heating, stop going out and eating out, etc.."

"Turning heating off Not making proper meals but eating bits and pieces from the fridge and cupboards Not cooking anything in the oven"

"It's impossible"

Q9. Can you give examples of ways other people you know are managing their living costs? This could be people you work with, family, friends or neighbours.
191 responses

Responses very much reflected those seen above with the most common response being 'turning the heating off'.

Respondents also told us that their friends and family members are:

- budgeting more
- using foodbanks
- borrowing money
- skipping prescriptions
- reducing socialising

Skipping meals turning heat off not going out as much as can't afford bus fares skipping prescriptions

Comments reflecting key themes:

"Borrow money off friends, food banks, do without"

"Much the same as above or eating less or just heating one room. Wearing hats and gloves inside the home. Hot water bottles. Using left overs and out of date food. Using food banks. Not using appliances as much Eating more cold foods."

"Turning the heating off. Using food banks, going without food. Having no social life, not able to afford to do physical activity eg going swimming. Spending savings."

"I do know people who are restricting the amount of heating they use and who are cutting back on certain items when it comes to food shopping."

"I have friends who are having to downsize their property due to increasing interest rates on their mortgage"

"Pretty much the same things I'm doing. Not living just existing. Cutting down on everything that they can. Sitting in cold homes."

"Some went to stay in library to keep warm, not going out, reduce socialising, eat less, etc.."

"Mostly turning the heating off Walking 4 miles each way to and from work to save the cost of travel Economising on food by eating differently Moving to a much smaller house to cut living costs."

"Some people I know don't switch their heaters on but this strategy is not good at all. Keeping the heater on at a low temperature throughout is better not only for inhabitants but for the house itself"

"Very similar to above I am aware of work colleagues who have used the food bank and do not put the heating on"

"I've no idea how other people manage."

Q10. If you had the power to change 1 thing in York to help people affected by rising living costs, what would you do?
151 responses

The top responses to this question were:

- reduce council tax in York
- create affordable, good quality housing
- help with the costs of food
- provide free school meals for all children
- help with the costs of energy bills
- create accessible and affordable transport in York
- provide insulation for people's homes
- ensure that whatever help is available is easily accessible to all, in every area of York

Comments reflecting key themes:

"The housing, rental market is utterly broken. Social affordable housing should be a right not a luxury."

"Free school meals for children affordable housing"

"Warm food provisions across the city and lunchbox fills at schools to take back home for family"

"To make basic foods cheaper so everyone can afford a nutritious filling warm meal everyday"

"Reduce fuel costs - this impacts the home, driving and food prices"

"I would give everyone a grant to provide them with enough money to put towards heating and food."

"I would lower the cost of rent. It's astounding how expensive it is to have a roof over your head in this city."

"Childcare, heating and shopping costs"

"Stop increase the council tax and free public transport."

"Provide free school meals to all children maybe."

"Lower council tax and bills for household - our council tax bill is a huge sum of money for low-income households"

"Not able to access foodbanks/community cafes as they are too far away"

"Make the help available more visible and accessible"

"Decrease rents and cost of housing"

"Suitable housing (the person, not housing organisation, should dictate what property is suitable) for disabled and vulnerable people of any age. Should be affordable and energy efficient. Help for people on benefits to rent privately, the discrimination is quite frankly disgusting. A complete overhaul of York council housing services; they are disgusting"

"Free public transport"

"Improve domestic insulation"

"More affordable, warm, sustainable housing"

"Ensure that council tax was not increased year on year by the maximum the government allows, which is what happens in York. Also review the way council tax is assessed, based on property size."

"Create affordable eating banks or free support for those who are less fortunate and can't afford to cook."

"Affordable good quality housing Cheaper and more frequent public transport"

"Provide free insulation for all homes"

"Reduce council tax"

"Provide more reasonably priced suitable housing. Not flats with no garden, storage, and clothes drying areas. We need more bungalows with gardens sheds, space to continue with many interests' hobbies and not being controlled by freeholder"

"Significantly lower council tax. Thats the killer"

"Keep bus fares and parking charges low"

"Major programme for home insulation"

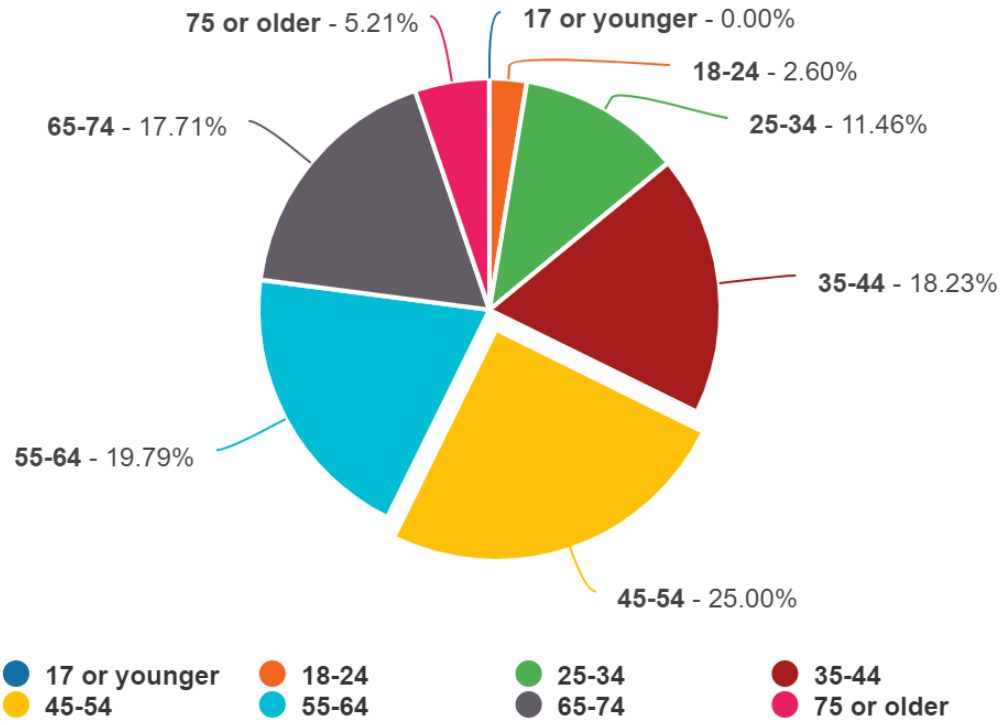
Demographic Information

At the end of the questionnaire there is an optional section in which we asked people to tell us about themselves.

