Notice of a public meeting of
Health and Wellbeing Board

To: Councillors Steels-Walshaw (Chair), Runciman, Webb and Cullwick
Sarah Coltman-Lovell – York Place Director, Humber and North Yorkshire ICB (Vice Chair)
Peter Roderick - Director of Public Health, City of York Council
Siân Balsom – Manager, Healthwatch York
Dr Emma Broughton – Joint Chair of York Health & Care Collaborative
Naomi Lonergan – Managing Director, Yorkshire, York & Selby - Tees, Esk and Wear Valleys NHS Foundation Trust
Sara Storey – Corporate Director, Adults and Integration, City of York Council
Martin Kelly - Corporate Director of Children's and Education, City of York Council
Pauline Stuchfield – Director of Housing and Communities, City of York Council
Clare Smith - Chief Executive, York and Scarborough Teaching Hospitals NHS Foundation Trust
Mike Padgham – Chair, Independent Care Group
Alison Semmence - Chief Executive, York CVS
Fiona Willey – Chief Superintendent, North Yorkshire Police
Tom Hirst – Area Manager Director of Community Risk and Resilience, North Yorkshire Fire and Rescue Service

Date: Wednesday, 13 May 2026

Time: 4.30 pm

Venue: West Offices

AGENDA

1. **Apologies for Absence**
To receive and note apologies for absence.

2. **Declarations of Interest** (Pages 5 - 6)
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].

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 **Monday, 11 May 2026**.

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.

4. Minutes (Pages 7 - 26)

To approve and sign the minutes of the last meeting of the Health and Wellbeing Board held on **Wednesday, 21 January 2026**.

5. Feedback from March Workshop and Future of the Health and Wellbeing Board (Pages 27 - 34)

This report summarises discussions at a recently held workshop for the Health and Wellbeing Board, facilitated by the Local Government Association (LGA), the purpose of which was to develop the work of the Board and enable it to become more effective.

The report also proposes a series of changes to the way the board operates, emerging from those discussions, to be agreed by members at today’s meeting.

6. Healthwatch York Reports: "Getting to Healthcare" and "What TNBI People Told Us About Health Services in York" (Pages 35 - 178)

This report is for the attention and action of Board members, sharing two reports from Healthwatch York.

These respectively share feedback received about how changes to non-emergency patient transport, following the tightening of eligibility criteria in April 2025, have affected people across York and North Yorkshire and an exploration into whether reports of poor experiences in accessing local healthcare services from some trans, non-binary and intersex (TNBI) people in York, shared with Healthwatch, were common for this community.

7. Update from the York Health and Care Partnership (Pages 179 - 188)

This report provides an update to the Health and Wellbeing Board (HWBB) regarding the work of the York Health and Care Partnership (YHCP).

The report also asks the Health and Wellbeing Board to respond to a recommendation in relation to Section 10.

8. Urgent Business

Any other business which the Chair considers urgent under the

Local Government Act 1972.

Democratic Services Officer

Ben Jewitt

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

- Registering to speak
- Written Representations
- Business of the meeting
- Any special arrangements
- Copies of reports

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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 جا سکتی ہیں۔ **(Urdu)**

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	21 January 2026
Present	Councillors Steels-Walshaw (Chair), Runciman, Webb and Cullwick; Sarah Coltman-Lovell – York Place Director, Humber and North Yorkshire ICB Siân Balsom – Manager, Healthwatch York Peter Roderick – Director of Public Health, City of York Alison Semmence – Chief Executive, York CVS Pauline Stuchfield – Director of Housing and Communities, City of York Council Sara Storey – Corporate Director of Adult’s and Integration, City of York Council Naomi Lonergan Interim Managing Director, North Yorkshire & York, Tees, Esk and Wear Valleys NHS Foundation Trust Lucy Brown – Director of Communications, York and Scarborough Teaching Hospitals NHS Foundation Trust (Substitute for Clare Smith) Toni Tranter - Head of Early Intervention and Prevention, North Yorkshire Fire and Rescue Service (Substitute for Tom Hirst)
Apologies	Martin Kelly – Corporate Director, Children’s and Education, City of York Council Clare Smith – Chief Executive, York and Scarborough Teaching Hospitals NHS Foundation Trust Tom Hirst – Area Manager Director of Community Risk and Resilience, North Yorkshire Fire and Rescue Service Fiona Willey – Chief Superintendent, North Yorkshire Police
Absent	Dr Emma Broughton – Joint Chair, York Health and Care Collaborative Mike Padgham – Chair, Independent Care Group

Officers in Attendance	Dr Tori Blake – Director of Urgent Care, Nimbuscare Phil Truby – Head of Public Health, City of York Council Jane Timson – Independent Chair of the City of York Safeguarding Adult Board (CYSAB) Michael Melvin – Assistant Director of Adults and Integration

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30. Apologies for Absence (4:32pm)

The board received apologies from the Corporate of Childrens and Education, City of York Council; there was no substitute.

The board received apologies from the Area Manager Director of Community Risk and Resilience, North Yorkshire Fire and Rescue Service, who was substituted by the Head of Early Intervention and Prevention.

The board received apologies from the Chief Superintendent, North Yorkshire Police; there was no substitute.

The board received apologies from the Chief Executive, York and Scarborough Teaching Hospitals NHS Foundation Trust, who was substituted by the Director of Communications.

31. Declarations of Interest (4:33pm)

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.

32. Minutes (4:33pm)

Resolved: To approve and sign the minutes of the last meeting of the Health and Wellbeing Board held on Wednesday, 19 November 2025.

33. Public Participation (4:33pm)

It was reported that there had been two registrations to speak under the Council’s Public Participation Scheme; one speaker sent apologies due to sickness.

Flick Williams spoke on item 7, questioning the decision-making process. She said it appeared unclear whether there would be any further public consultation on this matter and if the decision was being made here, she questioned the lack of a human rights and equalities impact assessment to accompany it.

She voiced concerns that adding fluoride to the water supply amounted to “universal dosing” of a medication, which would impact residents’ health and human rights, removing the element of individual choice. She also queried the possibility of an ensuing price rise for water bills.

34. Presentation: Direction and Purpose of York's Neighbourhoods - to inform Health & Wellbeing Board Planning for Neighbourhood Health Reform (4:37pm)

The Director of Public Health introduced the item, noting that it was the board’s duty to publish a Neighbourhood Health Plan, and this would hopefully allow acute hospitals to work much more at a neighbourhood level, with external services more deeply integrated and embedded with the NHS, which he said was a timely alignment for York. He suggested that the board’s role in this process should be to steer the agenda and outlined how the model fitted in with York’s wards and

The item was then presented by The Director of Housing and Communities and the Director of Urgent Care, Nimbuscare.

The Director of Housing and Communities summarised how health services would fit into this model, advising that the local authority had planned for services to work within communities via an early intervention and prevention approach, to work with people as early and locally as possible. She noted that in York there were various existing models of integrated working to build upon, such as Local Area Coordinators, SEND hubs, Frailty hubs, Family hubs, and Mental Health hubs.

She advised that Neighbourhood Partnership Boards had been organised across the city, and work was being undertaken with the voluntary care sector to better respond to local issues. She detailed how the Integrated Neighbourhood Team would support the population on an individual level as well as through more complex cases identified by data. A consistent approach to working with the INT had been agreed between York Health and Care Collaborative and the council's Executive.

The Director of Urgent Care went on to discuss Population Health Management. She advised that this involved using data to identify residents who needed multi-agency support, and working together to provide better support than the current single agency system was able to. She talked the board through a case study on how multi-agency social prescribing and trusted relationships looked in real terms.

The Director of Public Health advised that national guidelines concerning how Health and Wellbeing Boards needed to form their Neighbourhood Plan had not yet been received but were anticipated in the coming weeks. He stated that initial guidance suggested that boards would be required to offer leadership, and he hoped that partners would be able to further discuss this at the Local Government Association workshop being convened in March and at the subsequent meeting of the HWBB.

The Chair noted that York was in a strong position with this plan and the board simply needed to determine how deeply involved it wished to be with the neighbourhood plan.

Board members asked how "Caroline's story" - the case study in the presentation – tied in to the Neighbourhood Model and what about York's model had led to a different outcome in this case.

The Director of Urgent Care responded that the case study highlighted the need for different organisations to come together through a multiagency approach, working around the needs of an individual. She stressed that this was fundamentally different from partners looking after patients without interaction from other agencies. Partners were not fully at the stage where they had adopted a multi-agency approach, but were moving in that direction.

Board members asked about fixing problems upstream being preventative, and whether in future the Neighbourhood Model might thereby fix problems before they got to the point discussed in “Caroline’s Story”.

The Director of Public Health answered that this case study showed the difference a proactive model of social prescribing made. Traditionally, something goes wrong, and someone went to healthcare providers for support; the intention of the new model was different, rather than waiting for something to go wrong, people in high risk groups who are currently in good health can be identified on GP registers and providers can reach out to them to proactively make a personalised plan to attenuate risks. He noted that this was much clearer to see in a neighbourhood setting.

The York Place Director said that this discussion was the start of a conversation among board members that would need to continue over the next six months. She responded to the previous query stating that this was about creating a systematic approach for identifying need rather than relying on a single point of referral. and community champions, ward councillors and others could all provide early help and intervention, rather than the traditional reliance on primary care referrals. York Hospital and TEWV, needed to relate to neighbourhoods too.

The Chief Executive, York CVS commented that this was about centring care around individual people, and Social Prescribing was an ideal way of picking up on people who were otherwise off the radar of the system or isolated at home.

The Corporate Director of Adults and Integration said that the case study was positive, but even so Caroline had experienced a bad year, which had further impacted her health. Going forward, it would be even better to avoid all challenges. Thinking about may need assistance with movement by addressing problems earlier and utilising local teams to ensure fewer people around the patient.

The Manager of Healthwatch York suggested that the real challenge was around understanding neighbourhoods as real places and not just arbitrary compass directions or map zones.

The Managing Director, TEWV, endorsed the plan, adding that all organisations would need to properly engage with the scheme for it to work to its full potential. The Director of Communications, York and Scarborough Teaching Hospitals

NHS Foundation Trust added that York Hospital was already discussing how to achieve this within their organisation.

On behalf of the board, the chair then

Resolved: To receive the presentation.

Reason: To be informed on the direction and purpose of York's neighbourhoods to inform health and well-being planning for the neighbourhood health reform.

35. Verbal Update from the York Health and Care Partnership (5:18pm)

A verbal update on the York Health and Care Partnership was delivered by the York Place Director; she apologised for the absence of a written report, explaining this was due to ongoing changes around the Integrated Care Board, including aspects of the Neighbourhood Health Policy, and she wanted to wait for more information on the ICB’s plans and the national policy direction on the Neighbourhood Health work so that the York Health and Care Partnership could establish its position before reporting to the Health and Wellbeing Board.

She stated that the Neighbourhood Health strategy was a core policy to the board’s 10-year-plan, and that York had been identified as being in the best position to scale neighbourhood working around the city. She assured partners that this was something which the NHS took seriously and stressed the importance of scaling change, noting they needed to focus initially on prevention and early intervention in order to ultimately be a better partner for Neighbourhood Health, and that the strategy was more holistic than just NHS partners.

She noted four upcoming pieces of guidance that were anticipated, impacting the board’s statutory duty to the Neighbourhood Health Plan:

1. Work around the model neighbourhood, in the form of a document discussing success factors, key ingredients and so on.

2. Guidance on new contract forms; not simply a vision or a plan, this would involve new models for single and multi-

neighbourhood provider contracts with different forms to what had been used before and would incentivise providers to deliver this model, making improvements to cash flow and work flow.

3. The Better Care Fund, as already discussed by the Director of Public Health.

4. Guidance on better use of physical assets; within the City of York 50+ buildings were owned or rented between General Practice, York Hospital Trust and TEWV, not to mention the many civic and council assets. To work in a way that supports people going forward it would help to have some ability to share use of these premises.

On the ICB policy direction she explained the demand for ICB's to make a 50% reduction to their running cost by April 2026. The ICB needed to ensure its statutory functions continued to be delivered and this left relatively fewer resources for commissioning, but this remained a key focus.

She indicated that going forward, commissioning would have to focus on assessing population needs and developing the long-term population health strategy for system procurement contracting, getting contracts and incentives in place and then evaluating impact of services.

She outlined that the HWBB would still be able to engage with the ICB as a strategic commissioner, in the development of a long-term population health strategy and the evaluation of its implementation. She added that this came back again to the Neighbourhood Health model.

She discussed anticipated running cost and commissioning reductions, noting that approximately 150 redundancies were expected over the next few months. The outcome of the ICB's consultation was expected on 10 February, at which point the implementation of this would begin, which was expected to take a number of months. By summer the impact of these reductions would be clear.

She stated that strong partnership working remained vital to YHCP, but there would no longer be teams dedicated to Place funded by the ICB, as was currently the case. She felt that the model would move from the ICB leading Place to being a partner of Place.

She said the ICB had confirmed that the Joint Committee would continue to operate, reporting to the ICB and HWBB, and would remain a formal committee of both. She suggested evolving the Joint Committee to be as effective as possible in delivering the work required in York. She suggested that more would be known by the next formal meeting of the board, where she would provide a formal report setting out the operating model for YHCP moving forward, as well as the minutes from their previous meeting and a report covering the points that would have been raised, had the forward report been presented today.

She concluded that the main guidance for Health and Wellbeing Boards in the production of the Neighbourhood Health Plan had been expected on the day of the January HWBB meeting, which was one of the reasons she had delayed her report, but this was now expected mid-February and the other pieces of guidance were expected before the end of April.

There were no questions from board members.

It was thereby

Resolved: That the Board note the verbal update from the YHCP.

Reason: So that the Board were kept up to date on the work of the YHCP, progress to date and next steps.

36. Water Fluoridation (5:31pm)

The report was presented by the Director of Public Health, who explained that this was very detailed due to the tooth decay situation in York worsening over recent decades. He explained that this was against a backdrop of tooth decay being the leading cause of children 6-9 going into hospital, with 22,000 UK hospital admittances every year necessitating an extraction under general anaesthetic. He noted that this was a topic that had been debated and discussed for 90 years, and the debate over fluoridation was therefore not new.

Addressing the comments of the speaker during Public Participation, he offered to correspond or meet with the speaker to further discuss this. For the purposes of the meeting, he suggested that many of the speaker’s arguments had been extensively debated in the past but sought to reassure over two of her key points.

He confirmed that the addition of fluoride to the water system was supported by all four Chief Medical Officers in the United Kingdom; the Chief Dental Officer of the United Kingdom, the British Dental Association, the Royal College of Paediatrics and Child Health and the British Society of Paediatric Dentistry, and there was thereby significant weight of professional opinion behind this. The science of its effectiveness in reducing dental cases and hospital admissions was established.

He stated that adding fluoride to water reached everyone, passing on beneficial properties, noting that this was effective in narrowing the gap in dental health between affluent and poor communities, as it was generally poor and deprived children who ended up in hospital with this issue, but in areas which are have fluoride in the water that was far less the case. He advised that there were already 6 million people in the UK who had fluoridation in their water (either through natural means or via adding fluoride to the ater as was proposed for York). He noted that the paper cited studies suggesting this could have both an adverse but particularly a beneficial effect on children’s dental health.

He stressed that fluoride was not considered a medicine as the speaker had suggested, rather it was a part of the water system. He noted that drinking water was treated with additives to make it safe, removing impurities from it, such as bacteria and viruses. Adding fluoride was part of this water treatment process and did not constitute adding a medicine and people were already receiving it and other treatments in their water without specific consent.

He proposed that while this report was specifically calling on the board “in principle” to support in the addition of fluoride to the water for York, the board should additionally ask the Council Leader, Cllr Claire Douglas, to write to the Secretary of State, to reinforce that this is the conversation our local clinicians, elected members, senior officers, those in the voluntary and community sector have assented to. He suggested partners could put their names to a letter and statement, as this was something the government was proactively seeking from local authorities.

Board members asked whether there was any evidence regarding negative side effects. The Director of Public Health responded that the main side effect was fluorosis, which produced a mottled effect on teeth in a small number of people, and that this was far outweighed by the benefits. He suggested that while there were theories put forward by people regarding various side effects, the benefits were very high and these harms remained unproven.

The Managing Director, TEWV agreed that this evidence was very clearly laid out in the report. In such cases where there was any doubt, partners should be led by evidence.

Cllr Runciman stated that she felt very strongly about this matter, having campaigned for over 50 years about this. She felt it would do the world of good.

Cllr Webb suggested the paper was narrow but wider benefits to improving dental hygiene that should not be missed. He noted that fears circulated about “putting chemicals in water” neglected to take into account that water WAS a chemical.

The Manager, Healthwatch York suggested that publishing hospital dental figures for children had now stopped, but this was something York had not been getting right. She therefore agreed that fluoridation was a good thing.

The York Place Director referred to the ICB’s purpose, that in terms of interventions this was the biggest thing in terms of cost vs benefit.

Chair said this strategy was key to reducing health inequalities in most vulnerable children.

The board thereby

Resolved: To support the principle of the addition of fluoride to the water supply covering York residents.

Reason: To improve the oral health of residents in York and reduce inequalities in oral health outcomes.

Additionally it was

Resolved: To ask the Council Leader write to the Secretary of State, reinforcing support from local clinicians, elected members, senior officers, those in the voluntary and community sector.

Reason: This is something the Secretary of State has proactively sought from Council Leaders.

37. A Compassionate Approach to Healthy Weight (5:47pm)

The Head of Public Health presented the item, noting that there was increasing recognition that obesity was a chronic repeating condition. He discussed how the council was providing services around support to healthy weight within the city at each stage of life, the stigmatising effect of the wording on letters that had previously been sent out to residents and the impact of weight loss drugs. He summarised that the next step for the HWBB was for all partners to agree to approve and promote the compassionate approach to weight loss across all organisations, and where possible look to embed trauma-informed practice, weight stigma reduction, a focus on holistic health rather than just weight outcomes and have a real consideration of those commercial influences on food and activity choices.

The Managing Director, TEWV welcomed the change in approach. She acknowledged that in cases where people had severe and enduring mental illness there was a direct link between obesity and any measure that was more engaging and less stigmatising. She noted that TEWV had recently been involved in research and took a particular approach for mental health, so they already had some foundational work on this in place.

The Chair asked whether evidence supported the improved long-term outcomes from a greater focus on health gains and becoming healthy, rather than solely a weight loss programme. The Head of Public Health said this was supported by evidence, stating that when interventions focused solely on weight, they missed so much else in terms of the holistic view of health and someone could be of healthy weight and chronically unhealthy or vice versa. He stressed that embedding these basic

principles around physical activity and nutrition was key and being able to communicate the benefits to families, individuals, groups and organisations would result in better outcomes all across the city.
He noted that there were different sections of the community which experienced greater challenges than others achieving and maintaining a healthy weight, so the services listed in the report would need to be proportionate and directed to where the need was greatest.

Board members asked how Public Health was engaging with other parts of council (such as active transport or weaning children). The Head of Public Health answered that they were working closely with colleagues, noting that last year the city hosted the National Active Travel Conference and public health had worked with that team to look at how active travel could be embedded. Public Health were also working on the active schools programme, which linked in closely around looking at how walking and cycling into school was promoted.

The board identified a potential gap between breast feeding and healthy eating vouchers where parents of young children may be less supported than other age groups, and specifically discussed children who were weaning.

The Head of Public Health responded that he was working closely with colleagues across Children's Services concerning the Raise York Partnership (supporting parents, carers, children, young people and anyone who works with these groups) and the Best Start in Life interventions for healthy weight in under-fives was one of the key priorities for the partnership.

Regarding weaning he noted that as part of that pathway, one of the one of the offers was the HENRY program (Health, Exercise, Nutrition in the Really Young) which specifically addressed the topic of weaning, though he admitted this support was relatively limited and could be expanded more.

Board members supported the changes, noting that this plan was a lot more progressive and positive than historic strategies, where in the past there was no an attempt to understand the reasons for people being overweight and the complex relationship with food they had developed, they were simply put on a strict diet which helped them lose weight. Consequently, the impact on their mental well-being had been disastrous, since the focus had been on getting them to be thinner rather than actually helping them be healthy, well-adjusted adults. It was Going forward, concern was also raised against the normalising of weight loss jabs in an environment where young people are very sensitive to body image.

The board asked about the supplementary planning documents referred to in the report, and the sort of content that expected there in terms of planning.

The Director of Public Health discussed the Health Impact Assessment and the guidance laid out in the Supplementary Planning Document. He explained that the Local Plan contained a specific policy (HW7) which concerned the need for developers of major strategic sites to offer a Health Impact Assessment (HIA). York would soon be publishing what its HIA frameworks would look like, but ultimately this would allow the council to assess the impact of a new development and guidance would be laid out either in a supplementary planning document, or simply guidance on how the layout of a development might best enable people to make a journey without using a motor vehicle. He stated that this would focus on aspects of the planning policy that were currently in the National Planning Policy Framework around hot food takeaways such as where these can be sited or additional planning objectives; for example, local areas would typically stop these from being sited near schools.

The Director of Public Health also said that beyond the specific development there was a citywide strategy to enable people to travel without using a car and enable them to access sports provision and green space. He stated that there was already a process around developer contribution to these strategies, but it was important to ensure future developments continue to have the right green space in the right places and that contribution to sports and active leisure provision remained in the city.

The Chair concluded that the board was clearly supportive of these changes, the proposal was timely and suggested taking a holistic trauma-informed approach.

Resolved: To approve and endorse the ethos and service changes lying behind the proposed ‘compassionate approach’ to healthy weight

Reason: To provide effective, supportive and non-stigmatising services and support around weight in the city

Resolved: To consider the implications of this ‘compassionate approach’ for each individual organisation

Reason: To embed and disseminate our agreed approach across city organisations.

38. City of York Safeguarding Adults Board Update (6:06pm)

The item was presented by the Independent Chair of the Safeguarding Adult Board. The Assistant Director of Adults and Integration assisted her with questions from board members.

The Independent Chair noted that the purpose of her presentation was not to invite a decision from board members, but to update them on the work of the Safeguarding Adults Board in the year 2024/25 and its strategy for 2025-28.

She explained that in York the Chief Operating Officer had delegated responsibilities to the Corporate Director of Adult Social Care and Integration as well as the Executive Member for Health, Wellbeing, and Adult Social Care at City of York Council, who were the key points of professional and political accountability. She added that agencies and providers also had responsibilities to promote well-being and provide advice, regardless of whether a statutory adult safeguarding duty applied, or whether the local authority had identified an action for itself following a safeguarding inquiry. She stressed that CYSAB endorsed the collaborative, preventative, neighbourhood approach being advocated in other items on the agenda.

She discussed the three core duties of the CYSAB:

1. To develop and publish a strategic plan setting out how CYSAB would meet its objectives, and how member and partner agencies would contribute.

2. To publish an annual report which detailed how effective its work had been.

3. To commission Safeguarding Adults Reviews (SARs) for any cases which met the SAR criteria.

She noted that the voice of the lived experience of adults was important to the board and they had strengthened and focused in on this in the past year. It was not merely an issue of data, rather the board was working to let the voice of those adults influence its work as a partnership.

She stated that work on the three year strategy 2022-25 had been concluded in the past year, embedding guidance for professionals and staff working around safeguarding. Partnership working had been strengthened, and more emphasis had been placed on organisations that represented people in the City of York. Self-Neglect Practice Guidance had been published, because it was felt from studying SARs that this was an area that required systemic improvement. Other improvements included publishing guidance to encourage frontline staff to have better professional curiosity, to assist in responding to situations, and to establish an escalation protocol.

She noted that statistics showed concerns increasing year on year by at least 10%, this year was no exception, and she did not anticipate this changing in the future. She stressed that this didn’t mean more people were being abused within the City of York, rather it was an indication of greater awareness about how to raise a concern, and people understanding their roles and responsibilities in relation to that.

She noted that in addition to strong partnership working within the authority, CYSAB had this year strengthened its relationship with North Yorkshire, working collaboratively with colleagues there, which had been mutually beneficial, particularly as many partners had a shared footprint and collaboration saved a duplication of work in many areas.

With regard to the strategy for 2025-28 she stated there would remain a focus on prevention, awareness and engagement, and CYSAB would ensure the people of York have the confidence and awareness of how to raise concerns. She additionally emphasised continuing to learn, reflect and improve practice as key aspects of the strategy.

She stated that the key aspect of the strategy, which could be further supported by a neighbourhood approach, was a strengthening of multi-agency safeguarding responses to adults at risk of exploitation, rough sleeping and homelessness, as well as those experiencing self-neglect and hoarding.

As an example of joined up working around hoarding she stressed that health providers should be made aware of the situation, and not be discharging people unchecked to homes they have made unsafe. Instead there should be a wraparound partnership approach to find a solution. The strategy going forward would build a multi-agency (with Police and Children's) risk management protocol for hoarders. The board had already worked with the Assistant Director of Adults and Integration on a dashboard where concerns can be tracked, and they had engaged with the Director of Housing and Communities concerning rough sleeping and homelessness, who had established a task and finish group.

Board members asked about the contacts for people to raise a safeguarding concern and whether full details were provided in the presentation.

The Independent Chair confirmed that the presentation included links for professionals or members of the public to complete a safeguarding referral form online, and also the CYSAB phone number (these were listed in Section 11 of Annex A).

Resolved:

i. To note the contents of the annual report 2024/25.
ii. To consider how they can contribute to the joint work of the Board and note strategic plans for 2025 - 2028 and how they can be supported in particular to the areas of focus below:
    - Prevention, Awareness and engagement.
    - Learning, reflection and practice improvement.
    - Strengthening multi-agency safeguarding responses to:
      a. Adults at risk of exploitation.
      b. Adults at risk of self-neglect and hoarding.
      c. Adults at risk of rough sleeping and homelessness.

Reason: To keep the Health and Wellbeing Board informed of the work of the CYSAB.

39. Healthwatch York Reports: "Mental Health in York: A Progress Review" and "Mental Health: What good should look like" (6:26pm)

The report was presented by the Manager of Healthwatch York; she noted that it exemplified the way that Healthwatch York could convey residents’ experiences of health and social care, and utilise their reported experiences to identify areas for further exploration.

In this case the report concerned mental health support offered, and the expanded support of mental health through primary care. She thanked Rachael Maskell MP for working with Healthwatch on the report and responding to residents’ concerns, indicating that while there were no specific recommendations in this report, it reflected the recommendations in Healthwatch’s previous report, which she believed were still valid. She welcomed the commitment made to discuss these reports at the next Mental Health Partnership and expressed her hope the partnership could support the work being done there to continue the transformation of local mental health services.

The Managing Director, Yorkshire, York and Selby – Tees, Esk and Wear Valleys NHS Foundation Trust admitted that the content of this report was difficult to hear and that TEWV were sorry for the negative experiences of its services that had been raised. She advised that Alison Smith, the new Chief Executive, had been in York responding to these concerns, TEWV had spoken to Rachael Maskell to address residents’ complaints, and improvements were planned with the Trust’s Voluntary, Community and Social Enterprise partners. She emphasised the focus around York’s Mental Health hubs and stated that TEWV would be working with Healthwatch to retain the voice of lived experience.

The Corporate Director, Adults and Integration commented on the work still to be done, noting that there were currently two Mental Health Hubs with ambitions and funding for a third, and this was a positive foundation to build upon, working with partners to offer an integrated model of Mental Health in York.

The York Place Director stated that the team around the person had potential to make a key difference here; moving away from a referral-based to a relation-based model. She suggested that NHS services were not always helped to move to new models; somehow expecting providers to continue with traditional models while working in new ways. She agreed that the Mental Health hubs needed to be established as a central part of this new model and was optimistic that the Neighbourhood Health Policy would facilitate this, suggesting that partners including the ICB could do more to support bringing this new model together.

It was then

Resolved: To receive Healthwatch York's reports, "Mental Health in York: A Progress Review", and "Mental Health: What good should look like".

