York Community Mental Health Hubs

Connecting Our City
A Network of Mental Health and Wellbeing Support Across York

City of York Council

Community Mental Health Transformation
North Yorkshire & York

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

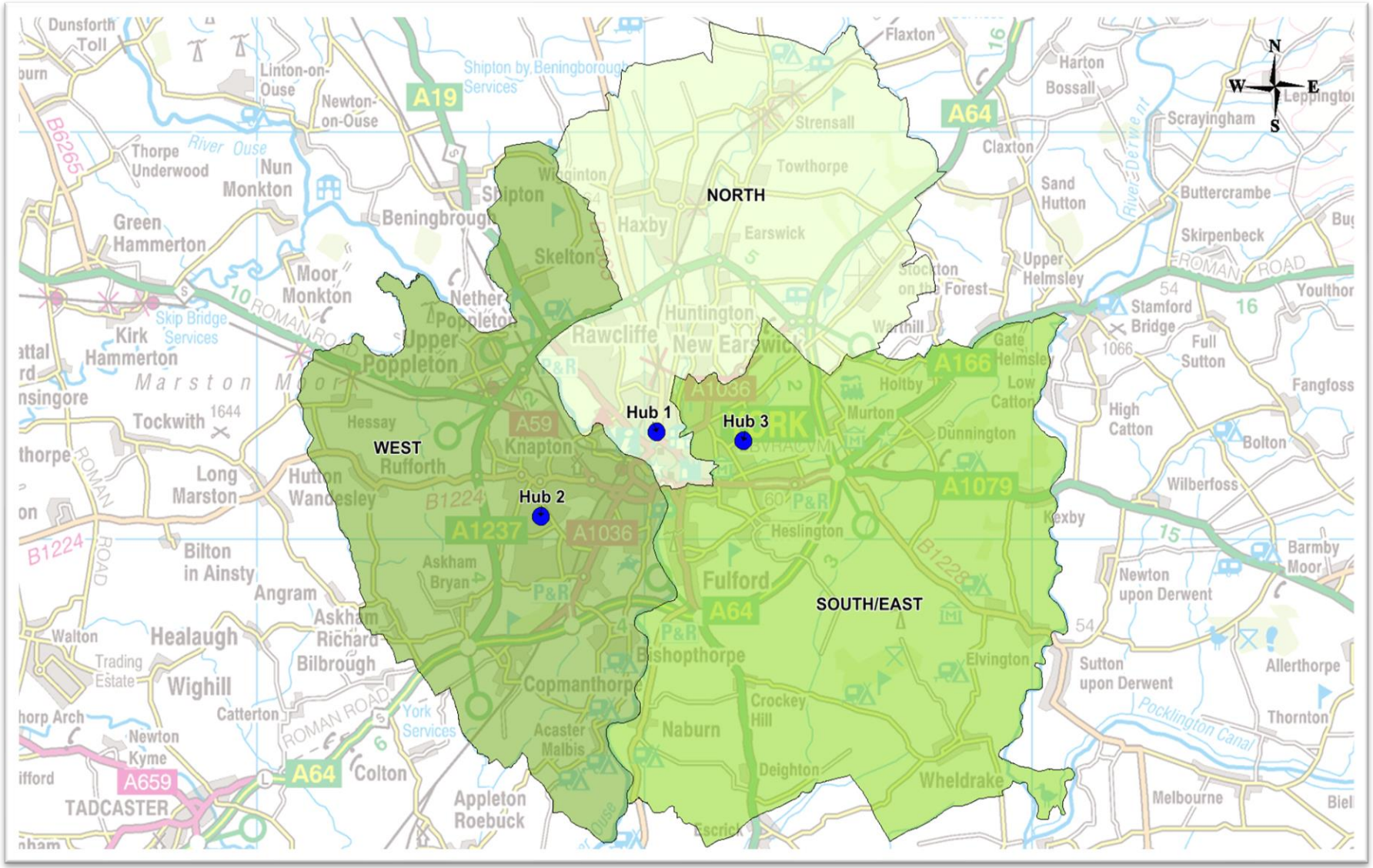
Innovation Unit
Creating impact
Reducing inequalities
Transforming systems

York Mental Health Partnership

Our Vision for York is a City where:

- We all feel valued by our community, connected to it, and can help shape it.
- We are enabled to help ourselves and others, build on our strengths, and can access support with confidence.
- We are proud to have a Mental Health Service that is built around our lives, listens to us, is flexible and responds to all our needs.

York's 3 Hubs



The 24/7 Hub is part of a wider vision to develop 3 Mental Health Hubs across the city of York.

Hub 1 – 30 Clarence Street

The first Hub is in the early stages of development at 30 Clarence Street, covering the North of the City. This is a daytime offer only. A codesign process was undertaken to develop the core principles, values and practice which underpin 30 Clarence St.

Hub 2 – 24/7 Centre

The second Hub will be located in Acomb, Westfield and Holgate. This Hub will be 24/7 as additional funding has been secured as part of the national pilot.

Hub 3 – Future Hub

The third hub will be in the South/East of the City and will be a daytime offer only. Development of this Hub has not started.

The Codesign Process

Objective:

- 10 people with lived experience of mental health services with a wide range of people from different communities and experiences from York, with a particular focus on people who will live in the catchment area of this hub.
- 10 professionals from mental health, community, and statutory services.

Process:

5 workshops over 3 months, focusing on:

- **Vision & Principles**: Establishing a shared vision, values, and group agreement.
- **Hub Offer**: Defining support services, desired outcomes, and user needs.
- **Hub Feel**: Designing a safe, welcoming physical space and user experience.
- **Hub Function**: Exploring staffing models, access levels, and operational logistics.
- **Sharing Back**: Presenting findings to stakeholders and planning next steps.

What we achieved....

4

sessions

40

pages of insights

Open access, low resource (tea and coffee)

Deciding to go to the Hub
- Inviting and inclusive website / social media
- Community awareness and signposting
- Clear & accessible information available about the hub, it's offer & in multiple varied locations in the community (leaflets, word of mouth, website with images of staff on it)
- Knowing you can go to the hub when you are well too
- Hub team find out about person's access needs as soon as possible with options to share access need before arrival
- Options to get in contact with the hub before arriving (free phone/text/email)

Arriving at the Hub
- Warm welcome from staff and other users
- Timely welcome conversation to identify needs / how best supported
- Given a seat and offered a cuppa, spoken to quickly
- Adjustable lighting, relaxing music/white noise, clean & nice smelling
- Doesn't feel clinical
- Welcome board - who's in, what's on today? Tomorrow? Menu prices for cafe
- Leaflets for other services
- Translator service available?