Age:

192 people responded to this section

Please tell us your age



Council Ward:

We asked people to tell us which council ward they lived in, 167 people responded. The main wards that we received responses from were:

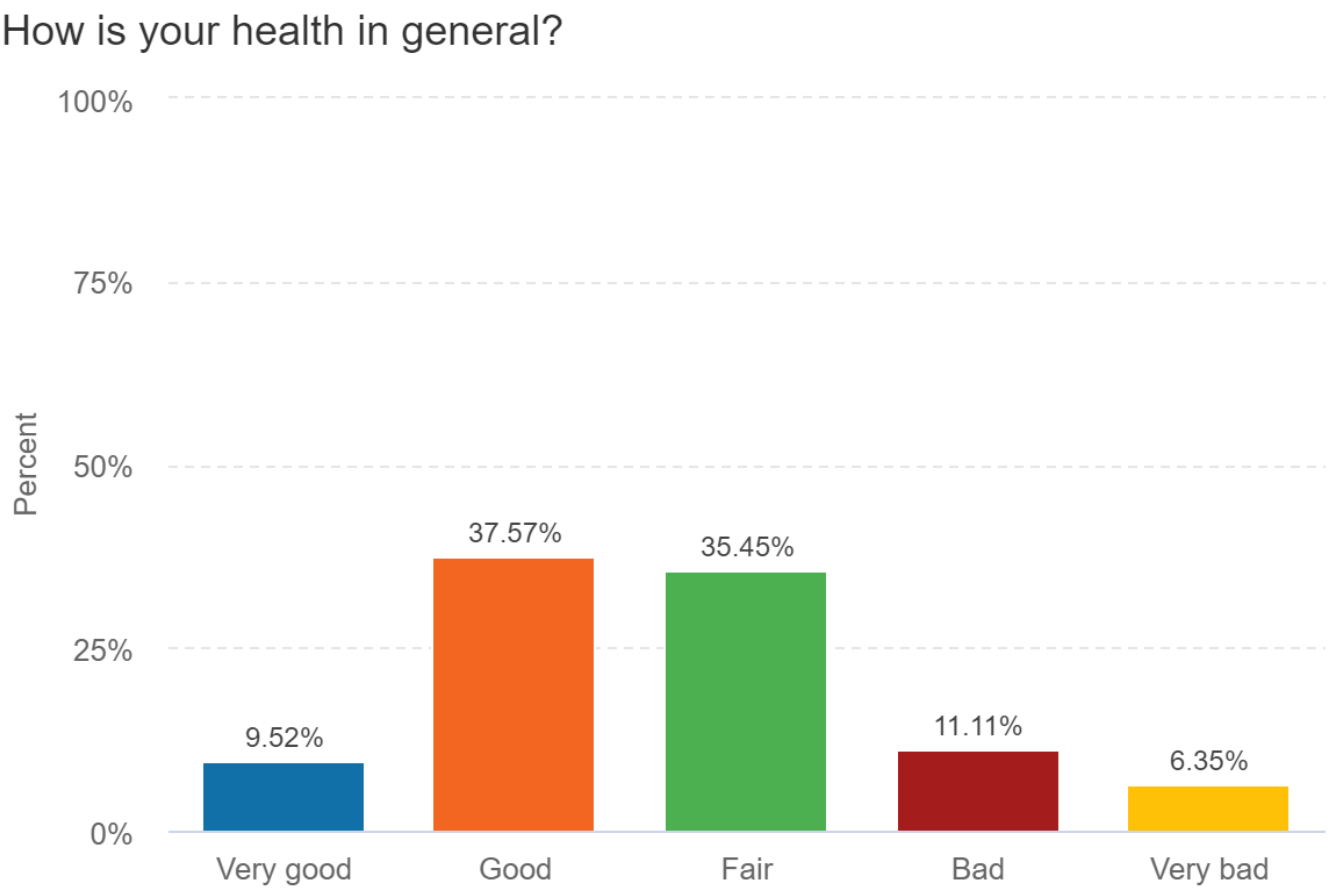
- Acomb (15)
- Heworth (14)
- Holgate (13)
- Micklegate (13)
- Clifton (10)

We received responses from all wards across York other than Copmanthorpe and Wheldrake ward.

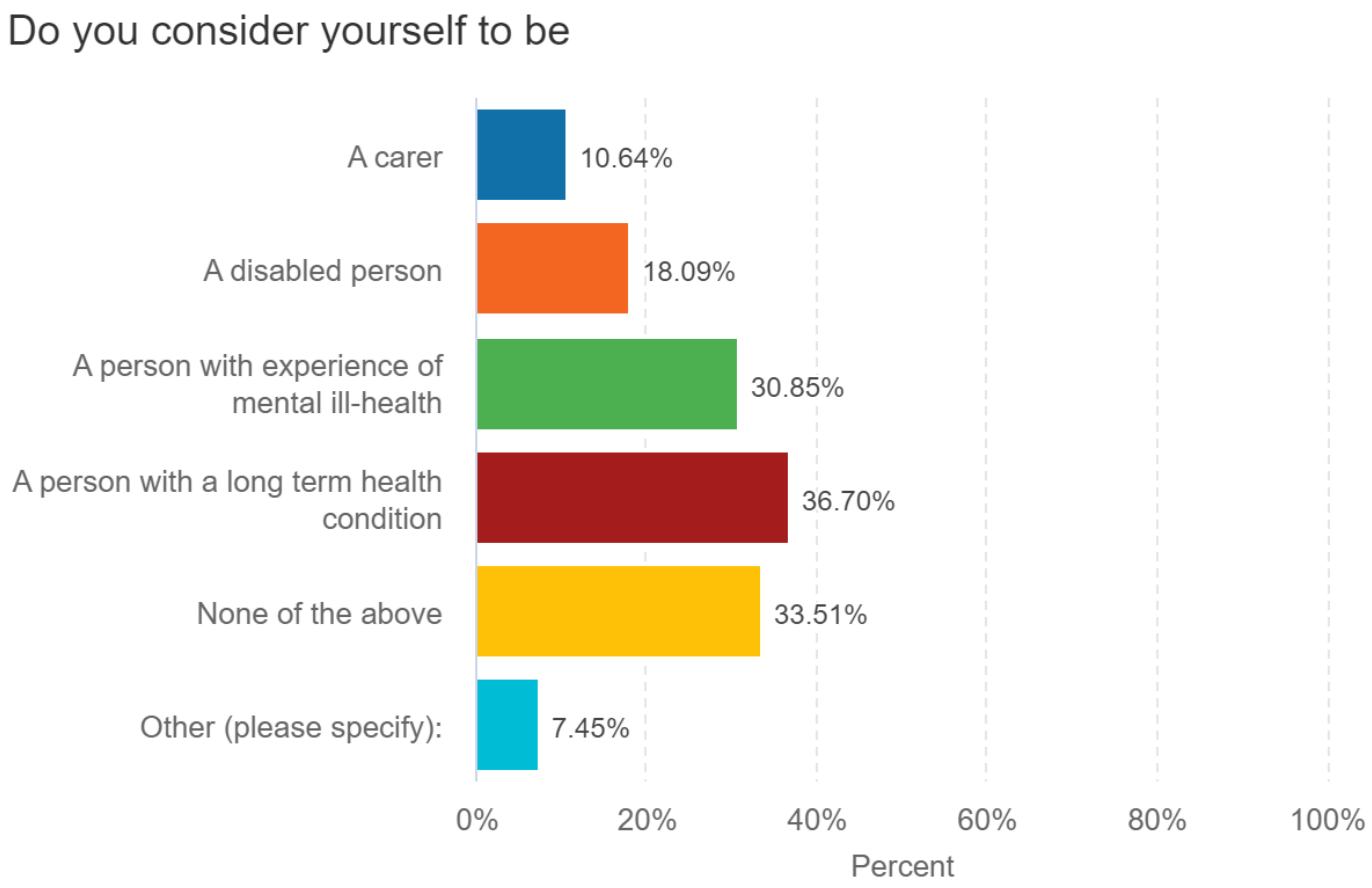
Gender:
We asked people how they would describe their gender; 182 people responded.