Reason: To keep up to date with the work of Healthwatch York and be aware of what members of the public are telling us.

40. Health and Wellbeing Board Chair's Report (6:36pm)

The report was presented by the Chair of the Health and Wellbeing Board, who broadly took the report as read, although members wished to discuss Annex A; specifically to express concern about the loss of 100 hours pharmacy provision and pharmacy services on Saturday afternoons and Sundays for Westfield Ward.

The Chair agreed that this was particularly unfortunate, and with the removal of out of hours provision, people who work, people with small children and others would have difficulty obtaining pharmacy services.

The Director of Public Health stated that the board had done what it could, and this was precisely why the Pharmaceutical Needs Assessment had been written. Although the PNA could not directly compel the opening of a pharmacy, it did lay the groundwork to encourage a business to open, giving favourable treatment to any application that was proposed for this area. Should any contractor wish to open a pharmacy here, the statement demonstrated a need, and the contractor's application was therefore likely to be approved.

The York Place Director noted that the ICB's pharmacy service, together with the Director of Public Health had fully investigated this issue to ensure that everything possible was being done. She acknowledged this was a rules-based system which was prescriptive in terms of what can and can't be done and when, but the HWBB had done everything it possibly could to advance this situation.

The Director of Public Health concluded by noting that following a similar need arising in Clifton, a contractor had now come forward and been appointed in that area. He was unable to give the board an exact date when that pharmacy would open, but on the basis of this example he wanted to reassure them that the process did work.

It was then

Resolved: That the Health and Wellbeing Board noted the report.

Reason: So that the Board were kept up to date on: Board business, local updates, national updates, and actions on recommendations from recent Healthwatch reports.

Cllr L Steels-Walshaw, Chair
[The meeting started at 4.32 pm and finished at 6.42 pm].

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York Health and Wellbeing Board

Health and Wellbeing Board 13 May 2026
Report of the Director of Public Health

Future Direction of the York Health and Wellbeing Board

Summary

1. York is facing a set of overlapping health challenges – from declining life expectancy to children and young people's mental health to an aging population to demand pressures within NHS services and beyond – which require a clear strategic direction and ambition if we are to match our Strategy's aspiration that York will be healthier and this health with be fairer in 2023 than it was in 2022.

2. The Health and Wellbeing Board should be our key city leadership for this ambition. This report summarises discussions at a recently held workshop for the Health and Wellbeing Board, facilitated by the Local Government Association (LGA), the purpose of which was to develop the work of the Board and enable it to become more effective in this leadership.

3. The report also proposes a series of changes to the way the board operates, emerging from those discussions, to be agreed by members at today's meeting.

Background

4. Health and Wellbeing Boards are statutory committees of local authorities in England, established under the Health and Social Care Act 2012. Their primary function is to provide strategic leadership and a forum for collaboration across the local health and social care system. By bringing together elected members, NHS representatives, directors of public health, adult social care and children's services, and the voluntary sector, Boards are intended to promote integrated approaches to improving population health and reducing health inequalities.

5. The core purpose of a Health and Wellbeing Board is to improve the health and wellbeing of the local population through coordinated planning and partnership working. Boards are responsible for developing a shared understanding of local needs and priorities, and for aligning the strategic intentions of commissioners and providers across health, social care and public health. In doing so, they seek to ensure that services are more responsive, preventative and focused on long-term outcomes for individuals and communities.

6. Statutorily, Health and Wellbeing Boards have specific duties to produce a Joint Strategic Needs Assessment (JSNA) and a Joint Health and Wellbeing Strategy (JHWS). The JSNA assesses current and future health and care needs, while the JHWS sets out agreed priorities and actions to address those needs. Boards must also be involved in promoting joint commissioning and encouraging partnership arrangements that support integrated care.

7. In York, the HWB has operated for 13 years. Initially supported by an extensive subgroup infrastructure, the Board now offers a more supportive and informal structure for local health and care partners to feed into, as a public and democratic forum meeting six times a year to receive updates on key work around its strategy and receive reports from other boards and organisation.

8. A number of policy changes over the years have changed the nature and context for Health and Wellbeing Boards, without any corresponding shift in the legislative / guidance base on which the Boards operate. These include:

    a. The development of the Better Care Fund in 20115

    b. The Five Year Forward View (2014), the NHS plan (2019) and the 10 year Health plan for England (2025)

    c. The creation of Integrated Care Systems in 2022, and local Place Partnerships in Humber and North Yorkshire (for us, the York Health and Care Partnership)

    d. The development of Neighbourhood Health, including the recently released framework which asks HWBs to lead the development of Neighbourhood Health Plans.

Main/Key Issues to be Considered

9. Nationally, the LGA report variance in performance, focus and impact, with some Health and Wellbeing Boards continuing to lead their local systems in a healthy and collaborative way, and others losing focus and purpose within the national policy changes referred to above.

10. Using a model developed working across a large number of HWBs, the LGA suggest that there are 7 components of an effective Board:

11. Arising from a recommendation in the 2025 LGA/ADPH York Public Health Peer Review, York HWB members agreed a developmental workshop facilitated by the LGA should take place, recognising a desire from members to optimise the work of the board to make the maximum difference to the health of residents in York.

12. In February 2026, the LGA interviewed a number of board members, with some consistent themes emerging from the conversations:

- Reducing health inequalities remains the perceived central purpose of the York HWB.
- York benefits from strong partnership relationships and good will across organisations.
- The HWB has the potential to play a stronger strategic leadership role in the system.
- Lived experience and community voices are vital to shaping effective policy.
- There is support for reviewing how the board works to maximise its impact.

- There is an opportunity to consider evolving the HWB so it becomes a more focused, influential and community connected forum

13. On the 18th March, Board members attended a workshop in which this feedback and best practice models were considered. The key outputs of the workshop were a series of 'stop', 'start' and 'sharpen' statements around the work of the board:

Stop	**Start**	**Sharpen**
• Focusing simply on where we are today – develop a future vision / story for York's health and wellbeing • Duplicating of work / discussions / papers with the York Health and Care Partnerships • Having all meetings in public/livestreamed (only some) • Meetings being so formal they could seem intimidating • Board agendas having so many papers it leaves little time for discussion • Receiving reports that have been discussed elsewhere, 'to note' • Having so many priorities • Having partners 'in name only' i.e. not regularly attending	• Regular development workshops • Better and more productive work in between meetings • Thinking about where we want York to be in 5 years • Asking the VCSE what they want to be discussed • More community engagement / co production • Including people with lived experience • Engagement forums with appropriate support for people to engage • A sponsorship approach, with board members appointed as 'sponsor' for themes • Publishing public interactions and	• How we differentiate the HWB from a council meeting • Our approach to engagement with the public and the VCSE • The number of partnerships: maybe fewer, more clear delineation and eliminate duplication • The link between the role of the HWB and the vision for neighbourhood health and wellbeing? • Focus on outcome / impact not just holding a partnership meeting • Few priorities/focus in on them • How we share information – more conversational? Key takeaways? • 2/3 formal meetings a year

	actions following meetings • Hosting a space to strengthen partnerships	• Choose 2 to 3 priorities

14. Building on this consensus, a new approach to Health and Wellbeing Board meetings in York is proposed, involving a number of ‘shifts’:

- From *Compliance* → *Strategic Neighbourhood Leadership*
- From *Committee Mode* →*Strategic Partnership*
- From *Structure-Focused* → *Impact-Focused*
- From *Individual Authority* → *Collaborative System Leadership*

15. This will involve a new approach to the rhythm, format and ‘feel’ of our meetings. Two types of meeting are proposed for municipal year 2026/27:

Health and Wellbeing Board Ambition and Engagement Workshops

These would:

- Be twice yearly workshop-style meetings, not held in public, lasting 2 1/2 hours, during the day
- Not be restricted to members of the board – board members or their substitutes would be mandatory attendees, but other subject matter experts would be invited to attend
- Be held in other, less formal, venues in the community
- Focus on strategic discussion around two or three strategic priorities aligned to the Joint Health and Wellbeing Strategy, which would continue to be the focus of the board until members request a change. These become ‘obsessions ‘of the board. This is best practice from other high-performing HWBs. Examples are given below of topics other areas have chosen to focus, but board members are asked to consider what works for York rather than seeing these as a list of options:
    - Health Inequalities

    - Healthy Life Expectancy
    - Housing and health
    - Health in an aging society
    - Health and poverty
    - The best start in life

- Include a significant element of engagement and co-production, this includes:

    - Internal, involving individual board members taking ownership of the sessions, facilitating the conversation, and working on actions in between meetings

    - External, involving inviting people with lived experience and from community or VCSE organisations to join and inform the conversation

Health and Wellbeing Board public meetings

These would:

- Be twice yearly formal board-style meetings which would be live-streamed, lasting 2 hours

- Include formal pre-submitted reports published on mod.gov

- Continue to include an opportunity for public participation, in as ‘soft’ a style as possible with clear accountability around follow-up for comments.

- Receive papers for assurance and decisions, for instance:

    - A summary of the key statutory duties to produce a Joint Strategic Needs Assessment, and progress against the Joint Health and Wellbeing Strategy

    - Any decisions and progress on duties placed on the Board to ‘sign off’: this would include the Better Care Fund, the Pharmaceutical Needs Assessment (PNA), any supplementary PNA documents, and the Neighbourhood Health Plan (subject to further guidance). It is likely decisions needing to be made in a timely manner will have to be taken by the chair in conjunction with the lead officer, in between meetings, so this will be to note.

  - A summary by the chair of any recent workshops held, in order to update the public on what discussions have happened in a non-public setting of the Board.

  - Other key reports to note: annual Health Protection Report, update reports on the York Health and Care Partnership, annual reports of the Safeguarding Adults Board, The City of York Safeguarding Children's Partnership, Aging Well Partnership, and a summary of recently published Healthwatch reports

16. In summary, this will mean the board will meet every quarter, with half the meetings in public and half in private as strategic partnership sessions.

17. For both of these formats, we must create opportunities for Board members to engage with residents and listen to their priorities and voice within our strategic conversations. York already has rich assets when it comes to co production and voice work, across children and young people's health as well as with adults, and this will be harnessed through creative ways of hosting the board (e.g. HWB 'on tour', children and young people's take-over etc, visiting our neighbourhoods) rather than setting up any new structures around co production.

18. From a governance perspective, it is proposed to consider 2026/27 a transitional year while these proposed arrangements are tested and developed. None of the proposals above entail significant changes to the purpose of the Board, and it is suggested that for now, the Board's Terms of Reference remain as they are.

Strategic/Operational Plans

19. This report aligns with the Health and Wellbeing Strategy and will enable the Board to deliver this strategy in a more impactful manner.

Recommendations

The Health and Wellbeing Board are asked to:

i. Discuss and agree the proposed new format, approach and meeting rhythm for the Health and wellbeing Board for the municipal year 2026/27 *ii.* Discuss and identify two or three ‘obsessions’ the HWB will choose to focus its partnership and engagement sessions on initially

Contact Details

Author:	**Chief Officer Responsible for the report:**
Peter Roderick	*Peter Roderick* *Director of Public Health*
	Report Approved ☒ **Date** *9/1/26*

Specialist Implications Officer(s) *List information for all i.e*
Financial Officer’s name
Job Title
Dept Name
Organisation name
Tel No.

Wards Affected: *List wards affected or tick box to indicate all [most reports presented to the Health and Wellbeing Board will affect all wards in the city – however there may be times that only a specific area is affected and this should be made clear]* **All** *tick*

Annexes

None

Health and Wellbeing Board 13 May 2026

Report of the Manager, Healthwatch York

Healthwatch Reports: "Getting to Healthcare – The impact of non-emergency patient transport eligibility changes on people in York and North Yorkshire" and "What Trans, Non-binary and Intersex People Told Us About Health Services in York"

Summary

1. This report is for the attention and action of Board members, sharing two reports from Healthwatch York. These share:

    a. Feedback received about how changes to non-emergency patient transport, following the tightening of eligibility criteria in April 2025, have affected people across York and North Yorkshire.

    b. An exploration into whether reports of poor experiences in accessing local healthcare services from some trans, non-binary and intersex (TNBI) people in York, shared with Healthwatch, were common for this community.

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. Through our information and signposting service we have continued to gather people's experiences of mental health services in the city.

Main/Key Issues to be considered

3. The key findings across the two reports are:

Report A:

i. People delayed, cancelled or did not attend appointments because they struggled to find or afford alternative transport.

ii. Without patient transport, the long distances to hospitals, limited public transport and fewer accessible taxis and have increased travel challenges for people living in rural areas.

iii. People with mobility needs and those requiring wheelchair accessible vehicles face significant difficulties finding alternative public transport if they are no longer eligible for patient transport.

iv. Where people no longer qualify for patient transport, the impact can be significant. Loss of independence, increased anxiety and feeling like a burden were common experiences.

v. People can be offered transport for some conditions and not others for some elements of the treatment for some conditions, but not for tests or consultant appointments for the condition or for some venues and not others.

vi. Voluntary transport schemes are facinf increased demand, limited resources and reliance on volunteers.

Report B:

i. Many TNBI people are not treated with respect and dignity. This includes healthcare professionals consistently using the wrong pronouns or names for people.

ii. Many healthcare professionals do not have appropriate/effective training around TNBI people’s healthcare.

iii. The waiting lists for gender specific care are too long, with little to no support for people while waiting.

iv. There is not a consistent approach to shared care in York between GPs and private hormone/gender affirming care.

Consultation

4. There has been no specific consultation involved in producing the recommendations report.

Options

5. Health and Wellbeing Board are asked to note this report.

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 this report.

Recommendations

9. The Health and Wellbeing Board are asked to:

   i. Review the responses to recommendations and confirm whether they are satisfied with these.

Reason: To keep up to date with the work of Healthwatch York and monitor progress regarding recommendations.

Contact Details

Author:	**Chief Officer Responsible for the report:**
Siân Balsom Manager Healthwatch York 01904 621133	**Report Approved** ☐ **Date** *1 May 2026*
	☐

Wards Affected: All

All ☑

For further information please contact the author of the report

Background Papers:

Annexes

Annex A – Healthwatch Report: Getting to Healthcare – The impact of non-emergency patient transport eligibility changes on people in York and North Yorkshire

Annex B – Healthwatch Report: What Trans, Non-binary and Intersex People Told Us About Health Services in York

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Annex A:

healthwatch York

healthwatch North Yorkshire

Getting to healthcare:

The impact of non-emergency patient transport eligibility changes on people in York and North Yorkshire

[Enter sub-heading]

Contents

Report published in January 2026

Summary

Purpose

This report explores how changes to non-emergency patient transport, following the tightening of eligibility criteria in April 2025, have affected people across York and North Yorkshire.

People living in York and North Yorkshire and local community transport providers shared their experiences of how these changes have impacted people's ability to access healthcare. The issues raised particularly affect people living in rural areas, disabled people, and people with long term conditions or complex medical needs.

Healthwatch heard from people about missed or cancelled appointments, increased financial pressures, long and exhausting journeys, and a growing reliance on family, friends and voluntary transport schemes where available. For some, the loss of patient transport support has affected their physical and mental wellbeing, reduced independence and increased anxiety about accessing essential care.

One person in North Yorkshire summed up the frustration felt by many:

> **"I have used patient transport for 10 years since being unable to walk, and then it stopped. I don't know why. I am no better, probably worse, with my mobility. I am too old to bother fighting for it."**

This report brings together responses to the Healthwatch survey, lived through experiences and feedback from community transport organisations to show the real-life impact of these changes.

Key findings

1. **Missed or cancelled appointments**
   People delayed, cancelled or did not attend appointments because they struggled to find or afford alternative transport.

2. **Rural access challenges**
   Without patient transport, the long distances to hospitals, limited public transport and fewer accessible taxis have increased travel challenges for people living in rural areas.

3. **Accessibility issues**
   People with mobility needs and those requiring wheelchair accessible vehicles face significant difficulties finding alternative transport if they are no longer eligible for patient transport.

4. **Emotional and social impact**
   Where people no longer qualify for patient transport, the impact can be significant. Loss of independence, increased anxiety and feeling like a burden on others were common experiences.

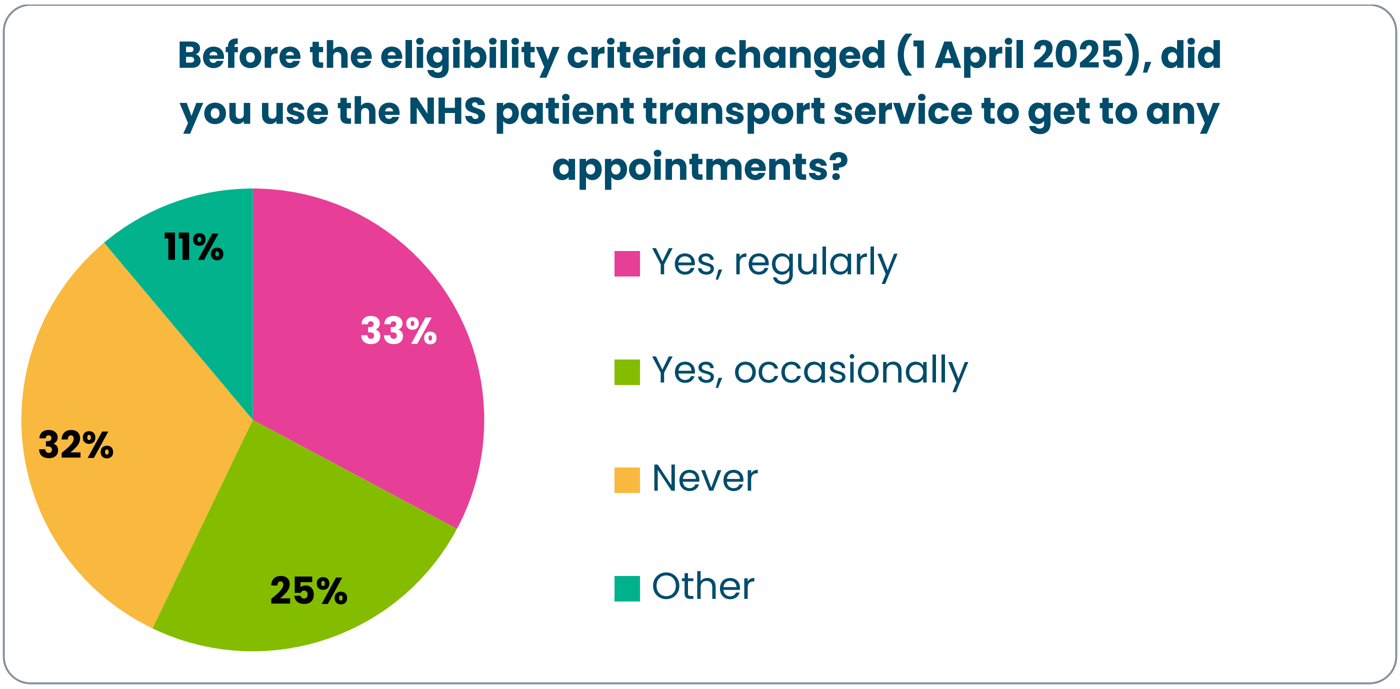
5. **Inconsistencies in non-emergency patient transport provision**
   People can be offered transport for some conditions and not others, for some elements of the treatment for some conditions, but not for tests or consultant appointments for the condition or for some venues and not others.

6. **Pressure on community transport**
   Voluntary transport schemes are facing increased demand, limited resources and reliance on volunteers.

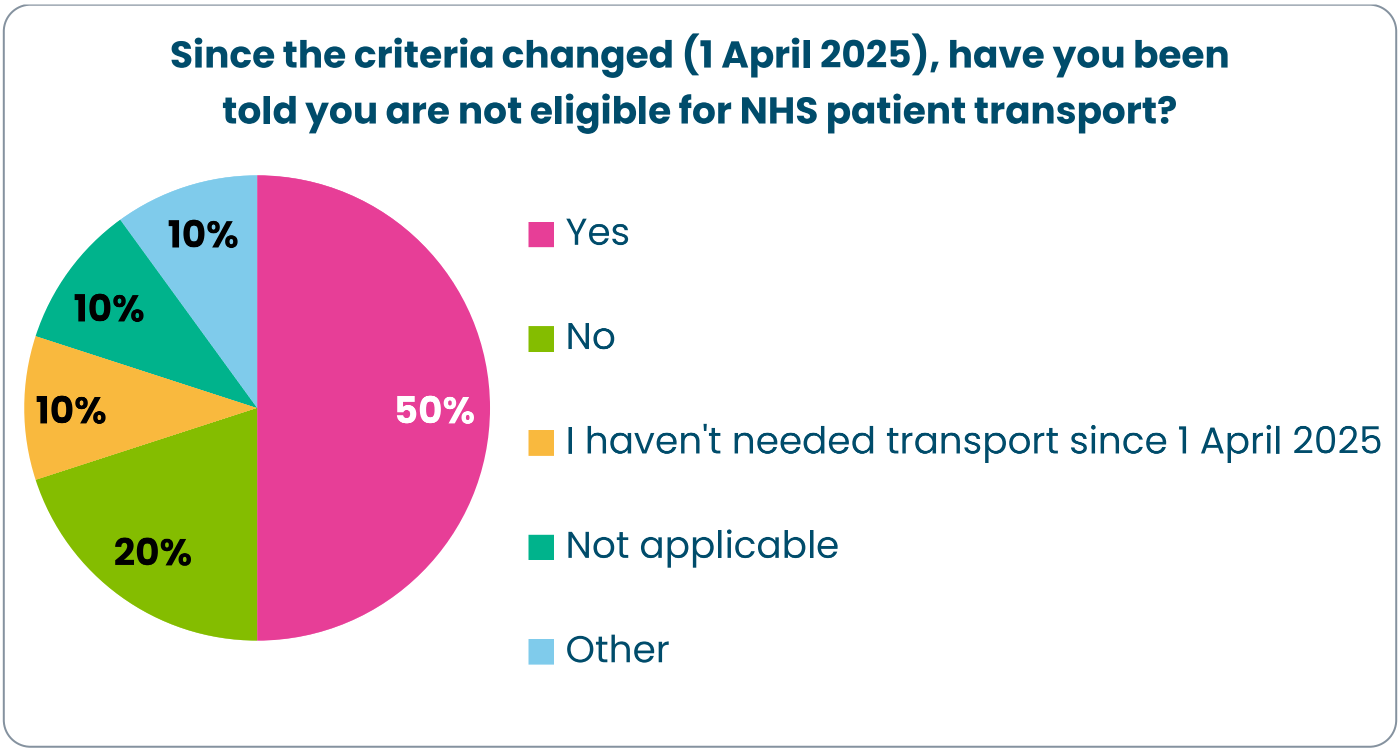
Key statistics

Healthwatch heard from 225 people including 191 who responded to its survey and others who gave feedback to Healthwatch North Yorkshire or Healthwatch York about this issue since April 2025.

The percentage of people who responded to our survey that used non-emergency patient transport before the criteria change:

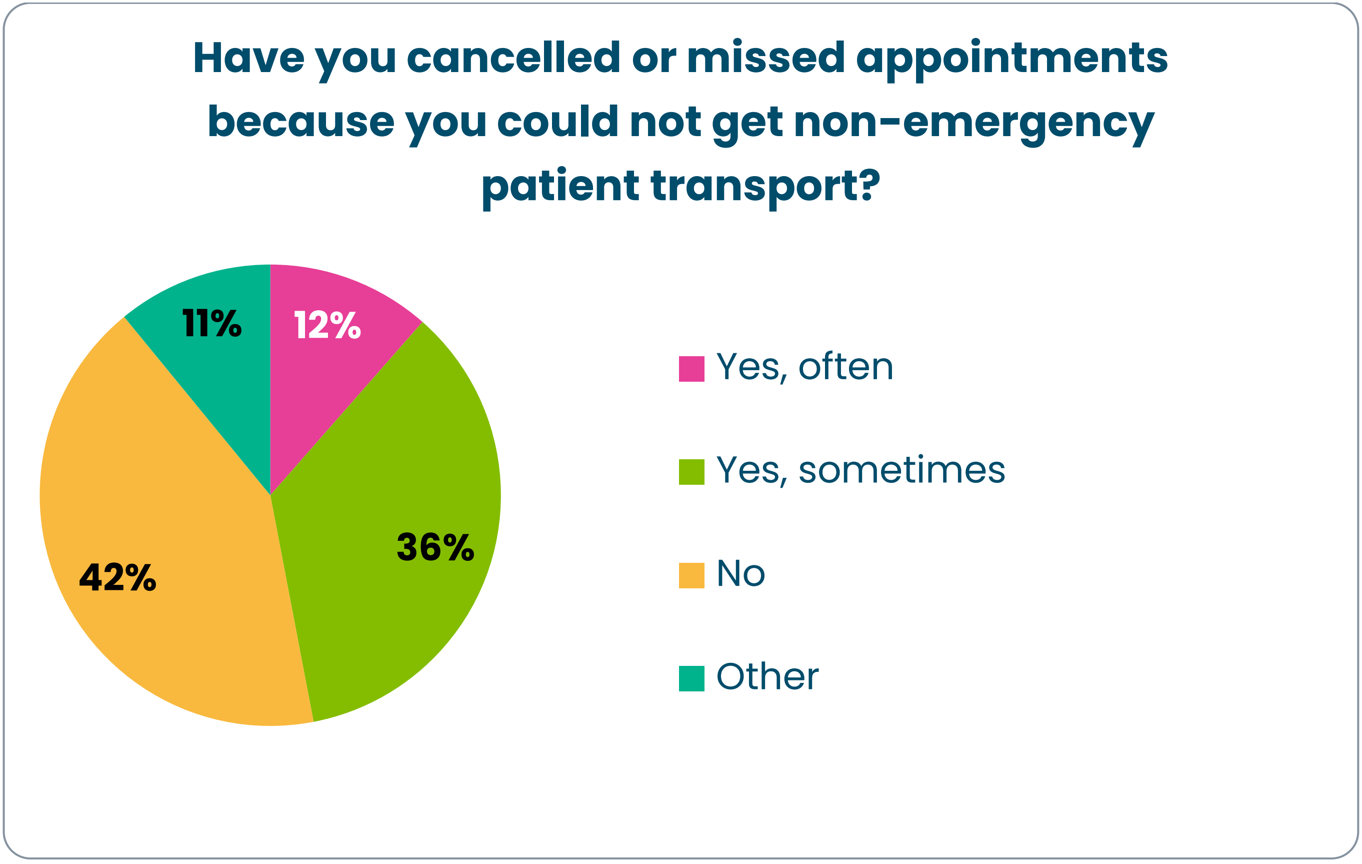


Percentage of survey respondents no longer eligible for non-emergency patient transport (note this includes responses from those above who said they had never accessed non-emergency patient transport):



Since the criteria changed (1 April 2025), have you been told you are not eligible for NHS patient transport?

Percentage of survey respondents reporting missed or cancelled appointments due to no longer accessing non-emergency patient transport:



Have you cancelled or missed appointments because you could not get non-emergency patient transport?

Recommendations

These are for NHS Humber and North Yorkshire Integrated Care Board, City of York Council and North Yorkshire Council as appropriate.

1. **Review eligibility criteria** to make sure those most in need can access transport and no one misses essential appointments.
2. **Be consistent** so eligible people can travel to all appointments for a particular condition, across different locations.
3. **Develop transport alternatives** in partnership with community transport providers, including exploring other models (for example, the East Riding Medibus service).
4. **Support and expand community transport** by making sure that community providers receive sustainable funding to meet the needs of their communities. Alternative transport options should be well communicated with information shared widely.
5. **Raise awareness of financial support** such as the Healthcare Travel Cost Scheme among those who may benefit.
6. **Integrate transport planning with healthcare providers** so appointment scheduling considers people's travel needs.
7. **Introduce immediate and regular analysis** of why patients do not attend appointments and procedures to identify the impact of transport issues to the NHS, including the cost of missed appointments due to transport problems.
8. **Monitor and evaluate the impact** of transport issues on patient outcomes and health inequalities.