Settling in to the Hub
- Comfy chairs - different heights, mats, beanbags, soft furnishings
- Space is warm and comfortable
- Environmental design for sensory needs e.g. ASD and dementia
- Confidential space as well as open group space
- Welcoming staff to help settle you
- Somebody to show you around on your first visit
- Option to have a conversation first off or to settle in themselves
- Food and drink available

Receiving Support
- Follow up afterwards
- Staff are knowledgeable, have compassion and a good attitude. Staff are allies.
- Appropriate referrals to other services, effective warm signposting (e.g. housing)
- Talking circles and group therapies
- People feel their needs are met and feel listened to through regular coproduction conversations
- People can share/not share what they want to

Leaving the Hub
- Safe transport options home: taxi, bus, train
- Person is clear on what the next steps are when leaving
- People know where they're going on to
- User friendly next steps cards
- People feel ready to leave
- People feel aware and comfortable to return

Next Steps
- Linked to peer buddy support
- Follow up call and ways to stay in touch
- Staff are clear on actions for next day - including signposting, contact, referral and reviewing feedback
- Next steps card
- Knowing what is happening at the hub so that they can return if they choose
- Pack-ups with food/drink
- Invitation cards to other groups/activities/services
- Self-reflection tools
- Ideas for how to resolve current issue

What would the hub need to be/have to manage this situation?

System/processes
- Boundaries/ground rules
- Cannot have open door policy at night - triage first
- Transport home/place of safety
- Joint agency working
- Clear policies (around crisis/wards)
- Staff alarm system
- Triage of immediate need and prioritisation
- Understanding of how resources are best used
- Clear expectations
- Strong relationships with other services
- Hubs will ease pressure on the system

Staffing
- More staff overnight
- Enough staff at each level
- 2.7 WTE staff needed to cover person on 24/7 rota. 7 staff to cover all 4 scenarios
- Shift coordinator/manager to organise

Facilities
- Necessities (basic clothing, toiletries etc)
- Toys etc for children
- First aid equipment
- Craft, fidget toys, games, tv, music (distraction and comfort)
- Neurodiversity assessment of the space

External support the Hub helps people to access

The Hub as a place to share local knowledge
- Increase accessibility to local groups for service users
- Range of flyers / leaflets about local support
- Online access / signposting
- Knowledge / database of local support
- Pin board with local resources & groups to be refreshed monthly

Facilities/skills the Hub can offer the community
- Garden? community gardening group
- Peer support
- Space for activities
- Meeting place for other offers
- Schedule & diary management

Connected services

The Hub will have clear and seamless communication & connection with:
- Social care
- Crisis team
- Link to MH trained police 24/7
- GP
- CMHT

External support
- Menfulness
- IT reuse
- Housing Options (CYC)
- Converge - share skills & knowledge
- Discovery Hub
- CRUSE (bereavement & family therapy)
- York Carers
- The Hut
- York MIND advocacy
- Andy's Man Club
- The Hub (@ Clarence St)
- Peasholme charity (benefit support)
- Employment support (job centre etc).
- Community repair shop
- Gateway community cafe
- Digital York
- Library tech support
- Family Hub
- Methodist church (volunteering & gardening)
- Haxby Community garden
- St Nicolas Gardening
- Foxwood Community garden

Key Takeouts

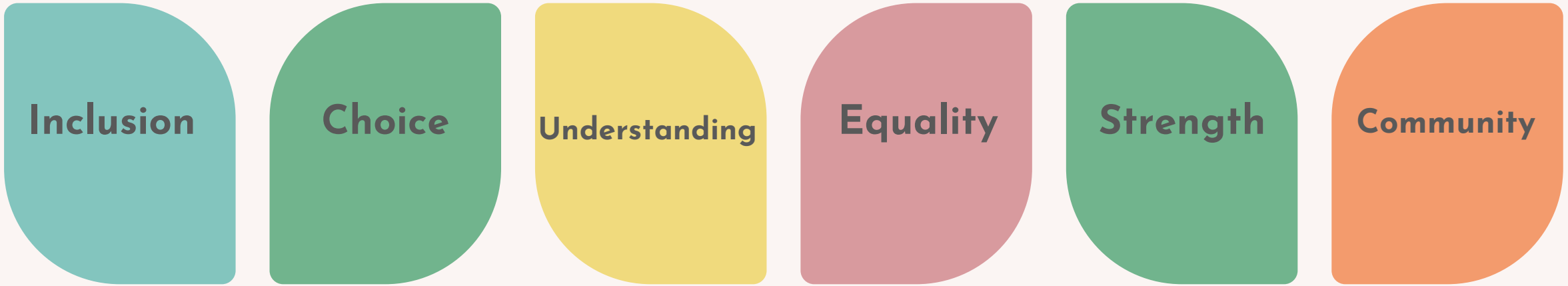
Hub Model:

Daytime (8am-8pm): Full multi-agency team offering appointments, peer support, and group activities.

Evening (8pm-10pm): Reduced team with community-led activities (e.g., movie nights, peer groups).

Night (10pm-8am): Quiet calm space with emotional regulation support, snacks, and relaxing activities such as board games.

