Notice of a public meeting of
Health and Wellbeing Board

To: Councillors Steels-Walshaw (Chair), Runciman, Webb and Cullwick
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
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
Tom Hirst – Area Manager Director of Community Risk and Resilience, North Yorkshire Fire and Rescue Service

Date: Wednesday, 16 July 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 - 22)

To approve and sign the minutes of the last meeting of the Health and Wellbeing Board held on **Wednesday, 7 May 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 **Monday, 14 July 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. Healthwatch York Report: Women's Health: Stories of Women's Health Experiences in York (Pages 23 - 94)

Sharing a Healthwatch York report focused on women's health. The report brings together women's experiences when navigating health and care.

6. Women's Health Needs Assessment (Pages 95 - 150)

This report presents the Women's Health Needs Assessment 2025, which is a picture of York's strategic needs around women's health and equality, shaped around six key areas which lay out systemic barriers, promote gender equity and improve well-being for women in the city.

As part of the Joint Strategic Needs Assessment (JSNA) process which the Board oversees, the Public Health team lead a number of topic-specific needs assessments each year.

7. The Commercial Determinants of Health - Exploring a York approach (Pages 151 - 178)

This report introduces to the Board the substantial evidence emerging within health and social policy research on what are termed the 'Commercial Determinants of Health' (CDOH). This concept, applied locally, refers to the way unhealthy commodity industries, for instance those selling tobacco, alcohol, unhealthy food, or gambling products, are undermining our local Health and Wellbeing Strategy objective to 'become a health-generating city' and have a negative impact on goals improve healthy life expectancy and reduce the gap between the richest and poorest in the city.

8. Update from the York Health and Care Partnership and Annual Report (Pages 179 - 240)

This report provides an update to the Board regarding the work of the York Health and Care Partnership (YHCP). On this occasion this report also includes a copy of the YHCP's annual report. The report is for information and discussion and does not ask the Board to respond to recommendations or make any decisions.

9. Healthwatch York Annual Report (Pages 241 - 290)

This report is for information, sharing details about the activities of Healthwatch York in 2024/25 with the Health and Wellbeing Board.

10. Progress Against Goals #3 and #4 in the Joint Local Health and Wellbeing Strategy 2022-2032 (Pages 291 - 306)

This paper provides the Board with an update on the implementation and delivery of Goals 3 and 4 in the Joint Local Health and Wellbeing Strategy 2022-2032. It also includes information on performance monitoring.

11. Health and Wellbeing Board Chair's Report (Pages 307 - 310)

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.

12. 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.

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

Alternative formats

If you require this document in an alternative language or format (e.g. large print, braille, Audio, BSL or Easy Read) you can:

Email us at: cycaccessteam@york.gov.uk

Call us: **01904 551550** and customer services will pass your request onto the Access Team.

Use our BSL Video Relay Service:
www.york.gov.uk/BSLInterpretingService
Select 'Switchboard' from the menu.

We can also translate into the following languages:

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)

This page is intentionally left blank

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.

This page is intentionally left blank

City of York Council	Committee Minutes
Meeting	Health and Wellbeing Board
Date	7 May 2025
Present	Councillors Steels-Walshaw (Chair), Runciman, Webb and Cullwick; Anja Hazebroek – Executive Director of Communications, Marketing and Media Relations, NHS Humber and North Yorkshire Health and Care Partnership Siân Balsom – Manager, Healthwatch York Peter Roderick – Director of Public Health, City of York Martin Kelly – Corporate Director, Children's and Education, City of York Council Sara Storey – Corporate Director of Adult's and Integration Alison Semmence – Chief Executive, York CVS David Kerr – Community Mental Health Transformation Programme and Delivery Lead – Tees, Esk and Wear Valleys Foundation Trust (Substitute for Zoe Campbell) Lucy Brown – Director of Communications, York and Scarborough Teaching Hospitals NHS Foundation Trust (Substitute for Simon Morritt)
Apologies	Zoe Campbell – Managing Director, North Yorkshire, York and Selby - Tees, Esk and Wear Valleys NHS Foundation Trust Simon Morritt – Chief Executive, York and Scarborough Teaching Hospitals NHS Foundation Trust Pauline Stuchfield – Director of Housing and Communities, City of York Council Mathew Walker – Deputy Chief Fire Officer, North Yorkshire Fire and Rescue Service Fiona Willey – Chief Superintendent, North Yorkshire Police

Absent	Dr Emma Broughton – Joint Chair of York Health and Care Collaborative Mike Padgham – Chair, Independent Care Group

---

41. Apologies for Absence (4:35pm)

The board received apologies from the Director of Housing and Communities, City of York Council; no substitute was available.

The board received apologies from the Deputy Chief Fire Officer, North Yorkshire Fire and Rescue Service; no substitute was available.

The board received apologies from the Chief Constable and the Chief Superintendent, North Yorkshire Police.

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

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.

42. Declarations of Interest (4:35pm)

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.

43. Minutes (4:35pm)

Resolved: To approve and sign the minutes of the last meeting of the Health and Wellbeing Board held on Wednesday, 19 March 2025, having noted and amended an error in item 38.

44. Public Participation (4:36pm)

It was reported that there had been one registration to speak under the Council's Public Participation Scheme.

Flick Williams spoke on item 7; she expressed serious concern about the effect of proposed disability benefit cuts on health inequalities.

45. Update on the York Drug and Alcohol Partnership: Strategic Priorities 2025/26 (4:40pm)

The item was introduced by the Director of Public Health and presented by the Public Health Specialist Practitioner (Advanced).

The Director of Public Health explained that this report followed on from a national review of services surrounding drug and alcohol provision in 2021 which gave local authorities license to set up "combating drugs partnerships" which was locally represented by the York Drug and Alcohol Partnership (YDAP), of which he was the Senior Responsible Officer.

He also noted that in the past decade there had been a move from treatment to recovery-based systems when dealing with addiction.

The Public Health Specialist Practitioner (Advanced) presented the report and summarised the strategic priorities agreed at the Drug and Alcohol Partnership Board in March 2025. Each priority has a lead within a relevant organisation. She noted that a fourth outcome (mental health) had been added this year.

The Health and Wellbeing Board were asked to support the priorities but also to consider how individual agencies within the wider health and well-being area could each offer support.

The board asked about the "What's the Score" conversation tool, used by YDAP; what was the purpose of it and how was it used?

The Public Health Specialist Practitioner (Advanced) answered that this toolkit had been developed by their current provider Change Grow Live as part of their young people's service – and

it was a type of scratchcard which helps user's establish their level of substance usage and whether this may be problematic. The intention was to roll this out fully to professionals who work with young people such as teachers and youth workers.

The board asked about the aim to increase the numbers of young people seeking support for substance misuse – the Public Health Specialist Practitioner (Advanced) said the numbers, set out nationally, were quite ambitious but were being delivered. These had started out at around mid-20s but were now approaching nearer 50.

The board asked how the partnership could work out where they need to be to capture any young people that weren't coming forward to seek support?

The Director of Public Health answered that regarding unmet need indicators for drugs and alcohol versus the expected number of people seen in treatment, there was about a 50% gap for substances and 80% for alcohol in the adult population currently, so on this basis he would expect to see four times as many adults seeking help for alcohol treatment and using a similar methodology he would consider 20-30 young people citywide to be a much lower than anticipated number of young people seeking help.

The board asked whether there was capacity to deal with an increase in demand for support with drug and alcohol misuse among young people.

The Public Health Specialist answered that there was capacity to support more children and to provide early intervention, which would also avert further need for these people as adults.

The Director of Public Health added that with the old model Children's Services was more a wing of the service as a whole, and was a smaller element. With the new provider there was a specific gateway offered to children, which he felt put the local authority in a much better place.

The board praised the report's specific acknowledgement of the importance of dual diagnosis. It was noted that on this topic the report did not cover the issue of neurodiversity and self-medicating to "normalise" for individuals.

The presenter acknowledged this point, and said there was a first prevention group later in May where she would bring this up. She would also discuss the prevalence of self-medication without a coexisting mental health condition.

The board raised the issue of gender specific pathways, noting that there was no discussion of domestic violence in the report.

The presenter accepted this and said while this issue had not been a priority for the year, the link between drugs and alcohol and domestic violence was recognised and work was being undertaken by her colleague in Public Health, Hannah Hall, on the Joint Domestic Abuse Strategy.

The board asked whether high risk individuals would trigger an automatic referral from the courts or prison service regarding self-medication linked to domestic violence or would they need to manually request a referral themselves?

The presenter stated that she believed a referral would have to be made in this instance but she would follow up and report back to the board.

The Chair responded that situations concerning very high-risk individuals would automatically trigger a Multi-Agency Risk Assessment Conference (MARAC).

The Director of Public Health suggested the board could confirm that the commissioned drugs and alcohol provider and commissioned domestic abuse provider were collaborating and talking to one another, because these were coexistent issues where two referrals may may be helpful but they must be coordinated referrals in which the teams talk to one another.

The Director of Public Health also requested that an action be noted that the board would like to assess some of these priorities and the data behind them to discuss measurable changes at a future meeting.

The board asked what work had been done around attitudes and behaviours surrounding adults buying alcohol for young people to take to gatherings, and the “normalising” effect this has.

The presenter acknowledged this, conceding this was a wider, national issue addressed to some extent in Personal Social Health Education (PSHE) lessons under the national curriculum and would form part of the focus of the Children and Young People's group taking place later that month.

The board asked about nitazenes/synthetic opioids being a problem in York that had contributed to several deaths in York in recent years, and how the process for dealing with this was changing.

The Public Health Specialist said that the North Yorkshire Drug Analysis Program (NYDAP) a harm reduction exercise was currently being undertaken together with the University of York, North Yorkshire Council and North Yorkshire Police. This gave a much faster return on testing any sample of drug paraphernalia (if not needed for evidence) and this could be tested at the university. A turnaround of 12 hours between getting a sample and putting out a drug alert could now be achieved. She would be happy to come back and talk about nitazenes further.

The board asked if this scheme was already taking place elsewhere or was York pioneering this?

The presenter answered that while York had not pioneered this scheme, it was close behind those that did; city size in York had allowed the scheme to be rapidly put in place. She advised that she could also provide the board with national statistics to show the wider outcomes for harm reduction.

The board thereby

Resolved:

i. To note and support the 2025/26 priorities of the York Drug and Alcohol Partnership.
ii. To 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.

46. Better Care Fund (5:09pm)

The Corporate Director of Adults and Integration presented on behalf of the report author (Interim Head of All-Age Commissioning), advising that the final plan, submitted in March and outlined in the report, had been approved in the hour prior to the board meeting.

She explained that the York Better Care Fund (BCF) plan had been developed through a collaborative process, ensuring alignment with national priorities and local partnership objectives. She highlighted a few of its key points, noting that there were no significant changes to the scheme but that there had been some work with partners through the delivering capacity group and key stakeholders to understand the scheme names; it was identified there were a number of existing schemes that were called different things but doing the same thing. The number of schemes had not really reduced, rather they have been amalgamated under some of the BCF plan headings

The board expressed concern about funding for pay award increases being met internally, asking whether this would total to be a significant amount.

The Corporate Director of Adults and Integration was not able to confirm for 2025/26 as she did not have full information for the current year's pay awards approved at this stage.

The board asked about "Move Mates" and the proposed redirection of its resources to other schemes; were these similar in terms of building confidence and promoting exercise outdoors?

The Corporate Director of Adults and Integration clarified that there were no other specific schemes undertaking the same activities as Move Mates, rather there were preventive schemes which the funding was being redirected towards, but given the overall budget had not increased significantly, it had not been possible to commission a significant amount of new services.

The board responded on this point of there being no great uplift in funding, asking whether or not this prompted further concerns.

The Corporate Director of Adults and Integration answered that funding was always a cause for concern and a balancing act, but that a significant amount of work, effort, consultation and engagement had gone into considering/funding each scheme, and continued review and evaluation was required through the year and beyond. It was not possible to source any additional funding for BCF at a national level, and the council had therefore provided significant additional funds over and above this.

The board suggested that there was more potential for Voluntary and Community Sector to get involved in this area.

The board noted that the largest BCF contribution listed on the tables as charity or voluntary sector was that to York Carer Centre Service and associated respite and other services and asked whether this funding all went into voluntary sector or whether these could be entered into two separate lines.

The Chief Executive, York CVS clarified that the Carers Centre receives £400,000 and this was only a fraction of the amount allocated.

The Corporate Director of Adults and Integration said she would clarify this information and follow up with board members after the meeting.

The Health and Wellbeing Board then

Resolved: To review and approve the 2025/26 plan, given its collaborative development and alignment to both BCF and HWBB priorities.

Reason: To keep the Board updated on the Better Care Fund Plan.

47. 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' (5:24pm)

The report was presented by the Director of Public Health. He noted the focus on “healthy life expectancy” versus “life expectancy” and the links to poverty and associated factors in

the York Inner parliamentary constituency. He went on to discuss what causes people in poorer areas to become ill and die earlier and what was being done to meet these residents' needs.

There was a discussion with board members about the statistics.

The board noted the inequality of the poverty/health figures across the city and asked if these statistics and correlations could be shared with ward councillors since they have discretion with regard to ward health spending (eg. areas where loneliness, suicidality and food poverty are a serious issue and cause of early death or a reduction of quality of life).

The Director of Public Health agreed with this, acknowledging that ward action plans existed already but that these could be incorporated or taken into account to change focus or refine strategies or best practices. He suggested he would also take this forward with the Director of Communities.

The board asked when a change in this data was likely to reflect whether commissioned public health schemes were effective and things were improving, noting that it was difficult to measure the success of some schemes (like supervised tooth brushing, which may not show the benefits until years into the future).

The Director of Public Health answered that funding for the schemes on this list was drawn from several different sources; but of those funded by public health some such as the Health Mela offered less immediately tangible progress but were excellent large scale health outreach and word of mouth to 3000 attendees, others such as mailings to get at-risk people to proactively sign up for the hypertension register could show hard statistics of a thousand people added and prescribed blood pressure lowering medication, meaning 17 fewer strokes a year and 6 deaths averted.

The board asked about the take up and effectiveness of the Health Inequalities Education Programme.

The Director of Public Health answered that he thought it had been very effective and he had seen really good changes of practice, and data showed that practices were finding more patients from private communities. Presentations from the

Poverty Truth Commissioners and York Travellers Trust had been undertaken earlier today, and workshops and seminars had allowed professionals to facilitate training.

Resolved: That the board would:

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

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.

48. Update from the York Health and Care Partnership (5:48pm)

The Executive Director of Communications, Marketing and Media Relations, NHS Humber & North Yorkshire Health and Care Partnership Invited the Interim Director of Place, NHS Humber and North Yorkshire Health and Care Partnership to assist her in presenting the item and answering questions.

The Executive Director of Communications, Marketing and Media Relations, NHS Humber & North Yorkshire Health and Care Partnership summarised the minutes of YHCP meetings noting that the children's plan which was draft at the time of being presented to the committee had now been approved by the partnership.

She also noted the restructure regarding the abolition of NHS England and the reform of the Integrated Care Board, due to delays surrounding the pre-election and bank holiday period this was all very new information but she highlighted that Humber and North Yorkshire ICB needed to make a reduction to costs of 47% with a revised allocation for Humber and North Yorkshire ICB of around £35million. The ICB would go back to being more of a strategic commissioner, setting out the strategy to improve population health outcomes and commissioning services and other activities to support this, rather than being involved in the delivery. She added that they would need to submit a plan by the end of May 2025.

The Interim Director of Place, NHS Humber and North Yorkshire Health and Care Partnership explained that the ICB Executive intended to continue to put existing agreements in place because this anchored its intended plans on a local level, even considering the national changes. He said that the report described the ways the ICB sought to go about doing this, and legal teams from the local authority and health had recently finished those documents for York and they were going through the final stages of ICB Executive approval.

The Corporate Director of Adults and Integration emphasised its support for the ICB, noting that taking an effective 50% cut to running costs must be extremely challenging and stating that they wished to support local citizens, particularly those who may be concerned that their healthcare or jobs could be threatened by these changes. Taking £35m from any system and will not lead to things getting better, and this was about mitigation rather than improvement.

The Chief Executive, York CVS noted the appointment of the new acting chair of the ICB, Jason Stamp who was previously the collaborative chair of Humber and North Yorkshire Voluntary, Community and Social Enterprise (VCSE), stating that this was particularly positive news for the voluntary sector.

The Executive Director of Communications, Marketing and Media Relations, NHS Humber & North Yorkshire Health and Care Partnership emphasised that the focus was on driving better outcomes through partnership working, and this would be a fundamental thread moving forward, with an emphasis on improving population health.

The Director of Public Health noted that the national report focused on a number of medical areas, but omitted areas such as social care, integration, and SEND. It would be important to secure these at a local level due to the high local authority overlap.

The Corporate Director of Childrens and Education noted challenges that national safeguarding practice was not standardised and a strong systems practice needed to be maintained. Multi Agency Child Protection teams were presented by challenges by new legislation in Education.

The Manager, Healthwatch York suggested it was concerning that the public were barely getting to know what the role of the ICB was before it was being defunded.

Cllr Webb suggested that the public were primarily focused on getting their appointment, not being educated about ICBs. How are changes communicated with this board? He emphasised that the focus on children in the report was welcome.

Cllr Runciman agreed that while the focus should always be on delivering people's appointments, public promotion of what the ICB could commission was appropriate.

The Executive Director of Communications, Marketing and Media Relations, NHS Humber & North Yorkshire Health and Care Partnership responded that the YCHP were committed to communicating with the board, and there was ambition to set a foundation for a ten year plan which would necessitate a broader conversation with the public.

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.

49. Health and Wellbeing Board Chair's Report (6:18pm)

The Chair summarised the report, stating that due to time constraints, unless there were any further points of discussion she would take the report to have been read by other members of the board.

There were no objections, although the Chair went on to highlight that the roundtable discussion with primary care had meant a gap for pharmacy provision in Clifton had been formally recognised.

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.

50. Healthwatch York Reports: GP Surgeries in York: Accessibility Audit Findings and GP Practice Websites in York: Audit Findings (6:19pm)

The Manager of Healthwatch York presented the board's report, encompassing two Healthwatch reports looking at the results of website and surgery access audits completed by Healthwatch York volunteers.

She stated that this report contained a lot of good news on the accessibility of GP practices and websites. The findings showed that many GP practices have been getting things right; others had responded with enthusiasm and an intention to change based on Healthwatch's findings.

The Director of Public Health asked whether specific recommendations had been fed back to the individual practices that had been audited and the Healthwatch Manager confirmed this was the case, and every single GP practice had received a report specific to their website and to each of their physical sites.

The Chair noted that the feedback concerning the impact of radios on people with hearing impairment was very welcome and drew attention to wider accessibility beyond simply mobility. The Healthwatch Manager responded that attention to this area of accessibility also benefitted neurodiverse individuals, and inexpensive changes such as putting a sign up to prompt those struggling to ask for assistance could also make a difference.

The Corporate Director of Childrens and Education highlighted the recent Ofsted report on the Childrens Social Care service, which was rated outstanding in all areas; he urged board members to seek this out online as it discussed the service's partnership work, including health.

The Health and Wellbeing Board

Resolved: To receive the 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.

Cllr Lucy Steels-Walshaw, Chair
[The meeting started at 4.35 pm and finished at 6.25 pm].

Health and Wellbeing Board 16 July 2025
Report of the Manager, Healthwatch York

Healthwatch York Reports: Women's health: Stories of women's health experiences in York

Summary

1. This report is for the attention of Board members, sharing a Healthwatch York report focused on women's health. The report brings together women's experiences when navigating health and care.

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. We are aware of the work at Integrated Care Board level to improve women's experiences of care through the Women Living Well Longer workstream. Also, as part of our work exploring GP access, we heard a number of concerns relating to women's health. In this report, we bring together feedback from partner organisations alongside the stories women chose to share with us.

Main/Key Issues to be considered

3. Our report's key findings are:

- Women want to be listened to, collectively and individually
- They want improved pathways of support for long term conditions, including:
  - Endometriosis and fibrosis
  - ME / CFS

  - Fibromyalgia
  - POTS
  - Ehlers-Danlos Syndrome
  - Osteoporosis
  - Pre-menstrual dysphoric disorder

- They want better support for menopause, especially early menopause

- They also want a greater focus on women's health after the menopause, considering issues like bone health

- Some are concerned about unhelpful labels and diagnoses, particularly borderline personality disorder, emotionally unstable personality disorder, and paranoid personality disorder

Consultation

4. In producing this report, we reached out to partners including York Disability Rights Forum, local menopause support groups, York Women's Centre and the York branch of the National Osteoporosis Society.

Options

5. We have included a small number of recommendations based on the themes we have identified from the stories shared. We would be happy to add any other recommendations partners identify from their reading of it. The recommendations can be found on page 64.

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, Women's Health: Stories of women's health experiences in York.

ii. Respond to the recommendations made in line with the Health and Wellbeing Board's processes.

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

Contact Details

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

Siân Balsom
Manager
Healthwatch York
01904 621133

Report Approved ☐ **Date** *03.07.25*

Wards Affected: All **All** ✓

For further information please contact the author of the report

Background Papers:
Annex A: Women's health: Stories of women's health experiences in York

Annex A:

Women's Health

Stories of women's health experiences in York

healthwatch York

Contents

Content warning: These stories include references to misogyny, mental ill-health, distress, self-harm, violence, suicidal ideation, birthing experiences, miscarriages, and discrimination. Please only read these when you feel able to.

Key

Blue background = story shared with Healthwatch York

Yellow background = story shared through York Disability Rights Forum (YDRF)

Pink background = concern shared by other partner organisations

Acknowledgements:

Thank you to all the women who shared their stories with us, and allowed us to share them in this report. All names have been changed. Thanks also to our partners including YDRF, York Women's Centre, and the York Branch of the National Osteoporosis Society.

Cover photo by the Reproductive Health Supplies Coalition via unsplash

Executive Summary

This report shares local women's experiences of health and care across the life course. We bring these stories together to try and provide a more complete picture of women's health in York.

Overall, women want to be listened to. Collectively and individually. Many women talked to us about their poor experiences in seeking help for health issues. They want to see improved recognition of, and support pathways for, long term conditions. These include:

- Endometriosis and fibrosis
- ME / CFS
- Fibromyalgia
- POTS
- Ehlers-Danlos Syndrome
- Osteoporosis
- Pre-menstrual dysphoric disorder

Women also shared their concerns about issues relating to menopause, especially early menopause. They reported concerns about dismissive attitudes, and a lack of consistency about the support available. But they also wanted to highlight that women continue to need good health and care support after menopause.

A number of women also raised concerns about 'labelling' mental health diagnoses mainly given to women. Those mentioned include:

- Borderline Personality Disorder (BPD)
- Emotionally Unstable Personality Disorder (EUPD)[1]
- Paranoid Personality Disorder (PPD)

[1] BPD and EUPD are essentially the same diagnosis.

Many people now disagree with these as diagnoses, and point to societal factors underpinning the problems people experience[2]. It is important to note however that some women felt getting a diagnosis was helpful, and validated their experiences.

We are committed to ongoing work with women in the city to further explore the issues they experience in living with long term conditions. We hope others find this report useful in identifying commitments now to improve the future for women in our city and beyond.

[2] E.g. https://www.mind.org.uk/information-support/types-of-mental-health-problems/personality-disorder/why-is-personality-disorder-controversial/

A message from our Chair

Healthwatch exists to be the voice of local people in our health and care system. We wanted to highlight what we have already heard from women across our area. We hope that collecting them together can help inform:

1. The work of Humber and North Yorkshire Health and Care Partnership in developing Women's Health hubs.
2. Action plans following the women's health needs assessment being led by the Public Health team at City of York Council.
3. Work across York and North Yorkshire to improve support for women's health.

This report is a collection of women's stories. They brought to us their experiences, the barriers they face, the good that they encounter and the things they believe would make life better for women.

We were established based on a simple belief – that the best people to help shape health and care services are those that use them. Indeed, we believe sometimes the only power we have to effect change is the power of our life stories. We hope these stories raise awareness of what women encounter throughout their lives, and help shape the work mentioned above to improve their daily experience.

Background

Women make up 51% of the UK population. They generally live longer than men but spend more time in ill health. It is widely accepted that there is not enough focus on health conditions that only impact on women, or how conditions that affect both men and women may present differently and have different outcomes.

National strategy

In 2022, the UK Government published its first strategy focusing on women's health inequalities[3]. The 10-year 'Women's Health Strategy for England' set out commitments to improve the health and wellbeing of women and girls and deliver better health outcomes. The strategy aims to reduce gender-based health inequalities. The priorities identified within it are based on responses to the call for evidence that preceded the new strategy.[4]

In the operational guidance for 2024/25, NHS England set out a requirement for Integrated Care Boards (ICBs) to establish women's health hubs by December 2024. Every ICB received £595,000 to support this work[5] regardless of the population size they serve. This varies from 520,000 to around 3.1 million people. These hubs can be virtual, and do not have to cover the whole ICB area. They must provide two of the core services from the core service specification[6], namely:

- menstrual problems assessment and treatment, including but not limited to care for heavy, painful or irregular menstrual bleeding, and

[3] https://assets.publishing.service.gov.uk/media/6308e552e90e0729e63d39cb/Womens-Health-Strategy-England-web-accessible.pdf
[4] https://www.gov.uk/government/calls-for-evidence/womens-health-strategy-call-for-evidence/outcome/3fa4a313-f7a5-429a-b68d-0eb0be15e696
[5] https://www.england.nhs.uk/long-read/womens-health-hubs/
[6] https://www.gov.uk/government/publications/womens-health-hubs-information-and-guidance/womens-health-hubs-core-specification

care for conditions such as endometriosis and polycystic ovary syndrome
- menopause assessment and treatment
- contraceptive counselling and provision of the full range of contraceptive methods including LARC fitting for both contraceptive and gynaecological purposes (for example, LARC (long acting reversible contraception) for heavy menstrual bleeding and menopause), and LARC removal, and emergency hormonal contraception
- preconception care
- breast pain assessment and care
- pessary fitting and removal
- cervical screening
- screening and treatment for sexually transmitted infections (STIs), and HIV screening

Cervical screening

NHS England set a target to eliminate cervical cancer by 2040, despite declining numbers of women taking up cervical screening over the past 20 years. In 2023-24 Healthwatch England and local Healthwatch, including Healthwatch York, undertook research into the barriers that prevent women completing cervical screening. The key findings were strong support for home testing, with many reporting their concerns about physical discomfort, embarrassment at undressing in front of health professionals, and a belief you don't need screening if not currently sexually active[7].

Maternity experiences

In 2022, the Black Maternity Experiences survey was completed by Five X More[8]. They received responses from 1340 women. This shone a light not just on the indisputable fact Black women experience

[7] https://www.healthwatch.co.uk/report/2024-09-16/cervical-screening-my-way
[8] https://www.nhsbmenetwork.org.uk/wp-content/uploads/2022/05/TheBlackMaternityExperienceReport.pdf

significantly poorer maternal health outcomes, but also the potential causes – racist attitudes, a lack of knowledge and assumptions made about Black mothers – for their negative experiences. More than half reported facing challenges with healthcare professionals, with 43% feeling they were discriminated against. 42% reported the standard of care they received whilst giving birth was poor or very poor. The same number, 42%, felt their safety had been put at risk by professionals either during labour or in the recovery period.

The Care Quality Commission (CQC) completed an annual survey of maternity experiences in 2024. Many people reported positively about their interactions with maternity staff while pregnant[9]. Most of those surveyed (83%) said that their midwives 'always' listened to them, that they were 'always' spoken to in a way they could understand (88%), and they were 'always' treated with respect and dignity (87%). A similarly large proportion of respondents (80%) said they were 'always' involved in decisions about their antenatal care. But the survey responses also highlighted areas where care could be improved. Fourteen per cent of respondents said staff did not do everything they could to help manage pain during labour and birth. Furthermore, a quarter (25%) of respondents felt they did not have the opportunity to ask questions after their baby was born, and only 58% of people surveyed said they were 'always' given the information and explanations needed (compared to 60% in 2023).

Long term conditions and the impact on women

There are many conditions that appear to disproportionately affect women. One such condition is Myalgic Encephalomyelitis (ME), also known as Chronic Fatigue Syndrome (CFS), with women nearly four times more likely to be affected than men. Following a commitment by Sajid Javid in 2022, the Government has developed a cross-party interim delivery plan for improving support for those with ME. The interim plan has a significant focus on education and training for professionals, and a commitment to more research into ME. The creation of the interim plan has been

[9] https://www.cqc.org.uk/publications/surveys/maternity-survey

repeatedly delayed. Despite this recent focus, a study by researchers at Edinburgh University, reported in the Times, found people with ME "felt invisible and ignored" by the NHS, with many struggling to access support[10]. The report also highlighted the significant barriers to getting a diagnosis and ongoing help, as there is no diagnostic test and no cure.

Medical misogyny and reproductive health

In December 2024, a new report by the Women and Equalities Committee[11] (a Parliamentary Committee) warned that "Women experiencing painful reproductive health conditions such as endometriosis, adenomyosis and heavy menstrual bleeding are frequently finding their symptoms 'normalised' and their 'pain dismissed' when seeking help." Their report painted a damning picture of stigma, medical misogyny, poor education, and limited, often painful options for treatment.

These findings were mirrored by the work of academics at the London School of Hygiene and Tropical Medicine, showing almost one in four women have a serious reproductive health issue[12]. The study also highlighted significant racial disparities.

Patient Safety Hub – IUDs and pain

[10] https://archive.ph/56ero

[11] https://committees.parliament.uk/publications/45909/documents/228040/default/

[12] https://www.theguardian.com/society/2025/apr/10/one-in-four-women-england-reproductive-health-issue-survey

Local picture

The Woman of the North report[13], published in 2024, by Health Equity North makes clear the inequalities faced by women in our region. In short, Women in the North of England live shorter lives, work more hours for less pay, are more likely to be an unpaid carer, and more likely to live in poverty than women in other regions of England. Speaking about the report, Professor Kate Pickett OBE said

"This report unpacks some of the wide-ranging challenges women face across many aspects of their lives, and the impact of these on their health. For women in the North, these challenges are often felt more deeply.

We know that much of the inequality we see affecting women in the North is a direct consequence of poverty, which is completely unacceptable in the 6th largest economy in the world. Cuts to welfare and public health funding, the pandemic and the cost-of-living crisis have hit the most deprived communities and the North hardest."

Women's Health Hubs

Through the Women Living Well Longer programme, Humber and North Yorkshire Integrated Care Board (ICB) has been working to establish women's health hubs. Locally, four priorities have been identified:

1. Reducing health inequalities and improving access
2. Creating sustainable services
3. Putting women's voices at the centre
4. Involving the whole health system.

The hubs will focus on delivering improved support to women around:

1. Access to contraception

[13] Woman-of-the-North-report.pdf

2. Menopause care
3. Pelvic health

Perinatal Mental Health

The issue of Mother and Baby Units for women experiencing significant mental health issues following giving birth has a difficult history in the city. There were plans from the 1970s to put a mother and baby unit in Clifton Park Hospital, but the hospital was closed in the 1980s[14]. Bootham Park Hospital had a mother and baby unit, though this was not consistently open[15], until the hospital's sudden closure in September 2015[16]. At the time there was concern about the loss of the mother and baby unit. In 2016, York Press ran an article with the headline "York mum with postnatal depression sent 100 miles from home[17]". There is no unit in the Humber and North Yorkshire area. Our closest units for York are in Leeds, Morpeth, Nottinghamshire and Derbyshire. There has been a national call to increase the number of mother and baby units across the UK[18].

[14] https://archiveshub.jisc.ac.uk/search/archives/21acbffc-3876-3cda-9a0b-a9e4ee1d46c6
[15] https://www.bbc.co.uk/news/uk-england-york-north-yorkshire-17221703
[16] https://www.yorkpress.co.uk/news/13791812.Bootham_Park_Hospital__Anger_and_upset_mount_as_doors_close_today/
[17] https://www.yorkpress.co.uk/news/14234197.york-mum-with-postnatal-depression-sent-100-miles-from-home/
[18] https://maternalmentalhealthalliance.org/campaign/specialist-services/

York stories

Menstrual health

Personal stories: 'Sitting in the toilet to eat' – Beth's story

I had heavy periods from my 11th birthday. I probably went to the doctors about 100 times before I turned 17, and then just overnight I started getting pain every day, not just on my period and I was missing college and missing social events, and 17 is quite a delicate age. So, I remember going to college and sitting in the toilet to eat my lunch because I didn't have any friends. I'm in so much pain I don't know what to do. I went to A&E. I was sent away from A&E a couple of times with just oramorph and expected to take that every day whilst driving and going to college.

Personal stories: 'A familial pattern' - Louise's story

There is a familial pattern. My mum started at a similar early age (10 and I started at 11) and my daughter the same (11). My periods were very regular, often to the day, and very heavy. Mum was really good at sharing her experience, when she first started her period - she thought she was dying as no-one had told her about it.

My experience was horrific. I started wearing a bra in year 5. At school the PE teacher said to us to talk to her, but she wasn't approachable and it would have been obvious what was happening if anyone had talked to her. My period started at school. I just used some paper towel and went home to talk to my mum.

The school lesson about periods happened after my periods had started! I didn't ever ask for help with my heavy periods, I just got on with it.

When I look back, my mum had a difficult time. She did go to the doctor about PMT and I remember her being slightly mad and my dad with his head in his hands. She was referred to a trial in Leeds for starflower and evening primrose oil. She also had a hysterectomy at 44.

My daughter also has very heavy periods. We had talked about it before they started. She went to the GP when she was 13 or 14 (before this I always sent her to school with a wash bag of supplies, just in case. The GP's answer was to go on a low dose pill. This did help, but she stopped at 17 as my daughter felt that her personality had changed.

I think they need to do education for boys as well as girls about periods. My daughter once asked her brother and he thought girls/women bled for a month.

Personal stories: 'It's my choice'– Tierra's story

When I was younger I suffered very heavy periods. Mother did too – it was just something women had to deal with. In my 20s, I basically destroyed an office chair passing a clot. I had to hide it from colleagues. When I told the doctor they were good – they said we should do something about this.

Birth control helped, but some doctors brought their own agenda to this saying things like "You have to bleed sometimes."

I got iron tablets because I was anaemic. Eventually I looked into options – I was refused a hysterectomy at 40 even though I don't want kids and I have mental health issues: having a child could cause psychosis. I get where they are coming from "you might change your mind." But I know my own body and mind and it's my choice.

I started doing my own research into androgen. If there was an androgen imbalance this might cause the issues I have. But when I raised this, no one was interested.

Fertility

Personal stories: 'Completely let down' – Mary's story

I went to the GP earlier this year with symptoms of PCOS (poly cystic ovary syndrome). I was referred quite quickly to York Hospital for scans and tests. The GP confirmed with me that I do have PCOS but wasn't willing to help with symptoms unless I was actively trying for a baby and told me to come back then.

I put in numerous requests to be seen as, due to insulin resistance, I can't lose weight naturally. I need to lose weight in order to go through with IVF. The GP got back to me via no-reply text after an eight week wait to say that they will refer me to Tier 3 Weight Management services. But this referral came back with the GP saying I don't fit any of the criteria that North Yorkshire ICB have set and that they suggest I go to Slimming World instead. But I have already told them this hasn't worked for me.

After looking into things a bit more, I did a self-assessment to Oviva (an NHS weight management program) but again, my GP came back saying I don't fit any ICB criteria and do not have the right to choose. I did get back to my GP asking to clarify how I don't fit ICB criteria as from research, I do and also how I don't have the right to choose. They have stated I will have another eight week wait for a response with this.

Overall, I feel completely let down by my GP, they gave me a diagnosis and basically said to get on with it by myself and won't help me lose weight nor will they allow any other service to help either.

I am at a loss which is affecting my mental health as I can't afford a private endocrinologist and can't move forward with IVF until I lose weight.

I have also struggled to get through to a GP. All the responses I've received have been either no-reply texts or GP receptionists passing on messages. I haven't spoken to a GP since I went to an appointment with my symptoms near the start of the year.

Contraception

That they fit coils in people without numbing, proper pain relief is absolutely barbaric, horrific, cruel and unnecessary.

Personal stories: 'Frustrated' – Tiana's story

My GP told me that they were no longer prescribing contraceptives. They said I should go to a pharmacy. I did that, but at the pharmacy they told me they weren't yet able to prescribe contraceptives. I've got mobility issues so I struggle to get to any pharmacies apart from the ones most local to me. I need to find a solution. I'm really frustrated that my GP stopped this service without making sure my pharmacy was able to prescribe contraceptives.

Personal stories: 'They all said no' – Penny's story

My GP gave me a prescription for contraceptives. I was then told I didn't need to renew the prescription, but could get the medication via my pharmacy. I phoned three pharmacies who all said no, they needed a GP prescription.

Maternity

I had an ectopic pregnancy in July 2021 and ended up in York Hospital. My husband wasn't allowed to be with me and I was in a women's ward with a wide variety of different people. It was an awful experience and I didn't want to go back to that hospital ever again. However, I have since had two children there and they have been very good. I had very good birth experiences.

Personal stories: 'Second opinion' - Rachel's story

I was on methadone when I had my first son, Dylan, two years ago. I was at another appointment at York Hospital when labour started. I was put in a room on the ward and left there. I was in a lot of pain and I'd always planned to have an epidural. But by the time the staff came back to me it was too late for pain relief and my son was born just 18 minutes later.

Every day on the ward they told me I could go home, but that wasn't true as I had to stay in for five days while they monitored Dylan for withdrawal symptoms. He was being monitored regularly and there were no issues.

On the fifth day I went outside for a cigarette, which the nurses suggested and said was fine. While I was outside, the nurses took Dylan for an assessment without telling me. They asked a different doctor who said that he was having issues withdrawing so they were referring him to a specialist team.

My partner and mum were both at the hospital, and they said Dylan was no different. I asked for a second opinion and that second doctor said he was fine and we were all OK to go home.

While I was in hospital I felt that they started giving me my methadone later and later. It puts me off having another baby there. But one good thing was my midwife who was excellent.

Personal stories: 'Too complex' – Fay's story

I have a number of neurological and other issues. When I became pregnant my doctors all discharged me as they said they wouldn't be able to tell which symptoms were to do with my pregnancy and which to do with my long term health conditions. I was very disappointed. I have now chosen to go to James Cook Hospital as they seem a lot better. The different departments seem to talk to each other and the care is much better even though I have further to travel.

Personal stories: 'Indigestion' – Scarlett's story

My experience of pregnancy and giving birth…. I want to start by saying that there are some wonderful midwives. But one or two were not good. I was supported by a newly qualified midwife. I felt that they didn't really know enough to be working on their own. She didn't know the answer to almost all the questions I asked. She was lovely, I'm not criticizing her, but she needed more support at this stage in her career. I had significant pains. I asked about them but was told it was indigestion. After giving birth, the pain continued at which point they diagnosed me with gallstones and removed my gallbladder. My baby was induced. I was in intense pain and asked for medication but I was told I was not in labour and it would be another 12 - 24 hours so there was nothing that could be done. My husband was told to go home. Four hours later my baby was born as the

pains had been labour. I didn't get any pain medication. My husband got back just in time to see our daughter born.

Personal stories: 'A living nightmare' – Willow's story

I would like to complain about maternity services which I can only describe as a living nightmare. Our lovely granddaughter Willow had her baby three weeks ago which should have been the best time of her and her partner's lives but sadly wasn't. Willow had an epidural which went drastically wrong. After days of going backwards and forwards [to maternity] her husband woke to her having seizures (she'd never had one before). She was rushed to hospital where I can only describe the next four days as living hell. No neurologist on site? No scan for days as it was a Bank Holiday? Couldn't have her newborn with her unless family slept at her bedside? Willow ended up on a renal ward as [there was] no bed availability on the correct ward where she was finally diagnosed with a blood clot on her brain which had caused the seizures. ([it was a] problem with the epidural [that] caused this). Even though Willow is now home on heavy duty medication she needs 24 hour supervision. This is not what anyone should endure; our NHS should have the correct staff available at all times. Emergency health problems DO NOT only occur during normal working hours. Why is this happening?

Personal stories: 'I wish they'd listened' – Nikki's story

I have back pain caused by arthritis and a slipped disc. There are some great people at the hospital, who supported me when I was expecting. But not everyone was so great. When I asked one staff member if there was anything that could help with the pain the response I got was "what do you want me to do about it?" I had a planned caesarian. The anesthetist was brilliant and coached me throughout. I was having a spinal block and I made sure that I had told everyone about my back pain. I even brought my medical notes with me. Despite telling everyone, the person who did my spinal block asked "do you have any back problems?" I gave them my notes and everything was fine. But I wish they'd listened to me in the first place rather than asking again. I had some problems breast feeding as my baby wouldn't latch on. When I asked a midwife for help they basically shut me down, saying "what would you do if we weren't here?" and then told me to calm down. I was very upset by this. Thankfully a different midwife came later. She was very understanding, supportive and helpful.

