Notice of a public meeting of
Health and Wellbeing Board

To: Councillors Storey, Stuchfield, Steels-Walshaw (Chair), Runciman, Webb, Cullwick, Balsom, Broughton, Campbell, Coltman-Lovell (Vice-Chair), Kelly, Morritt, Padgham, Forber, Roderick and SemmenceCullwick
Anja Hazebroek - Executive Director of Communications, Marketing and Media Relations, NHS Humber and North Yorkshire Health and Care Partnership (Interim 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
Zoe Campbell – 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
Simon Morritt - 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
Mathew Walker – Deputy Chief Fire Officer and Director of Service Delivery, North Yorkshire Fire and Rescue Service

Date: Wednesday, 7 May 2025

Time: 4.30 pm

Venue: West Offices - Station Rise, York YO1 6GA

A G E N D A

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

2. Declarations of Interest (Pages 7 - 8)
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. Minutes (Pages 9 - 20)
To approve and sign the minutes of the last meeting of the Health and Wellbeing Board held on **Wednesday, 19 March 2025**.

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

Please note that our registration deadlines have changed to 2 working days before the meeting. The deadline for registering at this meeting is at **5.00pm** on **Friday, 2 May 2025**.

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

Webcasting of Public Meetings

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

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

5. Update on the York Drug and Alcohol Partnership: Strategic Priorities 2025/26 (Pages 21 - 38)

This paper introduces the York Drug and Alcohol Strategic Priorities for 2025 / 26. These were agreed at the Drug and Alcohol Partnership Board in March 2025. Each priority has a lead within a relevant organisation. The Health and Wellbeing Board are asked to support the priorities and consider how as partners they can support the delivery of the outcomes.

6. Better Care Fund (Pages 39 - 100)

The York Better Care Fund (BCF) plan has been developed through a collaborative process, ensuring alignment with national priorities and local partnership objectives. The final plan was submitted on 28 March, meeting the national submission deadline. The York Health and Wellbeing Board is now asked to review and approve the plan as part of the BCF assurance process.

7. Goal 1 in the York Joint Local Health and Wellbeing Strategy 2022-2032: 'Reduce the gap in healthy life expectancy between the richest and poorest communities in York' (Pages 101 - 114)

As the Health and Wellbeing Board has now approved Action Plan 2 for the York Joint Local Health and Wellbeing Strategy, we will continue to report on all the Goals in turn, and this paper is intended to present to the Board the current data on Goal 1 around inequalities in life expectancy and healthy life expectancy in York, following a similar paper at the same stage in Action Plan 1. This is also in fulfilment of a Council Plan 2023-2027 objective to 'Increase council-wide action to reduce health inequalities' and report on this annually.

8. Update from the York Health and Care Partnership (Pages 115 - 120)

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

The report is for information and discussion and does not ask the Health and Wellbeing Board to respond to recommendations or make any decisions.

9. Health and Wellbeing Board Chair's Report (Pages 121 - 124)

This paper is designed to summarise key issues and progress which has happened in between meetings of the Health and Wellbeing Board (HWBB), giving Board members a concise update on a broad range of relevant topics which would otherwise entail separate papers.

10. Healthwatch York Reports: GP Surgeries in York: Accessibility Audit Findings and GP Practice Websites in York: Audit Findings (Pages 125 - 194)

This report is for the attention of Board members, sharing two Healthwatch reports which looks at the results of website and surgery access audits completed by Healthwatch York volunteers.

11. Urgent Business

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

Democratic Services Officer

Ben Jewitt

Contact Details:
Telephone – (01904) 553073
Email – benjamin.jewitt@york.gov.uk

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 جاسکتی ہیں۔ **(Urdu)**

Agenda Item 1

Declarations of Interest – guidance for Members

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

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

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

(3) Members in arrears of Council Tax by more than two months must not vote in decisions on, or which might affect, budget calculations, and must disclose at the meeting that this restriction applies to them. A failure to comply with these requirements is a criminal offence under section 106 of the Local Government Finance Act 1992.

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City of York Council	Committee Minutes
Meeting	Health and Wellbeing Board
Date	19 March 2025
Present	Councillors Steels-Walshaw (Chair), Runciman, Cullwick and Webb Sarah Coltman-Lovell - York Place Director (Vice Chair) Siân Balsom – Manager, Healthwatch York Peter Roderick - Director of Public Health, City of York Council (Left 6:21pm) Martin Kelly - Corporate Director of Children's and Education, City of York Council Sara Storey – Corporate Director, Adults and Integration, City of York Council Alison Semmence - Chief Executive, York CVS Fiona Willey – Chief Superintendent and Head of Local Policing, North Yorkshire Police (Substitute for Tim Forber) David Kerr – Community Mental Health Transformation Programme and Delivery Lead – Tees, Esk and Wear Valleys Fountation Trust (Substitute for Zoe Campbell)
Apologies	Zoe Campbell – Managing Director, Yorkshire, York and Selby - Tees, Esk and Wear Valleys NHS Foundation Trust Simon Morritt - Chief Executive, York and Scarborough Teaching Hospitals NHS Foundation Trust
Absent	Dr Emma Broughton – Joint Chair of York Health and Care Collaborative Mike Padgham – Chair, Independent Care Group

33. Apologies for Absence (4:34pm)

The board received apologies from the Chief Executive, York and Scarborough Teaching Hospitals NHS Foundation Trust; no substitute was available.

The board received apologies from the Chief Constable, North Yorkshire Police, who was substituted by the Chief Superintendent and Head of Local Policing.

The board received apologies from the Managing Director, North Yorkshire, York and Selby - Tees, Esk and Wear Valleys NHS Foundation Trust, who was substituted by the Community Mental Health Transformation Programme and Delivery Lead.

34. Declarations of Interest (4:34pm)

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.

35. Minutes (4:35pm)

Resolved: To approve and sign the minutes of the last meeting of the Health and Wellbeing Board held on 22 January 2025.

That minute 29, paragraphs 8 and 9 be amended to state: “*proactive* social prescribing” rather than “*practice* social practicing”.

36. Public Participation (4:36pm)

Ben Ffrench spoke on item 5, concerning the need for much greater access and visibility of mental health support for young people in York; and universal provision in schools.

37. Healthwatch York Report Core Connectors Report Young People's Experiences of Health and Social Care (4:40pm)

The Board received a report from the Core Connectors team, working with Healthwatch York, which shared the results of their peer research.

The Manager, Healthwatch York introduced the report. She explained that this scheme had begun as an NHS England programme concerning coastal areas of Humber and North Yorkshire, but that further funds had been made available for Healthwatch outside of these areas. Because of this origin, the aims of the project and prescribed questions were initially inherited, and Healthwatch York didn't have its usual autonomy concerning exactly what was asked, but together with the Public Health team, they had been able to add their own questions to focus on conversations with young people in the city.

Two young people from the Core Connectors team presented the report and spoke of their personal experiences and those of other young people with whom they had spoken. They conducted a semi-structured survey with 10 Core Connectors which addressed such issues as food insecurity, healthcare access, housing/financial strain, transportation challenges and mental/physical health.

Their conclusions were that the following factors would make York a healthier city:

- Reducing waiting times.
- Increased mental health care options.
- Better access to trans health care.
- More support systems in schools.
- Affordable food options.
- More social spaces that don't involve alcohol.
- Better transport (cheaper prices, more frequent bus times).
- Increased access to outdoor activities and green spaces for people with disabilities.
- Referrals from schools to support services.
- Improve cycle paths, pedestrian area and lighting.

And they made the following six recommendations:

- Introduce cost of living support.
- Reduce wait times for mental health support.
- Tackle GP and dental wait times
- Create affordable social and community spaces
- Transition to Adult Services
- Improve Public Transport

The Director of Public Health praised the Core Connectors presentation in particular and the wider work of Healthwatch's report. He also acknowledged the speaker who had referenced this item in Public Participation, which aligned with the discussion of mental health in the report.

He said the aims of the group were commendable. While he recognised that it would be good to fulfil all of the recommendations as soon as possible he was keen to see how these priorities could be aligned with the current structures.

He noted that York had not historically had a specific children and young people's mental health group – rather one for all ages, and within this group the voices of children and young people tended to be drowned out. With programmes such as Nothing About Us Without Us the case for an age-specific group, reiterated by the core connectors has been made and there was now a children and young people's mental health group.

Secondly there were plans ahead to work with York CVS along with ICB resources to invest in the third sector concerning Childrens and Young People's health.

He advised that every few years Public Health undertake surveys of children in various year groups. A 5-year sample of 2-3000 children to establish priorities, and this broadly aligned with what the Core Connectors had focused on.

The board noted the focus on alcohol-free spaces and also on public transport and asked what the main priorities of young people were.

The Manager, Healthwatch York responded that different cohorts of young people clearly had different contextual priorities (for instance those at Askham Bryan College had more

of a focus on rurality and transport, whereas those in Museum Gardens had a very different situational focus). She did however note that everyday living expenses were a recurring factor for young people. She added that NHS England would no longer be providing central funding for Core Connectors, but local funding would allow further support for a T level student at York College to take this plan forward – possibly with a focus on transport.

The board asked how the young people were selected to become core connectors and respond to the survey.

The core connectors responded that the broad parameters were that respondents be 14 to 25 years of age, and they began by asking people at York College, before broadening the field by talking to cohorts at Askham Bryan College, the Museum Gardens, an LGBT cafe in the city centre and a mental health event.

The board asked whether a formal follow up could be undertaken, tracking progress about the six recommendations and have a report back to say what has happened.

The Manager at Healthwatch York responded that the recommendations were quite broad and there were already some pieces of work being undertaken that may help to address some of the recommendations in the longer term, but the intention would be to have the Healthwatch report in July address this and any responses to the recommendations from board members would be appreciated.

The Director of Place noted that the Integrated Care Board had recently held a sort of public communication pre-engagement exercise, and some of the themes highlighted between that and this were very similar. While the sample size of this group was small, it was indicative of similar work done by the NHS.

In regard to priorities, she wondered whether transport, higher education and cost of living might form a focus for the next step, and in terms of the future of Core Connectors could they be used to assist with peer support networks?

The Corporate Director of Childrens and Education suggested that it was possible the authority had not been communicating well with the relevant people about what is already available – there are already capped £1 fees across the bus network for

under-18s. The Schools Wellbeing Service provides Mental Health provision, as does York Mind and significant commitment and financial investment has been put into bringing together youth services and making York a trauma-informed city. The adults do not know everything that is happening in the city and resources perhaps need to go into ensuring that children do as well.

The board suggested speaking to both the Council and the Mayor regarding issues raised.

Cllr Webb responded that the Combined Authority Mayor had recently met with care leavers with the discussion very much focused on transport.

The Manager, Healthwatch York noted that the past "Young People's Survival Guide" had been a useful resource in this area and pointed out that there would be a Core Connectors meeting at Priory Street on Tuesday 25 March.

Resolved: That the Board would:

i. Receive the Core Connectors report,
ii. Provide a response to the recommendations to be collated for the July Health and Wellbeing Board

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

38. Joint Local Health and Wellbeing Strategy Action Plan (5:16pm)

The report was presented by the Director of Public Health. He explained that this 2-year action plan constituted part of the overarching 10-year Health and Wellbeing strategy, and the focus which had been chosen was to bridge the gap in healthy life expectancy, and this could be measured in different ways, but deprivation was the most measurable metric.

He summarised the goals and fulfilment of these as well as the compassionate approach to discussing healthy weight. It was clarified that goal 5 should correctly read "Reverse the rise in

the number of children and adults living with an unhealthy weight.”

He discussed action 10, which had been left open for discussion, and concerned social isolation; proposing that the board identify a particular group within the city that suffers from loneliness and social isolation more than others and focus on this for action 10. He suggested that adult and young carers might be an appropriate group for this.

The Chair asked the board to approve actions but also to delegate formulation to lead officers for action 10.

The Chair said that she had been concerned that limiting action 10 to a single group might risk omitting particular demographics, but that the scope of the proposed group of adult and young carers actually gave sufficient scope in terms of age groups.

The Corporate Director, Adults and Safeguarding noted that some of the previous metrics and measures were from an Adult Social Care survey concerning carers and those with social care needs. She suggested talking to carers and young carers to ascertain their thoughts, but ultimately for the board to commit to some very specific and measurable actions - we could therefore follow up in a year's time with evaluation of those actions.

The Chief Executive, York CVS suggested working specifically with young carers first and foremost as a cohort, because they can be hidden in plain sight and the schools don’t always pick them up. It was suggested that Champions could be

The Manager, Healthwatch York further discussed young carers; suggesting this was a significant blind spot and the hospital has not routinely been asking whether young people had siblings or directing them to the centre for young carers. She said it was telling that only six young carers had been identified by schools in the recent survey, and that caring must be embedded in everything. She also discussed micro-caring as a career choice.

The Corporate Director, Adults and Safeguarding responded that micro-caring had come to her attention recently; there had been work around this in York in the past, but she cautioned that this sector was unregulated and dealt with potentially

vulnerable people, and checks/registers in this area had not been available. She suggested that micro-provision may potentially be beneficial for befriending and low-level support advice.

The Manager, Healthwatch York also drew attention to the importance of dementia diagnosis, alcohol awareness and adults living to a healthy weight on the action plan, suggesting further work could be done in these areas considering the discussion on Core Connectors item and previous board discussions on these topics.

Cllr Webb suggested that schools may need support knowing what a carer looks like, and also when Council teams are contacting residents about areas such as housing or adult social care, they could take the opportunity to discuss caring.

Cllr Runciman suggested that loneliness was not linked solely to poverty, and other factors such as bereavement must also be considered. She also suggested that many carers may not think of themselves as carers in their everyday lives, and asking bluntly whether people are “carers” would not necessarily result in all carers self-identifying and responding.

The Chief Executive, York CVS spoke on Goal 6 – requesting to amend the wording to reflect embedding of the standards across the system in the avoidance of being misleading. The Director of Public Health agreed to this.

The Board thereby

Resolved: i. To approve the action plan and receive regular progress updates on the delivery of these actions.

ii. To delegate the identification of specific actions for Goal 10 to the lead officers for this goal.

Reason: To ensure the HWBB is actively and effectively delivering on the vision and ambitions set out within the Joint Local Health and Wellbeing Strategy 2022-2032.

39. Health and Wellbeing Board Chair's Report (5:58pm)

The report from the Chair of the Health and Wellbeing Board summarised key issues and progress between meetings, providing board members with a concise update on a broad range of topics.

The Chair highlighted Healthwatch York's nomination for a National Impact award, recognising outstanding examples, such as the Autism and ADHD pathway. The Manager, Healthwatch York said they had since been commended for their work in this area.

The Chair advised that the draft Adult Social Care strategy for the next three years had now been completed. This focused on recognising strengths and reducing inequalities.

The board noted that consultation had been advertised as open until the end of March, but members had been made aware of some residents who were really interested in the strategy but may need a little bit longer to be engaged for their feedback. The board reassured these residents that if they were unable to submit their feedback before the end of March, their voices would still be heard.

The Chair advised that the full version of the Pharmaceutical Needs Assessment (PNA) would be available by autumn 2025. The main purpose of the PNA was to look at evaluation and applications for new pharmacies in the area there had been a lot of talk around pharmacies recently with residents wanting provision at weekends and out of hours (after 5pm) and concern around possible changes to opening times. She suggested that this was particularly prevalent in light of the increased services coming to pharmacies and advised that public health were working with the GPs and charities to work around people facing barriers. In June there would be a forum where public and professionals would be invited to comment on the draft PNA before publication of the final version.

The board congratulated the Public Health team for receiving over 400 responses to the PNA survey.

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.

40. Update from the York Health and Care Partnership (6:04pm)

The board received an update on the progress of York Health and Care Partnership initiatives.

The NHS Director of York Place presented the report – summarising recent YHCP meetings, discussing the Frailty Crisis Response and Health Integration service, mental health hubs, and various support programmes for vulnerable populations. She also summarised the draft Humber and North Yorkshire ICB annual report was now ready and advised that the draft York Health and Care Partnership annual report would be coming to a future meeting of the Health and Wellbeing Board.

The Community Mental Health Transformation Programme and Delivery Lead – Tees, Esk and Wear Valleys Foundation confirmed that the Acomb Medical Centre would open in (or around) summer 2025.

The Director of York Place advised the board of two significant government announcements.

Firstly she advised of the well-publicised abolition of NHS England – signalling greater direct control of the performance targets surrounding NHS Trusts.

Secondly, she advised that there had been a request for ICBs to reduce running costs – essentially staffing costs – by quarter three of the current year, meaning December, so they had a very short time scale to work with.

The Director of Public Health commented on this news saying how much he valued the hard work of the ten members of the York Place team, and looked forward to continuing to work with them, offering his support.

[The Director of Public Health left at 18:21]

The Chair thanked the Director of York Place for all her work on the board, prior to her planned leave.

Resolved: That the Board note the report of the YHCP.

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

Cllr L Steels-Walshaw, Chair
[The meeting started at 4.34 pm and finished at 6.22 pm].

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Health and Wellbeing Board 7 May 2025

Report of Peter Roderick, Director of Public Health, City of York Council

Update on the York Drug and Alcohol Partnership: Strategic Priorities 2025 / 26

Summary

1. This paper introduces the York Drug and Alcohol Strategic Priorities for 2025 / 26. These were agreed at the Drug and Alcohol Partnership Board in March 2025. Each priority has a lead within a relevant organisation. The Health and Wellbeing Board are asked to support the priorities and consider how as partners they can support the delivery of the outcomes.

Background

2. The government's 10-year strategy 'From Harm to Hope' (2021) lays out several aspirations which aim to reduce the harm caused by drug and alcohol use nationally.

3. Local delivery of this strategy has been in progress since its publication, including:

    i. the establishment of the York Drug and Alcohol Partnership in 2022, chaired by the Director of Public Health, which reports its activities through into the Health and Wellbeing Board

    ii. the development of a Health Needs Assessment for drugs and alcohol

    iii. the additional resourcing of the prevention and treatment system through the Drug and Alcohol Treatment and Recovery Grant, which in 2025/26 is £450,444.

Main/Key Issues to be Considered

4. Drugs and alcohol continue to present major issues for health and wellbeing in York, leading to early illness and death as well as hospital admissions, dual diagnosis issues together with mental ill health, as well as a large range of consequent health issues and conditions.

5. They also present a city issue, and interact considerably with significant issues around housing, criminal justice, community cohesion, employment and safety.

6. Our approach to supporting people with drug and alcohol issues has developed significantly over the last decades, from an emphasis on treatment and clinical services, to a much greater focus on recovery. The principle behind recovery is that a human's journey out of addiction is much more likely to be successful if they are part of a strong recovery community, which emphasises connection, a new recovery-based social life and as well as empowerment. In York this community has been going for many years, with cafes, meetings, activities, support and social events happening most days of the week, including at the recently opened York Community Recovery Hub on Wellington Row. This is the ultimate destination we are hoping for people in York who use substances, and the longer term solution which we believe will reduce the societal effects of substances.

7. National guidance requires a Combatting Drugs Partnership in every Local Authority, and in York we have called this the York Drug and Alcohol Partnership. It includes police, council, treatment, NHS, probation, DWP and voluntary sector partners.

8. The annexe presents the 2025 / 2026 Drug and Alcohol priorities for York, which contribute to the wider strategic direction and the national 10 years Drugs Strategy 'from harm to hope'. The national strategy specifies that local areas are required to have a strong partnership that brings together all relevant organisations and key individuals and provide a single point of contact for central government. In York, the Drug and Alcohol Partnership has proactive oversight of the implementation of planned priorities of the strategy ensuring that local organisations work together and jointly agree provision and areas to be improved.

9. The National Combating Drugs Outcomes Framework provides a structure for the metrics for monitoring. These include 6 outcomes that form the base for York's annual priorities:

Strategic outcomes:
- Reduce drug use
- Reduce Drug-Related crime
- Reduce drug related deaths and harm

Intermediate outcomes:
- Reduce drug supply
- Increase engagement in treatment
- Improve recovery outcomes
- Improve mental health outcomes

Consultation

10. The priorities were considered at board level following various reports and discussions to decide the focus for 2025. Each priority area was considered with relevant stakeholders prior to agreeing on 2-3, the leads from the priority areas were asked to decide on 2 to 3 to ensure focus to enable action.

Strategic/Operational Plans

11. The Council Plan 2023-2027 includes an ambition to 'Support more people on their journey of recovery from addiction, including through smoking cessation services and our recovery-based drug and alcohol model'.

Implications.

- **Financial** – The York Drug and Alcohol Service is commissioned by Public Health within CYC and a full procurement process was followed to contract Change, Grow, Live to meet a service specification that also supports these priorities. The Drug and Alcohol Treatment, Recovery and Improvement Grant (DATRIG) also enables funding to support the priorities.

- **Human Resources (HR) –** *There are no HR implications of this report*

- **Equalities** – *People with addictions are often one of society's more marginalised groups, suffer from significant stigma,*
- **Legal –** *There are no Legal implications of this report*
- **Crime and Disorder** – *The aim of the paper and strategic outcomes supports a reduction of crime and disorder in the city*
- **Information Technology (IT) –** *There are no IT implications* of this report
- **Property -** *There are no Property implications* of this report

Recommendations

The Health and Wellbeing Board are asked to:

a. Note and support the 2025/26 priorities of the York Drug and Alcohol Partnership

b. Consider how the priorities outlined are in line with wider HWBB priorities and how individual agencies can support this

Reason:

To keep the Board updated on the work of the York Drug and Alcohol Partnership and their Strategies.

Contact Details

Author:	**Chief Officer Responsible for the report:**

Author's name: Peter Roderick *Title: Director of Public Health* *Dept Name: Public Health* *Organisation name: CYC* *Tel No.*	*Chief Officer's name* *Job Title* *Organisation name* *Tel No*			
	Report Approved	*x*	**Date**	*28 April 2025*
Co-Author's Name *Title: Ruth Hine* *Dept Name: Public Health* *Organisation name: CYC* *Tel No.*	*Chief Officer's name* *Title*			
	Report Approved	*x*	**Date**	*28 April 2025*

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*

For further information please contact the author of the report
Background Papers:

All relevant background papers must be listed here*. A 'background paper' is any document which, in the Chief Officer's opinion, discloses any facts on which the report is based and which has been relied on to a material extent in preparing the report*

Either the actual background paper or a link to the background paper should be provided.

Annexes

All annexes to the report must be listed here*.*
Annexe A – York Drug and Alcohol Partnership Board Strategy 2025/26/ priorities.

Glossary

A separate document must be attached to each report *which clearly lists in alphabetical order any abbreviations used within the report and its associated annexes.*

York Drug and Alcohol Partnership Board Strategy – 2025/2026 priorities

Introduction

This document outlines the 2025 / 2026 Drug and Alcohol priorities for York, which contribute to the wider strategic direction and the national 10 years Drugs Strategy ‘from harm to hope’.

The national strategy specifies that local areas are required to have a strong partnership that brings together all relevant organisations and key individuals and provide a single point of contact for central government. In York, the Drug and Alcohol Partnership has proactive oversight of the implementation of planned priorities of the strategy ensuring that local organisations work together and jointly agree provision and areas to be improved.

The National Combating Drugs Outcomes Framework provides a structure for the metrics for monitoring. These include 6 outcomes that form the base for York’s annual priorities:

Strategic outcomes:	**Intermediate outcomes:**
S1. Reduce drug use S2. Reduce Drug-Related crime S3. Reduce drug related deaths and harm	I1. Reduce drug supply I2. Increase engagement in treatment I3a. Improve recovery outcomes I4b. Improve mental health outcomes

York Drug and Alcohol Strategy 2023-28

Vision for York Drug and Alcohol Strategy:

To take a public health approach across organisations through the York D & A Partnership Board to make York a place where people can be safe from the harms caused by drugs and alcohol

What are we going to do:

Across 6 areas we aim to reduce stigma, influence policy, reduce harm and provide access to quality services

Reduce Drug Use

- Targeted & comprehensive education and training
- Increase engagement between YDAS & under 18 services
- Supporting young people and families most at risk of substance misuse or criminal exploitation

Reduce drug-related crime

- Identify & tackle the causes of substance misuse and promote diversion from criminal sanctions

Reduce drug related deaths and harm

- Provide sound harm reduction advice
- Ensure robust process
- Strengthening Drug alert process across York & NY

Reduce drug supply

- Understand and tackle drugs supply & demand:
- Drug market profile
- Community drug checking/testing protocol

Increase engagement in treatment

- Increasing referrals into treatment in the criminal justice system
- Better integration of services
- Strengthening pathways

Improve recovery outcomes

- Support the recovery community to grow and thrive
- To gain Inclusive Recovery City Status
- Improving employment

How will we check on progress:

- Number of school based prevention and early intervention
- Training sessions delivered
- Engagement with families identified most at risk

- Drug related homicide
- Neighbourhood crime

- Monitor number of deaths
- Number of drug related hospital admissions
- Distribution of naloxone

- Number of county lines closed
- Number of organised crime gang disruptions

- Numbers in treatment
- Prison Continuity of Care numbers
- Treatment effectiveness

- York Recovery Hub to be established
- Inclusive Recovery City Status achieved
- Number supported through IPS service

S1. Reduce drug use

2025 Local priority objectives	Performance measure(s) Lead Organisation(s): Public Health & York Drug and Alcohol Children & Young People Service
S1.1, Establish a sub-group focused on children and young people	• Group established with participation from all relevant partners • Action plan developed
S1.2, Rollout of The Gate's 'What's the score' conversation tool for young people in schools and young people's services	• Number of professionals trained in use of 'What's the score?' • Number of YP referrals received by The Gate

There is an ambition over the course of the 10-year strategy that the rising trend in drug use will be reversed.

The D&A Partnership agreed that the focus for this year to enable the longer term aims of the strategy will focus on prevention for children and young people and decided a group to work towards the aims below would be created, with aims around:

- *Preventing the onset of drug use among children and young people; strengthening young people's sense of belonging in society.*
- *School-based prevention and early intervention; support local implementation of evidence-based approaches to reduce substance use through schools and the wider community.*
- *Supporting families and young people most at risk of substance use; facilitating early intervention, increasing identification and support for young people at particulate risk of substance use harms.*

An integral project to support this will be to roll out 'What's the Score' conversation tool, along with other training for frontline staff working with families.

S2. Reduce drug-related crime

2025 Local priority objectives	Performance measure(s) Lead Organisation(s): North Yorkshire Police, York & North Yorkshire Combined Authority, York Probation Delivery Unit
S2.1, Review of ATR and DRR targeting and delivery pathways to strengthen diversion approach and maximise delivery requirements.	• Review completed and recommendations for improvement being implemented • Numbers of ATRs and DRRs imposed and successfully completed • Re-offending among people who have ATR/DRRs
S2.2, Set up better quality data capture of criminal justice and OoCR referrals including intervention type to enable monitoring those who engage with YDAS	• Outcomes of Criminal Justice referrals tracked and analysed by OFPCC/NYP, including 'reoffending' data

It is well evidenced that drugs is a key driver of crime, with reoffending being largely linked to substance use. Criminal justice partners and focusing on ensuring those that meet the criminal justice system get support and referrals to the drug and alcohol treatment and recovery service.

S3. Reduce drug-related deaths and harm

2025 Local priority objectives	Performance measure(s) Lead Organisation(s): Public Health and York Drug & Alcohol Service
S3.1, Establish York Hospital Drug and Alcohol Care Programme for the identification of, and optimal treatment and effective discharge planning for people at risk of drug or alcohol related harm.	• AUDIT-C / equivalent assessments for all patients reportable • Number of referrals from hospital to York Drug and Alcohol Service
S3.2, Strengthen York and North Yorkshire Local Drug Information System and harm reduction activity	• Numbers of Naloxone kits distributed to people who use drugs and their friends/family who will be best placed to use it in the case of overdose • Synthetic opioids preparedness testing exercise complete and learning taken forwards

Drug and alcohol related deaths and harm continue to increase nationally, and with the introduction of Nitazenes in the drug supply more to reduce harm will be the focus for the D&A partnership for this year.

Another focus includes early identification of those within secondary care at risk of drug or alcohol related harm to support effective discharge planning to enable referral to key services and/or provide harm reduction advice.

I1. Reduce drug supply

2025 Local priority objectives	Performance measure(s) Lead organisation(s); North Yorkshire Police
I1.1, Reduce the number of drug supply lines operating in North Yorkshire and the City of York	• Number of drug supply lines
I1.2, Work in Partnership to improve community resilience to drug supply line infiltration through the use of place-based approaches such as Clifton Clear, Hold, Build	• Intelligence feeds • APMIS Disruption Data Dashboard • Community survey data
I1.3, Increase the number of vulnerable adults and children safeguarded from exploitation by County Lines and drug traffickers	• NRM referrals • APMIS 'Prevent and Protect' data

North Yorkshire Police are a key partner to assist with the reduction of drug supplies within York. May operations have already taken place and closed county lines and other serious organised crime groups. This will continue throughout 2025 and will be monitored through within NYP and the D&A partnership.

I2. Increase engagement in treatment

2025 Local priority objectives	Performance measure(s) Lead Organisation(s): York Drug and Alcohol Service
I2.1, Enhance gender-specific pathways for women into substance use treatment to better respond to distinct needs and remove barriers to access	• Number of women engaged in treatment with York Drug and Alcohol Service
I2.2, Increase the proportion of adults discharged from prison with substance use treatment need who are successfully engaged in community-based structured treatment following release from prison within 7 days	• Proportion of individuals contacted within 5 working days of referral from prison treatment service by YDAS • Proportion of adults with substance use treatment need who are successfully engaged in community-based structured treatment following release from prison within 21 days (NDTMS and contract monitoring)
I2.3, Review of pathways into substance use treatment services by NYP/Out of Court Resolution (OoCR) Team	• Review has been completed and recommendations for improvement are being implemented • Numbers of criminal drug and alcohol referrals and Out of Court Resolutions (if identified substance use need) into YDAS
I2.4, Increase number of young people provided treatment and support in relation to their own substance use by The Gate	• Number of young people under 18 in treatment for their own substance use

York Drug and Alcohol Service, (Change, Grow, Live as the contract holder) are the lead for this priority and continue to work with partners to ensure the service is meeting the needs of those that need specialist services.

The Clinical lead for Change, Grow, Live, Chairs the Clinical Leads meeting to ensure that strong pathways are identified and any issues that may be a barrier between services are worked through to safeguard the needs of individuals.

I3. Improve recovery outcomes

2025 Local priority objectives	Performance measure(s) Lead Organisation(s): Recovery Community Groups & Public Health
I3.1, Open Community Recovery Hub as a central venue for promoting recovery and hosting activities which support ongoing sustainable recovery from substance use disorders and other addictions and people affected by a family member's substance use	• Community Recovery Hub open • Number of different groups and events hosted in the Hub each month • Number of visits each month
I3.2, Establish strong IPS service within the treatment and recovery system	• Number of people supported effectively by the Individual Placement Support service to sustain employment

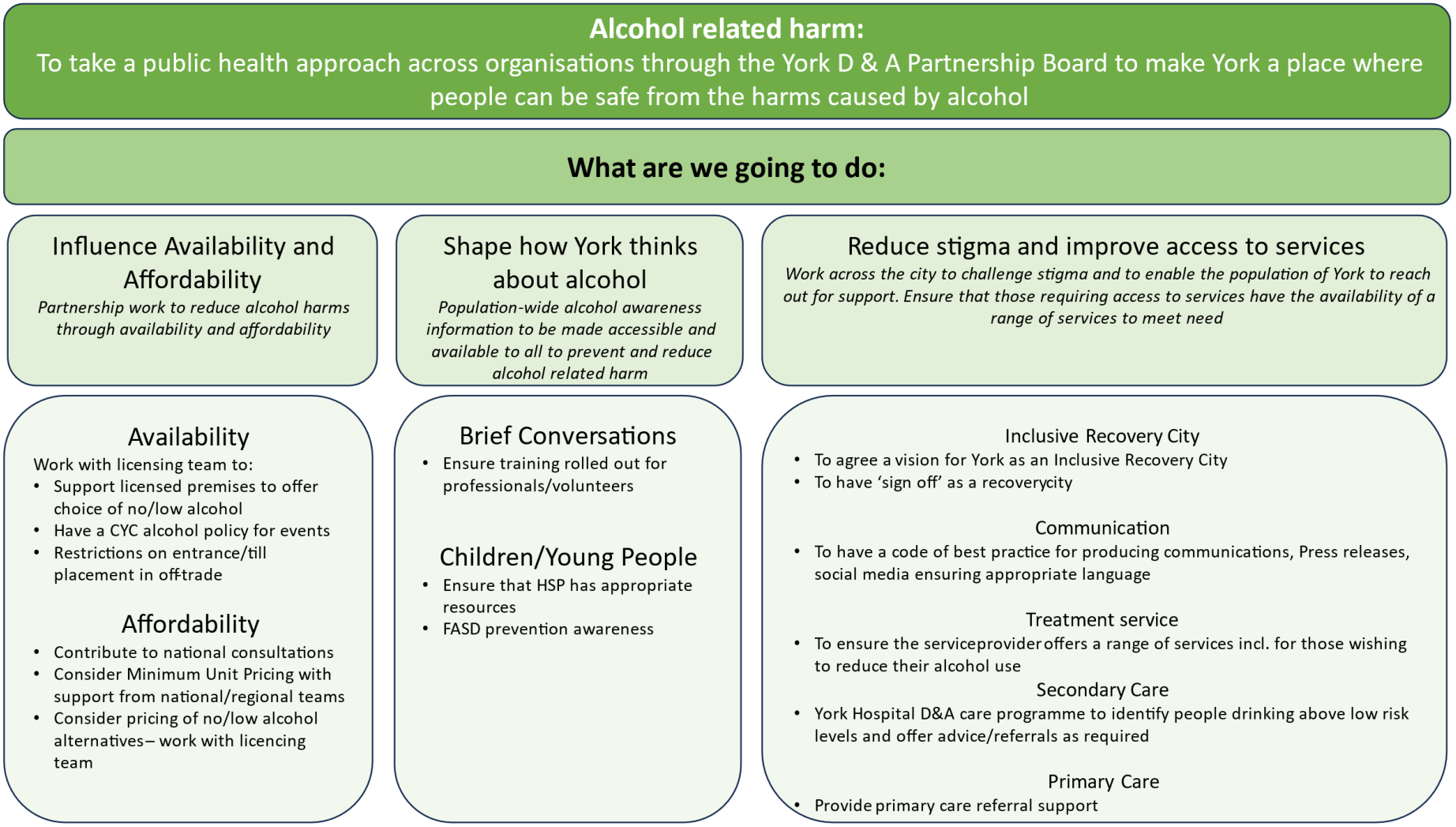
Recovery continues to be an integral element to the journey of those that access specialist treatment services. A key action for 2025 will be the opening of the Community Recovery Hub which will provide a venue for individuals to attend, supporting their ongoing journey.