6 Key Principles:



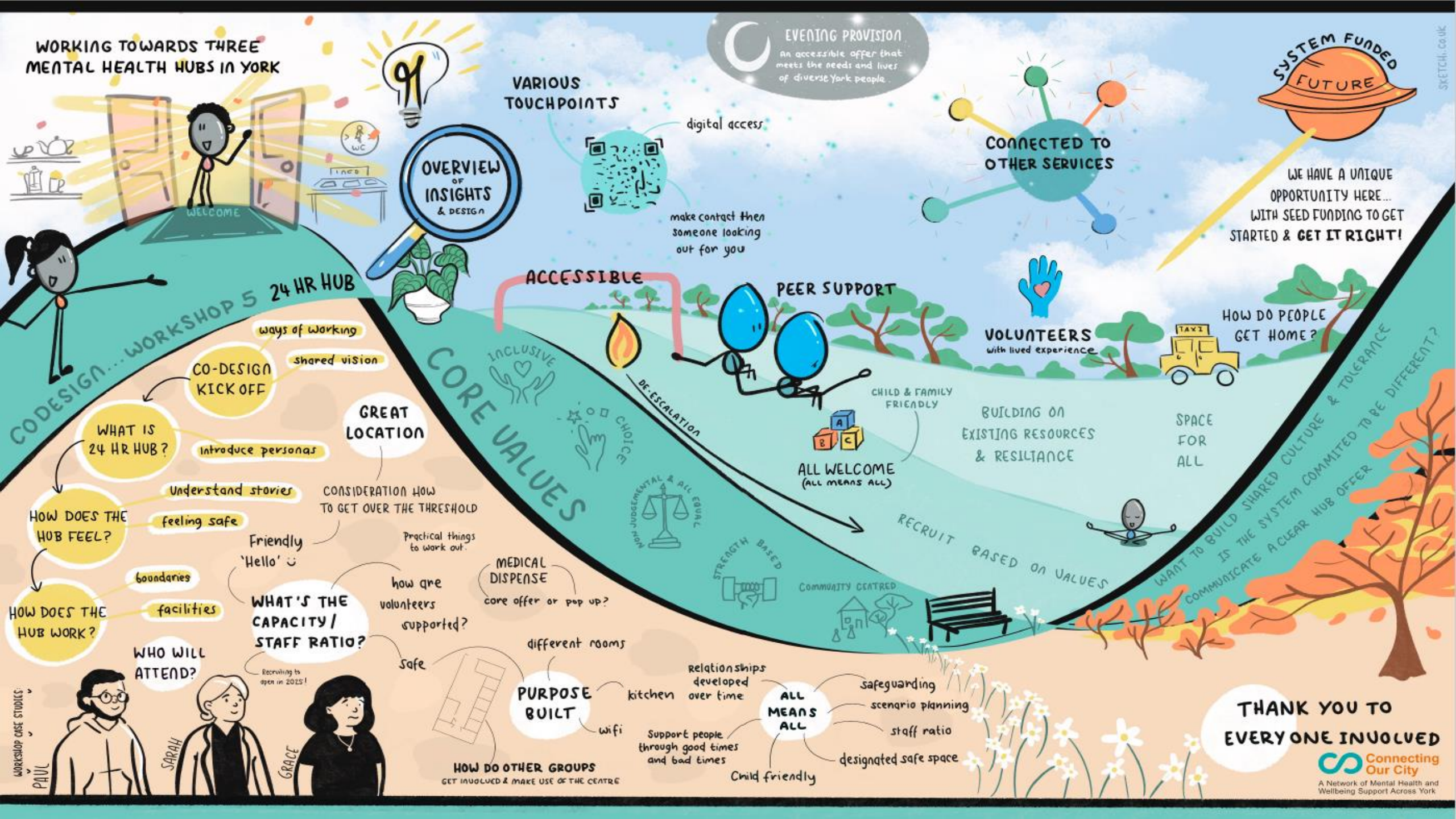
Key Learnings

Learnings from the process:

- **Balancing Ideas** Tensions arose due to opposing ideas and **power imbalances** between lived experience participants and professionals.
- **Navigating Power Dynamics:** Co-production required professionals to **relinquish some of their power** and traditional hierarchical thinking, which can be difficult given their training and established ways of working.
- **Shifting Mindsets:** It also demanded a shift towards **collaborative decision-making,** where lived experience expertise was valued equally to professional expertise.

What went well:

- **Shared Ownership:** The co-design process fostered a sense of **shared ownership** of the Hub, with both lived experience participants and professionals contributing equally to the vision and design.
- **Person-Centred Design:** The Hub was **designed around the needs of the people** using it, ensuring it is a welcoming, flexible, and responsive space.
- **Alignment of Vision:** By the end of the process, participants who may not have been fully onboard with the vision at the start were **more aligned,** demonstrating the power of co-design in **building consensus** and **shared understanding.**


WORKING TOWARDS THREE MENTAL HEALTH HUBS IN YORK
WELCOME
WC
LINED
OVERVIEW OF INSIGHTS & DESIGN
EVENING PROVISION
An accessible offer that meets the needs and lives of diverse York people.
VARIOUS TOUCHPOINTS
digital access
make contact then someone looking out for you
CONNECTED TO OTHER SERVICES
SYSTEM FUNDED FUTURE
WE HAVE A UNIQUE OPPORTUNITY HERE... WITH SEED FUNDING TO GET STARTED & GET IT RIGHT!
SKETCH.co.uk
CODESIGN...WORKSHOP 5
24 HR HUB
ways of working
CO-DESIGN KICK OFF
shared vision
WHAT IS 24 HR HUB?
introduce personas
HOW DOES THE HUB FEEL?
Understand stories
feeling safe
HOW DOES THE HUB WORK?
boundaries
facilities
WHO WILL ATTEND?
WHAT'S THE CAPACITY / STAFF RATIO?
Recruiting to open in 2025!
how are volunteers supported?
Safe
GREAT LOCATION
CONSIDERATION HOW TO GET OVER THE THRESHOLD
Friendly 'Hello' ☺
Practical things to work out.
MEDICAL DISPENSE
core offer or pop up?
different rooms
PURPOSE BUILT
kitchen
wifi
HOW DO OTHER GROUPS GET INVOLVED & MAKE USE OF THE CENTRE
CORE VALUES
INCLUSIVE
CHOICE
NON JUDGEMENTAL & ALL EQUAL
STRENGTH BASED
COMMUNITY CENTRED
ACCESSIBLE
DE-ESCALATION
PEER SUPPORT
CHILD & FAMILY FRIENDLY
ALL WELCOME (ALL MEANS ALL)
RECRUIT BASED ON VALUES
VOLUNTEERS with lived experience
BUILDING ON EXISTING RESOURCES & RESILIANCE
HOW DO PEOPLE GET HOME?
TAXI
SPACE FOR ALL
WANT TO BUILD SHARED CULTURE & TOLERANCE
IS THE SYSTEM COMMITED TO BE DIFFERENT?
COMMUNICATE A CLEAR HUB OFFER
ALL MEANS ALL
relationships developed over time
Support people through good times and bad times
Child friendly
safeguarding
scenario planning
staff ratio
designated safe space
WORKSHOP CASE STUDIES
PAUL
SARAH
GRACE
THANK YOU TO EVERYONE INVOLVED
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A Network of Mental Health and Wellbeing Support Across York

Community Mental Health Hub Journey

Journey through the Hub

Martha's Journey

1 Presented at A&E

2 Referral to Access Team

3 **Access assessment**
Does not meet criteria for CMHT

4 **NHS Talking Therapies**
Not accepted due to ongoing risk factors

5 **Identified Intervention**
Managing Emotions Pathway (but significant waiting times)

Connected with Hub

The multidisciplinary team discussed who would be best to support Martha

Mental Health Practitioner supports Martha throughout her hub journey

WELCOME CONVERSATION

Introduced to hub space by Mental Health Practitioner. During the welcome conversation – key themes identified:

- Anxiety/depression
- Managing emotions
- Gender transition
- Lack of community

Martha and the Mental Health Practitioner agrees the following steps

Step 1: Managing Emotions
Martha had individual sessions with the Mental Health Practitioner around learning to manage emotions

Step 2: Safety
Martha and the Mental Health Practitioner had an open conversation about their safety

Step 3: Social Prescribing
Connecting with community activities to reinforce sense of connectiveness and develop new friendships

- LGBTQ+ Cafe
- Generate
- Counselling

Martha can reconnect to the hub at any point

Types of Support

Phase 1 June 2024–February 2025

Individuals who were offered support from the Hub team had a variety of needs. The Hub team were able to respond to these needs through the varying skills present within the team:

137 people have been **booked in for a welcoming conversation**

69 people have had **support to develop skills and an understanding of their mental health to improve their well-being**

72 people **have accessed peer support**
38 **accessed 1:1 support**
34 **have engaged with group peer support**

24 people **have been able to identify and work towards existing goals with support from the recovery workers**

18 people have had **social care input**

13 people **had social prescribing support to link them up with the wider community**

49 people **have been supported by the hub Carer Peer Support Worker**
3 **have become volunteers with the Carers Centre**
1 **was part of the co-production for the 24/7 Hub**

=6 people

Thank you

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York Community Mental Health Hubs – Handout

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Yorks Story so far...

A group in York had a desire to do something different...

Visit to Trieste

A visit to Trieste showed York what different could look like

No langards!

Strengths first!

No stigma!

York Mental Health Partnership was established to improve support for mental health and wellbeing for all, building on existing assets to inform a community-based approach

Est. 2017

Est. 2019

Connecting Our City
A Network of Mental Health and Wellbeing Support Across York

The Connecting our City Partnership identified a mental health hub and network as a priority to start realising this vision

They brought on the Innovation Unit to support the development of this work through co-design and their expertise in facilitation and system change

Building a strong design team

"I like the way the co-design process was set up, clear, helpful, positive, equal."