Introduction

Patient transport plays a vital role in helping people access healthcare. Revised NHS non-emergency patient transport eligibility criteria have raised significant challenges for people and voluntary sector organisations across York and North Yorkshire. This report sets out what local people told local Healthwatch about how these changes are affecting them.

Who sets the rules for non-emergency patient transport

- NHS England sets national eligibility criteria
- NHS Humber and North Yorkshire Integrated Care Board commissions the service locally and sets the service specification and performance requirements
- Yorkshire Ambulance Service NHS Trust delivers the service in York and North Yorkshire under contract to the ICB

Further information can be found on the NHS England website: Non-emergency patient transport eligibility criteria.

Non-emergency patient transport provision in York and North Yorkshire is commissioned by the NHS Humber and North Yorkshire Integrated Care Board. This means it is responsible for planning and funding the service locally, including the service specification and performance measures. It has contracted Yorkshire Ambulance Service NHS Trust to deliver patient transport in York and North Yorkshire. Yorkshire Ambulance Service delivers the service to what is specified but does not set the criteria for who qualifies.
Non-emergency patient transport, (sometimes referred simply as patient transport or non-urgent patient transport), is intended for

people who cannot travel safely to appointments due to medical or mobility needs. In other words, it helps eligible people get to and from NHS funded care when they cannot travel safely by other means.

Eligibility criteria are set nationally by NHS England. The revised national eligibility criteria were launched in 2023. NHS Humber and North Yorkshire Integrated Care Board adopted the revised criteria and required its provider to implement them in line with national guidance. The overarching principle of the national criteria is that 'most people should travel to and from hospital independently by private or public transport, with the help of relatives or friends if necessary'. The revised criteria were introduced in York and North Yorkshire on 27 May 2025.

With eligibility criteria tightened, some people who previously qualified for support are no longer eligible. For a largely rural region, where public transport can be limited or inconsistent, these changes raise important questions about fairness, access and health outcomes.

Healthwatch North Yorkshire and Healthwatch York carried out this work to understand the impact of the eligibility changes on local people. Transport is one of the most common barriers to accessing health services that people share with Healthwatch. Changes to non-emergency patient transport have increased concerns about inequality, particularly for disabled people and people with long term conditions, people living in remote areas, and those on low incomes.

We are grateful for the insights shared by community transport providers, including Up For Yorkshire, whose Community Transport Car Scheme has been significantly affected by the tightening of eligibility.

How Healthwatch listened to people

Healthwatch North Yorkshire and Healthwatch York ran a survey between September and October 2025. The survey was available online, with paper copies provided on request. We received 191 responses. This work brings together quantitative data with detailed personal experiences. We also included feedback each Healthwatch had received about patient transport since April 2025. In total, we heard from 225 people.

Of the people we heard from in the survey and in other feedback, 82.5% were from North Yorkshire 14% were from York and 3.5% were from other areas including the East Riding and North Lincolnshire. Some feedback came from organisations and reflected more than one person's experience. These levels of feedback reflect differences in population size, and the practical challenges people face across the area. Much of the feedback from North Yorkshire and York highlights similar issues when people are no longer eligible for non-emergency patient transport.

This report has also been informed by the 'VCSE Community Transport'[1] report produced by charities providing community transport across North Yorkshire, East Yorkshire and North Lincolnshire. These include Humber and Wolds Rural Action, Hambleton Community Action and East Yorkshire Community Transport. These organisations support thousands of residents each year, with volunteers delivering hundreds of thousands of journeys. They see firsthand how transport affects people's health,

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[1] https://vcse.uk/news-article/2025-04-08/humber-and-north-yorkshire-community-transport-report

independence and ability to remain connected to their communities. Their report shows how important community transport has become in supporting people’s health, independence and social connection, particularly in rural and coastal areas. It also highlights wider health benefits, including reducing isolation and helping people remain active and well.

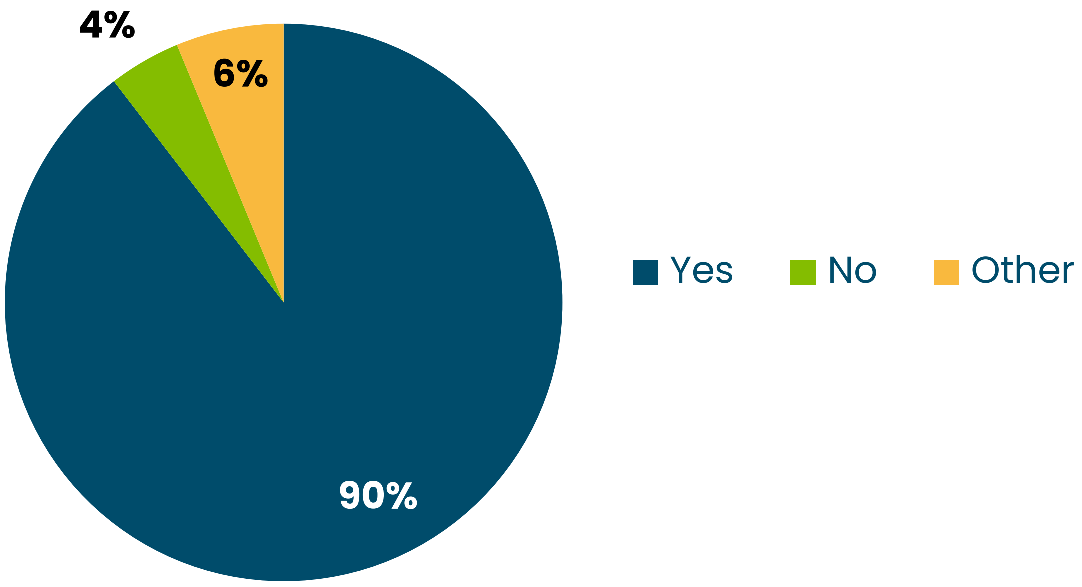
The evidence in this report shows that changes to patient transport eligibility have led to a sharp rise in people turning to community transport providers for support, often at short notice and with increasingly complex needs. It highlights the pressures created by rising demand and the challenges of providing sustainable, long-term support so these services can continue. These services are already constrained by volunteer capacity, rising costs and inconsistent funding

We have also included a small number of comments about difficulties travelling to GP and community dentist appointments. These journeys are not part of the non-emergency patient transport contract, but they help show the wider transport barriers people face when trying to attend healthcare appointments.

What the data shows

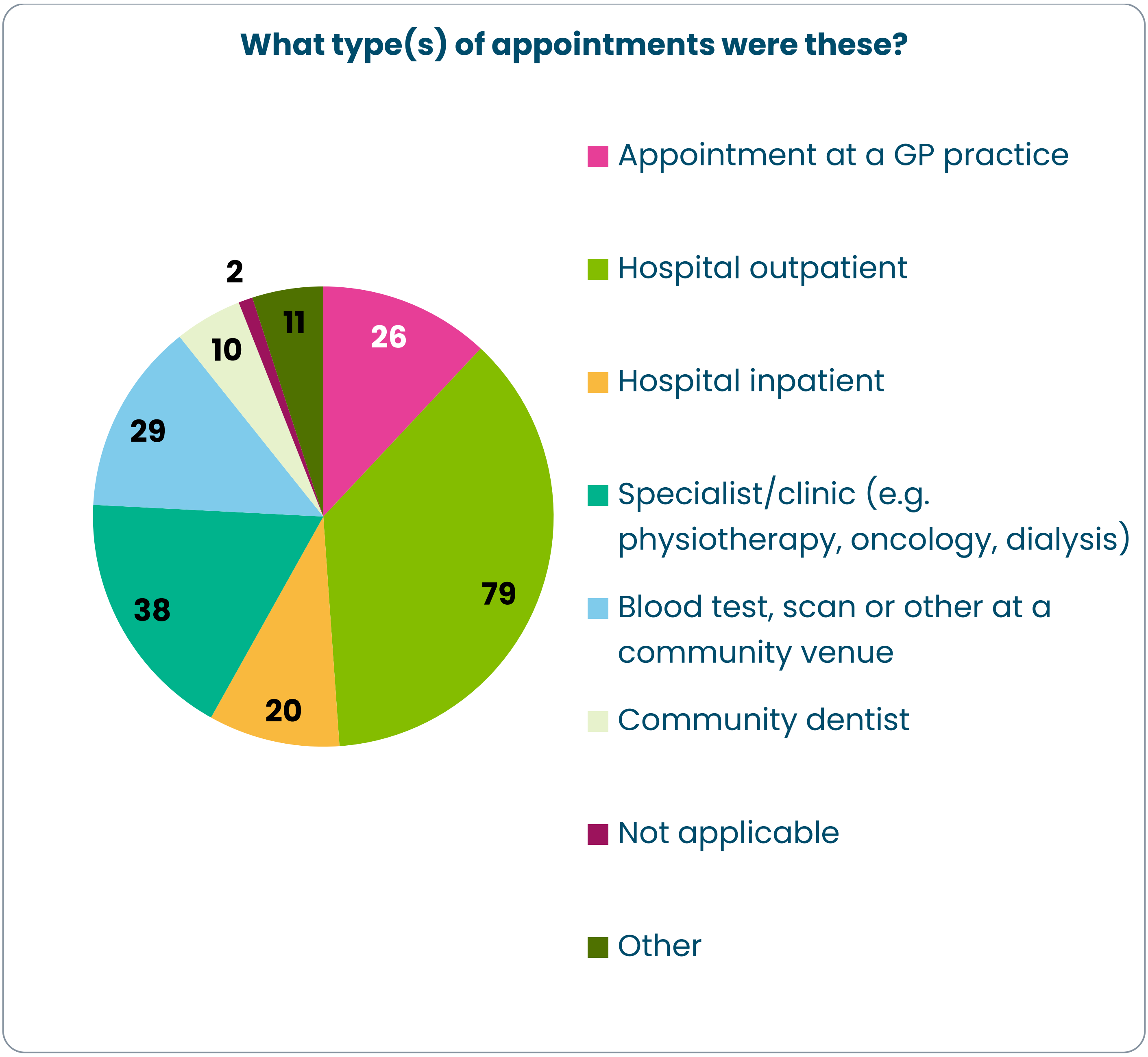
Survey responses show that many of our respondents across York and North Yorkshire often rely on non-emergency patient transport to access healthcare.

In the past 12 months, have you needed help to travel to a medical appointment?



Overall, **90%** of people said they had needed to access non-emergency patient transport at least once in the past year, highlighting how closely linked transport is to people’s ability to access the care they need.

For some people, this support is required only for occasional appointments; for others, particularly those managing long-term conditions, access to non-emergency patient transport is a regular and essential part of their healthcare journey.



People described needing help to reach a wide range of appointments. While hospital outpatient care was the most common (**79 people or 37%**), people also mentioned specialist clinics, routine investigations, community-based appointments and, for a minority of people, visits to their GP surgery.

This illustrates that people's transport needs extend far beyond one service or treatment type. For many, the issue is not where the appointment is, but whether they can get there at all, especially in rural areas where public transport is limited or irregular.

Before the eligibility changes came into effect, a substantial proportion of people had been using the NHS non-emergency patient transport service either regularly (**33%**) or occasionally (**25%**).

This suggests that many people who contributed to our survey were already familiar with the service and had been relying on it to get to hospital appointments. Those who told us they had never used non-emergency transport (**32%**), explained that they could previously manage through family support, community schemes or their own transport but several indicated that this was becoming increasingly difficult.

Impact of the eligibility changes

Healthwatch heard that changes to NHS non-emergency patient transport eligibility criteria have affected many people who no longer meet those criteria.

The impact varies depending on individual circumstances, the type of treatment and services people need and where they live. We have heard from many people who have been affected by the criteria changes in several ways. Those who require more hospital appointments and care have been hit hard.

The issues people experience is often interconnected. For many people, the removal of transport support has consequences across different areas of their daily lives. The key themes that emerged from what people told us:

- **Cost:** the financial burden of finding alternative ways to get to appointments.
- **Time:** the additional time required for travel when support is unavailable.
- **Lack of alternatives:** where public transport, family or community options are limited or unavailable.
- **Mental and physical health:** the stress, anxiety and physical strain caused by having to manage transport independently.
- **Inconsistencies in non-emergency patient transport provision:** variations in service availability and understanding of eligibility.
- **Accessibility issues:** specific barriers that make travel particularly difficult or unsafe.

Cost

Many people told us that the cost of travelling to appointments is a significant concern and can mean they aren't going to appointments or are considering not attending appointments in future.

Cost as a barrier to care

39% of survey respondents, told us that they either cancelled or missed appointments because they could not afford transport, highlighting the financial pressures created by the changes to non-emergency patient transport eligibility.

The impact of these additional costs is particularly challenging for people who require regular hospital visits. Several people warned that repeated long-distance taxi journeys quickly become unaffordable, forcing them to miss appointments altogether.

One person living in East Riding highlighted the financial strain when accessing care further afield:

"I've been asked to travel from Bridlington to Malton three times. It takes an hour and a half and costs £120 by taxi. I haven't gone."

Higher costs for people with mobility needs

For people with mobility needs, costs can be even higher. One person in North Yorkshire explained that as they were no longer eligible for non-emergency patient transport, they were left with only private options:

“Because a wheelchair was sourced, I have not been allowed patient transport. I cannot get into a car as I have poor mobility, so impossible for me to get to my appointments without paying £171 for transport as the cheapest one I could get; £18 per hour waiting time, and also fees for my carer.”

Limited alternatives and rural impact

Some people told us they live in areas with infrequent or poorly connected public transport, meaning taxis or community transport are their only options.

People in rural and coastal communities described how poor bus connections leave them with no viable or affordable way to reach hospital appointments.

One person in North Yorkshire told us:

“Buses don’t run regularly from where I live, my friend was working, I don’t have family nearby and the taxi costs £40 to £50.”

Impact on people on low or fixed incomes

For pensioners or those on limited incomes, transport costs can affect more than just healthcare access.

One person in North Yorkshire explained:

“I was taken into York Hospital last Wednesday and discharged the following Saturday. I had to take a taxi which cost me £108 to get home. This took all my money, and I had to borrow some to pay my month-end bills and buy food.”

Similarly, someone attending a radiotherapy clinic twice a week noted:

"It means that I have to continue to pay £40 for transport to Castle Hill Hospital in Hull or not attend. £80 is a big chunk out of my pension."

Cost preventing critical care

In some cases, the high cost of transport is preventing people from attending critical appointments.

One person in York facing a cancer operation explained how expensive travel is for their appointments and the impact of transport costs for their friends:

"I needed a pre-op, and the consultant wanted me to go to Castle Hill. York Wheels did help, but it cost me £100 for the return trip. If I'd gone by a taxi, it would have been over £200 each way. Friends of mine are saying they will have to refuse treatment as they won't be able to afford the transport."

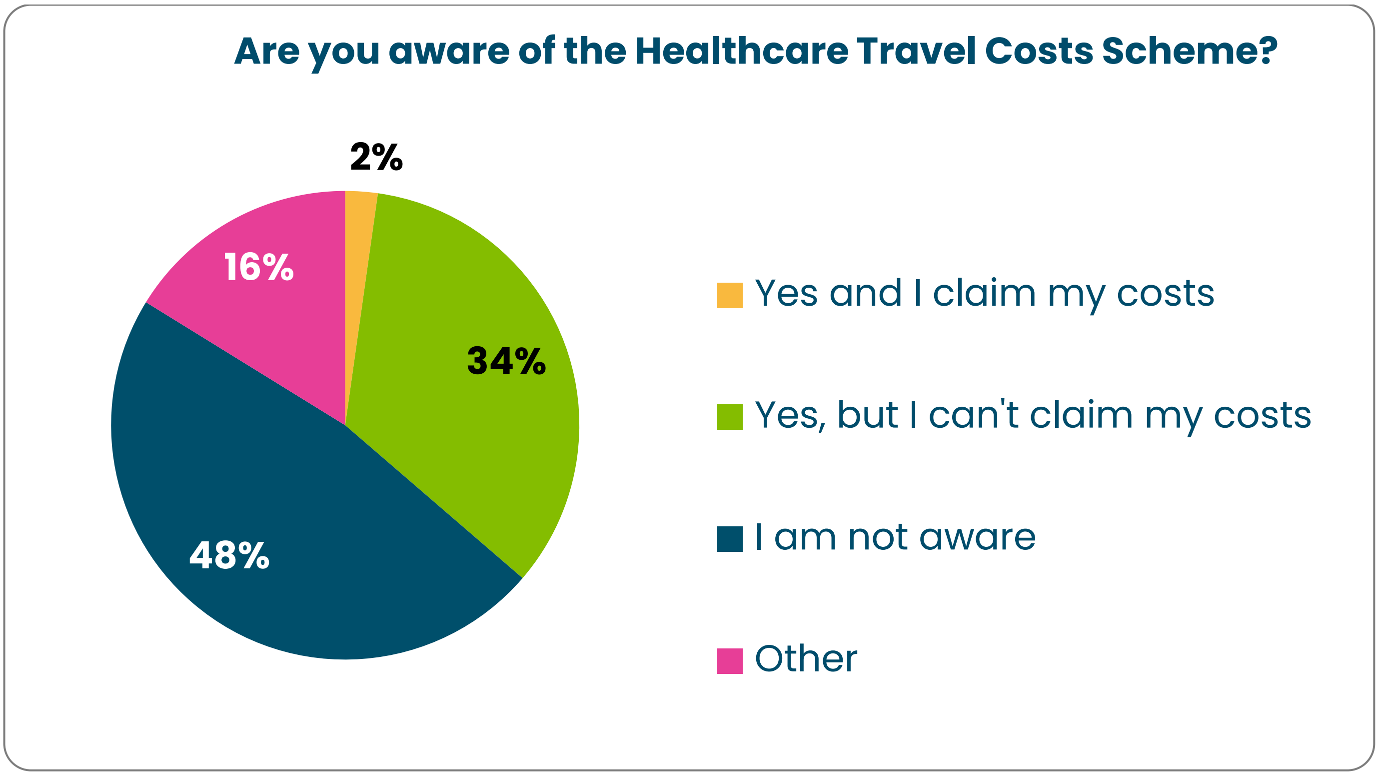
Awareness of financial support

Some people may be eligible for financial support through the Healthcare Travel Costs Scheme, which is available to people who receive certain benefits or meet other eligibility criteria.

The scheme can help cover the cost of travel to and from NHS appointments, including fares for accompanying carers where appropriate. However, awareness of the scheme is very low.

Our survey found that:

- **2%** of respondents knew about the scheme and could claim their costs.
- **34%** were aware but unable to claim.
- **48%** were not aware of it at all.



This indicates that although the Healthcare Travel Costs Scheme could help reduce the financial burden for some, many people are missing out due to lack of awareness or eligibility. People who were aware raised concerns about the timeliness of being reimbursed, and that the scheme does not cover the full cost of their journeys.

Overall impact

Overall, our data shows that cost is a recurring and serious barrier to accessing some healthcare appointments. For people who need frequent hospital appointments, are disabled, or live in areas with limited transport, the tightening of eligibility criteria for non-emergency patient transport has created new financial burdens that can directly affect people's ability to attend essential health appointments.

Additional experiences shared

People across North Yorkshire also said:

> **"Using a private taxi cost me £112 round trip to York Hospital and back. I cannot afford to pay this when I am visiting the hospital weekly."**

> **"The cost of living, bills and now extra burden to get hospital appointments has put me in debt."**

> **"Nobody can afford to pay for transport that costs that much three times a month."**

> **"There is only one bus from Robin Hood's Bay to get anywhere; most do not connect to get in time for an appointment. £150 for a return taxi is just not affordable."**

Time

Time is a major barrier for people accessing hospital appointments. Survey comments highlight how journeys, waiting and appointment times affect people's experiences. For many, the total time commitment required to attend an appointment is substantial, particularly for those relying on public or community transport.

Length and complexity of journeys

Some people face long and complex journeys to reach hospitals. Others described how poorly connected public transport can turn a single appointment into an all-day commitment. This is particularly difficult for people with health conditions that make long absences from home unsafe or exhausting.

One person from North Yorkshire said:

"Because buses are few and far between and don't connect up, it takes all day to get to a hospital appointment and back. I can't drive myself because I am having procedures on my eyes. I am diabetic so being out for a long time is difficult."

Appointment timing and flexibility

The timing of appointments can also create challenges. Some people reported having to rearrange appointments to fit the availability of transport, which can delay care.

One person told Healthwatch they **"had to change my appointment to Scarborough instead of Malton, meaning I had to wait another two**

months for an appointment that was already at least two months overdue."

Others highlighted that early appointments are not always possible for those who need extra time in the morning or have other responsibilities.

One person added that **"some individuals need longer to be able to wash and dress in a morning and cannot be ready for patient transport or early appointments and are very upset when given early appointments but don't know how to change things for fear of delaying treatment."**

Rural distance and travel demands

Time pressures are particularly acute for people who live further from hospitals or in rural areas.

One person in the East Riding described the experience of a friend in their 90s who lives in Bridlington but often has appointments in York:

"As they don't drive, that meant being picked up at 7am to make sure they got there in time. There needs to be more flexibility about who lives where and what appointment is most appropriate, rather than giving someone the next available appointment miles away. Thankfully, the surgeon said that next time they would go to Bridlington to see them."

Cumulative impact of time pressures

These responses illustrate that travel time, waiting and appointment scheduling can create significant challenges. Long journeys and delays are not just inconvenient, they can be exhausting, stressful and, in some cases, affect people's ability to attend appointments or manage daily routines safely.

Additional comments

"I live in North Yorkshire. The hospital is 20 miles away and involves three buses or bus, train, then bus. It takes two and a half to three hours. I have asked for afternoon appointments as the first bus from home is 10.55am, but I have had three appointments at 9:30 am or earlier. I am in good health for my age of 82 but find the journey tiring and I am dreading the winter."

"I'm in York. They gave me contact details for York Wheels, but my appointment is at 3pm and they finish at 4pm, so couldn't do both there and back."

"In North Yorkshire, I noticed longer wait times after my treatment for them to come and get me. It is often 8pm by the time I get home… I miss my evening meal and lunchtime meal as I am collected at 12 noon."

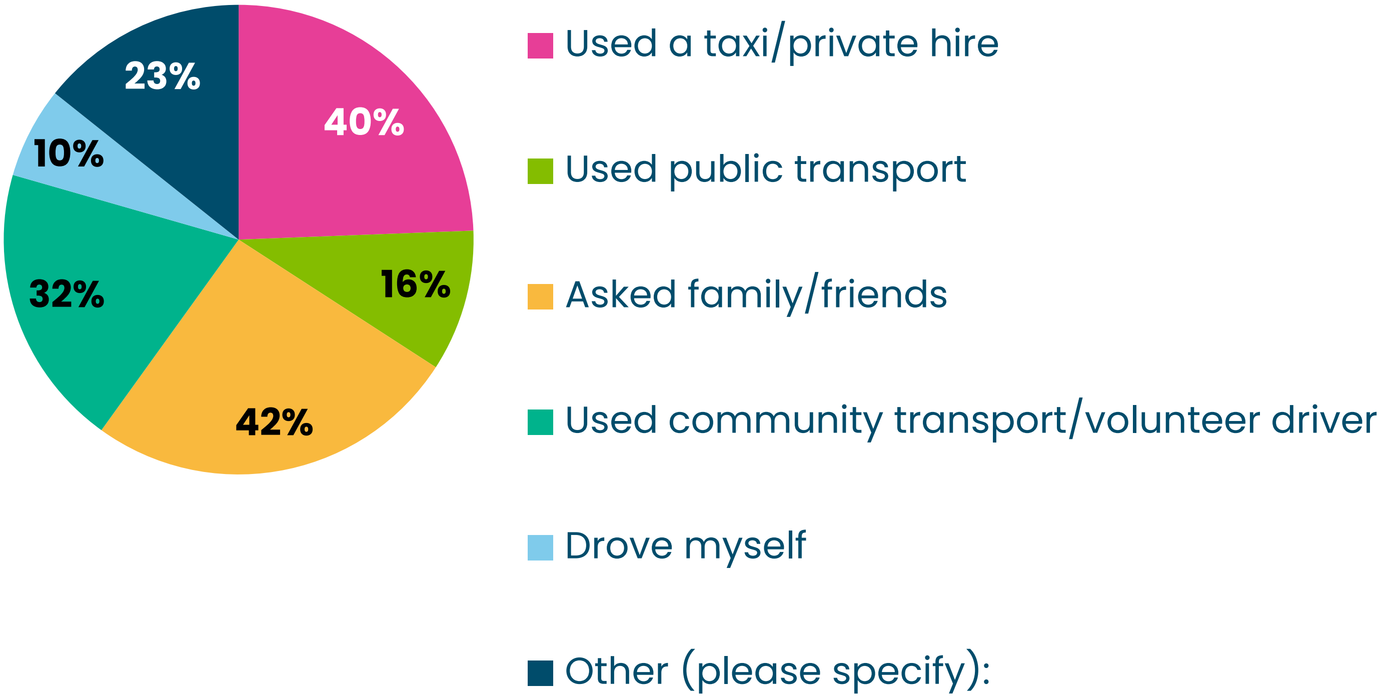
No alternatives available

For many people, the removal of NHS non-emergency patient transport has left them with few, if any, options to get to medical appointments.

What alternatives people are using

People told us that when they heard they were no longer eligible for non-emergency patient transport, the most common alternatives people used were asking family or friends (**42%**) and using taxis or private hire (**40%**). Community transport or volunteer drivers were used by **32%** of people we heard from. Public transport was used by **16%** and **10%** of people drove themselves.

If you were told you are not eligible for patient transport, what alternative(s) have you used to attend your appointments?



These numbers reflect real struggles, particularly for people living in rural areas or with mobility challenges. Several people described living in areas with very limited or non-existent transport options, combined with a lack of family, friends or volunteers who could help with long distance journeys.

No viable options for people with mobility needs

For people with severe mobility needs, alternatives can be non-existent. A person in North Yorkshire told us:

“No alternative available - paraplegic in electric wheelchair.”

Limited community transport options often force people to rearrange or delay appointments, which can have a direct impact on health outcomes. People told us that when community transport is unavailable, they are often left with no choice but to reschedule appointments or miss them entirely.

“Community transport was not available in North Yorkshire. I had to change my appointment.”

Public transport and distance barriers

Public transport was frequently described as impractical or not viable, particularly when multiple changes are required or travel time is excessive.

One person in North Yorkshire explained:

“To use public transport to Scunthorpe from my home in Eggborough is not viable. By bus it would take at least three changes and by rail, I would have to get two buses before getting a train. Taxi is out of the question as they cost approximately £70.”

Unsafe or unsustainable choices

Some people described having to take actions that carry personal risk. One person admitted driving despite being advised not to, because there was no other way to get to their appointment.

A person in York said:

“I also drove once despite not being medically fit to drive from York to Scarborough and was told not to.”

Others described relying heavily on family members who live far away, requiring significant effort, travel and coordination to attend appointments.

Practical issues with taxis and accessibility can further reduce options. Another York resident described giving up on taxis altogether and relying entirely on friends:

“I have had major problems in the past year with taxis and my scooters, so I gave up trying. I rely on friends now. York is hopeless for the disabled and old.”

Pressure on community and voluntary services

Local voluntary organisations reported that people often feel like a burden on services, and that the limited availability of wheelchair accessible vehicles makes transport particularly challenging.

“York Wheels currently doesn’t have a fixed wheelchair vehicle, and taxi options are limited and relatively expensive, so transport is clearly a challenge locally.”

Additional feedback

People across North Yorkshire said:

“There is no public transport living rural area. I am housebound apart from hospital appointments.”

“We have no taxis in the area and little public transport, and many have no family or friends that can drive; very limited volunteers who would drive 40 miles to a hospital.”

“Community transport was not available. I had to change my appointment”

“I have to travel to York Hospital for certain appointments which are unavailable in Harrogate. I am unable to drive there due to my long-term condition. I have nobody who I can ask to take me. My brother who lives in North Wales drives from there to take me when he is available. A taxi is unaffordable for me.”