I3B. Improve Mental Health outcomes

2025 Local priority objectives	Performance measure(s) Lead Organisation(s): Public Health & Mental Health
I3.1B, Improved support for individuals being referred by mental health services to York Drug and Alcohol Service or being referred by York Drug and Alcohol Service to mental health services for assessment of need. The Provider will a) ensure individuals are supported during the time they are referred between services and b) facilitate successful engagement with the service receiving the referral and c) improve dialogue between services where joint-working or re-consideration of a referral is needed.	• Percentage of YDAS referrals to MH services who attend MH service assessment • Percentage of MH service referrals to YDAS who attend YDAS assessment
I3.2B, Stronger multi-agency work between TEWV and York Drug and Alcohol Service, including attendance by relevant TEWV professionals at multi-disciplinary case meetings called by York Drug and Alcohol Service and joint pathway development	• Service Managers / Leadership Level Clinicians / appropriate substitutes participate in York Drug and Alcohol Clinical Leads meetings. • Percentage of multi-disciplinary case meetings called by York Drug and Alcohol Service where TEWV are invited that are attended by relevant TEWV professionals. • Percentage of joint TEWV-YDAS service-users whose care plan has been jointly developed with the service-user and both service

York D&A partnership recognises the role that mental health of individiuals, whether with a diagnosed mental health condition or not, can be instrumental to the care they may receive. It was decided to introduce an extra priority focusing on mental health as a separate element this is to ensure it isn't lost within other priorities.

The D&A partnership acknowledge the significance that alchol related harm has on the population of York. The diagram below demonstrates the long term approach to reducing alcohol related harm. The Board will be co-ordiating and mapping activity associated with this as a standard agenda item at the meetings.



York Health and Wellbeing Board

Health and Wellbeing Board Date: Wednesday 7 May
Report: Better Care Fund Planning Update
Author: Zoe Delaney - Interim Head of All Age Commissioning City of York Council and Assistant Director of Community Integration NHS Humber and North Yorkshire Integrated Care Board

Better Care Fund Planning Update

Summary

1. The York Better Care Fund (BCF) plan has been developed through a collaborative process, ensuring alignment with national priorities and local partnership objectives. The final plan was submitted on 28th March, meeting the national submission deadline. The York Health and Wellbeing Board (HWB) is now asked to review and approve the plan (which can be found in Annex section of this cover paper) as part of the BCF assurance process.

Background

2. The Better Care Fund was established in 2014 and is a national programme designed to support the integration of health and social care, aiming to improve outcomes for people with complex needs through more coordinated and person-centred services. It operates as a pooled budget, bringing together funding from the NHS and local authorities under an overarching Section 75 agreement, which enables the joint commissioning and flexible use of resources across organisational boundaries. For 2025/26, the BCF has two primary objectives: enabling people to stay well, safe and independent at home for longer, and providing timely and appropriate care in the most suitable setting when they need it. The 2025/26 BCF plan includes several key sections: a narrative outlining local priorities and partnership working; a breakdown of expenditure and funded schemes; a set of nationally mandated and locally agreed metrics to monitor progress; and a capacity and demand analysis to inform planning and resource allocation across the system. BCF plans are developed at HWB area

level, and it is a national requirement that each plan is formally signed off by the respective HWB.

Main/Key Issues to be Considered

3. The key components of the 2025/26 Better Care Fund plan will be presented to the Health and Wellbeing Board on Wednesday 7th May, however a summary has also been provided on the following pages in order to support the Board's strategic oversight and formal approval of the plan.

Core Performance Metrics and the Rationale Underpinning the 2025/26 Targets

BCF Metric	York 25/26 Target	Target Rationale
Emergency admissions to hospital for people aged 65+ per 100,000 population	Monthly target ranging from 1,778 to 1,944 admissions per 100,000 population, equivalent of 709 to 775 admissions.	Based on historical data from May 2023 – Nov 2024, the forecast increase in 2025/26 is 7%. The plan for York is to mitigate this rise to a forecast increase of 5%.
Average length of discharge delay for all acute adult patients	Monthly target ranging from 1.58 days in April 2025, decreasing to 1.30 days by March 2026.	Target of 3% improvement throughout the year, in-line with wider ICB.
Proportion of adult patients discharged from acute hospitals on their discharge ready date	Monthly target ranging from 66.4% in April 2025, increasing to 68.2% by March 2026.	Target of 3% improvement throughout the year, in-line with wider ICB.
For those adult patients not discharged on DRD, average number of days from DRD to discharge	Monthly target ranging from 5.20 days in April 2025, decreasing to 4.30 days by March 2026.	Most recent average in York was 5.2 days (December) with YTD average of 4.8. Target has been set as decreasing down to 4.3 days by March 2026, which is in line with the current national YTD average.
Long-term admissions to residential care homes and nursing homes for people aged 65+ per 100,000 population.	Annual target of 527 admissions per 100,000 population, equivalent of 210 admissions.	Target of 0% growth above the 2024-25 estimated number, with initiatives aimed at supporting people to remain at home for longer intended to mitigate the expected increase in this figure.

Income

	24/25 Income	25/26 Income	Uplift (£)	Uplift (%)	Description of Funding Source
Minimum NHS Contribution - ICB	£8,275,123	£8,306,736	£31,613	0.4%	Mandated contribution from ICB core budgets into the pooled BCF budget. The ICB element is not automatically passed over to social care.
Minimum NHS Contribution - Minimum Social Care Allocation	£7,450,197	£7,742,625	£292,428	3.9%	Mandated contribution from ICB core budgets into the pooled BCF budget. The minimum social care allocation is a protected minimum amount that must be spent supporting social care. Automatically passed over to Local Authority on a quarterly basis.
ICB Discharge Funding (included in NHS Minimum Contribution in 25/26)	£1,431,567	£1,431,567	£0	0.0%	BCF grant funding to support discharge introduced in September 2022 that has been recommitted annually. Value **now included within Minimum NHS Contribution ICB Element.**
iBCF (part of Local Authority Better Care Grant in 25/26)	£5,368,798	£5,368,798	£0	0.0%	Direct grant to Local Authority introduced in 2015. **Now included as part of Local Authority Better Care Grant.**
Local Authority Discharge Funding (part of Local Authority Better Care Grant in 25/26)	£1,254,495	£1,254,495	£0	0.0%	BCF grant funding to support discharge introduced in September 2022 that has been recommitted annually. **Now included as part of Local Authority Better Care Grant received directly by LA.**
Additional LA Contribution	£0	£0	£0	0.0%	Local Authorities may optionally include additional funding to be pooled into BCF budget.
Additional ICB Contribution	£0	£0	£0	0.0%	ICBs may optionally include additional funding to be pooled into BCF budget.
Total	**£25,381,376**	**£24,104,221**	**£324,041**	**1.28%**	

Key changes to 2025/26 income compared to previous year

- There is a significant 13.8% increase in the Disabled Facilities Grant compared to 2024/25, equating to an additional £220k.
- The protected social care element of the Minimum NHS Contribution has increased by 3.9%, amounting to an uplift of £292k.
- There has been no uplift to the Discharge Funding for 2025/26.
- The ICB element of the Minimum NHS Contribution has increased by £30k, representing a 0.4% rise.
- The ICB Discharge Funding is now incorporated within the Minimum NHS Contribution.
- The iBCF and Local Authority Discharge Funding have been consolidated into the Local Authority Better Care Grant.

Approach to scheme uplifts

- Limited uplift of 1.28% (£324k) to BCF funding allocation to support scheme uplifts
- A 2.15% uplift has been applied to the majority schemes in line with the standard NHS uplift that has been set nationally.
- Exceptions to this are:
    - Schemes delivered by either the ICB or City of York Council, where any pay award increases will be met internally through non-BCF funding.
    - A number of schemes that are contributions to larger costs, where the contribution amount from the BCF in 2025/26 will remain the same.
    - Uplifts to schemes delivered by NHS organisations within the ICB, where a 0.24% convergence factor has been applied in addition to the standard NHS uplift (net 1.91%) in accordance with NHS Planning Guidance.

Spend breakdown by BCF category

As part of the Better Care Fund (BCF) planning process, all schemes and associated expenditure must be categorised by both area of spend and primary objective. This ensures alignment with national reporting

requirements and supports strategic investment decisions that promote integrated, person-centred care across health, social care, and community settings.

The table below outlines the 2025/26 BCF allocation by area of spend:

Area of Spend	Total Spend	Percentage Spend
Social Care	£ 14,620,606	56%
Community Health	£ 10,744,734	41%
Mental Health	£ 198,739	1%
Primary Care	£ 4,000	0%
Continuing Care	£ 0	0%
Acute	£ 337,162	1%
Other	£ 0	0%

The largest portion of funding is allocated to Social Care (£14.6 million), representing 56% of total BCF expenditure, reflecting a continued commitment to supporting people to live independently at home and sustaining capacity within the social care sector. Community Health services account for 41% of total funding, supporting a wide range of preventative and community-based services. Smaller allocations are made to Mental Health, Acute, and Primary Care, with no planned expenditure under Continuing Care or Other categories this year.

Each scheme is also aligned to a primary objective to ensure that spending is targeted toward delivering measurable outcomes:

Primary Objective	Total Spend	Percentage Spend
1. Proactive care to those with complex needs	£ 2,738,938	11%

2. Home adaptations and tech	£ 2,345,521	9%
3. Supporting unpaid carers	£ 736,000	3%
4. Preventing unnecessary hospital admissions	£ 8,518,865	33%
5. Timely discharge from hospital	£ 1,611,189	6%
6. Reducing the need for long term residential care	£ 9,975,229	38%

This distribution of funding clearly reflects the BCF's focus on proactive, preventative care and timely interventions. The largest share is committed to reducing the need for long-term residential care (38%), followed closely by preventing unnecessary hospital admissions (33%). These priorities directly support the BCF's overarching national objectives: enabling people to stay well, safe and independent at home for longer, and accessing timely and appropriate care when needed.

Key changes to schemes and expenditure from previous year

- Significant piece of work to more accurately name and describe schemes
- Consolidation and aggregation of several schemes where separation was previously in place to distinguish different funding sources, for example aggregation of all schemes funding home care packages and funded through the Adult Social Care Discharge Fund - this has led to a reduction in duplication and contributed to a reduction in the number of schemes from 57 to 46.
- Reablement scheme now encompasses the rapid response element and reablement service, which now form part of the same contract.
- Seven-day discharge scheme funding until end of Q1 only to enable wider system discussion to take place.
- Additional contribution to staffing resource supporting hospital discharge – a further £73k funding to enable existing Hospital Social Worker Team administrative capacity (working Monday-Friday) to

continue following the loss of the original funding stream for these posts. Funding to enable the continuation of Hospital Trust element of the 7-day discharge scheme throughout Q1 also included within this scheme.

- Planned reduction and cessation of Move Mates scheme
- Resettlement bed at Union Terrace now commissioned by CYC, provided by CYC Housing team (previously delivered by Changing Lives).
- Increase in funding to the York Frailty Hub (approximately £100k).
- Increase in funding to intermediate care discharge to assess beds (approximately £52k).

Capacity and demand section summary

To inform the 2025/26 Better Care Fund planning, capacity data was gathered using 2024/25 activity records from the City of York Council's Mosaic system, alongside direct input from providers delivering services across both step-up and step-down pathways. This data was analysed in conjunction with local intelligence to produce forecasted activity levels for 2025/26.

Demand modelling across the ICB began with hospital discharge data by pathway, which was then refined using locally available insights. In some areas, current capacity does not fully meet demand, evidenced by increased waiting times from referral to service commencement. Specifically, demand for home-based care is estimated to exceed available capacity by 5%, whereas demand for bed-based care is forecast to be 5% below capacity. This reflects local understanding that, with improved access to home-based rehabilitation, more individuals could safely recover at home rather than in bedded settings.

Consultation

4. The development of the 2025/26 plan has been jointly led by City of York Council and York Place Integrated Care Board (ICB) core commissioning teams, with significant input from finance and business intelligence colleagues.

The regional NHS England team has led a series of meetings throughout the planning process to support and align plans across the Humber and North Yorkshire ICB footprint.

Other key contributors to the plan have included the BCF Performance and Delivery group (which was been refreshed for 2025 and will now meet regularly to review the ongoing effectiveness of the schemes in supporting the BCF, performance against national metrics, and ensure that we continue to reduce inequalities across the city) the Disabled Facilities Grant lead, and providers and scheme leads who have supplied vital information to inform capacity and demand data and metric targets.

The plan has also been reviewed and approved by the York Integrated Community Model Joint Delivery Board, and this approach has ensured compliance with the national BCF requirement for cross-sector involvement, including NHS trusts, social care providers and voluntary and community service partners.

Additionally, the plan has been reviewed and formally reviewed by the required senior stakeholders, including the Health and Wellbeing Board Chair, the Local Authority Chief Executive, the ICB Chief Executive, the LA Section 151 Officer, the ICB Finance Director, the Local Authority Director of Adult Social Services, the DFG Lead, and the ICB Place Director. This section should include details and results of any consultation that has taken place on this subject matter [both internal (to your organisation) and any external consultation that has taken place should be referenced here]

Options

5. *N/A*

Analysis

6. *N/A*

Strategic/Operational Plans

7. The Better Care Fund Policy Framework for 2025-2026 aligns closely with the York Health and Wellbeing Board's strategic and operational goals, particularly in promoting prevention, supporting independence, and improving hospital discharge processes. The BCF's focus on proactive, preventative support for individuals with complex health needs aligns with York HWB's commitment to early intervention and promoting independent living. A fundamental part of the BCF is to reduce the reliance on acute services through community-based care, home adaptations, and technology.

The planned spend under the BCF further demonstrates this alignment. A significant 38% of funds are allocated to reducing the need for long-term residential care, supporting York HWB's shared goal of enabling individuals to live independently and remain in their homes with appropriate support. In addition, 33% of the BCF spend focuses on preventing unnecessary hospital admissions, which directly complements the aim to reduce the demand on hospital services through early intervention and community-based care.

Further supporting the proactive approach, 11% of the BCF spend is dedicated to proactive care for individuals with complex health needs, aligning with York HWB's strategic objective to provide holistic, integrated care for vulnerable individuals. Another 9% is allocated to home adaptations and technology, highlighting a shared commitment to using innovation to support independent living and improve quality of life.

Additionally, 6% of the BCF spend is directed towards supporting timely discharge from hospital, directly aligning with York HWB's priority to enhance hospital flow and ensure individuals receive appropriate care upon leaving the hospital. Finally, 3% of the BCF spend supports unpaid carers, reinforcing York HWB's focus on providing holistic support for families and carers, who play a critical role in maintaining individuals' independence and wellbeing. Many of the 2025/26 Adult Social Care priorities outlined in the Adult Social Care strategy and the service plan contribute to both of the BCF objectives.

These include:

- Creation of a multi-disciplinary planned review team to address our backlog of annual reviews, helping people to remain independent
- Utilising our LACS to ensure people waiting for a strength-based conversation to assess their care and support needs are waiting well in the hope that we can prevent or reduce the need for more formal care
- Gathering feedback from people who use our services including those with complex needs that require both health and social care support and those that transition between health and social care and using this information to improve services
- Expanding our use of research across Adult Social care practice and implementing increased support for self-funders

- Improving our process for people using Direct Payments to promote independence and alternatives to traditional commissioned care to achieve identified outcomes

- Working across health and social care to improve our use of resources across the system to ensure timely and effective hospital discharge including a new Discharge to Assess model in the acute hospital and developing mental health hubs across the city and working closely with partners to improve our CHC process to improve outcomes and experiences from some of the most vulnerable people in the city

- Developing a new carers strategy and delivery plan to improve our support to unpaid carers

- Improving our supported housing offer (both internally and externally) to allow people to remain independent in their own homes, reducing or delaying the need for residential or nursing home care.

- In summary, the BCF objectives closely align with York HWB's focus on prevention, integration, and supporting individuals to live independently, reinforcing shared goals for better health and care outcomes.

Implications

8. The following implications have been considered:

- **Financial**

  The BCF plan outlines the proposed expenditure of a pooled total budget of £25,925,742.

  This includes the Disabled Facilities Grant (£1,821,521), a specified minimum contribution from NHS funding (£17,480,928) and the Local Authority Better Care Grant (£6,623,742).

  Finance colleagues from both the City of York Council and the Humber and North Yorkshire Integrated Care Board have been involved in the development of this plan and the plan has also achieved sign off from Chief Finance Officers from both organisations.

  The BCF plan is designed to optimise spending on services that prevent hospital admissions, support early discharge, and provide care in the community. While there are potential cost savings and efficiencies to be realised, particularly through integrated care and

reducing long-term residential care, there are also financial risks, especially where demand for services exceeds current capacity. Ongoing monitoring and adjustment will be necessary to mitigate these risks and ensure the plan remains financially sustainable.

Key changes to expenditure from the previous year have been outlined in section 3 of this report.

- **Human Resources (HR)**

  There are no human resources implications

- **Equalities**

  There are no equalities implications

- **Legal**

  There are no legal implications

- **Crime and Disorder**

  There are no crime and disorder implications

- **Information Technology (IT)**

  There are no information technology implications

- **Property**

  There are no property implications

- **Other**

  There are no other implications to highlight to the HWB at this time

Risk Management

9. There are no significant risks to flag.

Recommendations

10. The Health and Wellbeing Board are asked to review and approve the 25/26 plan, given its collaborative development and alignment to both BCF and HWB priorities.

Contact Details

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Title</td></tr>
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<tr><td colspan="3">Wards Affected: All wards</td><td>All</td><td>Yes</td></tr>
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Annex 1 – BCF 2025/26 Planning Template

Annex 2 – BCF 2025/26 Narrative Plan

Annex 3 – BCF 2025/26 Capacity and Demand Plan

Appendix 1 - Better Care Fund 25/26 Planning Update

Glossary

BCF – Better Care Fund
HWB - Health and Wellbeing Board
ICB – Integrated Care Board

Annex 1a:

Better Care Fund 2025-26 Planning Template

5. Expenditure

Selected Health and Wellbeing Board: York

<< Link to summary sheet

Running Balances	2025-26 Income	Expenditure	Balance
DFG	£1,821,521	£1,821,521	£0
NHS Minimum Contribution	£17,480,928	£17,480,928	£0
Local Authority Better Care Grant	£6,623,293	£6,623,293	£0
Additional LA contribution	£0	£0	£0
Additional NHS contribution	£0	£0	£0
Total	**£25,925,742**	**£25,925,742**	**£0**

Required Spend

This is in relation to National Conditions 3 only. It does NOT make up the total NHS Minimum Contribution (on row 10 above).

	2025-26 Minimum Required Spend	Planned Spend	Unallocated
Adult Social Care services spend from the NHS minimum allocations	£7,742,625	£8,166,699	£0

Checklist

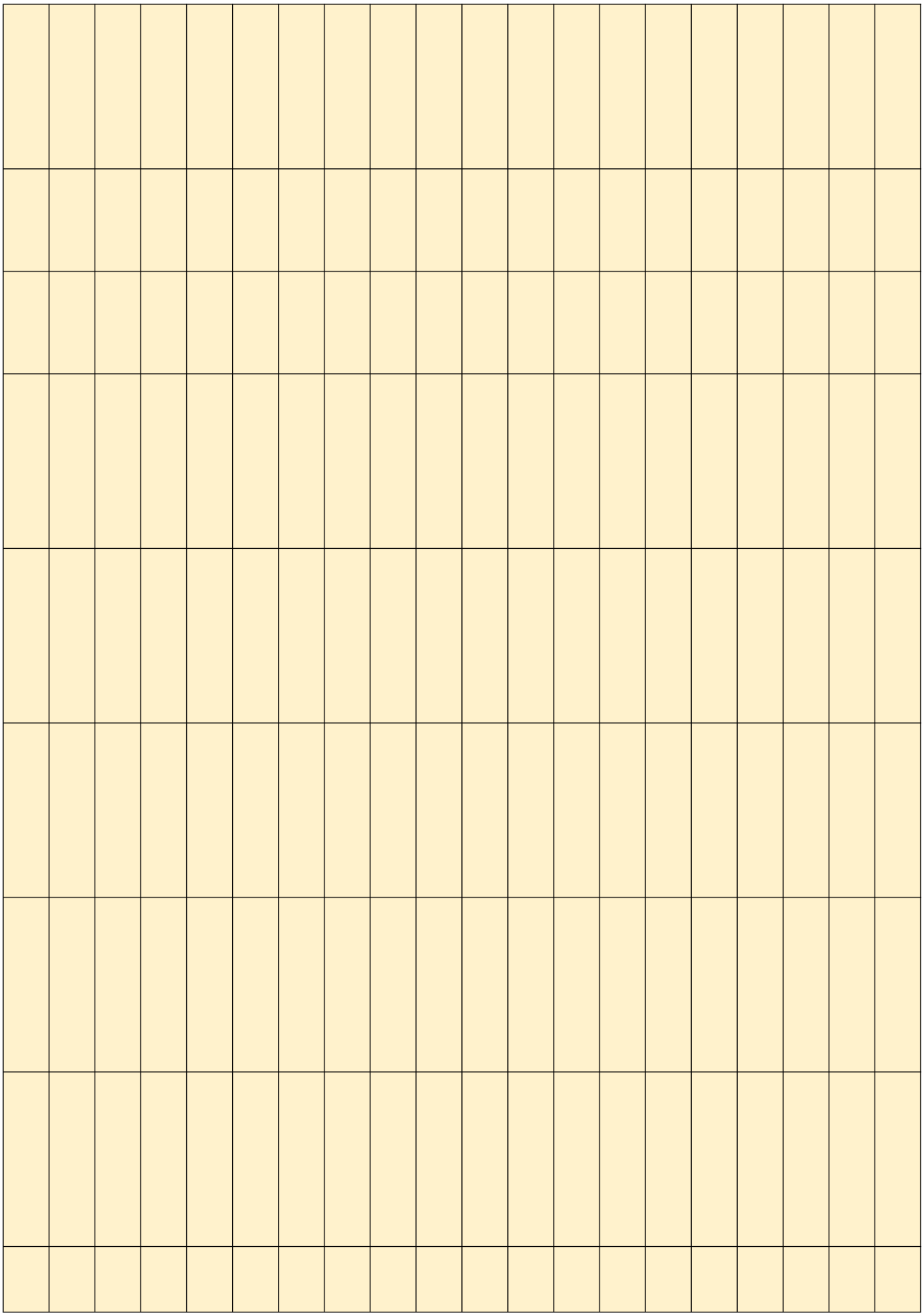
Column complete:

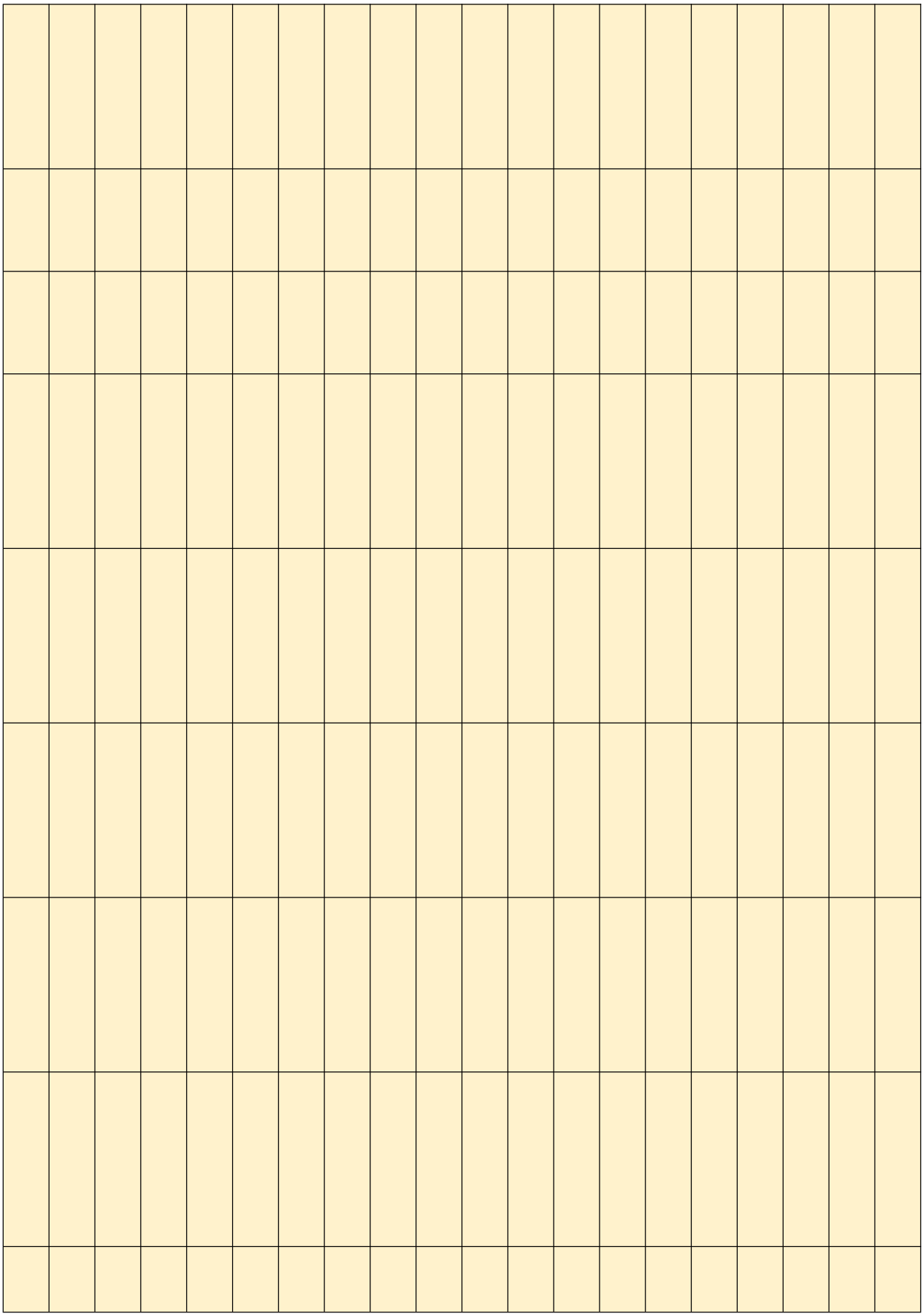
Yes	Yes	Yes	Yes	Yes	Yes	Yes

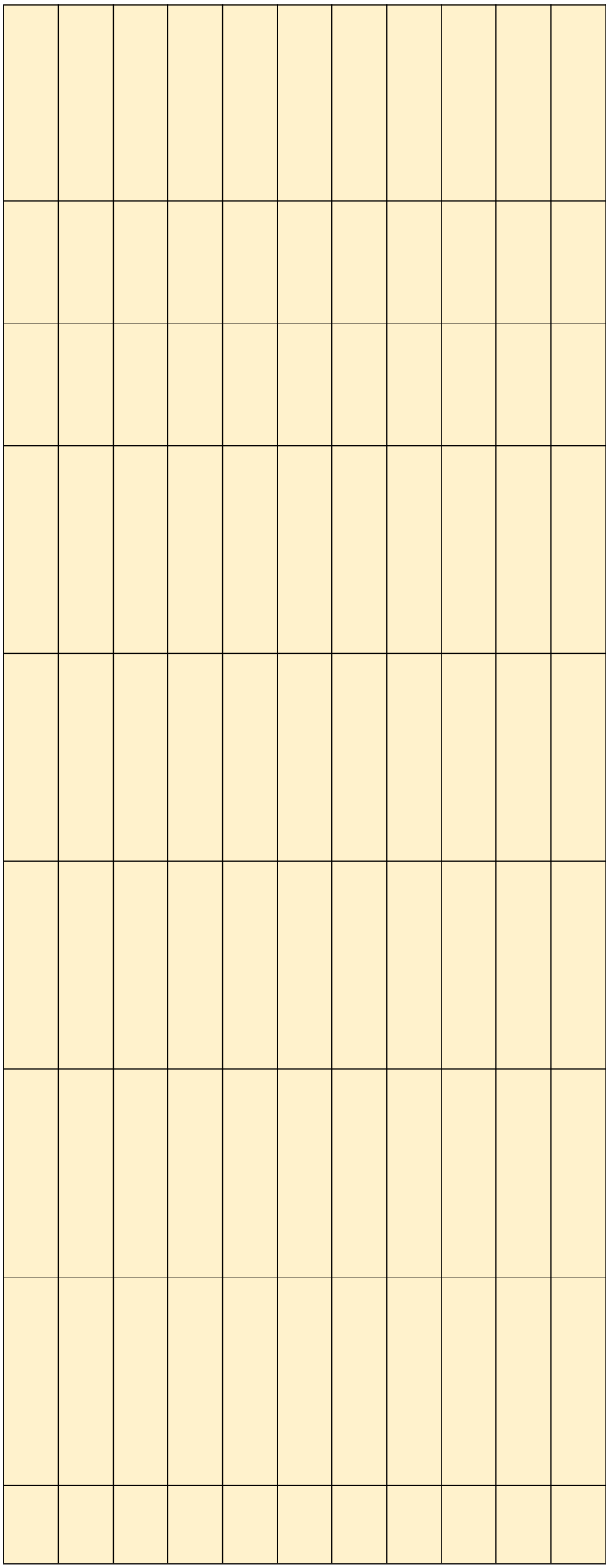
Scheme ID	Activity	Description of Scheme	Primary Objective	Area of Spend	Provider	Source of Funding	Expenditure for 2025-26 (£)	Comments (optional)
1	Disabled Facilities Grant related schemes	Disabled Facilities Grant to help disabled individuals with home adaptations to support independent	2. Home adaptations and tech	Social Care	Private Sector	DFG	£ 1,821,521	
2	Long-term home-based social care services	Contribution to cost of packages of care at home	6. Reducing the need for long term residential care	Social Care	Private Sector	NHS Minimum Contribution	£ 3,797,000	
3	Long-term residential/nursing home care	Contribution to cost of packages of care at home	6. Reducing the need for long term residential care	Social Care	Private Sector	Local Authority Better Care Grant	£ 2,273,386	
4	Long-term residential/nursing home care	Contribution to costs of long-term residential and nursing care placements	6. Reducing the need for long term residential care	Social Care	Private Sector	Local Authority Better Care Grant	£ 1,618,000	Primary objective choice does not fit with scheme but have selected most relevant option
5	Discharge support and infrastructure	Contributions to range of social care teams to support capacity required to deliver Care Act duties.	6. Reducing the need for long term residential care	Social Care	Local Authority	NHS Minimum Contribution	£ 674,000	
6	Discharge support and infrastructure	Contribution to Staffing Resource Supporting Hospital Discharge	5. Timely discharge from hospital	Social Care	Local Authority	Local Authority Better Care Grant	£ 98,000	
7	Support to carers, including unpaid carers	Contribution to York Carers' Centre service, Direct Payments for Carers and home-based packages of care to facilitate carer respite	3. Supporting unpaid carers	Social Care	Charity / Voluntary Sector	NHS Minimum Contribution	£ 736,000	
8	Wider local support to promote prevention and independence	Contribution to Local Area Coordination Team - Community Facilitator	4. Preventing unnecessary hospital admissions	Social Care	Local Authority	**Local Authority Better Care Grant**	£ 29,000	
9	Wider local support to promote prevention and independence	Contribution to Local Area Coordination Team - Local Area Coordinators	4. Preventing unnecessary hospital admissions	Social Care	Local Authority	Local Authority Better Care Grant	£ 386,000	
10	Home-based intermediate care (short-term home-based rehabilitation, reablement and	Reablement Service	6. Reducing the need for long term residential care	Social Care	Private Sector	NHS Minimum Contribution	£ 1,389,000	