Personal stories: 'Lucky I came in' – Maggie's story

When I had my oldest child, the pregnancy significantly affected my thyroid. After giving birth, my health really struggled. I had awful headaches and more. I went to the GP twice. Both times they were phone appointments with a male GP and both said it was just the situation of being a new mum. I knew that wasn't the case and I was feeling awful. I tried again and spoke to a female GP who recognised what was wrong and referred me to York Hospital. The consultant said that it was lucky that I came in then as I had critical levels of hormones and needed immediate treatment. Other than that, the GP practice has always been excellent.

Personal stories: 'Amazing until….' – Tamsin's story

I had my second daughter [a few] months ago in York Hospital. The experience was good until I went to the postnatal ward. That service needs significant improvement - there was a lack of any support. I had an allocated midwife, but I had to go to the nurses' station as no-one would come if they were needed. We forgot to take cotton wool with us so we asked for some. We were told that, even though the nurses had some, we needed to go and buy it. I was given no information about breast feeding until I was leaving to go home. It also didn't feel like the proper checks were being done and it took six hours longer than needed for us to be discharged. I've heard similar experiences from other mums. It's a shame as the experience on the labour ward and from the community teams was amazing.

Personal stories: 'So impersonal' – Maddie's story

The Badger Notes app is now being used in pregnancy. But the system is so impersonal and black and white - if your pregnancy situation is non-typical it is really stressful to try and use.

I've had two miscarriages in the past year. I found out quite late that I was pregnant. I thought my exhaustion and sickness was down to stress. When I reported this pregnancy in late I had to keep chasing because I knew I hadn't had a booking appointment and so wouldn't be offered a 12 week scan - the cut off for doing that is at 14 weeks. They did squeeze me in but I found I'd already lost the baby by the time I went for that 12 week scan late at 14 weeks.

So I left it on my phone and just didn't ever open it again. I didn't want to log in and face a screen that might be telling me what stage of development the foetus was at for that particular week. There was no advice, information or explanation of what to do next with that app or if

information was updated to offer different advice or stop that tracker continuing when you miscarry. I reported another pregnancy using the link to the Badger Notes app again in February when I got pregnant but used a different email so I wouldn't have to see any of the old information in case it was still there. I then miscarried again quite early. It was before I'd heard from a midwife, so I never had anything more to do with the app that time. The form I had to complete was also not helpful if you've experienced miscarriage. From what I remember it asked if it was your first pregnancy but the answer was Y/N with no option to explain that you hadn't carried to term. I suspect this would be useful information for a clinician as the risk factors are different if you've had children previously.

I've just found out I'm pregnant again, but felt forced to log in to the app as I have run out of alternative email addresses to use. There's no way for me to report a new pregnancy if I'm an existing user. On the page I had to open to try and update my case notes - I've got a 'sorry your baby has died' message.

I popped into the GP practice earlier to get the link and spoke to the receptionist. I explained that I had experienced a miscarriage but now needed to report in a new pregnancy. I did this in case they needed to give me something different. However, it seems to just be a standard link that they give out, they didn't have anything else.

I spent a while on hold this afternoon trying to speak to someone to see if I can report in a pregnancy in a different way, but they couldn't give me a number to contact the midwives directly, or any other alternative. The receptionist has passed the issue on to a GP so I'm waiting on a call back. I'm certain I won't be the only woman who has experienced miscarriages and had these issues with the app. I'm pretty resilient, but did end up crying on the phone to the GP practice when I tried to explain the situation. It feels needlessly distressing and impersonal. Eventually I found out you can contact the midwives direct, the GP practice passed on a number.

Personal stories: 'Over the threshold' - Lara's story

I went for my 40 week scan as I was pregnant. I had some other checks and they noted that my BMI had increased and that I would need to talk to a consultant as it was now over the threshold. I suggested it could be because I was heavily pregnant. The consultant said they had to ask as my BMI was over the threshold.

Personal stories: 'I nearly died' - Quinn's story

Women are called the fairer sex, but when it comes to pain, we are the stronger ones. I nearly died when I was giving birth. They had asked me before about pain relief and I said I wanted a tiered approach. No matter what happened, they stuck to this. So, even when I was clearly dying, they didn't offer me anything different and just waited. I was tachycardic and then brachycardic before they did anything. They were concerned about my son, who hadn't been born, but didn't realise that his vitals were dropping because mine were. In the end they had to do a crash C-section. The pain was horrendous.

I did a subject access request for my notes and it was full of lies and missing information. They didn't include that I had asked for assistance

for a bath (I was covered in blood and viscera after the birth and C-section). They said no one could help, so I'd have to do it myself. I managed, but it took four hours to get a shower. I felt abandoned after I'd given birth. It is as if the medical professionals feel that birth should be painful, so women should just get on with it. When I was having my caesarean they were rushing. So they were only just doing the pin test to see if I was still aware as the surgeon was about to make a cut. I could feel the pin and had to shout to stop them. It was dehumanising.

Personal stories: 'Amazing until….' – Sadie's story

I chose to have an elective caesarean. My pregnancy history was complicated and I was feeling anxious. This felt like the best option for us.

I was in all day waiting and they called me to theatre. A midwife got me ready to go and they cancelled after we'd got to the theatre. I spent 20 minutes outside the theatre in a gown expecting to be called in at any moment (this was late afternoon. I'd been in hospital since 7am and nil by mouth since 10pm the previous day).

If they'd told me it had been cancelled on the ward it wouldn't have been so bad. But I'd asked for an elective because I was so anxious. This obviously did not help a bit! The communication just felt so poor when someone must have changed their mind in a 20-30 minute window and we had an awful, anxious wait.

The wait for the next available c-section slot was long too, from the cancelled one to the next available slot was nine days. So quite a tense week or so of waiting for us.

Midwifery and postnatal care

I have no idea who I can speak to. The second appointment [was] on video. The call lasted five minutes maximum

Personal stories: 'Concern identified but ignored' – Zoe's story

When my baby was born, the midwife said he had a mild tongue tie and this should be checked at the six week check. That was with a GP and I mentioned the concern, but the GP said it was fine and didn't need anything more.

However, I realised that it wasn't right and went private to get advice. They said that it was a tongue tie which was affecting my son's eating and his neck. They said he needs a minor operation. I went back to the GP, but they said that York Hospital wouldn't do it as my son was now 11 weeks old. They were going to refer us to Leeds but it would take time. My in-laws offered to pay so we're going private.

It is really frustrating and shows that the GPs need a lot more training. This is something that should have been picked up and dealt with, especially after the mid wife had mentioned it, but it seems that GPs don't know what to look for.

Personal stories: ‘Failing to thrive’ – Chrissie’s story

I had lots of problems just after my son was born and for the first years of his life (he is now 18 months old). I had problems breast feeding and no one was helpful either on the post-partum ward or when I was home. They didn't seem to have the training that meant they could help. The baby had his new born tests but they didn't identify anything. However, the baby wasn't feeding and was losing weight and I was told he was experiencing a 'failure to thrive'.

We were so worried that we chose to use our savings to go private. The person we saw identified he was tongue tied and arranged an operation and treatment, including things we had to do at home, which made all the difference.

I know the staff at the hospital and was disappointed that they hadn't spotted the issue after he was born. They said that it can be difficult to identify a baby is tongue tied, but the staff should have had the training to identify that that was the problem.

There really needs to be more and better training for maternity staff about a child being tongue tied, but also about what to look for, including that, if a child isn't feeding. I was really keen to pursue breast feeding and I was able to later, but a lot of new mothers I spoke to just gave up. But better support would make all the difference. I also needed support from the perinatal mental health team. When I saw them they were really helpful, but I had to wait for eight months for psychological support and was only able to have support until my son was 12 months old, which limited the help I got. It would be better if you could get support earlier.

Perinatal Mental Health

Birth trauma is very real but it feels there is an underlying culture that 'we have all been through it', 'women have been doing this for years'. This is completely true but that should not diminish the fact that each person's experience is very personal and unique to them.

Personal stories: 'Untethered' – Sophie's story

I'm neurodivergent and have experienced poor mental health in the past. I was also still grieving the death of my mother when I found out I was pregnant. So I was under the perinatal mental health team throughout my pregnancy.

I had a planned caesarean in the summer, at the same time as a major stomach operation. This gave me a huge scar from one side of my pelvis to the other. They removed 6lb of old skin that would not have been able to heal after my caesarean.

I was in York hospital for six days. I was given opioids and tramadol in hospital to keep me comfortable. I was discharged with tramadol but without opioids as I was breastfeeding.

When I got home, I couldn't switch off. I was awake without sleep for three days. I slipped into psychosis on the evening of my third sleepless night. I wasn't eating or sleeping. I locked myself in the bathroom, and then lost control of my body and couldn't reopen the door. So I had no access to medication. The Crisis Team initially came and left because I was locked in the bathroom. They came back once the door was opened.

The Crisis Team gave me diazepam to calm me down. It didn't work. I know now that diazepam is known to react badly with tramadol. When it didn't work they gave me more. I reacted really badly to the second dose – I've never done drugs but when people talk about "being off your head" or "being high", well, that's what happened to me with dose two of diazepam. I completely lost it. I was wild. I hit and bit my husband. I'm not a violent person, but I simply wasn't myself. I firmly believe I had a paradoxical reaction to the diazepam. At this point, I was sectioned.

I was taken to Foss Park and given haloperidol. This finally let me sleep. I woke up in Ebor ward the next day after 13 hours of sleep. I had very little with me – I woke up virtually naked wrapped in a dress and a blanket. I knew I'd had a baby but I didn't even have a picture of her with me. People kept asking me what she looked like and I genuinely couldn't tell them which was distressing. I also didn't have a breast pump. My husband brought some of my things, but they were locked in the office and for the first couple of days I wasn't given them. I did ask, but there were lots of delays.

I started to develop mastitis – my milk was getting blocked. I raised it with staff, and was told "we don't normally handle postpartum psychosis; it's usually done in the community." A fellow patient, seeing how distressing and uncomfortable this was, took me into my room and cried out "feed me, feed me, I'm a baby, wah wah" to help me express my milk by hand massage. It was surreal, but it actually really helped, and I am so grateful to her.

I saw the perinatal mental health doctor, who talked to me about medications and about changing my bandages. But no one talked to me about the situation I was in – having just had a baby and being separated from her, my older child and my husband. It was so hard being separated from everyone. I finally got my photos of my baby and family on my third day on the ward. At a point where I desperately needed anchoring I felt untethered without these vital possessions.

On the fourth day after admission I finally saw my family again, but only briefly, before I was transferred out of area. We don't have a mother and baby unit in York and Leeds, an eight-bed unit, was already full. So late in the evening of that fourth day I was transferred by ambulance to the six-bed unit in Morpeth, 110 miles away from my family. I asked for an Independent Mental Health Advocate (IMHA) but there wasn't time.

In Foss Park staff were nice and well-meaning but there weren't processes and procedures or care pathways for breastfeeding mums. By the time I was able to be with my baby again my milk had already started drying up. I was still unwell. I was still struggling with holding because of my scar. This may all have happened anyway but I believe it was because I spent most of a week without my baby and without breastfeeding help.

The care at Morpeth was great, but it is such a long way away. My husband had to take a week's unpaid leave to be with me. He also spent over £700 on petrol, hotels and meals which all had to go on a credit card. They involved him in conversations about my care, but he felt like there weren't really any good options for hospitalised women with post-partum psychosis.

The reality is there are simply not enough mother and baby units. I should have been in Bootham, not transported miles away. Morpeth was outstanding, a purpose-built unit with great staff and facilities. York could have some really great support options around a women's wellbeing hub if something like it was built here.

My husband hasn't been well – he's been through this ordeal with me and is exhausted and traumatised. He was referred for a carer's assessment which happened in July but we haven't had any practical help yet. There's still a lot I can't do which has made all this even harder. I worry for him carrying so much.

Personal stories: 'Lost in the system' – Lydia's story

I was suffering from post-natal depression and my GP had referred me to the Community Mental Health Team (CMHT). I was told to expect them to make contact within two weeks. Eight months later my GP called me to see how I was getting on with CMHT but I hadn't heard from them. I later had a telephone consultation and they said I needed to be referred to IAPT (Improving Access to Psychological Therapies). I then didn't hear from IAPT and assumed I had just got lost in the system. Fourteen months later out of the blue I received a call from them asking if I had received any care.

Menopause and perimenopause

I've had to pay a private GP for some worthwhile menopause advice.

Personal stories: 'Full ovarian failure' – Gemma's story

I never had a problem with periods, but I did start when I was 11. I had no idea what was going on as no-one had ever told me about them.

Since I had my son, Archie, aged 19, I've had anxiety and I've often felt flustered and uncomfortable. I've never known why or what triggered these feelings.

When I was 31 my periods stopped. I went to the GP about it and they asked if I could be pregnant. I knew I wasn't but they didn't listen and did nothing.

Six months later, still no periods, a GP sent me for a blood test. This showed 'full ovarian failure'. A receptionist had to tell me this and she apologised for the brutal medical language. The same GP asked about my symptoms, but they said I was too young for HRT as it would increase my risks of breast cancer. So they prescribed me the combined pill.

I took that for two years and then went for a review to a pharmacist. The pharmacist told me I should have had two blood tests originally to check my hormone levels. She also said that I should be on HRT as the rules had changed so younger people were OK to take it.

I was still experiencing a lot of symptoms. But to be prescribed HRT, the pharmacist said I'd need to stop taking the pill for four weeks. I'd then

have another blood test to check hormone levels before starting on HRT. This was the worst month of my life. The pill had helped with my symptoms. I didn't have that, and it was August and there were two very hot spells that month. I was having hot flushes all day every day.

When I had the blood test it showed that my hormone levels were even lower. I was prescribed the HRT patch and progesterone. The patches were supposed to be waterproof and sweatproof but they weren't.

The new treatment did help. But by this time I didn't know what normal was. Maybe I've been perimenopausal since my early 20s.

For the progesterone, the doctors tried to encourage me to have a coil. But I was adamant that's not what I want. Eventually I found out that I could have it as tablets daily. I also changed to have oestrogen gel twice, once in the morning and once at night.

At this point I was still bleeding and didn't know why. From the day that I started the new treatment I bled for 28 days continually and then every other week for a week for a year.

I let my GP know about this and they referred me to an endocrinologist and a gynaecologist. The subsequent scans and tests ruled out a lot but never explained why this was happening.

It is only in the last six to eight months that the bleeding has stopped.

I still have symptoms, but it is much better. However if I forget to use the gel, my symptoms increase a few days later.

When I look back, my symptoms were awful. The intense hot flushes I had felt almost like panic attacks. I don't know how I coped in the hot August, I just remember having a glass full of ice in my hand at all times and a neck fan which was essential. My head was full of cotton wool and I constantly panicked that I would forget important information. I struggled to sleep and always felt lost.

No one has talked to me about what happens in the future. For now I'm on both progesterone and the HRT gel and these are reviewed every six months. I've now seen the menopause specialist at the GP. This has been good and helpful, but overall I feel that GPs don't understand. I don't think I can be the only person who has had early menopause, but that's how it feels.

I think there needs to be more information and discussion about perimenopause. I also think different language to talk about things would help. Full ovarian failure is a very brutal thing to hear.

A lot of my symptoms were put down to something else. If I hadn't had that medication review with a pharmacist I might still be on the combined pill and struggling. Whenever I have a medication review with a male doctor, they ask why I am taking the progeterone and oestrogen. I guess it is because of my age, but there is no other reason than menopause to take the medication so it is a strange question. Female doctors never ask.

One thing I'd like to see change is that women are listened to and all their symptoms taken seriously. You can be in perimenopause or menopause and still have anxiety or depression.

Personal stories: 'No holistic care' - Angie's story

At the same time [as trying to get an ADHD diagnosis] I was experiencing the peri-menopause and my symptoms got a lot worse. I could not cope with the combination.

I went to the GP and was put on HRT with no checks at all. I was told if the HRT didn't work, they'd review it in a year.

The first HRT didn't work and within two months I asked for a review. They said no. They also said they wouldn't refer me to the menopause clinic as

it was closing and they weren't taking any new referrals. I couldn't find any information about that.

I rang the menopause clinic to ask how to get a referral when a GP was refusing and they got me an appointment for the next week. I saw someone in October, had bloods done and they talked about increasing the HRT dose and then reviewing in December.

In January I went back to the menopause clinic, but I didn't see the same person. Instead, I saw a GP from [person's original GP practice]. I had monitored my symptoms via an app and took the report, but they refused to look at it.

They said I needed a Mirena Coil, but I don't want one. The previous person I saw had mentioned HRT with more testosterone, which I wanted to try. The GP person said that they would refer me for a coil and for testosterone-based HRT.

In December I had very bad diarrhoea and bad abdominal pain for seven weeks. I eventually went to the GP. I was sent to [GP surgery] and saw a Primary Care Practitioner who was very good. They listened did some tests and followed up. They sent me for a CT scan and referred me to the consultant. I spoke to the consultant on the phone who was lovely.

I had also gone back to the GP to say I didn't want a Mirena Coil. They also referred me for an ultrasound which found I had fibroids. As a result, the GP said they wanted gynaecology advice and made an urgent referral. However, urgent referrals at York Hospital are taking a minimum of five to six weeks.

I then had to go back to the GP as I had bad abdominal pain and bleeding. They arranged for the consultant to ring me. When they did, they had no record of the ultrasound. There is no holistic care between GP and hospital.

The GP doesn't understand the issues I am facing. Doesn't recognise I had an NHS ADHD diagnosis and the impact of menopause on ADHD symptoms.

I am thinking about changing GP, but don't want to do anything until the other health issues are sorted out.

Personal stories: 'Almost written myself off' – Jodie's story

I hadn't heard of the peri menopause until a social group I'm part of were talking about menopause. One person lent me a book about it which was really useful.

So then I talked to my mum about her experiences. I found out that she started peri menopause at a similar age to me which was also useful to know.

I was first aware of symptoms when I was around 39 or 40. I'd just got a new job at a call centre. It was more restrictive about what I could do when, including going to the toilet, as I was answering calls.

Not long after starting work there I had a series of urinary tract infections (UTIs) every few months - I later realised this was an early sign of the peri menopause.

A year later I started with night sweats. I woke every morning drenched and feeling awful.

I went to my GP but they said at 42 I was too young for menopause. One GP suggested taking meno-herbs. I was sceptical but I tried them and after six months the night sweats were gone.

When I went to Boots to get more meno-herbs the pharmacist explained I could only take them for six months. So I stopped and despite my worries, the night sweats didn't return.

Six months later I had more symptoms including feeling exhausted. I often had to sleep during the day at the weekend. My job was going well, but I was struggling to be awake and yawning a lot. I also had aches and pains all over and felt awful.

I went back to the GP and luckily this time I saw a doctor I'd known when he was training and I worked with him in a health role. He was very empathetic and listened as I listed out my 19 different symptoms. He ordered a blood test and after getting the results referred me to a female doctor. She said the blood tests didn't really tell her anything, but she wanted to focus on my symptoms which indicated menopause. So she talked to me about starting HRT. I'd done some research and I knew the gel was getting better reviews than patches so I asked for that.

This doctor was newly qualified, clued up and more willing to listen to me. I was grateful, but also very frustrated that it took two years of symptoms and feeling awful to get taken seriously and have a GP actually listen to me.

During those two years my self-esteem fell significantly. I gained weight as I didn't feel able to exercise because I felt so awful and exhausted. In all honesty I had almost written myself off, feeling about 100 years old, with only enough energy to go to work and see family.

I felt unattractive, my moods were all over the place. I was starting to struggle with losing words which was very difficult given that my job involved talking all day. My calls got longer as I had to find work rounds when I couldn't recall a word. This led to me feeling overwhelmed and panicky. I even started to wonder if I could only work part time from now on. I just felt utterly miserable.

I only got through those two years as other women recommended things that helped. This included a herbal treatment that helped with my UTIs.

After taking HRT, I feel like I have got my life ahead of me again. My memory is better, I have more energy and I simply feel a lot better. I have started running again and I've lost weight.

On talking with my new GP, I raised my UTIs, and the GP suggested a pessary which has helped.

The one issue with the HRT is that every time I need to reorder, usually every three months, I have to have a blood pressure check and be weighed. I don't know why this is, no one has ever explained. For my pill prescription I have a blood pressure check every year so I wonder why it isn't the same for HRT. For HRT this means a quarterly trip to the GP to get my blood pressure and weight done which isn't always convenient.

I would like to see changes because no-one else should have to go through the years of misery I had. I want GPs to improve and listen to patients. They need to take time to listen to people's symptoms and not simply dismiss them as being too young when there is clearly something wrong. The symptoms are key, not someone's age.

Personal stories: 'Dismissed before private care' – Daria's story

I had a variety of symptoms but wasn't sure what it could be. My main feeling was simply that I didn't feel myself. When I went to the GP, they asked me what I thought it was. I said I didn't know and that's why I was here. I felt dismissed by the GP I saw because of my age as they didn't think it could be perimenopause.

I didn't feel listened too. So I went to Nuffield privately. Here, they did listen. I was told by the female medical professional that I saw that I didn't have to put up with my symptoms.

I was waking up with soaking sheets. I'd even taken a photo to share to explain what was happening. I also had anxiety and depression.

I was referred to the gynaecology team at York Hospital and I am now on HRT.

Personal stories: 'I burst into tears' – Mel's story

My symptoms included brain fog. One day while driving I couldn't remember which side of the road I should be on. When I went to my GP, they wanted to put me on antidepressants. But I'd only just managed to get myself off those and I didn't want to start again. One of the reasons my GP thought it was depression was that when they told me I could only talk about one symptom, I burst into tears.

I went home and thought I'll just have to deal with everything on my own. And for the next five years that's what I did. I used diet and exercise to help with my symptoms.

Eventually I got referred to the menopause specialist GP at the women's centre. I was tearful and got talked into taking some anti-depressants. But my joints inflamed and so I stopped. Finally the GP suggested HRT. These have helped but by this time I hadn't had a period for 18 months so I don't know if was just time or the HRT that helped.

I would like to see GPs offering more options to talk to a GP about physical and mental health and have more mental health specialists in primary care. I also feel that women should see women GPs as you need to talk to someone who understands the issues you are facing when they are specific to women. You should always be able to ask to see a woman GP.

Personal stories: 'Misinformed on three occasions' – Grace's story

I have found it difficult to see a GP and particularly hard to get good advice on menopause. I have spoken to three different people and was misinformed on three occasions. Thankfully I had done some research in advance so I knew what I needed. But it is a gamble to get a good GP now.

Personal stories: 'Too young' – Caroline's story

I had an issue and rang the GP practice in tears. The receptionist just said I had to fill out a form. I feel that I am peri-menopausal as I have the right symptoms. I have tried to contact my GP practice five times and the only response I have had is that I am too young. Another time I was offered depression medication - this without being seen or listened to. Instead I asked my breast nurse (who I know due to a previous cancer diagnosis). She arranged a blood test which showed I am in fact peri-menopausal. But I still can't get any feedback from my GP...

Personal stories: 'It can't be menopause' – Jude's story

I have been back and forth to my GP for three years. My periods have been out of sync and I've had other symptoms. I initially waited for six months and tracked my symptoms on an app.

When I got to see a doctor, they said I was too young for the peri-menopause (I was 38) but they did say they would do blood and hormone tests. As part of the test results, they discovered I am coeliac (as I mentioned being tired.) So after that they put all my other symptoms down to that. But that is not the case.

They have referred me for an endoscopy, then to see the dietitian (18 months wait for an appointment) and to see the consultant (six month wait after the endoscopy). I have had a number of letters for my endoscopy but each time I then get a letter cancelling it.

The treatment for coeliac disease hasn't helped any of my other symptoms. They are not to do with this.

So I went back to my GP with the same symptoms, this took nine – 12 months. It was similar to the first appointment (with a different person) where they did tests and these came back normal, so nothing else happened. But my symptoms are still there and particularly brain fog, periods all over the place, low libido, fatigue... As I didn't mention hot flushes they said it can't be menopause.

I contacted the GP again for an appointment and was given an appointment on [day] by text. I rang to change the appointment as I was away. But every time I rang I got a message saying 'we are experiencing a high level of calls, ring back later'. I did, but the message was the same. I did get through, initially they couldn't find the appointment, but then cancelled it. But they didn't seem to then rearrange it, which is what I wanted. I kept calling and was told a clinician will call you on a particular day in the morning. But that doesn't work for me. I have three children

and could be busy with school drop off. I tried to call back, but couldn't get through and you can't reply to a text message.

Once I spoke to someone they did the same tests again and they came back normal. But this time they did refer me to the menopause clinic. I am going soon.

Personal stories: 'A long wait to change HRT' – Harlow's story

I spoke to the doctor a couple of months ago about reviewing the HRT I am taking and possibly trying something new as I am still struggling. I had a blood test and had to then make another appointment, waiting eight weeks, to discuss changing my HRT. That is a long time.

Now I am on HRT I have to get bloods done every three months and have to arrange an appointment which isn't easy. I am losing faith and don't believe I will ever see anyone.

Personal stories: 'Management of conditions is inconsistent' – Tess's story

I have a number of health conditions including a heart problem, Crohn's disease, arthritis, a stoma and menopause.

If I mention palpitations related to menopause as a symptom, the online form immediately tells me to ring NHS 111. I have a heart problem, so I know what is urgent and what isn't.

Before Covid the GP was very good at helping me manage my conditions, but now it is inconsistent. I have to continually repeat myself to different doctors and I am worried I will end up in hospital as things are no longer well managed. Now they send me a questionnaire about my health, rather than talk to me. It is just a tick box. It doesn't feel like they are interested.

My consultants send letters to my GP, but the GPs don't do anything about them. The consultant said I need HRT medication on repeat prescription but I don't get this. I have to order it and can only order a week in advance. Then I have to try and find a chemist that is stocking it due to the shortages. Boots website is very good at telling you what is available where.

The GPs never look at my notes, so I have to spend most of the appointment telling them things they should know. I often have to book double appointments. Thankfully I usually can do that.

If I want an appointment with a nurse, I can go into the practice to book that. But if I want to see a GP, I have to fill out a form. If I try to book an appointment in the GP practice, they just tell me to go to the practice computer and fill out a form. The forms are not helpful. My issues don't fit. It feels like they don't want people with complex issues.

I have had a stoma for 17 years and now they are asking me if I need all the things associated. Yes I do. I know what I need.

If I ever go to A&E, they just think I am going for painkillers. If I think I need to be admitted to hospital, I talk to my specialist nurses and try and avoid going via A&E

Personal stories: 'Telephone appointment not always appropriate' – Isabella's story

[My GP is] OK and when you see someone it has been good and they seem on the ball. They are good with vaccines. However, you can only get a telephone appointment, which isn't always appropriate especially when you want to talk about the menopause.

The online form is no help for menopause. You can tick lots of symptoms but there is no option that says menopause. Then if things aren't urgent, the option is a phone appointment in six weeks.

They need to tailor the form and have a menopause option from the beginning.

Personal stories: 'Despite our family history' - Rebecca's story

My sister is in the peri-menopause. She has no medication as the GPs say she is too young. She was given anti-depressants despite having a blood test and it showing peri-menopause and our family having a history of early menopause. She is still fighting for HRT after two or three years.

Cancer screenings and care

Personal stories: 'Made to feel vulnerable' – Rosie's story

I had a smear test done by a nurse who made me feel incredibly uncomfortable, silly and vulnerable. There was no consideration for dignity (being asked to get ready without explaining what get ready means, not closing the curtains around the bed or providing anything to cover myself with as is usual practice).

Personal stories: 'Wonderful nurse' – Donna's story

I went for a cervical smear. The nurse was wonderful. She put me at my ease and made a procedure which could be embarrassing and painful, very straightforward and easy. I cannot praise her highly enough. She is exceptional.

Personal stories: 'It's not 'routine' for me' – Fi's story

I am autistic and need time to process. I find accessing any healthcare distressing. It would be better if I had a relationship with someone and if there was some acknowledgement that this is a procedure [cervical smear] that causes distress.

Personal stories: 'Excellent' – Ava's story

I am a wheelchair user and went to the Magnolia Centre for a mammogram. They were excellent and very helpful.

Personal stories: 'Impossible' – Hannah's story

I work at York hospital and I have really struggled to book a smear test at my GP. I can only book online two weeks in advance but my work pattern means I can't book at that short notice. I need to book it in at least a month in advance. That means I can then change my shifts to make sure I can attend. But this isn't possible. So I've missed the date when I should have gone. In the current circumstances I just can't see a way to get it done. I raised a concern with my GP but they said that is the process. There should be another way.

Personal stories: 'Superb' – Leonie's story

I found a lump in my breast during lockdown. I rang the GP, was first in the queue and had an appointment within two hours. When I got home, I had a message with an appointment at the hospital within two weeks. I was diagnosed at that appointment, had a biopsy and a week later they confirmed the results. Two weeks after that I had surgery and then chemotherapy every week for 14 weeks. Everyone was superb, the nurses were kind, supportive and really great.

Personal stories: 'Waits too long, care is excellent – Lila's story

I have recently been diagnosed with breast cancer. I think that the waits during the diagnosis, for additional scans, were too long for me, but the support and treatment from the Magnolia Centre has been excellent. They are clear, do what they say they will and follow up.

Personal stories: 'I froze' - Gabriella's story

I had a cervical smear which they wanted to investigate further. I had a colposcopy and had some cells removed. I find anything gynaecological triggering as I had a traumatic birth with both my children. An ex-nurse friend went with me to the appointments. Six months later I had to go for another smear at the sexual health clinic. The nurse invited me into a room and there was a male healthcare professional there. I froze. I asked why he was there and they said the usual person was ill so he was going to do the smear. I said no and dashed out as I couldn't cope. I complained to PALS and they apologised and said it shouldn't have happened and I should have been warned it was a man. The nurse also apologised and said that she would do my smear from then on.

Personal stories: 'Kind and empathetic' - Dinah's story

I has a very positive experience with a smear. They asked for consent at every step. My wife was there as I have a hospital phobia. The staff were all women and eased me through it. They were kind and empathetic at every stage.

Gynaecology

I was on a waiting list for gynaecology and my (postponed) appointment was cancelled with two days' notice no reason why and I still have symptoms. Nobody seems at all interested.

Personal stories: 'They know their stuff' – Barbara's story

I was eventually referred to gynaecology by my GP practice. The service at York Hospital is very good. They are always on time, they know their stuff and couldn't be more helpful. It is a very good service.

Personal stories: 'All lovely' – Georgia's story

I came in as an emergency and was referred to gynaecology. The staff there were brilliant. I was seen promptly and they were all lovely and provided excellent care.

Personal stories: 'Warm, friendly, efficient and kind' – Ruth's story

I had a good experience of planned care with the gynaecology department. The appointment booking was brilliant - I kept having to rearrange things but the hospital accepted this and offered me alternative dates. My care was excellent, the staff were all lovely - warm, friendly, efficient and kind.

Personal stories: ‘My partner could have died’ – Rob’s story

My partner came in for a standard procedure yesterday. She had a local anaesthetic to have a centimetre of her cervix removed as a day patient. They took a bigger area, but said she was OK to go home later the same day even though she was still bleeding. They said the wound had been cauterised so it was fine to go home. But an hour later she was bleeding extremely heavily at home and we had to bring her back to A&E.

It took them three hours to stop the bleeding and in A&E the doctors didn't know that the procedure had happened - either it wasn't on my partner’s notes or they couldn't access the notes. I had to explain what had happened.

Yesterday the medical team accepted that the procedure had led to the bleed and my partner could have died. But today they are just saying it can happen and seem to be covering up what actually happened. It was a horrific experience for everyone, including my partner’s children who thought their mum was going to die.

Endometriosis

Personal stories: 'Felt pressured' - Kate's story

I had a bad experience with the gynaecologist. They ignored that I needed support. I was diagnosed with endometriosis outside of York but ignored in York. I felt I wasn't listened to by the doctor. I had to tell them five times that I was on my period and felt pressured into participating in a physical exam

Personal stories: 'Even the GP was frustrated' - Natasha's story

I saw a GP about some symptoms. They were good and said that they thought it was endometriosis. But even with that it took me three years to get diagnosed. The GP referred me to gynaecology, but they refused the referral and said to see the MSK team. They did diagnose osteitis, so it was useful to see them. They then sent me to a physio who misdiagnosed me with sacrioliitis and gave me exercises for that as well as offering two physio sessions and a referral to a gym. I was referred back to MSK again who referred me back to gynaecology to get an endometriosis diagnosis. Even the GP was frustrated with all this. It seems such a waste of time and money and incredibly inefficient. That said, it took my sister seven years to be diagnosed with endometriosis.

Personal stories: ‘Shaking due to stress’ - Ellie‘s story

I have endometriosis and was trying to find a birth control that would work, but I have vaginismus so it is difficult and I couldn’t have the pill. The only thing they could suggest was the coil. I suggested I would need to go to the hospital to have it fitted, but the GP practice said they could do it. I went to the appointment with my carer and they spotted my stomach muscles shaking due to the stress. It got so bad, my carer had to tell them to stop. They said they could try again another time, but for me to take paracetamol first. It was awful, they never mentioned consent. When I got to the hospital, the nurse asked me about consent at every step.

Long term conditions

Most GPs do not seem to understand or care about illnesses such as ME and fibromyalgia.

Personal stories: 'I'm frightened' – Immy's story

I was diagnosed with hEDS (hypermobile Ehlers-Danlos syndrome[19]) in April 2024. I have been struggling for over a decade. But Leeds Teaching Hospitals Trust Rheumatology department has recently decided not to support and treat patients with hypermobility disorders. My GP told me this just this week. There are no specialists. GPs say 'I don't know anything about hEDS, you need to see someone who does' but there's no one to refer us to. The doctor who diagnosed me has left. I'm in pain every day, I struggle with fatigue every day and no one knows what to do.

I'm researching it all myself and figuring it out on my own with charity help but when I go back to the NHS with the information given to me they still don't know what to do.

I'm frightened , I can't work full time, I can't get benefits, I'm struggling with my mobility. When it's very bad I'm housebound. I have MCAS (Mast Cell Activation Syndrome[20]) symptoms and was hospitalised last year but Leeds Teaching Hospital Trust says MCAS is 'too controversial' so they won't help. They still do not know what happened to me last year. I was incapacitated for six months. No one understands my health condition and I'd be homeless by now without my partner and family.

[19] https://www.nhs.uk/conditions/ehlers-danlos-syndromes/
[20] https://www.potsuk.org/about-pots/associated-conditions/mcas/

Personal stories: 'I thought they could be linked' – Thea's story

I contacted my local surgery about a women's health issue in summer 2024. I was given an in-person appointment with a women's health doctor which I was grateful for. She's been very supportive over the past few months. However, no mention was made of my chronic illness or mental ill health even though I thought they could be linked. I ended up having to see two different doctors over a number of months for separate symptoms.

Personal stories: 'Inadequate care for ME/CFS' – Jenny's story

There is inadequate specialist care for people with ME/CFS and little understanding on behalf of GPs. The NICE guidelines were updated in Oct 2021, but GPs are not educated about the condition (or worse still have unfounded and inaccurate assumptions that ME is psychological illness). In fact dismissal by HCPs is a key point mentioned in the NICE guidelines.

The Yorkshire Fatigue Clinic is staffed by OTs and offers only guidance for pacing. It conducts no tests and has no specialist physicians to investigate or provide care related to the many physiological aspects of the illness. The Yorkshire Fatigue clinic does not accept self-referrals and was reduced in size this year on the retirement of its clinical lead, thus reducing patient access. GPs have no specialists that they can refer people with ME to for further investigations and offer very limited care options. There are no specialists to whom I can go to get informed views about symptomatic treatment of my illness.

This is a highly debilitating illness, but there are some symptomatic treatment options that could be tried if one had access to a supportive and knowledgeable physician but there are none. The NICE guidance calls for specialist multidisciplinary teams and for patients to have care plans and annual reviews, but this just isn't happening! I have asked all three local GP practices and there are no GPs with special interest in this disease.

Personal stories: 'Disappointed, alone and afraid' - Yasmin's story

I've had problems walking for nearly five years, so my doctor referred me to the neurologist at York Hospital (I've been told there's only one). I waited 15 months then managed to get a last-minute appointment in March.

I explained my mobility issues to the neurologist, as well as the leg pain and cognitive issues, and was asked to do some physical activities, like hopping on the spot. I was told my brain and spine were fine, and to use graded exercise to improve my walking (with no mention of the other issues), in what I felt to be quite a patronising manner (I'm sure they would have spoken to an older male patient differently).

I've tried so hard to exercise more but it leaves me exhausted and in more pain (in fact, I've read in ME books and online that graded exercise shouldn't be used). I felt unable to reply to the neurologist, and left feeling very disappointed, alone, and afraid.

I know ME is a difficult condition to treat, and I'm not expecting a cure, but it would be nice if medical experts took it more seriously. It worries me to think there are other ME patients on the waiting list for the neurologist who will likewise leave disappointed.

Personal stories: 'Worried about waiting times' – Kai's story

I have a prolapse. I need my pessary replacing every six months. This procedure needs to be done at the hospital. Waiting times vary; for York it's 15 months, Selby eight months and Harrogate four months. I opted for Harrogate not knowing that by doing that, I will always have to go to Harrogate for the pessary replacement. I didn't want to do this forever and I have managed to get back on the York list, but I am worried about the waiting times which mean the pessary won't be replaced as regularly as required. I wonder why a GP can't do this instead?

Concerns about osteoporosis care

Representatives from the York branch of the National Osteoporosis Society raised concerns about osteoporosis care. They are hearing from members across York that GPs are not following protocols in osteoporosis care. They are concerned that people are being kept on treatments for too long. For example they are aware of people being on Alendronic Acid for far longer than the recommended five years. They also flagged concerns about the lack of a fracture liaison service in the city. They believe there is significant need for this service that would help to support people and prevent future fractures. However, a previous service in York stopped due to a lack of funding. Prior to Covid, some GP practices had an osteoperosis lead, but this also seems to have been lost.

Concerns shared with Healthwatch York.

Personal stories: ‘Never taken a break’ – Lucy’s story

I’ve been taking Alendronic Acid, for osteoporosis, since 2009 and have never taken a break from it. When I recently saw a specialist they were surprised I was still on the medication. They told me I was one of three people they’ve seen that have taken the medication for this long. I should have had regular reviews for the medication and had breaks from the medication. But my GP has never been in touch to arrange a review - they have continued to prescribe the medication on a regular basis. As a result of taking the medication for such a long time, the specialist told me that other treatments may not be open to me if a test I’m due shows that my osteoporosis has developed further. My daughter also has osteoporosis, but she lives in West Yorkshire. She has received annual medication checks and was advised to have breaks from taking Alendronic Acid.

Personal stories: ‘Lazy’ - Diana‘s story

I have MS and first went to the GP with symptoms of fatigue. I was told I was lazy and had to do more exercise.

Personal stories: ‘Dismissed’ - Kitty‘s story

My wife had an issue with fatigue and was dismissed by the doctors. She was feeling tired even after 10 hours of sleep. She had blood tests and was referred to the eye clinic (but didn’t know why). They then referred her to the diabetes nurse without explanation and she was diagnosed as having type 2 diabetes. She is not at all overweight. However, the GP explained the next steps to her about losing weight etc. It was later that they said that she actually had type 1 diabetes.

Personal stories: 'Long term damage' - Poppy's story

> I also went to the GP with fatigue and was told I was lazy and to push through it. I think this has led to long term damage.

Personal stories: 'Growing pains' - Sam's story

> I had chronic pain for years. I went to see a hospital doctor who said I was overweight and it was growing pains.

Further issues shared with Healthwatch York regarding long term conditions.

Women taking part in the Healthwatch York volCeS meeting exploring women's health wanted to see greater acknowledgement that women live beyond the menopause. They want to see a much greater focus on health issues affecting older women including bone health and recognising osteoporosis, nutrition, and wound management.

Mental health concerns

I don't know if it is my gender, age or something else, but I've been unable to get support for my restrictive eating disorder. Doctors and nurses have told me I'm underweight but not severely. But eating disorders are about much more than weight. Talking therapies have also told me they don't provide help for eating disorders.

Personal stories: 'I wasn't confident' – Frankie's story

I was referred to a mental health care coordinator by my GP as a result of a shutdown in the GP practice waiting room. I wasn't confident that the care coordinator would provide any help and I was right. Their approach was to say that life is not always easy and there are ups and downs. This despite knowing I had struggled with mental health issues including an eating disorder as well as having an autism diagnosis.