Overall impact

These experiences show that for many people there are simply no safe, reliable or affordable alternatives to non-emergency patient transport.

While family, friends, taxis and community transport are sometimes used, these options are not always available or accessible, particularly for people living in rural areas, with limited mobility or complex health needs.

Without reliable patient transport, attending appointments can be stressful, difficult and, in some cases, unsafe.

Mental and physical health

Many people told us that the loss of eligibility for NHS non-emergency patient transport has had a direct impact on both their mental and physical wellbeing. People's experiences describe the emotional strain, loss of independence, and heightened anxiety that comes with struggling to access essential healthcare.

Loss of independence and emotional strain

For some people, the change has made everyday life harder by taking away their independence. One person in North Yorkshire explained:

"I lost my independence at being able to get to appointments. This has had a huge impact on my mental health."

Others described feeling devalued and distressed by the eligibility process itself, reporting that interactions with services left them feeling judged and anxious about arranging transport to future appointments.

Anxiety linked to ongoing care

Anxiety was a recurring theme. A 76-year-old in North Yorkshire told us:

"It has caused me a lot of unnecessary anxiety. I am a vulnerable 76-year-old woman with mental health problems."

Another person in the county said:

"I am now really anxious about my ability to get to my health appointments at the hospital that are every six weeks. I cannot afford a

private taxi again as it costs £100; even the voluntary community journey cost me £56. I am anxious about my health anyway and this makes it all even more stressful."

For people already living with significant health conditions, this added pressure can often feel overwhelming. One person in North Yorkshire undergoing cancer treatment explained:

"Being unable to get to oncology appointments adds to the stress of already having cancer. It causes stress and anxiety and a delay in diagnosis and treatment."

Distressing interactions with services

Some people also spoke about distressing interactions when trying to arrange transport. People described becoming extremely upset during conversations with patient transport services, feeling blamed or questioned about their needs and left emotionally distressed after these interactions.

One person in North Yorkshire recalled:

"It's very upsetting to be treated as if I am a criminal by the transport woman. I was told 'why can't you use a taxi' and I was reduced to tears."

Another added:

"I find the way questioning is carried out and the questions asked make me feel like a second-class citizen, and I now dread my appointments coming round and having to ring patient transport services."

Clinical need and safety concerns

Others stressed that the issue is not just emotional but tied directly to clinical need. One person in North Yorkshire with a rare condition described:

"I was diagnosed at the end of 2024 with a rare disease that affects my whole body and have to attend a specialised clinic at least once a year for assessment. This clinic is 100 miles away. I am an OAP, registered as visually impaired and profoundly deaf. I need transport with health professionals for safe support. I qualified for transport last year but not now."

Impact on families and carers

The emotional burden extends to families and carers. One North Yorkshire parent told us:

"This is so scary, as a parent carer for a disabled child with multiple appointments at local and regional hospitals I am now faced with a dilemma of how to get him to appointments. I have had to stop driving for health reasons and can't bear the thought of how we will manage. It's an additional stress."

Compromised care and physical impact

Several people described having to compromise their care when no safe alternative transport is available. One person in North Yorkshire attending a glaucoma clinic said:

"I go to an eye clinic (glaucoma) where I am told not to drive myself because of drops in my eyes. However, if no-one available in my family to take me, I have no alternative but to drive and refuse the drops even

though it means the consultant can't look to see any problems that may result in blindness. The hospital is approximately 16 miles away. I am 80 years old and although not on benefits, cannot afford taxi fares .... Also need help getting to actual clinic, some of which are a distance from main hospital entrance."

For others, the stress of organising transport has physical consequences. One person shared that:

"It is difficult enough trying to get there without the stress I feel, it causes me to feel unwell for days afterwards. I don't know what the alternative is, I could just not go."

Overall impact

Together, these experiences show that the loss of eligibility for non-emergency patient transport creates more than practical challenges. It can intensify existing health conditions, generate significant distress and place people, particularly those already vulnerable, in situations that undermine both their physical and mental wellbeing.

Additional experiences shared

Several people in North Yorkshire shared further reflections that underline the emotional and psychological impact of losing access to non-emergency patient transport.

"I am now anxious about my ability to get to my health appointments at the hospital that are every six weeks. I cannot afford a private taxi again as it costs £100; even the voluntary community journey cost me £56. I am anxious about my health anyway and this makes it all even more stressful."

Inconsistencies in patient transport

Alongside concerns about eligibility, many people told us that the non-emergency patient transport system feels inconsistent, unpredictable and difficult to understand.

While the new criteria are intended to be clear, people described situations where eligibility appeared to shift between appointments, depend on the direction of travel, or vary across treatment types and hospital sites. These inconsistencies leave people unsure what support they can rely on, and often anxious about what will happen next.

Partial journeys and split eligibility

Several people have described cases where transport was approved for only half a journey. One person in North Yorkshire explained that they were **"eligible for the journey home but not the outward journey"**. Another person from North Yorkshire added: **"I only qualify for transport home after the procedure"**.

Situations like these create confusion for people who feel they may meet the criteria but are left without safe or viable options for getting to their appointments.

Differences between appointment types

Others told us that eligibility appeared to depend on the type of treatment, even when appointments were directly linked. One person in York highlighted the inconsistency of being deemed **"I'm ineligible for**

oncology but still eligible for chemotherapy", and another in North Yorkshire said:

"I can still get transport for chemotherapy but not for all the other consultant or investigative appointments linked to this treatment."

People going through complex treatment pathways, especially those managing cancer or long-term conditions felt that these distinctions made little sense and placed them at additional risk of missing essential care.

Variation across locations and days

People also reported inconsistencies across hospital locations. Some people described how transport eligibility varied between hospital sites or even from one day to the next, leaving them uncertain whether transport would be provided for similar appointments. One person in North Yorkshire explained:

"I don't understand because I had patient transport the day after I called to book patient transport for another appointment when they told me I'm not eligible. I am very worried and anxious about future appointments because I don't know how I am going to get to them. Some appointments can be incredibly painful for me and so I don't need to also worry about how I'm going to get there and back."

Restrictions on types of clinical visits

Some people said that they were advised that they were now eligible only for certain types of clinical visits. One person in North Yorkshire noted they were told they would **"no longer be eligible unless going for very specific types of appointments"**.

This selectivity can leave people stranded or forced to make difficult choices, as illustrated by one carer in North Yorkshire:

“My husband lives in Scarborough and he used to get patient transport for his appointments in Bridlington Hospital but last time they told him that they could take him there but not bring him back and he had to find his own way. He ended up having to pay £40 for this trip.”

Restrictions on types of clinical visits

These inconsistencies can also lead directly to missed appointments and disrupted care. One person living in a rural village in North Yorkshire described:

“I live in a rural village and not having hospital transport means that I am missing vital aspects of my care. I can still get transport for my appointments I am having chemotherapy at, but any related appointments with the consultant or for additional scans relating to my treatment I cannot get transport for. This makes no sense to me. I need to get to the hospital for all my appointments, regardless of whether I am having chemotherapy that visit, and I still cannot get myself to the appointment without hospital transport. This results in missed appointments and wastes money and resources of the NHS.”

Together, these experiences show how unpredictable eligibility decisions undermine confidence in the system. For many people, the issue was not just the criteria themselves but the difficulty in knowing whether those criteria would be applied fairly, consistently and in a way that reflects the realities of their treatment needs. We are aware that in the early days of the new criteria, some people were deemed ineligible who should be eligible. This has been sorted out, but there is concern that the people are likely to accept what they are told rather than challenge the decision.

Experiences shared

People in North Yorkshire shared:

> **“Was only allowed transport home after an operation even though for the first appointment I was allowed transport there due to having no one to help and I have disabilities.”**

> **“Transport is not available for hospitals in Leeds and Bradford which are being used more and more for treatment or specialist diagnosis.”**

Accessibility

For many wheelchair users and people with mobility impairments, the transport challenges described throughout this report are intensified by a lack of accessible alternatives.

People consistently told us that even when public transport or taxis exist, they are rarely suitable for people who use wheelchairs, particularly electric wheelchairs, or for those who cannot safely transfer into a standard vehicle.

People often felt they had no reliable way of getting to hospital appointments, and faced additional anxiety, physical strain or appointment cancellations.

The total figure of 57% includes only people who this question applied to.

If you are a wheelchair user and are no longer eligible for patient transport, have you experienced any additional problems in getting to appointments?

Availability of wheelchair accessible taxis

Across York and North Yorkshire, wheelchair accessible taxis were described as extremely scarce. People described some areas having only a single accessible taxi, which was unreliable, while others reported being unable to find any suitable wheelchair accessible service at all, regardless of cost.

Several people told us that taxi services' school contracts mean that accessible vehicles are unavailable at times people need to travel to healthcare appointments.

One person in York explained:

"The last time I got in touch to arrange transport they said that I no longer qualified. I need to use taxis, however, when I tried to arrange a taxi for a community dentist appointment, they could take me but couldn't take me home as they would be doing the school run. I managed to change the time of my appointment so it was in the morning and I could get a taxi. However, I know that in the future I will have to miss appointments as I won't be able to get there."

Others said: **"The main problem is the taxi services being used for schools and accessible public transport."**

Limitations of public transport

Public transport was also frequently described as unsuitable or unworkable. One person in North Yorkshire said:

"The bus only has one wheelchair space and so we have to go from the beginning of the route, arrive over 20 minutes early and cross our fingers that we don't miss our appointment."

In some areas, overcrowding means accessible spaces fill, with one person describing:

"Public transport only fits one wheelchair. There are pushchairs, rollators, dog pushchairs, suitcases from tourists, guitars and harps during certain weeks etc. The amount of accessible places on public transport in Whitby is a huge problem."

Another person in North Yorkshire was clear that for many wheelchair users: **"public transport would not be an option even if it was available"**.

Community transport and complex needs

Community transport and volunteer driver schemes were valued but often limited. Some people said these services were too few or unable to meet their needs.

One person in North Yorkshire noted that **"they have been sending inappropriate transport such as volunteer drivers that cannot accommodate a wheelchair"**. For those with complex needs , the lack of appropriate transport left them with no way to get to hospital appointments:

"I am a paraplegic who has to be hoisted everywhere and uses an electric wheelchair. There is no direct public transport to the hospitals I have to travel to. Many taxis cannot take electric wheelchairs - too heavy and too large. Cannot get into a car, so my family and friends cannot take me. Community transport often not available. Need a carer at all times but this is being refused."

Support on arrival at hospital

Concerns were also raised about the way non-emergency patient transport now operates for disabled people. One person from a voluntary sector organisation said:

“When they go by taxi, they are often just dropped off at the door and James Cook is a very large hospital with long corridors.”

People described feeling unable to manage hospital appointments independently when no assistance is provided, even when appointments are urgent: **“A taxi is no help as I cannot get to the department unaided.”**

Wider consequences of inaccessible transport

For some people, the combination of inaccessible taxis, restricted public transport and limited community options led to dependence on friends and family, even when this was not sustainable.

One person explained that they **”have limited mobility and I cannot get in and out of a standard vehicle, so I am needing to rely on people with a 4x4 or hire a mini van.”**

Others reported that the lack of accessible transport forced them to miss or rearrange appointments or left them anxious about making it home safely after treatment:

“Taxi drivers will often not be able, or be prepared, to wait as they have other commitments and are usually not available when it is school opening or closing times. This adds anxiety to the patient’s time, not concerned with their actual appointment but whether they are going to get there in time and not be left there, with no certainty of getting home safely.”

Inclusion issues

For some people, the impact of transport changes is closely linked to digital exclusion. People described challenges such as limited digital literacy:

“There are still a large number of people who do not have internet or technology and are not aware of any alternatives.”

These issues make it difficult to navigate or book alternative transport services independently and can exclude people from accessing healthcare appointments, even where transport technically exists.

Evidence from disability organisations

Recent concerns raised by North Yorkshire Disability Forum (NYDF) and Disability Action Yorkshire reinforce these findings. As highlighted in BBC coverage, the chair of NYDF noted that: **“Wheelchair users without their own vehicle find themselves unable to get to hospital or dental appointments and it leads to social isolation in rural North Yorkshire.”**[2]

Experiences shared

People in North Yorkshire also spoke about how it is for them.

> **“A taxi is no help as I cannot get to the department unaided.”**

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[2] **Whitby wheelchair user moves 45 miles to book a taxi - BBC News**

“There is only one wheelchair taxi in town, which breaks down frequently.”

“I cannot find a wheelchair taxi service in my area even if I could afford it.”

A person in York shared the difficulties they faced:

“I rang to arrange transport for two forthcoming hospital appointments and was told that they now only provide transport and won't give any support for me to get to the right departments even though I am registered severely sight impaired.

When I asked what I should do they said to either ring the department and they could arrange someone to meet me (but when I try and ring the department I don't get an answer so couldn't arrange this even if they had the staff to help) or to ask at reception.

One of my forthcoming appointments is at Malton Hospital, where I have never been. So, even though it is an urgent referral to urology, I don't think I can go as I won't be able to get to the department after being dropped off. I did ring the urology department to try and get help but just got an answerphone message that wasn't helpful.

I will try to go to an appointment at York Hospital as I feel I know it better. But this new approach probably means I won't be able to.”

Overall impact

Together, these accounts show that accessibility is not simply an additional barrier. It fundamentally shapes whether disabled people can receive timely care. For many, the current transport landscape means that attending hospital is no longer straightforward, and in some cases, no longer possible.

Other impact

Alongside concerns about eligibility and inconsistencies, people also described a wide range of broader practical, social and emotional impacts resulting from changes to non emergency patient transport.

Pressure on families and carers

We also heard about families being placed under considerable pressure.

One support worker in North Yorkshire explained:

> **"One client I support has a disabled daughter with multiple health conditions. She is no longer eligible under the new criteria apparently because her father is physically able. She has appointments at various hospitals all of which are far away from the house. The journeys require several buses and take hours. Is a difficult journey for the father to navigate and he often gets lost as he is not a native English speaker. Also travelling by bus with his daughter's condition feels nearly impossible. Due to the criteria changes, they have either missed her hospital appointments or paid for expensive taxis. The change has added more stress upon an already vulnerable family."**

Other families described the strain of providing transport themselves, often when they were unwell or needing to reorganise work commitments. One person told us:

“I have had to drive my spouse to an appointment at a time when I wasn't well myself.”

One North Yorkshire resident added: **“My father has to rely on me now, but I work away, so sometimes he has to change his appointments to fit in with my work schedule, which can delay his treatment. I am having to look for lower-paid employment.”**

Impact on parents and children

Parents also reported difficulties when children needed to attend hospital.

One person in York shared that although their treatment is only available at Scarborough Hospital:

“I am not medically fit enough to travel on my own there. No one will help when they realise you have a child. The transport service tries to discourage you from taking your child with you despite having no support with them. Local charity transport services are not insured to carry babies in their cars.”

Another person in North Yorkshire explained that since the service changed provider, the community transport provider will not accept people under 18 or those who do not speak English: **“So now most of our clients, who are arguably some of the most vulnerable people in our community, do not have any means to make it to their hospital appointments.”**

Other practical impacts

Some people raised concerns about additional practical barriers.

"My taxi will only wait two hours at the most to take me home and it is expensive."

One person raised concerns about the wider environmental implications:

"I also wonder how this requirement for extensive travel for hospital appointments fits with the council's stated policy of a 50 percent reduction in car travel by 2030."

Challenges when using patient transport

Some people told us they remain eligible for non-emergency patient transport and, for many, this support is essential. However, even when the service is available, it does not always meet people's needs.

Many people highlighted issues related to safety, long waiting times, communication and the suitability of the transport provided.

Positive experiences alongside ongoing challenges

While some people reported very positive experiences, others described significant challenges that affected their comfort, safety and confidence in the service.

One person shared:

“I was driven to Leeds Hospital for heart surgery and for all the check-ups beforehand. I am eternally grateful for this.”

Alongside this, many people told us about difficulties they continue to face when using patient transport.

Waiting times and shared journeys

Waiting times for non-emergency patient transport add another layer of difficulty. Many people described delays both to and from appointments.

One person in York said:

“When I did use patient transport after my surgery I was waiting for almost four hours to be collected at the hospital.”

A person in North Yorkshire explained that even early afternoon appointments could involve hours of waiting:

“My appointments can be early afternoon, but I can still be picked up at 9:30am onwards and have to wait up to four hours after my appointment, which is exhausting for a 78-year-old undergoing palliative treatment for cancer.”

Others highlighted how these long waits can disrupt basic daily routines, such as eating regular meals or returning home at a reasonable time.

Many people described having to share vehicles or experiencing long waits, which can create distress and, in some cases, negatively affect health.

One parent in North Yorkshire explained:

“Despite having been assessed and approved for ‘Must travel alone (with carer)' due to complex difficulties, we are told that this can't be guaranteed and have had to travel with other patients on occasions. Also, the wait time for return transport can be hours, which impacts enormously on my daughter's health and sets her back to a point where she can't recover. Therefore, each journey to an appointment is making her condition deteriorate further. The ambulance staff are fantastic with their help and understanding, but they are tied by the rules and the people allocating their jobs.”

Safety and support needs

Others raised concerns about feeling unsafe when carers are not allowed to accompany them. One person in North Yorkshire who had experienced a stroke told us:

“My wife is my carer. She now cannot travel to my hospital appointments with me. I am very dizzy all the time and feel very unsafe when she is not with me.”

Some people also reported problems with equipment and vehicle stability. One person said:

“My electric wheelchair has not been secured properly as it wasn’t the bog-standard manual one and they didn’t have the correct fixings or could work out how to adapt them to secure my chair.”

Unsuitable transport and missed collections

We also heard examples of people receiving transport that did not meet their mobility needs, even when an appropriate vehicle had been requested.

Delays and communication failures

Delays and communication problems caused considerable frustration and distress for patients, carers and hospital staff.

One person in York described the experience of a patient in their ward:

> **"A lady from York in my ward was due to be discharged, and patient transport arranged to pick her up at 4pm to coincide with her carers. Despite numerous calls from hospital staff they were assured the transport was on its way. By 8pm still no transport and the staff were advised that patient transport had closed for the night so would not be picking up the patient. Both staff and patient were very upset and the lady in question was moved to another ward late at night so she could be taken home the next day. This is unacceptable on every level."**

Overall impact

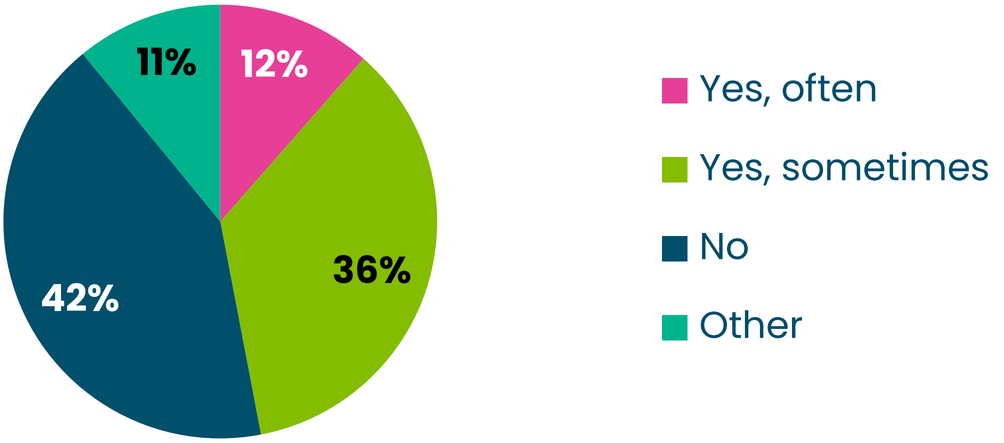
These experiences show that even where eligibility is confirmed, the practical challenges of non-emergency patient transport can still place significant strain on patients, carers and hospital staff.

Missed or cancelled appointments

Difficulties accessing non-emergency patient transport continue to affect whether people can attend healthcare appointments. While some people said they had not missed or cancelled appointments, a significant proportion told us that transport issues had prevented them from attending care they needed.

We asked people whether they had cancelled or missed appointments because they could not get transport.

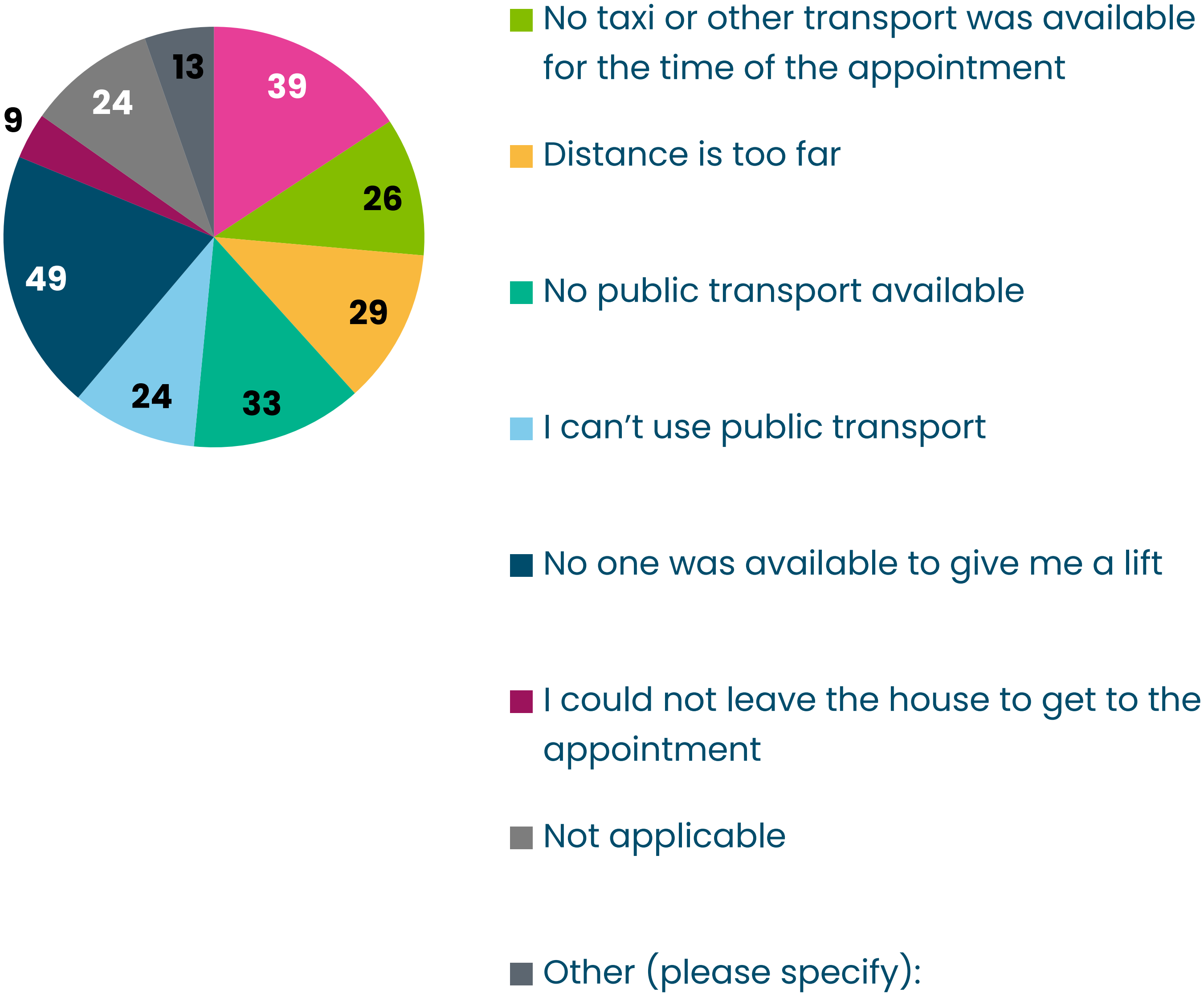
Have you cancelled or missed appointments because you could not get transport?



Overall, 42% of people said they had not missed or cancelled appointments. However, 36% reported missing or cancelling appointments at least sometimes, and 12% said this happened often. These figures highlight ongoing barriers to accessing care, particularly for people living in rural areas, those with mobility needs, and people without reliable transport options.

To understand why people were missing or cancelling appointments, we asked people to tell us the main reasons. People could select more than one option as for the reason for cancelling or missing an appointment.

What were the main reasons for cancelling or missing an appointment?



The most common reason people gave was that no one was available to give them a lift. Cost was also a major factor; with many people saying they could not afford to pay for transport. Other frequently cited reasons included lack of public transport, inability to use public transport, long distances to appointments, and taxis or other transport not being available at the time of the appointment.

Together, these responses show that missed and cancelled appointments are rarely the result of a single issue. Instead, they reflect a combination of affordability, availability, distance and accessibility challenges, often compounded by people's health conditions and where they live.

Experience behind the data

Many people described having to rearrange, delay or even abandon appointments because they could not get there.

Some people in North Yorkshire reported that appointments had to be changed to fit public transport schedules:

"I had to change appointment in order to be able to get there by public transport."

Others were unable to attend appointments entirely:

"I was unable to attend an inpatient operation."

One person explained how the loss of transport support removed the mum's alternative option to get to hospital if the daughter is not available:

"It had taken my back-up option away. If we are not available to take my mum to her appointments, then she must rearrange or delay possibly critical intervention. It has left my mum feeling like a burden.".

Rurality and limited transport options

Rurality and limited transport options were common factors in cancelled appointments.

One person in North Yorkshire explained:

"Living in a rural area with very little public transport as I don't drive means that I have to cancel appointments if I can't get a lift."

Another described how distance and cost made attending appointments impossible:

"I live in Bedale which doesn't have good public transport links. I do not drive. I was given an appointment in Harrogate recently and had to cancel as I cannot get there. I will not be able to go anymore as I can't afford it."

Reconsidering care altogether

For some people, transport difficulties have forced them to reconsider their care entirely. A voluntary organisation in York shared the experience of an older person with mobility needs:

"We had a 91-year-old client who has mobility issues and uses a wheelchair. She has missed appointments with her eye clinic. She is thinking of abandoning treatment as she doesn't want to make an appointment and not be able to keep it, and it's too hard to arrange."

These experiences show that missing or cancelling appointments is not just inconvenient, it can delay treatment, reduce access to care and place stress on people and their carers.

Additional experiences

People in North Yorkshire shared:

> **"I am supposed to return in a few weeks' time to complete my treatment but due to the cost I will not be doing so."**

> **"It is going to be very difficult for me to attend any appointment or procedure where I can't drive myself. I have recently hired a Motability vehicle with wheelchair hoist. I have already missed two diabetic eye checks as you're not allowed to drive for six hours afterwards. I think it's because I am only 65 and do not look particularly frail in appearance but they do not realise that my chronic conditions really affect my general health, making me more susceptible to infections and my ability to fight them. I am immunocompromised but my condition is unusual, so they don't recognise that. They usually ignore it or incorrectly discount it."**

> **"I worry about how we are going to keep appointments especially for tests without which we can't get treatment."**

> **"I have not attended as I am on pension credit so can't afford a taxi, poor mobility so can't get the public transport and have no family."**

Rural and urban challenges

Most survey responses, 72%, came from North Yorkshire. However, many of the challenges raised were also shared by people living in York. Across both rural and urban areas, people highlighted issues with public and community transport that affect their ability to access appointments, although the nature and scale of these challenges can differ.

Challenges in rural areas

For people living in rural areas, distance from hospitals, limited public transport and higher transport costs make attending appointments particularly difficult. People Healthwatch North Yorkshire spoke to described how infrequent, poorly timed or non-existent public transport can make even routine appointments hard to access.

"Living in a rural area often means public transport is non-existent or bad timings."

Others described the extreme limitations faced in more remote locations:

"Upper Nidderdale is very rural. There is no public transport service up the dale from Pateley Bridge. The cost of private taxi hire from Upper Nidderdale to Harrogate Hospital or beyond is prohibitive for many people. Oncology appointments in Leeds hospitals are almost impossible to attend via public transport for those with mobility issues."