126 identified as female (69.2%), 53 as male (29.1%) and 3 (1.65%) as non-binary.

How is your health in general?:
189 people responded to this section



Do you consider yourself to be; a carer, a disabled person, a person with experience of mental ill-health, a person with a long-term health condition, none of the above or other?
188 people responded to this section



Those who responded 'other' reported; recovering from alcoholism, multiple health conditions, Autism.

Feedback gathered between 10 February and 17 March

Within the survey period, we also recorded the issues below via our Information, Advice and Signposting service as part of our wider capturing of people's experiences of care. In each of these contacts, a key element of their concerns related to the creeping costs of care.

22% of all the issues that we heard about within this period related to the lack of NHS dentistry, with people telling us that they are having to go without dentistry as they cannot afford private care.

Going without dentistry can lead to serious health consequences such as dementia, poor heart health and poor nutrition.

"NHS dentist did not refer to hospital for two issues despite having said that if they got worse needed hospital advice. 2 weeks later I went private. I had asked for referral during consultation but dentist said 'next time'. There is a three year wait in York for an NHS dentist, Leeds dental hospital are not taking any self-referrals. I'm left with an increasing soft tissue lump inside my cheek and a broken tooth splintering down to my gum."

Another reported concern was the cost of accessible care. Specifically, people with additional access needs are unable to rely on NHS healthcare services in York.

"Call from a sign language interpreter who supports a family in York. Family have been going to this dentist for years and in the past the dentist has provided a BSL interpreter who would attend for the whole family to be seen together. The parents receive private care and the children have NHS care with the same dentist, and they were recently

informed that an interpreter would no longer be provided and the family would have to pay."

"My elderly Mum developed mobility issues a few years ago so was finding it increasingly difficult to access her dentist as no lift with the practice being in a listed building. She asked one of the reception staff if she could be treated in a downstairs room and the response was that, if she couldn't get upstairs, she could no longer be NHS registered there. She was really upset, having gone there for years. She subsequently developed oral cancer necessitating major invasive medical intervention and although both she and I realise that being kept on wouldn't have stopped the condition, it would have been spotted much earlier, resulting in speedier remedial action being taken. At the time this happened we both stopped attending and have been unable to source suitable alternative NHS provision in York. Neither of us can afford private treatment."

Other feedback received since the December cost of living report

In January, we received an enquiry about possible sources of funding for a family member to visit a mother and child in a specialist unit in Northumberland. The regular travel was causing the family financial hardship.

We also received feedback from a parent. They confirmed they had not received any letters from school for over 2 weeks as they had run out of data and had to wait for money to come through before they could buy more. The school uses an online platform to send out all parent information. This meant their child had missed out on a themed costume day and a school outing.

Recommendations

Recommendation	Made to:
Consider ways of measuring and monitoring the health impacts of cost of living rises across the York population, for example monitoring over time the levels of people admitted to hospital who are malnourished	York Population Health Hub
Consider ways of making sure everyone has access to advice and information, not just those living in known areas of deprivation in the city. This must include access for those in the outer villages and those experiencing digital exclusion.	City of York Council, Advice York
Consider the findings from the pilot of heating help for those with long term health conditions in Gloucester, and whether opportunity exists locally to support those most at risk through winter pressures funding	York Health and Care Partnership
Continue to make strong representations to challenge the perceptions of York as an affluent city, and speak out for our residents who are currently struggling. This must include making sure colleagues across the wider Integrated Care System are fully sighted on the particular issues York residents are experiencing	York Health and Care Partnership
Collectively recommit to the council motion to recognise socio economic status	City of York Council, York Health and Wellbeing Board, York Health and Care Partnership

Conclusion

Within this second report, respondents report increased use of foodbanks, significant challenges with mental and physical health, and struggles to heat their homes and eat well. Despite this, many say that they are doing okay financially. Herein lies the challenge ahead – many believe that there are others worse off than they are, despite the reality of not being able to themselves afford to live a healthy life, or maintain social contact with others.

We already know that the postcode you are born in is the biggest factor in determining your long-term health outcomes. But now there is a growing sense of not having enough as just how it is now. Huw Pill, the Bank of England's Chief Economist, provoked a backlash when he said people need to accept they are poorer[7]. Sadly though, people are beginning to accept this. For many, there is no alternative.

What our survey shows is just that. An acceptance of, or resignation to, life as a struggle. It's normal not to have enough to eat, it's normal to have the heating off, it's normal to have mould growing on your walls and ceiling as a result. Someone somewhere is probably having bigger problems.

These issues are widespread. They go beyond our current understanding of the areas in York where we expect people experiencing poverty to be. This makes the challenge of providing support much greater – as the information, advice and support we offer needs to cover the whole of York, not just targeting our most disadvantaged communities. We must also consider targeted support for those who are at an increased risk of ill-health due, because they cannot afford to travel to access healthcare, or pay for their prescriptions. Any solutions to the challenges people are experiencing must reflect local conditions.