When we discussed my eating disorder and I talked about the limited calories I was eating the care coordinator didn't really comment or offer any support to try and address the issue to have a healthier diet. They just said I can solve my own problems and I know what I am doing. I'm on a waiting list for support but there's a two year wait. I had asked to be referred to a dietitian but this has never happened. The care coordinator sent a letter summarising the appointment and offered to amend anything which needed it. I was grateful for that as in my eyes the letter didn't reflect the appointment.

Personal stories: 'Hysterical woman disease'– Isla's story

I'm one of the York women with a misdiagnosis of BPD (borderline personality disorder.) It's happened to me but I also know so many women who've had this as well. It's basically 'hysterical woman' disease. I got this diagnosis back when Bootham existed. I went to my GP saying "There's something wrong." First thing was "do you want some drugs?" No, I want a diagnosis. I was taken to Bootham, spoke to two women for an hour and got a BPD diagnosis.

I spent a lot of time questioning it. "This doesn't feel like me." I started reading stuff about neurodiversity. I spoke to a good mental health nurse. He said "I think you're autistic." I also read stuff about CPTSD (complex post-traumatic stress disorder). I started asking questions about support and misdiagnosis. I was very clear I'd spoken to health professionals who believed it was autism and CPTSD. Mental health services said "who told you that?" When I said a GP and nurse, this was not good enough. I needed to go back to a GP for a new diagnosis and they wouldn't do this. They just kept bumping up the Sertraline. Every time I'd say "I'm sad" and they'd increase the dose. Then they prescribed me another SSRI alongside Sertraline – for insomnia. It knocked me out, You can't be sad if you're unconscious I guess.

I decided to stop the anti-depressants. They make you put on weight, they make you "dull". Without them my moods are spikier, I do get panic attacks but I'm better. I'm not anti-meds, but they need to be the right ones.

Eventually the GP agreed it was time for a different diagnosis. But York had lost its diagnostician. So I went private, and the doctor said CPTSD immediately. This was updated on my mental health records.

Then I received a letter from the eye clinic. My BPD diagnosis was still on it. So I went back to my GP and said "you need to remove this. It's wrong

and there's lots of negative assumptions about this." The GP said "But a doctor diagnosed you with this." I replied "She also said I was wearing Doc Martens and she was wrong about that." But they still won't remove it from the record.

This is a massive issue for women. I had a friend who went to hospital with an injury. The nurse said "There's a BPD diagnosis on your record, you did it to yourself."

I understand empathy fatigue is a thing. It must be a miserable job at times and people doing it are not treated well enough. We need to support them well enough so that they can do their jobs with empathy.

I had a really bad experience with a GP. I went about a mental health issue. He could see the diagnosis on the screen. He said "I'm not going to help you. People like you scamming the Government, claiming benefits." I left in tears. My partner went in, and the receptionist said "oh yes, that's him, he's bad with mental health, we'll take him off the list of people you'll see."

Concerns about lack of support and inappropriate referrals

Women are going to the women's centre after contacting the crisis line. They say that the crisis line has referred them to the women's centre for support. The women's centre keep telling mental health services that this is not appropriate. They can't support people in crisis - that is the role of the crisis team. The referrals stop for a few weeks and then start again. The centre supports women who have tried to take their own lives on more than one occasion and who say that the crisis team has said they can't help. The women's centre team often have to take women to A&E because there is no other option and no support available from the crisis team.

Concerns shared with Healthwatch York.

Medical misogyny

I often feel, as a woman, any medical issue is brushed over as 'just being a woman' or 'it's because you're on birth control'

Personal stories: 'Ignored' – Wendy's story

If my son needs any healthcare input from the GP now I get my husband to take him as I am usually ignored where my husband is not. I have to write out what he needs to talk about as I am the main carer. But time after time, I am ignored so I've given up.

Personal stories: 'Anti-female bias' – Jamie's story

Getting my, female, health issues taken seriously. There seems to be an anti-female bias. My husband and I had the same symptoms. We both went to the GP to see different doctors. He was told that it was difficult for him, was given seven days of antibiotics and told to come back if things got worse. I was told that this was usual for women, I should get over it and was given three days of antibiotics. One male GP told me I'd have to see a female GP. Another said, 'you don't know how much is in your head'."

Personal stories: 'Didn't believe them' - May's story

> My partner went to the GP for help. They were anorexic, but the GP didn't believe them as they were wearing a big coat and the GP didn't ask them to take it off.

A number of people went to the GP with different symptoms and were told 'it's your hormones'. But even if it is hormones, there are symptoms. Surely something could be done?

Further feedback shared with Healthwatch York

Women taking part in the Healthwatch York voICeS meeting exploring women's health wanted to highlight the impact of caring, and 'women's load' – the cognitive load many women feel they have to carry on behalf of their family. Many highlighted that societal attitudes towards child-rearing and caring for family members add to the challenges women experience.

Navigating health and care

Every time I have phoned the health visitor (single point of contact number) about anything they just tell you to go to your GP so there's no point in ringing them.

Personal stories: 'Extremely helpful' - Xena's story

I have often had to book nurse appointments about women's health checks and issues and have found them all to be extremely helpful. They always seem to be running on time, are friendly and positive, give reassuring and personalised information and are thorough and efficient.

Personal stories: '"You can buy it at Tesco"' - Margaret's story

I bought something to help with women's issues at the pharmacy. I was later told I could get it on prescription. I am a pensioner and couldn't afford to keep buying it. I went to the GP practice to ask about getting it on prescription. The receptionist told me that 'you can buy it at Tesco'. Later I had a phone call with a GP about another issue and mentioned this to them. My GP said he would arrange for me to get it on prescription.

Concerns about safety and access to care for women

Workers at the women's drop in talked about the challenges of some of the people they work with going to A&E. The chaos, noise and general atmosphere can put them off. They are also very worried about who they might meet there and that they may meet their perpetrators. They believe a designated safe space for women to wait in, which would be a women-only space, could help increase access.

Concerns shared with Healthwatch York

Recommendations

Recommendation	To
Improve training around recognising tongue ties in newborn infants and make sure staff are aware of and able to put people onto the pathway for correcting this.	York & Scarborough Hospital Foundation Trust / City of York Council Health Visitors
Encourage local clinicians to take up opportunities to improve their knowledge and understanding of long term conditions such as ME / CFS and Endometriosis, including how this presents in younger women.	Humber and North Yorkshire Health and Care Partnership
Provide clarity about the pathway for women in our area with hEDS and POTS	Humber and North Yorkshire Health and Care Partnership
Continue to make a case for locating a Mother and Baby Unit in Humber and North Yorkshire with national health bodies	Humber and North Yorkshire Health and Care Partnership; Mental Health, Learning Disability and Autism Provider Collaborative; NHS England Specialised Commissioning.
Review the local pathway for women's bone health	York Health and Care Partnership

Initial response from

Women Living Well Longer, Humber and North Yorkshire Health and Care Partnership

With reference to Kai's story, Humber and North Yorkshire ICB introduced a new locally enhanced service (LES) for GP practices for pessary fitting from April 2025, alongside an IUCD fitting and removal LES.
Kai would now be able to access pessary fitting at her local GPs. There has been excellent provision in York from the introduction. In April 102 women had pessary fitting at York practices and in May 109.

For Jodie, Gemma and Angie's stories, what each of them really needed was a good, holistic first menopause appointment with a knowledgeable GP. Providing menopause care in line with the BMS vision for menopause care[21] would mean that women got the care they needed first time. The work we've delivered on Women Living Well Longer supports this, with clinicians undertaking the BMS Management of Menopause Certificate and accessing a monthly multi-disciplinary team meeting led by a consultant gynaecologist where there is discussion of themes in menopause care. The funding we've used for this work will be spent by August.

Jennifer Allott
Strategic Lead – Women Living Well Longer Programme

[21] https://bit.ly/BMSMenopause

Conclusion

Healthwatch York
Priory Street Centre
15 Priory Street
York
YO1 6ET

www.healthwatchyork.co.uk
t: 01904 621133
e: healthwatch@yorkcvs.org.uk
@healthwatchyork
Facebook.com/HealthwatchYork

CITY OF YORK COUNCIL

York Health and Wellbeing Board

Health and Wellbeing Board 16 July 2025

Report of the Director of Public Health

Telling the story of Women's Health in York – a Health Needs Assessment

Summary

1. This report presents the Women's Health Needs Assessment 2025, which is a picture of York's strategic needs around women's health and equality, shaped around six key areas which lay out systemic barriers, promote gender equity and improve well-being for women in the city.

2. As part of the Joint Strategic Needs Assessment (JSNA) process which the Board oversees, the Public Health team lead a number of topic-specific needs assessments each year.

Background

3. While women generally live longer than men, they often spend more years in poor health. Their health is disproportionately affected by factors such as financial hardship and caregiving responsibilities. Additionally, many healthcare systems and pharmaceutical treatments have historically been developed without fully accounting for women's specific needs.

4. This Health Needs Assessment (HNA) pays particular attention to women from groups known to experience poorer outcomes or additional barriers to care, such as those affected by deprivation, minority ethnic status, or complex social needs.

5. This HNA complements the Women's Health Strategy for England 2022-2032, building a clearer, York-specific picture to support local decision-making around commissioning and service design.

6. In 2024, Healthwatch York invited women to share their health experiences to improve future services. Their report – Women's

Health: Stories of Women's Experiences in York and North Yorkshire – will be presented to the board alongside this item, and covers a wide range of topics which overlap with this report, while also highlighting the need for a more prominent focus on women's health within healthcare services.

Main/Key Issues to be Considered

7. The aim of a Health Needs Assessment is to identify unmet health and care needs within a given population—in this case, women—and recommend the changes necessary to address them. It is a systematic, data-driven approach used to:

    - Describe population health issues
    - Identify health inequalities and gaps in service access
    - Set priorities for effective resource use.

8. The purpose of this Health Needs Assessment (HNA) is to build system-wide awareness of unmet health needs among women in York, with a particular focus on those experiencing social marginalisation. Our aim is to embed learning from this process into the working practices of our own commissioned services and influence wider commissioning and service design across the local health and care system.

9. The UK Supreme Court recently ruled that the legal definition of "woman" under the Equality Act 2010 is based on biological sex assigned at birth. This document uses the statutory definition, in part because much health-related data aligns with that approach. However, a trans and non-binary data and insights group has been convened and, along with partners such as Healthwatch feeding in the views and experiences of residents, will publish further data in the future of the health needs of other gender identities as part of the JSNA process.

Consultation and Analysis

10. Given the breadth of the topic, the HNA focused on areas where the Council and its partners can directly influence change—through commissioning, funding decisions, and collaborative action. Our aim was to use data, lived experience, and service feedback to highlight key issues and inequalities affecting women in York.

11. Over 20 interviews were held with key stakeholders – both in person and virtual. From this several topic areas were highlighted as areas of concern for women in York.

12. These topics became the focus of the HNA, and data was collected where possible to explore the issues and set out what the evidence says.

13. Writing this HNA was not without its challenges, in particularly the lack of readily available data, and as such the document should be viewed as a starting point, not a final answer. The process of gathering information from a range of sources to build a clearer picture naturally involves challenges and limitations and the work presented is exploratory. The lack of easy access to high-quality, comprehensive data is a key reason why the assessment was necessary in the first place, and one of the key findings of the work is the need to ensure all health data is disaggregated where possible, as releasing data solely on 'persons' can limit efforts to tackle gender-based health inequality. This work reflects an ongoing effort to understand and address the needs of women in York.

Strategic/Operational Plans

14. The Council Plan: One city of all 2023-2027 has aspiration for York to be a Health generating City for both adults and children and reduce Health inequalities which can only be achieved if the issues specific to the health of women are addressed.

Implications

- **Financial:** There are no known financial implications of this report
- **Human Resources (HR):** There are no known HR implications of this report
- **Equalities:** Every human being has the right to the highest attainable standard of physical and mental health. We have a legal obligation to develop and implement legislation and policies that guarantee universal access to quality health services and to address the root causes of health inequalities, including poverty, stigma and discrimination. The right to health is indivisible from other human rights - including the rights to education, participation, food, housing, work and information.

This HNA and follow on work will help the council to ensure equity of access to services for women.

- **Legal:** There are no known legal implications
- **Crime and Disorder:** There are no known crime and disorder implications
- **Information Technology (IT):** There are no known IT implications
- **Property:** There are no known property implications
- **Other:** There are no other known implications.

Risk Management

15. The purpose of this Health Needs Assessment (HNA) is to build system-wide awareness of unmet health needs among women in York, with a particular focus on those experiencing social marginalisation. Our aim is to embed learning from this process into the working practices of our own commissioned services and influence wider commissioning and service design across the local health and care system.

16. Despite the data challenges, we can confidently conclude that there is an unmet need for more detailed, gender-specific data collection to better address the health and care issues that affect women in York.

17. We intend to monitor for evidence of impact following publication and encourage all system partners to reflect on how they can respond to the findings, as to do nothing or maintain the “status quo” will result in the continuation of poor outcomes for women in York.

Recommendations

The Health and Wellbeing Board are asked:

- Note and discuss the report
- Consider the challenges system partners face to address poor health outcomes for women in the city, using the six key priorities outlined in the report as its focus.

Contact Details

Author:

Philippa Press
Public health Specialist
Public Health
City of York Council
Philippa.press@york.gov.uk

Chief Officer Responsible for the report:

Peter Roderick
Director of Public Health
City of York Council
Tel No: 07511160283
peter.roderick@york.gov.uk

Report Approved	x	**Date**	*7/7/25*

Chief Officer's name
Title

Report Approved	x	**Date**	*7/7/25*

Specialist Implications Officer(s):

Laura Williams
Assistant Director Customer, Communities and Inclusion
City of York Council
Tel No: 07563 252249
laura.williams@york.gov.uk
PA: Jacquie.Woodall@york.gov.uk

Wards Affected: **All** x

Annexes

Annex A - Women's Health in York: A Health Needs Assessment June 2025.

This page is intentionally left blank

Annex A:

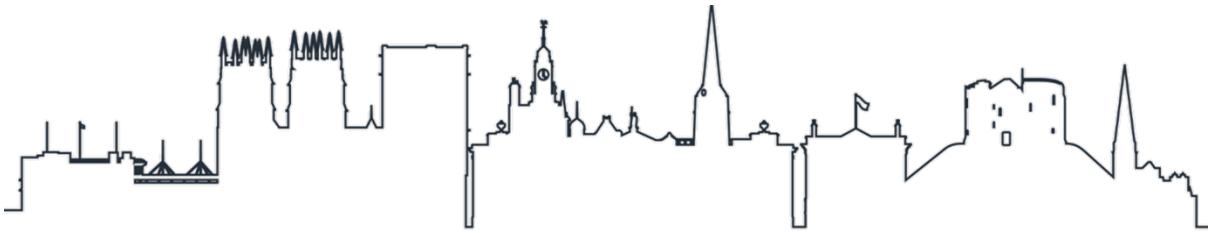
Women's Health in York

A Health Needs Assessment

June 2025

"Prioritising women's health is crucial for reducing inequalities and improving family and societal health outcomes."

Sue Mann, NHS National Clinical Director for Women's Health



Contents

1. Introduction

This report presents York's strategic approach to women's health and equality, shaped around six key priorities that aim to address systemic barriers, promote gender equality, and improve well-being for women in the city. Each chapter is deliberately short, and concise, designed to be easily digestible for readers while offering clear, actionable insights.

For those interested in learning more, relevant links to additional resources and detailed information are provided at the end of the report in the references and bibliography section. This report lays the groundwork for the future, and we look forward to continued collaboration across all sectors to bring about meaningful, lasting change.

Definitions used in this report

The UK Supreme Court recently ruled that the legal definition of "woman" under the Equality Act 2010 is based on biological sex assigned at birth. This document uses the statutory definition, in part because much health-related data aligns with that approach. However, a trans and non-binary data and insights group has been convened and, along with partners such as Healthwatch feeding in the views and experiences of residents, will publish further data in the future of the health needs of other gender identities as part of the JSNA process. In this document, the term "women" is used in both biological and social contexts:

- Biologically, when referring to issues like cervical screening or reproductive healthcare.
- Socially, when addressing factors such as gender-based violence or the gender pay gap and their impact on health.

Health Needs Assessments (HNAs)

A Health Needs Assessment (HNA) identifies unmet health and care needs within a population—in this case, women—and outlines the changes needed to address them. It is a systematic, data-driven approach used to:

- Describe population health issues
- Identify health inequalities and gaps in service access
- Set priorities for effective resource use
- Understanding women's specific needs is essential for planning responsive and inclusive local services.

Background

While women generally live longer than men, they often spend more years in poor health. Their health is disproportionately affected by factors such as financial hardship and caregiving responsibilities. Additionally, many healthcare systems and pharmaceutical treatments have historically been developed without fully accounting for women's specific needs.

This HNA pays particular attention to women from groups known to experience poorer outcomes or additional barriers to care, such as those affected by deprivation, minority ethnic status, or complex social needs.

Purpose

This assessment is not intended to replicate the Women's Health Strategy for England, but to build a clearer, York-specific picture to support local decision-making around commissioning and service design.

Given the breadth of the topic, we focused on areas where the Council and its partners can directly influence change—through commissioning, funding decisions, and collaborative action. Our aim was to use data, lived experience, and service feedback to highlight key issues and inequalities affecting women in York.

Methodology

A working group oversaw this project, and conducted over 20 in-depth interviews (in-person and virtual) with key stakeholders, including:

- Primary care
- Cancer Alliance
- Healthwatch York and Humber and North Yorkshire ICB
- Justice services
- Kyra Women's Project
- York Carers Centre
- Homestart York
- Midwifery, maternity, neonatal, and infant feeding teams
- IDAS (domestic abuse support)
- Healthy Child Service
- Sexual health providers
- Housing and resettlement services
- NHS screening teams
- Mental health services

We outlined the scope of the project to all key stakeholders, explaining that while it was inspired by the National Women's Health Strategy, our focus would be on the health of women in York, with an emphasis on the wider determinants of health.

Key principles

The national strategy takes a life-course approach to women's health, addressing areas such as workplace wellbeing, healthcare professional training, and medical issues including menstruation, menopause, and violence against women and girls.

Locally, the focus would be on areas we can influence—through strategy, commissioning, and programme funding—while also addressing broader determinants like deprivation, housing, insecurity, addiction, and involvement with the justice system.

We would use both quantitative data (to describe the "average" woman in York) and qualitative insights, including quotes, service feedback, and lived experience, to highlight health inequalities.

The primary focus would be on adult women, including older women, with a question raised about whether to also include children and teenage girls.

All stakeholders supported this approach.

We asked each stakeholder the following questions:

- What do you see as the key health issues facing women in York?
- How can you support this work? Do you have relevant data, stories, or capacity to help with writing or reviewing?
- Would you be willing to be part of a working group or participate in a follow-up interview?
- Who else should we speak to?
- Can we have your contact details?

Stakeholder feedback highlighted several priority areas for women's health in York, including careering responsibilities, maternal health, screening, period health, Violence against women and girls, isolation and mental health in older women, menopause, employment, and accessibility of primary care services.

These are the issues around which this report has subsequently been developed.

Next Steps

The findings of this report are being shared with stakeholders, who are invited to contribute any relevant resources—such as service data, case studies, evaluations, or personal stories—to support women's health improvement in York. This report will be discussed at the York Health and Wellbeing Board in July 2025, and we hope partners will take forward the key actions and take into account the 6 strategic themes at the document's conclusion.

2. What We Know

National Strategy

The Women's Health Strategy for England (2022) focuses on tackling health inequalities and improving the health and wellbeing of women and girls. As part of its implementation, Integrated Care Boards (ICBs) received funding to develop Women's Health Hubs—either virtual or physical clinics offering integrated women's health services.

- Key commitments in the strategy include:
- Coordinated care through Women's Health Hubs
- Expanded mental health support for women
- Improved sexual and reproductive health education in schools

Progress Since Publication - Notable achievements include:

- HRT Prepayment Certificates: Women can now pay £19.30 annually to access a wide range of hormone replacement therapies (HRT), including tablets, patches, and topical treatments.
- NHS Pharmacy Contraception Service: Women can consult with participating pharmacies for the initiation of oral contraceptives without needing a GP appointment.
- Expansion of Women's Health Hubs: Continued rollout of integrated health hubs for women.
- Domestic Abuse Support: A £2 million investment (January 2024) to provide financial assistance to survivors of domestic abuse. Police forces have also adopted new approaches to investigating sexual assault, with 2,000 officers trained in sexual offences by April 2024.

National and Regional Data

Women in the North of England face greater health and social inequalities compared to those in other parts of the country. According to the Woman of the North report:

- Women in the North are more likely to work longer hours for lower pay, experience poorer health, live in poverty, and have lower levels of educational attainment.
- They are also more likely to be unpaid carers, which adds further strain on their health and wellbeing.
- These inequalities have widened over the past decade, negatively impacting women's quality of life, employment, families, and communities.

The report also highlights a major gap in data:

"We cannot paint a complete picture of how the social determinants of health impact outcomes for marginalised northern women due to the lack of health data about the lived realities of marginalised northern women."

This underscores the urgent need for improved data collection and targeted interventions to address these disparities.

The Humber and North Yorkshire Health and Care Partnership published an interactive report offering an overview of women's health across the ICB area. While it highlights key inequalities and health risk factors, the report is not broken down by place or local authority, limiting its usefulness for understanding the specific needs of women in York.

Key Findings:

- Women live longer than men but spend more of those years in poor health.
- The gap in healthy life expectancy between the most and least deprived areas is widening.
- Cancer is the leading cause of death and early mortality, followed by circulatory diseases and dementia/Alzheimer's.
- About 25% of working-age women are economically inactive, compared to 21% of men.
- Women working full-time earn less, on average, than men.
- Nearly 13% of girls and women in the ICB area live in the most deprived 10% of neighbourhoods.
- Access to long-acting reversible contraception (LARC) has not returned to pre-pandemic levels.
- Abortion rates, including repeat abortions among under-25s, are rising but it is lower than regional and national averages.
- Hospital admissions for hip fractures in women aged 65+ are nearly double those of men.

The report highlights a lack of focus on women-specific health issues such as miscarriage and menopause. It also notes that women are underrepresented in clinical trials, leading to gaps in knowledge about conditions that uniquely affect women or affect them differently than men.

Marginalised groups

A growing body of research has highlighted the significant social and economic costs of 'severe and multiple disadvantage' (SMD) in the UK, attracting increasing policy attention.

For women, the routes into and out of SMD are often highly gendered. In homelessness, while street homelessness was less common, sofa-surfing and sleeping in hidden places were nearly universal. Substance use was frequently triggered by a partner and often served as a coping mechanism for past trauma. For many, prison was seen as a temporary escape from chronic domestic violence and harmful environments.

Women from minoritised ethnic backgrounds, those with long-term illness or disability, and neurodivergent women often face additional challenges, further increasing barriers

to support. Trauma linked to child removal was another key issue, with many women experiencing lasting emotional harm, though for some, fostering provided hope.

A gendered pattern also emerged in how women would go to extreme lengths to conceal or downplay their circumstances—staying in abusive relationships or exchanging sex for shelter or drugs—often to protect access to their children or to avoid exploitation by predatory men. This concealment was driven by fear of judgment or losing custody of their children, as well as a desire to protect themselves from further harm.

Key Local Programmes

In York, two key initiatives will support the reshaping of the local response to women's health care: the ICB-led Women Living Well Longer (WLWL) programme and a 2025 Healthwatch report on women's health, which has within it recommendations and future actions work with local GP's.

In 2023, the Department of Health and Social Care (DHSC) announced funding for Integrated Care Boards (ICBs) to develop Women's Health Hubs. These hubs were envisioned as 'one-stop' centres to deliver care closer to home, improve patient experience, tackle health inequalities, and ease pressure on secondary care.

In Humber and North Yorkshire, the WLWL programme implemented these hubs. The key principles included:

- Reducing health inequalities and improving access
- Placing women's voices at the centre
- Creating sustainable services
- Involving the whole health system

However, a single centralised Women's Health Hub was not feasible for the geography of the ICB due to accessibility concerns. Instead, the focus shifted to enhancing services in local GP surgeries. This approach allowed more women to receive the care they needed in their communities, without adding extra steps to their healthcare journey.

As a result, 24 Primary Care Networks (PCNs) became Women's Health Hubs, with funding used to train clinicians in menopause care, contraceptive provision, and pelvic health. A designated Women's Health Champion at each PCN led improvement projects and networking events. This initiative aimed to increase clinicians' skills and confidence in delivering women's health services locally. The programme will conclude in 2025, but the networks and relationships developed will continue.

Key focus areas for the Women's Health Hubs include:

- Menopause assessment and treatment
- Contraceptive counselling and provision
- Pelvic health, including pessary fitting and removal

In 2024, Healthwatch York invited women to share their health experiences to improve future services. This initiative was based on the belief that those who use the services are best placed to shape them.

The Healthwatch York report covered a wide range of topics, many of which overlap with this report, but others highlight the need for a more prominent focus on women's health within healthcare services. The full report, Women's Health: Stories of Women's Experiences in York and North Yorkshire, is expected to be published in 2025.

Women's health in York

A summary of the York Women's Health Needs Assessment 2025

A targeted stop-smoking initiative for pregnant women, delivered through the City of York Council Health Trainer Service, has contributed to a significant reduction in smoking rates among expectant mothers.

The self-reported **four-week quit rate** in York is currently **88.9%**, markedly higher than the regional (56.6%) and national (49.4%) averages.

Fewer women than men in York **claim out-of- work benefits** (1.7% vs. 2.1%), reflecting high overall employment.

19% of women in York are **obese at the start of pregnancy**. (21.3% nationally)

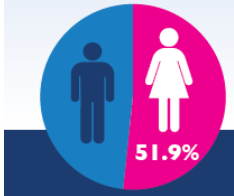
Breastfeeding rates see a notable decline by 6 to 8 weeks postpartum, with around **45%** of families in York **continuing to breastfeed** during this period. This rate is higher than the national average of 33% (OHID, 2025).

However, there is significant variation across different areas of the city. Westfield ward has the lowest breastfeeding continuation rate at 6-8 weeks, with only 29% of mothers still breastfeeding, in contrast to 61% in Micklegate ward.

However, **73%** of York **babies were breastfed at time of delivery** which is similar to the national average (71.7%).

75% of women aged 53 to 70 are **up-to-date with their breast screening** in 2022 and 2023. This is better than the England average of 67%. (VoY)

70% of women aged 25 to 49 years were **up-to-date with their cervical screening** in 2022 and 2023. This is better than the England average of 67% (VoY)



York has a population of **202,821**, with women making up **105,298**

83 years

At birth, women in York have a **life expectancy of 83 years** and a healthy life expectancy of 63 years—both aligning with the England average.

78% **62%**

At school entry, girls in York are more likely than boys to achieve a **"good level of development"** This trend continues in phonics and literacy assessments at the end of Year 1.

The average house is **9.3 times** average earnings.

For York, the median annual pay before tax (gross) for a full-time employee is **£32,300**. The England average for the same is **£35,100**.

Women born in the most affluent areas can expect to **live 10 more years in good health** compared to those born in the most deprived areas.

By age 16, girls are slightly more likely than boys to be **not in employment, education, or training** (NEET) – 4.2% compared to 3.9%.

11% are smoking at the start of pregnancy (England ave 13%), dropping to 6% by delivery (8.0% nationally)

A 2023/24 health and wellbeing survey in York showed that **5% of young women reported experiencing period poverty** in the last year.

The trend for **teenage conception rates among under 18's has been falling** each year since 1998. the latest data for 2021 showing York's count as being 10.2 cases per 1,000 people.

Nationally, the figure is 13.1 per 1,000.

Breastfeeding rates are significantly lower among mothers living in York's more deprived wards, particularly Westfield, Hull Road, and Clifton.

4 year aggregated data in York indicates that fewer than **half of babies are breastfed at 6 to 8 weeks** (44.8%).

York's fertility rate is significantly below the national average.
Fertility data from OHID Fingertips (2020/21) reported a general fertility rate of 39.74 live births per 1,000 women aged 15-44 in York – well below the national benchmark of 59.19.

63% of respondents to the York and North Yorkshire VAWG survey reported **experiencing a VAWG related Crime**.

3. Unpaid Care and Gender Disparities

In England, women disproportionately take on the responsibility of providing unpaid care, with those in their fifties making the most significant contributions. However, the full scope of who provides unpaid care remains underexplored, as many individuals who support family members or friends do not identify themselves as carers. This gap in understanding is highlighted in the Woman of the North Report (2024), which examines inequality in health and work.

Unpaid care can be provided to a range of dependents, including adult children, grandchildren, partners, parents, and friends, both within and outside of the household. While caregiving can be fulfilling, it is also mentally, emotionally, and physically demanding. The implications for carers are profound, affecting their access to education, employment, social activities, and, ultimately, their health and well-being. (Key Census Data on Unpaid Care (2021))

The 2021 Census data reveals that across all age groups up to 74 years, women are more likely to provide unpaid care than men. Additionally, more women in deprived areas provide care compared to those in the least deprived regions. (Office for National Statistics. (2023).

The Survey of Adult Carers in England (SACE), conducted biennially since 2012, sheds light on the experiences of informal, unpaid carers aged 18 or over. The most recent survey highlights significant disparities between female and male carers, with women reporting worse outcomes in various aspects of care provision. (Personal Social Services Survey of Adult Carers (NHS Digital).

Local Data on Care

In York, 936 carers known to Adult Social Care (ASC) and receiving services were eligible for the 2023-24 SACE survey. A total of 807 carers received questionnaires, and 311 responded, offering valuable insights into their experiences. These responses were compared with regional and national data, including results from York's Statistical Neighbour Local Authorities (SNLAs). Key Findings from the York Carers Survey (2023-24) included:

According to the Carers UK State of Caring 2022 report, 29% of carers reported feeling lonely “often or always.” In York, nearly 48% of carers expressed feelings of loneliness at least "some of the time," with younger carers and women more likely to report such feelings. This was notably higher than regional and national averages.

Carers' physical and mental health can suffer as a result of their caregiving responsibilities. In York, many carers reported poor health, including disturbed sleep, stress, and depression. Women carers, particularly those under 60, were more likely to report these negative health outcomes. Many carers neglect their own health Chapter 2needs, missing essential medical appointments due to their caregiving duties.

Juggling unpaid care with paid employment is a common struggle for many carers, especially women. Carers often face stress and fatigue, with many reporting difficulty in balancing work and caregiving. In York, a rise in carers facing financial hardship was particularly evident among younger carers and women. Nationally, financial hardship among carers has also increased since the 2021-22 survey.

Since 2021-22, there has been a marked decline in satisfaction with support services among women carers. Women were less likely than men to express satisfaction, with carers in the east of York particularly dissatisfied. In contrast, satisfaction levels have improved nationally.

Carers' ability to care for themselves has significantly declined since the last survey. The percentage of carers who reported being able to look after themselves fully dropped, particularly among younger carers and women. Social contact also decreased, with younger carers and women again reporting the lowest levels of social interaction.

Conclusions

- Women are more likely to provide unpaid care than men, with the largest proportion in deprived areas.
- Female carers experience worse outcomes than their male counterparts in areas such as health, social isolation, and financial hardship.
- Women carers, particularly in York, are less likely to prioritise their own health and well-being.
- There has been a marked deterioration in satisfaction with support services, especially among women carers.
- Social contact and the ability to care for themselves are declining, with younger carers and women facing particular challenges.

4. Women in employment

In the 2021 Census, there were 68,000 working-age women in York. Of these, 54,400 were classified as 'economically active,' meaning they were either employed or self-employed.

However, a pay gap persists in York. In 2024, the average weekly earnings for full-time male workers were £160 higher than those for women (£810 versus £649 gross, before tax). This continues into a gender pension gap, the latest pension contribution data from Aviva has found the gender pension gap is closing, but the rate of progress is slow and inconsistent across different age groups.

While local data for part-time female workers is unavailable, national figures show that the pay gap for part-time work is significantly smaller. In fact, part-time female workers tend to earn more per hour overall than their male counterparts (House of Commons Library, *Women and the UK Economy*).

Nationally, the gender pay gap widens significantly with age. There is virtually no pay gap for workers in their teens and twenties, but by retirement age, women earn about 10% less than men. This is often linked to career progression being slowed by time spent away from the workforce—due to childcare or caregiving responsibilities—or a preference for less demanding roles that offer more flexibility, shorter commutes, or family-friendly employment terms.

In York, women are slightly less likely than men to receive out-of-work benefits through Universal Credit. Around 2.1% of men receive these benefits compared to 1.7% of women. Both figures are lower than regional and national averages, reflecting the overall high rates of employment or study in the city.

A report from the University of York published in April 2025, offers a detailed snapshot of the current state of human rights across the city and highlights both areas of concern and positive progress. Based on its findings the report put forward a number of recommendations including a suggestion for the city's Human Rights and Equalities Board (HREB) to advocate for research into "the gender pay gap - which was found to have increased from 20.2% to 22.6% – and encourage the publication of data on other pay inequalities."

Conclusions

We can conclude that, in York:

- **There is high workforce participation, but ongoing pay inequality**
  80% of York's 68,000 working-age women are economically active, yet in 2024, full-time men earned £160 more per week than women.
- **Part-Time Work Masks Deeper Inequities**
  Though women working part-time earn more per hour nationally, gaps in local data hinder understanding of long-term career and pay equity.

- **Pay Gap Widens with Age**
  Earnings disparities grow over time due to caregiving breaks and shifts into lower-paid roles—highlighting systemic, not personal, barriers.
- **Low Benefit Uptake Doesn't Equal Equity**
  Fewer women claim out-of-work benefits, but this may reflect hidden underemployment and low-paid, insecure work, especially among carers.

5. Loneliness and Social Isolation

Social isolation and loneliness are prevalent issues across all age groups, but they have particularly significant consequences for older individuals, both physically and emotionally. In recent years, the UK government has recognized the growing concern around loneliness and launched its first loneliness strategy, appointing a Minister for Loneliness in 2018. This initiative follows the work of the Jo Cox Loneliness Commission, which raised awareness about the importance of tackling social isolation (Jo Cox Commission on Loneliness, 2017).

While both social isolation and loneliness are linked, they are distinct experiences. Social isolation is typically defined as the objective lack of meaningful, sustained communication, whereas loneliness refers to the subjective feeling of missing social interaction.

Several factors contribute to the feeling of loneliness, including:

- **Widowed older women** living alone with long-term health conditions.
- **Unmarried middle-aged individuals** with ongoing health issues.
- **Younger renters** who feel a lack of trust or belonging in their local community (ONS, 2018).

Health Impacts of Social Isolation and Loneliness

Social isolation and loneliness have been linked to various physical and mental health issues, including an increased risk of mortality. Multiple studies have shown that these experiences can lead to poor health outcomes, including heart disease, depression, and premature death. (The State of Women's Health in Leeds, White A., Erskine S, and Seims A, 2019)

A large study conducted in the UK on the effects of social isolation and loneliness on mortality revealed that while loneliness itself did not lead to excess mortality—except when associated with depressive symptoms—the higher death rates in socially isolated individuals were linked to lifestyle factors, socioeconomic status, and mental health problems.

Further research confirmed that individuals who are socially isolated or lonely are at a higher risk of mortality, especially when they also experience poor socioeconomic conditions, unhealthy behaviours (like smoking), and mental health issues. When social isolation is combined with food insecurity, the mental health risks escalate, with women being more adversely affected than men (The State of Women's Health in Leeds, White A., Erskine S, and Seims A, 2019).

Gender Differences in Social Isolation

Women, on average, live longer than men, and as a result, they are more likely to experience social isolation in later life. The combination of increased age and a higher incidence of multiple morbidities can make it more difficult for older women to maintain social connections or participate in social activities (Pettigrew et al., 2014). While women tend to report higher levels of loneliness than men, this may be partly

because women are generally more willing to acknowledge and report their feelings of isolation (ONS, 2018).

In addition, the growing number of divorces in people aged 60 and over (ONS, 2013b) may contribute to increased isolation for older women, as they navigate the challenges of maintaining or rebuilding social networks in the absence of a partner.

Conclusions

- **Increased Vulnerability of Older Women**
  Older women in York are more likely to live alone, facing higher risks of social isolation, worsened by health issues and widowhood.
- **Health Risks of Isolation**
  Social isolation, often linked to socioeconomic disadvantage, leads to poor physical and mental health, such as heart disease and depression, especially in older women.
- **Loneliness is Underreported**
  Older women may underreport loneliness or avoid seeking help, underscoring the need for proactive support from health and social services.
- **Need for Gender-Specific Approaches**
  Interventions should address the unique emotional and practical challenges older women face, moving beyond a one-size-fits-all approach.
- **Addressing Socioeconomic Factors**
  Loneliness in York is closely tied to income, housing, and access to services, with a focus on food insecurity, transport, and community infrastructure for older women.
- **Importance of Community-Based Support**
  Creating accessible social activities and supporting older women in staying connected, active, and mentally well should be a priority.

6. Menopause

Menopause is defined as the permanent cessation of menstruation for at least 12 consecutive months with no other obvious cause.

Menopause affects all individuals assigned female at birth, (referred to as "women" in this needs assessment). Common symptoms of menopause include hot flushes, night sweats, muscle aches/joint pain, low mood, vaginal dryness, changes to body shape and weigh gain and difficulty sleeping. In addition to these immediate symptoms, menopause is associated with several long-term health risks, particularly cardiovascular disease and osteoporosis.

Cardiovascular disease (CVD), which is the leading cause of death in women, is an especially significant concern during menopause, as the drop in oestrogen levels increases the risk of CVD. Osteoporosis can lead to fractures and higher rates of disability and urogenital atrophy, including vaginal dryness, urinary incontinence, and a higher susceptibility to urinary tract infections.

Common mental health symptoms include frequent mood swings, anxiety and low self-esteem and problems with memory or concentration – referred to as "brain fog".

Despite the severity of both the acute symptoms and the long-term health risks of menopause, access to appropriate care varies widely, with often limited access to healthcare professionals with expertise in menopause. NICE guidance QS143 published in 2017 and updated in 2024 describes high quality care. NICE recommends 5 Quality statements for women, trans men and non-binary people registered female at birth.

Cultural and societal factors can prevent individuals from seeking care, further complicating the management of menopause-related health concerns. This can lead to inadequate workplace support, early retirement and stigma. The lack of understanding and acceptance exacerbates the mental and emotional strain of menopause.

A report on "The effects of menopause transition on women's economic participations in the UK" published in 2017 reviewed English evidence base from 1990 to March 2016. (Transition refers to the time in women's lives when they are moving towards the menopause, when their periods stop permanently.) The report identified that the menopause is not well understood or provided for in workplace cultures, policy and training. The Equality Act (2010) protects women against workplace discrimination based on their sex or age and so the legal case for organisational attention to the menopause and the transition period is clear.

As life expectancy continues to rise globally, more individuals will spend a larger portion of their lives in the post-menopausal phase. This demographic shift, coupled with the far-reaching effects of menopause on health and well-being, underscores the need for improved management in the workplace and equitable access to care.

Stakeholder Feedback

Feedback from stakeholders interviewed as part of this Health Needs Assessment highlighted several concerns – common themes where:

- Access to health care, with long waiting times for women experiencing perimenopause or menopause to see a GP.

- All GP's and healthcare professionals should have the knowledge to support women presenting with perimenopause and menopause as it affects all women during their life course
- Menopause symptoms not always taken seriously or seen as "normal" and something to be endured.
- Women are often prescribed anti-depressant medication unnecessarily in the first instance. Many women described a lack of decent follow-up and care around menopause, and it is often a lottery in terms of who you get to see.
- Women who are carers where significantly affected, with complaints that they found raising issues around menopause, even with a health professional, challenging and feel disregarded. They are made to feel 'neurotic'. This had a huge impact on their ability to cope on top of caring responsibilities/holding down a job etc.
- There is a lack of information available for partners/men to understand the situation and what their partner is experiencing and the impact this can have.
- Questions were raised about workplaces, the lack of support women receive in the workplace, and how workplace menopause policies are implemented.

Conclusions

- **Inadequate Access to Menopause Care**
  Long GP wait times and inconsistent access to specialists leave many women feeling their menopause symptoms are dismissed, with some being inappropriately prescribed antidepressants instead of tailored treatments like HRT.
- **Need for Better Training for Healthcare Professionals**
  Many GPs and healthcare providers lack sufficient knowledge of menopause, highlighting the need for standardised training across the healthcare system.
- **Lack of Mental Health and Emotional Support**
  Women often feel dismissed or labelled "neurotic," this particularly affects those with caregiving responsibilities.
- **Insufficient Workplace Support**
  Menopause is poorly understood and unsupported in many workplaces, with women reporting difficulty discussing symptoms, resulting in challenges in job performance.
- **Persistent Social Stigma and Low Awareness**
  Cultural attitudes and limited public information create embarrassment and isolation for women seeking help, and there is insufficient support for partners and families to understand menopause.
- **Vulnerable Groups Face Greater Challenges**
  Women with caregiving responsibilities and those in low-income or precarious jobs experience compounded barriers to healthcare, workplace support, and overall well-being.