People also highlighted the impact on older people, for whom travelling even short distances to local services can be challenging, let alone long journeys to hospital:

“In rural Esk Valley with older people and little public transport (an occasional train which they cannot walk to) and taxis miles away, it is extremely difficult for them to get to the next village for a GP appointment - let alone 25 to 30 miles to a hospital.”

Challenges in urban areas

While York has more public transport options, these are not always straightforward or accessible. Some people described the need to take multiple buses and the limited availability of wheelchair accessible spaces.

One person in York explained:

“Even in York there are buses, but people almost always have to get at least two buses to the hospital and sometimes the buses don’t have space for wheelchair users. Many community transport providers, including York Wheels, do not have wheelchair accessible vehicles”.

Our survey focused on transport to hospital appointments in line with the contract for non-urgent patient transport. However, regular feedback to Healthwatch York highlights problems for people going to GP appointments where the appointment is not at the person’s local surgery, but another surgery in the practice.

This is already an area of concern for people locally. Recent feedback from people in York about getting to GP appointments includes:

“Often you get sent to other surgeries, but they are difficult to get to, or impossible to get to, on public transport. If you have an afternoon appointment and have to get a taxi, you then can't get home as the taxis are all doing the school run!”

“I live in Stockton on the Forest and have really struggled to get to the GP surgery since the local surgery closed. It is a three-hour return bus journey to get to the Huntington surgery from home, as well as the time at the surgery. It is not easy when you don't have a car, and I don't think the people who think it is a short drive understand how difficult it is on public transport.”

One person got in touch with Healthwatch York after seeing an article in the local paper about the Askham Bar Community Diagnostic Centre to raise concerns about getting there. They said:

“Why should people be expected to travel miles across town to receive treatment that was once provided on their doorsteps? They are required to take what are sometimes unreliable bus services, rely on kind relatives/neighbours for transport, expensive taxi journeys or use their own transport adding to the congestion on the roads. The whole thing does not make sense in many ways. Get the required medical services back where they belong, in the community where people can easily reach them.”

It will be important to consider how plans to develop more neighbourhood health services and neighbourhood teams can be developed with travel planning in mind to make sure that those people who rely on public transport can access services as needed.

The role of community transport

Community transport plays a vital role in both rural and urban areas, providing a lifeline for people who would otherwise struggle to reach appointments.

One person explained that they are: **"Very reliant on the volunteer transport system. Without it, it would be impossible to get to hospital"**. Others spoke about the importance of volunteer drivers not just for transport, but for the reassurance, patience and personal support they provide, especially for people whose independence has reduced over time:

"I really value community transport as you get to know the drivers, they help you and give you time to get in and out of the vehicle. The driver often comes to meet me, so I don't have to look and find them. This is really important for some of my appointments where my vision is adversely affected."

Another person in North Yorkshire praised a local service:

"The Little White Car in Hawes is brilliant. They have not been unable to take me to appointments so far. This is a vital community service and so valuable."

Overall impact

These experiences show that while cost and waiting times are experienced across both rural and urban areas, the practical challenges of distance, limited transport options and accessibility make rural journeys particularly difficult. At the same time, community transport remains a crucial support, helping people maintain access to essential care.

Additional experiences

People in North Yorkshire also shared how it was for them.

> **"Community transport drivers are an absolute lifeline for me, especially when I am taking my husband to appointments or with me. He has Alzheimer's. The drivers chat to him and are patient and helpful. I used to drive and medical appointments were no problem. I was shocked at how small and difficult my world has become and how stressful it is if I cannot get suitable transport."**

> **"Public transport is not easy for people living in rural communities and for some it is impossible. I have known of clients who had eye appointments and said they would drive, until I advised that they wouldn't be covered on their insurance if they had been advised not to drive by the clinician."**

Impact on community transport organisations

15% of survey respondents were from community transport schemes or other local organisations. Many highlighted the pressures that changes to non-emergency patient transport eligibility have placed on their services, as well as the knock-on effects for the people they support.

Increased demand and limited capacity

Several organisations described a sharp increase in demand which they are struggling to meet.

One person in North Yorkshire commented that there’s a **“large increase in new enquiries but, unfortunately, we cannot meet demand and do not have facilities for specialist transport”**.

Others explained that volunteer-led serviced have clear limitations, particularly around supporting people with complex needs, mobility requirements or urgent clinical conditions, which means they cannot safely meet all requests for transport.

“Crucially, we can't guarantee transport and our volunteers cannot 'manually handle' or support clients in appointments. Also, they aren't medically trained so cannot support clients who are really unwell and in need of a lift with urgent clinical needs.”

Urgent requests and operational strain

Community transport providers described the strain created by urgent requests, often made with little notice. This was particularly common for critical health appointments such as cancer treatments.

One organisation explained:

“Changes to patient transport have led to many clients contacting us in panic with not much notice for a critical appointment. It is impacting the ‘busyness’ of our service, which does not have the funding for a core admin post.”

Volunteers reported seeing increased numbers of people turned away from non-emergency patient transport and seeking help from community services, sometimes following eligibility decisions that do not reflect people’s real-life circumstances or availability of support.

Wider pressure on the health system

The impact of these changes is not limited to community transport providers. One GP practice added:

“From a GP point of view this has probably resulted in more home visits to patients who may have been supported getting here and are no longer able to. We do have frustrated patients because of this, and often there is little we can do to assist them, with them often taking their frustration out on our staff. We have on occasion had staff drive patients to the hospital, because there was no other option and patient transport had unreasonable waiting time.”

These experiences highlight how transport barriers can increase pressure on primary care, ambulance services and frontline staff.

Volunteer perspective and limits of support

Volunteer groups in North Yorkshire also described the limits of what they can provide safely.

> **“Our volunteer car scheme has noticed a massive uptake in people requiring the service which we are finding increasingly difficult to operate as demand outweighs available volunteers.”**

A volunteer in York described how people are increasingly being directed to community transport after being refused NHS transport.

> **“I volunteer with York Wheels and we are seeing more and more people come to us because they have now been turned down by patient transport. One person told me that when asked, they said a friend took them shopping. Then the person on the phone said, well if they can do that, they can take you to the hospital and refused any transport, even though the friend works and can't help on weekdays.”**

Conclusion

The findings of this report highlight the significant impact that the April 2025 changes to non-emergency patient transport eligibility criteria are having on people across York, North Yorkshire, and the wider region. While these changes were intended to make sure NHS resources are used appropriately, the experiences shared with us show that, in practice, they have reduced access to essential care for many people.

For those with mobility needs, wheelchair users, people on low incomes and residents of rural or coastal communities, the barriers are particularly stark. Longer travel distances, limited public transport, rising costs and the lack of accessible vehicles all contribute to widening inequalities in who can realistically reach their health appointments.

Beyond transport itself, the consequences affect people's health and wellbeing. Missed or delayed appointments, increased anxiety, loss of independence and a growing reliance on community and voluntary support demonstrate how transport challenges can erode wider health outcomes. Community transport providers, already delivering an essential safety net, are now under increased pressure. They are responding to rising demand without the long-term funding or capacity required to sustain their services.

Healthwatch North Yorkshire and Healthwatch York will continue to monitor the situation closely. We will keep gathering people's experiences, logging concerns and sharing evidence with commissioners, NHS Trusts, local authorities and community transport partners. The voices captured in this report make clear where improvements are needed, and we remain committed to making sure that those most affected are heard in ongoing planning and decision making.

This report sets out a series of recommendations which, if acted on, have the potential to significantly improve access to healthcare and support better health and wellbeing outcomes. However, if these issues are not addressed, there is a real risk that inequalities will deepen. More people may miss or cancel lifesaving or life improving appointments, conditions may worsen unnecessarily, and pressure may grow on urgent and emergency care as preventable issues escalate. Community transport schemes may become increasingly overstretched, limiting their ability to meet rising need.

Improving patient transport is not only about journeys, it is about fairness, dignity and ensuring that everyone, wherever they live and whatever their circumstances, can get the healthcare they need. The insights shared by local people and organisations throughout this report offer a strong foundation for positive change.

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What Trans, Non-binary and Intersex People Told Us About Health Services in York

February 2026

Acknowledgements

This report would not have been possible without the hard work and dedication of Heidi Jo Wood and Amy Collier, both local university students who supported the project.

Thank you also to the organisations and individuals who were part of our project group:

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- Myrte Elbers, City of York Council
- Victoria Etherington, Priory Medical Group
- Bethany Fenton

Contents

Content warning

This report contains content that some people may find distressing. This includes but is not limited to: mental ill-health, suicide and suicidal ideation, stigma and discrimination. Please consider your own mental wellbeing when reading.

Executive Summary

Healthwatch York had heard about poor experiences in accessing local healthcare services from trans and non-binary people living in the city. We wanted to find out if the issues people raised were common for trans, non-binary and intersex people in York.

We worked with local voluntary sector organisations and colleagues in the NHS to find out more. We heard from trans, non-binary and intersex people, their family and friends and healthcare professionals.

We found a mixed picture across all NHS services. Some people told us of gender affirming care from healthcare professionals who were empathetic, caring and wanted to support the people to get the care they needed. However, we also heard from people who had such distressing experiences that they no longer trust the NHS to provide any care for them.

We identified these key findings from the feedback we received:

1. Many people are not treated with respect and dignity. This includes healthcare professionals consistently using the wrong pronouns or names for people.
2. Many healthcare professionals do not have appropriate/effective training around trans, non-binary and intersex people's healthcare.
3. The waiting lists for gender specific care are too long, with little to no support for people while waiting.
4. There is not a consistent approach to shared care in York between GPs and private hormone/gender affirming care.

Some of the feedback we received highlighted good practice. This demonstrates that gender affirming care is not only possible but is already happening in York. It is led by committed and concerned healthcare professionals. This shows that good care for all trans, non-binary and intersex people is possible locally. With leadership and support it could be the rule rather than the exception. We have made a number of recommendations to help this become a reality.

Since we carried out our research and drafted this report, the Levy Review, an operational and delivery review of NHS adult gender dysphoria clinics (GDCs) in England, published its report[1]. While much of that report and the recommendations focus on GDCs, both include mention of hormone provision and the need for shared care arrangements with GP practices for this. This report is in line with the recommendations in the Levy Report in that hormone prescriptions should be managed by local primary care services – although the Levy Report recommends that this should be after a year where they are managed by the local GDC. The Levy Report recommendations include developing local hormone prescribing pilots. We strongly endorse this and believe that York is in an extremely strong position to implement a pilot in line with our recommendations.

Thank you to everyone who shared their experiences as part of this project and all those listed above. Without you all this project would not have been possible.

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[1] https://www.england.nhs.uk/publication/operational-and-delivery-review-of-nhs-adult-gender-dysphoria-clinics-in-england/ 18 December 2025

Background

According to 2021 Census data, approximately one in every 200 people aged 16 and over in England may be trans, non-binary or another gender identity that differs from their sex at birth. Data from Humber and North Yorkshire Health and Care Partnership noted that 742 people in York were coded on GP records as trans, non-binary or intersex. This is not the total trans, non-binary and intersex population of the city, just those with the appropriate code on their GP record.

Trans and non-binary people are protected by law from discrimination under the Equality Act 2010. Gender reassignment is one of nine protected characteristics under the Act[2], regardless of whether people have had medical treatment or acquired a Gender Recognition Certificate as part of their gender transition.

The **Equality Act 2010** says that it is unlawful to discriminate against patients based on protected characteristics, which include gender reassignment and sex. Refusing treatment because a patient is transgender or because of gender-related beliefs would likely constitute unlawful discrimination.

The legal protection extends to how trans and non-binary people are treated by public services, like the NHS. Under the Public Sector Equality Duty[3], public authorities must tackle unlawful behaviour among staff towards people with protected characteristics, advance equal opportunities and foster good relations between all types of people. However, equality in law does not guarantee equality in

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[2] https://www.legislation.gov.uk/ukpga/2010/15/part/2/chapter/1

[3] https://www.gov.uk/government/publications/public-sector-equality-duty-guidance-for-public-authorities/public-sector-equality-duty-guidance-for-public-authorities

everyday life, as an Equality and Human Rights Commission report concluded in 2018[4].

Inequality in everyday life is something transgender and non-binary people face, affecting all areas of their lives. A recent study found "problems associated with discrimination, healthcare, employment, housing, self-esteem and rehabilitation."[5]

As with the wider population, trans, non-binary and intersex people rely on general practice for general health care. As the Royal College of General Practitioners notes in its position statement of March 2025[6] "General Practice plays a vital role in ensuring (transgender patients) receive the care they need. GPs are expected to approach the holistic care of transgender people, those experiencing gender incongruence and / or questioning their gender identity as they do with every patient – openly, respectfully, sensitively and without bias." However, they go on to note the challenges for GPs in providing all aspects of the care required:

"As expert generalists, GPs are not trained to have the specialist skills required to assess and provide care to address specific needs related to gender incongruence… However, once adult patients are under the care of a specialist gender identity service, many GPs are likely to feel able to maintain prescriptions under a collaborative or shared care arrangement."

For specialist services relating to gender identity, these can be accessed through Gender Identity Clinics. These are commissioned

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[4] www.equalityhumanrights.com/sites/default/files/is-britain-fairer-accessible.pdf
[5] https://sciencescholar.us/journal/index.php/ijhs/article/view/7011
[6] https://www.rcgp.org.uk/representing-you/policy-areas/transgender-care

by NHS England to provide a national support service in line with their service specification[7].

In June 2024, the British Medical Association published guidance on 'Inclusive care for trans and non-binary patients'[8]. The guidance references the 2018 National LGBT survey[9] and its findings of negative experiences for LGBT people accessing healthcare services that are reflected in this report. In the introduction to the guidance: 'The BMA affirms the rights of all transgender and non-binary individuals to access healthcare and live their lives with dignity, including having their identity respected. Doctors should work collaboratively with their trans and non-binary patients as they do with any patient: in a respectful, open and sensitive way, free from discrimination or bias.'

The guidance goes on to outline the elements of a trans-inclusive approach for GP practices.

The General Medical Council also has guidance for supporting trans and non-binary patients on its website[10]. Similar to the RCGP and BMA, it stresses: 'While transgender and gender diverse people may have specific health needs in relation to gender dysphoria or gender incongruence – their general health needs are the same as anyone else's. As with any patient, it's important that you provide general care to meet their healthcare needs.'

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[7] https://www.engage.england.nhs.uk/survey/gender-identity-services-for-adults/user_uploads/specialised-gender-dysphoria-service-specifications.pdf

[8] https://www.bma.org.uk/advice-and-support/equality-and-diversity-guidance/lgbtplus-equality-in-medicine/inclusive-care-of-trans-and-non-binary-patients

[9] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721704/LGBT-survey-research-report.pdf

[10] https://www.gmc-uk.org/professional-standards/ethical-hub/trans-healthcare#confidentiality-and-equality

In July 2025, Healthwatch England published a report 'What trans and non-binary people told us about GP care'[11]. Healthwatch England heard from more than 1,300 people from across England. The report's findings are similar to those outlined in this report with mixed experiences for trans and non-binary people accessing GP services.

Those who had good experiences referenced healthcare professionals treating them with respect and compassion. However, much of the feedback was about the challenges and issues trans and non-binary people face in accessing gender affirming care. This led 39% of respondents to say they are not confident in using GP services for their healthcare needs.

The local picture

In 2025, York Health and Care Partnership produced data about the mental health and wellbeing of trans and non-binary people in the city.

The data shows the difference in York people diagnosed with any mental health condition comparing trans, non-binary and intersex people with cisgender people across age groups. It is important to be clear - being transgender is not a mental health issue. But transgender people experience higher rates of mental ill-health due to the societal pressures, discrimination and violence they experience.[12]

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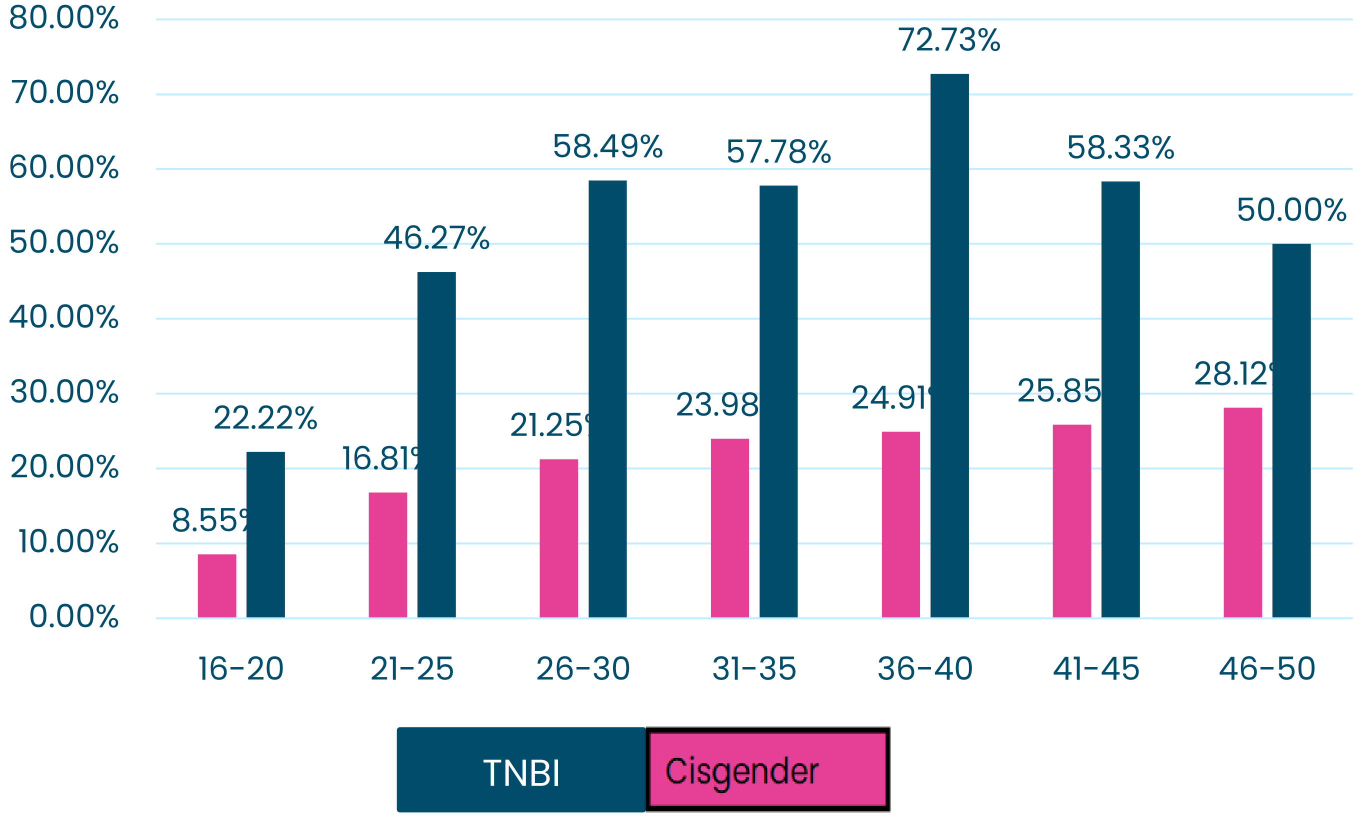
[11] www.healthwatch.co.uk/sites/healthwatch.co.uk/files/20250717_Trans%20experiences%20of%20healthcare%20PDF%20%281%29.pdf

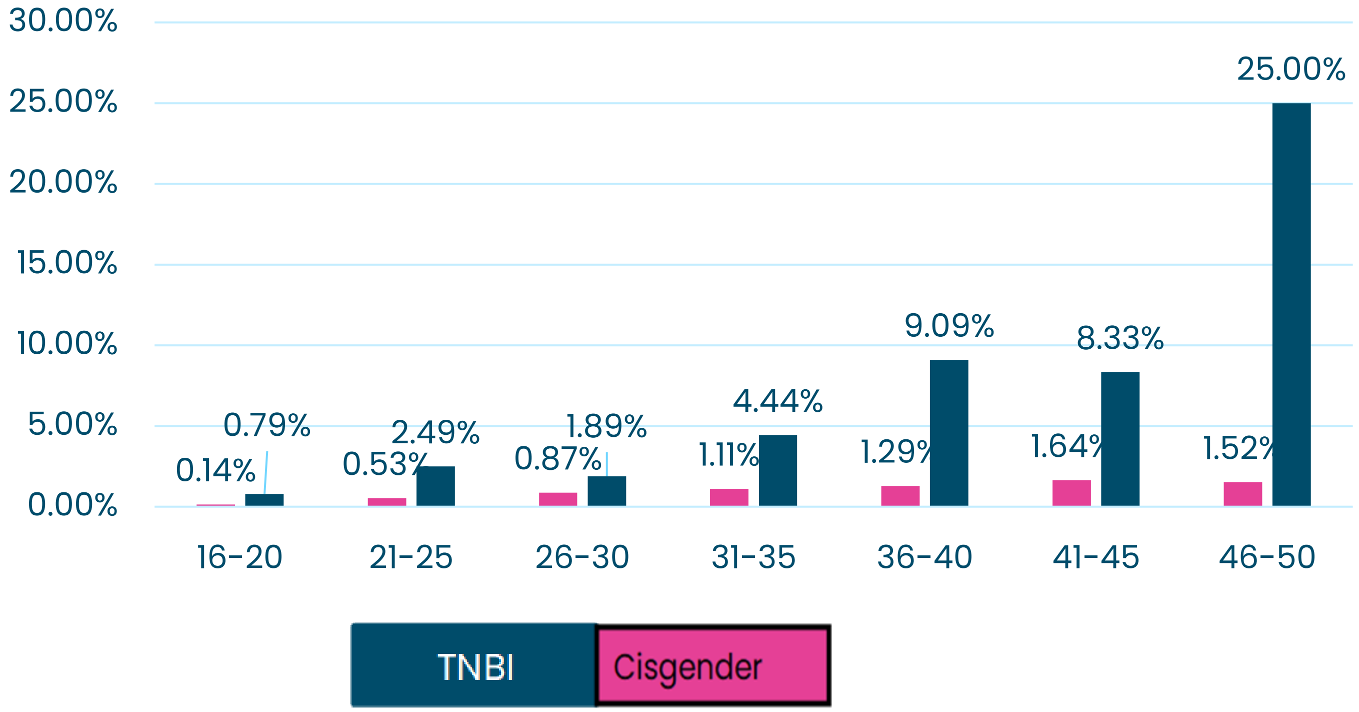
[12] https://www.healthpartners.com/blog/mental-health-in-the-transgender-community/

Percentage of patients with a diagnosed mental health condition by 5-year age band (18/03/2025)



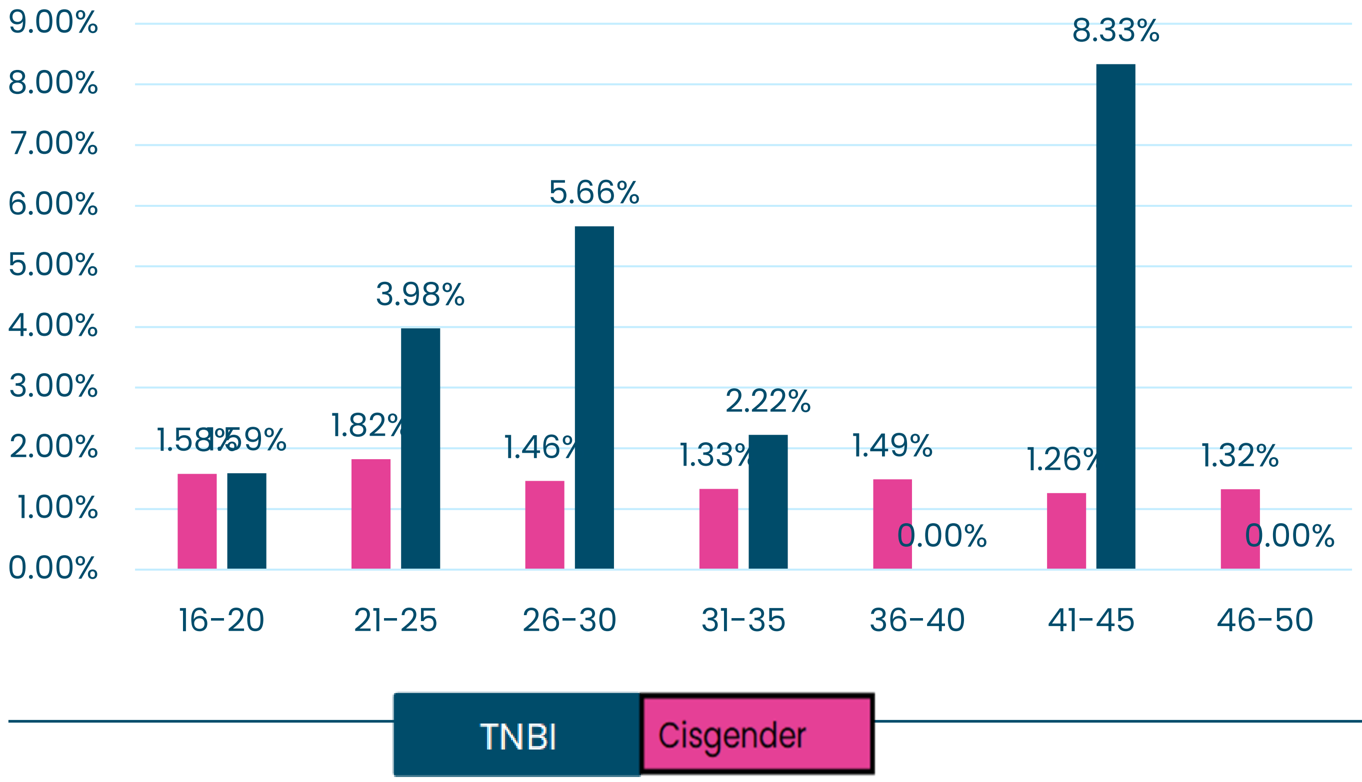
It is clear from this data that trans, non-binary and intersex people across all age groups experience significantly higher rates of diagnosed mental health conditions than cisgender people. This trend is also seen in diagnoses of serious mental illness and particularly stark in working age adults as serious mental illness diagnoses typically increase with age.

Percentage of patients with a severe mental illness by 5-year age band (18/03/2025)



This trend is also reflected in information about eating disorders:

Percentage of patients with an eating disorder by 5-year age band (18/03/2025)



The Humber and North Yorkshire Health and Care Partnership presentation that accompanies the above data recognises that the above disparities are driven by 'minority-stress pathways and structural factors, including discrimination, social exclusion and barriers to accessing gender-affirming care'. This references Puckett et al 2023[13] and Watkinson et al 2024[14].

Methodology

Feedback Healthwatch York had received in 2024 – 2025 highlighted challenges for trans, non-binary and intersex people in accessing healthcare. This was confirmed by other research (see above) which found that trans, non-binary and intersex people often experience poorer health outcomes than the general population.

We reached out to local LGBTQIA+ support groups and interested healthcare professionals who confirmed the issues we had heard about. In partnership with those and other organisations, we held an open meeting to explore the issues further. As a result, a working group was formed. Together we developed a project to gather more information about local people's experiences.

The project launched in July 2025 with surveys and engagement running between August and November 2025.

We ran three surveys (see below) promoted via LGBTQIA+ support groups, social spaces, the city's two universities, social media, local media, Quiet Pride and more. The healthcare professionals survey was circulated via the York Health and Care Board, GP practice manager meetings and hospital contacts.

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[13] https://psycnet.apa.org/record/2023-72636-001
[14] https://pubmed.ncbi.nlm.nih.gov/38307677/

The online survey for trans, non-binary and intersex people was supplemented using whispermeter[15]. This is a completely anonymous online space for people to post information about a topic. We identified this additional route in response to feedback from partner organisations that some people found the survey overwhelming.