[7] Bank of England: 'Accept' you are poorer remark sparks backlash - BBC News 26 April 2023

We will continue to monitor the feedback we receive for indications of local concerns on this issue. We will undertake further work as needed. We will continue to share information about support available and encourage people to take up the offers of help. We will also maintain links to the Poverty Truth Commission as their priorities emerge.

At the moment, we don't have all the answers to how in the current economic climate, collectively, we make sure residents in York can live healthy, satisfying lives. All of us within the health and care system in our city must continue to work together. We can each play our part to try and stem the tide of widening health inequalities.

Appendices

Appendix 1: Measure of financial security

Would you say you are...?
1. Living comfortably
2. Doing alright
3. Just about getting by
4. Finding it quite difficult
5. Finding it very difficult
We grouped 4 and 5 into a category of financially insecure vs. 1, 2, and 3 as financially secure.

Appendix 2: PHQ-2 and GAD-2 measures

To measure clinically meaningful depression and anxiety, we used the PHQ-2 and GAD-2, which are shortened but validated versions of longer measures. They are recommended by the Medical Research Council for use in surveys.

Depression (PHQ-2)

The PHQ-2 enquires about the frequency of depressed mood and anhedonia over the past two weeks. The PHQ-2 includes the first two items of the PHQ-9.

Over the last 2 weeks, how often have you been bothered by the following problems?
1. Little interest or pleasure in doing things
2. Feeling down, depressed or hopeless
Answer responses and scores are
Not at all 0
Several days +1
More than half the days + 2
Nearly every day + 3

Interpretation:

A PHQ-2 score ranges from 0-6. If the score is 3 or greater, major depressive disorder is likely.

Anxiety (GAD-2)

The Generalized Anxiety Disorder 2-item (GAD-2) is an initial screening tool for generalized anxiety disorder.
Over the last 2 weeks, how often have you been bothered by the following problems?
1. Feeling nervous, anxious or on edge
2. Not being able to stop or control worrying
Answer responses and scores are the same as for the GHQ-2:
Not at all 0
Several days +1
More than half the days + 2
Nearly every day + 3

Interpretation:
A GAD-2 score is obtained by adding the score for each question (total points). 3 is the cut-off point for categorising someone as having clinically meaningful anxiety.

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Health and Wellbeing Board 25 July 2023
Report of the Manager, Healthwatch York

Healthwatch York Annual Report

Summary

1. This report is for information, sharing details about the activities of Healthwatch York in 2022/23 with the Health and Wellbeing Board.

Background

2. Healthwatch York has a legal duty to produce an Annual Report by 30 June each year, and to share it with local and national stakeholders[i]. The report, Annex A, contains information about how Healthwatch York have fulfilled their statutory function over the past year.

Main/Key Issues to be considered

3. Healthwatch York are a small team, with a wide remit.

Consultation

4. There has been no specific consultation involved in this report, but it is informed by specific and general consultation and engagement activities that Healthwatch York undertake.

Options

5. Health and Wellbeing Board are asked to note Healthwatch York's Annual Report 2022/23.

Strategic/Operational Plans

6. Areas of work discussed within the report have helped contribute to a number of different strategic and operational plans.

Implications

7. There are no specialist implications from this report.

- **Financial**

There are no financial implications in this report.

- **Human Resources (HR)**

There are no HR implications in this report.

- **Equalities**

There are no equalities implications in this report.

- **Legal**

There are no legal implications in this report.

- **Crime and Disorder**

There are no crime and disorder implications in this report.

- **Information Technology (IT)**

There are no IT implications in this report.

- **Property**

There are no property implications in this report.

- **Other**

There are no other implications in this report.

Risk Management

8. There are no risks associated with the Annual Report.

Recommendations

9. The Health and Wellbeing Board are asked to:

   i. Receive Healthwatch York's Annual Report.

Reason: To keep up to date with the work of Healthwatch York.

Contact Details

Author:	**Chief Officer Responsible for the report:**
Siân Balsom Manager Healthwatch York 01904 621133	Siân Balsom Manager Healthwatch York 01904 621133

Report Approved ✓ **Date** 12.07.2023

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:

Annexes
Annex A – Healthwatch York Annual Report
https://www.healthwatchyork.co.uk/wp-content/uploads/2023/07/Healthwatch-York-Annual-Report-2022-2023.pdf

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[i] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/262761/local_healthwatch_annual_reports_directions_2013.pdf

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Annual Report 2022–23

How we're making health and social care better

healthwatch York

Contents

"In the last ten years, the health and social care landscape has changed dramatically, but the dedication of local Healthwatch hasn't. Your local Healthwatch has worked tirelessly to make sure the views of local people are heard, and NHS and social care leaders use your feedback to make care better."

Louise Ansari, Healthwatch National Director

Message from our Chair

It's been another busy year with significant challenges for the health and social care system. The team has listened to many difficult stories from individuals and their families and used those stories to highlight areas of concern in health and social care in York.

Janet Wright
Healthwatch York Chair

We are proud of our partnership working. Through our York volCeS network we have shaped conversations around health and social care in York. The network brings together the voluntary, statutory and private sectors with members of our York community.

We have continued to produce snapshot reports to highlight concerns around particular topics. Our snapshot report on the experiences of young people and their families using Child and Adolescent Mental Health Services (CAMHS) opened conversations with relevant agencies and led to discussions around practical and achievable solutions.

I sit writing this listening to the construction work taking place in my street as part of the development of a city-wide broadband network. York must be applauded for its ambition to improve connectivity, but we must not forget those people who are still digitally excluded. Healthwatch exists to listen to everyone's voices, and we continue to strive to be as accessible as possible. We continue to provide our reports in a range of formats and our regular drop-in sessions across the city provided opportunities to meet Healthwatch representatives face to face.

"I hope you enjoy this Annual Report in which you will read about the team and the range of work that has been undertaken. The team has risen to the challenges of an ever-changing environment with integrity and professionalism. It's a phrase used a lot at the moment but in these challenging times one thing we can do is be kind to each other."

About us

Healthwatch York is your local health and social care champion.

We make sure NHS leaders and decision makers hear your voice and use your feedback to improve care. We can also help you to find reliable and trustworthy information and advice.

Our vision

A world where we can all get the health and care we need.

Our mission

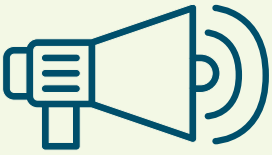
Healthwatch York puts people at the heart of health and social care services, enabling you to be heard. We believe that together we can help make York better for everyone.