7. Period Poverty.

What is Period Poverty?

Period poverty, also known as menstrual poverty or menstrual inequality, occurs when people who menstruate lack access to safe, hygienic period products, proper sanitation, or menstrual hygiene education. While the term is relatively new, it highlights a longstanding issue that disproportionately affects low-income individuals, communities, and countries.

Period poverty is a global health issue that is often overlooked. Research by Jaafar et al. (2023) and Rossouw et al. (2021) defines it as insufficient access to menstrual products, education, and clean, private sanitation facilities.

Why is Period Poverty a Public Health Issue?

Period poverty is driven by income inequality and the inability to meet basic household needs. Factors like conflict, climate events, and global health crises exacerbate the issue, as shortages of essentials like pads and tampons worsen the problem. Without affordable products, individuals are forced to improvise with unsafe alternatives, putting them at risk for infections, irritation, and toxic shock syndrome. According to a 2023 ActionAid report, 41% of respondents used period products for longer than recommended, and 8% reused disposable pads. Additionally, 37% used tissues, cotton wool, or other materials like socks, while 9% resorted to paper or newspaper.

Menstrual stigma — including myths and shame surrounding menstruation — can fuel gender bias in healthcare systems and society. A significant number of respondents (28%) reported that they could rely on period products at school or work, but 17% stayed at home during their period, impacting their mental health and social opportunities. The same ActionAid report found that 21% of women and menstruators in the UK are struggling to afford period products, up from 12% the previous year.

The COVID-19 pandemic exacerbated period poverty, as many individuals prioritised essentials like food and utilities over menstrual products, leading to the reuse of products or improvisation. The cost of period products has increased by 57% since 2022, putting an additional strain on already stretched household budgets.

Period Poverty in the UK

Period poverty has gained increasing attention in the UK over the past decade, especially considering the cost-of-living crisis. A growing number of people, particularly young people, are unable to afford menstrual products. Recent data shows that 10% of girls in the UK have been unable to buy products, 15% have struggled to access them, and 19% have turned to less suitable alternatives due to high costs (Jaafar, H et al., 2023).

In response, the UK government introduced the **Period Product Scheme for Schools and Colleges** in 2020, providing free menstrual products to students. However, a 2022 assessment by Girl Guiding found that further improvements are needed to ensure the scheme's effectiveness and prevent waste.

Efforts in York to Address Period Poverty

York has seen several initiatives aimed at tackling period poverty. In 2019, the Soroptimist Society began offering free period products, and in 2022, University of York students launched a program to ensure all students had access to menstrual products. York Minster also hosted a workshop to sew reusable pads for distribution. The **Period Angels** initiative, which connects volunteers with local organizations like food banks and GP practices, aims to eradicate period poverty by 2025.

A 2023/24 health and wellbeing survey in York showed that 5% of young women reported experiencing period poverty in the last year. The survey, based on responses from over 1,900 girls across six schools and a sixth form college, illustrates that period poverty remains a significant issue.

Conclusions

Despite ongoing efforts, period poverty is far from eradicated. A nationwide response is needed, with consistent access to menstrual products in schools, hospitals, GP practices, and other community spaces. Broader public recognition of the issue is crucial.

8. Cancer Screening

Cancer screening programmes are a vital component of the NHS's broader preventative health strategy and play a key role in public health. These programmes are designed to detect cancer at an early stage—before symptoms appear—allowing for timely intervention, improved treatment outcomes, and reduced mortality.

Screening not only enhances early detection but also provides an opportunity to educate the public, promote healthier behaviours, and empower individuals—particularly women—to take charge of their health. Educational components embedded within screening initiatives help raise awareness of risk factors, symptoms, and the importance of regular check-ups. Importantly, these programmes also help address health inequalities by offering free screening to all eligible individuals, regardless of socio-economic status.

However, challenges remain in ensuring equitable access. Barriers such as cultural stigma, lack of awareness, or logistical issues (e.g. transport, location) can limit participation—particularly for women in rural, marginalised, including those from different religious backgrounds or underserved communities. It is critical that cancer screening services remain accessible, inclusive, and responsive to diverse needs.

Improving cancer screening among Muslim women.

A Scottish project to encourage Muslim women to take up cancer screening invitations began in 2020 in Glasgow and aims to reach Muslim women with information to enable them to make informed choices. This expanded to the North of England in 2023 and will run to December 2025. It is hoped that the results and lessons learned from this project can help reduce barriers and increase uptake in other groups.

Screening programmes also support wider public health goals by enabling more efficient allocation of resources, particularly to those at greater risk or with higher need. Most programmes incorporate educational elements to raise awareness of cancer risks, early symptoms, and the importance of routine check-ups. This not only promotes healthier behaviours but also empowers women to make informed decisions about their health and helps reduce stigma associated with cancer and other health conditions.

Regular screening for breast, cervical, and bowel cancer plays a vital role in early diagnosis:

- **Breast screening** (via mammograms) women are invited every 3 years via their GP practice, and it is crucial for identifying tumours early.
- **Cervical screening** helps detect pre-cancerous cell changes. It is not a test for cancer but for Human Papilloma Virus (HPV). It is a preventative test, not a diagnostic one.
- **Bowel Cancer** via a home testing kit (FIT kit) delivered though the post, which allows for the early detection of potential cancer indicators.

Breast Screening

Breast cancer is the most common cancer in the UK, with around 1 in 8 women diagnosed in their lifetime. In England, the NHS Breast Screening Programme helps save approximately 1,400 lives annually through early detection.

Women registered as female with a GP are invited for screening every three years between ages 50 and 71, though some may not receive their first invite until age 52 or 53 due to the programme's rolling schedule.

York's screening coverage exceeds both national and regional averages, with consistent improvements since the COVID-19 pandemic.

The North Yorkshire and York Breast Screening Programme, led by York and Scarborough NHS Trust, collaborates with GP practices to identify eligible women, including those with disabilities. Invitations can be adapted for accessibility, and appointments rescheduled if needed. Non-attenders receive personalised follow-up support. Out-of-hours clinics are also offered to accommodate those with work or caring responsibilities.

Informed by a regional Health Equity Audit, targeted actions by the National Breast Screening System (NBSS) aim to improve access for underserved groups such as people experiencing homelessness, refugees, Gypsy, Roma and Traveller communities, LGBTQ+ individuals, military personnel, and those with severe mental illness or learning disabilities. While the current system cannot yet identify these groups, development are underway to enable ethnicity data collection in the future.

Bowel Cancer Screening

The Harrogate, Leeds, and York Bowel Cancer Screening Programme covers the York population. Currently, bowel screening is offered every two years to individuals aged 54 to 74, but this will soon be extended to include those aged 50 to 74.

Bowel cancer is the fourth most common cancer in the UK, and the risk increases with age. According to Fingertips data (Department of Health and Social Care), 77.7% of eligible residents in York participate in bowel screening, a rate significantly higher than the national average of 71.0%. Rates across England range from 57.4% to 78.3%.

Although data is not currently broken down by gender or other demographic groups—except for people with learning disabilities—the screening Hub that distributes the kits will identify individuals who may require additional support and arrange personalised assistance throughout the screening process.

Cervical Screening

Cervical screening is offered in England to women and people with a cervix aged 25 to 64. Those registered with a GP as female are automatically invited. The test checks for human papillomavirus (HPV), a virus that can lead to cervical cancer if untreated. It is a preventative, not diagnostic, test.

Screening is mainly delivered by GP practices. In York, Yorsexual Health offers additional support, especially in areas of low uptake and among marginalised groups. Outreach with LGBTQ+ and trans communities has improved participation. Further access is available through Women's Health Hubs and extended-hours clinics.

NHS England data shows York's screening uptake is above the national average: 70.5% for ages 25–49 (vs. 67.16% nationally) and 77.19% for ages 50–64 (vs. 74.69%).

Currently, only service providers hold data on uptake among marginalised groups, as national reporting is limited to practice-level figures and sample counts, without detailed demographic breakdowns.

To address this, a large York Primary Care Network, working with City of York Council, the Integrated Care Board, and the Cancer Alliance, has secured funding for a nurse-led project to build a real-time dashboard. This tool will identify disparities in screening uptake and support targeted community-led interventions.

National cancer awareness campaigns throughout the year promote screening for bowel, breast, and cervical cancer. These are locally supported by healthcare providers and the Cancer Alliance, which also runs a Cancer Champions programme to empower community members to talk about cancer, reduce stigma, and encourage early detection.

Screening is a key prevention strategy, helping detect conditions early, reducing the need for advanced treatment, easing NHS pressure, and improving outcomes across communities.

Conclusion

- **Cancer Screening and Its Importance**
  Cancer screening is a vital part of the NHS's prevention strategy, helping to detect cancer early, improve treatment outcomes, and save lives. It also encourages healthier habits and empowers women to take charge of their health.
- **York's Success in Screening Uptake**
  York is performing well, with screening participation rates higher than the national average. Local services are actively working to engage more people, particularly those facing additional barriers, through mobile units and out-of-hours clinics.
- **Challenges in Ensuring Fair Access**
  Despite success, there is still work to be done to ensure screening is accessible and equitable for all, particularly for marginalised groups.
- **Future Focus for Improved Health Outcomes**
  Continued emphasis on early diagnosis, education, and inclusivity will help improve health outcomes and reduce pressure on NHS services.

9. Maternal Health

Introduction

Maternal health is a critical aspect of women's overall health and well-being, significantly influencing both immediate and long-term outcomes for mothers and their children. This chapter explores the maternal health needs in York, focusing on physical health, mental well-being, and access to healthcare services.

Understanding the specific needs of mothers in York is essential for shaping responsive and inclusive services, enabling mothers to thrive and contribute to a healthier community.

Key Challenges Facing Mothers in York

- 24.1% of mothers are obese during early pregnancy.
- 16.5% of mothers smoke during pregnancy—higher than the national average.
- York's fertility rate is significantly below the national average.
- An increasing proportion of births are among women from ethnic minority backgrounds.
- The stillbirth rate in York is comparable to the national average but higher than many statistical neighbours.
- Breastfeeding rates are significantly lower among mothers living in York's more deprived wards, particularly Westfield, Hull Road, and Clifton. These disparities highlight the need for targeted support and culturally appropriate interventions to improve breastfeeding outcomes in underserved communities.
- Local experiences suggest a higher level of need in relation to Perinatal Mental Health than reflected by the data on service contact rates.

Preconception Health

Obesity in Early Pregnancy

A woman's weight before and during pregnancy strongly influences health outcomes. Obesity—defined as a BMI of 30kg/m^2 or more at the first antenatal appointment (usually within 14 weeks)—raises the risk of complications for both mother and baby.

Risk Factors:
Maternal obesity is shaped by complex, interconnected factors, including pre-pregnancy weight, socioeconomic disadvantage, limited access to healthy food and exercise, low health literacy, cultural influences, and mental health issues. Inadequate access to personalised preconception and antenatal care also limits early interventions.

Impact:
Obesity increases the risk of gestational diabetes, hypertension, pre-eclampsia, thrombosis, caesarean delivery, and anaesthesia complications. It also raises the

likelihood of miscarriage, premature birth, stillbirth, and macrosomia. Early identification and tailored support are essential to improve outcomes.

Prevalence in York:
In 2023/24, 24.1% of pregnant women in York were obese at their initial antenatal appointment, close to the national average of 26.2%. This highlights the need for targeted, evidence-based interventions.

Smoking During Pregnancy

Impact:
Smoking during pregnancy is linked to miscarriage, premature birth, low birth weight, stillbirth, and infant respiratory and congenital issues. It also increases maternal risks, including prevalence in York:**
11% of pregnant women in York smoke, lower than the national average of 13.6% (2023/24). However, data accuracy remains a concern, and improved methods are expected.

CYC Stop-Smoking Support:
City of York Council's Health Trainer Service offers personalised stop-smoking support for pregnant women. With a self-reported four-week quit rate of 88.9%—well above regional and national averages—this service has proven effective in improving maternal and infant health. Its success underscores the value of targeted, locally delivered interventions.

Fertility

As of 2023, the average age of first-time mothers in England and Wales is 30.9 years, up from 25.8 in 1993. While more women are having children later in life, overall fertility rates are declining. The total fertility rate in England and Wales reached a record low of 1.44 children per woman in 2023—a trend mirrored in York.

Fertility Rate in York
In 2020/21, York's general fertility rate was 39.74 live births per 1,000 women aged 15–44, significantly below the national average of 59.19. In 2022, the city recorded just 1,573 live births—the lowest since at least 2013—placing York among the lowest fertility rates compared to similar local authorities.

Implications of Delayed Childbearing
Having children later in life increases the risk of miscarriage, gestational diabetes, preeclampsia, stillbirth, and labour complications. It also heightens the likelihood of chromosomal abnormalities and fertility challenges, often requiring assisted reproductive technologies, which can be costly and emotionally demanding.

Drivers of Declining Fertility in York
Fertility decline in York is driven by factors such as rising living and housing costs, financial pressures of parenthood, and shifting societal norms. Higher rates of female participation in education and the workforce, evolving gender roles, and changing family structures also influence reproductive choices. These trends call for responsive local reproductive health policies.

Stillbirth and Infant Mortality

Stillbirth
Stillbirth—defined as the death of a foetus after 24 weeks of pregnancy—remains a major public health concern in the UK, which has one of the highest rates among high-income countries. The stillbirth rate, measured per 1,000 live and stillbirths, is a key indicator of perinatal health.

Risk Factors
Risk factors include maternal age (under 20 or over 35), smoking during pregnancy, obesity, pre-existing conditions (e.g. diabetes, hypertension), infections, multiple pregnancies, prior stillbirths, and inadequate prenatal care. Socioeconomic disadvantage further increases the risk.

Inequalities by Ethnicity and Deprivation
Stillbirth rates are higher in deprived areas than those less deprived , (4.69 vs. 2.37 per 1,000 births) and among Black and Asian women (7.52 and 5.15 per 1,000) compared to White women (3.30). Black African and Caribbean women in the most deprived areas face the highest rates (8.10 and 7.96 per 1,000). (MBRACE-UK)

York's Stillbirth Rate
York's stillbirth rate for 2021–2023 is 4.1 per 1,000 births, slightly above the national average of 4.0 and the third highest among its statistical neighbours. As this data new, it is too early to draw definitive trends. These figures should be interpreted with caution, as sample sizes and data collection methods are still being refined.

Maternal Deaths

Maternal mortality remains a major concern in the UK, with rates now at their highest in 20 years, highlighting persistent health inequalities. The latest MBRRACE-UK annual report on maternal deaths and morbidity has revealed that maternal mortality rates have reached their highest level in 20 years.

Inequalities by Ethnicity and Deprivation
The report found notable disparities in maternal mortality rates based on ethnicity and socioeconomic status. Black women are three times, and Asian women twice as likely, to die during or shortly after pregnancy compared to White women. Women in the most deprived areas face maternal death rates over twice those in the least deprived areas.

Causes of Maternal Death
Leading direct causes include obstetric haemorrhage, sepsis, and thromboembolism, with the latter most common recently (MBRRACE-UK, 2021). Indirect causes involve pre-existing conditions such as cardiac disease, diabetes, obesity, and mental health issues, notably suicide in the first postpartum year. Age is another important risk factor, with women over 35 at a higher risk of complications, including stillbirth and maternal death (NHS Digital, 2022).

Maternal Death Rate in York
As of April 2025, York's specific maternal mortality data is unavailable. Nonetheless, national trends highlight the critical need for targeted interventions to address these

disparities. Ensuring equitable access to high-quality maternal care, providing targeted support for at-risk populations, and continuing efforts to reduce preventable deaths through improved monitoring, early intervention, and personalised healthcare strategies are essential. Additionally improving mental health services, postnatal care, and education to reduce preventable maternal deaths locally.

Teenage Pregnancy

Teenage pregnancy can significantly affect a young woman's physical, emotional, and social wellbeing. While rates have declined nationally, the highest remain in the North East and Yorkshire.

Young women from disadvantaged backgrounds—particularly those in deprived areas or not in education, employment, or training (NEET)—are at greater risk. Key contributing factors include limited access to education, lower socioeconomic status, and inconsistent contraception use.

Teenage mothers face higher risks of preterm birth, low birth weight, pregnancy-related complications, and postnatal mental health issues. They are also more likely to encounter stigma, economic hardship, and disrupted education and career prospects, affecting both mother and child long term.

These challenges highlight the need for accessible sexual health education, youth-friendly services, and sustained support. Currently, there is a gap in under-18 conception data, with no confirmed release date for updated figures from the Office for National Statistics.

Teenage Pregnancy rate in York

Available data indicates a general decline in teenage pregnancies in York. In 2021/22, 1.6% of pregnancies at the time of booking were to teenage mothers, down from 2.2% in 2018/19. However, in some areas of the city, this trend has reversed. Wards such as Acomb, Guildhall, Holgate, Micklegate, Osbaldwick, Derwent, and Westfield have seen an increase in teenage pregnancies (CYC Business Intelligence Public Health Maternity and Pregnancy Indicators 2022/23).

Breastfeeding

Breastfeeding provides significant health benefits for mothers. In the short term, it aids postpartum recovery, reduces bleeding, and supports weight loss. Long-term, it lowers the risk of breast and ovarian cancers, cardiovascular disease, type 2 diabetes, and high blood pressure. It also supports maternal mental health and bonding with the baby, potentially reducing postpartum depression (WHO, NHS, 2020).

National and international guidelines recommend exclusive breastfeeding for the first six months (NICE).

Breastfeeding Initiation

In York, 74% of mothers initiate breastfeeding—slightly above the national average of

72%. However, data accuracy remains a concern due to data collection methods. Clear inequalities exist when considering socioeconomic factors. Initiation rates are lower in more deprived areas, particularly Westfield, Hull Road, and Clifton, with Westfield recording the lowest at just over 50%.

Breastfeeding duration at 6–8 Weeks
By 6–8 weeks, breastfeeding drops to 45% in York—higher than the national average of 33% (OHID, 2025). Rates vary widely, Westfield ward has the lowest breastfeeding continuation rate at 6-8 weeks, with only 29% of mothers still breastfeeding, in contrast to 61% in Micklegate ward.

Perinatal Mental Health

The perinatal period is a vulnerable time for women's mental health, with new or worsening conditions common. Postpartum psychosis is unique and severe, while depression and anxiety remain prevalent. Since 63% of mental health disorders begin before age 25 and the average first-time mother is 31, many enter pregnancy with pre-existing conditions, making early identification and ongoing support essential for maternal and infant wellbeing.

Impact on Mothers
Poor perinatal mental health can profoundly affect a mother's well-being and her ability to care for her baby. It can lead to inadequate nutrition, challenges with initiating or maintaining breastfeeding, and disruptions in the critical bonding process between mother and child.

Impact on the baby
Children of mothers with mental health issues face higher risks of developmental delays, poor health, and even infant mortality. These children are more likely to experience mental health struggles themselves during childhood, underscoring the intergenerational impact of insufficient support and intervention.

Women at Higher Risk of Developing Perinatal Mental Health Conditions. Women from lower socioeconomic backgrounds face greater risk due to financial stress, housing instability, and limited access to services, often compounded by barriers to care and support. These women may also face additional barriers to accessing care and support, including financial constraints or a lack of social support networks. Addressing these challenges is critical to improving perinatal mental health outcomes and ensuring better care for both mothers and their children.

Ethnic Inequalities
Ethnic minority women are less likely to register with GPs, seek help, or have mental health concerns recorded, leading to underdiagnosis and lower satisfaction with healthcare. With information regarding their mental health during the perinatal period being less likely to be recorded, and evidence that ethnic minority women are less often asked about their mental health by healthcare providers, they are less likely to receive a diagnosis for common mental health disorders during the perinatal period, exacerbating gaps in care and support.

This underreporting hinders effective support and national data collection and contributes to a lack of national health profile data on perinatal mental health among ethnic minority women, further complicating efforts to address these disparities.

Service Access and Regional Disparities
Access to perinatal mental health services is uneven, with long waits and limited availability. A notable disparity exists between regions in England, with the North-South divide in perinatal mental health access being a significant concern. Research and NHS data indicate that women in the North of England are more likely to experience delayed diagnoses, limited access to specialist perinatal mental health services, and higher rates of maternal mental illness compared to their counterparts in the South.

Cultural, spiritual and religious beliefs and practices can impact on health behaviours and practices, health outcomes, use of and access to healthcare, and decision-making regarding medical treatment. Other factors can also limit the success of healthcare provision, such as language barriers, insecure immigration status and housing, discrimination, lack of trust between patients and healthcare professionals, and time and financial cost of attending appointments.

Areas with the highest prevalence of perinatal mental health conditions often coincide with the lowest access to adequate services, further compounding the challenges faced by women in need of support.

Perinatal Mental Health in York
Approximately 24.1% of women in York experience perinatal mental health conditions, slightly below England's 25.8%. Specialist service contact rates are also lower than national and regional averages (52.7 vs. 77.8 and 63.6 per 1,000 women aged 15-54). Post-pandemic data is pending, but local reports, by Health and care professionals, indicate unmet need, with many women not accessing necessary support despite the lower recorded service use.

Suicide

Suicide is the leading cause of maternal death in the UK between six weeks and one year postpartum, accounting for about 39% of deaths in this time period.

The 2023 MBRRACE-UK report shows that mental health issues, including suicide and substance misuse, caused over a third of maternal deaths then. Many affected women had pre-existing mental health conditions and faced multiple challenges, such as domestic abuse and substance misuse.

These findings highlight the urgent need for improved mental health support and early intervention during the perinatal period to prevent such deaths.

Conclusions

- **Prevalence of Perinatal Mental Health Conditions**

  Estimating the prevalence of mental health conditions in pregnant and

postpartum women helps identify gaps in care and informs targeted interventions.

- **Impact of Demographic and Risk Factors**
  Understanding factors such as age, ethnicity, and socioeconomic status, along with risks like previous mental health issues and domestic abuse, is key to developing effective prevention strategies.
- **Role of Community Support for Prevention and Early Intervention**
  Leveraging local resources like support groups and outreach services strengthens community networks and prevents mental health issues from escalating.
- **Availability of Preventive Interventions**
  Ensuring accessible mental health and parenting programs during pregnancy and early parenthood is essential for improving outcomes and reaching those in need.
- **Mental Health Assessment in Maternity and Health Visiting Services**
  Integrating physical and mental health assessments in maternity and health visiting services enables early identification and timely intervention for mental health issues.
- **Perinatal Mental Health Support in Primary Care**
  Primary care professionals must be equipped to screen for mental health issues and refer women to appropriate services for effective support.
- **Trends in Specialist Perinatal Mental Health Services**
  Monitoring specialist perinatal mental health services helps assess if they meet population needs, identify service gaps, and inform better planning and resource allocation.

10. Accessibility of primary care services.

Published (March 2025) in the LSE Public Policy Review on-line, Jeffrey, G, paper "Barriers to women in accessing Healthcare in the UK" examined the persistent health gap in the UK and highlighted the disparities in health care access and outcomes between men and women.

The gender health gap.

While women report higher morbidity rates across a range of conditions compared to men, healthcare research have historically been structured around male-centric models, leading to diagnostic delays, inadequate treatment, and unmet healthcare needs. For example, endometriosis, which affects around 10% of women of reproductive age, often takes about seven years to diagnose. Conditions like Polycystic ovary syndrome (PCOS) which is also thought to affect about 1 in 10 women in the UK, and menopause-related health issues receive little attention in research and healthcare.

The study explores the socioeconomic, systemic, and behavioural roots of these disparities, and consequences, which include reduced productivity and labour market inefficiencies. Key factors contributing to the gender health gap – such as caregiving responsibilities, financial constraints, workplace policies, and structural biases in medical research – are analysed.

The gender health gap in the UK is caused by a mix of social, behavioural, and systemic issues that negatively affect women's health. Women often put their families' health before their own, especially in low-income households, leading to delays in seeking care. Female unpaid carers report more health issues than male carers. Stigma around periods, infertility, and menopause can also stop women from seeking help. Instead, many self-treat or rely on the internet or friends for health advice. A 2021 survey showed that many women lack reliable information on basic health topics like menstruation, menopause, and gynaecological conditions. "Women's Health - Let's Talk about it" Survey updated April 2022.

Investment in women's health.

There is little investment in women's health. In 2020, only 5% of global health research funding went to women's health (WEF May 2025), with most of it focused on fertility. FemTech[1] companies also receive very little funding. This lack of research leads to poor diagnosis and treatment—such as heart disease in women being mistaken for stress. Women from ethnic minority backgrounds face even greater barriers due to discrimination and cultural differences.

Low-income women face more health issues but are less likely to get medical help due to cost and lack of flexible work. Many delay treatment for chronic conditions like postpartum depression due to caregiving duties and financial stress. Menopause

[1] Femtech (or female technology) is a term used to define software and services that use technology tailored towards women's health. Femtech mainly focuses on menstruation care through period-tracking apps. Other aspects include fertility and reproductive system health care, pregnancy and nursing care, and sexual health.

symptoms alone participation, showing how health and job support are closely connected.

The Healthwatch report "Women's Health: Stories of women's health experiences in York and North Yorkshire" May 2025, highlights the difficulty of accessing services in York many women sharing their experiences of being passed from one health professional to another, of medical teams "presuming people knew who to go to", making appointments and seeing a GP seems unnecessarily difficult – some practices not making appointments for those to attend in person and others having queue at 8am with others waiting for the surgery to open, having to repeat their story to health professionals over and over again was a common complaint.

Medical Misogyny.

The "Healthwatch" report also highlighted "Medical misogyny". Medical Misogyny is described as "clinicians who have an "ingrained Belief" that women, particularly those from ethnic minority groups, are exaggerating their symptoms, meaning that conditions are left undiagnosed". (BMJ December 2024)

A parliamentary enquiry ("Medical Misogyny" is leaving women in unnecessary pain and undiagnosed for years" December 2024) found that doctors are too often dismissive of women's symptoms when they present for treatment for reproductive health conditions. Key Findings from the enquiry included:

- **Pain is often dismissed & normalised:** Women with conditions like endometriosis and heavy menstrual bleeding often have their symptoms dismissed or normalised by healthcare professionals.
- **Women often experience delayed diagnosis & treatment:** Delays in diagnosis and care can take years, disrupting women's lives, impacting education, careers, relationships, and fertility, often leading them to seek private care.
- **Stigma & Medical Misogyny:** Social stigma, gender bias, and a lack of education contribute to poor awareness, research gaps, and under-prioritisation of gynaecological care.
- **NHS Shortcomings where also identified:**
    - Inadequate training for primary care practitioners, particularly for young women and girls.
    - Poor understanding of treatment options.
    - Long waiting lists due to under-resourcing.
      Need for urgent training and better patient communication.

Violence against minorities ethnic women in the healthcare workforce.

The most recent NHS staff survey (March 2024) showed that frontline NHS staff are facing record levels of discrimination from the public. Minoritised ethnic women using health care services and providing them face a heightened risk of being targeted. For the first time, the survey asked NHS staff if they had experienced sexual harassment while at work, with the results revealing 58,000, or 1 in 9, of the roughly 670,000-strong workforce had experienced sexual harassment from patients, patients' relatives, or other members of the public in 2023.

These unacceptable findings have troubling implications for a workforce that employs high numbers of minoritised ethnic women. With nurses most likely to be both minoritised ethnic and women, it is troubling to see that 60% of nurses surveyed reported experiencing sexual harassment. Two-thirds of women surgeons reported being sexually harassed, and a third had been sexually assaulted, by male colleagues in the past five years.

Conclusion

- **Underdiagnosis and Delays in Care**
  The gender health gap is likely more significant than it seems, with many women facing underdiagnosis and delays in receiving care.
- **Barriers to Service Access**
  Despite efforts to improve access, women struggle to utilise healthcare services due to time constraints, financial limitations, and caregiving responsibilities.
- **Addressing Structural Inequalities**
  Closing the gender health gap requires tackling not only access issues but also deeper structural inequalities and economic barriers.
- **Need for Accurate Health Information**
  A lack of accurate and accessible health information for women must be addressed to ensure better healthcare outcomes and informed decision-making.
- **Intersecting racialised and sexualised violence.**
  It is well documented that significant inequality exists for women when accessing health services, the intersectionality of ethic inequity further exacerbates this.

11. Violence against women and girls (VAWG)

Introduction

Violence Against Women and Girls (VAWG) encompasses a range of crimes that disproportionately affect women and girls, though people of all genders may be impacted. These crimes include:

- Domestic abuse
- Rape and sexual offences
- Stalking and harassment
- 'Honour'-based abuse (e.g. FGM (Female Genital Mutilation), forced marriage, 'honour' killings)
- Digital abuse (e.g. revenge porn, upskirting)

Offenders may be partners, ex-partners, family, acquaintances, or strangers. Victims span all ages, backgrounds, sexualities, and races. VAWG is inherently intersectional[2] and factors including ethnicity, immigration status, economic inequality, LGBTQ+ status, and disability can increase risk.

Data Limitations

Police-recorded crime data is used to monitor VAWG incidents in York and North Yorkshire. However, survey data shows fewer than half of victims report these crimes, mirroring national trends. Specialist support services offer insight into victim demographics, but health-related data is often inconsistent, difficult to share, and dependent on individual workers' ability to identify and record needs.

VAWG also impacts families, friends, and communities. National research shows that 35% of stalking victims reported harm to others close to them.

Prevalence

Domestic Abuse

- 1,886 domestic abuse crimes recorded (2024)
- SafeLives estimates: 2,000 visible and 4,500 hidden victims in York
- 82% of domestic abuse crimes were "violence against the person," mainly common assault and actual bodily harm
- 7% of victims were repeat cases
- 1,966 high-risk cases reviewed by MARAC (Multi Agency Risk Assessment Conference)
- 0 domestic homicides reported in York in the same period

[2] Intersectionality is an analytical framework for understanding how groups' and individuals' social and political identities result in unique combinations of discrimination and privilege. A simpler term that captures the essence of 'intersectionality' is 'convergence. ' It refers to the way different aspects of a person's identity or background come together and interact.

Rape and Sexual Offences

In 2024/25, North Yorkshire Police recorded 90 cases of rape and sexual assault. In the same period, 202 individuals in York received support from Independent Sexual Violence Adviser (ISVA).

Stalking and Harassment

Nationally, 3.8% of adults aged 16–59 experienced stalking in the past year. In 2023/24, North Yorkshire Police recorded 66 cases of stalking involving fear of violence, following the launch of a specialist stalking team and screening tool.

'Honour'-Based Abuse

According to national data, between April 2024 and March 2025, 8,545 women and girls attended healthcare settings where FGM was identified, with a total of 15,905 attendances. An estimated 12 to 15 honour killings occur annually in the UK. In 2022, the Forced Marriage Unit (FMU) supported 302 cases of potential forced marriage.

Structural Gendered Racism

The UN's "16 days of activism against Gender-Based Violence" campaign take place every year and spotlights and advocates for the prevention and elimination of all forms of male violence against women and girls (VAWG).

To tackle VAWG we need to acknowledge the interlocking nature of gender and ethnicity – called structural gendered racism – as a root cause of health problems among black women and other women of colour. Structure gendered racism recognises that for minoritised ethnic women racism and sexism coalesce and intwine, leading to heightened risks, worse outcomes and is a root cause of health inequity among minoritised ethnic women.

The fact that minority ethnic women are disproportionately affected by gender based violence has been recognised at a national level by NHS England. Femicide is the most extreme manifestation of violence against women, in which a woman is killed by a man every three days on average in the UK, with government statistics showing that minority ethnic women being over represented in domestic homicide.

Digital Abuse

Nationally, 1 in 10 women have experienced online violence. This increases to:

- 25% among women aged 16–24
- 35% among LGBTQ+ women.
- Of those affected, 13% reported the abuse later escalated to offline violence.

Health impacts of VAWG

VAWG crimes can cause significant and long-lasting impacts to both physical and mental health, and even to loss of life including death by homicide and suicide.[i]

Physical Health

- In 2024/25, 12% of domestic abuse victims assessed by the IDAS hub had identified physical health needs, though professionals estimated this figure to be as high as 62% (SafeLives).
- 14% of 799 sexual assault survivors supported by ISVA (Independent Sexual Violence Advisor) services across York and North Yorkshire disclosed physical health needs.
- FGM-related impacts include severe pain, bleeding, infections, and potentially fatal complications.
- VAWG is associated with chronic conditions such as chronic pain, arthritis, asthma, and digestive issues.
- Nationally, 68% of those at risk of Honour-Based Violence (HBV) face serious harm or homicide.
- One woman is killed every five days in England and Wales by a current or former partner (SafeLives).

Sexual and Reproductive Health

- Sexual assault can result in STIs, including HIV, unintended pregnancies, and other reproductive complications.
- Women with FGM are more likely to experience serious childbirth complications, including the need for caesarean sections, severe bleeding, and increased infant mortality.
- Domestic abuse often intensifies during pregnancy, increasing risks to both mother and unborn child.

Mental Health

- 40% of domestic abuse survivors assessed by IDAS had mental health needs; professionals estimate this could be as high as 92%.
- 58% of individuals accessing ISVA support service disclosed a mental health need.
- Common barriers to mental health support include long waiting lists, unclear criteria, lack of communication and signposting back to domestic abuse services for support.
- National data shows VAWG survivors are twice as likely to experience depression.
    - 7% have attempted suicide
    - 17% have attempted suicide or self-harm (SafeLives)
    - High prevalence of PTSD (Post traumatic stress disorder) and generalised anxiety disorders

- 63.4% of sexual assault survivors reported emotional or psychological effects as their primary non-physical effect of rape or assault.
- 93.7% of women nationally have experienced street harassment, often leading to anxiety and avoidance behaviours.
- 21% of respondents to the York and North Yorkshire VAWG survey said their area felt somewhat or very unsafe for women and girls, affecting perceptions of safety even among non-victims.

Behavioural Health

- Among domestic abuse victims assessed by IDAS (2024/25):
  - 6% had alcohol support needs
  - 3% had drug support needs
- Professionals estimated 66% of victims may require substance misuse support.
- Similar figures were reported among ISVA clients.
- National research suggests substance use may be a coping mechanism for trauma linked to abuse.

Other Health Implications

National research shows healthcare practitioners are often the first point of contact for survivors. 80% of women in relationships with domestic abuse had visited their GP before accessing support, 57% of victims at risk of HBV had visited their GP in the last 12 months and 19% had visited A&E as a direct result of the abuse[i].

National data suggests 54% of stalking victims disclosed practical impacts on their lives and activities, including investing in extra security, limiting social activities and changing a workplace or home.[ii]

Over a fifth of sexual assault victims said that they took time off work because of the assault, and 6% reported losing their job or giving up work[iii]. Furthermore, women who have experienced sexual abuse are less likely to attend routine cervical screening appointments[iv].

According to Refuge 40% of homeless women state domestic abuse as a contributory factor to their homelessness.

Efforts to address VAWG in York and North Yorkshire.

In line with the national *"Tackling VAWG Strategy"*, a joint VAWG Strategy for York and North Yorkshire was launched in June 2022 by the Police, Fire and Crime Commissioner's Office (now under the York and North Yorkshire Combined Authority YNYCA) launched a new joint Strategy to Address Violence Against Women and Girls and accompanying delivery plan. In York this work is overseen by the Safer York Partnership. The strategy has six key objectives;

1. Listening to women and girls
2. Prevention and early intervention
3. Building trust in policing
4. Strengthening multi-agency collaboration
5. Enhancing victim support
6. Facilitating perpetrator behaviour change.

A progress report on delivery against the VAWG strategy completed June 2023 found that 12% more referrals were being made to victim services and those who access services 154% reported positive outcomes. This strategy is supported by the North Yorkshire and City of York Domestic Abuse Strategy 2024–2028, launched in spring 2024.

Conclusions

- **Data Gaps in Assessing Unmet Health Needs**
  Data gaps make it difficult to fully understand the unmet health needs of women and girls affected by Violence Against Women and Girls (VAWG).
- **Physical and Mental Health Impacts of VAWG**
  VAWG results in significant short- and long-term physical and mental health consequences for survivors.
- **Addressing Immediate and Long-Term Care Needs**
  Health systems must address both immediate care and long-term recovery for those affected by VAWG.
- **Need for Further Research and Improved Data Collection**
  More research and better data collection are essential to understand and address the health impacts of VAWG.

12. Challenges and limitations of this HNA

Purpose and Intended Outcomes

The aim of a Health Needs Assessment is to identify unmet health and care needs within a given population—in this case, women—and recommend the changes necessary to address them. It is a systematic, data-driven approach used to:

- Describe population health issues
- Identify health inequalities and gaps in service access
- Set priorities for effective resource use

The purpose of this Health Needs Assessment (HNA) is to build system-wide awareness of unmet health needs among women in York, with a particular focus on those experiencing social marginalisation. Our aim is to embed learning from this process into the working practices of our own commissioned services and influence wider commissioning and service design across the local health and care system.

Despite the data challenges, we can confidently conclude that there is an unmet need for more detailed, gender-specific data collection to better address the health and care issues that affect women in York.

We intend to monitor for evidence of impact following publication and encourage all system partners to reflect on how they can respond to the findings.

Learning from conducting the HNA

3.1 Approach to Data Collection

We opted not to interview women directly for their views, as this work was being undertaken concurrently by Healthwatch. As such, we recommend that this report be read in conjunction with Healthwatch's findings to ensure a more comprehensive understanding.

3.2 Evolving Insights

As we progressed with the report, it became apparent that the initial topics we had identified—such as caring responsibilities, maternal health, and employment—while important, were insufficient to provide a complete picture of the needs of women in York. It is acknowledged that the scope of this HNA does not fully capture the diversity and complexity of the challenges faced by women in York.

3.3 Challenges with Data Availability

Data was hard to gather related to the identified themes, especially at the local level, despite stakeholders often being open to providing it. This may stem from capacity constraints across the system, which has made gender-disaggregated data difficult to gather.

3.4 Limitations and the Imperfect Nature of the Assessment

This Health Needs Assessment should be viewed as a starting point, not a final answer. The process of gathering information from a range of sources to build a clearer picture naturally involves challenges and limitations. The work presented here is exploratory, and the lack of easy access to high-quality, comprehensive data is a key reason why the assessment was necessary in the first place. It's important to remember that this work reflects an ongoing effort to understand and address the needs of women in York.

3.5 Complexity of Women's Health and Data Gaps

Women's health is a vast and complex field, with each of the topics covered in this report representing a significant area of inquiry. A lack of comprehensive data and system capacity has limited the research we were able to conduct.

One key lesson from this assessment is the fragmented and incoherent approach to women's health services in York. The value of a comprehensive national Women's Health Strategy is clear, and while it is too early to measure improvements, national and local stakeholders have already begun responding to the need for change in response to the national strategy.

Conclusion.

It is crucial to emphasise that no needs assessment can speak to, and for all, 51% of the population. However, this report provides insights into how we can better support women across various areas of life, from healthcare and education to caregiving roles and service access. We must continue addressing issues such as misogyny, period health, menopause, and maternal care.

The Humber and North Yorkshire ICB report on women living in the wider geographical region offers some more nuanced insights, but its usefulness in addressing the unique needs of women in York is limited due to the vast and diverse area it covers.

An additional challenge is the lack of consensus on how to define "woman." The complexity of this debate has been underscored by the recent Supreme Court ruling (April 2025), which determined that the legal definition of a woman is based on biological sex, and clarified how the law defines the words 'man', 'woman' and 'sex' in the Equality Act 2010.This ruling could have significant implications for the health and care needs of women, particularly transgender women. The impact of this legal decision is still being explored, and organisations should respond appropriately.

Awaiting timeline infographic with key initiatives which will impact on the HNA.

13. Recommendations: 6 Strategic Themes for York

The data and evidence in this report suggest that York's approach to women's health and equality should be shaped around six key priorities.

Adopting these priorities would focus efforts on addressing the barriers women face, promoting gender equality, and improving well-being. By collaborating across all sectors – public, private, and voluntary – York could take a city-wide approach to create lasting impact, fostering a more inclusive and supportive environment for all women in the city.

Strategic Theme #1: Early Intervention and Prevention

Why it matters: Tackling the root causes of poor health and gender-based violence reduces harm before it escalates. Good practice suggests that this includes:

- Prioritising early identification of issues across health, education, and community services.
- Implementing school-based education on menstrual health, consent, and healthy relationships (PHSE).
- Training frontline professionals to recognise early warning signs of abuse, health neglect, or social isolation.
- Expanding public campaigns to shift social norms and promote healthy, safe behaviours from a young age.