11	Short-term home-based social care (excluding rehabilitation, reablement or recovery services)	Marjorie Waite Court - 10 units set aside in Council's Independent Living Scheme to support discharge	5. Timely discharge from hospital	Social Care	Local Authority	NHS Minimum Contribution	£ 284,000	
12	Assistive technologies and equipment	Contribution to Council-run alarm response and equipment service	2. Home adaptations and tech	Social Care	Local Authority	NHS Minimum Contribution	£ 434,000	
13	Assistive technologies and equipment	Home adaptations (private sector)	2. Home adaptations and tech	Social Care	Local Authority	NHS Minimum Contribution	£ 90,000	
14	Discharge support and infrastructure	Contribution to Community Social Worker Team and Intensive Support Service	5. Timely discharge from hospital	Social Care	Local Authority	Local Authority Better Care Grant	£ 115,000	
15	Wider local support to promote prevention and independence	Maintenance of Live Well York Website	4. Preventing unnecessary hospital admissions	Social Care	Local Authority	Local Authority Better Care Grant	£ 5,000	
16	Wider local support to promote prevention and independence	Alcohol misuse prevention	4. Preventing unnecessary hospital admissions	Social Care	Local Authority	NHS Minimum Contribution	£ 35,000	
17	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Therapy provision to Fulford Nursing Home Rehab beds (1 x Band 6 therapist)	6. Reducing the need for long term residential care	Social Care	NHS Acute Provider	NHS Minimum Contribution	£ 49,936	
18	Home-based intermediate care (short-term home-based rehabilitation, reablement and	Expansion of Community Response Team (1 x B4, 1 x B5, 1 x B6)	6. Reducing the need for long term residential care	Community Health	NHS Acute Provider	Local Authority Better Care Grant	£ 128,407	
19	Discharge support and infrastructure	Home from Hospital	5. Timely discharge from hospital	Social Care	Charity / Voluntary Sector	NHS Minimum Contribution	£ 55,501	
20	Discharge support and infrastructure	Home from Hospital	5. Timely discharge from hospital	Social Care	Charity / Voluntary Sector	Local Authority Better Care Grant	£ 24,000	
21	Wider local support to promote prevention and independence	York Integrated Community Team	1. Proactive care to those with complex needs	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 1,099,938	
22	Wider local support to promote prevention and independence	Contribution to YAS frontline paramedic capacity to enable urgent care to be delivered on-scene	4. Preventing unnecessary hospital admissions	Community Health	NHS Acute Provider	NHS Minimum Contribution	£ 652,467	
23	End of life care	Contribution to Hospice at Home Service - Extended Hours (part funded with NYCC)	4. Preventing unnecessary hospital admissions	Community Health	Charity / Voluntary Sector	NHS Minimum Contribution	£ 177,859	
24	Wider local support to promote prevention and independence	Contribtion to TEWV crisis response service	4. Preventing unnecessary hospital admissions	Mental Health	NHS Mental Health Provider	NHS Minimum Contribution	£ 176,739	
25	Long-term home-based community health services	Contribution to Community Health Services Contract	4. Preventing unnecessary hospital admissions	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 5,997,825	
26	Long-term home-based community health services	Contribution to Community Health Services Contract	1. Proactive care to those with complex needs	Community Health	NHS Community Provider	Local Authority Better Care Grant	£ 1,613,000	
27	Discharge support and infrastructure	RATS Extended Hours - Therapy	4. Preventing unnecessary hospital admissions	Acute	NHS Community Provider	NHS Minimum Contribution	£ 185,920	
28	Discharge support and infrastructure	RATS Extended Hours - Social Worker	4. Preventing unnecessary hospital admissions	Acute	Local Authority	NHS Minimum Contribution	£ 51,075	
29	Wider local support to promote prevention and independence	Vaccinations of Homeless	1. Proactive care to those with complex needs	Primary Care	NHS	NHS Minimum Contribution	£ 4,000	
30	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Intermediate Care Beds	5. Timely discharge from hospital	Social Care	Private Sector	NHS Minimum Contribution	£ 149,000	

31	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Discharge beds at Union Terrace to support those with homelessness	5. Timely discharge from hospital	Social Care	Local Authority	**Local Authority Better Care Grant**	£ 84,000	
32	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Fulford Nursing Home SUSD beds (4)	5. Timely discharge from hospital	Community Health	Private Sector	Local Authority Better Care Grant	£ 229,000	
33	Wider local support to promote prevention and independence	Contribution to Dementia Forward contract	4. Preventing unnecessary hospital admissions	Social Care	Charity / Voluntary Sector	NHS Minimum Contribution	£ 35,000	
34	Discharge support and infrastructure	Contribution to System Improvement Project Officer	1. Proactive care to those with complex needs	Mental Health	Local Authority	NHS Minimum Contribution	£ 22,000	
35	Wider local support to promote prevention and independence	Various VCS Contracts	4. Preventing unnecessary hospital admissions	Community Health	Charity / Voluntary Sector	NHS Minimum Contribution	£ 207,770	
36	Other	Cultural commissioning - various VCSE small grants	1. Proactive care to those with complex needs	Social Care	Charity / Voluntary Sector	Local Authority Better Care Grant	£ 20,500	
37	Wider local support to promote prevention and independence	Community Health Champions	4. Preventing unnecessary hospital admissions	Social Care	Local Authority	NHS Minimum Contribution	£ 48,000	
38	Short-term home-based social care (excluding rehabilitation, reablement or recovery services)	Voluntary sector supported discharge service	5. Timely discharge from hospital	Community Health	Charity / Voluntary Sector	NHS Minimum Contribution	£ 107,258	
39	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Intermediate Care Beds	5. Timely discharge from hospital	Social Care	Private Sector	NHS Minimum Contribution	£ 256,529	
40	Discharge support and infrastructure	Hospital Social Work Team - short term agency resource to support discharge	5. Timely discharge from hospital	Social Care	Private Sector	NHS Minimum Contribution	£ 65,733	
41	Discharge support and infrastructure	Discharge brokerage coordinator post - funded for 6 months	5. Timely discharge from hospital	Social Care	Local Authority	NHS Minimum Contribution	£ 20,000	
42	Urgent community response	Immedicare 24/7 virtual clinical assessment service for care homes	4. Preventing unnecessary hospital admissions	Community Health	NHS Acute Provider	NHS Minimum Contribution	£ 176,272	
43	Discharge support and infrastructure	Additional OT to support early discharge	5. Timely discharge from hospital	Social Care	Local Authority	NHS Minimum Contribution	£ 48,000	
44	Discharge support and infrastructure	Discharge Liaison Nurse	5. Timely discharge from hospital	Acute	NHS Acute Provider	NHS Minimum Contribution	£ 50,084	
45	Discharge support and infrastructure	Discharge Liaison Nurse	5. Timely discharge from hospital	Acute	NHS Acute Provider	NHS Minimum Contribution	£ 50,084	
46	Urgent community response	Contribution to Frailty Crisis Response Hub	4. Preventing unnecessary hospital admissions	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 354,938	







5a. Expenditure Guidance

Guidance for completing Expenditure sheet

How do we calcute the ASC spend figure from the NHS minimum contribution total?

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS minimum:

- **Area of spend** selected as 'Social Care' and **Source of funding** selected as 'NHS Minimum Contribution'

The requirement to identify which primary objective scheme types are supporting is intended to provide richer information about the services that the BCF supports. Please select [from the drop-down list] the primary policy objective which the scheme supports. If more than one policy objective is supported, please select the most relevant. Please note The Local Authority Better Care Grant was previously referred to as the iBCF.

On the expenditure sheet, please enter the following information:
1. Scheme ID:
- Please enter an ID to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.
2. Activity:
- Please select the Activity from the drop-down list that best represents the type of scheme being planned. These have been revised from last year to try and simplify the number of categories. Please see the table below for more details.
3. Description of Scheme:
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.
4. Primary Objective:
- Sets out what the main objective of the scheme type will be. These reflect the six sub objectives of the two overall BCF objectives for 2025-26. We recognise that scheme may have more than one objective. If so, please choose one which you consider if likely to be most important.
5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
6. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.
7. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the NHS or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.
8. Expenditure (£)2025-26:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
9. Comments:
Any further information that may help the reader of the plan. You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance.

2025-26 Revised Scheme Types

Number	Activity (2025-26)	Previous scheme types (2023-25)	Description
1	Assistive technologies and equipment	Assistive technologies and equipment Prevention/early intervention	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Housing related schemes	Housing related schemes Prevention/early intervention	This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
3	DFG related schemes	DFG related schemes	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place.
4	Wider support to promote prevention and independence	Prevention/early intervention	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and wellbeing
5	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Home-based intermediate care services Home care or domiciliary care Personalised care at home Community based schemes	Includes schemes which provide support in your own home to improve your confidence and ability to live as independently as possible Also includes a range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services

6	Short-term home-based social care (excluding rehabilitation, reablement and recovery services)	Personalised care at home	Short-term schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period.
7	Long-term home-based social care services	Personalised care at home	Long-term schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient or to deliver support over the longer term to maintain independence.
8	Long-term home-based community health services	Community based schemes	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
9	Bed-based intermediate care (short-term bed-based rehabilitation, reablement or recovery)	Bed-based intermediate care services (reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.
10	Long-term residential or nursing home care	Residential placements	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
11	Discharge support and infrastructure	High Impact Change Model for Managing Transfer of Care	Services and activity to enable discharge. Examples include multi-disciplinary/multi-agency discharge functions or Home First/ Discharge to Assess process support/ core costs.
12	End of life care	Personalised care at home	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home for end of life care.
13	Support to carers, including unpaid carers	Carers services	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
14	Evaluation and enabling integration	Care Act implementation and related duties Enablers for integration High Impact Change Model for Managing Transfer of Care Integrated care planning and navigation Workforce recruitment and retention	Schemes that evaluate, build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Schemes may include: - Care Act implementation and related duties - High Impact Change Model for Managing Transfer of Care - where services are not described as "discharge support and infrastructure" - Enablers for integration, including schemes that build and develop the enabling foundations of health, social care and housing integration, and joint commissioning infrastructure. - Integrated care planning and navigation, including supporting people to find their way to appropriate services and to navigate through the complex health and social care systems; may be online or face-to-face. Includes approaches such as Anticipatory Care. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated plans, typically carried out by professionals as part of an MDT. - Workforce recruitment and retention, where funding is used for incentives or activity to recruit and retain staff or incentivise staff to increase the number of hours they work.
15	Urgent Community Response	Urgent Community Response	Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
16	Personalised budgeting and commissioning	Personalised budgeting and commissioning	Various person centred approaches to commissioning and budgeting, including direct payments.
17	Other	Other	This should only be selected where the scheme is not adequately represented by the above scheme types.

Better Care Fund 2025-26 Planning Template

6. Metrics for 2025-26

Selected Health and Wellbeing Board: York

8.1 Emergency admissions

		Apr 24 Actual	May 24 Actual	Jun 24 Actual	Jul 24 Actual	Aug 24 Actual	Sep 24 Actual	Oct 24 Actual	Nov 24 Actual	Dec 24 Actual	Jan 25 Actual	Feb 25 Actual	Mar 25 Actual	Rationale for how local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.
Emergency admissions to hospital for people aged 65+ per 100,000 population	Rate	1,706	1,856	1,793	1,831	1,869	1,831	1,844	1,793	n/a	n/a	n/a	n/a	Based on historical data from May 2023, the forecast increase in 2025_26 is 7%. The plan for York is to mitigate this rise to a forecast increase of 5% through admission avoidance and prevention schemes, for example the Frailty Crisis Response Hub, the York Integrated Care Team In-Reach model and the RATS service.
	Number of Admissions 65+	680	740	715	730	745	730	735	715	n/a	n/a	n/a	n/a	
	Population of 65+*	39,869	39,869	39,869	39,869	39,869	39,869	39,869	39,869	n/a	n/a	n/a	n/a	
		Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan	
	Rate	1,778	1,941	1,854	1,901	1,944	1,894	1,914	1,859	1,886	1,914	1,926	1,941	
	Number of Admissions 65+	709	774	739	758	775	755	763	741	752	763	768	774	
	Population of 65+	39,869	39,869	39,869	39,869	39,869	39,869	39,869	39,869	39,869	39,869	39,869	39,869	

Source: https://digital.nhs.uk/supplementary-information/2025/non-elective-inpatient-spells-at-english-hospitals-occurring-between-01-04-2020-and-30-11-2024-for-patients-aged-18-and-65

Supporting Indicators		Have you used this supporting indicator to inform your goal?
Unplanned hospital admissions for chronic ambulatory care sensitive conditions. Per 100,000 population.	Rate	Yes
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Rate	Yes

8.2 Discharge Delays

*Dec Actual onwards are not available at time of publication

	Apr 24 Actual	May 24 Actual	Jun 24 Actual	Jul 24 Actual	Aug 24 Actual	Sep 24 Actual	Oct 24 Actual	Nov 24 Actual	Dec 24 Actual	Jan 25 Actual	Feb 25 Actual	Mar 25 Actual	Rationale for how local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.
Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)	n/a	n/a	n/a	n/a	n/a	0.46	0.60	0.60	n/a	n/a	n/a	n/a	National BCF data assumes the unknown DRDs are discharge on the same day as their DRD, which inflates the %.
Proportion of adult patients discharged from acute hospitals on their discharge ready date	n/a	n/a	n/a	n/a	n/a	86.0%	88.7%	86.0%	n/a	n/a	n/a	n/a	The 2025_26 target mitigates this calculation by assuming 50% of these unknowns will be discharged on the same day.
For those adult patients not discharged on DRD, average number of days from DRD to discharge	n/a	n/a	n/a	n/a	n/a	3.3	5.3	4.3	n/a	n/a	n/a	n/a	The 2025_26 target is based on a 3% increase on 2024_25 YTD (Apr-Dec).
	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan	
Average length of discharge delay for all acute adult patients	1.78	1.74	1.70	1.66	1.62	1.57	1.56	1.52	1.49	1.44	1.40	1.37	Average no of days from DRD to discharge: The YTD Apr-Jan rate from local data was 4.8 days. The target is to reduce this to 4.3 by March 2026.
Proportion of adult patients discharged from acute hospitals on their discharge ready date	66.4%	66.5%	66.7%	66.9%	67.0%	67.2%	67.4%	67.6%	67.7%	67.9%	68.1%	68.2%	
For those adult patients not discharged on DRD, average number of days from DRD to discharge	5.30	5.20	5.10	5.00	4.90	4.80	4.80	4.70	4.60	4.50	4.40	4.30	

Source: https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/discharge-ready-date/

Supporting Indicators		Have you used this supporting indicator to inform your goal?
Patients not discharged on their DRD, and discharged within 1 day, 2-3 days, 4-6 days, 7-13 days, 14-20 days and 21 days or more.	Number of patients	Yes
Local data on average length of delay by discharge pathway.	Number of days	Yes

8.3 Residential Admissions

		2023-24 Actual	2024-25 Plan	2024-25 Estimated	2025-26 Plan Q1	2025-26 Plan Q2	2025-26 Plan Q3	2025-26 Plan Q4	Rationale for how the local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	524.2	486.6	526.7	132.9	130.4	115.4	148.0	We aim to maintain the rate of long-term residential admissions at the same level as is estimated for 2024/25. Setting a target of 0% growth is a realistic yet challenging goal, given the expected rise in support requests continuing
	Number of admissions	209	194	210	53	52	46	59	

nursing care homes, per 100,000 population	Population of 65+*	39,869	39,869	39,869	39,869	39,869	39,869	39,869		into 2025/26 and the recent slow down in admissions.

Long-term admissions to residential care homes and nursing homes for people aged 65+ per 100,000 population are based on a calendar year using the latest available mid-year estimates.

Supporting Indicators		Have you used this supporting indicator to inform your goal?
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	Percentage	Yes
The proportion of people who received reablement during the year, where no further request was made for ongoing support	Rate	Yes

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HM Government

NHS England

Better Care Fund 2025-26 Update Template

7: National Condition Planning Requirements

Health and wellbeing board: York

National Condition	Planning expectation that BCF plan should:	Where should this be completed	HWB submission meets expectation	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Timeframe for resolution	Complete:
1. Plans to be jointly agreed	Reflect local priorities and service developments that have been developed in partnership across health and care, including local NHS trusts, social care providers, voluntary and community service partners and local housing authorities	Planning Template - Cover sheet Narrative Plan - Overview of Plan	Yes			Yes
	Be signed off in accordance with organisational governance processes across the relevant ICB and local authorities	Planning Template - Cover sheet	Yes			Yes
	Must be signed by the HWB chair, alongside the local authority and ICB chief executives – this accountability must not be delegated	Planning Template - Cover sheet	Yes			Yes
2. Implementing the objectives of the BCF	Set out a joint system approach for meeting the objectives of the BCF which reflects local learning and national best practice and delivers value for money	Narrative Plan - Section 2	Yes			Yes
	Set goals for performance against the 3-headline metrics which align with NHS operational plans and local authority adult social care plans, including intermediate care capacity and demand plans	Planning Template - Metrics	Yes			Yes
	Demonstrate a 'home first' approach and a shift away from avoidable use of long-term residential and nursing home care	Narrative Plan - Section 2	Yes			Yes
	Following the consolidation of the previously ring-fenced Discharge Fund, specifically explain why any changes to the use of the funds compared to 2024-25 are expected to enhance urgent and emergency care flow (combined impact of admission avoidance and reducing length of stay and improving discharge)	Narrative Plan - Section 2	Yes			Yes
3. Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC)	Set out expenditure against key categories of service provision and the sources of this expenditure from different components of the BCF	Planning Template - Expenditure	Yes			Yes
	Set out how expenditure is in line with funding requirements, including the NHS minimum contribution to adult social care					
4. Complying with oversight and support processes	Confirm that HWBs will engage with the BCF oversight and support process if necessary, including senior officers attending meetings convened by BCF national partners.	Planning Template - Cover	Yes			Yes
	Demonstrate effective joint system governance is in place to: submit required quarterly reporting, review performance against plan objectives and performance, and change focus and resourcing if necessary to bring delivery back on track	Narrative Plan - Executive Summary	Yes			Yes

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Annex 2:

Integration and Better Care Fund

Better Care Fund 2025-26 HWB submission

Narrative plan template

	HWB area 1	HWB area 2
HWB	York	Please insert HWB name here
ICB	Humber and North Yorkshire	Please insert ICB name here
ICB	Please insert ICB name here (where appropriate)	Please insert ICB name here (where appropriate)
ICB	Please insert ICB name here (where appropriate)	Please insert ICB name here (where appropriate)

Introduction and guidance – **this can be deleted before submission**

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans. Although the template is optional, we ask that BCF planning leads ensure that narrative plans cover all headings and topics from this narrative template. Formatted text boxes have been included but these can be removed and a standard text used.

These plans should complement the agreed spending plans and goals for BCF national metrics in your area's Excel BCF Planning Template and intermediate care capacity and demand planning.

Although each Health and Wellbeing Board (HWB) will need to agree a separate Excel planning template and capacity and demand plan, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their Excel planning template and capacity and demand plan.

Further guidance on completing HWB submission templates can be found on the Better Care Exchange.

Section 1: Overview of BCF Plan

This should include:

- Priorities for 2025-26
- Key changes since previous BCF plan
- A brief description of approach to development of plan and of joint system governance to support delivery of the plan and where required engage with BCF oversight and support process
- Specifically, alignment with plans for improving flow in urgent and emergency care services
- A brief description of the priorities for developing for intermediate care (and other short-term care).
- Where this plan is developed across more than one HWB please also confirm how this plan has been developed in collaboration across HWB areas and aligned ICBs and the governance processes completed to ensure sign off in line with national condition 1.

A refreshed BCF Performance and Delivery Group regularly reviews the effectiveness of all schemes in supporting the BCF national metrics as well as ensuring we continue to reduce inequalities across the city. We have also established an annual BCF Meeting, bringing together all scheme leads to review the plan and showcase work. Our integrated data sets enable us to specifically target high risk areas with enhanced support offers. We have used our Adult Social Care Management Systems as sources of data to forecast capacity and demand within the community, based on our historical trends. To understand the capacity and demand in the hospitals, we used the NHS Operational Plan estimates along with the internal database to understand the levels of activity we aim to achieve. We work closely as a system to meet the demand on our hospital services by creating the capacity within the community (and equally for our hospitals).

We have established a data cell which will meet regularly throughout the year to monitor scheme performance from scrutinising the actual datasets and in addition to this we will have regular Performance and Delivery Groups which will oversee general performance and finance against schemes. Finance colleagues from Place and City of York Council will meet separately to discuss specific issues relating to funding and finance around the schemes. The Performance and Delivery Group will be the mechanism by which quarterly reporting is monitored an overseen as well as review from the Joint Commissioning Forum and York Integrated Community Model Joint Development Board.

Our current Social Care Data shows an increase in referrals into our front door services, building up a waiting list for people awaiting assessment. This is a key area of focus for us and we are working closely with system partners both from an acute perspective but also within community services to ensure we are focusing on prevention and admission avoidance wherever possible to ease the pressure at the front door.

We acknowledge that there are some areas where we currently do not capture, as a system, the level of data in the requested format. Following the implementation of a workstream focused around developing a mechanism to reflect this, we are now working with system colleagues in a joined-up effort to ensure we can capture this data in a robust and accurate way.

Now more than ever the requirement and desire to work together has come to the fore. These new ways of working continue to require joined up leadership with the values, behaviours and attitudes we collectively aspire to, exhibited in a consistent way. In order to continue the great work that has been witnessed and maintain the momentum to deliver services collaboratively we must ensure we have the platform in place to facilitate this.

Partners have been working collaboratively to jointly commission key services as we continue to develop our integrated team model, supporting in-reach and early intervention. Through our shared vision, partners have built strong, trusting relationships with improved communication. This is underpinned by robust governance, leading to effective decision making to improve outcomes for York's residents. Through the further development of the York Integrated Frailty Community Services model, we have developed a proactive place-based model of delivery, integrating the community health and social care offer. This involves proactive identification of individuals with complex needs, for example frailty and multiple long terms conditions, using data provided by our population health hub. Individuals have a comprehensive assessment, and review carried out by the right professional, development of personalised care and support plans resulting in the delivery of a range of health and social care interventions to support them to remain well and maintain their independence at home. We are looking to further expand the service and integrate more teams to offer a single point of access across Primary Care Networks. By flexing capacity throughout the year to align with periods of greater need, we can flexibly manage social care and NHS services to maximise the benefits of the Better Care Fund (BCF). This includes ensuring the availability of reablement and social care beds during the winter months while reducing bed numbers and care hours during periods of lower demand.

We know that our intermediate care model needs focus and development. The scope of this is extensive, reflecting the degree of transformation that is required. This is central to driving our collective aim in ensuring people are supported in the right way, at the right time, by the right person. A review of our intermediate care model highlighted several key areas to focus on:

1. York has sufficient care services in the system; however, these services were not being utilised and allocated in the most effective way
2. Our community and voluntary sector is a great asset in reducing admissions and enhancing this would have a greater impact on reducing admissions.
3. An integrated approach to reablement and intermediate care would be beneficial and equally some initial quick wins were identified to improve pathways.

Following the review, several immediate and long-term recommendations were put forward for the system to consider and action. These were:

- Changes in eligibility criteria for intermediate care and reablement.

Eligibility will now be determined based on individual need rather than predefined service delivery models. This shift ensures that support is provided to those who require it most, rather than being restricted by existing service structures. It aims to improve accessibility, enhance patient outcomes, and enable a more flexible approach to care provision.

- Amalgamation of current intermediate care services.

The existing system includes multiple pathways and access points, making it complex and difficult to navigate for both professionals and individuals seeking care. By streamlining and integrating these services, the aim is to create a more cohesive and accessible system, ensuring that patients receive the right support in a timely and efficient manner.

- Review of the discharge hub to develop an integrated hub

Through the development of the integrated discharge hubs, we have also identified a gap for housing colleagues from the local council and have ensured that there is now a space for key colleagues to input as we have recognised that often, there are much broader issues to tackle around discharge, than place of discharge only. In a similar way, we will be working alongside hospices and mental health teams to ensure a truly integrated, multidisciplinary approach is taken.

- Intermediate care and reablement alignment

We have worked with our reablement provider to ensure that pathways and referral criteria support the demand for the service and we have embedded these into the key performance metrics. This, together with robust monitoring and contract management, have ensured that the reablement service is truly aligned to the needs of the people accessing it and the broader intermediate care model.

- Embed home first approaches across the discharge pathways

We have worked with colleagues in social care to highlight the importance of home first approaches. We have reviewed data from the Pathway 1 Bridging Service which demonstrates that we can successfully get people home and, in some cases, without the need for further care when under other circumstances, this cohort of people may have been admitted to hospital resulting in delayed discharge and further care needs. We have also reviewed the data which shows significantly low numbers in terms of people who use this pathway, re-presenting to hospital.

The service has had the additional impact of supporting the development of a true discharge to assess model for City of York Pathway 1 discharges.
Patients discharged through this service are, on average, discharged within 1 day of being medically optimised, which is significantly shorter than the previous average of 9 days.
The service is now fully embedded as part of the 'discharge arm' of the YICFS service and aligns with the 2025/26 funding priority of supporting the development of a robust Discharge to Assess (D2A) model.

Initially developed to address a capacity gap, the Pathway 1 Bridging Service has evolved into a fundamental component of the 'discharge arm' of the Integrated Frailty Service model. It enables the Frailty Service to in-reach into the acute setting, ensuring patients are transferred promptly back into the integrated network of community-based support. This approach has significantly improved patient outcomes and has been a key step towards the development of an effective integrated community frailty model.
Between June and September 2024, patients discharged through the service left hospital within one day of being medically optimised—a major improvement on the previous nine-day average for this cohort. Notably, 16 patients were able to either end or reduce their package of care back to baseline after receiving support, despite being initially identified by hospital teams as lacking reablement or rehabilitation potential. During this period, 89% of patients were successfully discharged and remained well at home two weeks post-discharge.

At the heart of this success is the Discharge Care Coordinator, who plays a crucial role in Pathway 1 discharges, providing real-time intelligence and hands-on support to accelerate the discharge process. This role has strengthened links between the Frailty Service and the acute hospital and positioned the service as a key driver in the development of a robust D2A model.

One of the most significant advantages of this approach is the removal of the Trusted Assessment Form (TAF) requirement for patients on this pathway. The Discharge Care Coordinator proactively gathers the necessary

information before discharge and ensures that patients receive an assessment for their short-term needs within two hours of arriving home. This eliminates the time-consuming back-and-forth between discharging teams, which often delays the process as colleagues work to obtain accurate information for a safe discharge. If adopted more widely, this approach could substantially reduce discharge times and lower the number of patients classified as no criteria to reside (NCTR).

Expanding the model could also lead to a more efficient use of social care resources, allowing social care colleagues to be redeployed from the acute setting and engaged with patients only when necessary, in the community. This shift would streamline in-hospital processes, optimise workforce capacity, and mark a significant step towards a more effective and responsive discharge model.

This service has been recommissioned in 2025/26 as part of the York Frailty Hub.

- Develop a community single point of access to support care navigation

Using the frailty hub model as a foundation, we are building on this by developing integrated hubs which will have the ability to signpost people appropriately, taking away the need for multiple hand-offs. To an extent, this has already been created as the frailty hub now includes GPs, social workers, care navigators, social prescribers, community health links and we are building on the success of this approach.

- Integrate a holistic mental health offer into our community services

Through the development of our integrated discharge hubs, we are planning to embed a mental health support offer as part of this MDT model. Ensuring that a patient's needs are looked at on a holistic level, identifying any needs that may not fit the traditional model around health needs and instead, look at creating a model that truly brings together a person's needs from health, social care, housing, social issuers and we will then have the ability to signpost people appropriately. We have already begun this with the establishment of the existing mental health hub and work is underway to develop a 24/7 offer for people.

- Improve data flows and interpretation of local data to ensure service improvements are data driven and prioritised based on local need.

Enhancing data collection, sharing, and analysis will enable a more informed approach to service planning and delivery. By improving the flow of information between services and refining how local data is interpreted, decisions can be based on real-time insights and emerging trends. This will help identify gaps, allocate resources more effectively, and ensure that service improvements align with the specific needs of the local population.

We have strengthened data governance and analysis to ensure service improvements are driven by robust local intelligence. The BCF Performance and Delivery Group now meets regularly to assess scheme effectiveness against BCF national metrics and ensure resources target areas of greatest need. An annual BCF Meeting brings scheme leads together to review data insights and refine strategic priorities.

To improve real-time decision-making, we have established a dedicated data cell that monitors performance, scrutinises key datasets, and supports ongoing service evaluation. This is complemented by our integrated data sets, which enable us to identify high-risk areas and provide targeted support.

We are enhancing data sharing and predictive modelling by using Adult Social Care Management Systems to forecast community capacity and demand based on historical trends. Additionally, NHS Operational Plan estimates, and internal hospital data help us better anticipate acute care pressures and align community capacity accordingly.

To address gaps in system-wide data collection, we have launched a data cell focused on improving the accuracy and consistency of data reporting. This ensures we capture the necessary information to drive informed decision-making and prioritise services based on local need.

- Enhance partnerships between health and social care regarding Urgent and Emergency Care.

The Frailty Crisis Response Hub is strengthening the partnership between health and social care services by creating a more integrated approach to supporting frail individuals with urgent care needs. A dedicated social worker is embedded within the hub, acting as a crucial link between the hub and wider social care services. This ensures that individuals receive the right support at the right time, whether in hospital, at home, or within the community.

Key ways the Frailty Hub is enhancing this partnership include:

- Coordinated Decision-Making – The dedicated social worker works alongside health professionals within the hub, ensuring that care plans consider both medical and social care needs. This helps prevent unnecessary hospital admissions and supports timely, well-planned discharges.
- Stronger Links to Social Care Services – The social worker provides a direct connection between the hub and wider social care teams, ensuring that individuals can quickly access community-based support, reablement, or long-term care where needed.
- Improved Data Sharing – The social worker helps bridge gaps between health and social care by ensuring relevant information is shared efficiently, enabling more informed and coordinated decision-making.
- Faster Access to Social Care Support – Having a social worker within the hub means social care input can be provided at an earlier stage, reducing delays in discharge planning and ensuring appropriate care arrangements are in place.
- More Seamless Transitions Between Services – The close collaboration between the social worker, hub clinicians, and wider social care teams helps ensure a smooth transition from acute care to community-based support, reducing pressure on hospital services and improving patient outcomes.
- By embedding a dedicated social worker within the Frailty Hub, the partnership between health and social care is significantly strengthened. This model enables quicker access to social care expertise, better coordination of support, and a truly integrated approach to meeting the needs of frail individuals in the most appropriate setting.

- Further partnerships with the VCSE to support early discharge and admission avoidance using the BCF as a lever

From 1st April 2025, a number of existing services will be coming together under the overarching umbrella of the York Integrated Community Frailty Service. The contract for this service will be awarded to current lead provider of the York Integrated Care Team (YICT) and the York Frailty Crisis Response Hub. A key part of the service contract and specification is the requirement to work and promote the role of the voluntary sector, working across the 3 service arms of proactive care, crisis support/admission avoidance, and discharge support.

The service will be to commission the voluntary care sector to provide an integrated offering to support residents in York living with Frailty, and to promote an increase in the utilisation of non-statutory roles, demonstrating added value based on spend vs outcome.

The service will therefore be required to report on the proportion of the workforce delivered by non-statutory roles and should work with voluntary care sector services to maximise their contribution to service delivery.

A ringfenced allocation has been included within the total contract value as a minimum contribution to the voluntary care sector. As the service develops, it is expected that this contribution will increase as a proportion of total expenditure, whilst remaining within the existing overall service funding envelope.

The service will work as a minimum with the following voluntary care sector stakeholders:

- Age UK
- Dementia Forward
- York CVS
- York Carer's Centre
- St Leonard's Hospice

Voluntary care sector services currently supporting early discharge and admission avoidance include:

- Supported Discharge Service (delivered by Age UK, funded through the BCF)
- Home from Hospital (delivered by Age UK)
- Social Prescribing working across admission avoidance, crisis support and discharge support (delivered by York CVS – partially funded by the BCF)
- Age UK Frailty Hub Support (service specifically dedicated to supporting the Frailty Crisis Response Hub – completing welfare checks and providing urgent support to those at risk of admission – partially funded by the BCF)
- York Carer's Centre discharge support
- Dementia Forward
- St Leonard's Hospice (inpatient unit and hospice-at-home service – partially funded through the BCF)

We have already implemented several of the recommendations of the system review and we continue to monitor the progress of this work whilst focusing on delivering the remaining recommendations.

This plan has been a collaborative effort between multiple partners, including using crucial feedback from stakeholders who attended the winter workshop, VSCE, scheme leads, community health services. In addition to this, YSFT have been involved, and the process has been jointly led by York Place colleagues and City of York Council, which has included input from the local authority housing team. The strong partnerships that already exist have enabled this approach.

Through a process of engagement with existing service leads, and community providers via the York Integrated Community Model Joint Delivery Board, the plan has been developed to support the overarching priorities.

YSFT have played a crucial role in the capacity and demand data collection and what makes us somewhat unique as a system is the fact that our community health services are hosted by our acute trust. Community health colleagues have been pivotal to helping us understand challenges and priorities across communities and since the inception of the York Integrated Community Model Joint Delivery Board, we have been able to weave in these priorities and address challenges as we continue our journey towards integration.
We have been able to identify bottlenecks within community outreach such as therapy and understand some of the challenges faced. For example, when the local council place someone in bedded care which is out of area, whilst this may be the best option for several reasons, this then means that therapy input is much more challenging due to radius, proximity and resource. It is this that has contributed to the sourcing of local bedded facilities wherever possible. This development reflects the local priorities of our system and demonstrates the strong partnership working ethos that we have created amongst partners.