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Reducing inequalities
Transforming systems

2022

A team with a mixture of expertise and experience was brought together to go on a journey to design what a Trieste inspired Hub would look like in York

Explored the challenge to consider what better looks like

lets explore
What if?

let's be
radical

Not making assumptions about people. Some of us have really varied experiences and backgrounds

Paying attention to power imbalances that might be in the room – making sure we're not perpetrating them

Remembering that listening is a gift!

The codesign team attend 4 workshops and developed Hub principles that underpin the core values of the space.

- A warm welcome
- There in the good times and bad times
- Flexible
- Understanding people
- Focus on strengths
- Relationships matter
- Dignity and Respect
- Believing in better
- Inclusive
- Accessible

Yorks Mental Health Partnership submitted a bid to establish a 24/7 Community Mental Health Neighbourhood Centre in the West of the City...


BBC NEWS

Home UK World Business Politics

Funding secured for new 24/7 mental health hub

YORK CITY COUNCIL

York's Mental Health Partnership has secured funding for a new support hub

Key themes

- Whole system redesign in place
- Participation in work, community and social life
- Service accountability to the community
- 'Mentally different' not 'mentally ill'
- Exclusion of coercion, seclusion and closed doors
- Embracing individual stories, freedoms and strengths

Est. 2024

Learning from the prototype, the Hub @ Clarence Street officially opened in May 2024

- Person Centred
- Relational
- Collaboration

In 2023, a multidisciplinary team at 30 Clarence Street prototyped the hub co-design model. Working with a small cohort to explore different ways of working and demonstrate the model's impact.

The partnership agreed a 24/7 Hub Workforce model

The 24/7 codesign team attended 5 workshops and presented outputs to the wider system

Developments and evaluation are supported by NHSE

System wide workshops to support realignment with Hubs

Operating procedures from Hub 1 adapted for 24/7 offer

A third Hub will be developed in the South/East of the city proving a daytime support

The three hubs will provide a city-wide offer.

Setting up a permanent Hub @ 30 Clarence Street

Co-designed Hub Principles

1

A warm welcome
The hub feels warm, welcoming and is embedded as part of the community

2

There in the good times and bad times
People are asked what they need when they're well in preparation for when they're not

3

Flexible
The hub is flexible, working around people's needs and commitments to prevent further disruption to their lives

4

Focus on strengths
A focus on what people and communities *can* do, not what they *can't*

5

Relationships matter
Relationships are based on respect, trust and reciprocation

6

Believing in better
Advocating to improve the conditions of people with unmet mental health needs, and influencing others in the city to do the same

7

Understanding people
Understanding each other as individuals within our contexts rather than a set of symptoms to diagnose

8

Inclusive
Accepting others without biases based on differences of any kind, and making sure everyone feels valued and accepted

9

Dignity and Respect
Recognising people as experts in their own lives, and treating them with dignity and respect

10

Accessible
Making sure that everyone can access the hub's services and community in a way that works for them

The Core Hub Team

Hub Manager

Full time position
Oversight of the team, the support, and the learning.

Lived Experience Leadership

Shared leadership is an important integral part of the model. Embedded in the hub developments and governance structure.

Peer Supporters
Group Peer Supporter

A bank of peer supporters offering one to one support as well as group work. Using their lived experience to support people.

Carer Support

Part time position
Providing support for carers on a one to one and group basis.

Social Prescribing Team Leader
Social Prescriber

Part time position
Full time position

Mental Health Recovery Workers

1 full time senior recovery worker
2 full time recovery workers

Mental Health Practitioner

2 Full time position
Band 6 clinicians

Mental Health Social Care Worker

Full time position

York Mental Health Hub

Support Offer

The Hub @ 30 Clarence Street is a team made up of social prescribers, peer support workers, mental health practitioners, carer support workers, social care worker, recovery workers and volunteers. The team provide mental health and wellbeing support to address the range of challenges people face, in a flexible manner to connect people with their local communities. It meets individuals in the Hub space or within their local communities to support them to achieve the goals they identify to improve their mental health.

How is the Hub different to current mental health provision in York?

- By offering a range of support in a flexible manner the team is able to be more responsive and enable early intervention to prevent a decline in mental health.
- If we compare this to current services where there are limited alternatives to clinical input, the Hub is able to support a person to develop a network of community assets to support them to thrive in their local communities. It is a multi-faceted approach rather than a linear approach.
- The Hub has been able to see people who would normally be waiting on the Access Team waiting list for 5-6 months within a much quicker time-period with an aim to move towards open access
- The opportunities offered by partnership working mean that an individuals' social care needs can be met at the same time as a piece of anxiety management and then they can seamlessly move onto practising these skills whilst having support to access wider community activities.

Types of Support

Phase 1 June 2024–February 2025

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=6 people

Co-Production

The Co-Production Champion Role

Facilitate: Co-production across mental health services, ensuring lived experience is central to decision-making.

Bridge: Act as a connector between communities, organisations, and services to create inclusive, user-led solutions.

Empower: Support individuals and groups to actively participate in shaping the services they use.

How we engage

With Services: Collaborate with primary care, VCSE sector, and grassroots organisations to embed co-production in service design and delivery.

With Communities: Build meaningful connections with diverse groups, including underrepresented voices, to ensure inclusivity.

With Individuals: Empower individuals with lived experience to actively participate in shaping mental health services.

Facilitating Conversation Cafes

- **Organise:** Host regular Conversation Cafés to create safe spaces for open dialogue between service users, communities, and organisations.
- **Encourage:** Ensure diverse participation to ensure a wide range of lived experiences are heard and valued.
- **Utilise:** Use insights gathered to inform service design and decision-making.

Promoting Co-Production Benefits

- **Champion:** Actively spread awareness about the value and impact of co-production across health services and community organisations.
- **Showcase:** Share success stories and case studies to demonstrate how co-production leads to more inclusive and effective services.
- **Deliver:** Provide training and resources to help organisations embed co-production principles into their practices.

The Co-Production Principles

- **Equality:** Everyone’s voice is valued equally.
- **Diversity:** Actively seek out and include underrepresented voices.
- **Transparency:** Open and honest communication throughout the process.
- **Mutual Benefit:** All partners benefit from the collaboration.

Community-based VCSE Investment

kyra women's project

CHOCOLATE & CO

OUT of CHARACTER

St Nicks
The Green Heart of York

SURVIVE

YORK IN RECOVERY STRENGTH TO CHANGE

emerging voices

CONVERGE
CREATE CHALLENGE INSPIRE

VCSE Grant Recipients:

A community-based ecosystem of mental health support

High quality, innovative and person-centred provision, that is **locally trusted and co-produced** in the **heart of the community**

From equine, arts and eco therapies; programmes of 1:1/group-based wellbeing support for women, Gypsy Traveller communities and adults with substance dependency; to trauma-informed counselling for survivors of rape and sexual abuse

Offering **safe and supportive environments** where **barriers to access are low, available and adaptable at different stages of need**

To prevent crisis, support recovery and empower people to connect, build healthy networks and to develop confidence - empowering people to gain independence, to self care and stay well