Strategic Theme #2: Gender-Specific Data, Research, and Monitoring

Why it matters: Lack of detailed, disaggregated data hides disparities and limits targeted action. Good practice suggests that this includes:

- Improving gender-disaggregated data on health, employment, and care burdens, taking into consideration the intersection of other protected characteristics including race and disability.
- Standardising recording of VAWG-related health needs across sectors.
- Commissioning local research to better understand hidden or unmet needs (e.g.' mental health, economic abuse).
- Embedding equity-focused data analysis in service planning and funding decisions.

Strategic Theme #3: Partnership and Multi-Agency Collaboration

Why this matters: Strong multi-agency collaboration ensures a coordinated, efficient, response to the complex, needs of women and girls, improving safety, support, and long-term outcomes. Good practice suggests that this includes:

- Strengthening cross-sector working between health, policing, education, local authorities, housing, and the voluntary sector.

- Embedding healthcare workers in domestic and sexual violence services.
- Use frameworks like MARAC more broadly to coordinate care and risk management.
- Co-producing solutions with lived experience voices through advisory panels and community engagement.

Strategic Theme #4: A Public Health Approach to Gender Inequality

Why this matters: A public health approach to gender inequality addresses the causes of women's health issues, builds resilience, and creates fair solutions for everyone. Good practice suggests that this includes:

- Addressing women's health issues as systemic public health challenges, not niche concerns.
- Tackling the root causes of inequality—poverty, trauma, discrimination, and social norms—through upstream investment.
- Promoting community-based supports (e.g. befriending, peer recovery, women's hubs) that reduce isolation and promote resilience.
- Focusing on intersectionality, recognising how age, ethnicity, religion, disability, sexuality, and income intersect with gender.

Strategic Theme #5: Accessible, Trauma-Informed and Gender-Sensitive Services

Why this matters: Women face multiple and overlapping challenges that require joined-up, sensitive responses. Good practice suggests that this includes:

- Improving access to reproductive, mental, and primary care, particularly for menopause, period health, and cancer screening.
- Ensuring trauma-informed practices in all medical procedures (e.g. IUD fittings).
- Reducing waiting times and barriers to mental health and substance misuse support with tailored services for women.
- Embedding support for survivors of VAWG into housing, health, and employment

Strategic Theme #6: Economic Empowerment and Workplace Equality

Why this matters: Economic empowerment and workplace equality remove barriers, giving women the opportunity to succeed, grow, and be financially independent. Good practice suggests that this includes:

- Addressing structural barriers to women's employment: flexible work, caregiving penalties, unequal pay, and lack of progression.
- Supporting women to re-enter, remain in, and progress through work, particularly carers and return.

14. Bibliography, references and further reading.

General

Women's Health Strategy for England 2022

Easy read version of the Women's Health Strategy for England.

NHS 10 Year Plan. Launched in October 2024 to hear people's views, experiences and ideas to help shape the new 10 year health plan. Due to be published in 2025.

Woman of the North Report, inequality, health and work.

Women's Health Profile: Humber and North Yorkshire Integrated Care Board, October 2023

Our City Health Narrative V4 A summary of the York Joint Strategic Needs Assessment (JSNA) in 2025

For information about York's demographics and wider determinants of health: York Health and wellbeing JSNA

Census Data for York: number of households.

Public health Outcomes Framework (fingertips) PHOF

The PHOF was introduced in 2012 to allow the whole public health system to be refocused around achieving positive health outcomes for the population and reducing inequalities in health, rather than focused on process targets.

Office for Health Improvement & Disparities. Public health profiles. [27 May 2025] https://fingertips.phe.org.uk © Crown copyright [2025].

Hard Edges: The reality for women affected by severe and multiple disadvantage Heriot Watt University published January 2024

New report provides snapshot of human rights in the City of York University of York 2025

Supreme Court ruling on the meaning of 'man', 'woman' and 'sex' – what it means for health and care Healthwatch North Yorkshire. Published April 2025.

Local Resources from Benenden Health

Please note that Benenden Health is a private healthcare provider, and we are not recommending this private provider above any other.

Benenden Health have also been working on *"Understanding the Gender Health Gap"*. Their National Survey results from 2024 are available here. *"Supporting women in the workplace – a guide for businesses"* is downloadable here.

Benenden Health partnered with The Fawcett Society to publish *The Gender Health Gap: Our Stories,* six real life stories of women's experiences in the health system and the impact on work and life.

Unpaid care and gender disparities.

Woman of the North Report Inequality health and Work, 2024
Ref: Bambra C, Davies H, Munford L, Taylor-Robinson D, Pickett K et al. (2024) Woman of the North. Health Equity North: Northern Health Science Alliance

Unpaid care by age, sex and deprivation, England and Wales: Census 2021

Survey of Adult Carers in York, Business Intelligence Hub 2024

Wellbeing and relationships Carers UK 2022

Caring as a social determinant of health Public health England, 2021

The state of caring 2022. Carers UK 2022

Women in employment.

Labour Market Profile - Nomis - Official Census and Labour Market Statistics York data

Women and the UK economy. Research briefing. Published February 2025. House of commons Library.

Mid-life women face growing pension gap Published 26 June 2025 AVIVA.

Loneliness and isolation in older women.

The State of Women's Health in Leeds White A., Erskine S., and Seims A (2019)

Jo Cox Commission on Loneliness and social isolation, 2017.

The state of aging 2022. Centre for ageing better. Summary The State of ageing 2023/24

Public Health Outcomes Framework – Fingertips

Loneliness Strategy 2018 (Published by Theresa May's conservative government).

State of healthy Ageing in Yorkshire and the Humber 2023. A resource to support Health Needs Assessments. February 2023.

Aging Well – York JSNA. York Health and Wellbeing.

Social Isolation and Loneliness in Older Adults—A Mental Health/Public Health Challenge. JAMA Psychiatry 2020.

Menopause

Menopause: a global health and wellbeing issue that needs urgent attention. Delanerolle, Gayathri, Pathiraja, Vindya et al.
The Lancet Global Health, Volume 13, Issue 2, e196 – e198

Nice Guidance QS 143 Quality statements | Menopause | Quality standards | NICE
Menopause NHS website Menopause - NHS

Menopause transition: effects on women's economic participation. Published 20 July 2017

Challenging the culture on menopause for working doctors report

Your guide to Menopause - BHA for Equality

Primary-care-HRT-guidelines-v15.pdf

Period Poverty.

Period product scheme for schools and colleges - GOV.UK Updated May 2025

Period Poverty in UK Higher Education: Addressing Stigma and Empowering Students - HEPI Higher Education policy Institute. January 2024

Home | PeriodPoverty.uk

Period Poverty - What is it and what can be done? - Initial UK - Blog

Who Will Tackle the UK's Crippling Period Poverty Crisis? Shout Out UK (SOUK October 2024)

york-youth-council-make-your-mark-report-2019

Period poverty: a public health crisis. Peer reviewed by **Dr Krishna Vakharia, MRCGP** Authored by **Amberley Davis** Originally published 10 Mar 2023

Period Poverty: A neglected Public Health Issue. Jaafar et al 2023. KJFM

UK Youth Parliament 2018. Briefing paper. Period poverty has been debated many times – May 2024, December 2021, March 2020 April 2019.

.Secondary and Sixth Form School Health and Wellbeing City Report. 2023/24 York

Understanding Period Poverty: Socio-Economic Inequalities in Menstrual Hygiene Management in Eight Low- and Middle-Income Countries. Rossouw, et al 2021. Int J Environ Res Public Health. 2021 Mar 4;18(5):2571. doi: 10.3390/ijerph18052571

Cost of living: UK period poverty has risen from 12% to 21% in a year. May 2023. Pyecroft, H. Action Aid

Cancer Screening

Women's Health Strategy for England – Chapter 15: Cancers. Updated August 2022.

Breast Screening Programme. England 2023-24. NHS England NHS Digital.

Public Health Outcomes Framework. Fingertips. Cancer Screening coverage York 2023/24.

Cervical Screening Programme for England 2023-24. NHS England. NHS Digital

Bowel Cancer Screening Programme for England 2023-24. NHS England. NHS Digital

Bowel Cancer screening - NHS UK

Breast Screening - NHS UK

Cervical Screening - NHS UK

Life-saving scheme to improve cancer screening among Muslim women. Cancer Research UK July 2023

Maternal Health

Births in England and Wales - Office for National Statistics
How is the fertility rate changing in England and Wales? - Office for National Statistics
Births in England and Wales - Office for National Statistics
Global, regional, and national estimates and trends in stillbirths from 2000 to 2019: a systematic assessment - The Lancet
MBRRACE-UK Maternal MAIN Report 2024 V2.0 ONLINE.pdf
Child and Maternal Health | Fingertips | Department of Health and Social Care
A national cohort study and confidential enquiry to investigate ethnic disparities in maternal mortality - PubMed
NHS Digital. (2022). *NHS maternity statistics 2021–2022* https://digital.nhs.uk
https://www.npeu.ox.ac.uk/mbrrace-uk Saving Lives improving mothers' care.
Woman-of-the-North-report.pdf
Conceptions in young people – RCPCH – State of Child Health
Suicide still a leading cause of maternal death | Maternal Mental Health Alliance
Culture, spirituality and religion: migrant health guide Gov.UK Updated September 2021

York JSNA – Health across the life course – starting and growing well.

York JSNA - Health across the life course – living and growing well

Accessibility of Primary care services.

Barriers to women accessing healthcare in the UK. Jeffery, G. LSE Policy Review. Published March 2025.

Women's Health – Let's Talk about it, survey. Updated in April 2022

North Yorkshire and York Healthwatch report: Women's Health: Stories of women's health experiences in York and North Yorkshire" Due to be published in 2025

Women's Health is a $1 trillion opportunity that demands greater investment. World Economic Forum (WEF) May 2025.

"Medical misogyny" leaves many women in pain, MPs' inquiry finds. *BMJ* 2024; 387 doi: https://doi.org/10.1136/bmj.q2780 (Published 11 December 2024) Cite this as: *BMJ* 2024; 387:q2780

Violence against Women and girls.

Tackling violence against women and girls strategy, Home Office, GOV.UK accessed 21/05/2025

Measuring gender equality in the UK: data on violence against women and girls report, King's Global Institute for Women's Leadership, 2024

The Impact of Stalking and Its Predictors: Characterizing the Needs of Stalking Victims. Storey et al, 2023 Journal of Interpersonal Violence

Safer York North Yorkshire and City of York Domestic Abuse Strategy 2024-2028

VAWG survey analysis 2025, York & North Yorkshire Combined Authority. Unpublished

SafeLives Safe Accommodation Strategy 2021-2024. North Yorkshire and City of York. Please note 'invisible' in this context means those not known to services such as the police or victim support services.

North Yorkshire Police Domestic Abuse Operational Problem Profile 2023-2024. Unpublished.

Home Office Community Safety Partnership Open Data Tables 2024-2025.

Crime in England and Wales: year ending December 2024, ONS

Female Genital Mutilation Enhanced Dataset (FGMED) accessed from NHS digital 20/05/2025

Forced Marriage Unit. Home Office and Foreign, Commonwealth & Development Office

Open University Observatory on Online Violence Against Women, Open Research Online

The lasting impact of violence against women and girls. ONS 2021

World Health Organization (2012). Understanding and addressing violence against women: Health consequences. Retrieved from: https://iris.who.int/bitstream/handle/10665/77431/WHO_RHR_12.43_eng.pd

www.haloproject.org.uk/img/FGM

The association between violence against women and chronic pain: a systematic review and meta-analysis, Uvelli et al *BMC Women's Health* volume 24, Article number: 321 (2024)

SafeLives, your choice spotlight on HBV and forced marriage https://safelives.org.uk/wp-content/uploads/Your-choice-Spotlight-on-HBV-and-forced-marriage.pdf

FGM the facts, Home Office, 2011

SafeLives Safe Accommodation Needs Assessment and Wider Review, North Yorkshire and City of York, 2023 (Unpublished)

Experiences of domestic violence and mental disorders: A systematic review and meta-analysis. Trevillion, K., Oram, S., Feder, G., & Howard, L.M. (Pub Med 2012)

Women's Aid, Domestic Abuse Report 2022. https://www.womensaid.org.uk/wp-content/uploads/2022/03/The-Domestic-Abuse-Report-2022-The-Annual-Audit.pdf

Alcohol and violence briefing statement, Faculty of Public Health
IRISi, accessed from https://irisi.org/ May 2025) and SafeLives Spotlight on HBV and forced marriage.

Barriers to cervical screening in women who have experienced sexual abuse: an exploratory study. Cadman L et al, 2014, BMJ

Male violence against Minoritised ethnic women exacerbating ethnic health inequity and endangering staff. NHS Health and Race Observatory. **Published:** 10.12.2024

Acknowledgements

This document was produced by the Public Health Team at City of York Council.

We would like to thank all the stakeholders and colleagues who generously gave their time to be interviewed and shared valuable insights and data to inform this report. This report would not have been possible without the collaboration and commitment of everyone involved.

Note: This document contains a small amount of content generated by Artificial Intelligence (AI). AI-generated content has been reviewed by the author for accuracy and edited/revised where necessary. The author takes responsibility for this content.

Health and Wellbeing Board 16 July 2025

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

The Commercial Determinants of Health – Exploring a York approach

Summary

1. The activity of the private sector shapes the physical and social environments in which people are born, grow, work, live and age – both positively and negatively – and therefore influences the health and wellbeing of York residents.

2. This report introduces to the Board the substantial evidence emerging within health and social policy research on what are termed the 'Commercial Determinants of Health' (henceforth CDOH). This concept, applied locally, refers to the way unhealthy commodity industries, for instance those selling tobacco, alcohol, unhealthy food, or gambling products, are undermining our local Health and Wellbeing Strategy objective to 'become a health-generating city' and have a negative impact on goals improve healthy life expectancy and reduce the gap between the richest and poorest in the city.

3. In particular the evidence is strongest about our youngest: if York is committed to giving every child the 'best start in life', we need to protect our youngest residents from the influence and marketing of harmful products, and give them freedom to live healthier lives.

4. Partners around the Health and Wellbeing Board are asked to note the report, as well as the presentation to be given on the day, which includes a number of recommendations around

    - greater awareness of CDOH amongst partner organisations
    - suggested policy positions organisations may want to take
    - The Board endorsing the Association of Directors of Public Health (APDH) Y+H Consensus Statement on the CDOH.

The link between unhealthy commodities and health in York

5. In York, two thirds of the life expectancy gap in both females and males between our richest and poorest communities comes from three areas: cardiovascular diseases, cancer and respiratory diseases.

6. An estimated 80% of CVDs are considered preventable (World Heart Foundation), 30% of cancers are considered preventable (World Health Organisation) and around 60% of respiratory diseases are considered preventable (Office for National Statistics).

7. Data from the Global Burden of Disease study shows that the trio of three unhealthy commodities leads to more than a third of all deaths in York, tobacco (at 17%), unhealthy food (at 13%) and alcohol (at 4%).

8. The burden of these unhealthy commodities falls particularly hard in terms of early deaths. 594 deaths in York in 2021 were of people under 75 whose death was considered ‘preventable’, 90% of these were from non-infectious causes and an estimated 45% of these were from unhealthy commodities; this means that 240 out of 594 early deaths in York in 2021 were due to unhealthy commodities.

9. Beyond early mortality, unhealthy commodities result in a significant amount of life lived with long terms illness or disease in York – in fact, compared to a decade previously, in 2023 males in our city lived with an additional 27 months of ill health, and females 43 months.

10. Unhealthy commodities cost the York economy dearly, through health and care costs, lost productivity, economic drag through taxation, and wider societal implications such as smoking-related fires or alcohol-related antisocial behaviour. It is estimated by Action on Smoking and Health that smoking costs York £109m per year, and by the Institute of Alcohol Studies that alcohol costs York £91.7m per year.

Commercial determinants of health – the academic evidence

11. The literature on the commercial determinants of health stretches back decades and begun with significant evidence that global and local action to regulate the harmful effects of tobacco was very slow to be implemented due to the actions of the tobacco industry. Whilst conclusive proof of the link between smoking and lung cancer emerged in the early 1950s, the first piece of legislation (ban on TV advertising) did not come in until 1965, and subsequent legislation such as a wider advertising ban and indoor smoking bans were not introduced until the 2000s.

12. Leaked releases from major tobacco companies showed extensive use of a shared ‘playbook’, the aim of which was to dissemble, sow doubt around the evidence, introduce distraction tactics (e.g. cigarette filters and ‘mild’ cigarettes), and aggressively lobby governments to avoid or delay stronger legislation.

13. With the tobacco industry, such tactics and activity still persist, although the signing by 182 countries of the WHO Framework Convention on Tobacco Control has been a highly successful measure to curb its influence. Similar tactics are however now known to be used by other unhealthy commodity industries, such as alcohol, gambling and unhealthy food companies.

14. In 2023, the Lancet Commission on the Commercial Determinants of Health published a definitive series of articles laying out a definition of CDOH as

> *private sector activities which impact public health, either positively or negatively, directly or indirectly, and their enabling political and economic systems and norms.* [1]

15. The authors were clear that ‘Commercial entities can have positive effects on health and society, not least through the creation of products and services that are beneficial, or even essential, to health’. However ‘there is now overwhelming evidence that some, particularly the largest, multinational and transnational corporations … are having increasingly negative effects on human and planetary health and social and health inequities’.

16. Examples of industries where these unhealthy commodity practices occur including gambling, tobacco, fossil fuels, formula milk, alcohol, unhealthy food, the car industry, companies offering loans which could be considered ‘predatory’, sugar sweetened beverage manufacturers, and social media companies.

17. However, it should again be emphasised that CDOH approaches are not designed to focus on any industry specifically, but on the tactics which are found to be common across unhealthy commodity industries and which undermine health, which in summary include:

    - Preventing, undermining, or circumventing public policy
    - Manufacturing doubt on the science, and shifting blame

[1] Commercial determinants of health

- Aggressive marketing and advertising
- Shaping social norms around personal responsibility
- Public-private partnerships (e.g. sponsorship)
- Reputational management

18. The Lancet series identified three issues that lie at the heart of the CDOH: the political and economic system, the commercial sector and key underlying drivers – power, externalities, and norms; and it concluded that

    'Reshaping the model in the public interest will therefore require the political and economic changes that are increasingly being called for. Commercial entities will need to meet the true costs of the harm they cause; governments will need to exercise their power in holding commercial entities to account; and norms need to be reshaped in the public interest, drawing attention to the right to health and governmental obligation to protect health and not just corporate freedoms.'

19. Three examples are now given of how these mechanisms of commercial influence work in practice.

Example #1 – Infant formula

20. The protection, promotion and support for breastfeeding are a vitally important public health priority as breastfeeding promotes health, prevents disease, and provides numerous benefits for both mother and baby. There is overwhelming evidence that breastfeeding saves lives and protects the health of babies and mothers both in the short and long term.

21. UNICEF and the World Health Organisation recommend exclusive breastfeeding for the first six months of an infant's life, with continued breastfeeding alongside the introduction of appropriate complementary foods up to two years of age; however, breastfeeding is no longer seen as the norm.

22. Research has shown that eight out of ten women stop breastfeeding before they want to. Factors for this include: a lack of support from family or professionals; belief that they have insufficient milk supplies to nourish their baby; employers who have not got adequate provision to support women returning to work and expressing breast milk; or lack

of supportive environments in which women feel comfortable feeding their babies when out in the community.

23. Breastfeeding is viewed by many as difficult to achieve and often unnecessary because formula milk is seen as a close second best. This is largely due to the strong commercial influences from formula milk companies, which use marketing strategies to promote formula milk as equal to breast milk.

24. The marketing of commercial milk formula (CMF) has irrevocably altered the infant feeding ecosystem, as more infants are fed formula milks than breastmilk.

25. CMF marketing is a multifaceted, sophisticated, well resourced, and powerful system of influence that generates demand and sales of its products at the expense of the health and rights of families. Digital platforms and use of individual data for personalised and targeted marketing have substantially enhanced the reach and influence of this system.

26. CMF marketing oversimplifies parenting challenges into a series of problems and needs that can be resolved by buying specific products. Marketing of CMF manipulates and exploits emotions, aspirations, and scientific information with the aim of reshaping individual, societal, and medical norms and values.

27. Health professionals and scientific establishments are also targeted through financial support, corporate-backed science, and medicalisation of feeding practices. Conflicts of interest threaten the integrity and impartiality of health professionals.

28. To limit the impact of CMF marketing on breast feeding The International Code of Marketing of Breast Milk Substitutes was developed for regulating inappropriate marketing and promotion of CMF

29. The International Code of Marketing of Breastmilk Substitutes (the Code) is an international health policy framework to regulate the marketing of breastmilk substitutes in order to protect breastfeeding. It was published by the World Health Organisation in 1981 and is an internationally agreed voluntary code of practice.

30. The Code was written in response to the marketing activities of the infant feeding industry which were promoting formula feeding over

breastfeeding, in turn leading to dramatic increases in maternal and infant morbidity and mortality.

31. The underlying basis for the Code is the belief that the health of babies is so important that the usual rules governing market competition and advertising should not apply to products intended for feeding babies. Therefore, all Governments should legislate to prevent commercial interests from damaging breastfeeding rates and the health of their population.

32. The Code regulates the marketing of breastmilk substitutes, which includes infant formulas, follow-on formulas and any other food or drink, together with feeding bottles and teats intended for babies and young children.

33. The Code also sets standards for the labelling and quality of products and for how the law should be implemented and monitored within countries.

34. Restricting marketing does not mean that the products cannot be sold, or that factual and scientific information about them cannot be made available. Nor does it restrict parents' choice. It simply aims to make sure that their choices are made based on full and impartial information rather than misleading, inaccurate or biased marketing claims.

35. Parents make decisions, frequently in vulnerable situations, and often in the absence of timely, clear, accurate and impartial information. Understandably, they want to do the best for their babies, and are highly responsive to brand reputation, which is built in different ways, including through marketing of adjacent products such as follow-on formula, and messaging on packs. Most parents are likely to find it difficult to meaningfully assess information about product quality. Price is often used as a proxy for quality despite NHS advice that 'It does not matter which brand you choose, they'll all meet your baby's nutritional needs, regardless of price'. Once parents have found a brand that works for their baby, they are unlikely to switch, remaining loyal to their chosen brand.

36. Recommendations for protecting, supporting and promoting breastfeeding nationally and locally:

National government and policy makers	Local healthcare systems and education
An end to the marketing of formula milk via effective legislation, monitoring and implementation of the Code	Provision of culturally appropriate breastfeeding care and support
Increased regulation and transparency around lobbying to decrease the influence of formula milk companies	Improvements in breastfeeding education, training and skills of healthcare professionals
Investments in maternity protection, supporting breastfeeding in the workplace and enforcing legislation prohibiting discrimination against women during maternity	Empowering parents and families to breastfeed their children for as long as they wish
Health organisations rejecting funding from the Commercial Milk Formula industry	Education and training so professionals and families understand “normal” baby behaviours to reduced introduction of early infant formula

2

Example #2 – Alcohol

37. From headaches and poor-quality sleep to high blood pressure, anxiety and cancers, the wide-ranging impacts of alcohol affect a significant proportion of the population. There are also increasing numbers of people requiring hospital admission and dying before their time because of alcohol-related illnesses. High alcohol-related hospital admissions rates are of particular concern in York and represent the tip of the iceberg of local alcohol-related harms. In addition, it is noted that people in socio-economically disadvantaged groups experience greater levels of harm from alcohol despite lower consumption levels.

38. The key factors influencing alcohol consumption and therefore driving alcohol harms, are:

[2]Adapted from The Lancet Breastfeeding Series, 2023

- price (‘affordability’)
- how we think about alcohol and what’s normal (‘acceptability’ / social norms)
- ease of purchase (‘availability’), recognising that availability may also impact both price and norms / cues around drinking alcohol.

39. The large companies that make, promote and sell alcohol play a major role in influencing these factors through shaping not only our environments and the nature and pricing of products on offer, but also social and political perceptions and responses to alcohol, steering focus away from action on these factors in favour of implementation of less effective measures.

40. Without strong laws to direct their activity, alcohol companies market alcohol intensively and pervasively, not surprisingly looking to target new groups (notably women in the past few decades), increase sales among existing consumers and promote new opportunities for alcohol consumption. Influence begins early; children and young people’s exposure to alcohol marketing paves the way for current and future alcohol harms by encouraging them to develop brand preferences and positive expectations around alcohol, as well as creating and reinforcing social norms around alcohol consumption.[3]

41. Alcohol companies’ marketing and ‘corporate social responsibility’ strategies also, through subtle but powerful means, shape the way people think about alcohol and divert public attention from the influence they have over available options and choices.

42. The ‘drink responsibly’ tagline that often accompanies alcohol adverts is difficult to define and can mean different things to different people. It implies that (1) there is a safe level / way to consume alcohol, which is not the case from a health perspective – the UK Chief Medical Officer’s alcohol guidelines provide a guide on ‘low risk’, not safe, levels of consumption, and (2) those who experience alcohol-related harm do so due to their individual choice without any recognition of the role of the substance itself and its marketing. This emphasis on individual responsibility also increases stigma around those who develop alcohol use disorder and ignores the significant role of the industry in misinforming the public of the true harms of alcohol and lobbying against effective measures to reduce alcohol-related harm.

[3] McClure, A. *et al.* (2013). Alcohol marketing receptivity, marketing-specific cognitions, and underage binge drinking. Alcoholism: Clinical and Experimental Research, 37 (Suppl 1), E404-E413.

43. Major alcohol producers and retailers fund alcohol education programmes and Community Alcohol Partnerships Community Interest Company (CAP CiC), which is a national organisation that currently works in various locations to run ‘Community Alcohol Partnerships’ (CAPs).

44. CAP CiC directs dissemination of alcohol industry-backed resources for education settings. Academic analysis of school educational materials and programmes produced by industry funded Drinkaware, Alcohol Education Trust, and Smashed (Diageo’s anti-underage drinking programme) revealed that the programmes:

- promote familiarisation and normalisation of alcohol as a ‘normal adult consumer product’ which children must learn about and master how to use ‘responsibly’ when older
- selectively present harms, including misinformation about cancer
- do not address the role of alcohol price and availability and the impacts of alcohol and the alcohol industry on inequalities.[4]

45. In short, youth education programmes can be used to disseminate alcohol industry-preferred narratives and aren’t only ineffective but can actually cause harm.[5]

46. Alcohol industry action also seeks to steer government policy / regulation away from effective measures that address price, availability and social norms of alcohol through activities such as:

- development of alliances, with trade associations and with non-industry allies such as think tanks
- funding researchers, and summarising and disseminating findings
- direct engagement with policymakers – shaping and responding to consultations, but also through unsolicited lobbying
- influencing trade rules and using these regulations to challenge unfavourable laws.

[4] van Schalkwyk et al. (2022) Distilling the curriculum: An analysis of alcohol industry-funded school-based youth education programmes https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0259560
5 van Schalkwyk et al. (2022) Denormalising alcohol industry activities in schools https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(22)00341-3/fulltext?rss=yes

Example #3 – Ultra-Processed Food

47. Food is a basic necessity, but also a commercial product deeply influenced by market forces. The concept of food as a commercial determinant of health goes beyond what we eat—it encompasses the entire food system, including production, processing, distribution, marketing, and sustainability. It also involves the environments in which we make our food choices[6].

48. Obesity and overweight are complex public health issues influenced by a range of biological, behavioural, environmental, and socio-economic factors. A growing body of evidence highlights the impact of ultra-processed foods and the broader commercial determinants of health—factors shaped by the food industry that influence what people eat, how much they eat, and how they move.

49. These interrelated influences form what is known as an *obesogenic environment*—an environment that promotes weight gain and discourages physical activity. Key features of such environments include:

    - Ready access to high-calorie, nutrient-poor foods
    - Increasing portion sizes
    - Limited opportunities for physical activity
    - Sedentary lifestyles
    - Urban design that discourages active travel
    - Limited availability of affordable, healthy food
    - Aggressive marketing of unhealthy food products

50. The commercial determinants of obesity[7] are particularly concerning. These include:

    - Food Marketing: Aggressive promotion of sugary drinks, processed snacks, and fast food contributes to overconsumption.
    - Food Pricing: Unhealthy options are often cheaper and more accessible than healthier alternatives.

---

[6] ADPH-NE-Position-Statement-CDoH-Food-appendix_FINAL.pdf
[7] Commercial determinants of health: A critical component of the obesogenic environment - ScienceDirect

- Food Availability: In low-income and rural areas, access to fresh, nutritious food is limited, leading to reliance on processed items.
- Food Labelling: Misleading or unclear labels can make it difficult for consumers to make informed dietary choices.
- Portion Sizes: Larger portions encourage overeating.
- Industry Influence: Lobbying by food companies can weaken policies related to marketing, labelling, and pricing of food.
- Physical Inactivity: Urban design and digital lifestyles promote sedentary behaviour, further compounding the problem.

51. Although York is often regarded as a city in good health, recent findings from the Our City Health Narrative[8] 2025 Joint Strategic Needs Assessment (JSNA) paints a more nuanced picture: an increasing number of children are living with unhealthy weight in both reception and Year 6, two-thirds of adults in York are overweight or obese, and 20% of the population leads a sedentary lifestyle.

52. In December 2019, the City of York Council signed the Local Government Declaration on Healthy Weight[9], committing to a place-based approach to health and wellbeing. The declaration includes several commitments, notably:

- Promoting sustainable and active travel, aligning with York's target to become a carbon-neutral city by 2030.
- Developing a Sport and Physical Activity Strategy for York.
- Supporting the health and wellbeing of council staff.
- Using health evidence in planning decisions
- Mobilising community assets, such as York's vibrant community food programmes.

[8] Our City Health Narrative_V4
[9] Annex A - City of York Council_Declaration Layout FINAL.pdf

Example #4 – Tobacco

53. Tobacco use remains one of the leading causes of preventable illness and death in the UK, with 2 out of 3 long tobacco users ultimately dying from smoking-related causes.

54. While significant Public Health progress has been made in reducing smoking prevalence, the role of the tobacco industry as a key commercial determinant of health continues to undermine these efforts. The industry's strategic marketing, lobbying, product innovation (e.g., heated tobacco, nicotine pouches), and corporate social responsibility tactics continue to influence policy, shape public perception, and drive consumption—particularly among disadvantaged populations.

55. Tobacco companies have historically used misinformation, lobbying, and opposition to regulation as they seek to delay, weaken, or circumvent public health regulation, including restrictions on marketing, plain packaging, and taxation. There is strong lobbying against the current Tobacco and Vapes Bill that is moving through the Commons and Lords.

56. Despite declining smoking rates nationally and locally, tobacco use remains disproportionately high in areas of deprivation, driven in part by commercial targeting. Local retailers, many of whom are economically dependent on tobacco sales, are caught in the tension between health harm and commercial need. Furthermore, tobacco industry actors continue to exert influence on local policy indirectly, for example, through front groups or so-called "corporate social responsibility" initiatives.

57. There are strict rules on the amount of tax charged to tobacco companies on cigarettes and tobacco products – with an annual price escalator to ensure that the price rises each year. However, the tobacco industry uses many tactics to circumvent these rises.[10] One such tactic is raising the price of premium products more than on budget products, in order to keep prices lower and more accessible to those on lower incomes.

[10] Tobacco Industry Pricing Strategies

58. More recently, tobacco companies have diversified into alternative nicotine products (e.g. heated tobacco, nicotine pouches), marketing them as harm reduction tools while maintaining dual product use and continuing to recruit new users. The use of flavoured products, sleek designs, and attractive packaging often appeals to non-smokers and children. At present, regulation of these new novel products is far less robust than traditional tobacco products.

59. Effective action on tobacco as a commercial determinant requires robust implementation of the WHO Framework Convention on Tobacco Control (FCTC), particularly Article 5.3, which mandates protection of public health policies from industry interference.

60. Continued system-wide collaboration across public health, education, trading standards, housing, and voluntary sectors is also required, to create environments that discourage tobacco use and reduce exposure. This is alongside sustained investment in targeted support for priority populations, including pregnant smokers, people with mental health conditions, routine and manual workers and those who face inequality in accessing health-based services.

How to respond: the ‘anti-playbook’

61. It may seem that, in the face of the trans-national forces and large-scale issues set out above, members of the York Health and Wellbeing Board have little agency or influence within the sphere of the CDOH.

62. A telling example of how the CDOH can often seem like a ‘David and Goliath’ issue is to compare, for example the marketing budget in 2022

of a global manufacturer of sugar sweetened beverages (£3.1bn) with the entire public health grant in England in the same year (£3.5bn).

63. While acknowledging the scale of this issue, and the necessity of global, national and regional action, there are still significant ways in which local partners in an area can take action to limit the negative effects of CDOH for the benefit of population health.

64. The 'Local Health Global Profits' Consortium is a UKRI funded research consortium bringing together leading researchers from the Universities of Bath, Cambridge, Edinburgh, Sheffield, and the London School of Hygiene and Tropical Medicine. LHGP's work 'aims to identify, implement and evaluate population-level actions most likely to improve health, wellbeing and equity at local authority level by addressing the commercial determinants of health'. This work offers and emerging and strong evidence platform for local action.

65. In terms of what works, there is consensus in the literature on how CDOH can be tackled, constituting an 'anti-playbook' which aims to counter the tactics of unhealthy commodity industries:

- The key levers of **availability, accessibility and pricing**, for instance the granting of gambling licenses, a minimum unit price for alcohol, installing 'healthy vending machines'
- Restrictions on **advertising and marketing** of health-harming products
- Shaping the local environment through the **planning** system, for example guidance which aims to reduce the density of Hot Food Takeaways in poorer areas
- **Framing** health messages away from narratives of 'personal responsibility' and 'choice' towards a recognition that ubiquitous addictive and cheap consumer products actually reduce choice
- Good **governance**, including the cessation of public / private partnerships and sponsorship from industry, removal or industry representation on steering / advisory groups, and clear rules on conflicts of interest
- Participation in **advocacy** work, for instance supporting calls through professional groups (e.g. Royal Colleges) for tighter regulations on health-harming products.

66. Examples of local work in the region which aims to tackle the CDOH include:

- Introducing comprehensive advertising and marketing policies relating to gambling, alcohol, high fat salt sugar food, vaping (see from York and from Sheffield, which also includes fossil fuel industry advertising)
- Responding to planning applications made by companies selling unhealthy commodities, aiming to tackle the targeting of poorer communities with high densities of outlets
- Introducing Supplementary Planning Documents (SPD) which take an evidence-based approach to where unhealthy commodity outlets can be approved, for instance the Newcastle SDP which does not allow new Hot Food Takeaways in areas where childhood obesity levels are higher than 10% of the yr 6 population
- Removing Community Alcohol Partnership / Alcohol Education Trust / Smashed materials from the school curriculum given their clear links to the alcohol industry
- Using a licensing harm matrix to identify geographical areas at higher levels of such alcohol-related harm as done by Leeds
- Values-based public health messaging which aims to undercut the influence of commercial industry such as the Gambling Understood campaign
- Objections to the siting of Adult Gaming Centres, such as in Sheffield
- Development of the Good Governance Toolkit which offers advice and guidance on how to safeguard public bodies from commercial interests and influence.

APDH Yorkshire and the Humber Consensus statement on the CDOH

67. Annex A of this paper contains the Association of Director of Public Health Yorkshire and the Humber Consensus statement on the CDOH

68. This statement offers a broader and more in-depth summary of the contents of this paper, and board members are asked to note the contents and recommendations of this paper.

Recommendations

69. Board members are asked to:

- note the Association of Director of Public Health Yorkshire and the Humber Consensus statement on the CDOH
- consider how they can avoid use of educational or promotion materials produced by organisations established or funded by (whether entirely or in part) unhealthy commodity industry bodies in our educational settings or communities.
- consider ending any partnerships, sponsored or funded work which has links to unhealthy commodity industries, using the Good Governance Toolkit as guidance
- Consider their approach to advertising and marketing, and adopting a policy which matches the City of York Advertising and Marketing Policy

Strategic/Operational Plans

70. The Health and Wellbeing Strategy 2022-2032 contains an aspiration to become a ‘Health Generating City’, and this paper supports this goal.

Implications.

- **Financial** – There are no direct financial implications of his report. Action on the CDOH is likely to prevent chromic illness and reduce costs on the public sector.
- **Human Resources (HR) –** There are no direct HR implications of this report
- **Equalities** – There is a direct link between this report and health inequalities, affecting people based on socioeconomic status as well as other equalities characteristics such as age, gender and ethnicity. Unhealthy commodities adversely affect poorer communities, through for instance the targeting of advertising / marketing.
- **Legal –** There are no direct legal implications of this report

- **Crime and Disorder** – There are no Crime and Disorder implications of this paper
- **Information Technology (IT) –** There are no IT implications of this report
- **Property -** There are no Property implications of this report

Contact Details

Authors:

Phil Truby (Public Health Specialist Practitioner)

Philippa Press (Public Health Specialist Practitioner)

Anna Brown (Health Improvement Officer)

Natalie McPhillips (Public Health Specialist Practitioner)

Chief Officer Responsible for the report:

Peter Roderick
Director of Public Health

Report Approved √ **Date** 04.07.2025

Chief Officer's name
Title

Report Approved *tick* **Date** *Insert Date*

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

Annexes

Annex A: Commercial Determinants of Health Position Statement

Annex A:

Commercial Determinants of Health Position Statement

Stefanie Gissing and Anna Brook supported Y&H ADPH to develop this statement with thanks to Kylie Murrell and Alice Wiseman from ADPH North East, the South Yorkshire Mayoral Combined Authority Report, Anna Brook and Katherine Körner for their Good Governance toolkit, Anna Brook's action research on CDoH workshops for public health teams, and the ADPH Yorkshire & Humber Commercial Determinants of Health Report 2023

1. What are the commercial determinants of health?

The commercial determinants of health (CDoH) are private sector activities which impact public health, either positively or negatively, directly or indirectly, and the enabling political economic systems and norms (WHO*).* The Lancet series broadens this definition to include '*the systems, practices, and pathways through which commercial actors drive health and equity'* (Lancet). These actions and omissions play a significant role in shaping the environments in which we are born, live, grow, and work.

As DsPH we affirm the importance of inclusive wellbeing economies that serve the wellbeing of people and the planet, making life better for all (ADPH Y&H). Along with the WHO, we recognise that '*commercial activities shape the physical and social environments in which people are born, grow, work, live and age – both positively and negatively*.' We also echo the Lancet series on the CDoH by acknowledging the diversity of the commercial world ranging from '*transnational and multinational corporations with revenues larger than the gross domestic product of some countries to small-scale, locally owned businesses*' (The Lancet). We start by noting some of the positive impacts that commercial entities can have for society (such as creating ethical employment) and the necessary role that specific industries can play in improving health (such as the cycle industry in active travel). Our work to improve the health of the public and drive equity must also recognise the substantial harms that commercial entities can cause. Again, as the second paper in the Lancet series on CDoH points out '*few commercial entities, if any, are wholly good or bad for public health*' and our concerns are directed at specific forms of commercial activity that harm health (The Lancet). Unhealthy commodity industries (UCIs) are companies who manufacture, produce, process, distribute, import, sell and/or market other products or services (including any company that derives significant revenues from producing, selling, or marketing such products or services) that could be considered detrimental to physical or mental health and, as a result, profit from their sale (Spectrum). Some of this paper starts with a focus on the key UCIs: the tobacco, alcohol, gambling, unhealthy food (such as ultra-processed food and food high in salt, sugar, and fat), and fossil fuel industries - but we recognise activities that harm health can be caused by any industry.

2. Why do they matter?

2.1 CDoH cause significant morbidity and mortality, and people are dying before their time

- The products and associated commercial practices from just four UCIs (fossil fuel, tobacco, alcohol and ultra-processed food) have been estimated to cause *at least* one-third (36%) of

global deaths, and over 4 in 10 (45%) deaths from noncommunicable disease (NCD). *Note: these are likely to be significant underestimates as they take no account of products such as lead or prescribed opioids, or practices such as dumping of toxic substances in water courses, and a more likely figure is that CDoH contribute to 78% of NCD deaths (GBD/Lancet).*

- NCDs accounted for almost 9 in 10 (88.1%) of the premature deaths in England in 2019 (GBD/IHME).