The three surveys conducted were:

1. Trans, non-binary and intersex people's experiences of health services in York.
2. Healthcare professionals' experiences with supporting trans, non-binary, and intersex people in York.
3. Friend and family members' views of trans/non-binary/intersex experiences of health services in York.

The surveys were self-selecting, meaning that we relied on those willing to complete the questions and who had the ability to complete an online survey. Therefore, it is not a locally representative sample.

We received:

- 67 responses from trans, non-binary and intersex people.
- Nine responses from healthcare professionals*.
- 14 responses from friends and family members.

*After we launched the surveys, NHS England announced it would be issuing new clinical guidelines about supporting trans, non-binary and intersex people following the Supreme Court ruling[16]. As a result, we heard that a number of healthcare professionals were awaiting updated guidance before responding to the survey.

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[15] https://whispermeter.com/

[16] https://commonslibrary.parliament.uk/research-briefings/cbp-10259/

Key findings:

1. **Many people are not treated with respect and dignity.**

> “My GP surgery would not use my chosen name or pronouns, despite it being recorded on my notes. I avoided doctor appointments for a long time because of this.”

2. **Many healthcare professionals do not have appropriate/effective training around trans, non-binary and intersex people’s healthcare.**

> “You have to educate every one of the medics you go to since they are routinely ignorant to trans health.”

3. **The waiting lists are too long, with little to no support while on the waiting lists.**

> We are currently booking appointments for people who were referred in approximately July 2019.
>
> *Leeds Gender Identity Clinic*

4. There is not a consistent approach to shared care in York between GPs and private hormone/gender affirming care.

During my five years on the GIC waiting list I paid for private gender treatment, including blood tests and medications.

Refused blood tests due to no longer doing shared care.

What we heard

The information below comes from survey responses, whispermeter responses, conversations and feedback to Healthwatch York as part of its ongoing work. Where appropriate, we have included comments from all the surveys under headings and have indicated which of the three groups it is from. Any comments from friends and family and healthcare professionals that did not fit under these headings is included later.

One of the first survey questions for trans, non-binary and intersex people was whether they felt they faced barriers because of who they are. 82% of respondents said they did. We also asked friends and family if their family member/friend had experienced issues when accessing health services and 92% said yes.

However, while 82% said they had faced barriers, we did hear from people about positive experiences of local healthcare.

We have explored some of the barriers people raised below and included some of the positive experiences to show what good care can look like. We have started with our key themes but also included wider feedback.

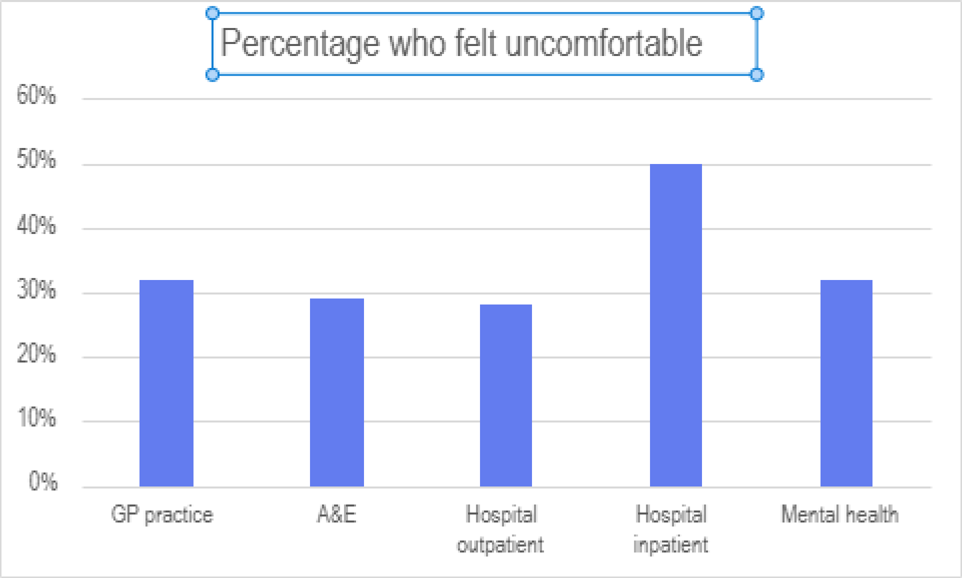
Respect and dignity

As above, a significant majority of respondents said they felt they faced barriers in accessing healthcare because of who they are. We asked about experiences in a range of healthcare settings and had a mix of responses both positive and not. For those who did not have a good experience, healthcare professionals not following a request to use the person’s chosen pronouns and name was a significant issue. This is something easy to address and can make a big difference to someone’s experience.

Many people feel scared about accessing healthcare as they feel they will be treated differently, that they will be denied services or that any issue they raise will be linked to their gender identity – this is colloquially known as 'trans broken arm syndrome[17]' where any symptom is put down to someone being trans or non-binary.

More than 50% of survey respondents said they hide their identity to access health services. Some told us that when their gender identity was known, healthcare professionals ask questions about it even when the person felt it had nothing to do with the issue they presented with.

32% of trans, non-binary and intersex respondents said a GP practice staff member had made them feel uncomfortable due to their gender identity; this was 29% for people attending A&E; 28% for people who were hospital outpatients; 50% for hospital inpatients (but note this was a much smaller sample) and 32% for people seeking mental health support.



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[17] https://pubmed.ncbi.nlm.nih.gov/36736052/

People told us:

- “I avoid doctors as much as possible because I am scared, they will deny me healthcare or take away my existing healthcare.”
- “… person used the wrong name and pronouns even though I explained my preferred ones. When they knew I was trans my care seemed to slow down and funding was withheld.”
- “GP misgendered me in patient notes and generally gives a feeling of having personal biases against trans people and trans healthcare.”
- “In the past have had doctors not look into issues they believe are related to "being trans" even when I don't believe they are related. This has led to the GIC having to tell GPs to manage ordinary conditions "as they normally would".”
- “My GP surgery would not use my chosen name or pronouns, despite it being recorded on my notes. I avoided doctor appointments for a long time because of this.”
- “I have also been misgendered in patient notes that I can see through the NHS app, and my repeat prescriptions that I ordered through the NHS app were sent to the pharmacy under my deadname.”
- “I have also had a GP tell me that I shouldn't get care on the NHS; she also asked me why I would do this (meaning transitioning) to myself. I have also had a nurse tell me that I'm lucky to get treatment via the NHS when attending an appointment for my hormone blocker injection.”
- “It feels like there is always at least one extra step or thing to do with everything, over and above what other people have to do, because of my gender identity. It is exhausting and I experience this on a daily basis with many other aspects of my life so these experiences are cumulative, which takes a toll on my general health and well-being.”

- “Healthcare professionals often dismiss non-binary identities, and as a community we have found that this leads to health needs also being dismissed.”
- “Sometimes avoided mentioning gender identity in case doctors get sidetracked from helping me with my actual issues if they see my gender as a problem that they need to fix.”
- “I have chosen to not inform doctors of me being non-binary, as while being misgendered in my medical records and appointments etc is upsetting, my gender identity is not an important aspect of my care, and I do not wish to be treated any differently or denied access to services due to not being cisgender.”
- “I have made the decision not to disclose it when it has not been at all relevant, due to an experience I had when attending the eye clinic at the hospital. I was questioned by the doctor about my gender (I was there because I had something stuck in my eye, very painful and needed removing) and he asked me many, many questions about my gender identity. He said it was so interesting and that he had thought I was just a "normal man".”
- “York for the most part is very welcoming of LGBTQ+ individuals and so far I have had pleasant experiences both at York hospitals and GPs in regards to my identity.”

Friends and family of trans, non-binary and intersex people said:

- “They have been refused health services due to being trans.”
- “They have had medical professionals make it clear that they don’t support trans identities.”
- “Misgendering, patronisation, GPs and mental health staff refusing to do anything to ease dysmorphia.”

When we asked friends and family if they felt GPs and healthcare teams are well informed and respectful regarding trans / nonbinary /

intersex individuals, no-one said yes, 54% said sometimes and 38% no.

Comments included:

- “Some are respectful, and some are confused.”
- “Some are [respectful] but that seems to be because they’ve made an effort to learn. Others see it as an optional interest, which it shouldn’t be.”
- “Our lived experience is that GPs are not well enough informed, often not respectful and generally try to do as little as possible for our daughter.”

Another issue raised is about medical records. Many people raised the issue that NHS records often only allow someone to state if they are male or female only. Sometimes GP practices will ask is someone’s gender is the same assigned at birth. There are also no options for different gender markers/titles.

- “111 Service … There is no option to be counted and recognised as the person you are, only the sex you were assigned at birth. I understand the need for medical professionals to know this. However, I feel completely discounted as a human being in my identity when completing this online form. It would be better to have the option to self identify gender, even if that information isn’t used at all and goes nowhere behind the scenes, and still have the assigned at birth question … so the medical professionals get all the information they need.”
- “Have updated name and title but not gender marker on NHS record, though this was offered by my GP. When updating title I provided one that is not part of their system (Mx) and as a result the title section is blank on my record. Have had practitioners ask for my pronouns due to this, though many still default to an assumption based on my presentation, typically she/her.”

- “Not applicable as there is no option to change a gender to non-binary.”

A healthcare professional said:

“It is sometimes difficult when the gender recorded on the system does not refer to biological sex at birth. I feel it would be more appropriate to have gender at birth and current gender. It has health and treatment implications if staff do not have access to this information. There are potential risks to not having access to this information.”

Some people have changed their medical records and NHS number and have had mixed experiences. Some people haven’t tried as they fear what might happen if they do. Changing an NHS number and identity is very important for some people as part of their new identity. However, there are challenges for the person and for healthcare professionals to make sure that vital health information is carried forward into their new record. Further work is needed to make sure this process is simple and safe in both primary and secondary care.

Feedback included:

- “Yes, it took about a year to complete and there was initial confusion about whether it was possible from GP surgery staff. … Initially they gave me an invalid NHS number which had to be reissued but that at least was only a couple of weeks before completion. My records were not carried over in the way I’d have expected. They are not easily accessible to GP or hospital and I think are essentially drag and dropped as a single history entry. … Due to my records not carrying over, I had to tell the GP what medications I was on for them to prescribe. That is absurd that they couldn’t look that up.”

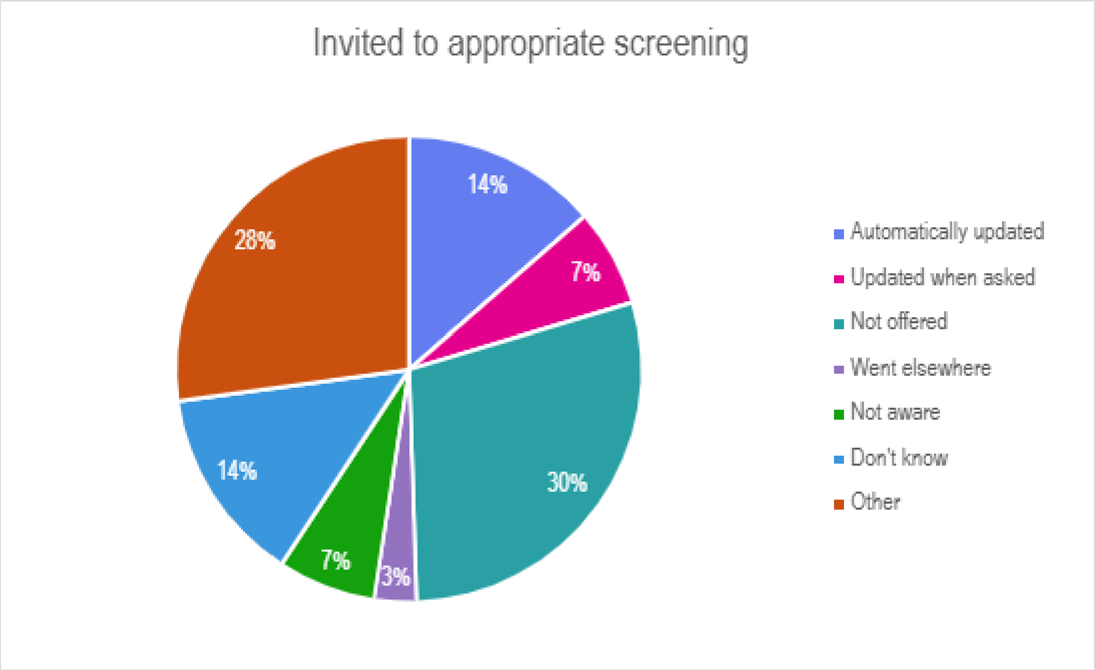
- “I have asked to do so but am told this is not possible/not advised as I will no longer be able to access or be reminded of cervical screening services. I have recently had cervix removed so will attempt to change again. This has caused issues as when interacting with receptionists/staff when looking up my health record as if they put a male filter on they fail to find me on initial searches which forces me to out myself to receptionists and other staff. Also, my title is not able to be changed to Mr with a female sex so I am forced to use Mx which confuses staff as they assume that I am non-binary and try to treat me as such.”
- “… the way it is currently done makes it extremely hard for me to continue the other forms of care that I need as it requires a whole new NHS number. This personally is a very outdated way of doing it. It means I have a sacrifice to make. I have spinal issues that are ongoing and I also have a vascular issue … that is currently being investigated medically. If I update my gender identity on my NHS record it means my NHS number will change and I will lose all records of the previous care that I am receiving and would potentially mean that I either have to start it all again or wait for an unnecessary amount of time to be able to recover and match the records to my new NHS number. Why we can't just change it on our existing record is beyond me. It would require simple and very quick IT skills to be able to do this and the NHS IT team throughout the county could get this done within minutes.”

Some GP practices have succeeded in changing records and carrying information over:

- “The receptionist at my GP was able to change my gender marker and link my records together.”
- “Yes, contacted by GP practice who asked if I wanted to have my gender marker updated. The practice admin undertook all of the

> necessary processes on my behalf, including updating my NHS record number… I believe that due to the IT system architecture, transfer of my records was problematic, but everything was eventually fully completed. I was very impressed with the service which I received from my GP practice."

We asked those people who had changed their NHS number if they were still invited to appropriate screening related to their sex assigned at birth. It was a mixed response with 14% saying it was automatically updated, 7% getting it addressed when they asked, 30% of respondents not having been offered this and others not sure or seeking screening independently.



Training

Our feedback highlighted people's perception of a lack of training and understanding around transgender, non-binary and intersex identities. This included the issues above including not using the correct pronouns, deadnaming, general comments about making the patient feel nervous and uncomfortable to express their gender identity.

We heard through the healthcare professionals survey and throughout the feedback from trans, non-binary and Intersex people that often healthcare professionals were wanting and willing to learn and help, but had to get the patient to teach and educate them.
When asked what training healthcare professionals get around trans, non-binary and intersex people, they said there is “no formal or mandatory training just optional e-training”.

When asked in the friends and family survey “Do you feel GPs and healthcare teams are well informed and respectful regarding trans/nonbinary/intersex individuals?” every respondent said either ‘no’ or ‘sometimes’. This shows that there is still a lot of work to be done around training and understanding.

Feedback from trans, non-binary and intersex people also demonstrated that they felt there was a lack of basic training stating, “they often fail to meet the low bar of getting pronouns right”. 64% of trans, non-binary and intersex respondents said they didn’t feel that GP practice staff know how to support them in relation to their gender identity.

Positive experiences highlighted the difference when a healthcare professional was informed: “the GP I have now is great and actually listens to me. She has done her own research and is helpful”.
It is important to recognise that not every healthcare professional is doing harm, and a lot of healthcare professionals do not want to cause harm. Training and understanding is important so healthcare professionals gain a deeper understanding of the medical processes and treatment of gender care but also the language used and what gender dysphoria is really like for people.

People also told us:

- “No-one seems to understand even a little bit what HRT is and what it does.”
- “I don't feel comfortable disclosing my gender to GPs when dealing with "women's issues", as GPs are often confused.”
- “Trying to book a routine cervical screening examination at my local GP surgery - the only option at the time was to telephone the surgery and ask for an appointment. I have a very male gendered name and a deep voice following hormone treatment. It took a lot of courage to call in the first place because I was worried about being challenged by the receptionist about needing the appointment, which is exactly what happened. I found this very difficult and triggering having to explain myself to the receptionist and convince her I needed the appointment. She would have benefited from some sensitivity training.”
- “According to most people in the NHS I am female despite having a non-binary identity. Non-binary doesn’t exist in most settings including GP, hospital, most mental health services. It’s just not worth potential conflict correcting people on ‘actually they/them, I’m non-binary’.”
- “Some are more informed than others. I’m aware that for the vast majority, they have had very little/no specific training in this area just like many other highly specialised areas. I don’t expect my GP to know everything. It is my belief that many GPs simply do not feel sufficiently qualified themselves regarding gender identity issues.”
- “You can immediately tell those who are genuinely happy to deal with trans, nonbinary and intersex people. The rest, at the best case scenario, will exhibit the following types of behaviour (one at a time or, possibly, combined): they will start by smirking suggestively, then move to trying to blame you or your gender identity for your current 'secondary' health issue. Always demonstrating that you are wasting their precious time

> with the whole 'basket case' of your existence. … please train your staff. Until then, only those who are trained and relatively sympathetic should be dealing with us.”

Heavens no. When I first came out my GP asked me if I really wanted to be a woman since from her perspective it seemed to be much worse, which was honestly such a baffling comment - I like that doctor a lot and know it was meant sincerely, but it speaks volumes about how clueless even good GPs can be. GPs are criminally undertrained when it comes to gender dysphoria and the transition process and have to be talked through every stage by patients who usually know much more - a good GP is one who listens to the trans patient and a bad one is one who refuses to allow them access to HRT or referrals to necessary services, but I never expect a doctor to actually know what to do themselves.

One healthcare professional completed a training session delivered by a trans woman and found “… I felt reluctant … to raise any of my concerns. I would have much preferred training from a disinterested trainer where I could have openly discussed my views.”

Another healthcare professional felt that training on gender care should be mandatory.

Waiting lists

Waiting lists for NHS gender clinics (GICs) have reached up to 20 years in some cases, far exceeding the 18-week target. Leeds GIC (the closest one to York) is currently seeing people who joined the waiting list approximately five years ago. This has led to local speculation that those joining the list now may also face waits of 15-20 years. Many highlighted the lack of support for people waiting years for an initial appointment. Over two-thirds, 69%, of trans, non-binary and intersex respondents said they had not received any support while waiting.

During their time on the waiting list, a lot of people seek alternative/private care to get hormones and gender treatment.

- “During my five years on the GIC waiting list I paid for private gender treatment, including blood tests and medications.”
- “Seven+ year wait list to access gender clinic plus further waits for treatment.”
- “I am on the waiting list for gender affirming care and expect to be so indefinitely.”
- “I’ve still yet to even get a single NHS gender clinic appointment despite being on the waiting list for more than seven years.”

Support people told us they were offered while waiting included:

- A talk about what to expect from the GIC and what they offer.
- Newsletters/leaflets.
- Occasional conversations with an outreach worker.
- Online information.

The support people said they would find helpful while on the waiting list included:

- Updates (knowing where they were on the waiting list).
- Mental health support.
- Support groups.
- Access to other forms of gender care such as vocal training and laser hair removal.
- Check ins with the GP (even once a year or every six months) to discuss where they’re at with their mental health and on their transition journey.

When asked to share any positive experiences people had had once they had reached the GIC we were given very few and heard some disheartening stories.

> After five years, I got my first appointment, arrived early and sat waiting to be seen. Thirty minutes after the appointment time I was still waiting. I asked why. Apparently, the nurse came out looked around and saw me and thought I was the wife of someone else being seen at the hospital. Clearly, he was looking for a man in a frock … I had three appointments and the only thing I needed was some NHS electrolysis. They said I couldn't have that … and I was discharged after that saying I didn't need their help, and I was well adjusted.

Family and friends added some comments including:

- "Waiting times are obscene and for suicidal teenagers even five years … may as well be never."

Shared care

Currently, there is no formal city-wide shared care arrangement for the treatment of trans and non-binary people in York. One healthcare professional respondent said: "Absence of a Shared Care agreement to allow prescribing is causing a great deal of distress to trans patients".

Another healthcare professional added: "Lack of a specified service for prescribing/monitoring hormonal treatments. Clinics have expertise but insufficient resource. Primary care is not resourced. Patients become stuck in the middle".

A limited number of trans, non-binary and intersex people have had shared care from York GPs historically but the numbers are declining. People have reported that these historic agreements, including blood tests for monitoring when someone is getting their own hormones, are now being cancelled and people are being discharged. GPs report feeling that they are in an “impossible situation” - they don’t have the training or support to provide these services and therefore do not feel it is safe to offer shared care but know this leaves people without vital healthcare.

In 2023 the Humber and North Yorkshire Integrated Care Board (ICB) published its Pride in our Health report.[18] One of the report’s recommendations was to: "Support primary care to establish and agree LGBT+ principles of good practice so that models of shared care between GenderGP services, other private trans health care and NHS GPs can be validated and maintained". This project has shown that the ambition of the recommendation is still needed. This is reflected in our recommendations.

Trans, non-binary and intersex people said:

- “I asked my GP to do blood tests and prescriptions, but they still refused because they no longer do shared care. So, I am still stuck paying for (somewhat inadequate) private care, and for the whole time have been dealing with anxiety that the government might make efforts to shut down even that route to care.”
- “I am trans, and trying to get shared care with my clinic has been really difficult. I am "lucky" because my surgery … will do blood tests for me, but they will not do shared care so I have to pay for my own testosterone. The people working there that I see for appointments are very supportive, and do not

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[18] https://humberandnorthyorkshire.icb.nhs.uk/wp-content/uploads/2023/05/Item-8-Pride-in-Our-Health-Report-Final-.pdf

discriminate against me but the organisation and bureaucracy that forbids them from being able to give me shared care does.”

I have faced multiple barriers to healthcare because of who I am and what I am. I have faced unnecessary refusals, gatekeeping and barriers to the simplest of healthcare for who I am. Transgender healthcare is not a specialist requirement. It is relatively simple in terms of care especially after a formal diagnosis of gender dysphoria. After this diagnosis it is a case of prescribing HRT and monitoring blood results to maintain a safe regimen of HRT. This is not specialist medical care. This is basic medical care, which is so basic that people DIY it themselves, learn how to interpret their own blood results and are able to administer their own dosages and injections and many people do this successfully. I have been on the receiving end of rejections for even shared care with other NHS services who specialise in transgender healthcare simply because of "practice policy". … If other places in the country can provide LGBTQ+ healthcare on an informed consent model, then York should be able to too.

[X practice] stopped prescribing my HRT out of the blue. There was no medical reason, I'd been prescribed it for years with no issues. They said it was a funding issue. Almost every other GP in York then refused to prescribe my HRT. I was under the care of NHS gender clinics who'd recommended this treatment for me since 2019. [X practice] cut my treatment just before Christmas, six months after my partner killed themselves, and I was really fragile at the time. I didn't find out I could have my HRT back from [a different practice] until they could see me at the end of January. I had panic attacks every day, nightmares about becoming a man, and after a month I'd started to make suicide plans. … It felt like no doctor valued the importance of these treatments, and it had become so politicised, that they'd cite that they're doing it out of concern for my safety due to them not being trained in this area. I'd die without my treatments. I'd recovered from gender dysphoria and was happy with myself and considered it dealt with. I'd made so much progress mentally from my partner's death, all of it was lost in a single text message from a doctor. A week before it was taken away, I'd told my mum that I was still grateful in life because at least I had access to my HRT … Seeing me completely mentally degrade made my parents pay for me to have bottom surgery, which cost over £20,000, just so that I would never have to worry about my testosterone coming back because a doctor will refuse to prescribe the blockers. …"

Family and friends of trans, non-binary and intersex people said:

- "I am aware many trans people are not getting the healthcare they need. Many are going to private providers, unregulated sources of medications that they are not taking under medical supervision."
- "Access to healthcare is another difficult topic as they often have to battle to get hormones, whilst they have shared care there is the constant threat that it will be withdrawn."
- "… In the end we, her parents, paid for her to access gender affirming care in London and also via Gender GP because of the barriers – prior to this desperation she ordered hormones from the internet which turned out to be very risky. After she was left a legacy from my parents she was able to medically transition and have gender affirming surgery. This has been a life saving process – she would not have been here without this…"

Healthcare professionals added:

- “Absence of a Shared Care agreement to allow GID prescribing- causing a great deal of distress to trans patients. Working to support improving access to cervical screening for LGBTQ+”.
- “Complexities around prescribing hormonal medications and extremely long waits for referral to gender clinics.”

However, one person told us that holistic healthcare for trans people is possible in York and they are receiving it. They explained that they have and continue to receive shared care for hormones, including blood tests all within General Medical Council guidelines. The person feels that their experience demonstrates that effective care can be provided and is happening thanks to supportive healthcare professionals who prioritise the health and wellbeing of their patients.

Wider feedback

GP practices

GPs are often the first line of call for people seeking gender affirming care so how GPs respond and handle this is very important and impactful on the individual seeking the care.

Almost all our survey respondents (91%) had been in touch with their GP practice in the past two years. When asking trans, non-binary and intersex people about their experience with GPs we got a mix of responses. 70% of respondents felt comfortable and safe in disclosing their gender identity to their GP practice. Some people felt it isn’t always relevant to share the information and others found it difficult to fully trust GPs in disclosing their gender identity: “Generally, I don’t share my gender identity with GP/work due to anxiety surrounding how they would react and finding most still default to seeing me as my assigned sex at birth”.

We also got responses from people that were concerning:

- “I avoid doctors.”
- “I am scared they will deny me healthcare, or take away my existing healthcare.”
- “I worry this [my gender identity] would be held against me and would muddy the waters when trying to get treatment for issues like PCOS (polycystic ovary syndrome).”

As above, we have heard from non-binary people that they feel their gender identity is not recognised or understood:

- “My GP practice doesn’t record non-binary identity or pronouns, there is no official record of my gender identity on my NHS record, I’d essentially have to come out to whoever I speak to every time to tell them, and this would take up time and make me anxious”.
- “To the GP I am female as it’s easier than explaining every time that I’m non-binary”.

There have also been some positive experiences spoken about where patients have been grateful with how they’ve been treated by healthcare professionals.

- “Most GPs and nurses, although not always clued up on terminology or equipped with an in depth understanding of gender identity, have been brilliant. I recently submitted compliments around my latest cervical screening appointment. The nurse was open in saying that I was the first transgender patient she'd done screening for but could not have done more to make the appointment as comfortable as possible. She acknowledged that it must be crap for me having to attend, she took every step she could to reduce discomfort (both physical and emotional) and was just generally a lovely person who treated me with kindness and compassion”.

- “Everyone I have encountered at the practice has been fully supportive and accepting, including admin staff, receptionists, practice nurses and GPs.”
- “I prefer to see one particular GP as she is particularly good with this and I have been seeing her for many years now, since coming out to her as trans.”
- “The nurses know exactly how to handle the support they give and so do the doctors.”
- “The GP I prefer to see … has been fantastic over the years and helped enormously, particularly at the beginning of my transition. I think it was in 2013/2014 I wanted to ask for a referral to the gender identity clinic and visited the GP three times for spurious reasons before plucking up the courage and mentioning in passing on the way out of the appointment that I’d like a referral to the gender identity clinic. The GP could clearly see I was very anxious, brought me back in and sat me down taking the time to get to the bottom of why I was really there. She then was very honest with her knowledge of the subject at the time and wasn’t sure of the referral procedure but said she would find out but had experience with trans patients elsewhere. She made an unbearable time in my life feel like it would be okay. From that moment on, I made appointments for all my health issues with this GP and had full confidence in feeling safe and supported.”
- “When I had my first appointment with the GP practice after I moved, the GP checked with me what my preferred name and pronouns were.”
- “x practice will always use my correct name, my correct pronouns and the nurses I see there are always very supportive and complimentary too. They have very good humans working for them. I say "humans" because it is not

the title of "doctor" or "nurse" that makes a genuinely decent person. It is the person themselves."