£250K invested in **7** projects led by **11** VCSEs across York

403 people supported, **2,007** 1:1 & group sessions delivered in **Yr1**

Watch the work in action here

71% reported they were better able to manage their mental health & wellbeing

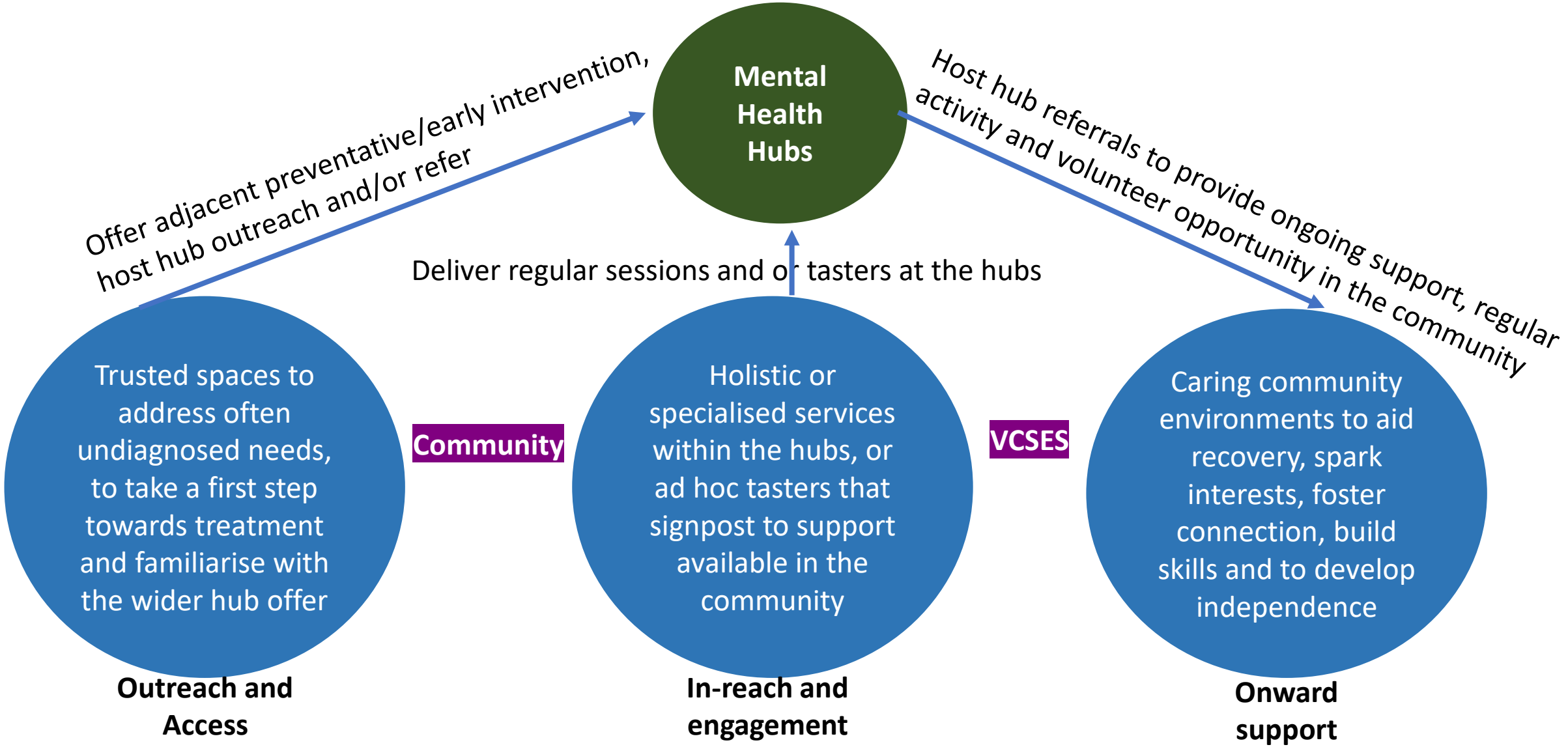
67% reported they had stopped or reduced their use of statutory services

'I've said more to you in 2 weeks than I have ever said in 7 years.'

Community participant

The Hub and community-based VCSES:

Building towards a collaborative pathway of MH support



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KICES (Kirklees Integrated Community Equipment Service)

The Care We Want: Community Equipment Services

Mark Rance

KICES Contract Manager

KICES@kirklees.gov.uk

The Care Act 2014

- Principles of wellbeing and prevention
- Undertake person-centred, strength-based assessments
- Enable and empower people to achieve the outcomes that matter to them
- Part 1, clause 2 – Preventing needs for care and support
- Equipment can increase the resilience of clients and carers and enable them to continue living in a way and a place that matters to them
- Practitioners should consider alternatives to traditional packages of care

Community Equipment Services

- Provides equipment that has been assessed for and prescribed by a health or social care professional, usually therapist, nurse or trusted assessor
- Prevent hospital admission or facilitate hospital discharge
- Enable participation in activities of daily living – prevent, reduce delay need for a POC
- To manage and prevent deterioration of health needs
- Conserves health and social care resources

- **But the impact of these services often remain unrecognised**

Our service users must always be our priority – what do THEY want from THEIR equipment service ?

- They want easy access to the equipment that helps them remain in their own homes
- They want equipment that is modern and up to date
- They want a responsive service that can provide a solution when they require it
- They want good communication and to have a say in their care
- They want support in understanding what is available to purchase

- Insights gathered via service user feedback surveys and co production events supported by user groups, Healthwatch and Medequip

Our colleagues in Health and Social care – what do THEY want from THEIR equipment service ?

- They want a fast and responsive service to support their patients
- They want easy access to a wide range of equipment
- They want to be able to trial the equipment
- They want standardisation across regions
- They want to be able to easily and effectively communicate with the equipment service
- They want support and guidance with their decision making