Partnership Working Groups support each programme area, ensuring we reduce duplication, align eligibility criteria, and explore joint training for our multi-disciplinary workforce. These groups also support implementation of our Integrated UEC and Community Offers (York Health and Care Partnership priorities), through work such as the development of the Frailty Hubs and Urgent and Emergency Care Redesign.

Partners work collaboratively to jointly commission key services and we continue to develop our integrated team model, supporting in-reach and early intervention. Through our shared vision, partners have built strong, trusting relationships with improved communication. This is underpinned by robust governance, leading to effective decision making to improve outcomes for York's residents.

We have agreed that building on existing schemes and collectively redesigning new models will further support the delivery of our target, reducing LoS across all discharge pathways. Whilst in previous years, additional funding was used to secure additional bed capacity to support flow through hospital over winter months of significant pressure, key learning from this has been to ensure that mitigations are in place for the removal of the additional beds whilst still demonstrating timely discharge. We are actively working with providers to look at the potential to flex beds where appropriate. By using this learning, we have been able to build these elements into the plan to ensure we are maximising every opportunity available to us. One area of learning that we are working on is challenges around data collection. At times it has been difficult to quantify the impact of things due to how data is collected, coded or available to us. We are working through these challenges to understand what we need from data sources and how this links in with national data coding requirements and guidance.

Very few changes have been made to the funding plan since 2024/25, however an extensive piece of work has been undertaken to improve the accuracy of the scheme names and descriptions and to consolidate schemes where there was previously duplication. The purpose of this has been to enhance the clarity of the plan to enable more informed system feedback, and the exercise has resulted in a reduction in the total number of schemes from 57 to 46.

Aside from inflationary uplifts applied at the standard NHS rate, changes to schemes since the previous year include:

- Cessation of the scheme 'Move Mates' - the Move Mates contract has now ceased as per a planned two year tapering down of the service. Resources have been redirected to other schemes delivering more successfully against the BCF objectives.

- Cessation of the 7-day discharge scheme (funding supporting additional discharge planning capacity at weekends to enable weekend discharges) - the scheme has had little success in enabling discharges to take place over the weekend due to the lack of wider reciprocal capacity across the care market etc. As a result, the decision has been made to redirect this funding towards other schemes more successfully delivering against the BCF objectives. The social care element of the scheme was ended in 24/25, and funding for the Hospital Trust element has been built into the plan for Q1 (see below), after which it will be reviewed.

- Additional contribution to staffing resource supporting hospital discharge – new scheme for 25/26, additional funding to enable the continuation of Hospital Trust element of the 7-day discharge scheme throughout Q1, and a further £73k funding to enable existing Hospital Social Worker Team administrative capacity (working Monday-Friday) to continue, following the loss of the original funding stream for these posts.

- Increase in funding to the York Frailty Hub (approximately £100k).

- Increase in funding to intermediate care discharge to assess beds (approximately £52k).

Section 2: National Condition 2: Implementing the objectives of the BCF

Please set out how your plan will implement the objectives of the BCF: to support the shift from sickness and prevention; and to support people living independently and the shift from hospital to home. This should include:

- A joint system approach for meeting BCF objectives which reflects local learning and national best practice and delivers value for money
- Goals for performance against the three national metrics which align with NHS operational plans and local authority social care plans, including intermediate care demand and capacity plans
- Demonstrating a "home first" approach that seeks to help people remain independent for longer and reduce time spent in hospital and in long-term residential or nursing home care
- Following the consolidation of the Discharge Fund, explain why any changes to shift planned expenditure away from discharge and step down care to admissions avoidance or other services are expected to enhance UEC flow and improve outcomes.

The BCF is led through partnership working at Place. Our Partnership is inclusive of our vibrant voluntary and community sector and Independent Care Group representing care homes and domiciliary care agencies.

We are committed to early intervention and preventative approaches, supporting early discharge of people who require hospital admission and providing support for people to remain at home for longer. Working together we are further developing strength-based approaches, supporting people and communities to build on their strengths, introducing self-care models of care and support building resilience and independence. Through partnership working we are developing stronger healthier communities by listening to what matters to our citizens and codeveloping services to meet needs.

Four example schemes that will support admission avoidance funded via BCF include:

1. Rapid Assessment Team Service (RATS)

The Rapid Assessment Team Service (RATS) plays a crucial role in admission avoidance by providing rapid, multidisciplinary support to patients at risk of hospitalisation. The service operates beyond its original hours, with the extended hours funded through the Better Care Fund (BCF) to ensure greater access to timely assessments and interventions. This additional capacity helps reduce unnecessary hospital admissions and alleviates pressure on urgent and emergency care services.

The team consists of occupational therapists, physiotherapists, social workers, and emergency department clinicians, working together to provide comprehensive assessments and immediate interventions. A key innovation within the service is the two-hour rapid response provision delivered by a local home care provider, ensuring that vulnerable patients discharged from the emergency department receive swift support at home. By enabling patients to be treated in the most appropriate setting, the RATS team enhances patient outcomes while maintaining hospital capacity for those with the most urgent needs.

2. Contribution to YAS Frontline Paramedic Capacity (previously referred to as the Urgent Care Practitioner (UCP) scheme)

The BCF contribution to YAS (Yorkshire Ambulance Service) supports paramedics to deliver urgent care directly in the community, reducing unnecessary hospital conveyances. Initially, the funding was used to create dedicated Urgent Care Practitioner capacity across York, allowing ambulance crews to provide on-scene treatment for individuals who might otherwise have been taken to hospital. Over time, this approach has become embedded into the standard practice of all frontline paramedics, ensuring that more patients receive timely care in their own homes or community settings. The funding now supports overall paramedic capacity, enhancing the ability of ambulance services to manage urgent cases effectively while preventing avoidable hospital admissions.

3. York Integrated Care Team

The York Integrated Care Team (YICT) plays a crucial role in admission avoidance by providing proactive, community-based care for patients with complex health and social care needs. The team focuses on anticipatory care, working with a caseload of approximately 3,000 frail patients, many of whom are at high risk of hospital admission due to multiple long-term conditions, frailty, or recent episodes of ill health. By identifying and addressing potential deterioration early, YICT helps to stabilise patients in the community and reduce the likelihood of unplanned hospital visits.

YICT offers short-term intensive support to patients following a deterioration in their health, ensuring they receive the right care at the right time. This includes Health Care Assistant (HCA) support as a 'step-up' from the Rapid Assessment Team Service (RATS) in the Emergency Department (ED), providing additional care to help prevent avoidable hospital admissions. The team also has a care coordination function, ensuring that patients on the caseload receive well-integrated and timely interventions.

A key aspect of YICT's work is facilitating multi-disciplinary team (MDT) meetings for complex case management and discharge planning. These meetings bring together professionals from health and social care, including GPs, community nurses, therapists, and social workers, to develop personalised care plans that support patients to remain safely at home or in their usual place of residence. Through this collaborative, preventative approach, YICT is instrumental in reducing unnecessary hospital admissions and enabling patients to receive care in the most appropriate setting for their needs.

4. York Frailty Crisis Response Hub

Following a successful pilot launched in November 2023, the Frailty Crisis Response Hub has become a key component of the Integrated Community Frailty Service, supporting patients in crisis to remain at home while receiving appropriate care. It integrates multiple crisis care services, leading the coordination of a multi-agency, community-based response. The service is delivered by a multidisciplinary team, including a GP with a Special Interest in Frailty, a CRT triager, social workers, care navigators, and voluntary care sector social prescribers. Its primary objective is to maximise home-based care, ensuring patients receive the right support at the right time while promoting the utilisation of non-statutory services.

The Frailty Crisis Advice and Guidance Phone Line, managed by a Senior Frailty Clinician, provides urgent advice to professionals caring for frail patients. It operates within the Frailty Crisis Response Hub during core hours and as a standalone service out of hours. Calls from the Yorkshire Ambulance Service are prioritised to reduce system pressures.

In addition to the co-located MDT, the service also provides and coordinates 'on the ground' capacity to support patients within their own homes, including UCR visiting capacity, including clinicians who are able to

utilise technology such as point of care blood testing and mobile bladder scanning to enhance their ability to keep patients at home, and Age UK support workers who have been trained in delivering basic clinical observations.

The Frailty Crisis Hub will support admission avoidance and is evidenced by its use by the wider system, with 24 different organisations having used the Frailty A&G line for support since November. The most frequent referring organisations have been UCR, YICT, GPs, appropriate self-referrals from patients on the YICT caseload (as determined by YICT triagers), CRT and YAS paramedics. This winter, the increase in ED conveyances in York was significantly lower compared to East Riding, Hull, and North Yorkshire.

5. York Integrated Care Team In-Reach Model.

The in-reach service provided by the York Integrated Care Team (YICT), funded through the BCF, also supports in preventing unnecessary hospital admissions. It works in collaboration with the RATS service to support patients in the Emergency Department (ED) who do not require admission. A direct referral pathway between RATS and the in-reach service enables patients to return home with appropriate support, thereby avoiding unnecessary hospital admissions. This model is now fully embedded.

As a system we are committed to reducing the number of unnecessary admissions into hospital, through helping more people to be supported at home with the right service and right support through a person-centred approach. A key aim of the Better Care Fund, and the Discharge Fund, is to reduce emergency admissions, which brings within it the potential to invest in services closer to home to prevent, reduce or delay the need for health and social care services or from the deterioration of health conditions requiring intensive health and care services. We acknowledge that some schemes are part of existing core services, however through innovative approaches and commissioning we are looking at ways to move resources and funds around the BCF and several sub contractual arrangements. These approaches include the expansion of an existing in-reach model aimed at identifying patients in ED who have low level needs and an admission can be avoided. With additional funding we have been able to expand the service by increasing the workforce meaning further reach into the hospital (SDEC/wards) to bring patients, facilitating earlier discharge.

In addition the above four example schemes, other schemes supporting admission avoidance include the Local Area Coordinators, the reablement service (which also accepts step up referrals), CRT capacity, the hospice at home service, the contribution to the TEWV mental health crisis response service and a number of proactive care schemes that will indirectly reduce admissions.

The three scheme areas within the BCF are:

- Early Invention and Prevention

<u>Proactive anticipatory care</u>

The service will be required to proactively identify York's most frail and vulnerable residents who are at risk of crisis or loss of independence without multidisciplinary and proactive support. This will include individuals with unstable complex frailty and a Rockwood score of five or above. Identification should be carried out through GP registers, referrals from the wider system, and recognising patients following a crisis or hospital discharge via the Integrated Community Frailty Service.

Individuals identified will primarily receive support through a Comprehensive Geriatric Assessment (CGA), ensuring a holistic approach to care, the development of a shared care plan, and appropriate referrals.

Multidisciplinary discussions will also be integral to patient management. A direct access phone line will be available for patients facing health or social challenges, with a direct link to the crisis arm of the service. The number of CGAs anticipated monthly is 225 minimum.

Integrated Community Frailty Service MDT

In addition to regular multidisciplinary discussion throughout the day to support patients as part of the Frailty Crisis Response Hub Service, the service will facilitate a weekly Complex Frailty MDT to coordinate care for frail patients in crisis, those receiving bridging care, and those requiring anticipatory support that would benefit from a multidisciplinary and multiorgansiational approach. Referrals from external organisations are accepted to ensure comprehensive community-based care, reducing unnecessary hospital admissions and supporting the evolving neighbourhood health model.

Step Up / Step Down Bridging Care

The service will provide 9 WTE Health Care Assistants to provide time-limited step-up and step-down support to patients in the community to prevent admission, support discharge and to support patients to regain independence following a crisis and/or admission.

Championing and Supporting the Role of the Voluntary Sector

A key part of the Integrated Community Frailty Service will be to commission the voluntary care sector to provide an integrated offering to support residents in York living with Frailty, and to promote an increase in the utilisation of non-statutory roles, demonstrating added value based on spend vs outcome.

We will ensure that available funds are directed to schemes that create the biggest outcomes for people, reducing inequalities and the need for acute care. We will continue to offer versatile services that are responsive reducing delays in discharges as well as supporting people with long term conditions through our developing frailty hub.

We understand the need to ensure we have a responsive well skilled workforce and through our joint workforce board we are working towards a multi-agency approach to training using generalist training models for health and care staff. We will further build on our intermediate care offer reflecting the needs of our wider population including people with dementia, mental health issues, learning disabilities and those with autism. Our jointly commissioned BCF services continue to:

- Reduce the need for ongoing support through social care, promoting independence and control
- Continue to enhance our VCSE and utilise resources to promote early intervention and prevention approaches.
- Build on the strength of local communities and provide services that build on peoples own abilities and strengths
- Enhance personalised care and support through commissioning tailored support through personal budgets
- Enhance mental health and wellbeing services building on the mental health hub and the connecting our city programme.
- Reduce waiting times for people contacting social care
- Reduce length of stay within a hospital setting through enhancing rapid response services and in reach integrated teams

There is an acknowledgement that higher levels of acuity continue to result in discharges that are not consistent with usual places of residence – patients who would normally be discharged home are often requiring additional onward/packages of care preventing them from being discharged to their usual place of residence in some cases. Our ambition is to ensure that all patients are discharged to their usual place of

residence without the need for additional or onward care which prevents this. The Frailty Crisis Hub and the in-reach model are good examples of how we have mitigated this (identifying patients before they are admitted and getting them back home/usual place of residence instead of a potential admission which may then result in additional care needs, preventing the patient from returning home.

The focus of our BCF services remain in line with the BCF policy objectives and national priorities. We will continue to build on the schemes that are supporting the delivery of good outcomes. An integrated workshop was held in December 2024. The workshop further confirmed agreement from partners to reduce the number of short-term pilots and focus building on effective and efficient BCF schemes that result in positive outcomes. This event also gave partners the opportunity to showcase some examples of the work that their schemes were doing and how this contributes to the overarching objectives of the BCF. The workshop did not lead to the decommissioning of any schemes or the introduction of new investments, however it did significantly enhance understanding of the current initiatives and how they interconnect to support BCF priorities.

We are embedding our vision for 'Preparing for adulthood strategy' to support a seamless approach for young people transitioning out of adult services, particularly considering individuals using mental health services and learning disabilities services as well as those with Special Educational Needs. This will enable seamless pathways to services, reducing the number of young people falling through the transitional gap between children's and adult services. We will continue to work with partners, in particular mental health services and the acute trust, to build in specialist support for people who require hospital admission.
As part of our personalisation offer, we are looking to expand the access to Direct Payments. Direct payments offer flexibility and choice to people by meeting their needs through a bespoke package of cares that they can commission and use to support their needs in innovative ways. We are currently updating the policy to offer further flexibility and choice. Alongside this we are developing further community and support offers, and through the market sustainability and commission groups we are looking to jointly commission the right services at the right time. We recognise that there are things that we can do together, that we cannot do alone. Working closely with ICB colleagues, we are developing joint approaches to commissioning, identifying areas of duplication and using shared learning to contribute to efficient and productive ways of working.
The City of York is a human rights city and last year agreed that we wanted to be an anti-racist city recognising that racism exist across the city impacting not only on the wider population but also the workforce. We are currently working with an independent group to explore the changes of inclusivity we need to look to make over the next 12 months.

DFG funding supports the shift from sickness to prevention by providing financial support towards the costs of carrying home adaptations to enable people with disabilities and complex health and care needs to live safely, healthily, and independently in their own homes. In City of York Council, funding is provided in the form of Disabled Facility Grants, Disabled Adaptations Grants, and Minor Work Grants to carry out a wide range of home adaptations such as level access showers, access ramps, level door thresholds, stairlifts, through floor lifts, safety measures, kitchen adaptation, and minor adaptations such as handrails, half steps etc. The provision of such adaptations and technologies not only help the disabled person to live in their home but , also provides support to unpaid carers by increasing the independence of the disabled person to carry out tasks on their own rather than relying on assistance from carers to carry out everyday tasks. By enabling people to remain in their homes, the DFG also supports preventative care, as it helps individuals avoid situations that could lead to hospitalisation or a decline in health

DFG funding supports the BCF objective two (reform to support people living independently and the shift from hospital to home shift from sickness to prevention) by providing financial support towards the costs of carrying home adaptations to enable people with disabilities and complex health and care needs to live safely, healthily, and independently in their own homes. Provision of home adaptations help to reduce the risk of harm occurring to individuals, arising from falls in the home, or through provision of adaptations which enable an individual to be able to remain in the home rather than needing long term residential or nursing care.

Adaptations provided by City of York Council also help ensure that people in hospital can be discharged back to their homes by ensuring that homes are suitably adapted to meet the needs, this being done through the provision of grants.

There majority of the 2025/26 Adult Social Care priorities outlined in the Adult Social Care strategy and the service plan contribute to both of the BCF objectives. These include:

- Creation of a multi-disciplinary planned review team to address our backlog of annual reviews, helping people to remain independent
- Utilising our LACS to ensure people waiting for a strength-based conversation to assess their care and support needs are waiting well in the hope that we can prevent or reduce the need for more formal care
- Gathering feedback from people who use our services including those with complex needs that require both health and social care support and those that transition between health and social care and using this information to improve services
- Expanding our use of research across Adult Social care practice and implementing increased support for self-funders
- Improving our process for people using Direct Payments to promote independence and alternatives to traditional commissioned care to achieve identified outcomes
- Working across health and social care to improve our use of resources across the system to ensure timely and effective hospital discharge including a new Discharge to Assess model in the acute hospital and developing mental health hubs across the city and working closely with partners to improve our CHC process to improve outcomes and experiences from some of the most vulnerable people in the city
- Developing a new carers strategy and delivery plan to improve our support to unpaid carers
- Improving our supported housing offer (both internally and externally) to allow people to remain independent in their own homes, reducing or delaying the need for residential or nursing home care.

Please describe how figures for intermediate care (and other short-term care) capacity and demand for 2025-26 have been derived, including:

- how 2024-25 capacity and demand actuals have been taken into account in setting 2025-26 figures (if there was a capacity shortfall in 2024-25 what mitigations are in place to address that shortfall in 2025-26)
- how capacity plans take into account therapy capacity for rehabilitation and reablement interventions

For 2025-26, capacity figures have been derived from 2024-25 actual capacity data, supplemented by local knowledge and improved data flows developed over the past year. This year, we have expanded our capacity and demand modelling to include a broader range of services, such as the Pathway 1 bridging service, community hospital beds, and Fulford nursing home beds (BCF-funded rehab beds). Additionally, we have refined the distinction between step-up and step-down capacity for services that deliver both, ensuring a more accurate representation of available resources.

Our approach to determining demand figures aligns with the methodology used across the ICB Places. Initially, we used hospital discharge by pathway data from the 2024/25 operational planning template, applying a 2% uplift agreed with acute provider planning leads. However, this data alone underestimated demand compared to available capacity and expected service levels for 2025-26. To refine our projections, we incorporated more accurate local intelligence, ensuring a closer alignment between demand and capacity.

In York, this approach has led to the estimation that home-based care demand will exceed capacity by 5%, whereas Pathway 2 bed demand is projected to be 5% lower than available capacity (aligning with our understanding that, with the right support in place, more patients could be cared for at home rather than requiring bedded care). Where demand is expected to exceed capacity, we anticipate wait times for beds or services. While there has been some variation in methodology across the six places in Humber and North Yorkshire (HNY), the core approach has remained consistent, starting with hospital discharge by pathway data and refining projections using the most reliable local data available.

We anticipate that demand will exceed capacity primarily in community-based therapy services, a key component of home-based intermediate care. While overall home-based care capacity may appear below demand, this shortfall is largely driven by therapy provision rather than other service elements.

To address this, we are implementing several key developments over the next year:

Integrated Neighbourhood Teams (INTs): These will be established over the coming year to enhance collaboration and improve care coordination for complex patients.

Integrated Community Frailty Service: Our investment in this service includes expanding voluntary sector involvement, helping to alleviate pressure on statutory services by providing additional community-based support.

Urgent Care Improvement Programme & Home First Approach: The Urgent Care Improvement Programme, alongside CYC social care discharge teams, is driving the reinforcement of the Home First approach to reduce unnecessary admissions to bedded care and ensure more people receive appropriate support at home.

Integrated Discharge MDT: Recently developed, this multidisciplinary team will continue to be strengthened to improve hospital discharge processes. Looking ahead, we will also work towards implementing a fully integrated discharge hub.

Discharge to Assess Model: A key focus for 2025/26, this will be developed to ensure patients are discharged to the most appropriate setting as efficiently as possible.

These initiatives will collectively enhance system-wide coordination, improve patient flow, and help mitigate capacity challenges in community-based therapy and beyond.

Section 3: Local priorities and duties

Local public bodies will also need to ensure that in developing and delivering their plans they comply with their wider legal duties. These include duties:

- to have due regard to promoting equality and reducing inequalities, in accordance with the Equality Act 2010 public sector equality duty.
- to engage or consult with people affected by the proposals. For ICBs, trusts and foundation trusts this includes their involvement duties under the NHS Act 2006.
- for ICBs, to have regard to the need to reduce inequalities in access to NHS services and the outcomes achieved by NHS services.
- for ICBs, to have regard to the duty to support and involve unpaid carers in line with the Health and Care Act 2022

Please provide a short narrative commentary on how you have fulfilled these duties

Through the BCF Performance and Delivery Group we will continue to monitor the success of these services and redesign and deflect resources as required. All services developed through the additional funding were agreed following reflection and learning from previous years.

Population Health and Health Inequalities

In planning and developing services across the Humber and North Yorkshire Integrated Care Board (HNY ICB), we adopt a population health approach to identify areas of greatest need and determine where services should be targeted. This ensures that we are addressing health inequalities and focusing resources where they will have the most impact. As part of our commitment to promoting equality and reducing inequalities, we undertake Equality and Quality Impact Assessments (EQIAs) when significant service changes or developments are proposed. These assessments are integral in shaping our plans and ensuring that potential impacts on diverse groups are considered and addressed. Proposals with the potential for major impact are escalated to the Health and Wellbeing Board and the Overview and Scrutiny Committee, ensuring transparency, engagement, and oversight.

Our Better Care Fund (BCF) Plan for 2025/26 continues to prioritise supporting the most vulnerable individuals in our communities, enabling them to live independently for as long as possible through home-first, person-centred, and asset-based approaches. In line with our legal duties, we ensure meaningful engagement with affected individuals and communities, including unpaid carers, and pay specific attention to reducing inequalities in access to NHS services and outcomes. Each scheme review carefully considers how to improve access for health inclusion groups, and where necessary, we make recommendations to extend service reach and improve monitoring. Promoting equality and reducing inequalities are embedded throughout our BCF plan, which forms part of our broader place-based transformation work. This includes developing community service specifications aimed at enriching community wellbeing and ensuring universal, timely support. We recognise that wellbeing is influenced by a wide range of factors – from transport and housing to green space and education – and we work across sectors to address these. Through the BCF Performance and Delivery Group, we will continue to monitor service performance and impact, using learning

from previous years to inform decisions and reallocate resources as needed to ensure the best possible outcomes for our communities.

Our approach across Humber and North Yorkshire

The Humber and North Yorkshire Integrated Care Board (HNY ICB) remains committed to improving population health outcomes and reducing health inequalities. The actions summarised below are part of the Humber and North Yorkshire ICB Population Health, Prevention and Health Inequalities Action Plan (2025-2026) which has been shared with the ICB Board. The plan builds on the achievements and insights from the Humber and North Yorkshire's live Population Health and Prevention Metrics dashboard and Programme Highlight Reports, incorporating data-driven, evidence-based approach to tackling inequalities through Core20PLUS5, prevention strategies, and system-wide collaboration.

Our Strategic Priorities are -

- Tackling health inequalities through targeted interventions in cardiovascular disease (CVD), cancer, maternity, severe mental illness (SMI), and inclusion health
- Embedding prevention at scale by addressing smoking, alcohol misuse, and weight management.
- Improving access, outcome and outcomes in key public health functions, including vaccinations, dental health, and health protection.
- Enhancing data-driven decision-making by integrating population health intelligence.
- Strengthening system-wide capacity and leadership to reduce health inequalities through education, training, and the ICB's Anchor role.

There are key workstreams and actions for adults covering CVD, Cancer, Maternity, SMI and inclusion health, and for children, focus areas are; Oral health, asthma, epilepsy, diabetes, mental health. There are also workstreams and actions for prevention, public health and ICB building blocks.

Our approach in York

York has a reputation for being a city in good health. With a growing economy, high skills and a strong community fabric, we have many assets and things which keep people healthy. However, our health outcomes are not as good as you would expect with declining life expectancy, similar levels of preventable disease as other areas, large health gaps between our richer and poorer communities, and some key areas of health need identified by the Joint Strategic Needs Assessment.

In response to these challenges, we've set a clear vision in our Health and Wellbeing Strategy to become a health generating city, and to reduce the gap in healthy life expectancy over the next ten years by tackling the chief causes of ill health in poorer communities.

Our population health approach in York underpins our work and all system partners are committed to improving outcomes for our population and addressing health inequalities. Our Health and Care Partnership's agreed objectives clearly prioritise a focus on population health, reducing inequalities, and engaging with our local communities.

- Prioritise the health and wellbeing of the population within place, addressing inequalities, equity and promoting preventative care and help people live longer healthier lives.

- Enable communities to shape, participate in and take ownership of their local health and wellbeing services.

- Develop and deploy effective joint approaches that join services and systems together to better support people to positively manage their health and wellbeing.

Some of way that the programmes in our Better Care Fund plan directly address population health and health inequalities are as follows.

- The changes in eligibility criteria for intermediate care and reablement ensure that people's needs are assessed as individuals, taking into account their own personal circumstances.

- Our home first approach to discharge aims to get people back into their own environment sooner, into the integrated network of community-based support. In particular the pathway 1 model allows the discharge process to take account of individuals health and care needs as well as their wider circumstances such as housing and existing support networks.

- The impact we have demonstrated with the frailty hub model allows us to build on this approach, and further development of the multi-disciplinary hub model will be designed around local population needs informed by population health approaches.

- Further partnerships with the VCSE to support discharge and admission avoidance will bring deeper insights into our communities and the people that our VCSE partners support.

- Funding to support alcohol-related harm and misuse

- A wide array of schemes specifically targeted at those with worse health and who typically have difficulty accessing health services, for example the Local Area Coordination scheme, the frailty hub model, the Union Terrace Homelessness Discharge Beds, contribution to Dementia Forward, contribution to Mental Health Crisis Response and a number of voluntary sector services supporting York's most vulnerable residents.

In addition, the following examples of work undertaken in York specifically target health inequalities.

- Co-design and implementation of a targeted community-based intervention to improve health inequalities in our most vulnerable groups of Children and Young People.

- Enhancing the General Practice Quality and Outcomes Framework to provide additional resource to improve reach into deprived communities and inclusion health groups to increase uptake of secondary prevention.

- Utilising population health approaches from the inception of our approach to Integrated Neighbourhood Teams, starting with the compilation of detailed neighbourhood health profiles to inform the design of our neighbourhood model, and ensuring that prevention and early intervention is embedded throughout.

- Strengthening our integrated prevention and early intervention approach through a robust review of existing prevention services, with targeted strategies now being implemented to build on our strengths and improve access to prevention.

We continue to develop the building blocks for population health management being the foundation to our work at place, making progress in the following areas.

- The York Population Health hub brings together health and local authority colleagues and continues to drive initiatives aimed at improving population health outcomes in our city. Recent initiatives include completion of a health promotional campaign on the risks associated with high blood pressure, offering data insights to support local Pharmaceutical Needs Assessment, and holding 'lunch and learn' sessions for health and care professionals on pertinent topics.

- The Population Health hub have also led the development of our CORE20PLUS profiles for Adults and Children and Young People, which serve as an important resource to inform service design and delivery.

- We have piloted a scheme to improve coding of inclusion health groups in general practice data, which will ensure people in these cohorts can be identified both when accessing health services and also ensures that planning and designing of local services can be informed by a better understanding of the distribution of inclusion health groups.

- Completion of a local health inequalities training programme, attended by a representative of every General Practice in the York area.

- Publication of 'Our City Health Narrative' which summarises the Joint Strategic Needs Assessment in an accessible and informative format and highlights key areas of health need.

- We have reviewed our approach to partnership working, including governance arrangements, and have strengthened the input of community VCSE representatives in our local partnership forums.

The discharge support provided by the York Carer's Centre, as part of the wider Early Discharge Support Service (EDSS), plays a critical role in supporting carers during the often stressful hospital discharge process. Over the past nine months, the Carer's Support and Advice Worker has become an integral part of the hospital system, helping carers navigate the complex health and social care landscape. By providing tailored information and emotional support, the service ensures that carers are better equipped to manage their responsibilities, reducing the likelihood of hospital readmissions and improving outcomes for both carers and the individuals they support.

The impact of the service has been significant, with key performance indicators consistently exceeded despite operating with just one member of staff working 30-hours per week. Over the past few months, the service has nearly doubled its target for the number of carers supported. Carers have benefitted from a range of services, including access to financial advice, respite breaks, and mental health support, reducing their overall stress and improving their ability to provide care. The service has also fostered strong partnerships with hospital staff, leading to more effective collaboration in discharge planning and post-hospital care.

The need for ongoing support for carers is well documented. Studies show that unpaid carers contribute an estimated £162 billion annually to the UK economy, yet many experience severe physical, mental, and financial strain. Recently, York and Scarborough NHS Foundation Trust have reported that many carers feel excluded from the care process and struggle to access relevant support. Without adequate intervention, carers may reach breaking points that result in greater strain on health and social care services. This service helps mitigate these risks by providing proactive and immediate support during the crucial transition from hospital to home.

The Carer Support and Advice Worker has demonstrated exceptional ability in addressing the unique needs of carers. Case studies illustrate how timely interventions have prevented failed discharges, enabled carers to feel supported throughout the discharge process, and ensured that patients receive appropriate care after leaving the hospital. Positive feedback from carers and healthcare professionals further underscores the service's effectiveness in bridging gaps in care provision. York Carers Centre have recently completed a Social

Return on Investment (SROI) tool that is bespoke to the work undertake by Carers, indicating that for the whole York Carer's Centre service, for every £1 spent on supporting carers there is a social return on this investment of £15.94.

Increasing investment in the voluntary sector aligns with our strategic intentions to maximise the utilisation of the non-registered workforce, ensuring that skilled but unregistered professionals can contribute effectively to patient care. This specific service directly supports both discharge and prevention agendas by empowering carers to support discharge, whilst also reducing the likelihood of future carer breakdown which compromises patient wellbeing and leads to worse outcomes for both patients and their carers.