Our values:

- **Accessible**
- **Diversity**
- **Empowering**
- **Participative**
- **Informative**
- **Responsive**
- **Inclusive**
- **Choice**
- **Accountable**
- **Flexible**

Year in review

Reaching out



1,301 people

shared their experiences of health and social care services with us, helping to raise awareness of issues and improve care.

576 people

came to us for clear advice and information about topics such as mental health and the cost of living crisis.

Making a difference to care

We published

8 reports

about the improvements people would like to see to health and social care services.

Our most popular report was

Cost of Living

which highlighted the struggles local people face with the rising cost of living

Health and care that works for you

We're lucky to have

29

outstanding volunteers who gave up 220 hours to make care better for our community.

We're funded by our local authority. In 2022-23 we received

£115,000

which is 6.4% less than the previous year.

We currently employ

6 part time staff

who help us carry out our work.

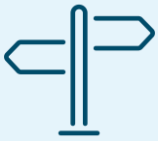
How we've made a difference this year

Spring

With Healthwatch North Yorkshire, we raised the issues people face when providers fail to meet the Accessible Information Standard.

We started our research into people's experiences of mental health crisis care in York.

Summer



We updated the Healthwatch York Dementia Guide, helping people to navigate services.

Via our summer magazine and engagement events, we kept the public informed of NHS changes.

Autumn

We set up the York volCeS network to enable the public to speak directly with service providers and decision makers.

Via our work with York Safeguarding Adults Board, we have contributed to improvements in local safeguarding.

Winter

We evidenced the impact of the rising cost of living on the health of York residents, calling for practical changes.

We met local information and signposting needs by publishing a guide of essential services that were open over the Christmas period.

10 years of improving care

This year marked a special milestone for Healthwatch. Over the last ten years, people have shared their experiences, good and bad, to help improve health and social care. A big thank you to all our Healthwatch Heroes who stepped up and inspired change. Here are a few of our highlights:

How have we made care better, together?

Trusted information and signposting

We continue to provide public information and signposting. We update, print and post the York Dementia guide and York Mental health and wellbeing guide. Information pages on our website are regularly updated and we take enquiries daily.

Care home assessing

Our team of friendly, trained volunteers meet care home residents to understand how care could be provided better. Information is shared with York Council and CQC to make positive changes for residents.

More accessible information

We provide a free readability service, ensuring NHS literature is understandable. We continue to be public facing, meeting the public and engaging via social media and the press.

Co - production

Our staff continue to champion co-production approaches across health and care. We're called upon to run workshops and deliver training. We're excited to see this embedded into ICB policy.

Relationships

We continue to nurture our relationship with NHS and council partners so we can understand changing systems and bring public voice into decision making.

Healthwatch Hero

Celebrating a hero in our local community.

Kirsty is a volunteer with us at Healthwatch York. Outside of her time with us, she's actively raising awareness of menopause issues across the city, helping people to identify symptoms and raising awareness of the support available.

Kirsty's passion is clear when talking to her. Through friendly conversations she's been able to inform and signpost York residents to life enhancing services and information points. Kirsty tells us that many do not realise they're going through the menopause, or those that do often don't feel supported. Kirsty has set up coffee mornings and menopause walks around the city giving people a safe and confidential place to share their worries and experiences with people who can relate and understand.

Kirsty is amazing and her work continues to improve the lives of residents. We can't wait to see what the future looks like for Kirsty and all the people she supports along the way. This is why Kirsty is our Healthwatch Hero. Keep up the amazing work Kirsty.

Listening to your experiences

Services can't make improvements without hearing your views. That's why over the last year we have made listening to feedback from all areas of the community our main priority. This allows us to understand the full picture, and feed this back to services to help them improve.

Improving access to children's mental health support

The pressures on mental health services have been widely reported. The Care Quality Commission's (CQC) State of Care report highlights issues including workforce recruitment and retention. The CQC Community Mental Health report, conducted after the pandemic, shows the impact this further pressure has had on outcomes for patients.

With services struggling to meet demand, increasing the risk of children and young people's mental health worsening and reaching crisis point, we wanted to understand local residents' experiences of accessing child and adolescent mental health services.

We identified challenges relating to inefficient administration, poor communication from service providers and lost opportunities for effective information and signposting. For patients and carers this has contributed to longer waiting times for support, challenges with 'waiting well' and mistrust in the system.

Changes to patient and carer experience

Our findings gained media attention and have resulted in practical changes across the system including:

- Better support provided to teachers, aiding and improving the quality of referrals
- CAMHS now provides information and signposting at the first point of contact, including the anticipated patient pathway
- Improved appointment administration and communication internally and with patients

What difference will this make?

Our report was presented to the Health and Wellbeing Board on 16 November 2022. The resulting conversations showed the power of sharing people's feedback – decision makers listened to your voice and took action.

With these changes in place, it should be easier for people to make quicker and more informed decisions around how they access mental health support. Better administration, communication and signposting will support patients with waiting well.

"CAMHS regularly loses paperwork and it is common to have to fill out the same assessment forms for the same children several times."

Holding health and social care to account on the Accessible Information Standard

Getting health and social care is challenging for people who need information in an accessible format. Despite health and care services being legally required to meet the Accessible Information Standard since 2016, many York and North Yorkshire residents' needs are not being met. Fortunately, after hearing your experiences, services are committing to reviewing and correcting their practices.

The Accessible Information Standard states that health and care organisations are legally required to provide a consistent approach to identifying, recording, flagging, sharing, and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment, or sensory loss.

For many, failing to meet these standards can lead to missed appointments, an invasion of privacy or unmet medical needs.

In partnership with Healthwatch North Yorkshire, our recommendations included:

1. Ask what helps and do something about it. Put the user first.
2. Once identified, share people's information needs within organisations.
3. Involve people with lived experience to help find pragmatic answers.
4. Review what you're doing to make sure it is working and learn from what is and isn't going well.

What difference will this make?

As a result of this partnership work, we've received confirmation of changes being made from several health and care providers.

We continue to inform the public around their rights, and providers of their obligations. These changes should ensure that people don't miss health and social care appointments simply because they're not provided with information in a format they can understand.

"The system doesn't anticipate that not everyone can use the phone. It is a legal requirement of the Equality Act that NHS Trusts make reasonable adjustments by providing alternatives to use of a telephone."
– Ian, York Resident

Three ways we have made a difference for the community

Throughout our work we gather information about health inequalities by speaking to people whose experiences aren't often heard.