2.2 People are spending many years in ill-health

- Many of the leading risk factors for the commonest NCDs are exacerbated by CDoH, and these are responsible for significant disability in England. For example in 2017 in England the top three risk factors for YLD (years lived with disability) were high BMI (622 per 100,000), smoking (508), and high blood glucose (490) (GBD/ONS).
- Healthy life expectancy at birth in England in 2018–20 was 63.8 years for males and 63.6 years for females, meaning that more than one-fifth of life will likely be spent in ill health (ONS).
- Healthy life expectancy (HLE) at birth in the UK showed no significant change between 2015-17 and 2018-20 and disability-free life expectancy at birth decreased significantly. In Yorkshire and Humber, HLE decreased by 0.6 years for males to 61.1 years, and increased slightly by 0.5 years for females to 62.1 years (ONS).
- Both sexes saw significant declines in HLE if living in deprived areas; especially females in the most deprived areas who were expected to live less than two-thirds (66.3%) of their lives in good health compared to more than four-fifths (82%) in the least deprived areas (ONS).

2.3 Inequalities are substantial

This significant contribution to mortality, disability, and worsening health-related quality of life occurs alongside driving inequality. Not all harmful products are consumed equally, and some groups experience disproportionately more negative impacts.

- People from disadvantaged groups are more likely to smoke, be overweight, and experience greater levels of harm from alcohol (even when they consume less). (ASH, Lancet, Obesity).
- The health harms from UCI products are much higher when risk factors are combined, which is more common in disadvantaged groups (Kings Fund).
- This contributes to people from more disadvantaged groups living shorter lives, and spending a smaller proportion of their lives in good health (ONS).
- People living in the most socio-economically deprived communities are four times more likely to die from CVD as those in the least deprived (UKHSA).
- Climate change impacts have key inequalities dimensions: lower income and disadvantaged groups often live in poorer-quality housing in locations that are vulnerable to flooding or other climate impacts. Low-income households in the UK are more likely to be affected by flooding, and their homes are more likely to be prone to overheating and lack green space (Environment Agency).

2.4 There is evidence of deliberate targeting of those who will be harmed the most

There is evidence to show that parts of the private sector target groups who are vulnerable to the most harm from their products and activities in order to drive higher consumption and maximise profits.

- Examples from the USA include predatory loans such as subprime mortgages that disproportionately disadvantaged Americans of colour, employer organisations increasing worker vulnerability by keeping wages low during the COVID-19 pandemic, and the meat industry increasing marketing to force re-opening of processing plans when workers in such environments had twice the fatality rate of those in the EU (Milbank Quarterly).
- Cigarette brands and products have also been developed and marketed to specifically target ethnic minorities and women. People who are homeless and who have mental health issues have also been targeted (Tobacco Control).
- Marketing of unhealthy foods to ethnic minority children (Berkeley Media Studies Group).
- Infant formula has also been previously targeted at ethnic minority women with accompanying reduced breastfeeding rates (Milbank Quarterly).
- Here in the UK, organisations are uncovering how the food and drinks industry is specifically targeting young people, for example through sports sponsorship, misleading food labelling, and online marketing (BiteBack).

2.5. As well as the human cost, there is a substantial economic cost

The premature disability, disease, and death from NCDs linked CDoH (as discussed previously) is increasingly affecting those of working age and thereby affecting the economic productivity of our society.

- Sales of health-harming products are enormously profitable for industries. Recent economic analysis has found that, after tax, £53 billion combined industry revenue is made from sales from smoking (£7.3 billion), alcohol (£11.2 billion) and food (£24.2 billion) at levels harmful to health. These profits come at huge expense for society, with billions spent on health and social care detailed below, and £31 billion lost in wage penalties, unemployment, and economic inactivity due to tobacco, alcohol and obesity (ASH/OSA/AHA 2023).

- **Tobacco** kills up to half of its users who are unable to quit (WHO). Many of these are due to the cancers, cardiovascular disease, and respiratory disease it causes. In 2022, 12.7% of England's adult population smoked (ONS), and there were over half a million related hospital admissions in 2020 (NHS Digital). ASH estimates that each year, smoking costs England £17.3 billion (ASH).

- Over 1 in 5 (21%) of people in England drink above the recommended levels of **alcohol** (14 units per week) (Alcohol Change UK), and there were almost one million related hospital admissions in 2021 (NHS Digital). Alcohol has been estimated to cost society £21 billion per year (PHE).

- Nearly 2 in 3 adults (63.5%) in England are living with **overweight or obesity** (OHID), and nearly 1 in 4 (23%) children (OHID). There were over 1 million weight-related hospital admissions in 2020 (NHS Digital). The direct and indirect cost of obesity in the UK was estimated to be £58 billion annually (Frontier Economics).

- In England, over half the adult population (54%) **gambled** in 2018 (OHID) with 1.76 million participating in harmful gambling (OHID). We also know that gambling-related harms are felt broadly across families and communities, not isolated to individuals (van Schalkwyk et al). Most (86%) of online betting profits come from just 5% of those gambling, usually from those already experiencing harm (Gambling With Our Lives). Gambling costs society over £1 billion annually (OHID).

- **Climate change** has been called the biggest threat to global health of this century, and emissions from fossil fuels are the main driver. In the UK, outdoor air pollution is estimated to cause 28,000-36,000 deaths each year, and has been described as a 'public health emergency' (BMJ). A high proportion is caused by the fossil fuel-dependent nature of our economic and social systems. This includes their use for energy generation, industrial processes, and especially transport which causes over a quarter (26%) of UK carbon emissions (Our World in Data), as well as indoor air pollution in our homes (for heating and cooking).

  Heatwaves, flooding and wildfires and other extreme weather events are becoming more common, posing a significant health concern. An estimated 1.8 million people in the UK are at significant risk of flooding (Climate Change Committee). Increasing invasive mosquito numbers and rising Lyme disease cases are being observed in the UK, and impacts on multiple infectious diseases are of global concern. Climate-related crop failures and reduced yields worldwide are likely to impact food availability and pricing, with consequences for dietary quality and nutrition in the UK. Climate change and related economic impacts can also undermine security, potentially driving conflict and instability. Increasing population movement is likely, and will demand a humane and ethical collective response that centres health, particularly in view of the historical responsibility of countries in the Global North.

2.6. This harm is preventable, and we can do something about it

- Around 1 in 5 (22.8%) deaths in Great Britain were considered avoidable in Great Britain in 2020, that is, preventable or treatable in those aged under 75 (ONS). Since 2011, this figure has been 22-24% for the UK.
- Evidence based on individual industries gives us an indication of what is likely to be needed and effective across different industries and at cross-industry level. We have seen substantial success (albeit more still needed) from comprehensive tobacco control. We will need to rapidly test out these approaches at a CDoH level. We will also need to ensure our approaches are informed by power analysis and systems thinking - otherwise we risk our actions being undermined by organised and well-resourced opposition to the most effective actions, or intervening only with actions rather than trying to shift the system.

Transport for London's food **advertising policy**, and support from Sustain, have led to other councils implementing similar policies. Early evidence indicates reductions in energy, sugar, and fat purchased from High in Fat Salt and Sugar (HFSS) products is likely to result in improved health (PLOS Medicine). Bristol's Advertising and Sponsorship Policy includes guidance and principles for the content of adverts on Council-controlled spaces and sponsorship deals. It prohibits advertising for tobacco, gambling, payday loans (high cost short-term credit), organisations who offer ways to avoid paying UK tax, HFSS Foods, alcohol, and promotion of food and drink brands that are not advertising specific foods or drinks (Bristol City Council).

Fresh and Balance is a regional programme in the North East of England working on a population level to reduce harm from tobacco and alcohol. Their comprehensive approach is based on international evidence for effective Tobacco Control and includes highlighting the practices and activities of industry and working to limit their influence, as well as advocating for population-level interventions (FRESH-BALANCE).

3. Commercial practices and common industry tactics

The 'systems, practices, and pathways through which commercial actors drive health and equity'

The Lancet series on CDoH covers several commercial sector practices, some of which are outlined below but a more comprehensive set is available here. Many of these practices currently shape the system in the interests of the commercial sector so that, as the Lancet outlines, we have:

- 'Political and economic system that increases commercial sector power, sales, and involvement in, and influence on all aspects of society
- Regulatory approaches and upstream policies that enable and embed commercial sector influence and misconduct and limit options for public interest policy making'

There are common tactics used across UCIs:

3.1 Preventing, undermining, or circumventing public policy

This leads to the impediment of evidence-based policy decisions that would support public health. For example, there is a strong push by industry to avoid mandatory regulation by suggesting self-regulation instead, but research suggests this does not lead to any public health benefits (BMJ, EPHA). A review of the Public Health Responsibility Deal found that pledges to improve health were driven by industry interests and not by the most effective interventions available (instead focusing on providing information and individual choice) – especially for alcohol (Int J Environ Res PH, Addiction).

In a further example, 82 third parties with tobacco industry links opposed the UK's product standardisation policy, giving the impression of widespread opposition (BMJ Open). Legal threats and challenges (which are almost always unsuccessful) from the tobacco industry can also be prohibitive to people taking action, due to fear over legal costs (Journal of Public Health).

3.2 Manufacturing doubt and shifting blame

UCIs contradict and cast doubt on the scientific evidence that reveals the harm caused by their products and instead promote their own (industry-funded) research (PLoS One, Lancet). For example, the tobacco industry promotes alternative causes for lung cancer to distract from the link to smoking (SSM - Population Health).

3.3 Aggressive marketing and advertising

There is product placement and promotion across all media, often particularly concentrated in areas of greater deprivation and/or towards vulnerable groups. A recent study in Scotland found that children from more deprived areas were more likely to be exposed to unhealthy food and drink product advertising compared to those living in less deprived areas (Health & Place). In 2020, over one fifth (21%) of England's gambling outlets were concentrated in areas in the most deprived decile (University of Bristol).

3.4 Shaping social norms around personal responsibility

The personal responsibility narrative is central to this approach; industry framing argues that as individuals, we must take responsibility for what we choose to consume and when. UCIs argue that public health interventions are akin to a 'nanny state', unduly interfering in personal choice. They fail to acknowledge their significant role in shaping our environments and ultimately influencing our available options and choices through their own activities.

One example is British Petroleum's creation of the term 'carbon footprint' (Mashable) and further framing around individual responsibility from the fossil fuel industry (One Earth). A further example is a tobacco industry-funded smoker's rights group likening England's proposed smoke-free generation tobacco sales ban to 'creeping prohibition' (Forest).

The targeting of children and young people is an established tactic for UCIs. Industry-sponsored education and awareness raising in schools is a common occurrence and has been shown to be biased towards industry interests (for example, promoting moderate alcohol consumption (PLoSOne), and shifting the blame for gambling onto individuals (SSM Popul Health)). There is growing recognition of these tactics amongst this population group and advocacy from young people against the tactics and the harm caused by UCIs (BiteBack, UK Youth Climate Coalition).

3.5 Public-private partnerships (PPPs)

Partnerships between the public sector and industry can provide commercial actors opportunities to exert undue influence over decision-making and public policy processes, such as weakening of enforcement mechanisms (J Ac Man Rev) and narrative-shaping.

An evidence review of effectiveness found that PPPs in health promotion were more frequently classed as "not independent" and of poor quality. Negative evaluations were more common when the private partner involved had a high potential for competition between the health promotion activity undertaken and their financial interests (BMC Public Health)

An evaluation of the 'Public Health Responsibility Deal' suggested that it did not result in much added value to the government due to most industry pledges being already planned (Health Policy). A study of negotiations over a calorie reduction 'pledge' showed that more informal governance approaches prioritised commercial interests over public health (University of Edinburgh)

(above examples from the Good Governance toolkit for local authorities, Brook & Körner, in progress)

3.6 Reputational management, including through corporate social responsibility

UCIs commonly invest in charities, 'good causes', and training/educational initiatives to distract from evidence of harm from their activities. For example, "Keep Britain Tidy" was a media campaign to encourage individuals, companies, and local groups to clean up after themselves, with the UK government involved as a partner until 2015. It was founded by three major waste and litter producers (Imperial Tobacco, McDonalds, Wrigleys), and would now be construed as "greenwashing" (Tobacco Tactics). "Safer Gambling Week" is an industry-funded initiative aimed at awareness-raising and encouraging individuals to gamble more safely and responsibly.

4. A public health approach to CDoH is needed

A 'Public Health Playbook' has been developed with strategies that utilise the assets of the public health system and create opportunities to counter the commercial tactics previously discussed (The Lancet Global Health).

A public health approach is a population-focused approach based on intelligence and evidence, to advance the public good. It does this by promoting health, equity, and social justice, collectively through partnership between organisations and communities and through system leadership (Lancet). The scope of the public health approach begins with the causes of the causes of ill-health and spans the whole life course. In this section we sketch out what a public health approach to CDoH could look like.

4.1 Population level

The harms driven by the CDoH occur at a population level, not just at an individual level. Private sector activities play a significant role in shaping our environments to ultimately influence our choices. Focusing only on individual behaviour overlooks the ongoing drivers of that behaviour which we encounter throughout our lives. Focusing only on those with acute issues overlooks the significant

proportion of the population who are at risk of harm and could benefit from preventive intervention. Furthermore, focusing on individuals perpetuates the personal responsibility narrative which can be stigmatising and result in a narrow and less effective set of responses and solutions. The increasing burden of related NCDs despite investment in related health services shows that individual treatment is not the sole solution.

4.2 Promoting health equity and social justice through partnership and systems leadership

There are health, financial, and relationship harms alongside significant monetary costs to society. As a society we are paying for private sector products, and for responding to the harms they cause to our health and planet. Industry is enabled by the current system to make profit that causes harm with the costs externalised to society, including the public sector. Our ability to promote health and equity is diminished as we try to respond to those harms and meet the resulting health needs, and the private sector's wealth and power increases (The Lancet). We need to shift the system so that it prioritises public and planetary health and equity over a narrow focus on profit from products and practices that harm health. Our society needs regulating and organising in line with these priorities so harms are reduced and benefits amplified – this also levels the playing field for businesses and organisations that want to work in health-promoting ways by incentivising practices that benefit health and equity rather than relying on individuals and organisations to go against the grain (The Lancet). For example, inclusive wellbeing economies aim to reduce inequality through improving the health of people, communities, and the planet, and ensure that economic activity is sustainable (Y&H Public Health Network).

4.3 Evidence and intelligence led

The public health approach is rooted in the best available evidence and intelligence. For CDoH, there is clear and increasing evidence of the harm caused by industry tactics (*see section 3*). An effective public health response requires the development of practice-based evidence through public health action. For CDoH, these actions are based on the theory of applying what we know has worked in individual industries (such as for the tobacco industry) to practices and/or commercial entities in combination.

4.4 Causes of the causes

CDoH are increasingly recognised as a part of the wider determinants of health so addressing them becomes a critical aspect of any public health focus on fundamental causes of ill-health (Freudenberg, Lee et al 2021). Emphasis is needed on re-balancing power and shifting the practices that currently shape the system in the interests of the commercial sector so that they 'prioritise public interests over commercial profit.' This is what the Lancet series framework describes as the underlying drivers which are shaping the whole system but especially levels 1 and 2 (see Lancet, and Lancet). This is about collective leadership to develop, describe, and influence for alternative systems that enable benefits over harms and will include strategic work to shift public perceptions and norms.

4.5 Community-led approaches

Fundamental to a public health approach is understanding what matters to our communities and working to redistribute power away from vested interests and towards community interests. Commercial practices and influences can harm all of us so our understanding of community needs to remain broad, whilst recognising the importance of hearing from population groups who are harmed the most by CDoH. We must ensure that evidence and intelligence includes insights from our population. Our recognition of 'the causes of the causes' must take note of the shifting and growing power imbalances between commercial entities and communities. We need to work with communities

to shape the Public Health agenda on CDoH through meaningful approaches suitable for complex work such as deliberative democracy.

4.6 Key principles

System-wide collective action focused on the methods and tactics of industry is a legitimate and direct target for public health intervention. There are key principles that apply, agnostic of the specific industry, which elevate into a general approach to CDoH:

1. People with relevant expertise (and whose goals align with public health) should primarily influence health policy, health services, education (including health messaging and risk information) and awareness raising. UCIs should not have any influence over decisions and processes related to health policy due to a clear conflict of interest.

2. UCI marketing drives harmful consumption and health inequalities and needs to be tackled (restricted through regulation)

3. Reframing the narrative from personal responsibility to the actions of industries and their harmful products is a legitimate public health intervention

4. Children and young people and other groups in vulnerable circumstances who are the most harmed, are priority groups to protect from the tactics of UCIs

5. Tackling CDoH has high public support. Protecting the rights of children (and adults) to be free from harmful commercial environments is more important than the right of corporations to profit at the expense of the health of current and future generations.

6. A public health approach to tackling the CDoH must work to shift power and rebalance the system to prioritise health, equity, and the environment over commercial profits.

5. Actions

We recognise that different areas are at different stages in their CDoH work. In some places this may begin with awareness raising internally and progress to other actions with partners at place and system level. Different areas will need to tailor their approach for their local context.

1. **Implement a '*CDoH in all policies*' approach: in the absence of government regulation, use the tools and policy levers available locally to adopt a CDoH approach to licensing, planning, advertising, and marketing, event sponsorship, and partnership working with those parts of the commercial sector purveying harmful products.**

A report from The Health Foundation "*Addressing the leading risk factors for ill health – a framework for local government action"* can assist local government in taking a 'CDoH in all policies' approach locally

2. **Develop materials for framing CDoH with the public and press, including FAQs and responses to anticipated challenges. Use these to assist public health teams in responding to industry arguments, as well as raising awareness of private sector tactics in communities.**

3. **Up-skill our public health teams and wider internal colleagues including Councillors through training and/or workshops. Training will include understanding industry tactics, and how to**

scrutinise stakeholders and sources. It will be important to develop robust methods to address issues identified through such scrutiny - for example what to do about conflicted evidence or funding. Build on this over time to include partners at place and system level.

4. **Work with other regions to influence national policy and take collective action on the CDoH**

5. **Secure endorsement for the principles outlined in this document at local Health and Wellbeing Boards, and relevant partnership groups such as Scrutiny Committees**

6. **Commit to finding opportunities for funding and capacity for proper work with the public to shape this agenda. The most helpful way to do this on system-level issues like CDoH is likely through deliberative democracy approaches. This requires time and resources. We can build on and learn from the SPECTRUM approach being tried in Scotland.**

7. **Use good governance and organisational conflict of interest policy development resources to implement policies on partnership with industry and using harmful product industry funding for interventions. Focus not just on policies for specific industries or products but on corporate political activity and the systematic exclusion of health-harming industries from the policy process.**

8. **Develop networks for sharing knowledge and best practice between relevant staff working in public health through a seminar series focused on key CDoH issues.**

9. **Develop champions and networks amongst local politicians and other partners beyond public health to drive action forward.**

10. **Commit to seek opportunities for, and develop over time, more shared leadership and capacity for shared delivery mechanisms (building towards an expanded Fresh and Balance model for the region).**

This page is intentionally left blank

Health and Wellbeing Board 16 July 2025

Report of the York Health and Care Partnership (including Annual Report)

Summary

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

2. On this occasion this report also includes a copy of the YHCP's annual report.

3. 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

4. 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.

5. The YHCP has an Executive Committee which is the forum through which senior Partnership leaders collaborate to oversee the delivery of the Partnership priorities. The Partnership draws on membership across Integrated Care Board (ICB) senior officers, City of York Council senior officers, York and Scarborough NHS Teaching Hospital, Tees, Esk and Wear Valley NHS Mental Health Trust, primary care, York Centre for Voluntary Services, Healthwatch York, the university and education sectors, and City of York Council elected members. Since June 2025, the Executive Committee also operates as a committee of the ICB and City of York Council, governed by a section 75 agreement between the two organisations.

Update on the work of the YHCP

6. The Executive Committee meets monthly, and a summary of the meetings held in May and June 2025 is set out below.

May 2025 Executive Committee Meeting

7. The May meeting of the Executive Committee focused on the following items and a copy of the minutes from the meeting are at **Annex A**:

   - **York Mental Health Partnership Sub-Group Report**: This report provided an update on the work of the York Mental Health Partnership, including a reminder of the vision of the Partnership as follows:

     The Mental Health Partnership's vision for York is of a ***Whole Life, Whole Person, Whole System*** approach and a city where citizens can:

     - All feel valued by our community, connected to it, and can help shape it.
     - Are enabled to help ourselves and others, build on our strengths, and can access support with confidence.
     - Are proud to have a Mental Health Service that is built around our lives, listens to us, is flexible and responds to all our needs.
     - To work towards achieving this high-level vision, the YMHP meets every two months to consider the workstreams.

     Connecting our City Project

     Hub at Clarence Street: as reported to the YHCP in May 2025 the hub is now open three days of the week for ad hoc drop ins and for appointments on the other days. A variety of other groups and support are also able to utilise the space. We have received significant positive feedback about the hub and the support being provided.

     The hub has also supported several visits, for example the Chair of NHS England and the Director for Mental Health from DHSC. The Hub Manager, Co-Production Officer and

the Project Team have also delivered presentations at various meetings and conferences including the ADASS Care We Want event, the Yorkshire and Humber Clinical Assembly, and The NHS England Associate sites event.

As of February 2025, the team at the hub were supporting 101 people. Due to the lack of a shared recording system and staff shortages, the team have had to slow down referrals into the hub.

Some key challenges still remain, particularly around the lack of a joint recording system which is impacting on the wellbeing of team. The hub has also not yet developed or tested pathways into wider specialist offers in the system.

24/7 Neighbourhood Mental Health Centre: Progress has continued at pace for the mobilisation of the 24/7 neighbourhood mental health centre at Acomb Garth. The aim is to open in June/July 2025 although is dependent on several factors. A hub manager has been appointed and is in post; additional project support is in place and a joint recruitment plan has been finalised and agreed by the implementation group.

Third Hub Development: confirmation of funding for a third hub in the city has been received which will allow the rollout of the hub model citywide. This will fund the voluntary sector roles and recruitment will begin in the summer. Further staffing within the hub will rely upon the realigning of existing resources. The third hub will be located in the Tang Hall/Burnholme area and community engagement work has begun in this area.

A Community Mental Health Transformation Whole System Workshop was held on 1 May 2025 and had excellent multi partnership attendance; commitment to a shared vision, scope and timescale for transformation; and the identification of interdependencies and opportunities for collaboration. Challenges had also been recognised in terms of workforce development, communication, funding, redesigning of the system, resource, and the wider context such as increasing service costs, current changes to the

NHS and the development of neighbourhood health services.

Children and Young People's Mental Health Group: A Children and Young People's Mental Health Group has been established to enable us to fulfil the Partnership's aim to be all-age. Several meetings have been held to discuss its development, develop terms of reference for the group and map the current provision in the city.
The Group has recently RAG rated the 50 recommendations put forward by the Nothing About Us Without Us Group to help us to understand where strengths and weaknesses are. The group is in its infancy and still needs further development. It is currently chaired by the co-chairs of the York Mental Health Partnership, but this will only remain the case until approximately September this year as they offer their time on a voluntary basis. The Children and Young People's Mental Health Group will need to appoint two further independent co-chairs or co-chairs from within the health and social care system over the coming months. The group is currently meeting once a month.

Further Progress: The following further progress updates have been provided as work has progressed since the York Mental Health Partnership reported to YHCP in May. This is as follows:

24/7 Hub: Several key staff are now in post, including the manager, service manager and carer support roles. The majority of daytime roles are due to start over the coming month. Due to delays with recruitment and building works, the aim is to open in August 2025 on a phased basis. The team will be based within Acomb Garth and doing community outreach from the end of June 2025. Building works are scheduled to be complete mid-August and work is underway to finalise the name and branding for the hub and ensure communications within the local community. A national evaluation workshop took place in June, and we are developing a local evaluation framework to ensure we can demonstrate the impact of the hub offer.

Clarence Street Hub: We have recently re-recruited to a number of roles. A successful networking event took place

on 6th June that was really well attended. The hub has recently established a peer support gardening group and an emotional regulation group. A library pop up at explore library introducing hub staff ran in May and was very successful.

System wide workshop: An action plan has been developed following this and is being monitored by the Joint Delivery Board. A recent meeting of an Executive Steering Group was also helpful in progressing conversations about future sustainability of the model.

Recording Systems: The lack of a single shared recording system continues to be a significant challenge both for the Clarence Street hub in terms of wellbeing of staff and ability to increase capacity safely, but also for the opening of the 24/7 centre and ongoing reporting and evaluation. Consideration of the need for an alternative interim solution is being considered as a matter of urgency by the Joint Delivery Board.

- **York Health and Care Partnership Executive Committee Terms of Reference:** These have now been approved and are attached at **Annex B.**

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

8. The June meeting of the Executive Committee focused on the following items:

   - **York Health and Care Partnership Executive Committee Annual Report 2024/25 and Forward Plan**: during 2024/2025 there has been significant development of the York Health and Care Partnership. Substantial progress has been made against the plans set out this time next last year. Partnership working has been strengthened with the establishment of a joint committee between Humber and North Yorkshire Integrated Care Board and City of York Council. The annual report at **Annex C** looks back at progress against 2024/25 plans and looks to the future with a forward plan of priorities for 2025/26.

- **YHCP Joint Commissioning Forum Sub-Group Report**: Recent topics discussed at the Joint Commissioning Forum include:

  March: Joint commissioning plan progress update; Section 75 agreement and joint committee; co-commissioning opportunities for Integrated Neighbourhood Teams and VCSE commissioning and compact.

  April: Joint committee and Section 75 legal and governance; health inequalities and prevention quarterly monitoring; budget setting and NHS planning for 2025/26 and social care funding for 2025/26.

  June: prevention community equipment; children's commissioning and integration approach and working with the VCSE sector

- **Community Joint Delivery Board** the purpose of the York Integrated Community Model Joint Delivery Board (JDB) is to provide oversight of the design and delivery of York's Integrated Community Model. The JDB are tasked with co-design and implementation of a model for community health services that moves away from multiple services towards a larger scale, system-wide approach. The JDB will monitor and steer the direction of travel of this integrated community model.

  The overarching aim is to reduce health inequalities by providing efficient, holistic, co-ordinated care for adults that have reduced access to support, ensuring better health and social care outcomes as a result.

Work of the York Population Health Hub

9. The Population Health Hub continues to advance a range of projects that use data and insight to reduce health inequalities, support system integration, and inform evidence-based planning.

   - June marked Pride Month, and there has been continued progress in the recording of LGBTQ+ identities in primary care. As of 6th June 2025, 741 patients in York Place are recorded as self-identifying as Transgender. While this reflects improvement, the true figure is likely higher, emphasising the ongoing need for inclusive healthcare

environments and accurate coding practices. Local population health data highlights significant inequalities affecting Transgender and Non-binary (TNBI) individuals, including disproportionately high levels of diagnosed mental health conditions, severe mental illness, eating disorders, and anxiety. In response, the Hub is supporting Healthwatch York's TNBI healthcare review by contributing analytical expertise and population-level data.

- In addition, the Hub is progressing two requests for population projections, one from City of York Council and one from the Integrated Care Board. These projections are critical for anticipating future health and care needs, shaping long-term plans, aligning preventive strategies with emerging demand, and improving the integration of services. The Hub is working to ensure consistency across both models to maximise their usefulness for system partners.

- The Hub continues to support the development of Integrated Neighbourhood Teams by producing neighbourhood-level population health intelligence. This includes demographic and health outcome data, enabling the system to understand variation, identify priorities, and plan services that reflect the specific needs of the community.

- A further area of focus involves supporting general practice to identify patients who have received multiple MED3 fit notes and exploring their associated health conditions. This analysis will inform the identification of individuals who may benefit from coaching or targeted support to return to work. The project contributes to the York and North Yorkshire Combined Authority's Inactivity Trailblazer, part of the national Get Britain Working programme. By identifying and engaging individuals with long-term health conditions, the initiative aims to reduce economic inactivity and support inclusive pathways back into employment.

Contact Details

Authors:

Compiled by Tracy Wallis, Health and Wellbeing Partnerships Co-ordinator, City of York Council

Chief Officer Responsible for the report:

Michael Ash-McMahon, Interim Place Director, York Health and Care Partnership

Report Approved Yes

Date: 02.07.2025

Wards Affected ALL

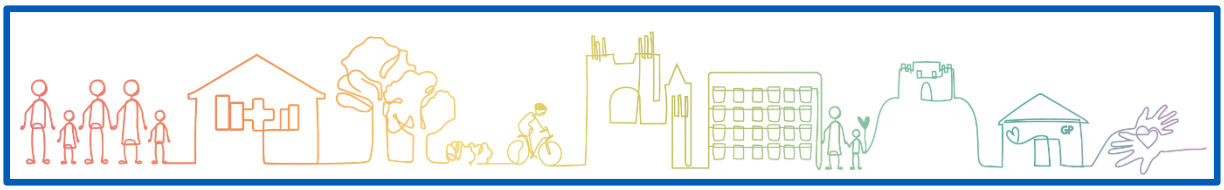
For further information please contact the author(s) of the report

Annex A: Minutes from the May Meeting of the York Health and Care Partnership

Annex B: York Health and Care Partnership Executive Committee Terms of Reference

Annex C: Annual Report and Forward Plan

Annex A:



York Health and Care Partnership Executive Committee

Thursday 8 May 2025, 10:00 - 12:30
Severus Meeting Room; First Floor, West Offices
Chair: Ian Floyd

Present		
Ian Floyd (Chair)	Chief Operating Officer	City of York Council (CYC)
Michael Ash-McMahon	Interim York Place Director	Humber and North Yorkshire Integrated Care Board (H&NY ICB)
Sian Balsom	Manager	Healthwatch York
Gail Brown	Chief Executive Officer	Ebor Academy Trust
Professor Karen Bryan	Vice Chancellor	York St John University
Cllr Claire Douglas - part	Leader of City of York Council	CYC
Helen Hart On behalf of Michelle Carrington	Deputy Director of Nursing – Health and Care Integration	H&NY ICB
Emma Johnson (T)	Chief Executive	St Leonard's Hospice
Simon Morritt	Chief Executive	York and Scarborough Teaching Hospitals NHS Foundation Trust (YSTFT)
Alison Semmence	Chief Executive	York Centre for Voluntary Services (CVS)
Sara Storey	Director Adult Social Care and Integration	CYC
In Attendance		
Natalie Caphane	Assistant Director of System Planning	York Place, H&NY ICB
Chris Davis (T) – item 2	Head of Mental Health Partnerships	Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) / York Health and Care Partnership
Professor Lynne Gabriel - part	Mental Health Partnership Co-Chair	H&NY ICB
Kate Helme – item 2	Community Mental Health Programme Manager	CYC
Kim Hinton	Deputy Chief Operating Officer	YSTFT
Michele Saidman	Executive Business Support Officer	York Place, H&NY ICB
Rachel Shapcott (T) – item 2	Senior Innovation Consultant	Innovation Unit

Dr Stephen Wright	Mental Health Partnership Co-Chair	H&NY ICB
Apologies		
Mark Bradley	Acting North Yorkshire Place Director	H&NY ICB
Zoe Campbell	Managing Director North Yorkshire and York Care Group	TEWV
Michelle Carrington	Place Nurse Director North Yorkshire and York / Deputy Executive Director of Nursing	H&NY ICB
Brian Cranna	Director of Operations and Transformation, North Yorkshire and York and Selby	TEWV
Dr Helena Ebbs	Clinical Place Director, North Yorkshire and York	H&NY ICB
Dr Rebecca Field	Joint Chair	York Health and Care Collaborative
Martin Kelly	Corporate Director of Children and Education	CYC
Debbie Mitchell	Chief Finance Officer	CYC
Peter Roderick	Director of Public Health	CYC
Cllr Lucy Steels-Walshaw	Executive Member for Health, Wellbeing and Adult Social Care	CYC
Cllr Robert Webb	Executive Member for Children and Education	CYC

'T' designates joined the meeting via Microsoft Teams

Partnership Items

1. Welcome and apologies for absence

The Chair welcomed everyone to the meeting.

Apologies were as noted above.

There were no declarations of interest in the business of the meeting.

The minutes of the meeting held on 10 April 2025 were approved subject to amendment of the second paragraph of Item *3 System Update* to conclude:

> '…and shift towards prevention. The Integrated Care System (ICS) submitted a balanced plan on 27 March. However the main risk was to live within the budget allocation as the forecast spend was above expected income across the ICS due in part to the significant system finance risk/unidentified savings.'

Matters arising

York Health and Care Partnership Executive Committee (Place Board) Structure Review: Members noted the refresh of the governance structure and supporting subgroups with regard to Governance Structure (Partnership), Governance Structure (Section 75) and 'How it works in practice'.

Yorkshire Ambulance Service (YAS) addition to membership: The Assistant Director of System Planning explained that the Director of Partnerships and Operations of YAS had requested her organisation be represented at the Committee and associated arrangements. The request for YAS to be added to the Partnership Agreement was supported and a written variation will be drawn up to this effect.

Outcome

The Committee:

i) Approved the minutes of the previous meeting subject to the above amendment.
ii) Noted the York Health and Care Partnership governance structure.
iii) Agreed the addition of Yorkshire Ambulance Service to the Partnership Agreement.

2. York Mental Health Partnership Sub-Group Report including *Path to a sustainable community mental health model*

A detailed presentation, circulated after the meeting, was provided to complement the report issued with the meeting papers which also included an update on the Connecting our City Project.

The Mental Health Partnership Co-Chairs emphasised the Mental Health Partnership's vision for York as being a *Whole Life, Whole Person, Whole System* approach, highlighting this integrated partnership working being recognised as ahead of many areas, also noting a number of "asks" of the Committee, discussed and detailed below.

The Senior Innovation Consultant reported on a Community Mental Health Transformation Whole System Workshop held on 1 May 2025 commending the multi partnership attendance; commitment to a shared vision, scope and timescale for transformation; and the identification of interdependencies and opportunities for collaboration. Challenges had also been recognised in terms of workforce development, communication, funding, redesigning of the system, resource, and the wider context such as increasing service costs, current changes to the NHS and the development of neighbourhood health services.

With regard to risk the Director of Adult Social Care and Integration explained her statutory responsibilities as Director of Adult Social Services and Executive Senior

Responsible Officer, also noting the complexities of the new and innovative working arrangements but emphasising this as the approach to proactively meet the needs of the population. She also supported the "asks" in terms of involvement and engagement in York's commitment to develop a sustainable model for mental health services.

The Leader of City of York Council left the meeting during the following discussion to attend the Victory in Europe commemoration ceremony.

Detailed discussion included:

- The need for robust governance arrangements.
- Noting work taking place to develop quality discharge standards.
- Emphasis on developments being through coproduction with local teams.
- Ensuring systems and processes in place to manage risk and support a culture of maximising opportunities for learning.
- The requirement for a sustainable solution beyond the two years funding of the hubs via transition to a new model utilising existing resources, evaluation of impact of developments, and also noting substantial evidence being accrued through such as 30 Clarence Street in York.
- Aspects of workforce including primary care and the role of the voluntary sector.

The requirement for a resolution to professionals having access to partner systems and information was highlighted as key to achieving the ambitions relating to joint working arrangements.

In conclusion the "asks" of the Mental Health Partnership were each noted and support confirmed as sought.

Outcome

In commending the presentation and continuing work, the Committee:

i) Supported ongoing development of York Mental Health Hubs including the opening of the 24/7 Neighbourhood Mental Health Centre @ Acomb Garth.
ii) Supported York Mental Health Partnership to contribute to the alignment of system risk and safety.
iii) Approved York Mental Health Partnership taking a higher profile and role in influencing the mental health housing and accommodation workstream.
iv) Endorsed York Mental Health Partnership’s work on bringing together key partners and players to progress the *Children and Young People* group.
v) Supported identification of co-chairs for the *Children and Young People* group.
vi) Noted the need to resolve challenges associated with information sharing and recording to enable professionals to work more effectively.

The Head of Mental Health Partnerships and the Senior Innovation Consultant left the meeting.

3. York Health and Care Partnership Executive Committee Terms of Reference

The Assistant Director of System Planning explained minor amendments had been made to the Committee's Terms of Reference since the previous iteration and noted they aligned with the Section 75 Agreement.

In response to the Mental Health Partnership Co-Chairs requesting consideration of their addition as attendees it was agreed that all the subcommittee co-chairs be included in this capacity.

Outcome

The Committee approved the Terms of Reference subject to addition of subcommittee co-chairs as attendees.

The Mental Health Partnership Co-Chair and Community Mental Health Programme Manager left the meeting.

4. York Health and Care Partnership Executive Committee Annual Report 2024/25 and Forward Plan

The Assistant Director of System Planning presented the draft annual report and forward plan which mirrored the format of the previous year and included contributions from a number of sources and partner organisations. The final report would be presented at the June meeting. If this was to be published the context of alignment of publication of the Section 75 and Partnership Agreements should be taken into account.

In response to feedback noting the omission of reference to workforce in the forward plan the Assistant Director of Planning agreed to include wording to the effect that the workforce would be kept informed of the current changes to ways of working and be supported with training, development and well-being.

The context of the *Model ICB Blueprint* and expectations/impact emanating from NHS changes were also noted.

Outcome

The Committee noted the draft annual report 2024/25 and forward plan with the opportunity to provide further feedback outwith the meeting.

5. Standing Items - System Update and Item 6 Integrated Care Partnership (ICP) Update

York Interim Place Director reported there had been predominantly NHS attendance at the System Leaders Forum the previous day to enable consideration of the recently issued *Model ICB Blueprint*. Discussions were also taking place with Local Authorities for inclusion in the work of the ICB's Design Group who were developing a structure in accordance with the end of May requirement.

The context of varying timescales was highlighted with reference to such as areas that would require legislative change.

York Interim Place Director noted that the ICB Executive Director of Strategy and Partnerships advised continuation of the current approach and developments including with regard to Section 75 Agreements.

York Interim Place Director explained that the ICS had submitted a financial plan at the end of March 2025 with a further submission at the end of April in the main for triangulation of workforce, performance, financial plans and efficiency programmes. The plan had been confirmed with a number of conditions:

- The requirement for total unidentified savings to be reduced and to be at zero by the end of May.
- No high risk schemes by the end of June.
- Robust governance arrangements including clear leadership, a programme management office and in terms of capacity.

Work was taking place to mitigate the financial risk across the system, including from the clinical perspective with regard to such as optimising commissioning, medicines and referrals.

The Director Adult Social Care and Integration noted potential alternative approaches to delivery of statutory services such as through partnership and other providers. She advised that the Humber and North Yorkshire Directors of Adult Social Services had agreed an approach of one of them representing the whole of the ICB area for technical support in such forums as the Place Design Groups and also emphasised commitment to engage from the York perspective. However, while recognising the tight timescales for this work, consideration of availability would be appreciated in terms of meetings being arranged at short notice.

In the context of money being taken out of the system, concern was noted from the perspective of potential loss of focus on York therefore the need to mitigate risk and operate on a wider footprint where appropriate.

There was no ICP update on this occasion.

Outcome

The Committee noted the updates.

7. Standing Item - City Leaders

In response to the Chair noting this item as an opportunity for any updates:

- The Director Adult Social Care and Integration detailed the requirements and processes pertaining to the Care Quality Commission inspection later in the month, also noting similar inspections in other areas of the ICB.
- The Chief Executive Officer of Ebor Academy Trust reported on discussions at the Schools Forum with regard to mapping school estate across the city in terms of alignment to neighbourhoods and potential for availability of empty buildings to be utilised.
- The Chair noted some of the results of the Local Government elections held in parts of England on 1 May.

Outcome

The Committee noted the updates.

8. Any Other Business

Update on Collaboratives

The Mental Health Partnership Co-Chair described the progress in relation to transition of the Mental Health Collaborative to the Mental Health, Learning Disability and Autism Joint Venture with a view to establishment in shadow form from September 2025 and full establishment from April 2026. Subject to due diligence, Humber Teaching NHS Foundation Trust would be the host organisation. Implications for staff and potentially for flow of mental health funding were highlighted.

The CVS Chief Executive explained that the Voluntary, Community and Social Enterprise and Primary Care Collaboratives were being brought together to form a new collaborative focusing on integrated care. She advised she is Chair of the Voluntary, Community and Social Enterprise Collaborative.

Outcome

The Committee noted the updates.

Next Meeting: Thursday 19 June 2025

This page is intentionally left blank

Annex B:

YORK HEALTH AND CARE PARTNERSHIP EXECUTIVE COMMITTEE

Terms of Reference

(PURSUANT TO THE SECTION 75 AGREEMENT MADE BETWEEN THE COUNCIL OF THE CITY OF YORK AND HUMBER AND NORTH YORKSHIRE INTEGRATED CARE BOARD)

Terms of Reference:	**York Health and Care Partnership Executive Committee**
Authorship:	**Natalie Caphane, Assistant Director of System Planning, Humber and North Yorkshire ICB**
Board / Committee Responsible for Ratifying:	**Humber and North Yorkshire ICB City of York Council**
Agreed Date:	**March 2025**
Approved Date:	**May 2025**
Review Date:	**May 2026**
Version Number:	**1**
The online version is the only version that is maintained. Any printed copies should, therefore, be viewed as 'uncontrolled' and as such may not necessarily contain the latest updates and amendments.	