Annex 3.1:

Better Care Fund 2025-26 Capacity & Demand Template

3.1. C&D Step-down

Selected Health and Wellbeing Board: York

Step-down

Capacity - Demand (positive is Surplus)	Capacity surplus (not including spot purchasing)												Capacity surplus (including spot puchasing)											
	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Reablement & Rehabilitation at home (pathway 1)	-10.5	-10.5	-10.5	-10.5	-10.5	-10.5	-10.5	-10.5	-10.5	-10.5	-10.5	-10.5	-10.5	-10.5	-10.5	-10.5	-10.5	-10.5	-10.5	-10.5	-10.5	-10.5	-10.5	-10.5
Short term domiciliary care (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	-1.5	-1.5	-1.5	-1.5	-1.5	-1.5	-1.5	-1.5	-1.5	-1.5	-1.5	-1.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5
Other short term bedded care (pathway 2)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	-0.5	-0.5	-0.5	-0.5	-0.5	-0.5	-0.5	-0.5	-0.5	-0.5	-0.5	-0.5	0	0	0	0	0	0	0	0	0	0	0	0

Average LoS/Contact Hours per episode of care

Full Year	Units
23.2	Contact Hours per package
72	Contact Hours per package
23.4	Average LoS (days)
0	Average LoS (days)
11.8	Average LoS (days)

Capacity - Step-down		Refreshed planned capacity (not including spot purchased capacity)												Capacity that you expect to secure through spot purchasing											
Service Area	Metric	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Reablement & Rehabilitation at home (pathway 1)	Monthly capacity. Number of new packages commenced.	207.9	207.9	207.9	207.9	207.9	207.9	207.9	207.9	207.9	207.9	207.9	207.9	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home (pathway 1)	Estimated average time from referral to commencement of service (days). All packages (planned and spot purchased)	1.46	1.46	1.46	1.46	1.46	1.46	1.46	1.46	1.46	1.46	1.46	1.46												
Short term domiciliary care (pathway 1)	Monthly capacity. Number of new packages commenced.	10	10	10	10	10	10	10	10	10	10	10	10	0	0	0	0	0	0	0	0	0	0	0	0
Short term domiciliary care (pathway 1)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3												
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly capacity. Number of new packages commenced.	65	65	65	65	65	65	65	65	65	65	65	65	5	5	5	5	5	5	5	5	5	5	5	5
Reablement & Rehabilitation in a bedded setting (pathway 2)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	3.6	3.6	3.6	3.6	3.6	3.6	3.6	3.6	3.6	3.6	3.6	3.6												
Other short term bedded care (pathway 2)	Monthly capacity. Number of new packages commenced.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other short term bedded care (pathway 2)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	0	0	0	0	0	0	0	0	0	0	0	0												
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly capacity. Number of new packages commenced.	0	0	0	0	0	0	0	0	0	0	0	0	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	28	28	28	28	28	28	28	28	28	28	28	28												

Demand - Step-down		Please enter refreshed expected no. of referrals:											
Pathway	Trust Referral Source	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Total Expected Step-down:	Total Step-down	**295.4**	**295.4**	**295.4**	**295.4**	**295.4**	**295.4**	**295.4**	**295.4**	**295.4**	**295.4**	**295.4**	**295.4**
Reablement & Rehabilitation at home (pathway 1)	Total	**218.4**	**218.4**	**218.4**	**218.4**	**218.4**	**218.4**	**218.4**	**218.4**	**218.4**	**218.4**	**218.4**	**218.4**
	YORK AND SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRU	218.4	218.4	218.4	218.4	218.4	218.4	218.4	218.4	218.4	218.4	218.4	218.4
	OTHER												
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Short term domiciliary care (pathway 1)	Total	**10**	**10**	**10**	**10**	**10**	**10**	**10**	**10**	**10**	**10**	**10**	**10**
	YORK AND SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRU	10	10	10	10	10	10	10	10	10	10	10	10
	OTHER												
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Reablement & Rehabilitation in a bedded setting (pathway 2)	Total	**66.5**	**66.5**	**66.5**	**66.5**	**66.5**	**66.5**	**66.5**	**66.5**	**66.5**	**66.5**	**66.5**	**66.5**
	YORK AND SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRU	66.5	66.5	66.5	66.5	66.5	66.5	66.5	66.5	66.5	66.5	66.5	66.5
	OTHER	0	0	0	0	0	0	0	0	0	0	0	0
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Other short term bedded care (pathway 2)	Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	YORK AND SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRU	0	0	0	0	0	0	0	0	0	0	0	0
	OTHER	0	0	0	0	0	0	0	0	0	0	0	0
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Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Total	**0.5**	**0.5**	**0.5**	**0.5**	**0.5**	**0.5**	**0.5**	**0.5**	**0.5**	**0.5**	**0.5**	**0.5**
	YORK AND SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRU	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
	OTHER	0	0	0	0	0	0	0	0	0	0	0	0
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Annex 3.2:

Better Care Fund 2025-26 Capacity & Demand Template

3.2. C&D Step-up

Selected Health and Wellbeing Board: York

Step-up **Refreshed capacity surplus:**

Capacity - Demand (positive is Surplus)	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home	-5.78	-5.78	-5.78	-5.78	-5.78	-5.78	-5.78	-5.78	-5.78	-5.78	-5.78	-5.78
Reablement & Rehabilitation in a bedded setting	0.33	0.33	0.33	0.33	0.33	0.33	0.33	0.33	0.33	0.33	0.33	0.33
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

Average LoS/Contact Hours

Full Year	Units
3	Contact Hours
24.5	Contact Hours
11.8	Average LoS
72	Contact Hours

Capacity - Step-up

Please enter refreshed expected capacity:

Service Area	Metric	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Social support (including VCS)	Monthly capacity. Number of new clients.	25	25	25	25	25	25	25	25	25	25	25	25
Reablement & Rehabilitation at home	Monthly capacity. Number of new clients.	115.6	115.6	115.6	115.6	115.6	115.6	115.6	115.6	115.6	115.6	115.6	115.6
Reablement & Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	6.6	6.6	6.6	6.6	6.6	6.6	6.6	6.6	6.6	6.6	6.6	6.6
Other short-term social care	Monthly capacity. Number of new clients.	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8

Demand - Step-up

Please enter refreshed expected no. of referrals:

Service Type	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Social support (including VCS)	25	25	25	25	25	25	25	25	25	25	25	25
Reablement & Rehabilitation at home	121.38	121.38	121.38	121.38	121.38	121.38	121.38	121.38	121.38	121.38	121.38	121.38
Reablement & Rehabilitation in a bedded setting	6.27	6.27	6.27	6.27	6.27	6.27	6.27	6.27	6.27	6.27	6.27	6.27
Other short-term social care	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8

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Appendix 1:

York
Humber and North Yorkshire
Health and Care Partnership

Better Care Fund 25/26 Planning Update

Department of Health & Social Care | Ministry of Housing, Communities & Local Government | NHS England

Better Care Fund policy framework and planning requirements 2025-26

Better Care Fund policy framework and planning requirements:
The aim of the 2025 to 2026 BCF Policy Framework is:

- To be a first step in a broader shift to align with the government's Health Mission and the shift to a "neighbourhood health" approach
- To better support patients and service users by enabling people to live more healthy and independent lives for longer
- To support hospital flow and positively contribute to the NHS' ability to move towards constitutional standards
- To make the BCF work better for local authorities and the NHS by reducing administrative burdens and providing greater flexibility ~~in~~ to meet BCF objectives
- To support the government's objective to simplify the local government funding landscape

BCF Objectives for 2025-26
In line with the government's vision for health and care, the Better Care Fund policy framework sets out the vision, funding, oversight and support arrangements, focused on 2 overarching objectives for the BCF in 2025-26:

- reform to support the shift from sickness to prevention
- reform to support people living independently and the shift from hospital to home

Objective One - reform to support the shift from sickness to prevention	Objective Two reform to support people living independently and the shift from hospital to home
Local areas must agree plans that help people remain independent for longer and prevent escalation of health and care needs, including: • timely, proactive and joined-up support for people with more complex health and care needs • use of home adaptations and technology • support for unpaid carers	Local areas must agree plans that: • help prevent avoidable hospital admissions, • achieve more timely and effective discharge from acute, community and mental health hospital settings, supporting people to recover in their own homes (or other usual place of residence) • reduce the proportion of people who need long-term residential or nursing home care

Department of Health & Social Care | Ministry of Housing, Communities & Local Government | NHS England

BCF timelines 2025-26

The timescales for system planning, submission of HWB plans and assurance are set out below:

Date	Publication/Key Milestone
28 January 2025	Better Care Fund planning requirements published • submission guidance, metrics handbook and headline FAQs available on Better Care Exchange • HWB submission templates available to systems via Better Care Exchange • HWB areas allocations available on Better Care Exchange
Week commencing 27 January 2025	Webinar series to support local planning – full details to be shared via BCF Bulletin and Better Care Exchange.
February	Proactive and supportive discussions with HWB areas or groups of areas at risk of facing higher challenge to successful delivery.
3 March 2025	Draft headline HWB submissions to be made to regional Better care managers for feedback and discussion.
31 March 2025 (noon)	Full HWB submission to be made to the national Better Care Fund team and regional Better care managers.
May	Outcome letters to HWB areas.
30 September 2025	Section 75 agreements must be in place across HWB areas.

Department of Health & Social Care | Ministry of Housing, Communities & Local Government | NHS England

Better Care Fund Headline Metrics and supporting indicators 2025/26

These metrics will help local areas to focus on impact and outcomes and are aligned to the revised objectives of the BCF, the outcomes expected from the BCF, and the government's overall reform vision for neighbourhood health. Data on these metrics will be centrally collected and made available to HWBs on a new BCF dashboard. We will require local areas to set goals against the 3 headline metrics. We also encourage local areas to consider the local metrics which will most support all partners to measure progress towards the policy outcomes.

Headline Metrics	Supporting Indicators
These are mandatory metrics that HWB areas must use as part of planning for 2025/26. It is expected that local goals will be set for each of these metrics.	**HWB areas may also use supporting indicators to better understand the drivers of their performance against BCF objectives and specific local priorities. We recommend using the six indicators set out below, but additional indicators can be adopted locally.**
1. Emergency admissions to hospital for people aged 65+ per 100,000 population.	• *Unplanned hospital admissions for chronic ambulatory care sensitive conditions* • *Emergency hospital admissions due to falls in people aged 65+*
2. Average length of discharge delay for all acute adult patients, derived from a combination of: Proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD) For those adult patients not discharged on DRD, average number of days from DRD to discharge.	• *Patients not discharged on their DRD, and discharged within 1 day, 2-3 days, 4-6 days, 7-13 days, 14-20 days and 21 days or more.* • *Average length of delay by discharge pathway.*
3. Long-term admissions to residential care homes and nursing homes for people aged 65+ per 100,000 population.	• *Hospital discharges to usual place of residence* • *Proportion of people receiving short-term reablement following hospital discharge and outcomes following short term reablement*

Metrics

BCF Metric	York 25/26 Target	Target Rationale
Emergency admissions to hospital for people aged 65+ per 100,000 population	Monthly target ranging from 1,778 to 1,944 admissions per 100,000 population, equivalent of 709 to 775 admissions.	Based on historical data from May 2023 – Nov 2024, the forecast increase in 2025/26 is 7%. The plan for York is to mitigate this rise to a forecast increase of 5%.
Average length of discharge delay for all acute adult patients	Monthly target ranging from 1.58 days in April 2025, decreasing to 1.30 days by March 2026.	Target of 3% improvement throughout the year in line with wider ICB.
Proportion of adult patients discharged from acute hospitals on their discharge ready date	Monthly target ranging from 66.4% in April 2025, increasing to 68.2% by March 2026.	Target of 3% improvement throughout the year in line with wider ICB.
For those adult patients not discharged on DRD, average number of days from DRD to discharge	Monthly target ranging from 5.20 days in April 2025, decreasing to 4.30 days by March 2026.	Most recent average in York was 5.2 days (December) with YTD average of 4.8. Target has been set as decreasing down to 4.3 days by Marc 2026, which is in line with the current national YTD average.
Long-term admissions to residential care homes and nursing homes for people aged 65+ per 100,000 population.	Annual target of 527 admissions per 100,000 population, equivalent of 210 admissions.	Target of 0% growth above the 2024-25 estimated number, with initiatives aimed at supporting people to remain at home for longer intended to mitigate the expected increase in this figure.

Income

	24/25 Income	25/26 Income	Uplift (£)	Uplift (%)	Description of Funding Source
Minimum NHS Contribution - ICB	£8,275,123	£8,306,736	£31,613	0.4%	Mandated contribution from ICB core budgets into the pooled BCF budget. The ICB element is not automatically passed over to social care.
Minimum NHS Contribution - Minimum Social Care Allocation	£7,450,197	£7,742,625	£292,428	3.9%	Mandated contribution from ICB core budgets into the pooled BCF budget. The minimum social care allocation is a protected minimum amount that must be spent supporting social care. Automatically passed over to Local Authority from the ICB on a quarterly basis.
ICB Discharge Funding (included in NHS Minimum Contribution in 25/26)	£1,431,567	£1,431,567	£0	0.0%	BCF grant funding to support discharge introduced in September 2022 that has been recommitted annually. Value now included within Minimum NHS Contribution ICB Element.
iBCF (part of Local Authority Better Care Grant in 25/26)	£5,368,798	£5,368,798	£0	0.0%	Direct grant to Local Authority introduced in 2015. Now included as part of Local Authority Better Care Grant.
Local Authority Discharge Funding (part of Local Authority Better Care Grant in 25/26)	£1,254,495	£1,254,495	£0	0.0%	BCF grant funding to support discharge introduced in September 2022 that has been recommitted annually. Now included as part of Local Authority Better Care Grant received directly by LA.
Additional LA Contribution	£0	£0	£0	0.0%	Local Authorities may optionally include additional funding to be pooled into BCF budget.
Additional ICB Contribution	£0	£0	£0	0.0%	ICBs may optionally include additional funding to be pooled into BCF budget.
Total	**£23,780,180**	**£24,104,221**	**£324,041**	**1.28%**	

	24/25 Income	25/26 Income	Uplift (£)	Uplift (%)	Description of Funding Source
DFG	£1,601,197	£1,821,521	£220,324	13.8%	This funding is passed over to Local Authority and is used to support disabled adults and children to make home adaptations to support independent living.

Expenditure – Spend Breakdown by BCF Category

Area of Spend	Total Spend	Percentage Spend
Social Care	£ 14,620,606	56%
Community Health	£ 10,744,734	41%
Mental Health	£ 198,739	1%
Primary Care	£ 4,000	0%
Continuing Care	£ 0	0%
Acute	£ 337,162	1%
Other	£ 0	0%

Primary Objective	Total Spend	Percentage Spend
1. Proactive care to those with complex needs	£ 2,738,938	11%
2. Home adaptations and tech	£ 2,345,521	9%
3. Supporting unpaid carers	£ 736,000	3%
4. Preventing unnecessary hospital admissions	£ 8,518,865	33%
5. Timely discharge from hospital	£ 1,611,189	6%
6. Reducing the need for long term residential care	£ 9,975,229	38%

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Health and Wellbeing Board **7th May 2025**

Report of the Director of Public Health

Goal #1 in the York Joint Local Health and Wellbeing Strategy 2022-2032: 'Reduce the gap in healthy life expectancy between the richest and poorest communities in York'

Summary

1. From 2022-2032, the York Joint Local Health and Wellbeing Strategy sets out our ambition to reduce the gap in healthy life expectancy between the richest and poorest communities in our city.

2. The Strategy made clear that this was an 'overarching goal', one that can't be approached through single actions but will instead be the result of a whole-system shift to greater health equity and to a health-generating city. The 10 goals in the strategy are the evidence-based route map to reduce inequalities, as they are based on where we know the gap comes from in terms of the causes of early disease and death.

3. As the Board has now approved Action Plan 2 for the strategy, we will continue to report on all the Goals in turn, and this paper is intended to present to the Board the current data on Goal 1 around inequalities in life expectancy and healthy life expectancy in York, following a similar paper at the same stage in Action Plan 1. This is also in fulfilment of a Council Plan 2023-2027 objective to 'Increase council-wide action to reduce health inequalities' and report on this annually.

4. This paper also updates on some key schemes in the city which aim to tackle health inequalities.

Recommendations

5. The Board are asked to:

   - Note and comment on the current data on inequalities in life expectancy and healthy life expectancy in York

   - Discuss where and how the inequalities arise, and 'where to look' for solutions

What is Life Expectancy and Healthy Life Expectancy?

6. The life expectancy of any given area is

   'the average number of years a person would expect to live based on contemporary mortality rates, if he or she experienced the age specific mortality rates for that area and time period throughout his or her life' (OHID, 2023)

7. Life expectancy can be measured at birth, and at age 65. The first measurement will reflect the impact of infant mortality on life expectancy to a higher degree than the second. Both will reflect the determinants of health across the life course.

8. The healthy life expectancy of any given area is:

   'a measure of the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health.' (OHID 2023)

9. This essentially means that healthy life expectancy (henceforth HLE) is a composite measure, combining a local area's life expectancy (henceforth LE) with the proportion of people reporting 'good' or 'very good health' from the Annual Population Survey (ONS).

Measuring and understanding the gap

10. Whilst the definitions of LE and HLE are clear, measuring the gap in these statistics (i.e. the *inequalities*) between local areas is more complex. This may explain why there are sometimes several 'versions of the truth' for York's health inequality gaps.

11. Firstly, because of the sample size of the Annual Population Survey, data on HLE is actually not available for small areas, such as council wards. The only comparisons which can be made are between York and another local authority (or with regional/national data)

12. Secondly, LE data is available at a small area level (down to areas with populations of a few thousand people). This presents another challenge: whether to highlight the LE difference between one council ward and another council ward, or between the most deprived small areas in a local authority (which could be located across a number of different council wards) and the least deprived.

13. Thirdly, sometimes data on inequalities in HLE / LE is presented as the difference between the lowest and highest areas, but also sometimes as the gradient of the line between them.

14. Locally, we have decided that as part of the Health and Wellbeing Strategy Population Health Monitor which will come regularly to the board we will take this last approach and measure the Slope index of inequality in life expectancy at birth (3-year average), which is:

    'a measure of the social gradient in life expectancy, i.e. how much life expectancy varies with deprivation. It takes account of health inequalities across the whole range of deprivation within each area and summarises this in a single number.' (OHID 2023)

Trends in York's Life Expectancy and Healthy Life Expectancy

15. The table below presents the current LE and HLE data for York, comparing it with national / regional data and breaking down LE into ward and deprivation decile.

HEALTHY LIFE EXPECTANCY				
	Male Healthy Life Expectancy at birth (years)	**Female Healthy Life Expectancy at birth (years)**	**Time period**	**Trend**
York	62.0	62.7	2021-3	Worsening
Y+H	58.8	59.3	2021-3	Worsening
England	61.5	61.9	2021-3	Worsening

LIFE EXPECTANCY				
	Male Life Expectancy at birth (years)	**Female Life Expectancy at birth (years)**	**Time period**	**Trend**
York	79.8	83.6	2021-3	Static
Y+H	78.1	82.1	2021-3	Static
England	79.1	83.1	2021-3	Static

GAP IN LIFE EXPECTANCY				
	Male Life Expectancy at birth (years)	**Female Life Expectancy at birth (years)**	**Time period**	**Trend**
Lowest Ward (Westfield)	76.1	80.6	2016-20	Not available
Highest (Copmanthorpe)	87.1	91.8	2016-20	Not available
Gap between wards	11.0	11.2	2016-20	Not available

SLOPE INDEX OF INEQUALITY IN LIFE EXPECTANCY				
	Slope index of inequality in Male LE at birth (years)	**Slope index of inequality in Female LE at birth (years)**	**Time period**	**Trend**
York	8.4	5.7	2018-20	Static
Y+H	10.7	8.8	2018-20	Static
England	9.7	7.9	2018-20	Static

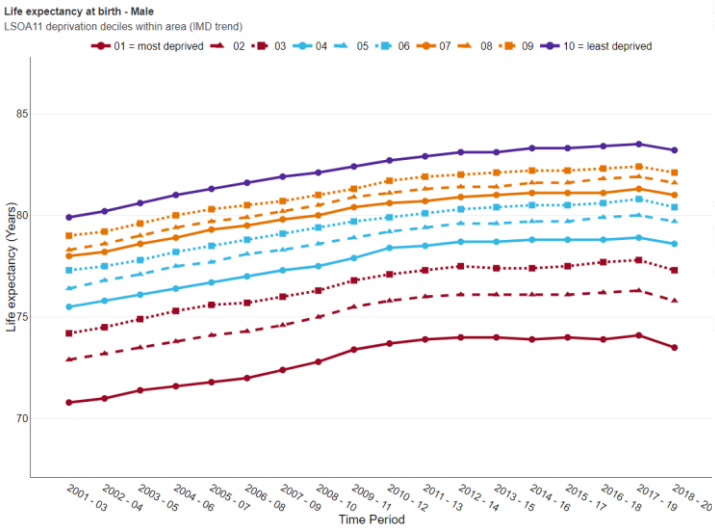
Source: OHID fingertips tool

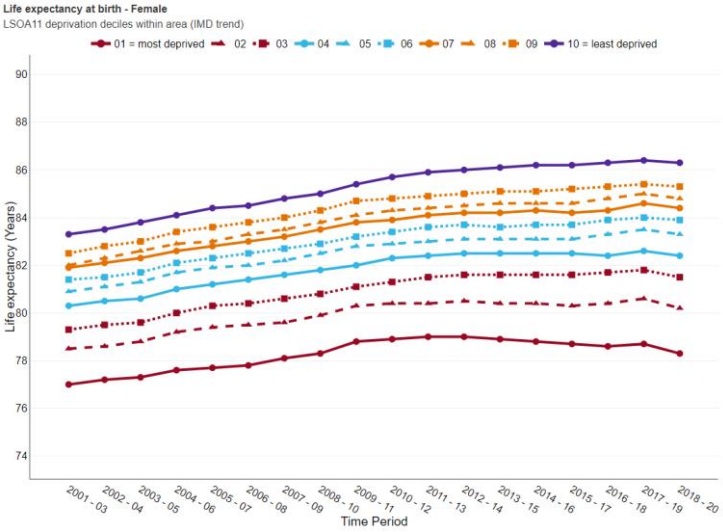
16. This table also illustrates that between 2021-23 men could expect to live in ‘bad or very bad’ health for, on average, 17.8 years, and women 21.9 years. Over the decade since 2011-13, this is an increase of 2.4 years of extra male ill health and 3.6 years of extra female ill health.

17. It should be noted data for LE and HLE is timely, whereas data for the gap in life expectancy is now increasingly out of date.

18. Recently, data has been released breaking down 2016-20 LE for all persons at Parliamentary Constituency level. LE at birth for York Outer is 83.5 years, which places it 61st in the UK out of 650 constituencies (with 1 being the highest LE). LE at birth for York Central is 78.89 years, which places it 541st in the UK out of 650 constituencies (with 1 being the highest LE). This puts the constituency in the bottom 20% of constituencies nationally in terms of LE, and shows that lower life expectancy in York is mainly concentrated in a ‘ring’ of residential suburbs around the city centre.

19. Trends in LE over two decades in our city are shown below, with each line of the graph representing 10% of York’s population according to deprivation levels. Three long-term shifts can be seen: first the gap in LE has grown between the most and least deprived deciles, from 9.1 to 9.7 years in males, and from 6.3 to 8 years in females. Secondly, improvements in LE were made in the first decade of the century and stalled in the second. Thirdly, the gap between the most deprived decile and second most deprived decile is large that all other decile gaps (the ‘cliff edge’ effect).

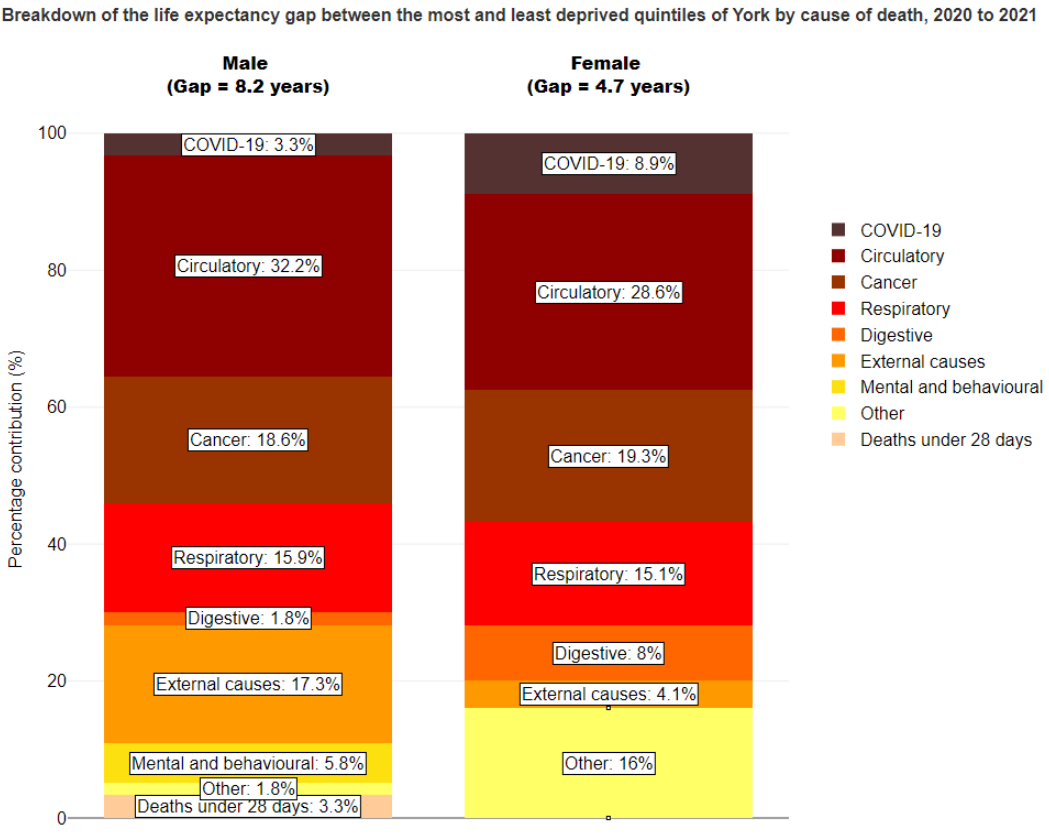




Source: OHID Health Inequalities tool

Explaining the gap

20. It is important to understand the drivers of these gaps so that action can be targeted to tackle them. One way of doing so is by breaking down the clinical reasons for the LE gap between richest and poorest areas:



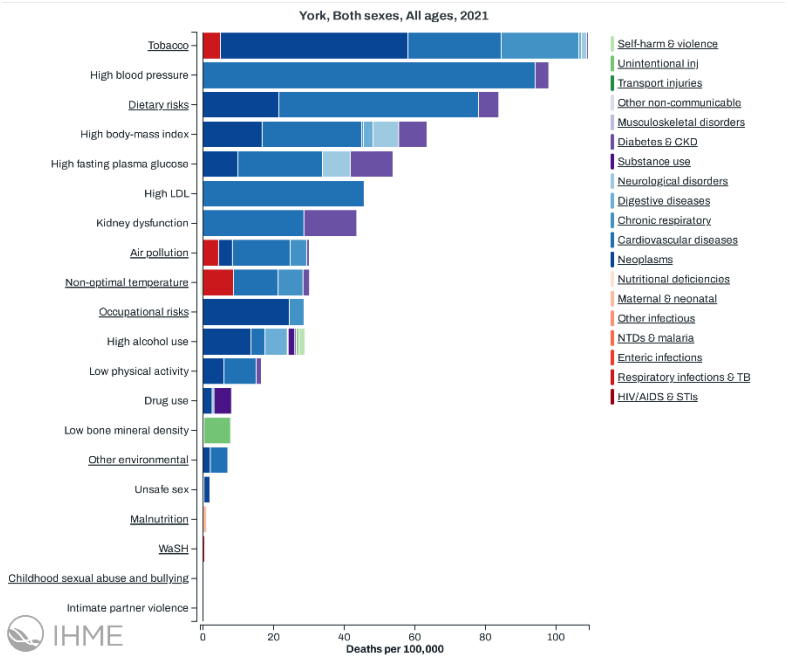
Source: OHID Segment tool

21. As the chart shows COVID-19 contributed within this year, following a pattern seen in other areas where higher death rates were seen in poorer communities from the virus. But in keeping with other years where COVID was not a factor, around two thirds of the LE gap in both females and males comes from three areas: cardiovascular diseases, cancer and respiratory diseases.

22. An estimated 80% of CVDs are considered preventable (WHF), 30% of cancers are considered preventable (WHO) and around 60% of respiratory diseases are considered preventable (ONS).

23. Preventing these three diseases is, therefore, highly achievable, and likely to be the highest impact thing we can do to reduce health inequalities.

24. Lying behind these diseases areas there is a set of ‘risk factors’, as the following chart from the Global Burden of Disease study shows:



25. Unsurprisingly, the trio of tobacco use (20%), high blood pressure (15%) and poor diet (14%) are responsible for a large proportion of the diseases noted above which contribute the most to the LE gap.

26. Underlying the clinical areas and their risk factors are, of course, the wider determinants of health, and again significant variation is seen in these:

	Variation between wards in York	
Households in fuel poverty	25.9% (Hull Road)	8.1% (Copmanthorpe)
Child Poverty (IDAC)	19.8% (Hull Road)	2.2% (Bishopthorpe)
Older people in poverty (IDAOP)	16.6% (Clifton)	4.0% (Heworth Without)
Unemployment	5% (Westfield)	1.3% (Wheldrake)
Overcrowded housing	21.3% (Guildhall)	0.9% (Copmanthorpe)
Prevalence of overweight and obesity in Reception	27.9% (Heworth)	12.5% (Bishopthorpe)

Source: Local Health (OHID)

CORE20PLUS5

27. NHS work to tackle health inequalities uses the CORE20PLUS5 framework.

28. CORE20 populations are those who live in the most deprived 20% of areas according to the Index of Multiple Deprivation. In York this is 9,343 people, this represents 4.6% of the whole population but

more children live in the most deprived 20% of areas (6.1% of the 0-19 population).

29. PLUS populations are identified at local level based on what are referred to as 'inclusion health' groups. These people experience poorer access or outcomes from healthcare, and as researchers from UCL have demonstrated, experience mortality rates 11.9x higher (women) and 7.9x higher (men) and are 'denied legal protection from the extreme health harms of poverty and systemic discrimination'.

30. Local PLUS groups identified in York are:

Adults	Children and Young People
Minoritised Ethnic Communities	Minoritised Ethnic Communities
People experiencing homelessness	Vulnerable Housing (Homeless & Risk of homelessness)
Drug and alcohol dependence	Young Carers
Gypsy, Roma, and Traveller communities	Transgender & Non-Binary CYP
Recent migrants, Asylum seekers and Refugees	CYP who are Gypsy or Travellers
Sex workers	Children and Young People's Mental Health
Transgender and non-binary people	Special Educational Needs and Disabilities (SEND)
People with Learning Disabilities	CYP transitioning out of care (care leavers)
People Leaving Care	Children who are looked after
	Children and Young People Experiencing Parental Substance use

31. The 5 refers to the clinicals areas (eg oral health, CVD, mental health) where the highest levels of health inequalities are seen.

32. The Population Health Hub has produced profiles on our Adult and Children and Young People CORE20PLUS5 population.

Conclusions

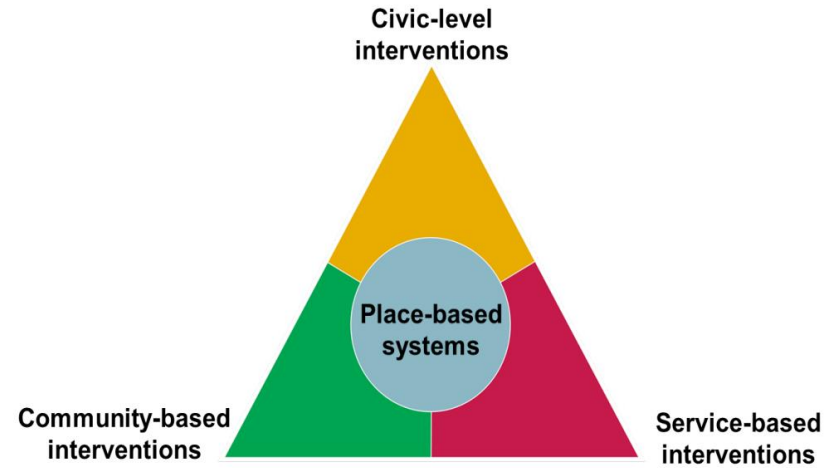
33. This data shows that:

- Trends in our key Health and Wellbeing Strategy indicator are hearing in the wrong direction, and the direction of travel will need to be reversed first before a reduction in the inequalities gap is seen.

- Female HLE is worsening in York, and females are living longer in poorer health. Male LE, both for the city as a whole and in terms of an inequality gap, is worse in absolute terms.
- The number of people living with multiple long terms conditions is a large driver in the downward trend in HLE in York.
- There is variation across the city in the distribution of the physiological factors which lead to early disease and death, for instance high blood pressure, which could be tackled fairly swiftly (within a 3-5 year window)
- There is variation in the distribution of the risk factors which lead to early disease and death, for instance poor diet, which could be tackled within a reasonable time frame (within a 5-10 year window)
- Ward based outcomes in LE largely follow the pattern of the wider determinants of health in each ward. These will take longer to shift (within a 10-15 year window)

Examples of work across partners to tackle health inequalities

34. A great deal of work takes places in York which will positively impact the gap in healthy life expectancy between richest and poorest. One commonly used framework for such action was developed by Public Health England in 'Reducing health inequalities: system, scale and sustainability (2017):



Credit: PHE Public Health Data Science based on the original concept created by Chris Bentley.

35. Using this framework, several examples are given in the table below of work done by partners across primary, secondary and mental health care as well as the VCSE and council to reduce health inequalities. These are by no means exhaustive, but they illustrate a small number of local projects where a health inequality 'lens' has been taken.