Creating empathy by bringing experiences to life

It's important for services to see the bigger picture. Hearing personal experiences and the impact on people's lives provides them with a better understanding of the problems.

Healthwatch York includes a personal health and care story within every magazine. This is usually a 'day in the life' of a carer, voluntary sector provider or NHS worker. Through these stories we're able to bust myths about what it's like to be supporting people day to day, and offer a different perspective to health and social care. It's an opportunity to really showcase good practice, and highlight often unseen personal challenges.

Getting services to involve the public

Services need to understand the benefits of involving local people to help improve care for everyone.

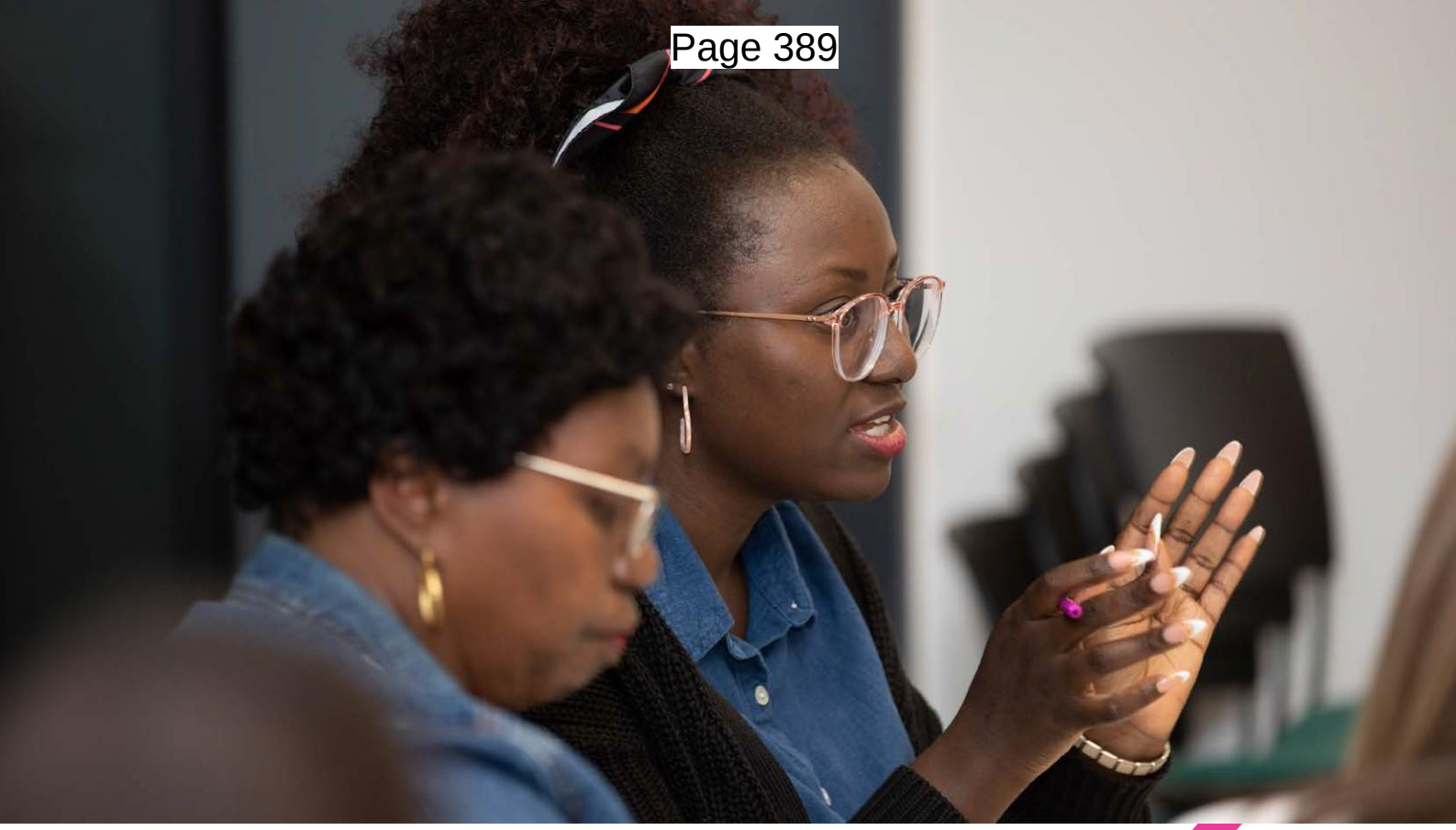
We're active participants in local mental health transformation initiatives, including the neurodiversity and mental health workstream.

Through these channels, we've cultivated working relationships with underrepresented communities and the providers that serve them. From this, we've evidenced a need for a co-produced information and signposting tool for neurodivergent people and we look forward to signing off the finished version.

Improving care over time

Change takes time. We often work behind the scenes with services to consistently raise issues and bring about change.

Access to NHS dentistry continues to dominate the issues and enquiries we receive. From your feedback, we've produced two major reports and continue to call for more NHS dentistry in York, at both local and national government level. Most recently, we submitted evidence to the Health and Social Care Select Committee about poor experiences in York and the need for contract reform, and we await the outcome.



Hearing from everyone

Over the past year we have worked hard to make sure we hear from everyone within our local area. It is important to reach out to the communities we hear from less frequently, to gather their feedback and make sure their voice is heard and services meet their needs.

This year we have reached different communities by:

- Having a regular presence within the local mental health hub.
- Liaising with community leaders and council colleagues to ensure we're hearing from people living in current areas of deprivation.
- Hosting York volCeS – inviting underrepresented communities to comment on health and care services alongside service providers and commissioners.
- Being active contributors to key strategic meetings; putting your voice at the centre of discussions, sharing good practice and holding services to account.

York voICeS Network

Through our voICeS network, we facilitate meetings to ensure that community voices are key to decision making. At each meeting we update people on local health and care and, through activities, workshops and discussions, provide York residents with the opportunity to share their experiences.

Each of these meetings has a different theme, for example, women's health and mental health. This allows people from various backgrounds and experiences to participate and to have their voices heard.