If any part of these Terms of Reference conflict with Law, these shall be deemed deleted, but that shall not affect the validity and enforceability of the rest of this Agreement.

1. Background

The Partners have developed commissioning arrangements for the Section 75 ("s75") Services as defined in the Agreement.

The Joint Committee is a meeting between Humber and North Yorkshire ICB ("the ICB") and City of York Council (CYC). The Joint Committee is designed to ensure delivery of outcomes as set out in the section 75 agreement ("Agreement") and will collaborate to work towards the objectives as set out at Schedule 1 (Objectives) of the Agreement.

Partners shall comply with the framework for making decisions as set out in this document and the Agreement at Clause 4 (Partnership Flexibilities, Functions and Commissioning Arrangements).

The Joint Committee will operate alongside the York Health and Care Partnership and both will meet in one forum to be known as York Health and Care Partnership Executive Committee.

The role of the Health and Care Partnership is set out in the Partnership Agreement.

These Terms of Reference shall set out the roles, responsibilities, and workings of York Health and Care Partnership Executive Committee, encompassing the role of the Joint Committee and York Health and Care Partnership.

2. Governance

These Terms of Reference shall commence on 1st April 2025. They will be subject to an annual review by York Health and Care Partnership Executive Committee to ensure it remains consistent with the evolving requirements, of any changes to legislation, developments in best practice or requirements imposed by or on the Partners) in relation to the s75 arrangements; and will be published by the Partners on their websites.

3. Roles and Responsibilities of the Joint Committee

The role of York Health and Care Executive Committee is:

- Contribution to the delivery of the Health and Wellbeing Strategy for York and contribution to delivery of the Integrated Care Strategy for HNY in response to the Joint Strategic Needs Assessments for York residents – aligning national and local agendas to establish priorities for the local population.

- Making joint decisions, recommendations and plans regarding budgets and functions included in the Section 75 agreement.
- Act as the authorising environment for joint and aligned system leadership for York – ensuring peer accountability for the charter of behaviours and delivery of objectives.
- Ensuring capability, skills, capacity and supporting infrastructure are in place to deliver objectives.

The objectives of the place partnership are included in schedule 1.

4. Chair, Membership and Attendance

Chair and Vice Chair

The Committee will appoint one member as Chair. This role shall be reviewed annually.

The Committee will appoint one member as Vice Chair. This role shall be reviewed annually and be concurrent with the role of the Chair of the Committee.

The role of Chair and Vice Chair shall not be fulfilled by members drawn from the same Partner organisation at the same time. Should the Chair be unable to attend, then the role of the Chair shall be fulfilled by the Vice Chair, and they shall be referred to as the Chair for the purposes of that attendance.

The Chair shall be responsible for approving the agenda and ensuring that discussions progress the objectives as set out in these Terms of Reference. A forward plan will be developed to support the setting of the agenda.

The Partners have agreed that the chair of the York Health and Care Executive Committee shall be the Chief Operating Officer of CYC. This role of the chair shall be reviewed annually.

The Partners have agreed that the Place Director of the ICB will deputise as chair of the York Health and Care Partnership Executive Committee meetings. The role of the deputy chair which shall be reviewed annually.

Membership

Each Partner will have at least one representative to be in attendance at the meetings of the York Health and Care Partnership Executive Committee.

In these terms of reference, 'Partner' refers to the Partner organisations that are signatories to the Partnership Agreement and the associate members of the partnership as defined in Recital G of the Partnership Agreement.

Members of the Joint Committee will be senior responsible officers from Humber and North Yorkshire ICB and City of York Council and will hold appropriate delegated

authority for decision making. Both organisations will have four members on the Joint Committee.

Representatives from other partner organisations will be attendees at the meetings of the Committee, as set out in the 'attendees' section that follows.

The elected representatives of City of York Council will be attendees at the meetings of the Committee.

The resignation of a Member from their role with Humber and North Yorkshire ICB or City of York Council shall require resignation from the Committee and replacement of that Member with another Member prior to the next meeting.

The resignation of an Attendee from their role with a Partner shall require resignation from the Committee and replacement of that Attendee with another Attendee of equal delegated authority from that Partner before the next meeting and where this is not practicable a nominated deputy shall attend committee meetings until a replacement Attendee is appointed.

Each member or attendee will be permitted to have a nominated deputy from their partner organisation. Each Deputy will have the same rights and responsibilities as the Member or Attendee.

Attendees

The S75 Joint Committee will be operated alongside York Health and Care Partnership. The S75 joint committee and the place partnership will meet in one forum to be known as York Health and Care Partnership Executive Committee.

Representatives of the partnership that are not members of the S75 Joint Committee will be attendees of the executive committee. They will not be voting members of the committee and therefore do not make decisions but will be able to contribute through discussions to the forming of recommendations by the committee.

By exception, on occasions where the presence of the wider Health and Care Partnership would cause conflicts of interest that cannot be reasonably managed within the York Health and Care Partnership Executive Committee single forum, the meeting will be divided into Part 1 which will run as the S75 Joint Committee and Part 2 which will run as York Health and Care Partnership. However, York Health and Care Partnership are committed to transparency of decision making therefore whenever possible will make decisions and recommendations within the York Health and Care Executive Committee forum.

York Health and Care Partnership Executive Committee may have regard to the impact of its work on the wider Humber and North Yorkshire Health and Care Partnership parties and other partners and potential partners outside of partnership (together, "stakeholders") and the work of those stakeholders on the partnership arrangements.

It may consider involving stakeholders in specific items of business to be considered at York Health and Care Executive Committee meetings. The York Health and Care Partnership Executive Committee may invite any person to attend and participate in discussion at the Committee meetings but these attendees shall not participate in any decision-making.

The York Health and Care Partnership Executive Committee Partners will ensure that, except for urgent or unavoidable reasons, their respective representatives (or their Nominated Deputies) attend and fully participate in the meetings of the York Health and Care Partnership Executive Committee.

The Members and Attendees of York Health and Care Partnership Executive Committee shall comprise of:

Name	Title	Organisation	Representing
Ian Floyd (Chair) **(M)**	Chief Operating Officer	City of York Council	City of York Council
Sarah Coltman-Lovell (Deputy Chair) **(M)**	Place Director, York	NHS Humber and North Yorkshire ICB	NHS Humber and North Yorkshire ICB
Siân Balsom **(A)**	Manager	Healthwatch York	Healthwatch York
Mark Bradley **(M)**	Place Finance Director	NHS Humber and North Yorkshire ICB	NHS Humber and North Yorkshire ICB
Dr Emma Broughton **(A)**	Joint Chair	York Health and Care Collaborative	York Health and Care Collaborative, Primary Care Networks
Gail Brown **(A)**	Chief Executive Officer	Ebor Academy Trust	York Schools and Academies Board
Professor Karen Bryan **(A)**	Vice Chancellor	York St John University	Higher York
Zoe Campbell **(A)**	Managing Director North Yorkshire and York Care Group	Tees, Esk and Wear Valleys NHS Foundation Trust	TEWV – Mental Health provider, Mental Health Learning Disabilities and Autism Collaborative
Michelle Carrington (M)	Director of Nursing Health and Care Integration / Deputy Executive Director of Nursing	NHS Humber and North Yorkshire ICB	NHS Humber and North Yorkshire ICB
Cllr Claire Douglas **(A)**	Leader of the Council	City of York Council	City of York Council

Dr Helena Ebbs **(M)**	Clinical Place Director, North Yorkshire and York	NHS Humber and North Yorkshire ICB	NHS Humber and North Yorkshire ICB
Dr Rebecca Field **(A)**	Joint Chair	York Health and Care Collaborative	York Health and Care Collaborative, Primary Care Networks
Professor Lynne Gabriel **(A)**	Joint Chair	Mental Health Partnership	NHS Humber and North Yorkshire ICB
Jeevan Gill **(A)**	Director of Partnerships and Operations	Yorkshire Ambulance Service NHS Trust	Yorkshire Ambulance Service
Professor Mike Holmes **(A)**	Chair	Nimbuscare	Nimbuscare – GP Federation
Emma Johnson **(A)**	Chief Executive Officer	St Leonard's Hospice	St Leonard's Hospice, Hospices
Martin Kelly **(M)**	Corporate Director of Children and Education	City of York Council	City of York Council
Debbie Mitchell **(A)**	Chief Finance Officer	City of York Council	City of York Council
Simon Morritt **(A)**	Chief Executive Officer	York and Scarborough Teaching Hospitals NHS Foundation Trust	YSTHFT – Acute and Community provider, Collaborative of Acute Providers
Peter Roderick **(M)**	Director of Public Health	City of York Council	City of York Council
Alison Semmence **(A)**	Chief Executive Officer	York Centre for Voluntary Service	VCSE sector
Cllr Lucy Steels-Walshaw **(A)**	Executive Member for Health, Wellbeing and Adult Social Care	City of York Council	City of York Council
Sara Storey **(M)**	Corporate Director – Adults and Integration	City of York Council	City of York Council
Pauline Stuchfield **(A)**	Joint Chair	York Health and Care Collaborative	City of York Council
Cllr Bob Webb **(A)**	Executive Member for Children, Young People and Education	City of York Council	City of York Council
Dr Stephen Wright **(A)**	Joint Chair	Mental Health Partnership	NHS Humber and North Yorkshire ICB

In the table above (M) indicates Member and (A) indicates attendee.

5. Meeting Frequency, Quoracy and Decisions

Frequency

York Health and Care Partnership Executive Committee will meet monthly.

To be deemed in attendance, members and attendees must be in attendance in person or virtually, and only votes cast in that forum by those deemed in attendance shall be counted towards the quorum.

Members and attendees are normally expected to attend at least 75% of meetings during the year.

Quorum

For the purpose of decision making, the S75 Joint Committee will be quorate when Humber and North Yorkshire ICB and City of York Council are equally represented by Members, or their Nominated Deputies in numbers by a minimum of two per Partner.

For the purpose of making recommendations, York Health and Care Partnership Executive Committee will be quorate when at least 50% of the membership are present and the following are all present - the Chair or Deputy Chair, one ICB representative, one City of York Council representative and two partner attendees.

No decision may be taken, nor recommendation be made at any York Health and Care Partnership Executive Committee meeting unless it is quorate.

Nominated Deputies with the appropriate delegated authority in attendance count towards the quorum.

No person can act in more than one capacity when determining the quorum.

If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflict of interest, then that individual shall no longer count towards the quorum.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken, nor may any recommendation be made.

In exceptional circumstances, Joint Committee decisions may be taken by e-mail by participation of a quorate number of voting Members i.e. equal representation from the ICB and CYC and a minimum of two Members per Partner. The Chair shall e-mail any decisions to be voted on by e-mail directly to the members from their professional e-mail address. Any voting responses by e-mails in return shall be sent directly by the Members from their professional e-mail addresses. The outcome of the decision shall be recorded in the minutes of the next meeting of the York Health and Care Partnership Executive Committee.

Decision Making and Voting

The Joint Committee must comply with the framework for making decisions as set out at Clause 4 of the s75 Agreement and have regard to the matters specified in this paragraph.

The Joint Committee will seek to make decisions on a consensus basis. In cases where consensus cannot be reached, the Chair may call a vote.

Voting: A vote will be taken, with each member or their nominated deputy having one vote. The decision will be based on the majority vote. If a majority is not achieved, the decision doesn't pass, and dispute resolution may need to be considered.

For the sake of clarity, only Members of the s75 Joint Committee have voting rights. Attendees of the York Health and Care Partnership Executive Committee (denoted (A) in the table on page 5-6) do not have voting rights for decision making.

Any decisions taken will be recorded in the minutes of the meeting.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis by of telephone, email or other electronic communication. Rules of attendance and quorum shall be maintained for the purposes of this meeting, and any such meetings shall be recorded.

Recommendations and Voting

Members who have organisational responsibility through delegation for Partner functions, will retain decision making responsibility for those functions. In these cases, York Health and Care Partnership Executive Committee can make recommendations only.

York Health and Care Partnership Executive Committee can make recommendations to partners on matters that are relevant to the partnership's objectives. However, recommendations are not binding on the accountable partner organisation. Recommendations will be made through consensus following discussion with contribution from Members and Attendees. Voting arrangements do not apply to recommendations made by the committee. If a consensus recommendation cannot be reached, the accountable partner organisation will ensure that it gives due regard to the contributions of the committee.

6. Behaviours and Conduct

Partners commit to behave consistently as leaders and colleagues in ways which model and promote our shared values and have aligned these to the Nolan Principles which define the standards of conduct expected by a person or people in public office.

The place partnership's agreed charter of behaviours are included in the Partnership Agreement.

7. Equality and diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

8. Accountability and Reporting

The Joint Committee is accountable to each of the Section 75 Partners' respective Executive Committee and Board. An annual report will be prepared and shared with the respective Executive Committee and Board of each of the Partners (and any other statutory or other committees as notified by that Partner).

The minutes of the meetings shall be formally recorded by the secretariat and the Chair / Deputy will ensure these are shared to be included in each of the Partners' respective Cabinet and Board meetings and shall draw to the attention any issues that require disclosure or require action.

YHCP provides a regular narrative report on the committee's activities to York Health and Wellbeing Board. The minutes of YHCP Executive Committee are included as annexes to the report and are therefore published as part of the Health and Wellbeing Board's papers.

The Joint Committee will provide a quarterly assurance and escalation report to the ICB Board.

9. Sub-Groups of the Joint Committee

York Health and Care Partnership Executive Committee may develop sub-groups as appropriate to support the discharge of its functions. York Health and Care Partnership Executive Committee retains responsibility and accountability for the work of any appointed sub-groups.

To provide a consistent approach in receiving assurance back to York Health and Care Partnership Executive Committee, all groups accountable to the Committee will complete on a quarterly basis a standardised form that will include key messages and shall draw the attention of any issues that require disclosure or require action. These forms will be managed by the secretariat.

The sub groups of York Health and Care Executive Committee are shown in the governance diagram in Schedule 3.

10. Secretariat and Administration

York Health and Care Partnership Executive Committee shall be supported with a secretariat function provided by Humber and North Yorkshire ICB (York Place) which will include ensuring that:

- The agenda and papers are prepared by the secretariat and distributed no less than 5 working days ahead of each meeting, having been agreed by the Chair in consultation with the Deputy Chair. By exception, and only with the agreement of the Chair or Deputy Chair, acting reasonably, amendments to papers may be tabled before the meeting.

- No matters shall be considered which are not included in the agenda for the meeting, unless this is agreed by the Chair and the Deputy Chair and the reasons for the urgency are minuted.

- At least 10 clear working days prior to a meeting of the Committee an invitation to attend the meeting shall be sent by email to each Committee Member and Attendee and any other stakeholders.

- The draft minutes of each meeting will be circulated promptly to all Members as soon as reasonably practical and no later than 10 working days after the meeting. The Chair will be responsible for approving the draft minutes before circulation.

- Attendance of those invited to each meeting is monitored by the secretariat. Those that do not meet a minimum of 75% attendance in a 12-month period are highlighted to the Chair.

- Good quality minutes shall be taken and agreed with the Chair and a record of matters arising, action points and issues to be carried forward shall be maintained by the secretariat.

- Action points are taken forward between meetings and progress against those actions is monitored.

- The secretariat is responsible for ensuring that the annual programme of business is regularly updated according to the Joint Committees objectives and associated risks.

- The Chair is supported to prepare and deliver the reports outlined in Section 6.

- Where a new member or attendee is proposed, this must be approved by the Chair and Vice Chair. Where this relates to a new partner organisation, their introduction to the partnership should be managed as detailed in Section 16 of the Partnership Agreement.

11. Virtual Meetings / Recording of Meetings

Before starting a recording, the Chair is legally required to inform attendees if the meeting is being recorded and that the purpose of the recording is as an administrative tool to support the provision of clear and accurate minutes.

The recording is only retained for the period of drafting the minutes and then subsequently deleted from all systems.

No person admitted to a meeting of York Health and Care Partnership Executive Committee will be permitted to record the proceedings in any manner without written approval from the Chair.

12. Conflicts, Potential Conflicts and Declarations of Interest

In advance of any meeting of York Health and Care Partnership Executive Committee, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed.

Where the Chair or a member, or attendee, of York Health and Care Partnership Executive Committee believes that they have any actual or perceived conflicts of interest in relation to one or more agenda items, they must declare this at the beginning of the meeting wherever possible, and always in advance of the agenda item being discussed. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises.

It will be responsibility of the Chair to decide how to manage the conflict and the appropriate course of action.

Any interests which are declared at a meeting must be recorded within the minutes of the meeting. Individuals must ensure that they comply with both the ICB's and their employing organisation's policies / professional codes of conduct with regard to the recording of declarations

13. Freedom of Information Act 2000

The minutes and papers of this Committee are considered public documents, except where matters are specifically deemed to be unsuitable for publication. This will usually be due to draft work in progress, issues of confidentiality, or commercial sensitivity.

14. Review

York Health and Care Partnership Executive Committee will review its effectiveness at regular intervals through a number of means which may include peer review, audit, and effectiveness review.

These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the each of the Partners' respective Cabinet and Board for approval.

END

SCHEDULE 1

PARTNERSHIP OBJECTIVES

The Partners will work together to achieve the following Objectives:

- 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.
- Improve the quality and efficiency of services by planning and undertaking activities together.
- Develop and deploy effective joint approaches that join services and systems together to better support people to positively manage their health and wellbeing.
- Work towards organisational and financial sustainability, recognising the challenges ahead in relation to workforce, rising costs, and rising demands, by taking decisions together that take account of interdependencies between health care services and the wider determinants of health.
- Foster a culture of mutual respect, trust, and open communication that builds strong partnerships.
- Embrace learning and continuous improvement to optimise care delivery and outcomes, encouraging local innovation.

SCHEDULE 2

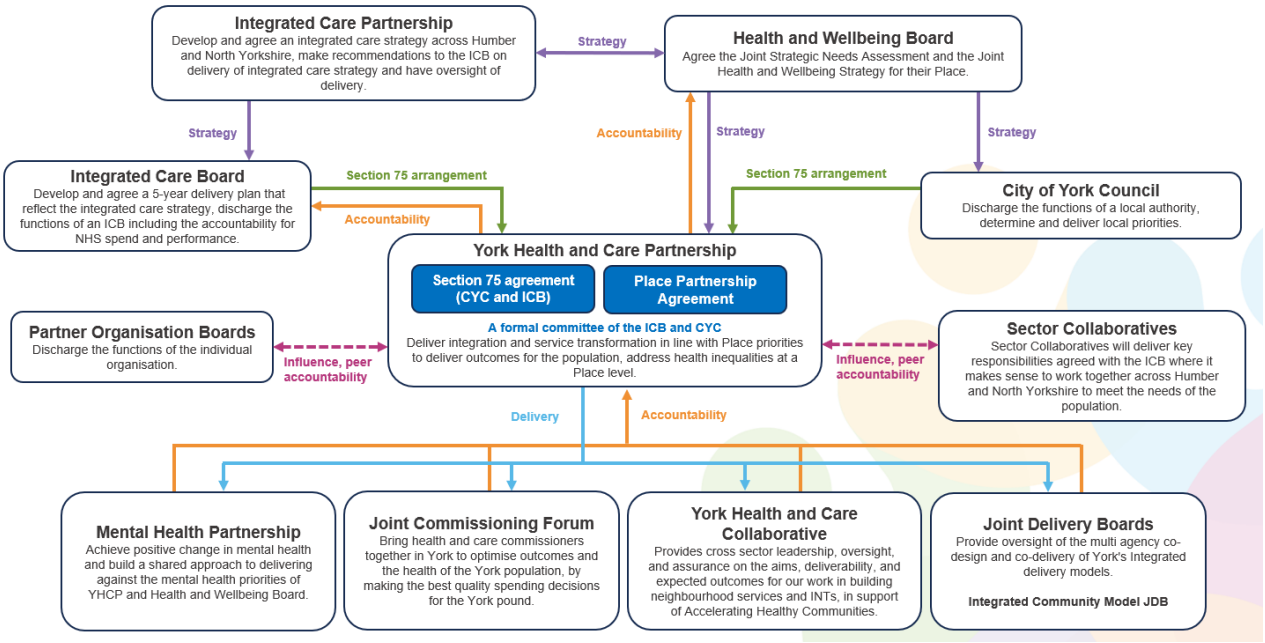
CHARTER OF BEHAVIOURS

- **We are in it together** - We agree that we will have a robust airing of views, but that once our partnership has reached a decision, we will all abide by that decision and support it publicly.
- **We will trust in people -** We agree to openly discuss all matters that affect our ability to make firm decisions, including any conflicts of interest and any limits on our mandate (where we carry these from participant organisations), so that all members of our team are fully aware of any restrictions, caveats or further authority that may be required.
- **We will be permission-giving and empower staff -** We will support our teams, and in particular professional/clinically-led service development. We will deliberately try to enable decisions to be made by 'front-line' staff by saying 'yes' to their solutions. We will promote an environment of high quality and low bureaucracy. We will recognise that Health and Care rises and falls on staff wellbeing.
- **We are person-centred -** Recognising the diversity of our population we will develop solutions that are 'bespoke by default' focussing on understanding the needs of our residents. We will put people at the centre of decision making and be able to question where we think this is not the happening.
- **We will free the power of the community -** People/patients will be actively involved in the system, providing feedback, supporting and leading change.
- **We are committed to improving population health -** We recognise the significant health inequalities experienced across the city. We recognise the upmost importance of working to address these inequalities and support vulnerable individuals and populations when participating in our activities.
- **We will connect clinicians and professionals -** We are committed to restoring the connections between clinicians and professionals from primary and secondary care, nursing and social care, and the voluntary sector. Staff are empowered to make the right decisions without bureaucracy getting in the way and will understand the system as a whole.
- **Our finances will align -** We will explore ways in which we can use our collective resources to the best possible effect for the population. We will strive to understand the consequences of our decisions on all partners and manage any repercussions so as not to destabilise any organisation and managing risk collectively.

- **We are open –** We will operate with transparency, honesty, shared accountability and clear decision-making mechanisms.

SCHEDULE 3

GOVERNANCE STRUCTURE



York Place and East Riding Arrangements

The ICB contribution to this arrangement includes aligned functions and funding relating to the ICB's definition of York Place. This includes the population East of York centred around Pocklington, resident in the East Riding council area.

A separate Section 75 agreement between Humber and North Yorkshire ICB and East Riding Council includes the aligned local authority functions and funding relating to this population.

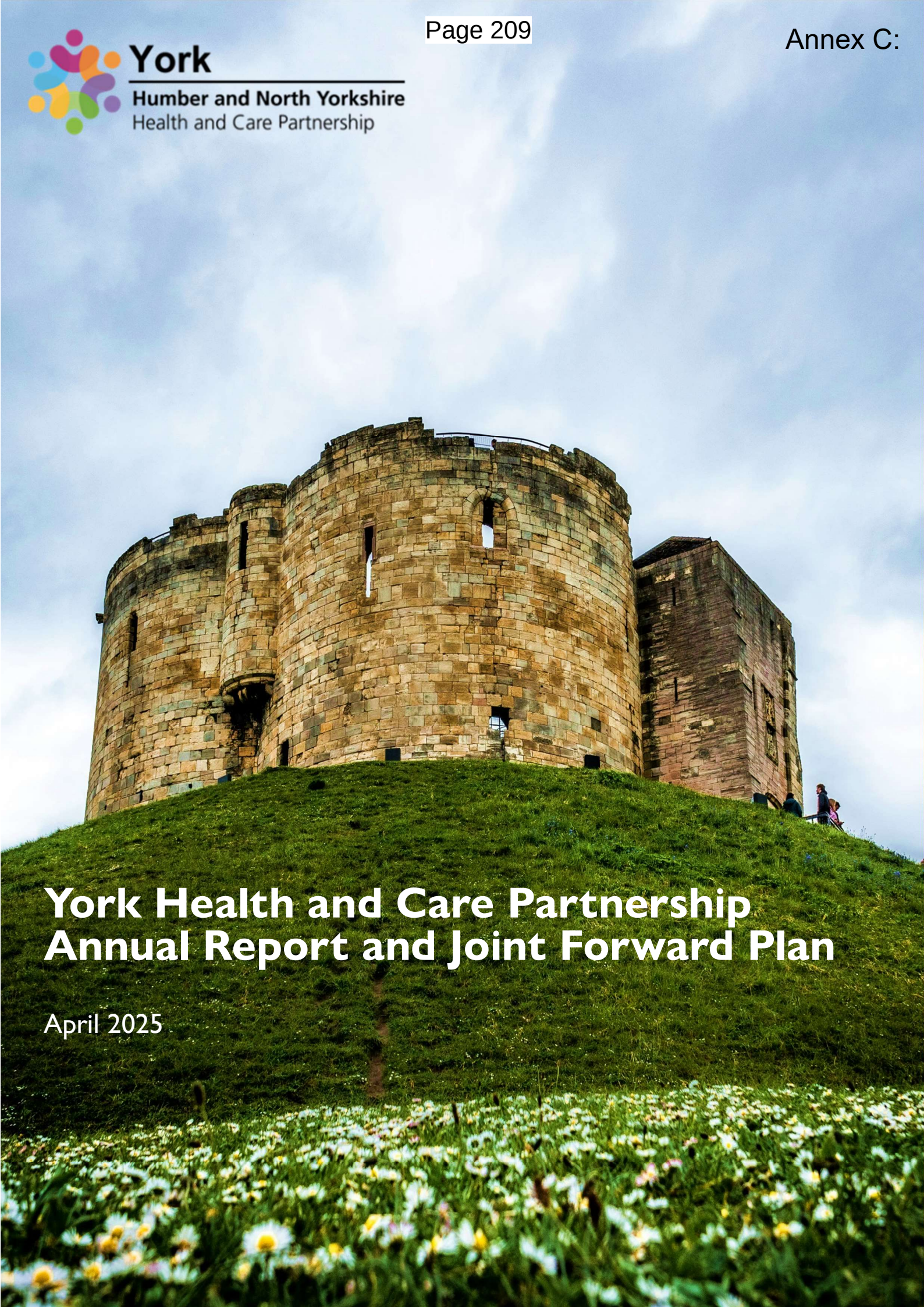
The Joint Commissioning Plans for York and East Riding Health and Care Partnerships will make specific reference to this area.

Proposals relating to the population that are residents of East Riding and within the ICB's York Place Area must be reviewed by both York and East Riding s75 Joint Committees. Dependent on the specific proposal, this may mean that members need to attend the other committee to represent the relevant health / local authority view.

Sub groups of YHCP are required to consider representation of East Riding partners either through representation on the sub group itself or dedicated working groups.

Annex C:

York
Humber and North Yorkshire
Health and Care Partnership



York Health and Care Partnership Annual Report and Joint Forward Plan

April 2025

1. Introduction

1.1 Context

2024-25 has been a year of significant development in our Health and Care Partnership. We have made substantial progress against the plans we set out this time last year and are now in a position to further focus our plans and priorities for 2025-26. We've strengthened our partnership working, with a joint committee between Humber and North Yorkshire Integrated Care Board (ICB) and City of York Council (CYC) set to be established for 2025-26. As a place partnership, we are committed to improving health and wellbeing outcomes for the people of York. We will make York a healthier and fairer city to live and work in, for current and future generations.

This report serves two purposes – a look back at our achievements and progress against our 2024-25 plans, and a forward plan of what we will prioritise and act on in 2025-26.

The government's 10 Year Health Plan, to be published in the spring 2025, will set out the three big shifts our NHS needs to be fit for the future:

- from hospital to community
- from analogue to digital
- from sickness to prevention.

Joint commissioning of effective and efficient out of hospital and prevention services is an important initial step in delivering these left shifts. We believe the plans and priorities that we have set for 2025-26 are well aligned with these three big shifts and will be the right ones to start delivering on the 10 Year Health Plan for York.

1.2 York Health and Care Partnership (YHCP)

The Humber and North Yorkshire Health and Care Partnership (HNY) is the Integrated Care System (ICS) which plans healthcare in our region. Within this partnership, York sits as one of six 'Places'. You can find out more about the Humber and North Yorkshire Partnership here. In York, our Place Partnership is called the York Health and Care Partnership (YHCP). The YHCP brings together a collection of partner organisations to collaboratively improve health and care outcomes and service provision in York.

2025-26 will mark a new era in partnership working as we formalise our collaboration under a revised Partnership Agreement. The agreement sets out the Partnership's objectives and priorities and the role and responsibility of senior leaders to work with and on behalf of the wider health and care partnership in addition to their organisational responsibilities.

Locally, the ICB's operating model of six places recognises delegation to place as key to planning and commissioning on a local footprint, informed by the needs of our local population. The development of a joint committee in York from 2025 will allow us to set out how we will plan and commission services together.

This sets the foundation for integration and transformation of health and social care to reduce health inequalities and improve the health of York's population. However, we recognise that this is a step in a longer-term journey towards partnership working and integration of services to ensure an effective and

sustainable health and care system for future generations. There is much further to go, and our 2025-26 plans in this document are part of that journey.

2024-25 has been a busy, challenging, and exciting year for the YHCP. Health and Care organisations in York are continuing to develop strong, multi-agency system teams to meet the health and social needs of our residents and, whilst we always strive for continuous improvement, significant progress has been made towards delivering our priorities in 2024-25.

1.3 Our purpose and priorities

The purpose of the YHCP is to reduce health inequalities and increase healthy years lived for people in York, by working together to address the wider determinants of health. We want to improve people's lives by providing the right support at the right time, to ensure everyone can have a happy and healthy life in York. We share the ambitions highlighted in the Joint Local Health and Wellbeing Strategy and are working in partnership to deliver the six big ambitions and ten big goals for York.

In 2023, YHCP identified six priorities to be delivered collaboratively, focused on strengthening integration, reducing health inequalities, and improving population health for people who live in York. The priorities support delivery of the Joint Health and Wellbeing Strategy for York, as well as contributing to the delivery of the Humber and North Yorkshire Health and Care Partnership Strategy.

The six key priorities for 2023 to 2025 were:

For 2025-26, we have refreshed our priorities and will focus on the following areas:

Accelerating Healthy Communities

Our overarching priority to transform how we operate together to deliver a new model of neighbourhood health, care and provision in the City for future generations.

Realising the benefits of Joint Commissioning for York's people

Including community equipment, Continuing Healthcare, Adult Social Care, addressing areas of duplication, a sustainable model for Community Mental Health, Better Care Fund.

Deliver our vision for an integrated neighbourhood model

Incorporating community, primary care, mental health and prevention, alongside an aligned partnership approach to workforce and estates.

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

Create capacity through a joint commissioning approach, including a sustainable model for family and Special Educational Needs and Disabilities hubs.

1.4 Key achievements in 2024-25

Achievements against our priorities in 2024-25 include:

- **Launch of the first Mental Health hub**: The Hub offers flexible mental health and wellbeing support tailored to the diverse challenges individuals face. It connects people to their local communities to support them to achieve the goals they identify to improve their mental health. This approach enables early intervention, preventing declines in mental health. The long-term goal is to establish three fully integrated Mental Health Hubs across the city, seamlessly linking with existing mental health services in York.
- **Expansion of the York Integrated Frailty Crisis Response Hub**: Now operating seven days a week, the hub allows multi-disciplinary teams to manage frail and vulnerable patients in their homes, reducing the need for hospital admissions. The hub, first introduced in November 2023, has expanded to support around 7,300 crisis cases per year. This has prevented 2,920 Emergency Department (ED) attendances. Case studies demonstrate improved outcomes for patients and their families and a significant time saving across local services.
- **Enhanced Health and Social Care Integration**: Our collaborative approach has streamlined hospital discharge processes and invested in "home first" care and support, leading to more patients who no longer require medical care being able to leave hospital much sooner compared to the previous year, and remain independent in their own homes.
- **Improved Support for Children and Young People**: Through the Asthma Friendly Schools project and establishment of a Reintegration Support Worker to improve school attendance for children and young people with autism and anxiety.
- **Addressing Health Inequities**: A range of initiatives have focused on supporting vulnerable populations in York, including social and wellbeing activities for asylum seekers and GP outreach services for women with urgent healthcare needs who struggle to access existing care.
- **Support for People with Cognitive Impairment and Dementia**: We've developed a more integrated Dementia Community Support model, combining resources across health and social care to offer comprehensive support both before and after diagnosis.
- **A second Brain Health Café** has been launched to assist individuals with mild cognitive impairment, offering a supportive space for those waiting for memory service assessments or those considering seeking a diagnosis.
- **Our Neighbourhood Model**: We've laid the groundwork for how services will look and feel in future for residents and practitioners, through co-creation of a set of guiding principles, shaped with over 200 front line leaders from across 30 local health, council, and partner organisations.

1.5 Engagement in 2024-25

The organisations that make up the YHCP all undertake their own engagement and coproduction exercises to ensure that services are developed alongside the people who will be using them, and the Partnership continues to benefit from this work when organisations share their findings and best practice around coproduction. As a key strategic partner of the YHCP, Healthwatch York (HWY) have continued

to champion the voice of people in York and ensure that people's views are captured to influence and shape local health and care services. Key highlights from Healthwatch York's work include:

Publication of the Core Connectors report which has provided valuable insights into young people's experiences of health and social care in York. Core Connectors are young people aged 16–25 who help other young people have their voices heard. The report highlighted many factors that are adversely impacting upon young people's physical and mental health including the cost of living, long waiting times, and challenges around social and family connections.

Publication of the Listening to Neurodivergent Families report in partnership with the Land, York Carers Centre, York Disability Rights Forum and Parent Carer Forum York in January 2025.

Publication of Exploring access to GP services in York - Interim report, in September 2024.

Publication of Migrant Healthcare Experiences in June 2024.

Enter and View Reports including Riverside Care Complex, Ebor and Birchlands Care Home reports. Themes include quality of life, quality of care and health checks.

Publication of What we are hearing April to June 2024, a quarterly report sharing what people have said from April to June 2024 across various areas of health services including hospital, GPs, mental health care and dentistry.

Wider engagement has taken place across the ICB called 'We Need To Talk.' Three priorities were published in the February 2025 report including (1) the need to improve access to services due to long waiting times; (2) develop a person centred approach including more integrated care delivery; and (3) having enough staff with the right skills and experience to support our population.

1.6 Reducing Health Inequalities

The YHCP has continued to deliver projects that target health inequalities, and they have been evaluated to inform plans in 2025-26. The York Population Health Hub has produced Core20PLUS5 profiles for Adults and Children and Young People, outlining the groups who are most likely to experience health inequalities in the city.

Case study

Inclusion Health Register Pilot in York - A Pioneering Approach to Equity in Healthcare

The Inclusion Health Register Pilot in York represents an innovative, data-driven approach to identifying some of the most vulnerable populations within the healthcare system. Designed to better recognise, track, and support Inclusion Health groups—including veterans, people experiencing homelessness, Gypsy, Roma and Traveller communities, potentially vulnerable migrants, and other at-risk populations—the pilot has demonstrated significant early benefits. The aim is to refine the model in York before scaling it across the wider Integrated Care Board (ICB) footprint.

The pilot is focusing on increasing the identification and coding of patients within Inclusion Health groups across participating practices. The initiative has driven a notable 32.18% increase in the total number of patients coded under these categories, equating to an additional 2,667 individuals now formally recognised

within the system. This progress is particularly encouraging as it lays the groundwork for better-targeted interventions and resource allocation.

Positive outcomes demonstrated by the pilot include:

- Increased Visibility of Vulnerable Groups: The growing number of patients coded within Inclusion Health categories ensures that these groups are no longer invisible within the healthcare system. This visibility allows for more tailored care pathways and targeted interventions.
- Data-Driven Decision Making: The insights gained from register trends help inform future healthcare planning, ensuring that resources are directed towards the populations with the greatest need.
- Gypsy, Roma and Traveller Communities: targeted work from January to March 2025 has led to more than a 200% increase in registrations amongst this population. Registrations rose from 103 to 313 between February and April 2025.

Case Study

Proactive Social Prescribing

The Proactive Social Prescriber (PSP) works across Primary Care Networks in York, contacting people directly, based on analysis and identification of people who might benefit from support. This analysis was developed through an algorithm in Year 1 and by individual Primary Care Networks in Year 2.

By proactively reaching out to individuals with respiratory conditions and tailoring support to their unique needs, the PSP bridges critical gaps between clinical services and social support networks. The initiative addresses challenges like social isolation and digital exclusion, which are often overlooked but can significantly impact health outcomes. The PSP connects people to support from established organisations as well as grassroots services that can offer a range of support for individuals.

Through an initial phone call, the PSP offers to meet people in a way that is accessible, familiar and safe for them, either over the phone or through face-to-face meetings (for example, in a local, familiar café or community centre). The PSP prioritises what matters to each person and what challenges they face and supports them to develop a mutually agreed personalised care plan, connecting each individual to a range of support, which could include mental health support, access to groups and activities, physiotherapy, occupational therapy, or services that can advise on benefits, housing, employment or smoking cessation.

The PSP uses a person-centred approach, giving choice and control back to people and attempting to educate and improve confidence in healthcare.

1.7 Delivery through the Charter of Behaviours

The Partnership has committed to a set of principles that will guide partners in our work.

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

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

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

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

We will free the power of the community – People and patients will be actively involved in the system, providing feedback, supporting and leading change.

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

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

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

We are open – We will operate with transparency, honesty, shared accountability and clear decision-making mechanisms.

2. Delivery against our six priorities in 2024-25

This section of the document provides an update towards the delivery of our six priorities in 2024-25. We have looked back at what we said we would deliver in our joint workplan and provided an update against each of these actions.

2.1 Strengthen York's Integrated Community Offer

This priority includes our ambitions to strengthen community integration across health and social care, and physical and mental health. The aim of this work is to improve models of community-based support which are preventative, so people do not need to seek professional help so often and can find mental wellness in connections and communities.

What we said we would deliver	What we have delivered in 2024-25
A new Reablement Contract, redesigned specification to ensure we are providing a sustainable, fit for purpose service, achieving best value	A revised reablement service specification was developed collaboratively by colleagues working across both the ICB and council, with a greater focus on integrated working, restoring patient independence, and a more seamless integrated discharge pathway. Since the new contract was implemented there has been a notable increase in service utilisation, with more individuals receiving reablement care upon discharge and as part of community step-up services.
Fully integrated Discharge to Assess Model	In June 2024, the Pathway 1 Bridging Service was commissioned, which employs a discharge care coordinator to carry out a short in-hospital assessment for immediate short-term needs and manage the rapid transfer to home. Initial results have been excellent, with most patients on this pathway being discharged within one day, and many patients seeing a reduction in the care needs previously identified whilst they were in hospital. Discharge to assess pathways were agreed in principle at a partner workshop in November, with implementation of integrated discharge hubs identified as key to implementing this model. Integrated discharge hubs are due to be implemented by September 2025 and the continued development of this model is a key priority for 2025-26.
Integration of Community Services	The York Integrated Community Model Joint Delivery Board was formed at the end of November to oversee the co-design and implementation of a new model for community health services that moves away from multiple, fragmented services and towards a more unified, system-wide approach.