Friends and family of trans, non-binary and intersex people said:

- "The GP practice I spoke with seemed very supportive, and they expressed frustration with the system and that they were not able to provide the care and services they would like to, but nevertheless, were doing what they can. I hear other practices vary, some are supportive, some not so, and it depends on the individual GP and admin staff that people speak with."

However, one person also highlighted the impact of a lack of continuity of care: "The lack of continuity in healthcare teams/professionals has at times formed a barrier."

Self-prescribing hormones due to lack of help from GPs was mentioned frequently. "All GPs need to do is prescribe and monitor bloods to see that they are in a range that's given by endocrinologists who specialise in this area, the GPs aren't required to make decisions on treatment. Bluntly, I could be my own GP at the stage I am at … they've forced trans people to become their own doctors".

When we asked trans, non-binary and intersex people what their ideal GP surgery looked like, many reflected the comment: "where they just respect who I am".

Other suggestions reflect the key themes outlined above and included:

- "A form to easily notify of name and pronoun changes. Preferred name and pronouns always used by all staff. Ability to specify non-binary as a gender marker on record. Not asking invasive questions. Not denying healthcare."

- "They would work positively with Leeds Gender Identity Clinic about hormones and prescribing. … There should be more public information about them supporting trans and non-binary people and actions to show their support. And they should be more aware about trans people and issues."
- "I would like for my GP to provide the blood tests requested by my endocrinologist, and to be prescribed my HRT by the GP under the guidance of the endocrinologist."
- "Taking the time to listen and not assume everything is actually about gender issues."
- "Having well-educated, empathetic and supportive practitioners and receptionists who can help guide you through the process and feel confident in doing so. More GPs should also state whether they are trans inclusive or not, so that trans patients know they are entering a safe and supported practice before registering with them. By 'inclusive', this could include a section on their website explaining policies or resources."
- "To be seen only by trained people."
- "Making sure that Mx and "no title" are options on the intake form; having boxes for both legal name and preferred name on the intake form; having options to choose which anatomical parts you still have and would like to be reminded of care for (ie invited to smear tests, etc) on the intake form, and having that be something that GPs are able to update throughout your time with the surgery; having options for both standard pronouns (he/she/they) and also a write-in box on the intake form. Ensuring that surgeries are also familiar with prescribing and being responsible for HRT prescriptions, rather than forcing split care. Having surgeries be willing to discuss things like hystos or salpingectomies for trans folks without defaulting to recommending the GIC (given GIC waiting lists)."

Hospital services

We asked trans, non-binary and intersex people about their experience of York hospital including A&E, outpatient appointments and inpatient care. Not as many people had accessed hospital services as GP services.

Of our respondents, 48% had been to A&E in the past two years; 59% had had an outpatient appointment and 18% had been an inpatient.

We asked if services used people correct pronouns and correct names:

Service	A&E	Outpatients	Inpatients
Correct pronoun always used	48%	52%	38%
Correct name always used	62%	60%	88%

Other responses were never, sometimes or not applicable.
Similarly to GP services, feedback reflected some very good and kind staff and some rude staff who refuse to use people's correct pronouns or name.

In terms of A&E many of the comments were positive:

- "Yes, the nurses I have seen have always been discreet and understanding. They have asked for example how I would like to handle having cardiac monitoring leads attached for the ECG, am I okay taking my shirt off or do I want to put them on myself, etc."

When we asked what a good, gender informed, A&E service would look like most comments related to making sure staff use people's correct pronouns and name. People generally said they want to be treated like any other patient, with dignity and respect.

The main issues raised in terms of outpatient appointments were about people's correct pronouns and name being used. One person also explained an extreme reaction from a clinician when they realised the person had had gender surgery, even though previous surgery had no bearing on what they were being treated for.

Again, some people had positive experiences:

- "The staff at York hospital during my visit and incident there (I passed out and a team was called in) was absolutely amazing. The staff there are brilliant, all of them. Not a single one of them mis-gendered me or used my incorrect name. They treated me with the utmost respect. Even complimenting me. All they cared about was my wellbeing and health, they had nothing against me and only had wonderful things to say to me/about me. I have never been treated in such an amazing way by medical staff before in my life. That team (MRI and the team that was called on) was a picture-perfect example of how a medical facility should operate."
- "The nurses who redid my dressings a few days after my surgery were super lovely and made sure to invite me to have my first look at my chest after surgery, because they know from experience how important that moment can be for trans folks. They were really friendly and cheerful and made sure to let me know what to look out for while I was healing - they were just lovely people, and I wished in the weeks afterwards that I could have remembered their names so I could have left feedback."

When asked about what a good outpatient experience would look like, most people reflected the above good practice and wanted it to be the situation consistently. One person suggested that ‘My name is …’ badges should also display someone’s pronouns.

We also asked about experiences if people had been inpatients. Only eight respondents had been inpatients. The negative comments related to being misgendered, the person having their trans identity publicly visible and being asked intrusive questions about gender identity when it was not related to the reason they were in hospital.

Some people reported positive experiences. These were often related to kind and understanding staff: “The cancer ward have always treated me well with compassion and respect! I appreciated it a lot! It made me feel safe there.”

When we asked what a good inpatient experience would look like, people again said having correct pronouns and name recorded and consistently used. Another person added: “I want to feel safe and be in a ward that matches my lived gender identity. I do not like being in isolated rooms in inappropriate places … I would feel much better in a main shared ward that matches the identity I have been living fulltime in for the past 22 years.”

We have heard that a number of initiatives have happened at York and Scarborough Teaching Hospitals NHS Trust to raise awareness of issues for trans, non-binary and intersex patients and to improve facilities and services. These include:

- Activities within the LGBTQ+ network.
- Better signposting for visitor toilet facilities across main hospitals.
- LGBTQ internal communications campaigns – themed key messages within a set period.
- The Trust’s Accessibility Hub: https://www.yorkhospitals.nhs.uk/accessibility-hub/ which

provides information about how someone can request reasonable adjustments and provides information about accessibility features.
- Community events including a Trust presence at York Pride and Scarborough Pride with staff nurse 'Ivy Drip' leading the way.[19]

Mental health and neurodivergence

We asked survey respondents about other protected characteristics and whether they face additional barriers due to this – often called intersectionality. 77% of trans, non-binary and intersex respondents identified as neurodivergent; 65% identified as experiencing mental ill health and 35% as being disabled.

When we asked specifically about intersectionality, 48% of survey respondents said this was relevant to them.

It is important to understand that this intersectionality compounds the challenges that people experience. For example, Clinical Partners in discussing the overlap between neurodivergence and LGBTQ+ identity state that:

"In the case of LGBTQ+ and neurodivergent groups, both communities already face higher rates of anxiety, depression, and discrimination that can lead to trauma. When someone belongs to both groups, those risks can increase. Making an effort to hide differences when accessing care can take its own toll on mental health over time, so support that affirms both aspects of a person's identity is essential.[20]"

Responses about this varied and demonstrate the complexity of intersectionality for trans, non-binary and intersex people and for

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[19] https://www.facebook.com/YSTeachingNHS/posts/staff-from-across-the-trust-enjoyed-a-wonderful-day-out-at-scarborough-pride-on-/880858097480927/

[20] https://www.clinical-partners.co.uk/insights-and-news/autism/is-there-a-link-between-neurodivergence-and-the-lgbtq-community

healthcare professionals. For some people there are clear links between their gender, being neurodivergent and/or experiencing mental ill health as all are elements of them as a whole person. Others express frustration that connections are made where they don’t feel that they are appropriate. We have also heard from people who have been told that they can be neurodivergent or have gender dysphoria, not both.

It is clear that more research exploring effective holistic support and positive impacts on mental wellbeing is needed in this area.

People told us:

- “I find it hard to untangle gender identity from autistic identity. Overall, I just want to feel safe and believed and supported. Online there is so much information about interconnected conditions and comorbidities and yet the GP doesn't seem knowledgeable or interested. My health care moved on the most a few years ago when I had a lovely and thorough student doctor and I felt that her training was more up to date or had included more about the issues I face.”
- “Oftentimes because my gender presentation isn’t overwhelmingly stereotypical, I have been put aside and told that this ties into my neurodiversity and/or some other area of my psyche.”
- “I have felt in the past that I couldn't access support for mental health as this would interfere with my interactions with the GIC.”
- “To access “mental health counselling” I’ve been advised that gender has no connection with symptoms of depression and should ignore it for the sake of finding the root problem. It’s generally led to me feeling dissociated with gender as a concept.”
- “I think autism and also being perceived as a female of a certain age impacts how I am treated (or not treated).”

- “I think some medics - even therapists and psychologists - make judgements, for example, since you have ADHD … they arrive at an irrational judgement that you want to, or did transition because of the ADHD or autism and not because you have/had gender dysphoria (GD). There are many neuro-typical people with GD and many neurodivergent people who do not have GD. There is no direct correlation but even the report done on the Tavistock and Portman stated it as fact. Ergo, the medics' ignorance of the subject causes them to reach erroneous conclusions about treatment pathways.”
- “Find that only one element of identity is acknowledged if at all.”

  “Being black and trans means doctors don’t really understand how symptoms could present differently because of my different race and them not taking my gender identity seriously.”

  “People assume my mental health is due to singular factors rather than the whole picture of neurodivergence, trans existence, non-binary erasure, workplace stress
- “I suspect I have autism and/or ADHD but do not want to get assessed because I am concerned about a diagnosis making it harder to access HRT and other gender services through the NHS.”
- “It can be very hard to have mental health stuff taken seriously outside of trans things, and vice versa. "Oh you're just depressed right now; once you're feeling better the gender feelings will go away" or "Oh, all trans folks are depressed, that's just part of the trans experience." It can often feel like because there are high proportions of the trans population who do face mental health struggles, that those are just something you have to deal with if you "opt in" to being trans.”
- “Sometimes there are links between my overlapping experiences, but more oftentimes there are not. It would be good to be heard and taken seriously in my opinion whether they are linked or not. I mentioned briefly before that my experiences of being trans throughout other aspects of my life are cumulative.

This is the same for my experience of being disabled, neurodivergent etc. When you add all of these experiences together through everyday life, it can make day-to-day life difficult to navigate and exhausting. …”

- “The GP at [x practice] told me they can't refer me to mental health services because I'm trans and they don't help with gender dysphoria, and ignored entirely that I might have mental health issues separate from gender dysphoria, and I was just prescribed anti-depressants which I didn't take. This was back in 2022, she then misgendered me in all my notes and made me feel way worse.”

Family and friends of trans, non-binary and intersex people said:

- “Her intersectionality is far from the reason she feels fear and marginalised – being neurodivergent is much more accepted than being trans and it is less stigmatised, and the ‘debate’ is far less toxic.”
- “Medical professionals often blame everything on autism, so they don’t have to provide any help or intervention.”

We asked about people’s experience of accessing mental health services. 61% of trans, non-binary and intersex respondents had accessed mental health support in the past two years. Of those, 67% had done so via their GP practice, 37% via the Community Mental Health Team, 29% via the crisis line and 15% through another service. Other services mentioned included talking therapies and private providers.

Feedback about experiences was mixed. Many respondents talked about being misgendered or the wrong pronouns or names being used. As above, others also struggled to get the right care related to the issue, rather than their gender identity.

Comments included:

- “Sometimes my trans-ness is zeroed in on as the cause of my distress - it’s usually my neurodivergence.”
- “Didn’t use my name or pronouns. Didn’t feel like I had a chance to talk about my identity at all and was afraid that would cause me to be treated differently.”
- “I tried using the local NHS service. They told me the practitioner was supposedly specialised to deal with trans people. I never heard so many outdated ideas packed into one session, e.g., 'Do you hold your mother or your father responsible for your condition?'”
- “I've had therapists who aren't educated/interested in gender issues, and have felt unsafe discussing this aspect of my identity.”

Some people shared positive experiences:

- “Genuinely the best medical experience I’ve received is with my current therapist. She’s been so kind and thoughtful of who I am. My trans-ness has never been an issue.”
- “Mental health staff are generally very good with dealing with LGBTQ+ issues from what I have experienced.”
- “Most recently they have done what I needed and recognise the link between mental health and gender. They can see my gender dysphoria and the fact that by wanting to rip my body apart there is an impact on my mental health. The new staff understand and are trying to reassert what I need to their managers.”
- “Mental health services through my GP practice have been generally positive if a little short-term, addressing the relevant mental health problems without associating everything with my gender identity.”
- “The last batch of mental health help I've had finally got me to a place where I feel like I've healed from past trauma.”

Comments about what a good mental health service should look like reflect the positive comments above, asking for a gender informed service that treats people with respect. Comments recognise the complexity of intersectionality. They included:

- "They should be more welcoming and actively promote / display signage about supporting trans and non-binary people. They should also ask about the best way to support people, including not shouting out names in waiting areas when that is not appropriate."
- "The ideal service would fully understand what gender dysphoria actually is, how it works and what it can do to the mental health of a person suffering with it. They would know how to deal with it and know what to do and what sort of help to provide. Take GeneraTe as a prime example of exactly how this works."
- "To understand the complexity of mental health, to not associate it all with gender dysphoria, recognise how these issues can act adjacent to each other. To address me in my gender identity and not part patronise me. Don't assume I'm neurodivergent, I'm not, and even if I was, I shouldn't have my identity belittled because of it."

Feedback from friends and family

Many of the comments from trans, non-binary and intersex people's friends and family are included above. However, there were other comments that we wanted to include:

- "It worries me greatly what is happening to trans people. They are experiencing the greatest attack and erosion of human rights I have ever seen in the UK."
- "… fear for their safety. … I am almost consistently hypervigilant when they go out, particularly if it involves public transport."
- "It feels lonely being the parent of a trans adult child."

We asked friends and family about any support they had received or if they would approach healthcare professionals for themselves. Responses included:

- "I don't feel they have the appropriate services or training to help."
- "Whilst I've tried to do this, I have ticked no because my GP could not have been more disinterested if they had tried!"
- "Trying to use the correct language without proper guidance and conflicting information is [difficult]."
- "Intersex or VSDs/DSDs – there is very little knowledge, understanding, experience etc in general society, in healthcare settings and in education settings etc."
- "There is no NHS support for family members … you need an organisation you can trust."
- "[We need] someone to talk to who is not judgmental. Someone who can tell me what the NHS provides for my family member including timescales."
- "Leaflets/booklets or websites with correct, unbiased information would be helpful."
- "It would be helpful to know what is available locally and nationally for trans people… What services are local GPs and other providers providing?"

For those family and friends where their family member or friend is currently undergoing hormone therapy, only 36% feel they are informed about what hormone therapy is and how it works. Everyone said it would be helpful to have information for friends and family about gender affirming healthcare. When we asked if there are enough support services or groups for family members 42% of respondents said no and the same number said they weren't sure.

We asked family and friends where they go for information and support. Most (75%) looked online, 67% were in touch with friends or peer networks, half were in touch with local or national charities, half used social media and 42% accessed books or podcasts. One person commented about finding information:

- "It really depends where you go. Our GP has been next to useless with our family member so I don't ever go there about that. Some of the groups such as the Good Law Project, Transactual, Mermaids etc re good sources of information. I follow trans activists online and find that helpful, though heartbreaking at times. … Statutory information is awful and non-existent as is healthcare support for either our family member or us as a family."
- "There is basically nothing for parents who are not ready to accept the idea that being trans is OK."

Feedback from healthcare professionals

Many of the comments from healthcare professionals are included above. However, there were other comments and information that we wanted to include.

All the healthcare professionals who completed this survey identify with the same gender they were assigned at birth. Half of the respondents worked in primary care and half at the hospital.
Most 87% of healthcare professionals had provided care/treatment to a patient that they knew to be trans, non-binary or intersex.

We asked how confident healthcare professionals feel about providing general care to trans, non-binary and intersex people. Half said quite confident and half, extremely confident. We then asked about providing gender affirmative care/treatment; 12.5% said extremely confident, half said quite confident, a quarter said somewhat confident and 12.5% said slightly confident.

One respondent wanted to ensure that gender critical views are acknowledged:

- “Yes, this is difficult for me. My beliefs are gender critical. … I believe it is not possible for a human to change sex. … I would happily see the whole field of gender treatment removed from NHS services.”
- “I think gender affirmative care is an intervention that has not been adequately evaluated on many levels: medical outcomes, legal situation, human rights (my right not to be compelled to say things I don't believe vs the patient's right to be addressed in their preferred manner), logical consistency.”

However, most healthcare professional respondents felt their role is to best support their patients, including trans, non-binary and intersex people:

- “As a practice nurse I regularly see trans/non-binary patients for hormone treatment. It is essential to have that continuity of care and I genuinely look forward to my appointments with my regulars, which I hope they do too. This continuity builds a great rapport, trust and respect between us, making us a great team!”

Only half of our healthcare professional survey respondents said they could signpost people to voluntary sector support. Most respondents would welcome information about services and how to refer people to them.

Experiences from other areas

In our research we looked at healthcare services and support for trans, non-binary and intersex (tnbi) people in other parts of England compared to the service in York. This looked at health services and wider support.

The other areas we looked at were suggested as part of the project. We found:

	TNBI[21] support/info on local council website	Some GP practices awarded 'Pride in Practice[22]'	Easily accessible TNBI information on health service websites	Local LGBTQ+ support groups	Local Gender Identity Clinic
Birmingham	✓	✓	✓	✓	✓
Brighton	✓	x	x	✓	✓
Manchester	✓	✓	✓	✓	✓
York	x	x	x	✓	✓ (Leeds)
Bristol	✓	✓ (one)	x	✓	✓
Nottingham	✓	x	✓	✓	✓
London	x	✓	x	✓	✓

The Sussex trans health hub

We spoke to one of the practitioners at the WellBN Trans Health Hub[23] in Sussex to better understand their approach and how it had developed.

The model is a hub that offers trans affirmative healthcare for anyone in Sussex. It will provide treatment, including hormones for anyone following informed consent and a referral from the local Gender Identity Clinic. The initial idea was to have trans champions in every GP practice in the county

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[21] Trans, non-binary and intersex

[22] https://lgbt.foundation/help/pride-in-practice/

[23] https://www.wellbn.co.uk/trans-health-hub/

supported by a comprehensive training programme. However, as soon as people and GPs knew about the expertise at the WellBN practices, the model shifted to the hub approach.

Patients were more confident going to a GP practice that had trans staff members and clearly understood and supported trans, non-binary and intersex people. Other GP practices were much happier to refer people into a service with specialist expertise that they did not have.

The hub model was developed in partnership with the local ICB as part of work to reduce health inequalities. The hub offers holistic services for trans, non-binary and intersex people including hormone treatment and monitoring in partnership with the local Gender Identity Clinic as well as:

- Cancer screening, sexual health, and fertility services.
- Expertise and support for intersex issues.
- Mental health awareness and support.
- Support for additional issues including neurodivergence.

The service now supports 2,500 people across Sussex and has developed a partnership with Somerset ICB to provide gender care to Somerset patients funded by Somerset ICB.

Lily’s experience in north London

We spoke to Lily, a trans woman from north London who transitioned in 2015.

After visiting her GP, they referred her to the Gender Identity Clinic (in central London). There was a one year wait for her first appointment. This worked well for Lily as she hadn’t decided if she wanted to transition, if she wanted hormones or surgery. The year gave her time to consider the pros and cons of what she wanted. She was referred to a counsellor in the first year which was helpful.

Within two months of the referral, she spoke to a doctor at the GIC. At the GIC appointment a year after referral she spoke to a doctor who confirmed she was a transgender woman and agreed that she should start treatment. They explained that there would be a wait for treatment. It took three years for her to get the treatment. She was not told how long she would have to wait, just not to expect treatment soon.

During that wait, she was offered counselling (in central London) and voice training (which she had already been doing). Neither was useful for Lily, but she recognises that they could have been helpful. She had previously received counselling and by the GIC appointment she just wanted treatment not more conversations.

The longer she waited, the more frustrating it was (partly as she did not know how long it would be) and the last four months were the worst as she felt the wait was going to be indefinite. This delay related to Lily’s GP practice getting things set up to prescribe the treatment for her. She also felt somewhat pressured by a professional to go to a clinic to freeze sperm. She was not allowed to start HRT until it was done. This added an extra six months of waiting. She understood that HRT would make her infertile but would rather have started HRT sooner. She was clear that she had no desire to have children. But she was convinced to go through with it because she was told "you don't know if you will feel that way in the future and you are quite young". The process was ultimately in vain as she did not have the income to pay to have her sample retained for more than the allotted five years that was paid for by the NHS.

Lily was the first person at that practice to transition and so they were not sure what to do and needed help from elsewhere. They did call Lily twice to apologise and throughout they have been helpful and used the correct pronouns, name etc.

She was not given any choice as to the manner of HRT she got given (pills/injections/patches etc.) but doesn’t feel that has been a problem.

Once the prescriptions started there have been no problems. Lily’s local GP provided injections, with the prescriptions arranged through a local pharmacy. She had blood tests every three months, then six months and now annually and there have been no problems.

Lily has now been on medication for seven years and feels like one of the lucky ones. She has had no problems. She had supportive family, a supportive GP practice etc. She has not been misgendered and has successfully got a new NHS record. She does get invitations to screening for people assigned female at birth, but that is a minor thing.

Support groups and resources

York Support groups and information

- GeneraTe and GeneraTe Plus - https://generate.org.uk/
- York LGBT Forum - https://www.yorklgbtforum.org.uk/
- Over the Rainbow Café - https://otrcafeyork.wixsite.com/over-the-rainbow
- The Portal Bookshop - https://the-portal-bookshop.square.site/
- York Carers Centre - https://yorkcarerscentre.co.uk/
- Gender Identity Clinic, Leeds - https://www.leedsandyorkpft.nhs.uk/our-services/gender-identity-service/
  Gender Outreach Workers information and advice line: tel: 0800 183 1486, email: genderoutreachworker.lypft@nhs.net
- York Disability Rights Forum - https://ydrf.org.uk/
- York Mind Young People's Service LGBTQ+ group - https://www.yorkmind.org.uk/how-we-help/young-peoples-service/lgbtq-support/
- York Disability Rights Forum Quiet Pride - https://quietpride.co.uk/
- YorSexualHealth LGBT Services - https://www.yorsexualhealth.org.uk/our-services/lgbt/

Many employers and education settings also have LGBT Networks. Local examples include:

- York St John LGBT Network - https://blog.yorksj.ac.uk/lgbt/lgbt-york/
- York Hospital LGBT Network - https://www.yorkhospitals.nhs.uk/about-us/equality-and-diversity/
- University of York LGBTQ+ info - https://www.york.ac.uk/education/ed/lgbtqi-/

Other useful information

A toolkit has been created for families and professionals through a community-based participatory study. This explores the importance of family support in improving mental health outcomes for transgender and nonbinary youth. The toolkit includes co-created digital stories that share how open communication, shared reflection, and inclusive family involvement can reduce isolation, foster empathy, and build stronger connections.
Find the toolkit here: https://www.ttfntoolkit.com/

National helplines and information

The NHS is extending targeted support offer to anyone affected by the puberty blocker ban. Children, young people and their families can access this service by contacting agem.cyp-gnrss@nhs.net or calling 0300 131 6775 and selecting option three. Further advice can be found on the NHS website.

Switchboard provides a national LGBT+ helpline to discuss anything related to gender identity and sexuality. The helpline runs from 10am to 10pm every day of the year. Call 0800 011 9100, email hello@switchboard.lgbt or access the chat option via their website at: https://switchboard.lgbt/

Mermaids, a trans youth charity, offers a website https://mermaidsuk.org.uk/contact-us/ and hotline (0808 801 0400) for those in need between Monday and Friday from 1-8.30pm.

DSD (Difference of Sex Development) Families is an information and peer support charity for families. Every year around 150 children are born with differences of sex development. This means around 2,300 children are living with DSD in the UK. They provide a range of information resources and run two Facebook groups for parents. Read more at https://dsdfamilies.org/charity; find resources at https://www.dsdfamilies.org/resources; email info@dsdfamilies.org

Resources for healthcare professionals

As above, the British Medical Association, General Medical Council and Royal College of GPs all have information and guidance for healthcare professionals providing care for trans, non-binary and intersex patients. This includes:

General Medical Council - https://www.gmc-uk.org/professional-standards/ethical-hub/trans-healthcare#changing

- This includes information about how to make GP practices more inclusive, providing good general medical services, referring to a specialist medical service and more. The web pages include information about prescribing, confidentiality and medical records. The latter has information about changing medical records and ensuring someone receives screening appropriate to their sex assigned at birth.

British Medical Association – https://www.bma.org.uk/advice-and-support/equality-and-diversity-guidance/lgbtplus-equality-in-medicine/inclusive-care-of-trans-and-non-binary-patients

- This guidance includes information on terminology, core principles of supporting trans and non-binary patients, and actions practices can take to demonstrate a trans-inclusive approach. It also includes information on changing patient records, prescribing and more.

Royal College of General Practice:

- Position statement, March 2025: https://www.rcgp.org.uk/representing-you/policy-areas/transgender-care
- Guidelines for the care of trans patients in general practice from the RCGP in Northern Ireland: www.rcgp.org.uk/getmedia/18e6238d-6fff-

43c7-b027-e3fb2d718fff/RCGPNI-Trans-Patient-Guidelines-for-GPs-2017.pdf

In addition, there are other resources to support healthcare professionals:

- Practice Index gender identity toolkit for general practice: https://practiceindex.co.uk/gp/blog/updated-gender-identity-toolkit-for-general-practice/
- Primary Care Support England (PCSE) guidance on changing patient records linked to gender reassignment (and adoption): https://pcse.england.nhs.uk/contact-us/patient-registrations-enquiry-categories/adoptions-and-gender-reassignment

LGBT Foundation Pride in Practice scheme
The Pride in Practice scheme was established in 2010. The team has worked with over 1,000 primary care services across the UK, presenting over 650 accredited awards recognising excellence in LGBTQ+ healthcare. Practices must pay to access training and accreditation. (This is a paid for training and membership package and other schemes are available.) https://lgbt.foundation/help/pride-in-practice/

Recommendations

We have identified recommendations under particular health and other organisations below. We have also themed the recommendations under key headings:

- Respect, dignity and patient experience.
- Access to services, care pathways and reducing inequalities.
- Training, knowledge and professional standards.
- Records and administrative processes.
- Partnership working, community engagement and support.

There are not recommendations under all headings for each organisation.

NHS Humber and North Yorkshire Integrated Care Board (ICB)

Respect, dignity and patient experience

- Introduce an approach like the Accessible Information Standard where there is an obligation for every healthcare setting to ask about someone's gender identity, pronouns and the name they want to use; this is recorded on the appropriate system and that information is always used when interacting with that person in every way – face-to-face, by letter, email, phone and text.
- Promote the organisation's support for trans, non-binary and intersex people and include information about this on websites, in information etc.

Access to services, care pathways and reducing inequalities

- Implement the recommendations in the Pride in our Health report and particularly:
    - Support primary care to establish and agree LGBT+ principles of good practice so that models of shared care … can be validated and maintained.
- Explore the option to introduce a specialist GP-led multi-agency NHS service model for trans, non-binary and intersex people, similar to

the Sussex approach. This specialist service model could be a pilot for York with the potential to expand to the wider ICB region.

- Expand future phlebotomy Local Enhanced Services (LES) contracts to include blood tests and monitoring for trans, non-binary and intersex people as standard. This could include additional funding for a specialist GP-led service to deliver this or be part of the standard LES for all GP practices.

Training, knowledge and professional standards

- Implement the recommendations in the Pride in our Health report and particularly:
    - Identify and invest in training, education and resources to ensure that health care staff and professionals have sufficient knowledge to ensure inclusive policies and practices are developed and maintained across HNY. This should be consistently implemented across all health and care services.
- Work with GP practices to develop an approved private provider list – and from this develop shared care agreements with these agreed private providers.
- Make sure information is available for trans, non-binary and intersex people and for healthcare professionals about treatment options and what is available locally, regionally and nationally.
- Reiterate the necessity for healthcare professionals to follow existing guidelines for the treatment and care of trans, non-binary and intersex patients in line with the RCGP statement.
- Develop guidance for GPs about interpreting blood tests for hormone prescriptions to enable GPs to offer blood tests even if they can't offer shared care at the moment.