"Now I am in the menopause, my GP puts all symptoms down to the menopause! It's like I can't have anything else wrong with me. I have had a stomach complaint for several years which is now being put down to the menopause so I can't get any investigations done for it." - York Resident

Highlighting the impact of the rising cost of living on health

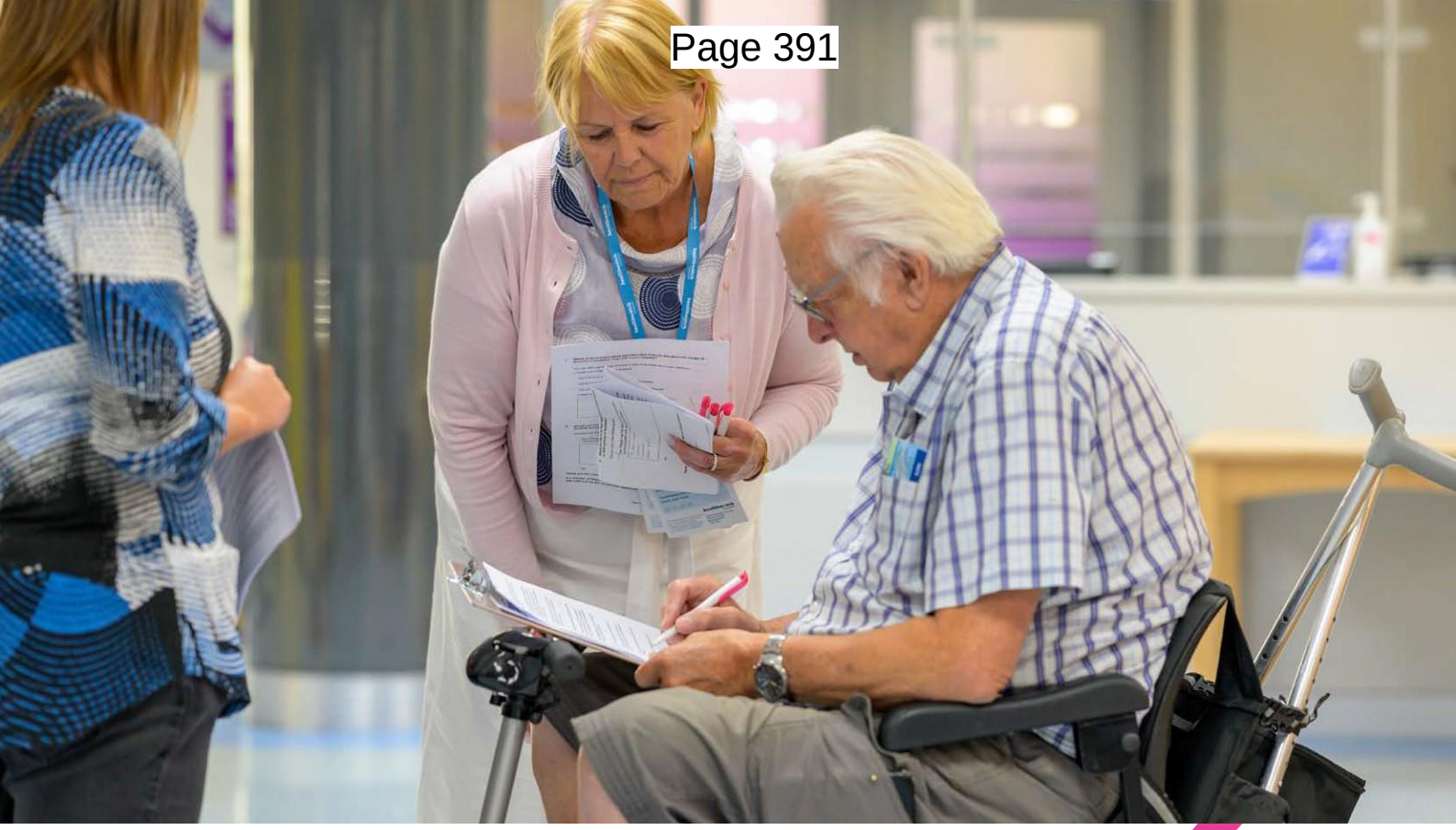
In response to the increase in complexity and severity of issues we were receiving, we ran a survey asking people to tell us about the impact of the rising living costs on their health. We heard from 200 people across York.

We found that people were no longer able to afford nutritious food, heating, and non-essential items. This was causing isolation, worsening of physical health conditions and feelings of anxiety, depression and shame.

We presented our findings at the City of York Council cost of living summit to demonstrate the very real health impact of rising costs. Recommendations from the findings were shared to provide an informed cross sector response.

"We are in financial hardship now. I'm losing sleep worrying where we will be in a few months' time! Christmas around the corner and my children won't have any presents to open."

York Resident



Advice and information

Our Advice and Information service provides independent, confidential support to help people find the correct information, to understand the options available and get the right help. Whether it is navigating primary care, finding a dentist or choosing a care home, we will support you.

This year we've helped people by:

- Providing up to date information people can trust via telephone, social media, email, bulletins, magazines, signposting guides and engagement stalls.
- Supporting people to look after their health with the rising cost of living.
- Helped people access the services they need.
- Signposted to valued community-led support.

We are one of the few organisations who continue to print materials and make sure they're publicly available in a format that works for you.

Help to find dental care in York

Enquiries about dentistry constitute around 20-50% of enquiries to us every month.

The situation in York has declined rapidly this year as several dental practices have stopped providing NHS care. Only one dental practice in York is taking people onto a waiting list, but they are advising that there will be a wait of at least five years. Following our dentistry reports in recent years, we submitted evidence to the Health Select and Social Care Select Committee's inquiry in January 2023, and work to maintain pressure for change.

> "I know a Ukrainian lady who is in a lot of pain from a tooth. It is spreading to her face. She thinks she may need root canal treatment. She is planning to return to Ukraine to her town which is a war zone to get dental treatment as she can't find an NHS dentist and can't afford private care." - **York resident**

Advice and information guides

Our co-produced information and signposting guides are central to the information work we do. These are printed guides that we post to residents and disseminate to community spaces, and frontline staff across the city.

Our Mental Health & Wellbeing Guide is widely recognised across York. The guide is updated every two years to account for service changes. We published our latest edition in April with a print run of 3,000 copies to cope with local demand.

> "I love these guides. I'm hoping to carry a few with me when I meet up with friends or when people ask me who they should turn to when they need extra support or advice." **- Resident**

Our Dementia Guide was published in June 2022, and contains relevant advice and resources for people living with dementia and their families and carers.

> "“Healthwatch York is doing an amazing job and your guides support many in York” - **Resident supporting their parent**

We acknowledge that it's particularly challenging to know what services are available over the Christmas period.

We produced a guide of services open in York. Following conversations with residents, the guide included warm spaces, foodbanks and community food hubs. We worked with the CVS wellbeing team to make sure the residents they work with received this list directly.

Volunteering

We're supported by a team of experienced volunteers who are at the heart of what we do. Thanks to their local knowledge and professional skills, we're able to reach more people and have a greater impact.