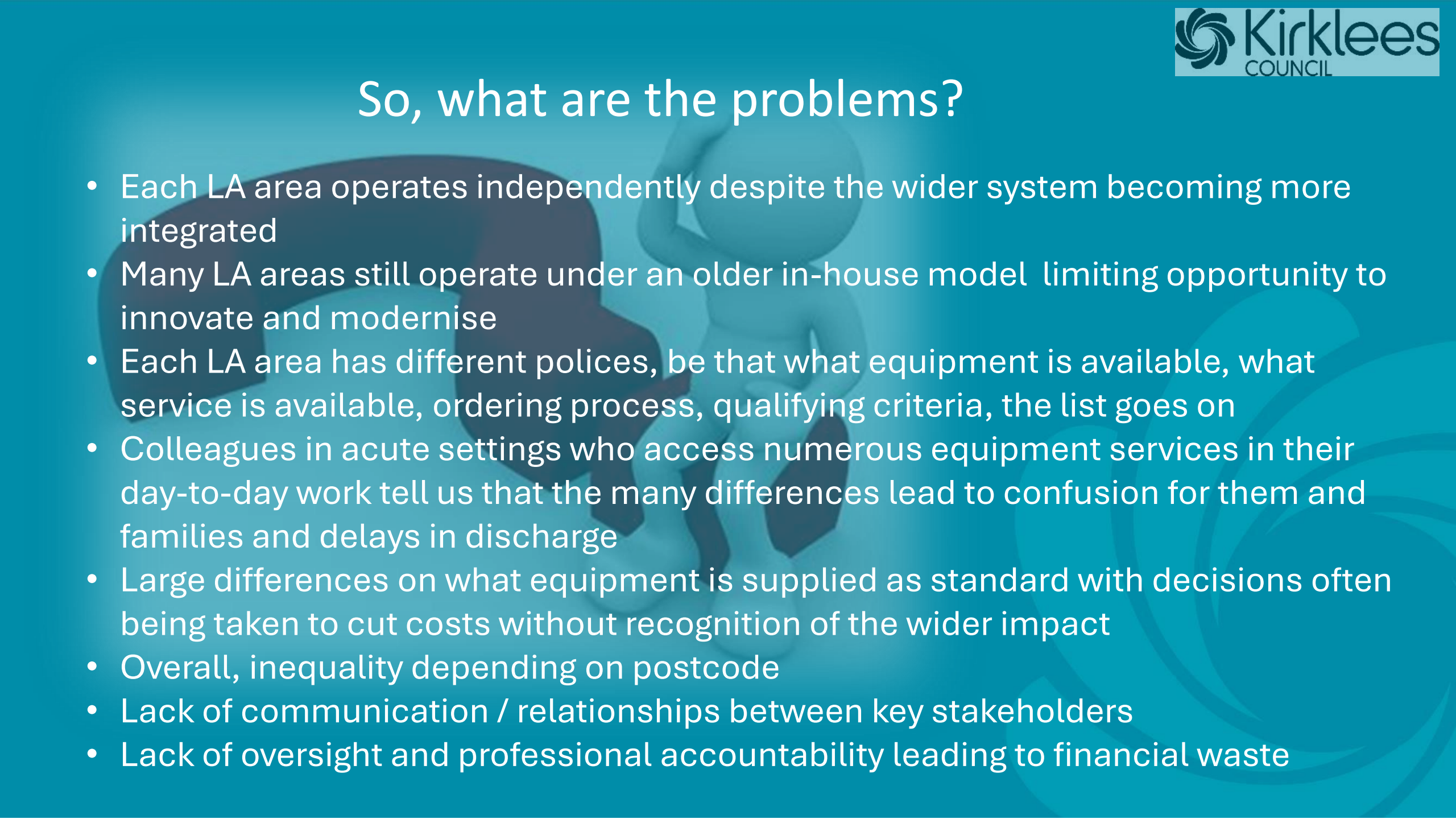
- Insights gathered via prescriber forums and surveys

What does the system want?

- The wider system, of course wants to put service users' wellbeing and safety at the forefront of everything and to ensure they have what they need when they need it
- The system wants an equipment service that can deliver urgently to support discharge or prevent admission and improve hospital flow
- The system wants a service that has clear eligibility criteria, has an accessible and comprehensive IT system, keeps up to date with market changes to ensure a comprehensive and effective catalogue of solutions.
- Demonstrates transparent and clinically led decision making
- Has robust and evidence-based processes and pathways – including increased awareness of risk through incorrect prescription
- Proactive management of existing stock & increased volume of returned stock/decreased scrappage
- ..... BUT.....
- it also has a duty to ensure an equipment service is cost effective and value for money, working within the ever-pressured budgets.

- Insights gathered via prescriber forums and surveys and discussions with acute leadership and staff

So, what are the problems?



- Each LA area operates independently despite the wider system becoming more integrated
- Many LA areas still operate under an older in-house model limiting opportunity to innovate and modernise
- Each LA area has different polices, be that what equipment is available, what service is available, ordering process, qualifying criteria, the list goes on
- Colleagues in acute settings who access numerous equipment services in their day-to-day work tell us that the many differences lead to confusion for them and families and delays in discharge
- Large differences on what equipment is supplied as standard with decisions often being taken to cut costs without recognition of the wider impact
- Overall, inequality depending on postcode
- Lack of communication / relationships between key stakeholders
- Lack of oversight and professional accountability leading to financial waste

What is possible?

Over the past 2 years, at KICES, we have planned, implemented and embedded new ways of working, our aim was to develop a service that makes pragmatic decisions for the good of the wider system, helping to conserve health and social care resources by demonstrating positive relationships, with key stakeholders, ensuing a timely and responsive service which meets the needs of our local residents.

The headline results have been:

- Reversal of a £500k overspend in 12 months
- Evidenced cost avoidance of >£700k / year
- Delivery KPI >99.7%
- Service user and Prescriber satisfaction >99%
- Scrap rates reduced by 38%
- Urgent service tracking to save NHS £5.6M this year at a cost of just £36k to the service
- We have become integrated into the wider health and social care system

What did we do?

Identified 4 key areas for improvement:

Provider performance and contract management

Prescriber behaviour and appropriacy of orders

Sustainability

Collaborative working and person-centred approach

Identified 4 key areas for improvement

Provider performance and contract management

- Worked with our provider, service users and wider system colleagues to produce an updated specification that met the needs of the system and met the needs of our service users
- Introduced a contract management framework that enabled and encouraged constant improvement and innovation whilst giving assurance on quality
- Introduced robust contract KPI measures to give assurance on service delivery
- Built close working relationships at all levels with the KICES team based at the providers depot working together to problem solve in the moment

Identified 4 key areas for improvement

Prescriber behaviour and appropriacy of orders

- Upgraded TCES to latest version and introduced forms for products, speeds and minor adaptions as well as general forms for all orders.
- Implemented a ‘Professional Statement’ for prescribers to certify they had met their obligations as a registered professional on their order.
- Used the data gathered from the forms to identify training needs.
- Worked closely with the hospital and community leads to implement training programmes focused on what individual teams required.
- Updated the criteria and guidance document to be more user friendly and relevant.
- Removed all authorisers from the system, outside of the KICES team.
- KICES team to take responsibility for reviewing every order to ensure consistency in approach
- Forged collaborative relationships with prescribers and managers to ensure good, open lines of communication and a genuine person-centred approach.

Identified 4 key areas for improvement

Sustainability

As a contracted service we work on a credit model, as an item leaves to fulfil an order, we are charged its agreed purchase price, once it is collected and recycled back to shelf, we receive an 80% credit. Maximising product back to shelf and minimising scrap was vital to ensure we ran in a cost-effective way, but also to ensure we are as environmentally friendly as possible.

We:

- Introduced new criteria for what could be scrapped.
- Lowered the value threshold for scrap v's repair
- Addition of an auditable sign off process for any scrapped equipment including photographic evidence.
- Nominated named members of staff who are authorised to process scrap.
- Started a programme of active recall of equipment and care home audits.
- Created a trade price catalogue to support care homes in purchasing their own equipment.
- Undertook catalogue reviews to ensure high quality products at a cost-effective price

Identified 4 key areas for improvement

Collaborative working and person-centred approach

A key element that brings everything together was to ensure genuine collaboration with all our system partners, our provider and of course, our service users.

- Putting the voice of our service users at the heart of our service by commissioning Healthwatch to undertake independent, monthly reviews including monthly ‘ride along’ days with a driver to get face to face feedback, with an annual report published each year.
- Building relationships with all our partners in hospital and community settings with clear and easily accessible lines of communication.
- Being truly responsive to the need to support the often rapidly changing demand to support discharges.
- Where time is of the essence, taking a ‘do first, sort the politics later’ approach.

Bigger Picture

We have achieved what we set out to achieve, to become a central and integrated part of the health and social care system for Kirklees.