Community-based interventions	The **Brain Health Café** project aims to enhance the experience of individuals with mild cognitive impairment who are awaiting a potential dementia diagnosis by providing personalised care. This support helps people navigate the dementia pathway while promoting healthy lifestyle choices. The project will increasingly focus on specific groups facing health inequalities, such as individuals living alone, those in deprived areas, people with learning disabilities who have a higher risk of developing dementia, and other high-risk groups, including younger individuals at risk of dementia
	Delivering **Citizens Advice services to York GP patients**, supports clients in York's most deprived wards, offering crucial advice on benefits, tax credits, and debt. Demand has risen due to the cost-of-living crisis and COVID-19 impacts, prompting an increase to 30 hours per week. A new vulnerable debtor service will fast-track clients to in-house debt specialists, offering support within four working days to address the link between debt and mental health.
	To address loneliness, isolation, and mental wellbeing among **Asylum seekers at the Staycity hotel**, which has limited communal space, work has been funded around regular social and wellbeing activities with additional female-targeted culturally sensitive health information sessions and a Wellbeing Fund for asylum seekers to apply for small grants, covering items like burkinis for swimming, travel costs for visiting family, and trainers for running clubs.
	The **Health Mela** event, which will run in May 2025 and previously saw 3000 attendees in September 2023, will promote Health Awareness, strengthen community ties, increase access to healthcare services including screenings, consultations, and health education, and celebrate York's **c**ultural Diversity.
	Supervised toothbrushing programmes are now funded in all special schools and targeted early years settings (8 settings). The main settings targeted are nursery or pre-school provision with some primary schools being targeted, all using IMD scores.
Civic-level interventions	A **Winter Warmth Grant** is now available to carry out quick win interventions to address cold, damp and mould in residents' homes. 50 homes per year have been supported through identification of residents most in need, assessment

	of residents' homes, creation of Ventilation and Quick-Wins Strategy for each resident, and retrofitting properties.
	The **Homelessness Local Enhanced Service** increases access to healthcare of non-engaged members of society through a private space that can be fitted out as a consulting room, allowing a safe environment for residents to be seen in for both males and females. Collaboration with multi-agency partners, such as drug and alcohol services, community mental health teams, and Key Workers. Tailored healthcare assessments, including mental health, substance misuse, and preventive measures such as vaccinations.
	The new **Food Insecurity Pathway** will support families who are facing food insecurity and struggling to afford formula milk through the Healthy Child Service. Along with the vouchers, families will be connected to wrap around support services, including lactation support if needed.
	A **Reintegration Support Worker** has been employed to work directly with CYP, their families and schools to develop and implement reintegration plans through comprehensive holistic, outcome-based assessments, particularly for those children who's neurodivergence has led to barriers in access to education and other services.
	The **Asthma-Friendly Schools Programme** will deliver targeted training, advice & support to schools to ensure they are equipped to support CYP with this long-term condition, who are more likely to be from more deprived areas with worse air quality.
	A community-based intervention aims to improve outcomes for children and young people who are from the **Gypsy and Traveller community** by providing a bespoke health practitioner that is a child health nurse for these communities in York that will engage CYP and families through the York Travellers Trust and Raise York network and provide person-centred holistic care for vulnerable patient groups working in partnership with non-health professionals in a variety of settings reducing barriers to access.
Service-based interventions	**Targeting smoking cessation and NHS Healthchecks** work has been carried out for a number of years, including proactive invites made to both services through primary care systems using the IMD tool focussing on the most deprived 20%

	All adult **patients with a learning disability** diagnosis who are added to the elective / endoscopy waiting list in York and Scarborough Teaching Hospitals NHS Foundation Trust are now identified on booking and scheduling for procedure in an expedited time (within 8 weeks). There is also now a process for identification of Reasonable adjustments
	An onsite **GP service at Changing Lives Women's centre** for cases where women need to be seen urgently due to extreme situations e.g. domestic abuse. The benefits are anticipated that outreach model will help with building trust, a sense of security, stability and equal healthcare provision for a group that suffers negative health outcomes.
	The **Health Inequalities Education Programme** is a structured education programme for 30 professionals offering localised education sessions and workshops, where participants will take learning from the education sessions and apply this to real life practice. It will empower our leaders across primary and secondary care to reduce health inequalities with the skills, knowledge and sense of purpose that will enable them to achieve this goal.
	Inclusion health system searches have been created in primary care and as a result, in just three months at the start of 2025 the number of residents in York on a register has risen from 8287 to 10954.

36. It should also be acknowledged that work delivered by any partner in the health and care system has the potential to increase health inequalities if not delivered in the right way. An example of this is that, according to an NIHR evidence summary, 'people who are typically at higher risk of conditions for which screening programmes are available are less likely to participate in screening and receive benefit. This issue contributes to health inequalities'.

37. There are a number of tools available Health Equity Assessment Tool (HEAT) - GOV.UK

Consultation

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

Council Plan and other strategic plans

39. This paper reinforces some of the key aspirations of the Council Plan 2023-27 and the fulfils the Council Plan 2023-2027 objective to 'Increase council-wide action to reduce health inequalities' and report on this annually

Implications

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

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

Recommendations

41. The Board are asked to:

- Note and comment on the current data on inequalities in life expectancy and healthy life expectancy in York
- Discuss where and how the inequalities arise, and 'where to look' for solutions

Author:	**Chief Officer Responsible for the report:**
Peter Roderick Director of Public Health	Peter Roderick Director of Public Health

Report Approved	√	**Date**	23/04/25

Specialist Implications Officers
Not applicable

Wards Affected: **All** ✔

For further information please contact the author of the report

Background Papers
Joint Local Health and Wellbeing Strategy

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Health and Wellbeing Board 7th May 2025

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), progress to date and next steps.

2. The report is for information and discussion and does not ask the Health and Wellbeing Board to respond to recommendations or make any decisions.

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. Since 2022, the YHCP has been an Executive Committee of the ICB, drawing 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.

Update on the work of the YHCP

5. The Executive Committee meets monthly, and a summary of the meetings held in March and April 2025 is set out below.

<u>March 2025 Executive Committee Meeting</u>

6. The March meeting of the Executive Committee focused on the following items:

- **Joint Commissioning Forum/Plan and Section 75 Agreement**: This report provided an update on the work of the Joint Commissioning Forum (JCF) including the Terms of Reference for the JCF; a list of services for inclusion in a Section 75 Agreement between the Integrated Care Board (ICB) and City of York Council (CYC); and a case study of the shared Head of/Assistant Director of Commissioning between the ICB and CYC.

  The JCF is one of three sub-committees established under the YHCP; its current focus is the development of a commissioning plan between the ICB and the Council. The plan will cover services funded through prevention/health inequalities budgets; community equipment services; integration and alignment of some services to avoid duplication; York Integrated Community Model; an integrated approach to working with the voluntary and community sector; strengthening the alignment of pooled funds; children's commissioning and integration approach; continuing health care and the establishment of a path to a commissioned, integrated and de-medicalised 24/7 community mental health offer in York.

- **York Health and Care Partnership Executive Committee Terms of Reference:** These had now been updated to incorporate comments made by YHCP members at their December and February development sessions. The final version will be embedded within the Partnership Agreement. This will be presented to the HWBB at a future meeting.

- **Humber and North Yorkshire Children's Plan Framework – A plan for radically improving children's wellbeing, health and care**: this item highlighted the development of the draft children's plan for the ICB. The Integrated Care Partnership's Start Well Board had been established in response to the many concerns relation to children and young people, including preventable deaths; waiting times for speech and language therapy and other services resulting in poverty and inequality impact on the 0-19 age range; mental health issues for care leavers and Special Education Needs and Disability requirements.

April 2025 Executive Committee Meeting

7. The April meeting of the Executive Committee focused on the following items:

   - **York Health and Care Collaborative Update (YHCC)**: The purpose of the YHCC is to work with local providers, elected members and community representatives to improve population outcomes and reduce inequalities for the people and communities of York, through locality-based and integrated solutions.

     The YHCC has met in its current form since September 2024, and it holds monthly meetings which focus on a range of health and care topics, are well attended and have good engagement.

   - **System Update**: nationally 2024-25 operational plans submitted by 42 Integrated Care Systems were being evaluated on the basis of commitment, evidence of pace and credibility of delivery against 7 priorities, four of which could be grouped into waiting times: reduce the time people wait for elective care; improve A & E waiting times and ambulance response times; improve access to GPs and urgent dental care and improve mental health and learning disability care. The remaining three priorities were live within budget allocated reducing waste and improving productivity; maintain a collective focus on overall quality and safety of services and address inequalities and shift towards prevention.

   - **Urgent and Emergency Care**: the committee received an update on ongoing work to reduce waiting times in A & E; improving ambulance response times and ambulance handover times.

Work of the York Population Health Hub

8. Since the last meeting, the York Population Health Hub has continued to deliver and support key initiatives that promote equity, prevention, and innovation in population health.

9. The Inclusion Health Register pilot, which ran from February to March 2025, has now concluded. This initiative aimed to improve visibility of underrepresented groups—such as veterans, LGBTQ+ individuals, care leavers, and people experiencing homelessness—within York's GP records.

10. Over the pilot period, there was a 32% overall increase in patients coded to Inclusion Health groups, rising from 8,287 to 10,954 in York. Substantial increases were seen in the recording of Transgender and Non-binary individuals, Care Leavers, and Gypsy, Roma, and Travellers.

11. The pilot operated within budget and demonstrated the value of incentivised SNOMED coding to address known gaps in primary care data. The findings offer a foundation for wider implementation and highlight opportunities to strengthen targeted service planning for the Core20PLUS5 population.

12. Additionally, the PHH has been collaborating with colleagues from City of York council and Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) to support the development of the Mental Health Hubs. This work includes joint exploration of mental health data to inform the design of services that meet local needs more effectively.

13. The BP Kiosks for Hypertension Detection pilot ended on 1st April. The York Health Economics Consortium is now evaluating the outcomes of the scheme. Early discussions are underway between the ICB and the kiosk provider to explore a cost-neutral extension of the pilot. The aspiration is to relocate the three kiosks to new community-based settings to improve reach and early detection in underserved areas.

14. Through these efforts, the Population Health Hub continues to apply a data-led, collaborative approach to reducing health inequalities and improving outcomes across York.

Contact Details

Authors:	**Chief Officer Responsible for the report:**
Compiled by Tracy Wallis, Health and Wellbeing Partnerships Co-ordinator, City of York Council	Natalie Caphane, Assistant Director of System Planning, York Health and Care Partnership

Report Approved [√]

Date:

Wards Affected ALL

For further information please contact the author(s) of the report

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Health and Wellbeing Board **7 May 2025**

Report of the Chair of the York Health and Wellbeing Board

Chair's report and updates

Summary

1. This paper is designed to summarise key issues and progress which has happened in between meetings of the Health and Wellbeing Board (HWBB), giving Board members a concise update on a broad range of relevant topics which would otherwise entail separate papers.

Key Updates for the Board

Joint Strategic Needs Assessment

2. **Women's Health Needs Assessment:** The team who are working on this project are progressing with the Women's Health Needs Assessment. Following meetings with several stakeholders, the focus of the assessment will be on the following themes:

   - Carers
   - Mothers
   - Screening
   - Period health
   - Violence against women and girls
   - Isolation and mental health in older women
   - Menopause
   - Employment
   - Accessibility of primary care services

3. Data and insights are being collated and the assessment is due to be published in late-Summer.

4. **Pharmaceutical Needs Assessment (PNA)**: The PNA is in progress now with a full draft to be available in time for the statutory 60-day consultation in June. In addition to the residents' survey which was reported on at the previous Health & Wellbeing Board, stakeholders are being contacted for their insights into pharmaceutical services. We have already had a good response from GP Practices, Healthwatch York, the Healthy Child Service, and York Drug & Alcohol Service. The general

view is that pharmacy provision in York is good. However, access to prescription medicines following out of hours urgent appointments was highlighted as well as challenges to accessing additional services like needle exchange and supervised consumption. Further engagement with local organisations continues.

5. Following a Roundtable discussion with Councillors, Public Health, and the ICB, five market applications were approved for a new pharmacy at the Clifton site formerly occupied by Boots. These applications are currently being reviewed by ICB Commissioners.

6. This year, there have been three notifications of change of ownership and one application for a permanent decrease of supplementary dispensing hours to take effect from 1 May 2025.

7. On 31 March 2025, the Government published its CPCF Settlement for years 2024/35 and 2025/26. Funding has increased by over £800 million (over 30%) and is the largest uplift in funding across the NHS. The Government recognises that there was a funding gap as indicated by the Economic Analysis. This is an improvement for the sector and will go towards maintaining positive progress. There should now be better support to maintain opening hours and provide essential and enhanced services. However, there will be an increase in dispensing fees which may impact on services such as those providing drug and alcohol treatment and their commissioners.

Director of Public Health's Annual Report

8. In March, Council received this year's Director of Public Health (DPH) Annual Report. These reports are a statutory duty on the DPH to write and on the council to publish and offer an independent view on the health of our city each year, both the challenges facing our health and the things which can strengthen and improve it.

9. This year, the theme of the report is Adolescent Health, focussing on the 25,000 people between 10 and 19 years old in York.

10. Although young people in York are some of our most vibrant and creative individuals – and the movers, shakers, artists, scientists, mums, dads, entrepreneurs, politicians, public servants of the future – they are also a generation with huge challenges to their health: the generation perhaps most affected by the recent pandemic; the first generation facing worse living standards than their parents; and a generation who share many uncertainties around their future social, technological, financial and emotional wellbeing.

11. This report seeks to strike a positive note throughout, but it also shines a light on some of the key health issues, with the aim to prompt action

and greater partnership working amongst all who work with young people so we can better tackle these challenges together.

12. The report has six key findings, around the diversifying demographics of our young people, their changing educational and employment journeys, their mental health, their new and emerging health risks, societal factors affecting health, and the health of our most at risk young people. And it makes 10 recommendations, 6 of them costed and specific recommendations around programmes which partners are committing to, and 4 specific recommendations to young people and their carers or parents around gambling, vaping, smartphones and mental resilience.

Adult Social Care

13. Under the Health and Care Act 2022 the Care Quality Commission (CQC) has a new responsibility to assess how local authorities meet their duties under Part 1 of the Care Act 2014. The CQC has developed a 'Single Assessment Framework' which adult social care departments will be assessed against. This covers 4 domains

    - Domain 1: Working with People
        - Assessing needs
        - Supporting people to live healthier lives
        - Equity in experience and outcomes
    - Domain 2: Providing Support
        - Care provision, integration and continuity
        - Partnerships and communities
    - Domain 3: Ensuring Safety
        - Safe systems, pathways and transitions
        - Safeguarding
    - Domain 4: Leadership
        - Governance, management and sustainability
        - Learning, improvement and innovation

14. CQC assesses local authorities via 5 evidence categories – people's experience; feedback from staff and leaders; feedback from partners; processes and outcomes.

15. City of York Council have received notification of their CQC assessment and have submitted an information return which includes evidence of policies, processes, strategies and other documentation. CYC have also submitted a self-assessment that describes our strengths and areas for improvement. Notification has now been received that the on-site assessment will take place week commencing 16th June 2025.

Author:	**Responsible for the report:**
Compiled by Tracy Wallis Health and Wellbeing Partnerships Co-ordinator	Cllr Lucy Steels-Walshaw Executive Member for Health, Wellbeing and Adult Social Care

	Report Approved	**Date**

Specialist Implications Officers
Not applicable

Wards Affected:	**All**	✔

For further information please contact the author of the report

Health and Wellbeing Board 7 May 2025
Report of the Manager, Healthwatch York

Healthwatch York Reports: GP surgeries in York: accessibility audit findings and GP practice websites in York: audit findings

Summary

1. This report is for the attention of Board members, sharing two Healthwatch reports which looks at the results of website and surgery access audits completed by Healthwatch York volunteers.

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. One of the areas of health and care we hear most about is GP access. We published a report last year providing the findings of our general survey. These audits were completed to further explore some of the accessibility issues raised with us as part of the surgery.

Main/Key Issues to be considered

3. Our report's key findings are:

- Many GP surgeries already have excellent physical access. This included flat entries, automatic doors, plenty of space to manoeuvre wheelchairs and powerchairs, and friendly, helpful staff.
- Many websites were also praised for the ease of finding information, good search functions, clear, easy to read test and accessibility features.
- The main areas for improvement regarding physical access related to signage, such as letting people know how to attract help

if they cannot get into the surgery, that assistance dogs are welcome, and where to find accessible toilets and quiet waiting areas.

- The main areas for improvement regarding website access were making sure information is up to date, providing multiple ways to contact the practice, particularly for those who cannot use the phone, and making sure information about staff and their roles is included.

Consultation

4. In producing this report, our volunteers visited GP practices and practice websites to complete a short, simple survey about access. Where possible, they spoke to staff within practices to confirm what was in place.

Options

5. As these are general reports, we have included general recommendations about how to improve practice accessibility on page 37 of that report, and general recommendations about improving websites on page 22 of that report.

Implications

6. 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

7. There are no risks associated with this report.

Recommendations

8. The Health and Wellbeing Board are asked to:

i. Receive Healthwatch York's reports, GP surgeries in York: accessibility audit findings and GP practice websites in York: audit findings.

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

Contact Details

Author:	**Chief Officer Responsible for the report:**
Siân Balsom Manager Healthwatch York 01904 621133	**Report Approved** ☐ **Date** *11.09.24*

Wards Affected: All **All** ✓

For further information please contact the author of the report

Background Papers:
Annex A: GP surgeries in York: accessibility audit findings

Annex B: GP practice websites in York: audit findings.

healthwatch York

GP surgeries in York: accessibility audit findings

Report March 2025

Contents

Acknowledgements
We thank the amazing Healthwatch York volunteer team for the research for this report. Thirteen volunteers and staff members spent 18.5 hours visiting the 33 GP surgeries that cover York and the surrounding areas. The audits included observations based on a given set of questions and responses from reception or other staff to a limited number of questions.

The carried out between mid-November 2024 and mid-February 2025.

We also thank York Disability Rights Forum[1] who helped develop our audit questions.

Cover image from Julia Zyablova via unsplash

[1] https://ydrf.org.uk/

Executive Summary

GP surgeries are vital for people to access the healthcare and treatment they need. They are effectively the gateway to our health and care system. However, this is made more difficult if surgeries are not accessible or do not provide information in a way that works for their individual needs.

Our accessibility audit was about fact finding to understand how accessible York's GP surgeries are for a range of people, including wheelchair users, those with mobility issues, blind and partially sighted people, those with hearing loss, including British Sign Language users, and people for whom English is not their first language.

The audits were not a test, but rather to understand what is and isn't provided at different surgeries across York. Volunteers and staff members visited each surgery and completed a survey capturing their observations alongside questions asked of reception or other surgery staff. Each surgery only had one visit as part of this project.

The result was a varied picture with some good practice and some areas for improvement. Many of the improvements we identified are simple to rectify (see recommendations). We hope that our audits and this report will help to raise awareness of what GP surgeries in York are already doing to make their services accessible and provide ideas for simple and low or no cost things they can do to improve this.

Background

Local context

In our earlier report on GP surgeries, Exploring access to GP surgeries in York[2], we heard from people who said that they struggled to physically access GP surgeries. Those comments prompted the audit project and this report.

Comments in our earlier report included:

- "The GP will always look for a consulting room on the ground floor when I have an appointment, so I don't have to struggle with the stairs, it is much appreciated."
- "I am blind and they either phone me about things or send me a large print letter."
- "They make no adjustments to invisible disabilities, and I am constantly facing prejudice and ignorance, especially with regards to the complex comorbidities which come with my disabilities…"
- "I am blind, and they always send me information in standard print. It is as much use as a chocolate teapot. I need Braille. Instead, my son has to read everything for me."
- "I have to attend GP appointments with my family members to translate for them as they don't speak English and no interpreters are provided."

[2] https://www.healthwatchyork.co.uk/wp-content/uploads/2024/09/GP-Report-Final-September-2024.pdf

National context

The Equality Act 2010[3] is there to make sure disabled people are able to access services. Public bodies must take reasonable steps to achieve this, including:

- providing ramps or flat access to buildings
- providing accessible parking spaces and accessible toilets
- making sure signage and facilities help facilitate access for all.

The Accessible Information Standard[4] must be followed by all public bodies providing health or social care services. It outlines a consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss. This means that all patients at a GP surgery should be asked what their preferred format is and provided with written information in that format.

What we did to find out more

In partnership with York Disability Rights Forum, we developed an audit/survey. This included a section of observations for auditors to use when visiting the surgeries. There were also a set of questions to ask reception (or other) surgery staff.

[3] https://www.legislation.gov.uk/ukpga/2010/15/contents

[4] https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/accessibleinfo/

All the observations and questions were to help determine the accessibility of the surgery and its services for disabled people and those with long term conditions, including sight and hearing loss.

Each auditor took their own approach to the audit. Some people audited their own surgeries and others went to surgeries they had never been to. In total Healthwatch York volunteers and staff visited all 33 GP surgeries in York and its environs.

The GP surgeries we visited were:

- Dalton Terrace
- Elvington Medical Practice
- Front Street Acomb
- Front Street Copmanthorpe
- Haxby Group - Gale Farm (Acomb)
- Haxby Group – Haxby and Wigginton
- Haxby Group - Huntington
- Haxby Group – New Earswick
- Haxby Group – The Old Forge (Poppleton)
- Jorvik Gillygate - Stonebow
- Jorvik Gillygate – East Parade (Heworth)
- Jorvik Gillygate – Southbank (Bishopthorpe Road)
- MyHealth – Dunnington
- MyHealth – Huntington
- MyHealth – Stamford Bridge
- MyHealth – Strensall
- Old School Medical Practice (Copmanthorpe)
- Pocklington Group Practice
- Priory Medical Group – Cornlands Road (Acomb)
- Priory Medical Group - Fulford

- Priory Medical Group – Heworth Green
- Priory Medical Group – Lavender Grove (Boroughbridge Road)
- Priory Medical Group – Park View (Hull Road)
- Priory Medical Group – Rawcliffe (Water Lane)
- Priory Medical Group – Tang Hall Lane
- Priory Medical Group – Victoria Way (Huntington)
- Unity - Kimberlow Hill (Badger Hill)
- Unity – Wenlock Terrace (Fulford)
- York Medical Group – Acomb
- York Medical Group – Monkgate
- York Medical Group – Tower Court (Clifton Moor)
- York Medical Group – Water Lane
- York Medical Group – Woodthorpe

The auditors' feedback is the core of this report.

Findings

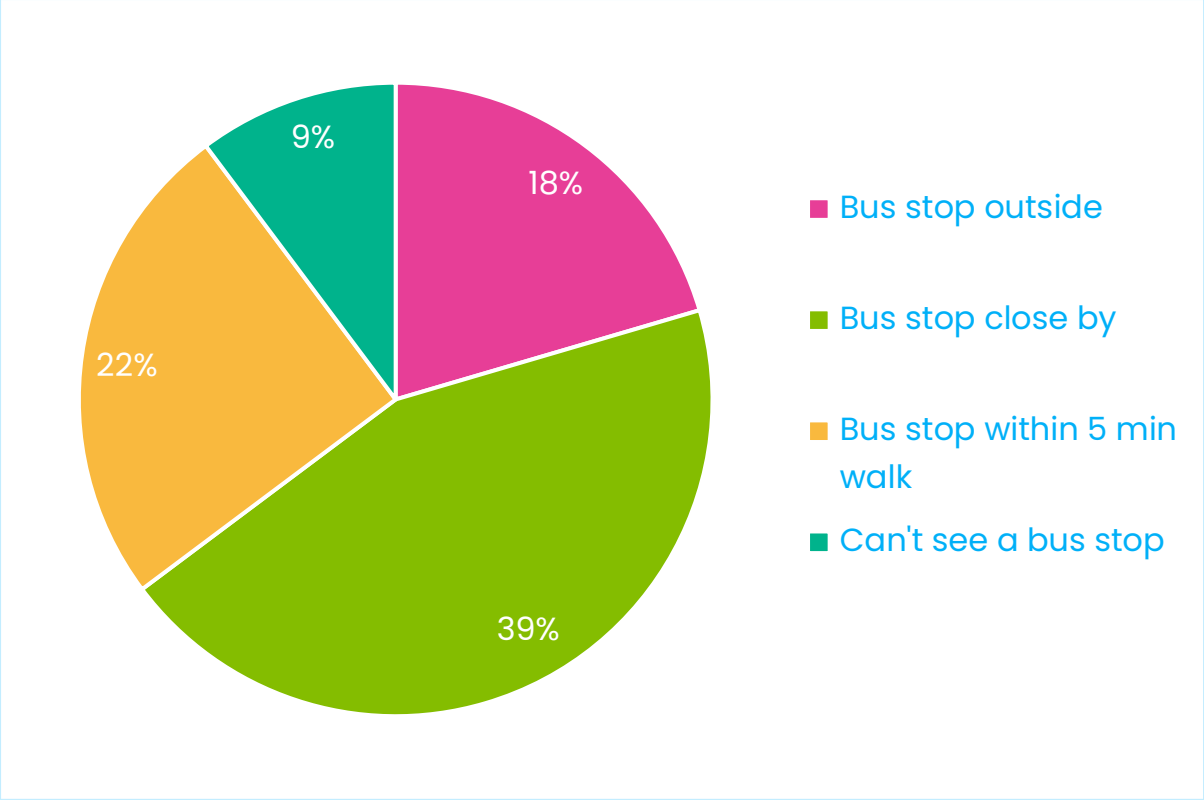
Observations

Auditors were asked to record information about a number of elements of each surgery they visited.

Transport

Auditors looked for bus stops close to the surgeries, bicycle parking and accessible parking spaces.

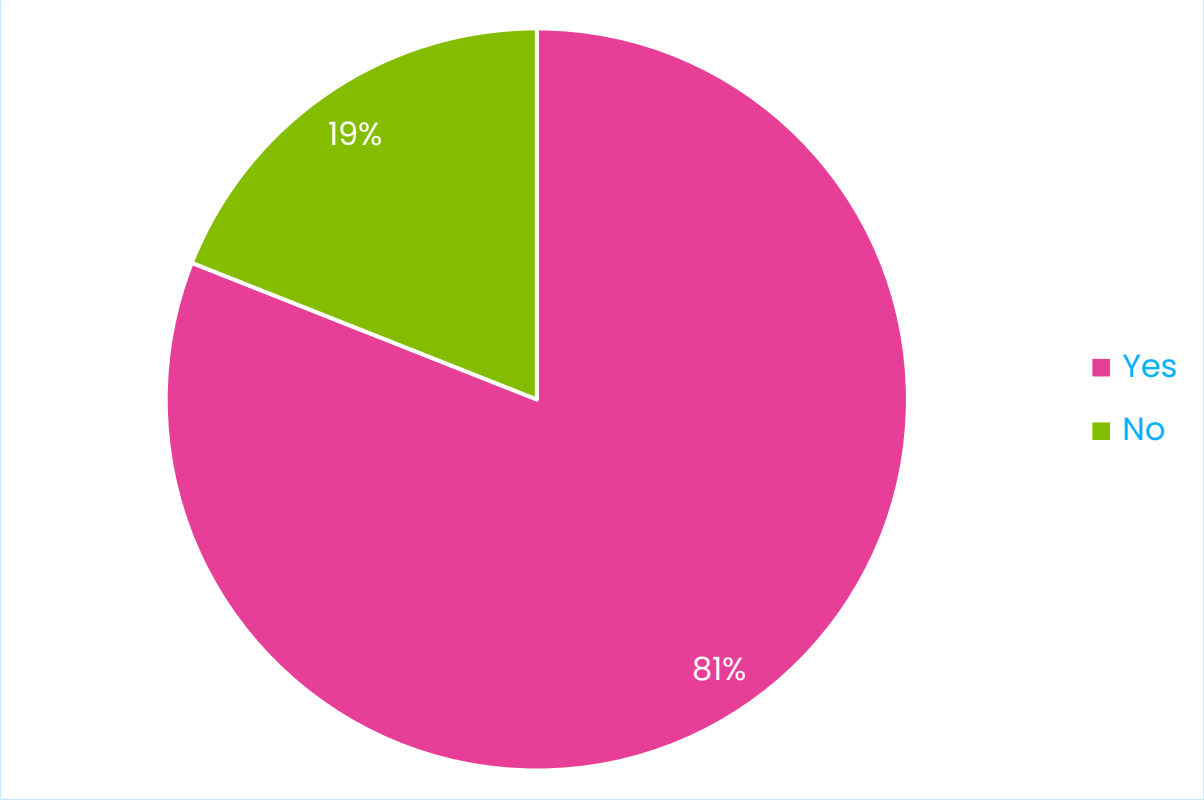
Most surgeries had a bus stop nearby. Nearly a fifth (18% or 6) had a bus stop outside, almost two fifths (39% or 13) had a bus stop relatively close. There was a bus stop within a five minute walk for a third (33% or 11) but auditors could not see a bus stop for 9% (3) of surgeries audited.



Comments included:

- "Bus on one way route, would only come back after it has reached its final destination."
- "Good bus service to and from York city centre."
- "Bus stops on the main road."
- "Bus stops are quite close in both directions."

Most surgeries (81% or 26) have accessible parking spaces 19% (6) did not have any we could see:

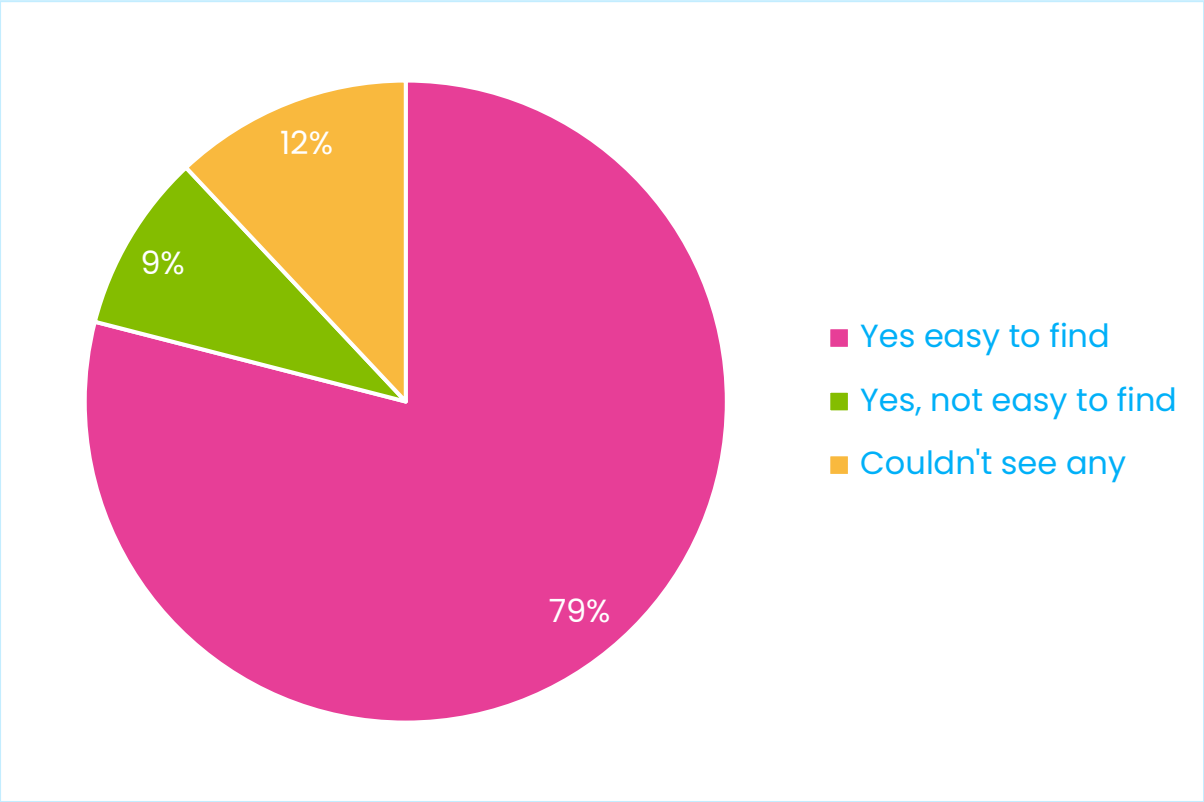


We also asked how many accessible parking spaces each surgery had. Where there were accessible spaces, the answers ranged from one to six, with most having one or two. We asked if the accessible spaces were free and generally at least one space was free at the time of the visit.

Comments about parking included:

- "Only on road parking for the surgery."
- "A large car park, but it was quite full."
- "There was a small car park, which was full. There weren't any obvious accessible bays."
- Designated blue badge spaces. Quiet when I visited."
- "The accessible parking spaces are quite tight and don't have enough space around them for a wheelchair user or person with mobility issues to safely get in and out of their car."

Most surgeries (79% or 26) had easy to find bicycle parking. It was difficult to find bicycle parking at 9% (3) of surgeries and auditors couldn't see any bicycle parking at 12% (4) of surgeries:



Comments included:

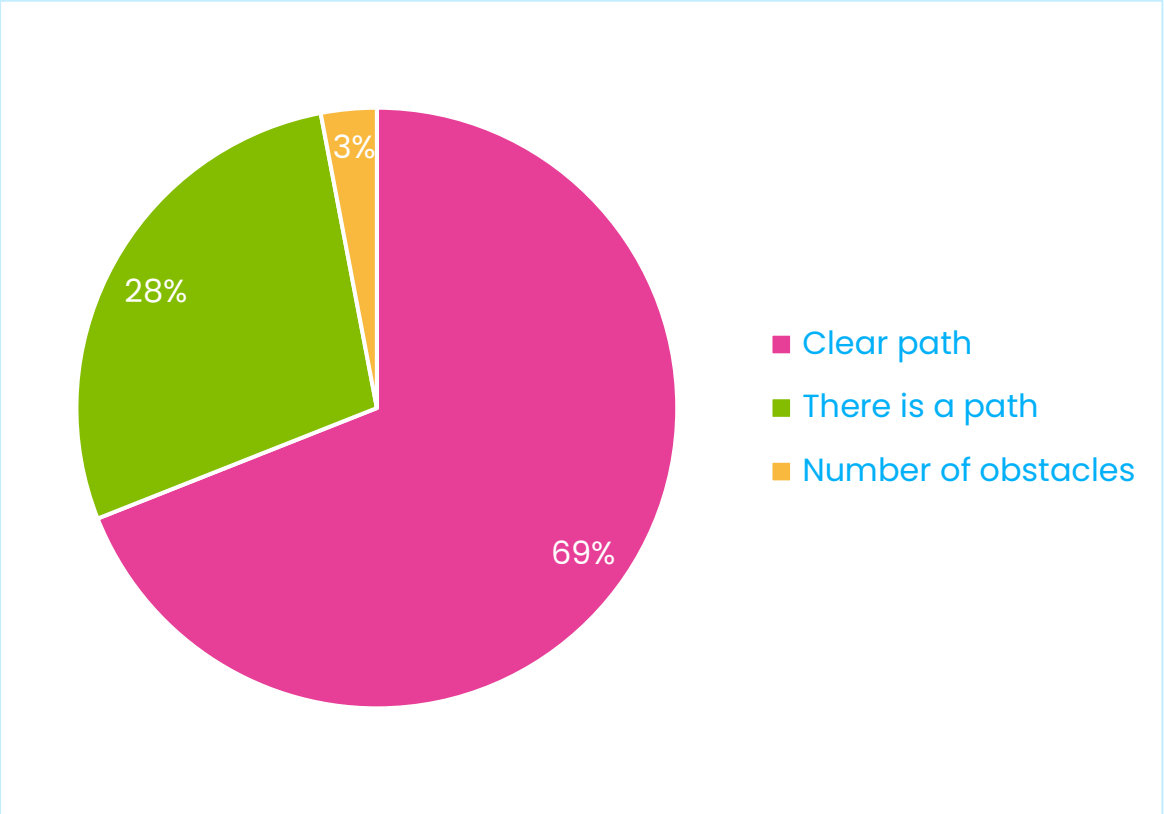
- "It is signed 'unauthorised cycles may be removed' but I think patients use it."
- "It is tucked round the corner of the building."
- "Immediately outside the building and good standard/number."
- "Low level wheel docking style."