This year Healthwatch York volunteers:

- Hosted community stands across the city; Providing information, gathering experiences and giving Healthwatch York greater visibility.
- Took part in Participatory Research training and began Projects focusing on different topics relevant to their communities.
- Rang all local NHS dentists to see if they were taking on new NHS patients to update our website and signposting information.
- Supported the revival of our care home work by visiting local care homes to chat with residents and staff; feeding back to us on the quality of providers.
- Produced interesting and insightful blogs for our website and social media.

Lesley

"I enjoy engaging with members of the public and listening to their experiences when using the health and social care services in York and seeing how these are taken on board when new services are planned. It is good to be involved with an organisation that not only listens but makes sure the public voice is heard at every stage."

Chris

"I am involved in the readability project where we review NHS and other leaflets and information to ensure they make sense to the people who will read them. It is a worthwhile piece of work and great to get feedback which confirms the value of what we do for patients. It can be quite challenging, but it is good to know you are part of a group working together. I really enjoy it and comment on as many as I can."

Phil

"I am the Service Manager for the York Drug and Alcohol Service. I have been working within the Drug and Alcohol field in York for 19yrs now and have seen the impact that health inequalities / barriers can have on people who access these services. It has been a privilege to sit on the Healthwatch York Steering group over the last year and being able to have an impact on improving services for all residents of York."

Do you feel inspired?

We are always on the lookout for new volunteers, so please get in touch today.

https://www.healthwatchyork.co.uk/

01904 621133

healthwatch@yorkcvs.org.uk

Finance and future priorities

To help us carry out our work, we receive funding from our local authority under the Health and Social Care Act 2012.

Our income and expenditure

Income		Expenditure	
City of York Council	£118,039	Expenditure staff salaries and expenses	£107,375
Additional Income	£2,750	Non-pay expenditure	£27,670
Total income	**£120,789**	Office and management fee	£17,130
Overspend (financed by prior year's surpluses)	**£31,386**	**Total expenditure**	**£152,175**

Additional income is broken down by:

- **£1,500 funding** received from Healthwatch England for IT changes
- **£1,250 funding** received from Healthwatch England for a care interview

Next steps

In the ten years since Healthwatch was launched, we've demonstrated the power of public feedback in helping the health and care system understand what is working, spot issues and think about how things can be better in the future.

Services are currently facing unprecedented challenges and tackling the backlog needs to be a key priority for the NHS to ensure everyone gets the care they need. Over the next year we will continue our role in collecting feedback from everyone in our local community and giving them a voice to help shape improvements to services.

We will also continue our work tackling inequalities that exist and work to reduce the barriers you face when accessing care, regardless whether that is because of where you live, income or race.

Top three priorities for 2023-24

1. Navigating primary care
2. Mental health crisis care
3. York volCeS

The contract for Healthwatch in York

Healthwatch York is proud to be part of York CVS. As such, our registered office is York CVS, 15 Priory Street, York, YO1 6ET. The Chair of Healthwatch York sits on the York CVS Board and the Chair of York CVS sits on the Healthwatch York Steering Group.

Healthwatch York uses the Healthwatch Trademark when undertaking its statutory activities as covered by the licence agreement.

The way we work

How we involve others in our governance and decision-making

Our Healthwatch steering group consists of nine members who work on a voluntary basis to provide direction, oversight and scrutiny to our activities. Our steering group ensures that decisions about priority areas of work reflect the concerns and interests of our local communities. Throughout 2022/23 the steering group met 4 times and provided Healthwatch York with advice and support around effective and ethically sound research approaches for our mental health crisis care work.

We ensure wider public involvement in deciding our work priorities via email, in person and post.

Methods and systems used across the year to obtain people's experiences

We used a wide range of approaches to ensure that as many people as possible had the opportunity to provide us with insight about their experience of using services. During 2022/23 we were available by phone, email, provided a webform on our website and through social media, as well as attending meetings of community groups and forums and hosting York volCeS.

We ensure that our publications are available to as many members of the public and partner organisations as possible. We publish them on our website, email to our vast mailing list, print and post copies. We also now provide local libraries with our publications – pop in and have a read at your convenience.

Taking people's experiences to decision makers

We ensure that people who can make decisions about services hear about your insights and experiences.

In York we take information to sector representatives (such as York CVS and/or Nimbus care), service providers, commissioners, council leaders, councillors, MPs, the Integrated Care Board and Integrated Care System. We also work with other local Healthwatch and Healthwatch England to address shared health and social care concerns.

We take insight and experiences to strategic meetings in the city including the Drug and Alcohol Partnership, Safeguarding Adults Board and Connecting Our City. We share our data with Healthwatch England to help address health and care issues at a national level.

Enter and View

We did not conduct any Enter and View visits this year and so no recommendations or actions were put forward.

Healthwatch representatives

Healthwatch York is represented on the York Health and Wellbeing Board by Siân Balsom, Healthwatch York Manager. During 2022/23 Siân has effectively carried out this role by sharing Healthwatch York reports, compiling update reports at the Boards request, and taking an active role in all Board discussions.

Siân also sits on the York Health and Care Partnership Executive Committee, and feeds into the Humber and North Yorkshire Integrated Care Board through regular meetings of the 6 Healthwatch leads across Humber and North Yorkshire. Siân also takes part in the System Quality Group, which aims to address quality concerns across Humber and North Yorkshire.

Feedback we received

"I value their professionalism and honesty, and the fact that they are willing and eager to work collaboratively" - **Ashley Green- Healthwatch North Yorkshire CEO**

"They are open and transparent about feedback statistics. They are a very valuable and trusted resource" – **Savanna Thompson, Adult Social Care Transformation Team**

"Healthwatch York is a critical friend, a source of really constructive critique. They help us to hold a mirror up to ourselves and highlight how the wider impacts of our decisions might affect the population." - **Sarah Coltman–Lovell, NHS Humber and North Yorkshire ICB**

2022–2023 Outcomes

Project/ activity	**Changes made to services**
CAMHS snapshot report	Improvements to communication, and information and signposting.
City of York Council re Council Tax	Pilot introduced to improve experiences of people struggling to pay
Mental health transformation	Mental health hub developed with co-production as a guiding principle
Accessible Information	Strong commitments from all local partners to improve accessibility. Action plans in place and changes underway.
Continuing to monitor the impact of lack of dentists in York	Healthwatch York actively involved in local discussions and sit on appropriate bodies to highlight concerns. Local MPs championing the issue, plans for a roundtable in place

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