Partnership working, community engagement and support

- Work with the voluntary, community and social enterprise (VCSE) sector, to introduce support for people waiting for an assessment at the Gender Identity Clinic. This could include:
    - Therapy or options about how to access therapy if needed.

  - Vocal training or information about how to access this if needed.
  - Laser hair removal or information about how to access this if needed.
  - Peer support or information about how to access this if needed.
  - Regular/annual updates on where someone is on the waiting list/when they may be seen.
    - Information about accessing bridging hormones – this should be via the NHS if possible or accredited private providers if not possible via the NHS locally.

GP Practices, Primary Care Networks and GP Federations

Respect, dignity and patient experience

- Promote the practice's support for trans, non-binary and intersex people and include information about this on websites, in information etc.
- Join the Pride in Practice scheme[24] or other initiative.

Access to services, care pathways and reducing inequalities

- Make sure that trans, non-binary and intersex people have a named GP and see them where possible. This GP should be interested in and supportive of gender affirming care, trained and up-to-date on the latest information, services and research.
- GP practices should offer blood tests to monitor people on hormones, even if they are not prescribing the hormones.
- Introduce annual health checks for trans, non-binary and intersex people.

Training, knowledge and professional standards

- Introduce mandatory training for all staff that is tiered for roles and prioritised for patient-facing staff. Any training should include information about intersectionality.

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[24] https://lgbt.foundation/help/pride-in-practice/

- Make sure there are disciplinary processes in place and followed for anyone who does not follow the RCGP position statement and appropriate guidelines.

Records and administrative processes

- All new name badges should have an option to include people's pronouns, where someone has an existing name badge, practices should offer staff pronoun badges (widely available) and encourage staff to wear them.
- Make sure that trans and non-binary people are invited to all screening related to their sex assigned at birth.

Partnership working, community engagement and support

- Work with the ICB to make sure GP practices and staff have information about gender informed care and treatment options to inform their work and that can be shared with patients.

York and Scarborough Teaching Hospitals NHS Foundation Trust

Respect, dignity and patient experience

- Make sure people's confidential information remains confidential in healthcare settings whatever the situation. This includes ensuring people's records are not left where they can be seen by other people, information is not discussed in public settings or shared with other healthcare professionals in public settings etc.
- Implement the Trust transgender and gender diverse communities policy at all levels of the trust and review the policy every two years as outlined. Any breaches of the policy should be addressed under the Trust's disciplinary policy as outlined in the transgender and gender diverse communities policy.

Training, knowledge and professional standards

- Introduce mandatory training for all staff that is tiered for roles and prioritised for patient-facing staff. Any training should include information about intersectionality.

- Identify and investigate any disparities in patient experience for people who are trans, non-binary or intersex. Where appropriate introduce interventions to address these.

Records and administrative processes
- New ‘hello, my name is …’ badges should have an option to include people’s pronouns. Where someone has an existing name badge, the Trust should offer staff pronoun badges (widely available) and encourage staff to wear them.
- Encourage trans, non-binary and intersex people to identify themselves as such on patient records.

Tees, Esk and Wear Valleys NHS Trust

Respect, dignity and patient experience
- Promote the Trust’s support for trans, non-binary and intersex people and include information about this on websites, in information etc.

Access to services, care pathways and reducing inequalities
- Introduce more gender inclusive therapists who are trained to support people who are also neurodivergent.

Training, knowledge and professional standards
- Introduce mandatory training for all staff that is tiered for roles and prioritised for patient-facing staff. Any training should include information about intersectionality.
- Make sure all practitioners recognise that gender identity issues are not the same as mental health issues.

Records and administrative processes
- All new name badges should have an option to include people’s pronouns, where someone doesn’t have a new name badge, the Trust should offer staff pronoun badges (widely available) and encourage staff to wear them.

- Make sure there are disciplinary processes in place and followed for anyone who does not follow appropriate guidelines, eg GMC.

York Health and Care Partnership

Training, knowledge and professional standards

- Develop a signposting document/guide about where people can find support in York. This should include information about screening options and be coproduced.
- Develop a 'how to act' document for healthcare professionals interacting with trans, non-binary and intersex people.

Other local public sector organisations

Respect, dignity and patient experience

- Ensure your organisation, staff and volunteers follow legal requirements in the Equality Act and Public Sector Equality Duty to treat trans, non-binary and intersex people with dignity and respect.

NHS England / national level

While locally it is difficult to influence national policy, we feel there are a number of national actions that are a necessary part of improving local services for trans, non-binary and intersex people. We have included those here. Some of these recommendations also reflect those outlined in the Levy Report[25].

Access to services, care pathways and reducing inequalities

- Explore ways to reduce the waiting times for people after referral to gender identity clinics in line with the Levy Report recommendations.
- Clarify the commissioning of tertiary gender services following the abolition of NHS England.
- Implement initiatives to make sure there is no longer a postcode lottery for gender services across England.

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[25] https://www.england.nhs.uk/publication/operational-and-delivery-review-of-nhs-adult-gender-dysphoria-clinics-in-england/

Records and administrative processes

- Amend the gender options for all patient records so there are options other than male/female or an option to say that someone's gender is not the same as their sex assigned at birth.
- Widely promote the existing guidance about people having new NHS records and encourage primary care practitioners to follow the guidance quickly and efficiently when requested.

Partnership working, community engagement and support

- Instigate broader research into the experiences of multiple disadvantage and mental ill-health in the trans, non-binary and intersex community and the extent to which holistic support embracing all elements of a person's identity bring benefits to health and wellbeing.
- Instigate and encourage conversations about sharing good practice.
- Work with NICE to develop guidelines for care for trans and non-binary people, particularly in the context of treatment for anyone who wants to transition and would like medical support.

Conclusion

Despite the fact that the rights of trans, non-binary and intersex people are protected by law, many people have shared poor experiences of national and local health services. People told us that they can no longer trust the NHS to support their health and others are struggling with multiple year waits for gender specific services.

It is clear that trans, non-binary and intersex people often face health inequalities because of who they are and the discrimination and lack of understanding that they face in trying to access services for physical and mental health. The data, shared by the York Health and Care Partnership, about trans, non-binary and intersex people's experiences of mental ill health is stark. It is clear that something needs to be done.

However, while there is some way to go before all trans, non-binary and intersex people in York can experience consistent gender affirming care, people shared pockets of good practice and support from healthcare professionals who do everything they can to provide the support trans, non-binary and intersex people need.

Building on this good practice and supporting it with training and adherence to the national guidelines from the BMA, GMC and RCGP among others will see consistently good care for local trans, non-binary and intersex people.

There is more work to do nationally to tackle extraordinarily long waiting lists for specialist gender services. However, local examples show what is possible working within national guidelines. We believe that a partnership approach can provide trans, non-binary and intersex people with the support they need to trust the NHS to support their wider healthcare with understanding, respect and kindness. As the RCGP statement says, care should be provided: 'openly, respectfully, sensitively and without bias’. We look forward to seeing that approach delivered across health services in York.

Appendix 1

Glossary

In this report, we refer to the people who took part in our research as 'trans and non-binary people', 'trans and non-binary community' or 'respondents'. This includes people who have a trans history or are gender diverse.

For more terminology and further descriptions, please see TransActual's comprehensive glossary.

Bridging prescription: A temporary prescription of, in this case, gender-affirming hormones (e.g. oestrogen for trans women and testosterone for trans men) given by a GP to a trans person who is waiting to be seen by a Gender Dysphoria Clinic.

Cisgender/cis: Someone whose gender matches the sex they were assigned at birth – someone who is not transgender.

Deadname: The act of calling a transgender or non-binary person by their birth name or other former forename (their '**deadname**') after they have chosen a new name. Many transgender people change names as part of gender transition, and wish for their former name to be kept private. Deadnaming is considered offensive and harmful as it misgenders people and potentially outs them, particularly when done in public spaces.

DIY/self-medicating: Where trans people obtain and self-administer gender-affirming hormones without medical supervision.

DSD: Differences of, diverse (or as doctors might say, Disorder of) Sex development.

Gender-affirming care: Healthcare that helps trans people to live in the way that they want to, in their preferred gender identity. It encompasses a range of social, psychological, behavioural, and medical interventions.

Gender-diverse: Individuals whose gender identity is at odds with what is perceived as being the gender norm for that particular person, including those who do not place themselves as trans or non-binary.

Gender dysphoria: A medical diagnosis that someone is experiencing discomfort or distress because there is a mismatch between their sex and their gender identity. Also described as gender incongruence.

Gender Dysphoria Clinic (GDC): Previously known as Gender Identity Clinic (GIC) A specialist service to support people with gender-affirming care. GDCs have a multidisciplinary team of healthcare professionals, who offer ongoing assessments, treatments, support and advice.

Gender identity: A person's internal sense of their own gender. This does not have to be man or woman. It could be, for example, non-binary.

Gender Identity Clinic (GIC): see Gender Dysphoria Clinic.

Gender markers: Information in health records about someone's gender.

Hormone Replacement Therapy (HRT): A form of gender-affirming care used by trans and non-binary people to align their physical appearance with their gender identity. Trans men may take testosterone, and trans women may take oestrogen.

LGBT/LGBT+: An abbreviation used to refer to lesbian, gay, bisexual and transgender people. Often used as an umbrella term for any minority sexual orientation or gender identities, such as asexual or non-binary.

Misgendering: Intentional or unintentional use of words, names or pronouns that don't align with a person's gender.

Non-binary: An umbrella term used to describe gender identities where someone does not identify exclusively as a man or a woman. They may regard themselves as neither exclusively a man nor a woman, or as both, or take another approach to gender entirely. There are many included within this, such as agender, genderqueer and gender fluid.

Outing: the act of disclosing an LGBTQ person's sexual orientation or gender identity without their consent. It may be done for malicious reasons.

Pronouns: Words used to refer to a person, according to their sex and/or gender – for example, 'he', 'she' or 'they'.

Sex: Registered by medical practitioners at birth based on physical characteristics. Sex can be either male or female. Assignment is based on hormones, chromosomes and genitalia.

Intersex: An umbrella term for people who are born with one or more traits in their chromosomes, genitals, hormones, or internal reproductive organs that don't fit the typical male or female patterns.

Shared care: Shared care for gender-affirming care involves collaboration between a GP and a Gender Dysphoria Clinic. This involves the GP taking over aspects of care, like prescribing hormones, while the specialist continues to monitor and provide expertise. It is not mandatory, and depends on all parties (the GP, the GDC and the patient) agreeing to it.

Trans/transgender: An umbrella term used to describe people who have a gender identity that is different to the sex recorded at birth. This might lead to gender dysphoria or incongruence. Non-binary people may or may not consider themselves to be transgender.

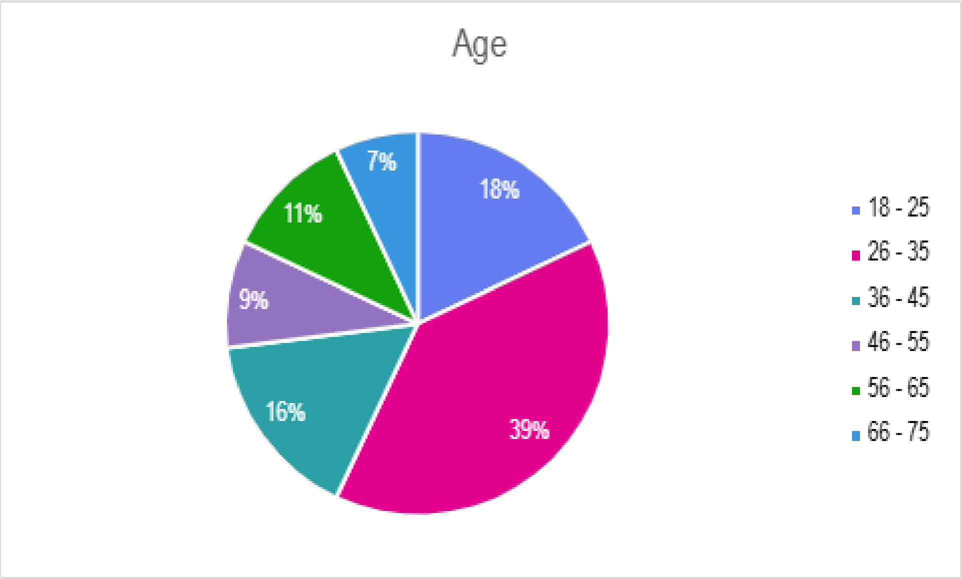
Transitioning: The steps a trans or non-binary person may take to live as, or be seen as, the gender they identify with.

Appendix 2

Demographic information

The information below relates to the 45 people who responded to our survey for trans, non-binary and intersex people.

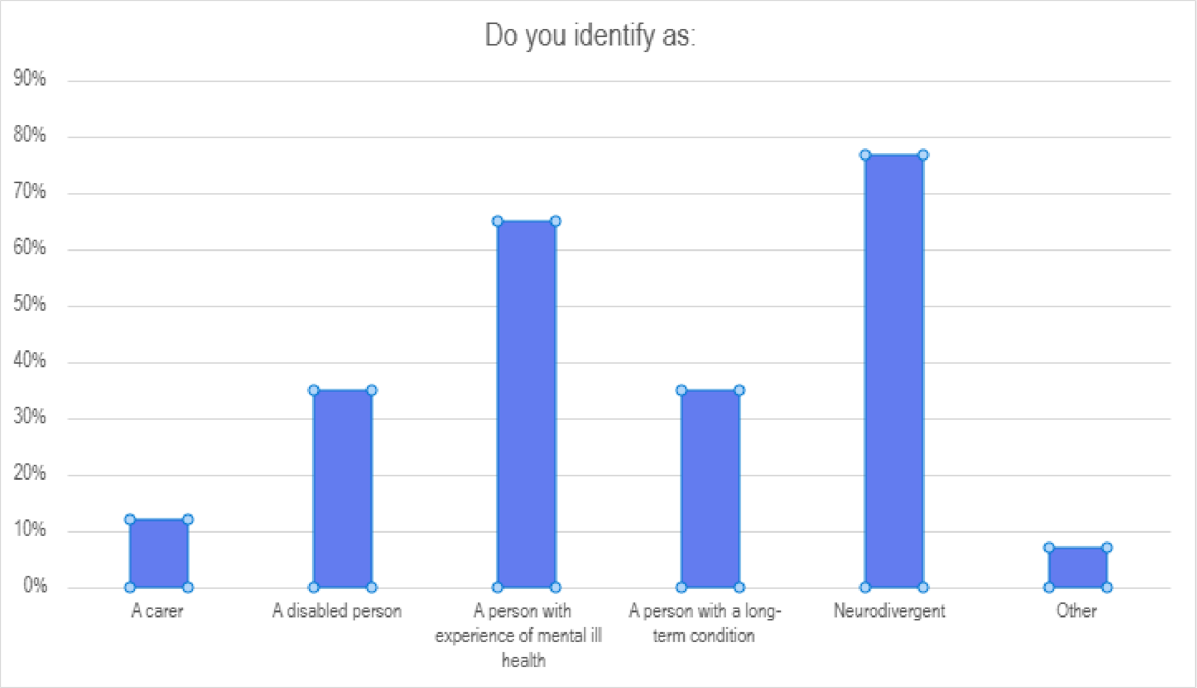
The majority (89%) lived in York. The age of respondents varied from 18 to 71.



We asked people to describe their gender identity. Respondents used the terms they are most comfortable with including:

- Trans man / trans woman
- Non-binary
- Female leaning
- Genderfluid
- Genderqueer

We asked people if they identified with a range of statements:



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Agenda Item 7

Health and Wellbeing Board 13th May 2026

Report of the York Health and Care Partnership

Summary

1. This report provides an update to the Health and Wellbeing Board (HWBB) regarding the work of the York Health and Care Partnership (YHCP).

2. This report asks the Health and Wellbeing Board to respond to the following recommendation in relation to Section 10:

Readiness for Neighbourhood Health

- Confirm the role of the HWB in the context of new national guidance; to lead development of the statutory Neighbourhood Health Plan and provide active system stewardship for implementation of Neighbourhood Health Services in York.

Background

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

4. The YHCP has an Executive Committee which is the forum through which senior Partnership leaders collaborate to oversee the delivery of the Partnership priorities. The Partnership draws on membership across Integrated Care Board (ICB) senior officers, City of York Council senior officers, York and Scarborough NHS Teaching Hospital, Tees, Esk and Wear Valley NHS Mental Health Trust, primary care, York Centre for Voluntary Services, Healthwatch York, the university and education sectors, and City of York Council elected members. The Executive Committee also operates as a committee of the ICB and City of York Council, governed by a section 75 agreement between the two organisations.

Update on the work of the YHCP in the Reporting Period

5. The Executive Committee has met three times since the last YHCP Report and the approved minutes of the meetings which took place in December 2025, February 2026, and March 2026 are enclosed.

6. **York Mental Health Partnership and Mental Health Hubs**

    - In December 2025 the YHCP Executive Committee received an update from the Mental Health Partnership outlining continued progress in developing York's integrated mental health system, with particular focus on the evolution of mental health hubs and wider partnership working. Since the previous report, work has advanced on key system priorities, including addressing data interoperability challenges, strengthening safeguarding oversight, and progressing collaborative approaches across health, care, and voluntary sectors. The introduction of an Open Dialogue model was highlighted as a promising relational approach to care, with early indications of improved outcomes.

    - Ongoing work to align services with neighbourhood models, improve prevention (especially for people with severe mental illness), and better understand local mental health trends was also highlighted. Feedback from system partners emphasised the importance of sustainable, joined-up delivery, stronger data sharing, and long-term commitment across organisations.

    - Looking ahead, the YHCP Executive Committee supported the development of a sustainable 24/7 mental health hub model for York in line with national expectations, including submission of a capital funding bid within required timelines. There was recognition of workforce and service design challenges, alongside the need to explore commissioning options to support a more integrated system. Partners committed to continuing work on early intervention, whole-family approaches, and inclusive engagement principles. The importance of community-based support was also highlighted.

    - In March, the YHCP Executive Committee received a further update on early scoping work underway with system partners to develop a commissioning "roadmap" for mental health services in 2026/27. This work will inform a future proposal and includes consideration of different contracting models. The YHCP Executive Committee highlighted the importance of maintaining protection for statutory responsibilities within any future arrangements, with clear expectations and boundaries for delivery built into contracts.

- The YHCP Executive Committee also recognised the financial pressures facing all partner organisations and the need to maximise existing resources in the absence of additional funding. The recently published Neighbourhood Health Framework (see section 10 of this report) was noted as a key opportunity to better align services and support more integrated, local delivery models.

7. York Health and Care Collaborative and Neighbourhood Health

- Since December 2025, the York Health and Care Collaborative (YHCC) has reported continued progress in developing neighbourhood-based working and population health management across York. This has been underpinned by shared guidance and principles focused on addressing holistic need, managing complexity, and delivering coordinated, multi-agency care rooted in neighbourhoods. City of York Council has progressed rapid transformation activity using data insights and community engagement, alongside recruitment to strengthen neighbourhood teams. Governance arrangements, including a programme management office and partnership task-and-finish groups, are now established, with improved connectivity across providers. The contribution of the Voluntary, Community and Social Enterprise sector and Healthwatch York has been recognised as critical, alongside the need for sustainable resourcing. York is also recognised as a leading place within the ICB, with Health and Wellbeing Boards playing a key role in oversight and accountability.

- By February 2026, this work had advanced further with the introduction of a draft York Neighbourhood Operating Model and supporting governance framework. The Health and Wellbeing Board made a valuable contribution to shaping the model through discussion at its January meeting. The model is designed to be flexible and scalable, building on existing strengths and informed by neighbourhood-level data. While initial delivery has focused on priority cohorts, there is a clear commitment to expand, including a strengthened focus on children and families. Ongoing discussions have highlighted system challenges, including funding and capacity constraints, alongside the importance of an approach that prioritises prevention, wider determinants, and community engagement.

- There remains a strong expectation to deliver measurable outcomes, demonstrate impact under system pressures, and continue positioning York as a leading exemplar for neighbourhood development.
- The YHCC will continue to focus on neighbourhood health development for York, with a renewed focus on prevention and addressing the wider determinants of health.

8. **Joint Commissioning**

- At the December YHCP meeting, the Executive Committee received an update on progress made through the Joint Commissioning Forum, including work to align and integrate services across health, care, and the voluntary sector. This includes prevention and health inequalities programmes, community-based services, and efforts to reduce duplication and improve value for money. Members also noted ongoing work to and develop a more integrated, community-based mental health offer. The update highlighted both achievements and continuing challenges as partners work towards more joined-up, efficient delivery.
- Members discussed the potential implications of proposed NHS commissioning changes, particularly the impact on local partnership working, integration, and joint funding arrangements. While concerns were raised, there was agreement to provide collective feedback to inform the consultation, alongside responses from individual organisations. The YHCP Executive Committee emphasised the importance of maintaining momentum during this period of change and agreed to hold dedicated sessions to consider future place-based working arrangements.
- The Better Care Fund draft plan has now been submitted, with feedback expected over the coming weeks ahead of the final submission. There has been less change or significant movement in the BCF this year than initially anticipated. While the updated guidance indicates a shift towards neighbourhood-based approaches, the plan itself remains largely consistent with

previous iterations. We anticipate that more substantive changes may be introduced in next year’s cycle.

- The section 75 agreement between City of York Council and the Integrated Care Board has now been extended into 2026-27, allowing work to align funding and commissioning to continue. This will be supported by a joint commissioning plan to be developed in quarter 1.

9. York Health and Care Partnership Development and Delivery

Development Fund

- In February the YHCP Executive Committee considered proposals for allocating a £250,000 non-recurrent development fund to support York Health and Care Partnership priorities. A total of £374,000 in bids had been received and assessed against agreed principles, with a focus on equitable investment, particularly for children and young people. Members approved the highest-scoring proposals, subject to conditions. A small number of lower-scoring proposals were not supported, and one proposal was conditionally supported pending confirmation of alternative funding sources.

- Discussion highlighted the importance of ensuring value for money, strengthening co-production, and maintaining partner commitment in the context of financial pressures and system change. It was agreed that any unallocated funding would be redirected to support co-production activity. The Committee also requested regular reporting on delivery and outcomes from funded projects and agreed to review all allocations after six months to ensure impact and alignment with partnership priorities.

Renewed Direction for ICBs

- In February the YHCP considered proposals to reform the York Health and Care Partnership (YHCP) governance and operating model in response to wider Neighbourhood policy developments and changes within the ICB. The report set out the need to reshape YHCP to ensure it remains effective in the next phase of system integration, particularly in light of reduced ICB support capacity. Members were advised of revised ICB arrangements, including a small number of dedicated roles for York and North

Yorkshire, and discussed how partnership leadership and delivery capacity could be maintained going forward.

- Proposed changes focused on streamlining governance, reducing voting complexity, and strengthening consensus-based decision-making, while retaining accountability through existing statutory structures. The model also emphasised shifting more delivery responsibility to providers, improving cross-organisational working, and aligning resources with the emerging Neighbourhood approach, including integrated community and mental health models. Mitigations were agreed to maintain leadership continuity and preserve system knowledge through designated Council and provider roles working alongside the ICB, as well as embedding staff working across organisational boundaries. A formal review of the revised arrangements will take place in six months.

Assurance report

- In March the YHCP received an Assurance Report covering progress from May 2025 to February 2026 across joint commissioning, neighbourhood development, and children and family services. The report set out evidence of delivery against the Partnership’s three priorities.
- A key theme throughout the update was system capacity risk, particularly within contracting and delivery functions, which was identified as a significant constraint on pace and implementation. Delays linked to commissioning capacity and ICB financial controls were noted as impacting roll-out of otherwise ready initiatives, including mental health and high-intensity support schemes. Concerns were also raised about funding availability and the ability of teams to sustain and lead multiple transformation programmes simultaneously.
- Despite these pressures, strong partnership commitment was highlighted, alongside continued modelling to support the “left shift” from acute to community services and prioritisation of investment with the greatest impact on reducing demand. Members noted the importance of addressing waiting lists and maintaining focus on workforce and system capacity to ensure delivery ambitions remain achievable.

10. Wider neighbourhood health updates

National Neighbourhood Health Framework

- The Neighbourhood Health Framework was published in March 2026 and sets out a major national shift towards integrated, community-based care delivered through Neighbourhood Health Teams and neighbourhood health centres, with Health and Wellbeing Boards (HWBs) positioned as the central statutory anchor for delivery. The framework requires ICBs and local authorities, working through HWBs, to agree neighbourhood footprints, establish integrated neighbourhood teams focused on frailty, long-term conditions, end of life care and children and young people, and put in place the foundations for pooled budgets and data sharing. It also signals a clear long-term move away from hospital-based care towards prevention, early intervention and coordinated community services.

- For HWBs, the guidance represents a significant strengthening of role and responsibility, shifting them from primarily strategic oversight bodies to active system stewards with accountability for delivery. HWBs are expected to lead the statutory Neighbourhood Health Plan, align NHS, local authority and wider public service reform (including housing, education, policing, VCSE and employment support), and ensure resources are directed towards neighbourhood priorities. They are also expected to oversee delivery performance, surface and resolve system tensions, and ensure integration across partners rather than duplicative governance. In practice, HWBs become the key point of accountability for neighbourhood health reform, with place-based partnerships acting as the operational engine for delivery and coordination across the system.
- This report asks the Health and Wellbeing Board to respond to the following recommendation:

  - Confirm the role of the HWB in the context of new national guidance; to lead development of the statutory Neighbourhood Health Plan and provide active system stewardship for implementation of Neighbourhood Health Services in York.

York readiness for Neighbourhood Health

- Partners have worked together to assesses York Place’s readiness to deliver the national Neighbourhood Health Framework and understand the preparatory work required for development of the 2027–28 Neighbourhood Health Plan under the leadership of the HWB.

- York Place has made notable progress in establishing the foundations of the model, including Integrated Neighbourhood Teams across all geographies, early frailty and complex care pathways, improved data sharing and population health management, and the development of neighbourhood-based service pilots.

- Partners highlight key areas requiring further development, particularly consistent delivery across all priority cohorts, stronger integration with secondary care, social care and children’s services, and more mature approaches to urgent care, diagnostics and planned care within neighbourhood settings. Workforce capacity, cross-system commissioning, and governance clarity are also identified as constraints.

- Overall, while York Place is assessed as having a strong foundation for neighbourhood working, further acceleration is required to fully meet national expectations. The HWB will play a pivotal role in driving the 2027–28 Neighbourhood Health Plan, ensuring system-wide alignment, overseeing delivery readiness, and addressing gaps in integration, capacity and consistency to enable a fully embedded neighbourhood health model.

Neighbourhood Health Centres

- NHS England has issued guidance outlining planning requirements for developing Neighbourhood Health Centres, including a deadline of 28 May 2026 for submitting a return that consolidates service and estates strategies and identifies existing, upgraded, and new facilities. The guidance requires the ICB to work collaboratively with regional teams and system partners to establish a coherent pipeline of schemes supporting neighbourhood health. This will involve close coordination across transformation, integration, strategy, estates, and local authority leads to ensure proposals reflect both nationally consistent services and local population needs, building on work already undertaken within the ICB.

- Early thinking suggests that York could consider a city centre site, particularly York Central, as a strong candidate for a Neighbourhood Health Centre, given its potential to anchor health services within a major regeneration area and support the development of a more balanced, community-focused city centre. At the same time, existing proposals such as Burnholme remain important, particularly in addressing areas of higher need, with any changes to primary care estate requiring significant engagement with GP partners and local communities.

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	Report Approved: Yes
	Date: Apr 26

Wards Affected ALL