Ease of getting to and into the surgery

We looked at how easy it is for people to walk to the surgery main door, whether there was clear signage to the main door and how easy it was to identify the main door.

Getting to the main door – we asked how easy it is to walk from the pavement or car park to the main door thinking particularly of people who have mobility issues or who are blind or partially sighted.

In just over two thirds of surgeries (69% or 22) there was a clear path. In less than a third (28% or 9) there is a path. For 3% (1) it was difficult with multiple obstacles to negotiate.



Comments included:

- “You can walk via the car park which is flat or from the street which has sloped access with rails.”
- “Very easy from the pavement, but not so easy from the car park.”
- “It would be very difficult for an unescorted blind person. There are bollards to indicate the limit of the parking spaces that one could bump into.”
- “From one direction you can walk on a path round the building and away from the car park. From another direction you would walk through the car park.”
- “The path from the car park is quite uneven and therefore difficult for a wheelchair user or someone using mobility aids.”

Our auditors looked for signage to get to and identify the main door. There was clear signage to get to the main door for almost two thirds (64% or 20) of surgeries, some signage for 9% (3) and no signage at all for a quarter (25% or 8).

It was easy to identify the main door for nearly all (94% or 31) surgeries.

Comments included:

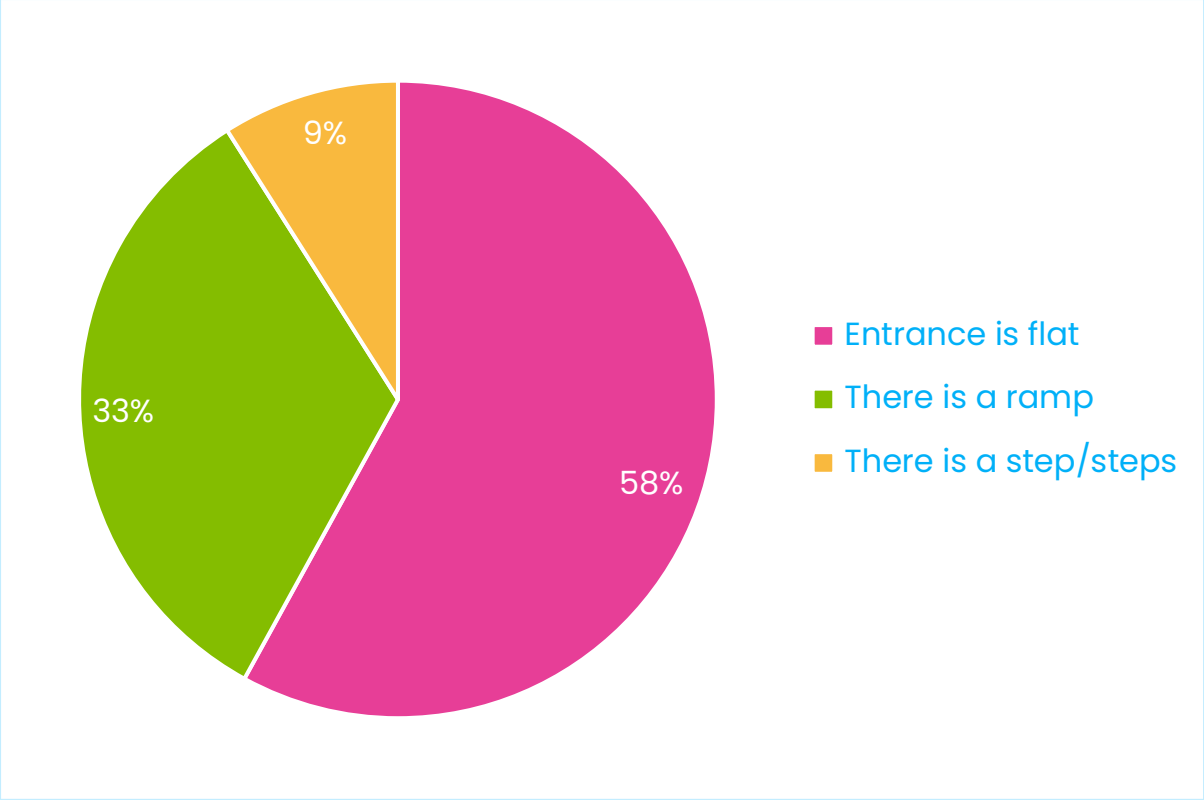
- “From the car park there are no signs … of where the main entrance is, although the accessible entrance is clear.”
- “Difficult to find if you don’t know where the surgery is.”
- “As you get nearer you can see the surgery name on a window pane.”

- “The signage from the main road and car park is not good. From the main road there is a sign to say the GP is there but not how to find it.”
- “Very clear signage.”

Physical access into the surgery

Our auditors looked at how easy it would be for a wheelchair user or someone with limited mobility to get into the surgery. This included the approach to the surgery and the doors to get in. If the entrance wasn’t accessible we looked for information about how to get in either via a bell or alternative entrance. We also wanted to know if there was information to say that assistance dogs are welcome.

We asked if the main entrance was accessible with either a flat approach or a ramp. More than half of surgeries (58% or 19) had a flat approach, a third (33% or 11) had a ramp and the remaining 9% (3) had steps or a step.



Comments included:

- "The ramp from the pavement/car park is the only route to the door. It is quite steep and curved."
- "The ramp is built into the path."
- "Patients can ring the doorbell/intercom to reception and they will come and put the ramp out as needed."
- "There are two steps leading up to the main entrance door."
- "The main entrance is flat all the way to reception."

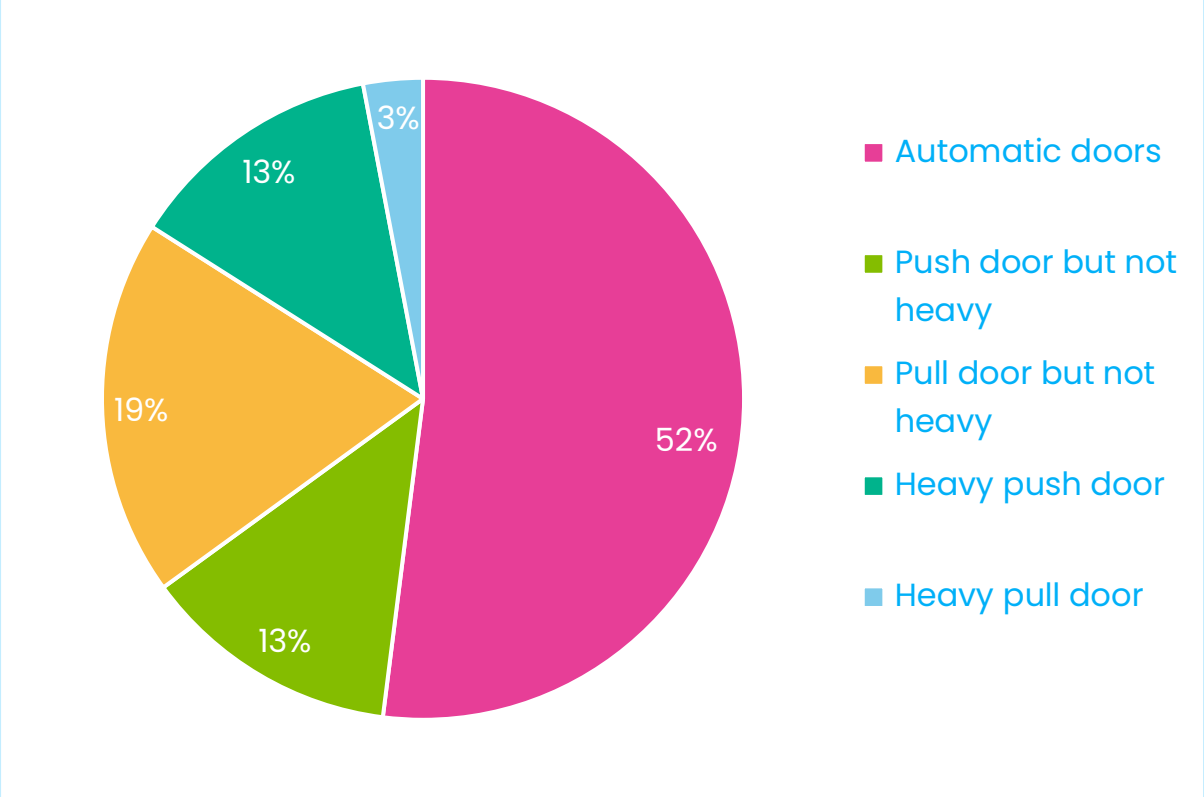
If the entrance wasn't accessible, we asked if there was information about an accessible entrance and where to find it. This question was not applicable to 80% (24) of the surgeries visited. Of the remaining 20%, 3% (1) had information entrance and 17% (5) did not.

Comments included:

- “The accessible entrance is clearly visible from the car park. If you come to the main entrance first there are no signs or directions for the accessible entrance.”
- “There is no accessible entrance. The surgery staff are aware it is not accessible and there are plans to improve things.”
- “There is signage once you get through the first door to say to ring if you need help to get in. It needs to be outside as the first door is not easy to negotiate.”
- “There is a large notice saying to ring the bell if you need help and a blue disability logo. The bell is very clear when you get to the door.”
- “There is a bell, but there is no information and the bell is too high for a wheelchair user.”
- “Good sign outside to say ring for assistance and the bell is at the right height for a wheelchair user.”
- “I asked the reception staff about the bell at the front door. We established it didn’t work so they would sort it out. I asked if it could be lower so that wheelchair users could reach it and I mentioned there needed to be signage with it. They were very receptive and friendly. When I returned in two weeks there was a new doorbell in a lower position, but no signage – yet!”

We then asked about the doors to get in to the surgery and how easy they would be for a wheelchair user, someone with mobility issues or someone who is frail to use. Just over half (52% or 16) of surgeries had automatic doors. Just under half (32% or 10) had

either a push or pull door that wasn't heavy, the remaining 16% (5) of surgeries had either push or pull doors that were heavy and could be difficult to open.



Comments included:

- "There are two doors. Both are push on the way in. They are not heavy and so it is not difficult. However, it would be more difficult on the way out as you need to pull both doors."
- "There are two doors, one push and one pull, so it isn't easy getting in or out."
- "There is a push button to open the automatic door, but the writing has faded. The signage should be better to say push to enter."

- “The accessible entrance is up a narrow ramp pathway that turns and the door is a light pull handle. It might be awkward without someone to help.”
- “Entrance would not be easy for a wheelchair user, someone with a walking aid or sticks.”
- “There is a push pad for automatic access and the signage is clear.”

Auditors looked for a sign to say assistance dogs are welcome. If there was no sign, some auditors asked the reception staff.

There was a sign on only 9% (3) of surgery doors. There was a sign in 15% (5) of surgery reception areas. For 40% (13) there was no sign but reception staff said assistance dogs were welcome. For 36% (12) of surgeries there was no information and we were not able to ask.

Some of the notices that auditors spotted said guide dogs; guide dogs and hearing dogs; or service dogs, not necessarily assistance dogs.

Booking in

We then wanted to know how easy it was to find the reception desk and to book in either via the reception desk or a computer if available. We also asked our auditors to note if the reception area had a hearing loop and whether there was a Perspex screen.

In every surgery it was easy to find the reception desk. Most were straight ahead as you entered.

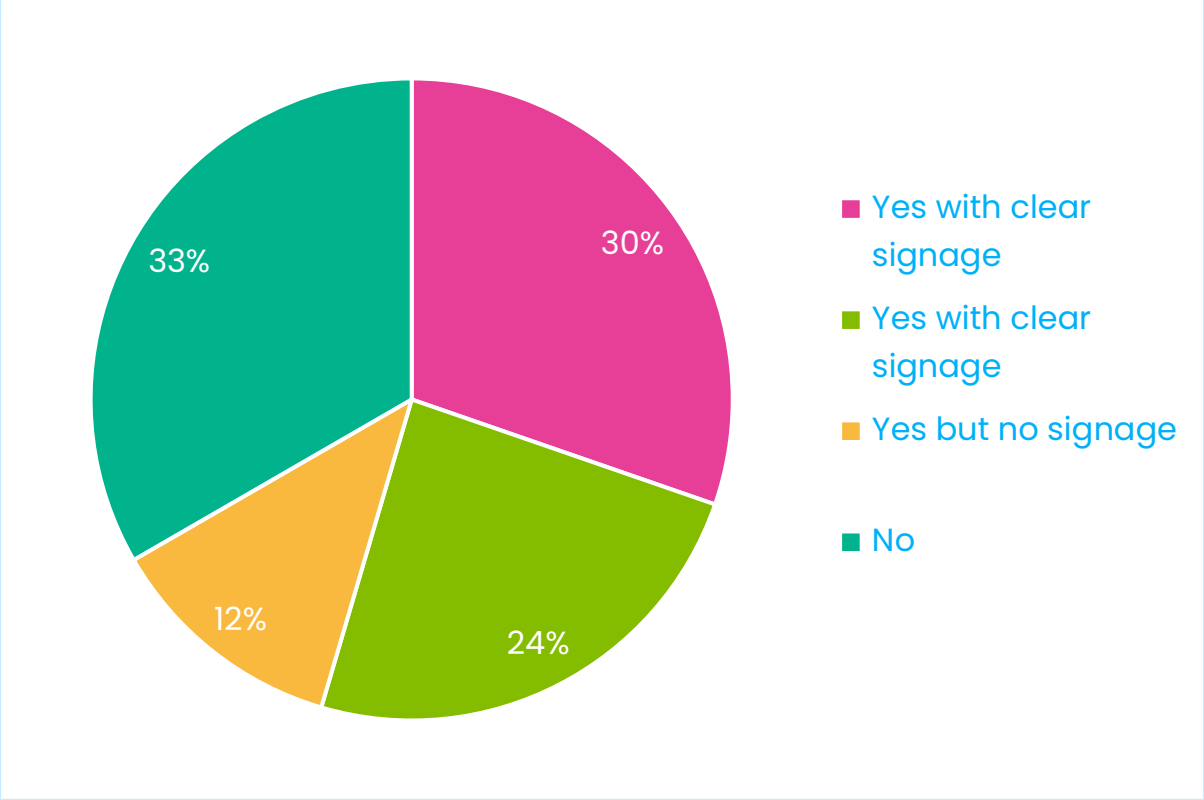
In more than half (53% or 17) of surgeries there was a computer to use to sign in. In 13% (4) the computer wasn't working and in 34% (11) there wasn't a computer. In all instances people could also report to the receptionist.

In more than half (58% or 19) of surgeries there was a full Perspex screen at the reception desk. For 21% (7) respectively there was a partial screen or no screen.

Comments included:

- "The screen is covered in posters which were difficult to differentiate as there were so many of them."
- "No screen where you talk to the receptionists and the desk was lower so it would be easier for wheelchair users to talk to the receptionist."
- "Sliding windows but with quite a small space to talk through."

Auditors looked to see if there was a hearing loop. Where there wasn't signage they asked receptionists (if possible). Just under a third of surgeries (30% or 10) had clear signage and a loop. Just under a quarter (24% or 8) had a loop but the signage wasn't good, 12% (4) had a loop but no signage and a third (33% or 11) didn't have a loop or we weren't able to see or find out about one.



Comments included:

- "Yellow sign says they have a portable induction loop and to ask a member of staff."
- The signage is on the Perspex screen, but not easy to see from a distance."
- "No signage but information on the website."
- "The staff didn't know about one."
- "There is a clear sticker on the reception screen and a poster about it in one of the waiting rooms (but not all)."
- "They have one but aren't sure how it works. There is signage on the second door in, but not really where it would be best."

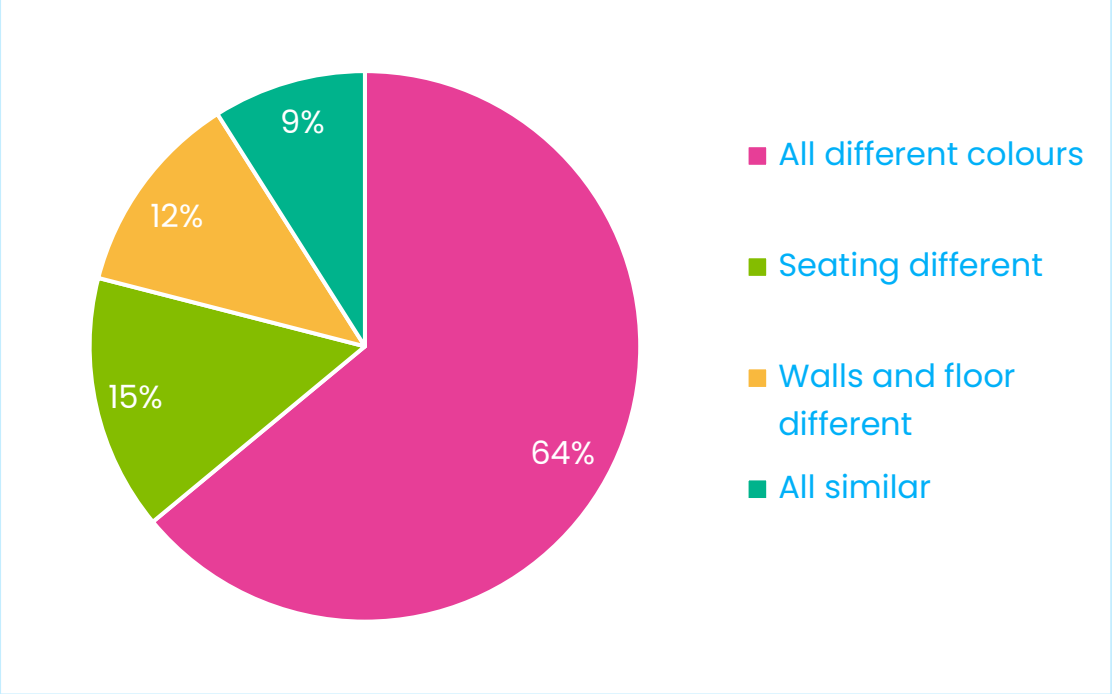
Waiting area

We wanted to understand how easy it is for people to sit comfortably in the waiting room and if it was easy to access.

This included whether there was good colour contrast, whether there was a choice of seating and whether there was space for a wheelchair user. We looked for a quiet space for people who are neurodivergent, have dementia or need a quieter area while they wait for their appointment.

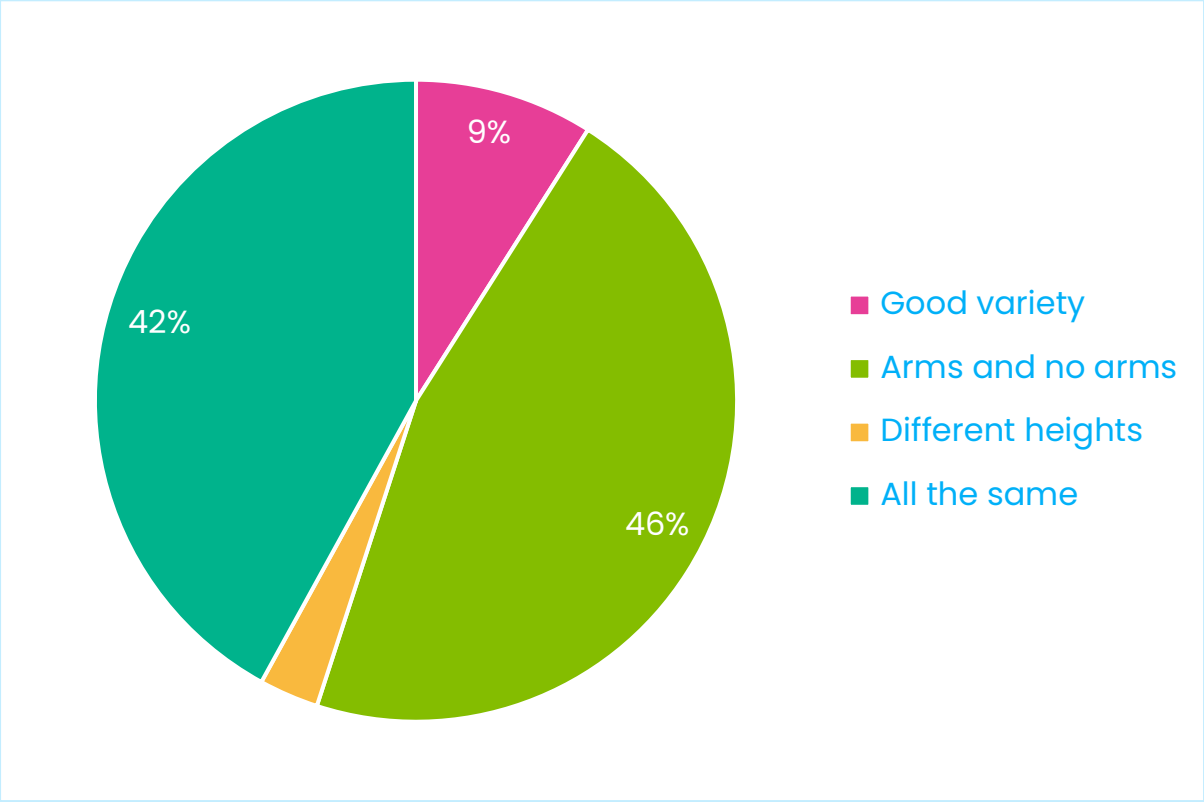
We also wanted to know if there was information to explain what to do if you needed help while waiting.

Nearly two thirds of surgeries (64% or 21) had good colour contrast between walls, floor and seating so it was easy for people to identify the chairs. In 15% (5) of surgeries the seating was a different colour, in 12% (4) of surgeries the walls and floor were a different colour and in 9% (3) of surgeries all were similar colours.



We wanted to know if there was variety in the seating provided to meet different people's needs. In 9% (3) of surgeries there

was a good variety. In nearly half (46% or 15) of surgeries there were seats with and without arms. In 3% (1) of surgeries there were seating of different heights and in 42% (14) of surgeries the seating was all the same.



Many surgeries had bench seating. Some did have a few chairs with arms to provide alternatives for people who couldn't use the benches. A few surgeries had bariatric chairs.

We asked if waiting rooms were accessible, either that they were on one level or there was a lift. Nearly all (91% or 29) were accessible. For 3% (1) one of the waiting rooms was accessible and in 6% (2) no waiting rooms were accessible. However, for one of the surgeries with more than one floor, the lift was out of order. Another surgery has multiple waiting rooms two of which are accessible and two not.

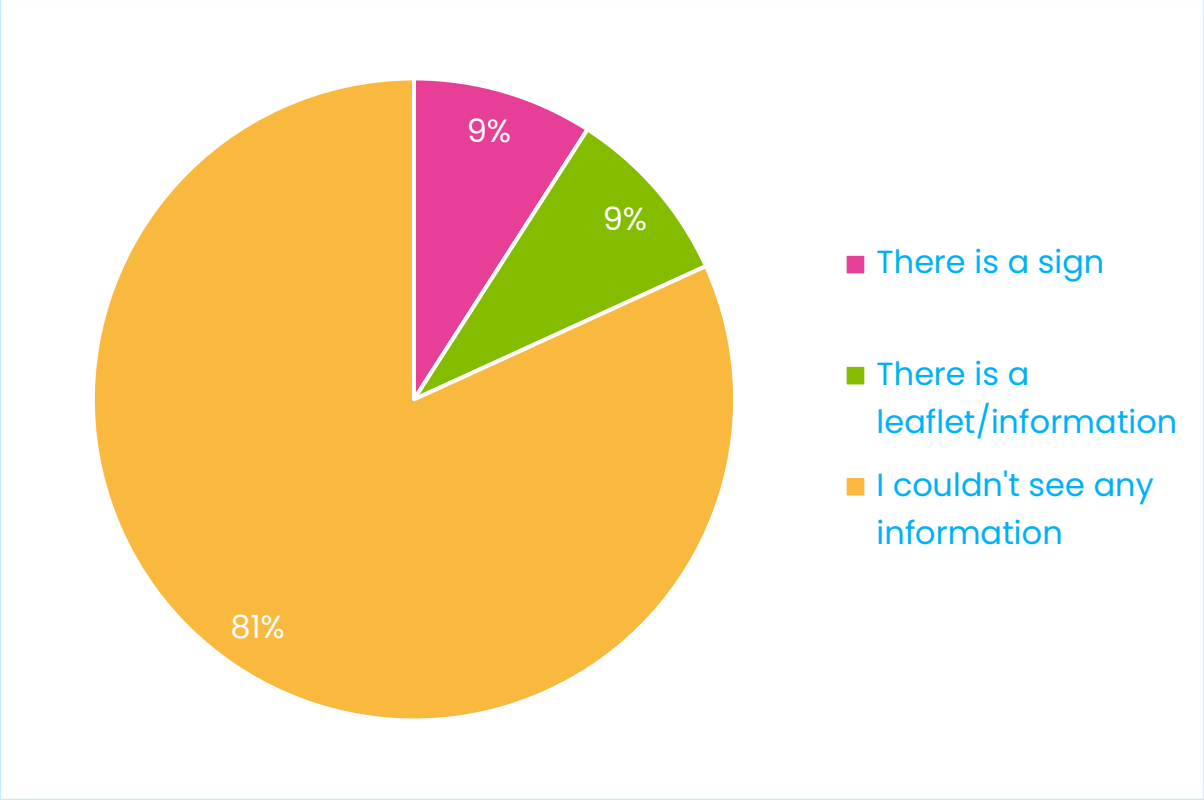
We also wondered if there was space in the waiting room for a wheelchair user and whether there was any signage to ensure other people didn't use that space. In most surgeries (81% or 26) there was space but no signage and in 19% (6) of surgeries there wasn't any space. In some surgeries where there wasn't space, the seating could be moved (if there was someone to help). In waiting rooms with fixed seating, wheelchair users would be forced to wait in the middle of the room where they could feel conspicuous or in the way. Often when our auditors visited, waiting rooms were quiet so this would not be such an issue. However, if the waiting rooms were busier it may be more difficult.

We wanted to know if there was a quiet waiting room (or a quiet space/area) for people who are neurodivergent, have dementia etc. In 12% (4) of surgeries there was a quiet waiting room, in 16% (5) there was information about being quiet in waiting areas, for nearly two thirds (66% or 21) there was no information and in 6% (4) auditors were not sure. Where there wasn't a clear quiet waiting room or no information, some auditors asked reception staff. In most cases, staff said they would always find, or try to find, somewhere quiet for patients to wait using empty consulting or other rooms. Most surgery waiting rooms were quiet when our auditors visited. However, some noted that there were radios on which some people might find distracting or difficult.

Comments included:

- “People use the space outside the upstairs waiting room. Reception staff are trained to pick up on anyone having difficulties and can use an available clinical room if needed.”
- “It is not signed, but there is a room someone can use if needed.”
- “They have a number of complex patients so are prepared to support people.”
- “The waiting room was busy, but not noisy. There are a few different areas to sit in, so there were quieter options.”
- “There is a sign in one of the accessible waiting rooms about the use of mobile phones and switching sound off, but not in other waiting rooms. One has a radio on quite loud. There is a sign up informing patients not to turn off or adjust the radio as it is used for confidentiality reasons. As a patient in the past, I have found it extremely difficult to sit in this area because I struggle with sensory overload, especially when it comes to sound.”
- “There is a sign on reception saying ‘need more privacy?’ saying to ask for help.”

Auditors looked for information to say what someone should do if they needed help while waiting. In most cases auditors could not see any information (81% or 26). For 9% (3) of surgeries respectively there was a sign or a leaflet or other information.



A number of auditors commented that there was so much information – leaflets and posters – in waiting rooms that it was very difficult to identify anything in particular. One person added: "Signs on reception, next to the screen and upstairs, would be useful letting people know what to do if they need help."

Other facilities

If the surgery was on more than one floor, our auditors looked for a lift and if it could accommodate a powerchair user and one other person. They noted if there is an accessible toilet and if it is well signed.

75% (24) of surgeries are on one floor so lifts are not needed. Where they are more than one floor, 16% (5) had a lift which

could fit a powerchair user and one other person. In the remaining 9% (3) our auditors were not sure if this was possible.

We also asked about accessible toilets and if there was signage to and from them. Nearly all (94% or 29) surgeries had an accessible toilet. Only 6% (2) did not or our auditors could not find one.

For 48% (10) of accessible toilets there was good signage. For 24% (5) respectively there was either poor or no signage. The remaining 4% (1) had good signage from the toilet back to the surgery. We did not ask auditors to provide feedback on the toilet facility, although one person did and commented that it was clean with ample space but no red emergency cord.

Many toilets were accessed via the waiting room or foyer on the way into the surgery, so the sign on the door was adequate and no signage was needed back into the waiting room.

Comments about accessible toilets included:

- "The accessible toilet is in the main body of the surgery. However, there is not any signage to say where it is."
- "There is a toilet, but it doesn't say accessible and the doors are not wide."
- "All toilets had out of order signs on!"
- "It was in the corridor on the way to the consulting rooms. You would need to ask to use it."
- "Just says toilet, but it is large and equipped for disabled people."

- “Couldn’t find it without help from the receptionist and it might be difficult to find your way back to the waiting room as there was no signage.”

Consulting rooms

As well as looking to see if consulting rooms were accessible, auditors looked at the space for people to get from the waiting room to the consulting room, including if there were doors between the two.

In just over half of surgeries, (53% or 17) the auditors were not able to see the consulting rooms. Of the remaining ones, 44% (14) of surgeries’ consulting rooms were accessible for a powerchair user. In the remaining 3% (1) some of the consulting rooms were accessible.

In terms of getting from the waiting room to the consulting rooms, 22% (7) did not have any doors between the two, 34% (11) had a single door, 3% (1) had double doors, 16% (5) had doors that can stay open without someone holding them and 28% (9) had doors with space for someone to hold them open. Where there were doors, these were usually opened and held open by the medical professional who was seeing the patient.
Comments included:

- “Medical staff hold the door open for people as they go to their appointment.”
- “Doctors collect people from the waiting room so they can open the door to the consulting room.”
- “The clinicians always come for the patients and happily help those with mobility needs.”

- "As a patient who has been in most of the consulting rooms, they all have a single door, with some rooms at awkward angles and down narrow corridors. In some rooms accessibility is easier than others. The rooms that present with challenges or are awkward would not make it impossible, but a wheelchair user might need support."

Questions for reception staff

The final element of the visit for our auditors was to ask the reception (or other) staff a number of questions. Not all reception staff felt confident to answer the questions and on some occasions, the surgery was busy and our auditors didn't have the chance to ask the questions. In all these instances we tried alternatives to find the answers from that surgery.

Reasonable adjustments

We asked reception staff if they record information about someone's reasonable adjustments (for example that they are blind or partially sighted, that they are neurodivergent, that they need a longer appointment etc.).

All surgeries we heard from do this. Comments include:

- "It is recorded in the patient's electronic notes."
- "Symbols are added to a patient's record across the practice."
- "Home screen for the patient lets the reception and clinical staff know the requirements of individuals."
- "When someone joins the practice there are questions about reasonable adjustments and this information is recorded on someone's record."

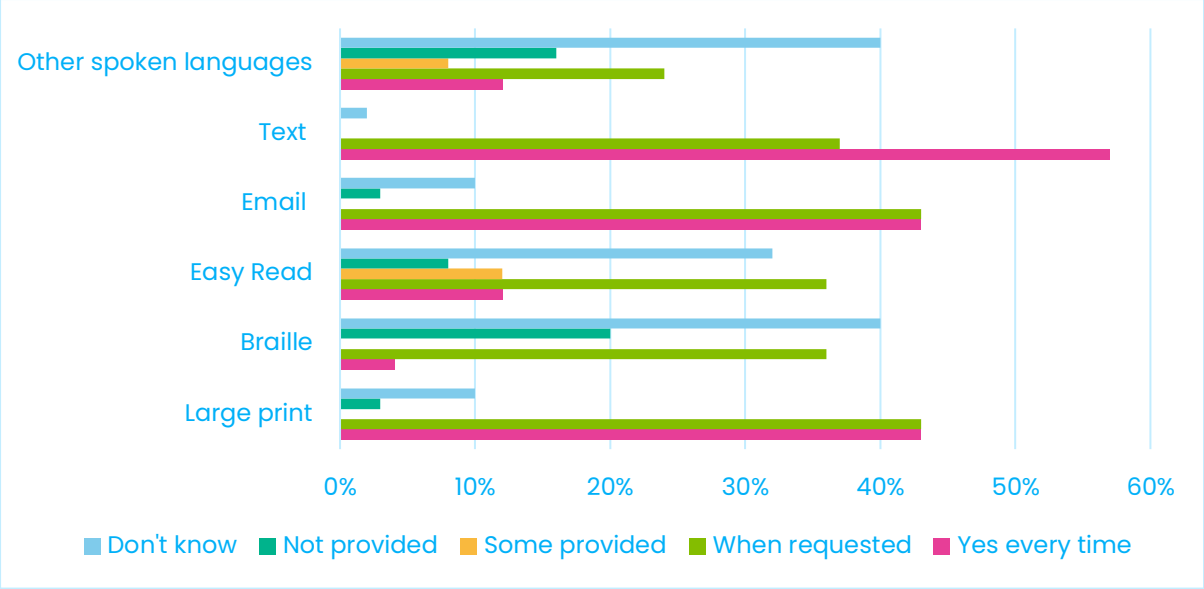
- "If the person or carer explains, information will be added to the home screen, which includes immediate reminders."