It is our belief that services that continue to work in isolation will continue to fall behind in meeting the needs of their residents, continuing to reduce costs by cutting the level of equipment that is available without recognising the wider financial impact across the system and inequality / postcode lottery that it creates

By taking a step back, working collaboratively and pragmatically we have an opportunity to overhaul equipment services across the country by learning from the success in Kirklees

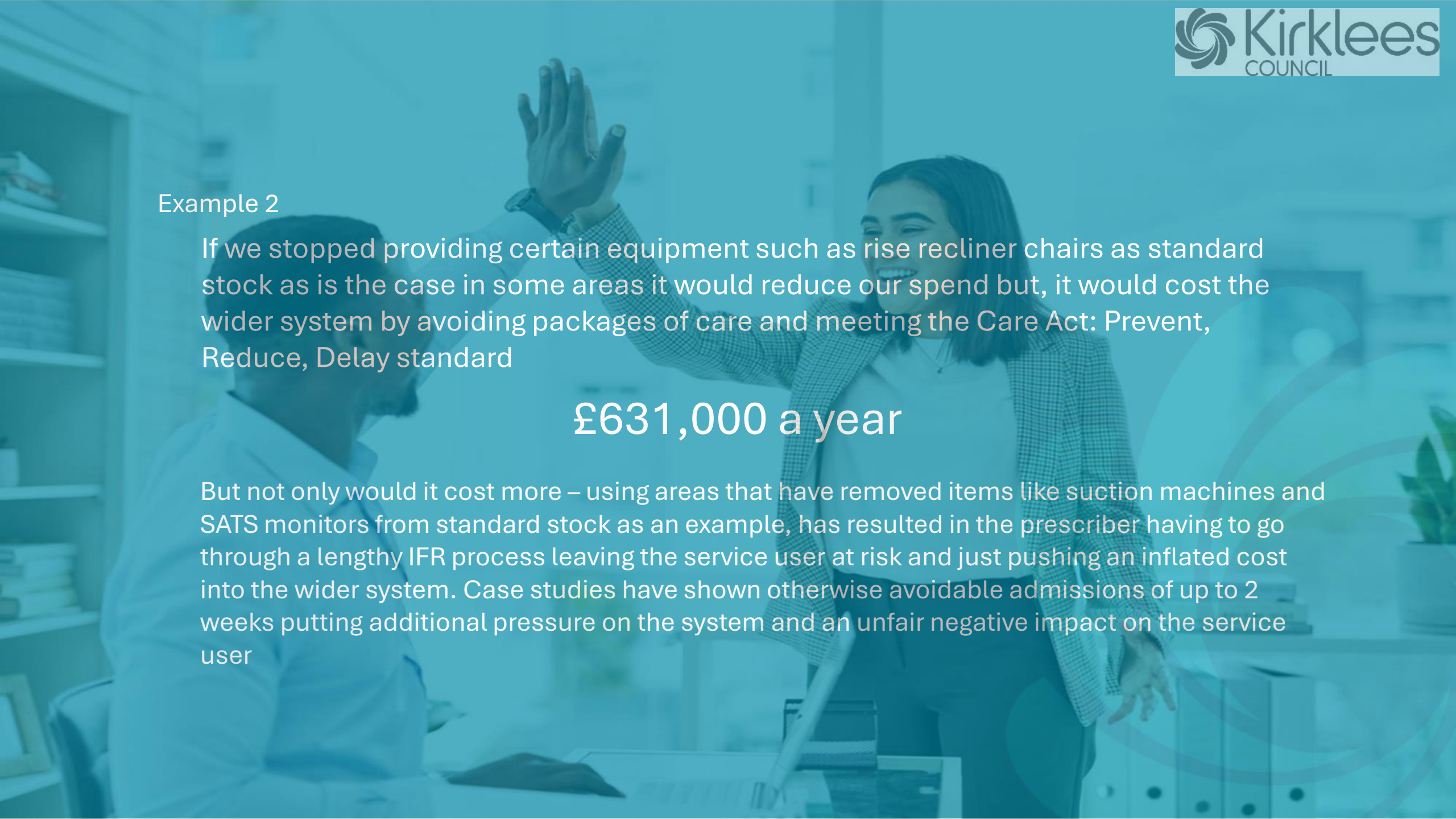
Example 1

If we stopped offering same day and urgent delivery options and reverted to a 5-day service as is the case in some areas it would save our service

£36,000 a year

It would cost the NHS, due to extended length of stay

£5,605,000 a year



Example 2

If we stopped providing certain equipment such as rise recliner chairs as standard stock as is the case in some areas it would reduce our spend but, it would cost the wider system by avoiding packages of care and meeting the Care Act: Prevent, Reduce, Delay standard

£631,000 a year

But not only would it cost more – using areas that have removed items like suction machines and SATS monitors from standard stock as an example, has resulted in the prescriber having to go through a lengthy IFR process leaving the service user at risk and just pushing an inflated cost into the wider system. Case studies have shown otherwise avoidable admissions of up to 2 weeks putting additional pressure on the system and an unfair negative impact on the service user

Example 3

If we stopped providing equipment into care and IMC settings to support discharge, it would reduce our spend by £132k, but increase in costs to them of an additional

£192,000 a year

IMC and spot purchase beds are increasingly used to support discharge out of acute settings which in turn has resulted in a wider variety of need and increased acuity seen in these settings – if the equipment service is flexible and supports these requests, we reduce delays, provide a smoother transition for service users whilst maximising potential for these beds to be used reducing pressure on acute beds

Our pragmatic and person-centred approach, includes:

- We have robust and clear guidance for prescribers, and we have criteria to meet, however, we will always take the pragmatic approach
- We will provide anything that has been appropriately assessed for and the need identified
- We will provide duplicate equipment into schools and homes to maximise a child's independence
- We treat every request individually with no blanket policy
- The KICES team works hand in hand with prescribers offering clinical guidance
- Upskilling prescribers by running regular equipment awareness days, increased awareness of risk of harm through incorrect prescribing
- Review catalogue in a collaborative way, including the voices of the service user & prescriber ensuring whole life costs and clinical input are not overshadowed by cost cutting
- Act as a central coordinator for system wide events **(MHRA alert)**
- Proactive recall of equipment **(£125K back APr-24 – Dec 24)**
- Proactive management and recall of special-order items **(£680k saved 12 months to Jan 25)**
- Guidance, support and intervention (**£466k saved Apr 24 – Dec 24)**

Outsourcing

Much of what we have achieved has only been possible due to the outsourced model we have in place, intrinsically linked to the inhouse KICES team, and the funding model we operate on

A section 75 agreement that is 50/50 funded between health and social allows us to effectively manage the budget and direct resource where its needed – eliminating the complicated and fractured funding models of Health V's Social we see in some other areas

Outsourcing to a provider with a clear and modern specification and genuine partnership working allows us to benefit in many ways, including:

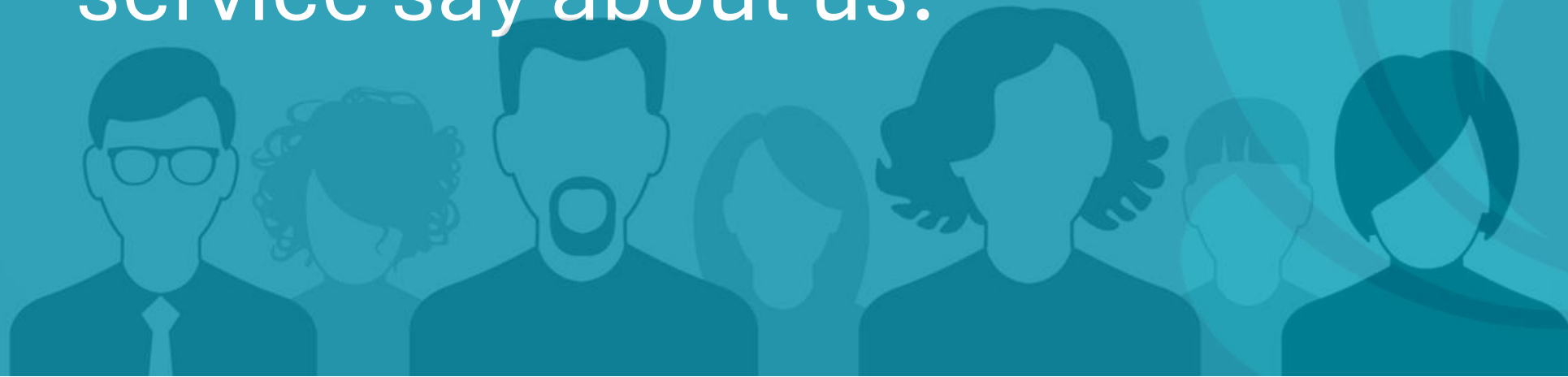
- Stock holding is liability of the provider
- Credit model balances costs and improves cash flow
- Harness the buying power of the provider to significantly reduce equipment issue cost
- Eliminate delays due to stock shortages as the provider has a national network of overnight transfers
- Harness the Clinical, Health, Safety, Environment, Quality and procurement expertise of the provider at a national level
- Ability to adapt the TCES system in a bespoke way at no additional cost
- Mitigate impact of unforeseen events, e.g Covid, MHRA alert

Next Steps

- We need to go further, at regional and national level to produce a standard approach to the procurement and delivery of equipment services to ensure equality and costs effectiveness
- We need to work in collaboration with all key stakeholders, including other services, acute settings and service users to co produce what good looks like
- We need look at the system pound and seize opportunities to ensure appropriate funding levels and models allow for pragmatic working and reduces delays due to bureaucracy
- We need to ensure we maximise what we offer on standard stock recognising the relatively low spend on equipment can save many £000,s in wider costs such as care packages or increased length of stay
- We need all services to work hand in hand to reduce the number of hand offs, reduce inappropriate orders and working collectively to put the service user's best interests first

This has all been achieved in Kirklees and is easily replicated !

And here is what people who use our service say about us:



“Person with chronic heart failure, not for admission had chest infection- able to order nebuliser on a same day delivery and avoided hospital admission.”

“Equipment ordered on emergency speeds for next day delivery on a Friday was accepted and delivered within 30 minutes of placing the order! Demonstrated excellent organisation of the service and family were thrilled that everything was in place for their relative who was due to be discharged on the Monday.”

“I have had a few instances where I have needed to discuss equipment before I put the referral through. It has been really useful to have a conversation with someone from the team to discuss the options and come to a solution together. This meant the correct equipment was ordered the first time round, enabling authorisation and delivery promptly.”

“I just wanted to send a massive thank you from the Inpatient Therapy teams at CHFT for the amazing work today. The feedback from the OT's and AP's has been that you have gone above and beyond to make sure equipment has been delivered to facilitate patient discharges today.”

“KICES is a great service who supports hospital discharges at Mid Yorkshire teaching NHS trust, they support us in many ways with ensure the patient receives the best service and reduces unavoidable lengths in hospital stays.

The team are very knowledgeable on products they provide and will assist Clinicians with their decision making to ensure the patients receive the correct equipment for their current needs. They have excellent communication to our services via email, telephone, meetings and keep us updated on any changes or product information.
The flexibility of the service is excellent with same day deliveries, which helps stop unnecessary hospital admissions and support end of life patients and their ability to support deliveries throughout the week to support flow from the hospital. They have a wide range of equipment on offer compared to other equipment stores in the region. They provide a satellite store to our DDH site. They have provided the space for the clinicians to be taught on equipment products.

Moving to a discharge to ax model the equipment store has support this change the best they can to meet demand in a timely way and they will increase their capacity to support the trusts opel levels when required.

They have changed their online referral process to make it simpler to order and have provided excellent risk ax online to support decision making no other equipment store we have contact with does this.”

Thank you

We hope we have demonstrated how a modern equipment service can offer early intervention and prevention for individuals to maximise independence and maintain them in their own home.

“It was nice to be involved in the equipment decisions, being able to go to the depot with the therapist and try the equipment and look at different options meant my Mum got what she needed, and the rest of the family could relax a little knowing she would be safe at night .”

Welcome to Barnsley Council's Supported Employment team

Department for Work & Pensions

Skills & Employability

BARNSLEY Metropolitan Borough Council

AIMS OF WORKSHOP

What is supported employment and how do we do it

The key benefits of supported employment

Outcomes and achievements

How supported employment contributes to economic development

Ruby's story

Department for Work & Pensions

Skills & Employability

BARNSLEY Metropolitan Borough Council

Introducing Barnsley

In Barnsley, we currently have 39,800 economically inactive residents.

Supported employment

5 stage model

- Client engagement - meet and get to know the person.
- Vocational profiling - learn about their strengths, achievements and ambitions to develop a plan.
- Job finding - supporting the person to look at opportunities, identify suitable roles and apply.
- Employer engagement - creating roles with suitable adaptions and identifying support.
- On and off the job support - job coaches learn the role and provide support.

Three key benefits

People and communities

- Changes lives.
- Grows aspirations.
- Enables equality and social mobility.
- Social development and inclusion.
- Financial freedom.
- New skills and abilities.
- Independence from Adult Social Care.

Business benefits and culture

- Saves on recruitment.
- Potential to increase retention.
- Enhances reputation.
- Contributes to corporate social responsibility.
- Team development.
- Enables cultural change.

Inclusive economic development

- £9500 annual savings and contribution to the national economy for each person going into work.
- Savings to the council and Adult Social Care.
- Increased local spending of the Purple Pound.

Top achievements and outcomes

40 opportunities
created for SEND students.

66% success rate
for our NHS internships - above the national 60%.

30 businesses
creating inclusive roles.

Leading the region
to deliver Local Supported Employment with government funding.

90% in external inspection
highest performer nationally.

Consistently above
National Level for ASCOF indicator 1E.

59% of people
in work for over 12 months.

Winners of
South Yorks Careers Award for Creativity and Innovation.

LGC Award winners
"Economic Development"

"Market leaders"
recognised in external audit.

Alternative recruitment source

Unique delivery of 5 stage model

Supporting inclusive economic development

£27k supported

per job in the Barnsley economy each year (GVA)

£2,500 per person

per year contribution into tax and national insurance

£5,000 per year

average savings from benefits

Business we support

meet some of our champions

Businesses we support

Savings on effective recruitment

Introductions and working interviews

Benefits for culture

Enhances corporate social responsibility

White's Bakery

The people we support

Ruby

- Ambitions
- Confidence
- New skills and abilities
- More stamina
- Friends

QUESTIONS?

Department for Work & Pensions

Skills & Employability

BARNSLEY Metropolitan Borough Council