Accessible information

We asked if the surgery could provide written information, such as appointment letters, in different formats as required by patients. We also asked if the surgery checks if patients are happy to receive text messages from the practice.

In terms of written information, surgeries had different approaches and not all the staff we spoke to knew what was available. Text messages were the format that most surgeries could provide every time (57% or 17) or on request (37% or 11). The next formats that surgeries were most confident at providing were both email and large print; provided every time for 43% (13) and when requested for 43% (13).

Surgeries were less likely to provide Easy Read (12% or 3) or Braille (4% or 1) information every time or even when requested (36% (9) for both). Information in other spoken languages was provided least often (12% (3) every time and 24% (6) when requested).



Comments included:

- "Reception staff said they pass requests on to admin staff to deal with."
- "The RNIB can print documents for us if requested. We have discussed the possibility with Nimbus for them to purchase a Braille printer to be shared with all the York practices."
- "There is a form available for people to ask for translated information."
- "They haven't had any requests for Braille or Easy Read so far. It is noted on the home screen if a person has a learning difficulty or is vulnerable. Often information is sent to a carer if requested."
- "They have resources to do translations. They do Easy Read versions for learning disability reviews."
- "They said they will always aim to accommodate what people need."

Every surgery said they check people are happy to receive text messages and note the response on people's records. This is different from feedback to our earlier GP report and

ongoing feedback which says that despite asking the GP practice not to send texts, patients are still getting text messages that they can't deal with, want in a different way or don't want at all.

Interpreters

We wanted to know if the surgeries provide interpreters for speakers of other languages, including British Sign Language (BSL) and, if they do, how this is arranged, face to face or by using telephone or video technology.

Just over half (52% or 12) of surgeries say they will arrange a face to face interpreter if needed, 44% (10) said they use online interpreting services and 4% (1) were not sure.

Comments included:

- "The surgery has two patients who are BSL users. They have a list of interpreters to call when one of those people has an appointment. The patient's preferred interpreter is recorded on their notes and that interpreter is booked if possible. The surgery checks with the patient if that is OK before booking the interpreter and books the interpreter if it is."
- "The surgery has staff who can speak Spanish, Italian and Polish if they are available. Otherwise the phone-based language system works well. Staff are beginning to learn BSL but not beyond beginner level. They would bring in someone who can use medical BSL. Three such interpreters are available locally."
- "Currently they use Language Line for spoken languages. If someone needs BSL, they write things down and ensure the person has a longer appointment."

- “Currently use Google Translate. Do have a form to use if someone needs a face to face interpreter for BSL. There will be a new policy across the practice from April 2025 to provide face to face interpreters for spoken languages and BSL.”
- “Use Interpreter Line and/or ask if someone can bring another person with them to interpret.”
- “Use video for BSL and audio for other languages.”
- “The surgery uses online interpreter services. It is some time since they have needed to engage a BSL interpreter but have access to an interpreter service if required.”
- “For spoken languages a task is sent to the operations manager who always books a double appointment. They also have a phone system for BSL users to enable them to phone the surgery.”
- “They use Big Word for phone interpreting. The need for an interpreter is noted on the patient’s home screen including the language they need. This is then set up by phone. The GPs can arrange BSL interpreters if someone doesn’t bring someone with them.”

This feedback is mainly positive, but contradicts information we have received from regular feedback and our earlier GP survey. When we attended York’s Deaf Café, none of the attendees, all BSL users, had ever been offered a BSL interpreter. It is a concern that some still ask friends or family members to interpret rather than booking interpreters trained in medical language and terms.

Facilities

We asked if any consulting rooms have hoists to support people with mobility issues to use the beds for an examination.

None of the surgeries who responded to the question had hoists, 80% (24) said no and 20% (6) did not know. A number did mention that their examination beds were electronically adjustable and so the height could be changed to help people use them.

A few surgeries suggested that home visits would be arranged for people who may not be able to access the surgery or who would need a hoist.

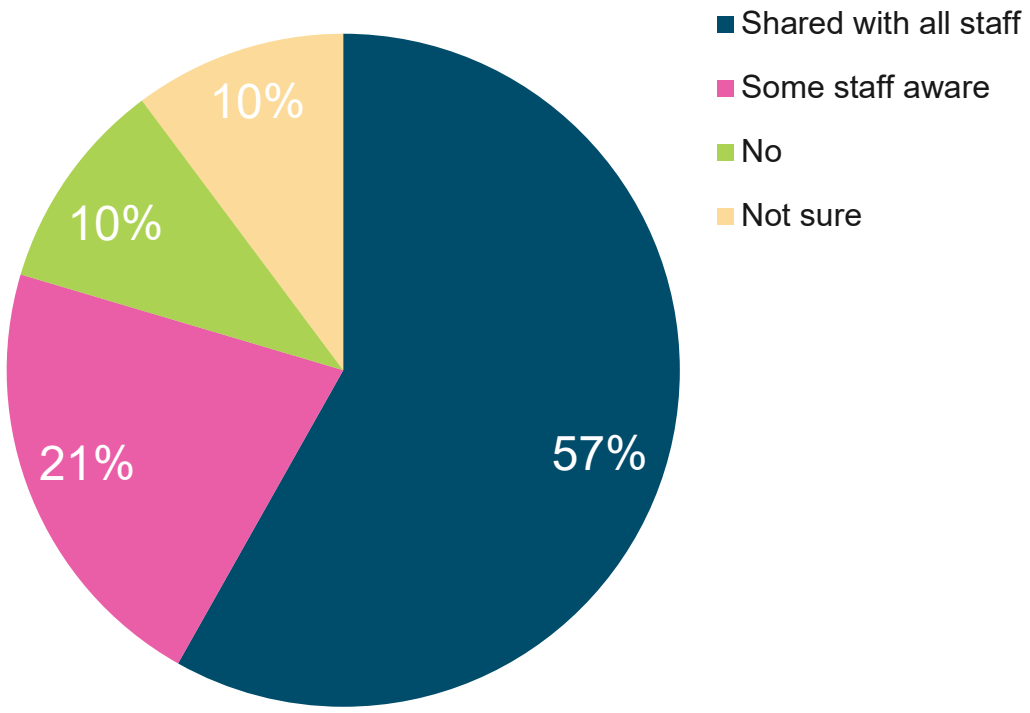
A number of surgeries also had a wheelchair for patients to use while there. We did not ask about this, so were only aware if it was mentioned or someone was using the wheelchair.

Training

We asked if the GP practices provide training on equality, diversity and inclusion for all staff.

As a result of an experience one of our volunteers shared, we asked if surgeries had a protocol or guidance for staff about supporting someone who is having an autism lockdown or panic attack in the waiting room.

More than half (57% or 16) of surgeries have a protocol or guidance which is shared with all staff. For 21% (6) of surgeries some staff are aware, in 11% (3) of surgeries there wasn't anything and 11% (3) of surgeries weren't sure.



Many surgeries had a panic button that they could use to get support from medical colleagues or reception staff would contact the person's GP.

Comments included:

- "The managing partner said: 'this is documented in our reasonable adjustment policy. If the receptionist wasn't trained in handling a patient in this condition, they would call for one of the nurses or the duty doctor to assist'."
- "They have a lot of different patients, including some with complex needs. Staff are briefed about supporting patients and would always go to talk to someone, offer a drink etc and try to calm any situation."

- “There is guidance about supporting people with mental ill health and e-learning about this for all staff.”
- “Generally use common sense and ask if the person needs help.”
- “They can take someone into a separate room if needed. Reception staff can ask clinicians for help. There is also a panic button. They would never ignore someone who needs help.”
- “They said the training is basic and they feel they could do this, but they also acknowledged they could do to know more, particularly about more invisible struggles such as autism shutdown.”
- “They have cameras, so know if anyone needs help in the waiting area. Would always go and check if someone is OK if they look as if they need help. There is a panic button that can call medical staff if needed.”

We asked whether the GP practice provides training on diversity and inclusion. Most (83% or 25) of surgeries said yes, all staff have that training, 10% (3) said there is some training and 7% (2) weren’t sure.

Good practice

Finally we asked our auditors to note any good practice or other comments that they felt could help to improve the experience of attending one of York’s GP surgeries. Our auditors said:

Good practice

- “Seemed a good, friendly surgery.”
- “The receptionist was very helpful. The surgery is in a new, modern building.”

- “There was information on a poster in the waiting room outlining support for people with hidden disabilities.”
- “Very welcoming and helpful staff.”
- “Very helpful practice manager.”
- “There is a mental health information board. Staff are helpful and pleasant.”
- “Very helpful staff. One had previously worked in a care home so wasn’t phased by anything. She was extremely helpful to patients, including helping someone with a phone message and link to a form.”
- “The reception staff are super friendly and helpful.”
- “It seemed clean, attractive and fit for purpose.”
- “Exceptional reception staff who know their patients, take time and talk well with people. There is a screen in the waiting room with useful information and a display about carers.”
- “The staff are friendly, accommodating and receptive. They are patient with me and don’t rush me when I am struggling for words or over sharing.”
- “Good screen with general health information. Very friendly and helpful reception staff.”

Other comments

- “The entrance door and toilet door could be easier to open.”
- “Possible access issues with the front door.”
- “Very poor wheelchair access that they are aware of.”
- “Notices need sorting out, there is too much information.”
- “Long queue at reception and arrangements didn’t encourage eye contact. Receptionists’ desk is low and patients standing have to look down.”

Recommendations

These are general recommendations. We recognise that some surgeries already provide some of the following:

- Make sure all signage is clear and easy to read for everyone. Signage should include:
    - How to get into the surgery if someone can't use the main entrance. If you have a bell, make sure it is at a height a wheelchair user can use and is clearly marked.
    - Assistance dogs are welcome. For more information about assistance dogs, visit: https://www.assistancedogs.org.uk/.
    - If there is a hearing loop at reception. All receptions should have a hearing loop if they don't already.
    - Tell people what to do if they need help while they are waiting.
    - Explain if there is a quiet waiting area available for patients to use if appropriate and how to access it.
    - To and from any accessible toilet as appropriate.
- For important signage, like that above, make sure it is not in a cluttered area, so it is easy for people to see and not surrounded by other information. Where possible use words and images with good colour contrast.
- Make sure that any display areas or posters are not cluttered and provide space around posters to make it easier for people to differentiate and read them. Perhaps theme posters under a heading/in a particular area.
- Make sure waiting areas are quiet. Don't have the radio or music on as this can make waiting difficult for some people. Or have a quiet waiting area/space and clear information about where it is or how someone can access it.
- If you are planning to redecorate, make sure there is good colour contrast between walls, floor and seating. This will

make it easier for blind and partially sighted people to identify the seating.

- If you are updating seating, make sure there is a mix of seating. If possible include seating with and without arms and bariatric seating. Some higher and lower seating is also beneficial for patients with different needs.
- Make sure the waiting room has space for a wheelchair user to wait comfortably, where they don't have to sit in the middle of the waiting area or in what could be thoroughfares. If possible add signage to say this is an area for wheelchair users so it doesn't get used for other things.
- If there isn't any accessible parking, investigate introducing some or providing information about where someone with a Blue Badge can park close to the surgery. Make sure there is clear space around the parking space in line with the appropriate BSI standard[5].
- Make sure that there is a clear, safe path for people to use to walk to the surgery entrance from both the pavement and car park. Where possible, this should be a straight and well-marked path which doesn't cross a car park. If it has to cross the car park, make sure there is a warning for car drivers to take care as people will be walking through the car park.
- Provide a dropped/lower part of the reception desk, so it is easy for wheelchair users to communicate with receptionists.
- If possible, make sure that there is a gap in any screens at a reception desk for people who are hard of hearing to see the reception staff clearly.
- Make sure your patient records are up to date with patients' reasonable adjustment and any language needs. Regularly check with patients about any changing needs or have

[5] https://www.disabledmotoring.org/park-access/criteria-for-park-acsess

information available to remind patients to let you know so their patient record can be updated.

- If someone requests information in a different format, ensure that this is recorded and they always get information in that format.
- Make sure patients who need interpreters are aware of how to be sure they have an interpreter booked for their appointment. This could include having information leaflets (including in other languages) available, contacting patients directly to let them know or introducing a card system whereby they can use a card/other to request an interpreter for an appointment or let the surgery know about their need.
- Surgeries should never ask friends or family members to interpret for a patient and should only ever use interpreters who have had training in medical language and terms.
- Work with patients who are wheelchair and powerchair users to make sure that the surgery, waiting areas, lifts (if appropriate) and consulting rooms are accessible for them.
- Always ask patients what works for them. Use the information you collect about people's reasonable adjustments to ask them if there is anything else that could help them comfortably and safely attend appointments.

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GP practice websites in York: audit findings

February 2025

Contents

Acknowledgements
We thank our amazing Healthwatch York volunteer team for their research for this report. Fifteen volunteers spent more than 60 hours looking at the 11 GP practice websites that cover York. They responded using a survey to provide feedback about information available on the sites and the look and ease of use of the sites.

In total 41 audits were carried out between mid-November 2024 and 31 January 2025.

We also thank Healthwatch North Yorkshire who ran a similar project in November 2023[1] and shared their questions and feedback which informed our project.

Cover image from Julia Zyablova via unsplash

[1] https://www.healthwatchnorthyorkshire.co.uk/report/2023-11-27/gp-website-health-check

Executive Summary

Websites are an increasingly important place for people to find out information and access services from local GP practices. The annual GP Patient Survey found that nationally, 61% of respondents had visited their GP website in 2023[2].

In addition, our earlier report, Exploring Access to GP Services in York[3], included feedback from people about their experiences of local GP practices, including comments about practice websites. The work explores that further to explore how York's GP practice websites are and are not helping people effectively access healthcare in the city.

This report looks at the 11 GP practice websites which cover York and the surrounding areas. We wanted to understand how useful GP websites are to find out information about practices and the services they offer. While the websites are all different, we have found some common positives and areas for improvement for the sites.

Positives

- The best websites had the most commonly searched for information on the homepage.
- Some websites have very clear information and are easy to navigate.
- Good information on the homepages. Clear and easy to follow.
- Where there were search functions, they were very helpful.

[2] https://gp-patient.co.uk/practices-search

[3] https://www.healthwatchyork.co.uk/wp-content/uploads/2024/09/GP-Report-Final-September-2024.pdf

- Where there was information about staff roles or staff themselves, this was helpful.
- All the websites had information about appointments on the homepage.
- It was most useful if the online forms, including those to report symptoms or book appointments, were available all the time and not just during practice hours.

Areas for improvement are included in the recommendations on page 15. Many are the opposite of the positives and include:

- Information should be up to date and links checked to ensure they are working.
- Improve colour contrast to ensure text is clear for all users.
- There should be multiple ways for contacting the practice so that people without IT access or those who can't use the phone can still easily get in touch.
- Remove visual clutter so it is easy for people to find information and particularly popular or important information.
- Include guidance on how to use forms for people who are not familiar with them.
- Provide accessibility options on the website.
- Provide information about staff roles (and staff as appropriate).
- Test your website, or any updates, with your patients.

Background

Local context

Feedback we received through our 2024 GP survey included a number of comments about GP websites. These included reflections and suggestions:

- "Different methods of contact, app, website, and phone can be confusing to navigate and give varying results."

- “To be able to arrange appointments over the phone and a simplified website.”
- “They want everything done via the website, which is not available at weekends!”
- “Website/portal - can only access between certain hours so if you’re working and unable to get access to internet then you cannot use this.”
- “The other problem I have is that the surgery no longer activates their patients' website to request my repeat prescription. This is now done via an NHS app which I am unable to do. I tried but I have eye problems. … So, I now have to do paper requests and go to the surgery several times every two months …”
- “Also website for trying to get in touch is very confusing (I am computer literate so even worse for those who struggle).”
- “The website is convoluted and dated. There is too much to go through to get what you need.”
- “Unable to get through on phone and using their website is a nightmare as it assumes you are tech savvy. It needs to be clear using easy to understand language. An Easy Read version would be helpful.”
- “Website works when it wants.”
- “Excellent website.”
- “I have a brain injury. I can't navigate the website.”

National context

NHS England have recently published a step-by-step guide to improving general practice website online journeys[4]. The guidance aims to help practices:

- understand the elements of an improvement plan and the information to collect

[4] https://www.england.nhs.uk/long-read/step-by-step-guide-to-improving-general-practice-website-online-journeys/

- benchmark the usability of current online patient journeys
- make a plan for improvement
- deliver and maintain that improvement

This was published after our volunteers completed their audits. We believe this is timely, as we are confident that our service user feedback forms part of the information to collect and will help York's GP practices make sure their websites are user friendly and work effectively for as wide a group of people as possible.

What we did to find out more

In partnership with our volunteers we adapted the Healthwatch North Yorkshire survey to develop something appropriate for York's 11 GP practices. The survey was circulated to volunteers, supported by a guidance document. Volunteers were given a list of the GP practices in York and asked to use the survey questions to audit as many websites as they were able to between November 2024 and January 2025.

At least three volunteers looked at each website and one volunteer looked at all the websites.

The GP websites audited were:

- Dalton Terrace
- Elvington Medical Practice
- Front Street
- Haxby Group
- Jorvik Gillygate
- MyHealth
- Old School Medical Practice
- Pocklington Group Practice
- Priory Medical Group
- Unity Health
- York Medical Group

Volunteers used a variety of devices including computers, tablets and smart phones. The majority of volunteers used a computer. We also asked how confident volunteers were in using computers with 1 being not at all confident and 10 very confident. Most volunteers scored themselves between 6 and 10, with the majority scoring 8 or above.

Findings

Ease of finding the website

All but five of the respondents found it easy to find the GP practice website via an online search. In most instances the website for the practice came up immediately and was top of the search. The practice that was particularly difficult was Unity as there is more than one practice with this name in England.

First impressions

We asked our volunteers to note their first impressions on opening the website they were auditing. Comments included:

- “It is clear and has page options for common questions but clicking on these options does take you away from the homepage but there is a 'Home' button on a bar near the top.” “Clear, but very cluttered.”
- “There is a lot of information on the homepage, with lots of buttons with writing and pictures. But while it could be overwhelming, it was reasonably clear when you start to look to see if the information you want is there.”
- “Clear layout with image boxes and large text links, plus additional links at the top. Perhaps a little bit too minimalist.”
- “It looks professional, with NHS logo the first thing you spot and designed in typical blue and white colours.”
- “Fairly easy to use but you have to look for information.”
- “Has a more local/friendly feel. But doesn't have links to all the most useful information on the homepage.”
- “I like it. The homepage is clear and presented well. Information is broken up nicely, with images, clear headings, and different colours. I also really like the fact it presents you with "Welcome to…” . It feels like a website for patients.”
- “Clear ‘subjects’ to click on. Excellent.”

- “Very easy to navigate and search facility seemed to be good, finding most things I was looking for and very few dead ends!”
- “Very impressive and business like!”
- “It was clear, had sensible sections easily accessed and provided useful information on the front page. I also liked the option to read the page in different languages (105 different languages available).”
- “Very good. Helpful links, informative text without being too much, images and graphics are clean and easy to understand, not too much on the homepage.”
- “There is some very key information which is in pale blue, which I missed entirely at the start of this review - suggest this needs re-doing in a more prominent colour.”
- “The information is easy to see, however, it is very colourful and the background moves making it a little overwhelming.”
- “Very neat, easy to follow, not cluttered.”

Searching the website

We asked our volunteers if the websites had a search function and then how easy it was to use.

Of the 11 GP practice websites they looked at, only one did not have a search function. Volunteers found the search function difficult to find on one and suggested it should be more prominent on the homepage. For the remaining nine practice websites, there was a search function and it was easy to locate.

In terms of using the search function, we asked how easy it was to search and find relevant information. In most instances, volunteers found it easy to use and find appropriate information. However, some commented that the search function only found some information and a few that it didn’t

find the information being searched for at all even though it was on the website.

Comments included:

- “You don't really need this because of the easy access that you can get to key information from the homepage.”
- “Managed to find information on most topics searched for.”
- “I searched 'register' and 'prescriptions' where both came up as top results.”
- “I tried searching 'appointments' and it came up with relevant and useful results very quickly.”
- “I put in the search box making appointments and was taken to a page about annual health checks for those with learning disabilities.”
- “On further searching during process, found that sometimes the search identified irrelevant information or no further information e.g. diabetes.”
- “I put diabetes into search engine. This took me to separate diabetes advice page but there was no further information about diabetes! (They could easily resolve this by creating a link to Diabetes UK or NHS website for diabetes). On further investigation I came across diabetes information under Long Term Conditions - Health Advice. The two webpages need linking.”
- “I typed in simple things such as "how to make a complaint" and "prescriptions" and direct information came up. When I typed in other things such as "online medical records" or "NHS App", it didn't come up with any relevant information.”

Information on the homepage

We asked our volunteers to look at some of the most common information people might be looking for on the homepage. We have listed below what we asked them to

look for and whether it appeared on the homepages of the 11 York GP practice websites.

- Different surgeries – if the practice has more than one:
    - Of those practices that have more than one surgery, six practices had information on the homepage and had the information elsewhere on the website.

- Opening times
    - Some of the smaller practices did have the opening times on their homepage. Where practices had more than one surgery, the information was elsewhere on the website, often on the contact us page, but not usually on the homepage.

- Registering as a new patient
    - Generally there was information on the homepage or, most often, a tab or button on the homepage that takes someone to information about how to register. However, on some websites it was difficult to find the information.

- Making, changing or cancelling an appointment
    - There was often either information or a link/button on the homepage to find out more information about appointments.

- Getting test results
    - Mostly this information was via a link or button on the homepage of each website. Some volunteers commented that this information could be difficult to find.

- Getting a repeat prescription
    - All websites had information about getting a repeat prescription. This was mostly via a link on the homepage or information elsewhere on the website.

- Getting a sick note
    - Information about getting a sick note was sometimes more difficult to find, but every practice had information somewhere on its website. Sometimes this was on the homepage, but mostly it was elsewhere on the website and needed the volunteer to search for it.

- Local pharmacy
    - It was less common to find information about the local pharmacy(ies) on GP websites and rare to find information on any practice homepage. Of the 11 practice websites, six had information about one or more local pharmacies on their site, for three websites some volunteers found some limited information and for two websites there was not any information.

- Vaccinations
    - Due to the time of year that the audits took place, some websites had information about Covid and flu vaccinations on their homepage including details of how to arrange them. Other sites had some

information on other pages but volunteers had to search for it. Some websites did not have any information or information only about travel vaccinations.

Contact details

As well as asking about contact details being available on the GP website's homepage, we also asked volunteers to see if the contact details provided at least two ways of getting in touch. That means a phone number, but also an email, or other means of contact for people who can't use the phone.

There was a mixed response about the number of methods to contact the GP practice. Many had a phone number and a physical address, supplemented by a form to complete to submit symptoms. There was only one practice that offered an email address as a means of contact.

Appointments

We asked if information about appointments was easy to follow, whether there was a range of options for how to book an appointment, if there was information about the process of getting an appointment and the time it might take as well as the types of appointment available (phone, face to face or virtual). We also asked volunteers to see if there was information about home visits and how to arrange them, if the websites explained how to cancel or change an appointment and whether there was information about what to do out of hours.

All the volunteers said the information about booking urgent and routine appointments was either very or quite easy to follow. Comments included:

- “How to make all appointments was clear from the homepage that directs you to appointments, and then breaks down the details easily, giving clear instructions for all options. It directs you to call the surgery for urgent appointments and says ‘reception staff will do their best to fit you in’.”
- “Detailed page on urgent and routine appointments with the option of booking online (via link that takes you to Patient Access) or an automated 24hr phone number for booking.”
- “On the appointments page, it differentiates between urgent and routine appointments and what to do quite clearly.”
- “Very limited information. No differentiation between routine and urgent appointments. The information is straightforward in terms of what it says, but not particularly helpful. It just says ring up or use the online form!”
- “The 'Appointments' page has plenty of detail on appointments but not same-day. Urgent appointments are 'managed within one working day' but it doesn't specify whether this means someone can get a same-day appointment.”
- “Information about an urgent appointment says to phone with no alternative if someone can't use the phone. Information about a routine appointment gives the options of using the NHS app (no other online option) phone or going to the practice.”

All volunteers said there is a range of options for how to book an appointment with options including phone, online (including the practice's form or the NHS app) and going into a surgery. However, not all practices offer all three options. One doesn't mention an online option and another doesn't include information about going to the surgery.

About two thirds of our volunteers either didn't find any information about the time it would take to get an appointment or found that the information was not clear.

Just under half of our volunteers said they found information about the types of appointment people could have, e.g. phone, face-to-face etc. Some included information about the healthcare professional that a patient might see. The remaining volunteers could not find this information on the websites.

All the websites had information about home visits and how to request one if appropriate.

Volunteers found clear information about how to cancel or change an appointment on all but two of the practice websites. On the remaining two, they either could not find any information or found it very difficult to find.

Every practice website had information about who to contact out of hours. This included NHS 111 and other options. Some websites mentioned phoning 999 in an emergency, some suggested going to the pharmacy and one mentioned the Urgent Treatment Centre.

Online forms, online services and the NHS app

Our volunteers tried to find information about different forms available.

Seven of 11 GP practice websites had a form available to report symptoms/request an appointment related to symptoms. Of those, two were only available at some times of the day, generally when the GP practice was open. However, not all volunteers could find the forms or information was not clear enough for them to identify what they were looking for. Four of the websites had clear information about how to use these forms. For the others, either our volunteers couldn't find information or there wasn't any. Our earlier report, Exploring Access to GP Services in York[5], included feedback from people who struggled to use the online forms or found them difficult to use. So, it was disappointing that guidance on using the forms wasn't available on all websites.

All but one practice had an online form to enable people to provide feedback, including compliments and complaints. These forms were available at all times. Some practices also linked to Family and Friends feedback and one to Care Opinion. The one practice that didn't provide an online form, did provide information about how to provide feedback by phone or letter.

We asked volunteers to note if there was a link to the GP practice's own online system. This wasn't always clear to our volunteers with a number of people reviewing the same website recording different answers. Six of the websites had a clear link,

[5] https://www.healthwatchyork.co.uk/wp-content/uploads/2024/09/GP-Report-Final-September-2024.pdf

for three websites volunteers couldn't find a mention of the GP's own online services and for three websites volunteers said they didn't know/could not find a link or reference.

We also wanted to know if the GP websites promoted the NHS app and they all did. Some of the practices use this rather than their own online systems for a range of services, others offer both options. Some GP websites had more information and guidance about how to use the NHS app, others had links to information on the NHS England website.

Accessibility

We asked volunteers to look at accessibility features on the website itself as well as looking for information about access when visiting GP surgeries.

In terms of website accessibility, we were particularly looking for making text larger, speaking the content and translating into other languages. Some of our volunteers again struggled to find the information when it was there. A number found an accessibility statement but nothing to help people use the website in different languages or formats. In total, volunteers found that five websites had these kind of accessibility features, two via Google translate. Five did not have any features and one had some information, including information in Easy Read, but nothing about how to change text into other languages or formats.

Regarding physical accessibility of surgeries, volunteers found some of the information difficult to find and it wasn't clear where

to look. Five websites had very good information about a range of things including accessible parking, the accessibility of the surgery and consulting rooms, hearing loops and more; four websites had more limited information about accessible parking or wheelchair access only and two websites had no information at all.

Volunteers commented:

- “Website has a facilities and accessibility page for patients in need of information regarding disabled access and hearing difficulties. At the top of the website there is a language button to change language. They also have an accessibility link at the bottom of the page with information and who to contact if they can't access the website. Also includes information on widgets that will help make text larger or text-to-speech.”
- “On the appointments page it mentions to let the surgery know if you require an interpreter or if you need any help with your appointment. It was not clear/I could not find any info on accessible parking/accessibility.”
- “There is an Easy Read guide to making an appointment, dealing with prescriptions and getting a vaccination, but nothing about making the text larger or speaking the content.”
- “Yes there are accessibility features - found under the policies section, not that easy to find.”
- “Button on homepage that says ‘Language’ takes you to a statement 'Translate with Google' (not very helpful).”

- “Contact us page says that they can provide Braille documents, accessible parking and toilet, signing service, step free and wheelchair access.”
- “Option to translate text into 105 different languages - really good and accessible. No information about making text larger.”
- “Braille translation service, accessible parking and toilet, induction loop, signing service, step-free access, text relay, wheelchair access, baby changing facility all listed.”

Staff and services

We wanted to understand if practices include information about either the people who work there or the roles that people fulfil. All but one website had information about either the staff team or roles, but the level of detail provided differed significantly.

Comments included:

- “Shows names and qualifications of the doctors and information sections regarding other staff members.”
- “Dedicated page listing names of all staff and which role they play within the practice team.”
- “Gives working days and titles - doctors, nurses, healthcare assistant, phlebotomist, practice management administration and secretaries.”
- “There is a list of GP partners including photos and short sentences about their qualifications and interests. There is then a list of the salaried GPs.”
- “Some photographs of: managing partner; clinical partners (GPs); salaried GPs; advanced care practitioner; physician associate and lead nurse. No information about the practice manager or information on how to contact them.”

- “There is a list of GPs, practice nurses, healthcare assistant, practice manager and operations manager all listed by name. But no information about different roles etc.”
- “There is a page about the different roles within the practice, but it doesn't give information about who works at the practice or which roles are at each surgery etc.”

Volunteers also looked for information about social prescribers. Some websites included information as part of the staff team, others had information on a different part of the website, often only found by searching. Two websites didn’t have any information about social prescribers.

We also asked whether websites included information about clinics and services the practice offers and whether there is any information about non-NHS services, including Healthwatch York.

All but one website had either some or a lot of information about clinics and services the practice offers. The best websites provide a lot of information including short introductions to the clinics/services, who runs them and how to get in touch and/or book an appointment.

All websites had some information about non-practice or non-NHS services, although this was easier to find on some websites than others. A number of sites link to the NHS Choices website for wider health information. Four websites contained information about Healthwatch England or Healthwatch York.

What could be better?

We asked volunteers what they thought could be better with GP websites in general. Their comments included:

- “There were links that didn't work and much of the information felt out of date and not reliable.”
- “Although the website and homepage look impressive and welcoming when you click onto other pages, for example, appointments, there is a lot of writing /information on the page which is a bit overwhelming. I think some of the pages could be revised, so they are clear like the homepage, and basic points clear and highlighted.”
- “There were a couple of links that led to information that had been temporarily removed. Not sure if this was because they're not registering any more patients or are updating the information. It would have been useful to have information about and how to contact the practice manager.”
- “When opening a page, they always opened on top of the existing page and not in a new window, so it was difficult to go back to what I was looking at.”
- “Some information is difficult to find and involves clicking multiple links. I understand that this keeps the main webpages clean and simple, but there could be drop-down menus added to the top links to make it a bit easier to find certain details.”
- “Lots of scrolling to find information and not always where you would expect it.”

Recommendations

These are general recommendations. We recognise that some of the websites already provide the suggestions below:

- Make sure information on practice websites is up to date and all the links work.
- Make sure that text and backgrounds have a good colour contrast, so it is easy for people to read. For example, dark text on light backgrounds or vice versa.
- Always provide two ways for people to get in touch, so there is an option for people who can't use a phone or for those who can't access IT.
- Keep the website as clear and simple to follow as possible. Use tabs or menus to provide easy to find information.
- Have the most important information for patients clearly on the homepage either as text, or more likely as a linked tab, box or in a menu. This should include frequently requested information including about opening times, contact details (including for multiple surgeries if appropriate), appointment information, ordering a repeat prescription, getting test results, registering as a new patient, sick notes etc.
- Where possible have seasonally appropriate information on the homepage like vaccination information.
- Provide a search function and thoroughly test it.
- If you have online forms, provide guidance on how to use forms for people who are not familiar with them.
- Provide accessibility options on the website which enables people to change the font size or colour, read the text out and to translate information into other languages.
- Provide information about physical accessibility at the surgery/surgeries. This should include information about how to arrange an interpreter.

- Provide information about staff roles (and staff as appropriate) that explains what that role does and why someone may have an appointment or be in contact with that person.
- Provide an email address for patients to get in touch about non-urgent issues, particularly those that do not require an appointment.
- Test your website, or any updates, with your patients or others and particularly with people who may not be familiar with the website or are not confident website users.
- Always make sure that there are options for people to use who don't use websites and that they do not have a poorer experience due to not having online access.

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