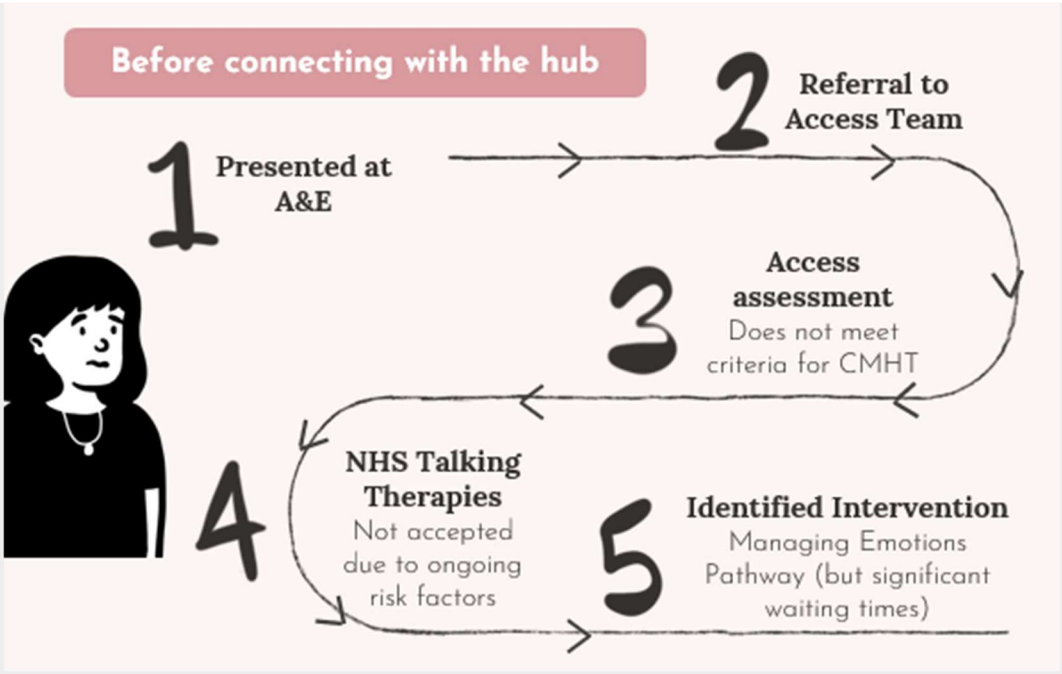
	The group has developed a proposal for York's future integrated community model which aims to reduce duplication, ensure care is delivered in the right place at the right time (with more care provided in the community and in patients' own homes), and deliver better patient outcomes while improving value for money. The next steps will be to finalise an action plan and timeline.
Realign existing resources to facilitate seamless support for people with dementia and their carers in the community	We have worked with Dementia Forward to combine the various health and social care funding streams to develop one joint agreement from 1st April 2025 that describes a complete wrap around support offer for people on the Dementia Pathway both pre and post diagnosis. The West Outer Primary Care Network (PCN) pilot for primary care diagnosis progressed well. Approximately 40 cases were redirected from the Tees Esk and Wear Valleys NHS Foundation Trust (TEWV) waiting list to the primary care Multi-Disciplinary Team (MDT). This is expected to have a further positive impact upon patient outcomes, reduced waiting times for memory clinic diagnosis, and an increase in the future overall diagnosis rate.
St Leonard's Hospice leading work to review end of life care pathways and processes	Progress to improve access has been made in a range of areas including: • As well as accepting referrals from the Specialist Palliative Care Team (SPCT) in the hospital, referrals are now taken directly from the hospital discharge liaison. • Improved communication with the hospital discharge team regarding capacity within the hospice at home (community care) team. • Co-location of hospice staff within the hospital discharge team to forge stronger connections and referral to hospice services when patients are imminently dying and would benefit from hospice care.

Continue to work in partnership to support implementation and expansion of Mental Health Community Hubs	Our first Community Mental Health Hub opened in June 2024 and is now a fully established multidisciplinary team. The team is made up of social prescribers, peer support workers, mental health practitioners, carer support workers, a social care worker, recovery workers and volunteers. The hub provides mental health and wellbeing support to address the range of challenges people face, in a flexible manner to connect people with their local communities. Ongoing evaluation, led by a PhD student at York St John University and supported by external evaluators, is shaping the hub's development based on data-driven insights. Monthly Conversation Cafés also provide a platform for ongoing community feedback and engagement. Funding for a 24/7 Neighbourhood Community Mental Health Centre as part of a national pilot has been secured. A second codesign process has been complete for the development of the 24/7 hub which incorporates individuals with lived experience, practitioners and those from the local community. The Centre will open in Acomb in June 2025.

Case Study

York Community Mental Health Hubs

The Hub is a team made up of social prescribers, peer support workers, mental health practitioners, carer support workers, social care worker, recovery workers and volunteers. Hub users have told us that the hub has positively impacted upon their lives: *"You have opened your hands and your hearts"* and *"You've made a huge difference to my life."* Martha's journey further illustrates how the Hub provides mental health and wellbeing support in a flexible manner to connect people with their local communities.



* *Note CMHT – Community Mental Health Team*

2.2 Implement an integrated Urgent and Emergency Care Offer for York

What we said we would deliver	What we have delivered in 2024-25
With mobilisation of GP Out of Hours (OOH) and Urgent Treatment Centres (UTCs) at Scarborough, Malton, and York all partners expect to realise the ambition, transformation, and benefits of an integrated urgent care service ahead of winter 2024-25.	York and Scarborough Teaching Hospitals NHS Foundation Trust have worked closely with local GPs in Scarborough, Whitby, York, and Selby, as well as with Nimbuscare to implement a single joined up 24/7 urgent care service. The first year of the new GP Out of Hours contract has delivered clear and measurable improvements, including consistently improved shift fill rates, timely call-back performance, positive patient feedback, reductions in emergency department referrals and hospital admissions, and enhanced incident reporting.
Build on the momentum generated at the Urgent and Emergency Care Summit in February 2024, work with system partners to implement the agreed outputs, including a review of the pathways into and out of hospital-based services supporting ED, including the Urgent Treatment Centre, and Speciality-led Same Day Emergency Care services to support effective emergency flow, and build on the success of the GP in Yorkshire Ambulance Service Control Room pilot.	Across North Yorkshire and York, partners maintained an intense focus on urgent and emergency care resilience throughout winter 2024-25, taking forward 3 key system actions. • Piloted an Integrated Co-ordination Centre – a multi-disciplinary team, including GP and community services, which supports paramedics in determining whether a patient needs to attend hospital, with a focus on community alternatives where suitable. The 2024-25 pilot saw positive results - 716 cases were reviewed in 13 weeks, 68% of which were age 65 and over. Ambulance dispatch was avoided in 66% of cases. • Continued to review and improve flow on the hospital site, maximising the impact of optimal care services which diverts low acuity patients away from ED. • Commenced implementation of Discharge Command Centre, with 'Home First' principles fully embedded and agreed Discharge to Assess pathways.

Expand and enhance the Frailty Crisis Response Hub (part of which is the Frailty Advice & Guidance Line) to deliver a true 'call before convey' service for Yorkshire Ambulance Service and the wider system to support a tangible reduction in unnecessary ED attendances for frail and vulnerable people.	The Frailty Crisis Response Hub was expanded from 5 to 7 days per week in early 2024-25, and GP capacity in the hub was doubled on weekdays to provide greater support for frail patients, helping them to remain at home where in their best interests during a crisis. A "Call Before Convey" pilot was implemented, requiring frontline ambulance crews to contact the frailty hub before transporting a patient to the emergency department, unless it was a true emergency. This process has now been integrated into standard practice, significantly increasing the ambulance service's utilisation of the hub. The number of ED attendances avoided by this service each month in 2024-25 has more than doubled compared to 2023-24.

Case Study

Helping People Stay at Home with Dignity – How the Frailty Hub Made a Difference

'A 91-year-old gentleman had recently become much frailer. He had been to A&E several times and was struggling to eat and losing weight. His daughter was deeply worried. One day, when he became so weak he couldn't even stand, she was on the verge of calling an ambulance—but instead, she contacted the Frailty Hub.

A care navigator quickly assessed the situation and connected her to a specialist team. A GP spoke with the daughter and arranged for a rapid response team to visit the gentleman at home within two hours. This included both medical and support staff to carry out a full assessment. The GP also had a video call with the family to talk through the gentleman's wishes. It became clear that he needed end-of-life care, and most importantly, that he wanted to remain in his own home. Thanks to the Frailty Hub, the right support was put in place. The Hospice at Home team was arranged, and they provided care and comfort in his final days. He passed away peacefully at home, surrounded by family—just as he had wanted. This is just one example of how the Frailty Hub helps people avoid unnecessary hospital visits and receive compassionate care where they feel most comfortable: at home.'

2.3 Further develop Primary/Secondary shared-care models

What we said we would deliver	What we have delivered in 2024-25
There is an ambition to further develop shared care models between Primary and Secondary Care across the ICB, with a view to providing more integrated care closer to home.	The Primary/Secondary Care Interface Group has acted as a forum for discussion and resolution of issues that present through general practice collective action with on-going work to reduce GP workload regarding onward referrals where clinically appropriate, and to agree collaborative working principles. We continue to work with GP colleagues, the Local Medical Committee (LMC) and hospital colleagues to develop Shared Care Models and Integrated Working to benefit patients and the wider system.
Bring more pathways on board with Referral for Expert Input to facilitate shared care pathways.	Undertaken preparatory work with Paediatrics and Haematology. Both specialities will go live with Referral for Expert Input in early 2025-26, with further specialties to follow.
Continue to develop the Primary/Secondary Care Interface Group as a key forum for agreeing principles and culture around joint/collaborative working and sharing pathway development ideas/progress. Develop a Pathway Transformation Group to oversee and approve changes in clinical pathways with a focus on clinical governance and safety.	The Pathway Oversight Group was established in November 2024 with a focus on clinical pathway improvement and transformation. Work is in progress around Breathlessness and Hormone Replacement Therapy (HRT) pathways.

2.4 Embed an integrated prevention and early intervention model

What we said we would deliver	What we have delivered in 2024-25
Delivery of the Secondary Prevention Programme.	A key area of focus has been improving the management of diabetes in primary care. Working closely with colleagues from York and Scarborough Teaching Hospitals NHS Foundation Trust, we

	have delivered targeted upskilling for general practice teams, which has led to an increase in the number of diabetic patients receiving all NICE 9 care processes. In partnership with York CVS, social prescribing support has been provided to over 100 patients with uncontrolled Chronic Obstructive Pulmonary Disease (COPD). This intervention is already showing promising results, with increases in both annual reviews and medication adherence among this cohort. Collaboration with general practice has enhanced the management of patients diagnosed with hypertension. Insights from across these initiatives have informed ongoing service modifications, strengthening our secondary prevention offer and improving early identification and proactive care for long-term conditions.
Integrated Prevention Scoping Offer.	In 2024–25, we undertook a comprehensive scoping exercise to map the prevention workforce and services across York, identifying existing strengths and proposing areas for improvement. A number of positive themes were highlighted, demonstrating that several prevention services are already working effectively across the system. Opportunities for improvement include: • Provide greater stability to the current prevention workforce through recurrent funding • Support the emerging Integrated Neighbourhood Team model • Address the needs of High Intensity Users through a Population Health Management lens. As a key outcome of the scoping exercise, funding for the continuation and expansion of Proactive Social Prescribing project was secured from 2025–26 onwards.

Continue to strengthen the York Population Health Hub. Develop our Population Health Management (PHM) Infrastructure and Analysis.	The Population Health Hub has enabled teams across the system to adopt population health approaches through targeted support, including a series of 'lunch and learn' sessions and bespoke workshops. These have built confidence and understanding of PHM tools and methods, supporting teams to embed data-driven planning into their work. Significant progress has also been made in improving data sharing capabilities, laying the groundwork for more integrated analytics across sectors. This will provide a critical foundation for advancing our PHM ambitions and supporting more coordinated, person-centred care.
Accelerated delivery of the Health Inequalities Programme.	Completed a full evaluation of projects funded between 2022–2024, with the learning directly shaping our future strategy. This has led to the development of a new approach for health inequalities funding from 2025–26 onwards, aligned with our Partnership's strategic priorities. Delivery of the PCN and Trust Health Inequalities training programme which brought together colleagues from across the system to learn about health inequalities and population health management to translate into real life projects to support a reduction in inequality for our population.
Strengthen the city-wide Integrated Neighbourhood early intervention and prevention system.	A key priority has been fostering the development of locality-based working through the emerging Integrated Neighbourhood Teams model, with the aim of delivering more proactive, personalised care closer to where people live. Commenced the development of neighbourhood health profiles, which will provide essential insights into local population needs, enabling targeted action and resource allocation.

Case Study

Health Inequalities projects in 2024-25 – Focus on Children and Young People

Since 2023-24 the YHCP has received funding from Humber and North Yorkshire Integrated Care Board to deliver projects focused on health inequalities in the local population. Some of the projects that have had a positive impact for Children and Young People in York are:

Children and Young People (CYP) School Absences - This initiative directly supports children with autism and anxiety-related school absences, helping them reintegrate into education. A dedicated Reintegration Support Worker (RSW) works closely with families, schools, and support services to develop personalised plans. Since its launch, it has successfully reduced school absences for 72% of participating children, while others have accessed alternative education provision suited to their needs. Schools have praised the initiative, recognising its positive impact on tackling the barriers that neurodiverse CYP face in education.

Asthma Friendly Schools - This project aims to improve asthma care in schools across York Place, ensuring children and young people (CYP) have the necessary support to manage their condition. By training staff, appointing asthma champions, and improving policies around medication access, the initiative fosters a safer school environment.

Maternal and Child Nutrition - This project supports maternal and child health by promoting breastfeeding and improving infant feeding practices across York. With the goal of achieving UNICEF Baby Friendly Accreditation, it is driving change through training, community engagement, and the introduction of a city-wide "Feeding Friendly" scheme. Initial data shows that breastfeeding rates in York exceed the national average, and targeted interventions in areas with lower uptake are helping to address disparities.

Chronic Pain Clinic - A dedicated chronic pain clinic is being developed to improve care for children with chronic and functional pain conditions. The project includes clinician training, patient education resources, and new referral support materials to enhance understanding among families, healthcare providers, and schools. Though early in implementation, this initiative has the potential to reduce unnecessary medical referrals, improve symptom management, and provide CYP with better long-term health outcomes.

Training Package for Schools – This project is developing an improved online training and resource hub for speech, language, and occupational therapy support. Schools, parents, and professionals will have access to engaging, easy-to-understand resources to better support children with communication and developmental needs, increasing awareness and early intervention.

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

What we said we would deliver	What we have delivered in 2024-25
Support for our schools to support Children and Young People (CYP) with Asthma to fully participate in school life and manage symptoms to ensure they can achieve optimal outcomes.	By training staff, appointing asthma champions, and improving policies around medication access, the Asthma Friendly Schools initiative fosters a safer school environment and ensures CYP have the necessary support to manage their condition. This ongoing initiative aims to significantly reduce health inequalities by ensuring all asthmatic students receive consistent and high-quality care at school.
Continue to develop the integrated offer for support to children who experience difficulties with bowel and bladder function.	Additional workshops and targeted support were provided for CYP with additional needs or who are neurodiverse and required more bespoke advice and support. Face to Face individual appointments were introduced by the specialist team to ensure that additional needs were met. Integrated Bowel and Bladder workshops commenced in February 2025 whereby the healthy child service and specialist nurses deliver education and support on healthy bladder and bowels.
Review of commissioning arrangements for Speech and Language Therapy services (SaLT) and consideration of joint commissioning possibilities to ensure Speech, language and communication needs (SLCN) of CYP are supported throughout childhood.	Significant progress has been made in this area although concerns around SaLT waiting list times continue. Progress in 2024-25 includes: • Service improvement work including piloting group interventions to review some of longest waiters and a number of short term initiatives to address the increasing waiting list. • An increased training offer to schools and settings to improve universal and targeted offers. • The successful programme of Early Talk for York was widened to reach more areas with a focus on inequalities. The programme was expanded to include screening and intervention

	for older children to enable earlier identification of unmet SLCN needs.
Reduce barriers that CYP who are neurodiverse experience in relation to school attendance.	The primary focus of the Partnership for Inclusion of Neurodiversity in Schools (PINS) has been to equip schools with the knowledge, skills and resources to create more inclusive learning environments, strengthen partnerships between schools and families and improve whole-school Special Educational Needs and Disabilities provision. York schools have access to a wide range of offers and resources through PINS, which have been designed to enhance understanding, provide practical tools and create supportive environments for neurodiverse pupils. While these offers contribute to reducing barriers to school attendance, the primary focus has been on enhancing school environments and building staff capacity to better support neurodivergent learners.
Consider an improved integrated approach to SEND (special educational needs and disabilities) using a Family Hub approach and coproducing services with children and families.	A multi-professional hub to support children with SEND and their families will be launched at Clifton Children's Centre in Autumn 2025. A significant amount of planning has taken place through 2024-25 to enable this local offer from early help to specialist support, including securing a financial contribution from health partners.
Increase support for children and young people with autism with the most complex needs.	The ICB and CYC began to explore the possibility of capital funding for complex needs to create additional placements at the Beehive, for children with the most complex needs. Partners have agreed that this work will be progressed in 2025-26.

An ICS approach to ensuring CYP have the best start in life and enable everyone to be safe, grow and learn as outlined in the HNY ICB Strategy.	The Director of Public Health Annual Report was published in March 2025 which provides an invaluable insight into the state of young people's health in York across a range of areas including physical health, mental health and wellbeing, SEND and neurodiversity and children with an experience of care. The newly established ICB CYP Integrated Start Well Board has membership across Executive Place Directors, Director of Children's Services and Public Health leads.

Case Study

Case Study - Raise York

Raise York brings together children; young people; families; communities and professionals so everyone can get the connections, help and support they want and need.

- **Raise York** - The network of people, places and online support for children, young people and families in York. It supports children, young people and families from pregnancy to adulthood.
- **Family Hubs** - The buildings where children, young people and families can access a wide range of Raise York services and support, all under one roof.

5,097 service users accessed services in Family Hubs (former children's centre) sites between Oct – Dec 2024 with 128 professionals involved in delivery of services in Family Hubs and the Raise York brand is starting to be recognised.

Co-production

Co-production has been at the heart of the development of Raise York throughout. 2,000+ families have been engaged in the development process and 325+ have been part of the co-production process.

Relationships and Integrated Working

- Partners are involved from a wide range of organisations including Local Authority, NHS / ICB, voluntary and community sector, and parents.
- Collaborative leadership and relational practice training has taken place, helping to place these at the centre of our Family Hubs model.
- Examples from pilot activity demonstrate how working in partnership has helped identify and address gaps in provision and use resource more efficiently.

To deliver Raise York's ambitions and achieve the outcomes families want and need, we have a range of tools and services available to us including information and support for families and tools, resources and support for professionals.

For the next 3 years, Raise York's priority areas of work are:

1. Infant feeding
2. Perinatal mental health and parent/carer-infant relationships
3. Healthy weight in under 5s
4. Communication and language skills
5. Children and young people's mental health
6. Cost of living

The Raise York Pledge

In order to achieve our outcomes for families, we are asking everyone that works with children, young people and families to make the Raise York Pledge.

Our pledge has three pillars, asking all partners to be:

Caring Together Trusted

2.6 Driving social and economic development

What we said we would deliver	What we have delivered in 2024-25
Infrastructure, Housing and Healthcare developments.	In 2024-25 YHCP developed proposals for establishment of the Accelerating Healthy Communities programme, our overarching vision for a new model of neighbourhood health. The proposal recognises the challenges we face – rising demand related to rising morbidity and population growth; the condition of the health and social care estate; funding deficits – and sets out the design principles for a neighbourhood health model. We've laid the groundwork for how services will look and feel in future for residents and practitioners, through co-creation of a set of guiding principles, shaped with over 200 front line leaders from across 30 local health, council, and partner organisations.
Workforce, training, and skills.	Student placements within the Frailty Hub have been progressed through the Nimbuscare Education Coordinator. Discussions are also progressing in relation to nursing staff from St Leonard's undertaking rotational placements within the Frailty Hub. Through the Care Connected Forum, engagement is underway to progress engagement with social care providers to understand and seek solutions to their workforce challenges, including issues and mitigations relating to sponsorship.
Supporting social development for vulnerable groups.	A key success from 2024–25 was the Inclusion Health Register Pilot, an innovative, data-driven approach to identifying and supporting some of the most vulnerable populations within the system. In 2024-25 we developed our health inequalities programme for implementation in 2025-26, a key

	element of which focuses on wider determinants of health in Children and Young People.
Strengthening links to wider partnership strategy.	We have contributed to the York and North Yorkshire Mayoral Combined Authority Local Growth Plan to build health and prosperity for the City's residents. Individualised Placement and Support is now up and running in mental health settings and through Drug and Alcohol services, supporting hundreds of people back to work. The Mayoral Combined Authority Economic Inactivity Trailblazer will shortly be launched, including a number of schemes which have health and work support at their heart. A wide range of partners have participated in the University of York's study focused on System Integration through Network Governance in NHS Place Committees. The outputs of this study, due in summer 2025, will illuminate our collaboration practices, successes, and challenges at these deeper levels, and strengthen awareness for Managers and Professionals leading system change to strengthen our future position as a Place and ultimately achieve better outcomes for our population.

Case Study

Joint Commissioning Lead for Health and Social Care

The ICB and City of York Council implemented a shared Head of / Assistant Director of Commissioning from July 2024. There are many working examples of how this role has successfully enabled delivery of our priorities and has moved us to a place of delivering better integration of care across our system. Some of the key successes of this role include reduced duplication, open and transparent conversations, alignment of working practices, boost in staff morale and empowerment to overcome specific challenges and barriers. As a result, the YHCP will consider more permanent and wide-ranging developments in the context of place delegation and integration, which can include joint posts alongside joint governance, budgets, and processes.

2.7 2024-25 Progress: Conclusion

As this report highlights, there has been a significant amount of work undertaken by the YHCP and its partnership teams through 2024-25 to improve health outcomes for people living in York and address health inequalities.

Now, we are re-focussing on three priorities for 2025-26 onwards which will build on the progress we have made so far and continue our dedication to improving the health and wellbeing of York's residents.

3. Joint Forward Plan 2025-26

Since we set our six priorities in 2023, the Partnership has evolved, the landscape has changed, and we have made significant progress against these priorities.

The YHCP has therefore produced a refresh of priorities for 2025-2028 to re-focus the Partnership on our 'must dos'. *Accelerating Healthy Communities* has been adopted as our unifying ambition, to provide clarity and constancy of purpose, and a guiding light for our Partnership's three 'must dos' over the coming years.

We will review our plans in response to the 10 Year Health Plan when published in Spring 2025 which will enable us to shift towards a medium-term approach to planning.

We must also recognise that 2025-26 will be a year of change and uncertainty in the health care sector, with fundamental alterations to the role and capacity of Integrated Care Boards underway and expected to take effect from Quarter 3. At the time of writing, it is unclear what this means for Place based capacity in the ICB and how this will apply to legislative functions, nor is it clear how or when providers will be expected to take on some of the duties of ICBs over time.

Although we will need to be mindful of these changes as we progress our delivery plans, commitment to our priorities and to delivering improved outcomes for our population will not waver.

3.1 York's Growing and Changing Population

In March 2025, we published a summary of the York Joint Strategic Needs Assessment (JSNA), Our City Health Narrative. Our Joint Forward Plan and priorities are adapting to meet the needs of our changing population and to mitigate the challenges these changes may bring.

3.1.1 Population growth

- The resident population of York is forecast to grow by approximately 35,000 between 2023 and 2033 with a projected 50% increase in the over 85 population by 2040.
- The proportion of adults with a major illness will grow by 38% by 2040.
- An extra 1,235 patients per year are seeking care in mental health services, an additional 52 patients are attending A&E each day, 60,000 more GP appointments take place per year and social care demand is rising by an extra 600 people per year.

3.1.2 Population health

- Life expectancy for both males and females living in York is falling and is now below the national average for males. There is a gap in life expectancy of over 10 years for both males and females across our city.
- There are several distinctive demographics in York. We have the third lowest fertility rate in the country, 1 in 6 of our residents are students, we have the 14th most transient population in England and we have over 9 million tourists visit our city every year.
- An increasing number of children (0-11) are living with an unhealthy weight at reception and year 6. Children within this age group have good vaccination coverage but also experience inequalities in speech and language and school readiness and have poor oral health and access to dentistry.
- There are now more young people (11-25) with special educational needs and disabilities (SEND) and there are concerning trends around emotional and mental health and young people's experiences of relationships, with higher levels of school absence post COVID.
- 2 in 3 adults (18-64) living in York are overweight or obese with 20% living a sedentary lifestyle.
- Cost of living pressures are adversely affecting health outcomes and the average house in York is 9.3x average earnings.
- Our older population (64+) report higher than average levels of loneliness, and there is a raising demand for mental health services amongst our older population. There are 800 falls-related admissions per year and 25% of our over 65s experience digital exclusion.
- York also has many strengths to draw on, including a strong voluntary and community sector with over 350 charities; we have a growing and resilient economy with a strong local employment profile; we have the most highly educated population in the region; good access to green spaces and an increasingly diverse city with more residents from a minoritised ethnic background.

3.1.3 Estates challenges

Rising demand for care from a growing and ageing population will put pressure on the healthcare estate.

The combined primary and community care space is estimated to be approximately 2,500m^2 short of current needs; forecasts indicate the overall shortfall in estate capacity will double to 5,500m^2 by 2033 - approximately the size of a football pitch.

A Local Development Plan for York has now been ratified. Through our Accelerating Healthy Communities programme, we will consider our strategic estates needs and how we will plan to address these challenges.

3.2 Engagement

Each statutory member organisation of the Partnership will retain its own approach to public involvement for the services that they remain responsible for.

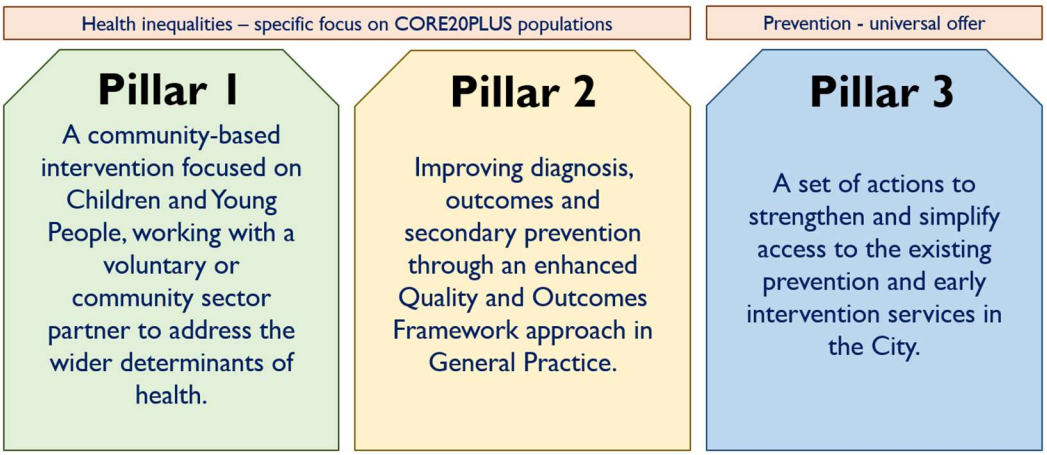
We intend for community engagement and co-production to happen extensively throughout our local integration journey, and in support of this the Partnership will:

- Continually consider how to engage members of the public so that their views can be reflected to YHCP Executive Committee and its sub groups, depending on the nature of the decisions to be taken.
- Utilise the involvement of patient engagement networks, carer networks, and other relevant organisations to ensure that there is public engagement and participation throughout the Partnership's work.
- Look to consolidate and where appropriate share resources across organisations for a common Partnership approach to communications and public involvement activities.

Healthwatch York will continue to work with people in York, giving individuals and communities a voice in what they want from local health and care services. Healthwatch's work in 2025-26 will include a continued focus on Core Connectors, Enter and View visits and a specific focus on Gender Health including women's health, men's health and the trans and non-binary community.

3.3 Health inequalities

Reducing health inequalities will continue to be a key role of Place Based Partnerships, and work to reduce health inequalities remains a golden thread throughout each of the YHCP's priorities for 2025-26. In 2025-26 the YHCP will receive health inequalities funding from the Humber and North Yorkshire ICB to address local need in line with the Core20PLUS5 Framework. This will be deployed through a two pillar approach, alongside a third pillar which will focus on prevention services.



3.4 Plans for delivery against the priorities in 2025-26

3.4.1 Delivering our vision for an integrated neighbourhood model

The development of a neighbourhood health model is a key national priority, articulated in the Fuller and Darzi reports and now confirmed in 2025-26 planning guidance with the requirement to –

Set the foundations of the neighbourhood health model by continuing to embed, standardise and scale core components of existing practice. This includes taking a consistent, system-wide population health management approach to patient segmentation and risk stratification.

Neighbourhood models are also expected to be a central development in the NHS 10 Year Health Plan, due in Spring 2025.

What are the benefits for our population?

Health and care services will feel joined up and will be provided in a convenient location – within the local community wherever possible.

People will be supported to stay healthy and well, maintaining independence and living at home as long as possible.

Care will focus on what matters to that person and their individual circumstances – and professionals will work behind the scenes to co-ordinate this.

People will know how to access the right support, advice and care at the right time.

People will be empowered to manage their own health through digital tools and technologies.

What will we do in 2025-26 to support this priority?

Deliver our vision for an integrated neighbourhood model	
What will we deliver?	**How will we deliver this in 2025-26?**
A co-ordinated approach to supporting High Intensity Users.	Identify a cohort of high intensity users of health care across our population. Design and implement a co-ordinated neighbourhood led approach to supporting the health and wellbeing of this cohort with general practice and wider partners, with the aim of improving outcomes and reducing healthcare resource use.
Complete development of Neighbourhood Health Profiles.	Complete our neighbourhood health profiles, which will provide essential insights into local population needs, enabling targeted action and resource allocation. These profiles will inform multi-agency discussions and decision-making at the neighbourhood level, allowing the system to better address health inequalities and increasing demand.
Mapping Neighbourhood services.	Identify the health and care staff, teams and assets in each neighbourhood and take steps to connect professionals who work in each locality to foster a culture of multi-disciplinary integrated working around a local population.
Establish Integrated Neighbourhood Teams in line with the agreed Neighbourhood Design Principles.	In partnership, we will develop and implement an operating model for our neighbourhood based teams. This will include confirming which services will operate 'in neighbourhoods' and which will relate 'to neighbourhoods' – operating on a different footprint but with strong links into each neighbourhood.
Build the revenue model based around the benefits of a neighbourhood health and care model for residents, practitioners and communities.	Appoint a health economics partner to work with our stakeholders and partner organisations to model the revenue impact of the neighbourhood model on NHS, social care and social housing.

Undertake a feasibility review for our strategic approach to health and care estate.	Identify future estate needs based on the neighbourhood service delivery model, consider future strategic estate options and their feasibility.
Establish integrated workforce models to support the neighbourhood delivery model.	Involve our workforce through the design of neighbourhood models, engaging with all staff groups throughout the process to ensure that their perspectives are reflected and that they can see the benefits of the transformation for their individual roles and the care they give to patients. Identify gaps in the workforce, including skills, behaviours and ways of working to develop as well as gaps in specific roles and staff groups that we need to develop across the Partnership. This may include developing skills to cover multiple functions that traditionally may have been delivered separately so that staff are safely able to work in a more agile way and increase continuity for people and carers. Identify barriers and opportunities to better enable productive integrated working so that staff have the skills and tools to safely work across organisational boundaries and serve their local populations, while improving workforce interactions and experience.

3.4.2 Improving Outcomes for Children and Young People

We will develop a partnership based, inclusive model for children, young people and families. Create capacity through a joint commissioning approach, including a sustainable model for family and SEND hubs.

Children and Young People (CYP) are central to our Partnership's ambitions – getting it right earlier in life is crucial for the future health and wellbeing of our population. With an all-age approach, everything that the Partnership does will be with reference to children and young people.

Humber and North Yorkshire Health and Care Partnership's integrated strategy highlights radically improving the health and wellbeing of children and young people as our system's golden ambition. The Partnership is prioritising children and young people through its Start Well Board.

The Children's Wellbeing and Schools bill (currently at committee stage) will put in place a package of support to drive high and rising standards throughout our education and care systems so that every child can achieve and thrive. It will protect children at risk of abuse, stopping vulnerable children falling through

cracks in services, and deliver a core guarantee of high standards with space for innovation in every child's education.

What are the benefits for our population?

Families and carers will find it easier to access the support they need for their children and young people, and they will be able to access it at the earliest point that support is needed.

Children and Young People will feel safe, and when they go to an adult for support, they will receive the right help without multiple hand offs or having their needs 'lost' between services.

What will we do in 2025-26 to support this priority?

Develop a partnership based, inclusive model for children, young people and families	
What will we deliver?	**How will we deliver this in 2025-26?**
CYP York Place Priority Plan.	We will develop a CYP York Place Priority Plan that will be informed by the latest planning and best practice guidance, will be driven by local data about the needs and wants of families, children and young people in York, supported by an extensive engagement process. The plan will outline how the Partnership will deliver our CYP priorities in 2025-2028. The purpose of the plan is to explain: "how will health, council and schools work together to improve outcomes and experience for children?" We will not wait for the CYP Priority Plan to deliver on areas of improvement that we know we need to make now. This includes children with Speech, Language and Communication Needs (SLCN) for which detailed improvement projects are already underway. We will align delivery with our existing local plans and those which are in development.
Children's commissioning and integration approach.	We will progress delivery against the identified priorities and plans as set out in the CYP Place Priority Plan.

Integrated Neighbourhood Teams (INTs).	We will ensure that children and young people are at the centre of our integrated neighbourhood plans and that education partners are included as a key partner in the development of INTs in accordance with the national guidance.

3.4.3 Joint Commissioning

By realising the benefits of joint commissioning, we will reduce duplication and ensure we are delivering the best outcomes within the financial, workforce and estate constraints.

This makes sense for where services are targeting similar populations, where there is benefit in multi-agency working, and where an active focus on prevention can reduce costs to statutory services.

Joint commissioning arrangements will allow us to increasingly take account of interdependencies between health care services and the wider determinants of health.

What are the benefits for our population?

Jointly commissioned services will reduce the number of referrals and hand offs between providers.

This in turn will reduce administrative delays that patients often face when being transferred between health and social care.

Services will support patients with a wider range of needs, bringing a more personalised approach, because they will not be contracted as separate health, care and social provision with differing specifications and criteria.

Reducing duplication and ensuring most effective use of our resource will mean that more care and support can be delivered to people.

What will we do in 2025-26 to support this priority?

Realising the benefits of joint commissioning for York's people	
What will we deliver?	**How will we deliver this in 2025-26?**
Prevention and Health Inequalities – including services funded through prevention and health inequalities budgets, local GP enhanced services, budgets funding communities and housing support, and wider council budgets supporting prevention (all age).	Co-produce and commission our 'pillar 1' health inequalities intervention focused on Children and Young People. Implement the 'pillar 2' enhanced quality and outcomes framework (QOF), which will increase delivery of QOF secondary prevention interventions in our health inequalities cohorts. Build on the prevention proposals approved in 2024-25, including contracting for the ongoing

	proactive social prescribing service and developing supportive preventative interventions for high intensity users. Develop an integrated falls pathway, including universal assessment, strength and balance interventions, building on services already in place to ensure that people at risk of fall are identified at the earliest opportunity and preventative personalised support is in place.
Community Equipment Services.	Review the future of community equipment services, assessing the available options to align leadership, operational management, specifications and outcomes.
Integrate or align services in areas of likely duplication to maximise value for money and create flexibilities to reinvest.	Identify areas where CYC and ICB contract for similar outcomes and agree new options when contract periods are up.
York Integrated Community Model.	Work together to develop and deliver a joint model for non-bedded community health services that moves us away from multiple services, reduces hand offs, strips out waste, improves resilience and shares resources, and is established on neighbourhood health principles.
An integrated or common approach to working with the Voluntary, Community and Social Enterprise (VCSE) sector.	Establish and agree principles for commissioning and contracting with the VCSE Sector.
Assess and strengthen the alignment of pooled funds and the transparency of pooled funds.	Undertake a Better Care Fund best value scheme review. Build on our joint working arrangements, considering where there would be benefits of going further with the scope of joint commissioning approach.
Continuing Healthcare / Section 117 aftercare and jointly funded care packages	Work with other places in Humber and North Yorkshire to develop an approach to consistency of

	process for decisions, panels and disputes, with local variation where needed.
Establishing a path to a commissioned, integrated and de-medicalised 24/7 community mental health offer for York.	Support the Mental Health Partnership Sub Committee and Mental Health Hub Joint Delivery Board with integrated commissioning that helps providers work together to do the right thing and implement a sustainable model for Community Mental Health, building on the strengths of the hub approach, bringing community mental health teams, crisis services and other place-based mental health services into an integrated, recurrently funded model.
Identify opportunities for joint commissioning in the East Riding area of York Place.	Explore opportunities for joint commissioning between the ICB York Place and East Riding of York Council, including reducing duplication and streamlining of commissioning and contracting processes. Establish priority areas for joint working. Set up a sub-group to focus on the development of the neighbourhood working for this area, ensuring that governance aligns with INT developments across York Place and East Riding Council.

4. Conclusion

We believe that our plans for 2025-2028 are ambitious, while being clearly focused on our priority areas. 2025-2028 will be an exciting time for the YHCP, as we collaborate more closely with formal partnership arrangements in place and explore how we can further develop partnership working in future.

We look forward to the publication of the government's 10 Year Health Plan, which we expect to give further direction and significance to the way we work together across our local health and care system. We will focus on delivery of the three big shifts from hospital to community, from analogue to digital, and from sickness to prevention.

2025-26 is also set to be a challenging year, with substantial restructuring expected in the NHS and organisations continuing to manage significant financial and operational challenge. More than ever, this underlines the importance of working together, in partnership, and not losing sight of our vision - making York a healthier and fairer city to live and work in, for current and future generations.

Health and Wellbeing Board 24 July 2024
Report of the Manager, Healthwatch York

Healthwatch York Annual Report

Summary

1. This report is for information, sharing details about the activities of Healthwatch York in 2024/25 with the Health and Wellbeing Board.

Background

2. Healthwatch York has a legal duty to produce an Annual Report by 30 June each year, and to share it with local and national stakeholders[i]. The report, Annex A, contains information about how Healthwatch York have fulfilled their statutory function over the past year.

3. We also include a link to our Summary Workplan for 2025/26 as Annex B.

4. Finally, at Annex C we share our Independent Evaluation, which explores how key stakeholders in the city view our work and considers potential developments for the future.

Main/Key Issues to be considered

5. Healthwatch York are a small team, with a wide remit. The Annual Report provides a summary of work completed through the year 2024/25.

Consultation

6. There has been no specific consultation involved in producing the Annual report, but it is informed by specific and general consultation and engagement activities that Healthwatch York undertake. The Independent Evaluation has been completed in consultation with key stakeholders, relevant to the specific activities of Healthwatch York during 2024/25.

Options

7. Health and Wellbeing Board are asked to note Healthwatch York's Annual Report 2024/25.

Strategic/Operational Plans

8. Areas of work discussed within the report have helped contribute to a number of different strategic and operational plans.

Implications

9. 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

10. There are no risks associated with the Annual Report.

Recommendations

11. The Health and Wellbeing Board are asked to:

i. Receive Healthwatch York's Annual Report

Reason: To keep up to date with the work of Healthwatch York.

Contact Details

Author:	**Chief Officer Responsible for the report:**
Siân Balsom Manager Healthwatch York 01904 621133	

Report Approved ☐ **Date** *Insert Date*

☐

Wards Affected: All **All** ☑

For further information please contact the author of the report

Background Papers:

Annexes

Annex A - HWY Annual Report 24/25
Annex B - HWY-Summary-Workplan-2025-26
Annex C - Healthwatch-York-evaluation-2025-Final

---

[i] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/262761/local_healthwatch_annual_reports_directions_2013.pdf

This page is intentionally left blank

Annex A:

healthwatch York

Annual Report 2024–2025

Your voice for change in health and care

Healthwatch York

Contents

"Thank you to every single person who shared their experiences with us this year. Sometimes the most important thing we do is just listen. But we always want to do more. In this report we share how in the past 12 months we have used your words to try and make York better for us all. We couldn't do this without you!

The Healthwatch York team

A message from our chair

Once again it has been an extremely busy year for Healthwatch York. The number of calls and contacts continues to grow. This enables us to raise issues of local concern and highlight best practice in health and social care. Without these contacts and contributions to surveys and reports, we would not be able to represent your voice.

Health and social care remain headline news nationally and many of these issues are mirrored locally. Healthwatch York continues to work to make sure, whatever the national picture, we first and foremost champion the issues that matter to you in our city.

The stories that people share with the Healthwatch Team are often difficult to hear. Many tell us they are struggling to access the support and services they feel they need. But alongside this, we continue to hear stories about people and organisations that go above and beyond what is expected.

The team continue to impress me with their professionalism, energy, and commitment. I want to take this opportunity to congratulate them on their well-deserved commendation from Healthwatch England for their work on the adult ADHD and Autism assessment pilot pathway work.

For such a small team, capacity continues to be a major challenge. But they remain absolutely committed to finding ways to hear from more people in our city.

This year, they have expanded the number of community venues you can meet them in. They have reinstated the care home visiting programme that had been suspended during the Covid pandemic and then remained paused.

A message from our chair, continued

They have begun a young volunteers programme, Core Connectors, and supported them to publish their first report. Alongside this they have published major reports on Access to GP services, and Listening to Neurodivergent Families. All supported by you!

It is always inspiring to see how many people in York take time to support us in our work. Together we can make sure York voices influence the planning and delivery of our city's services and support.

Whether you were one of the over 1,300 people who completed our Access to GP services survey, someone who got in touch about your experiences, or one of our Healthwatch York volunteers including our Core Connectors listening to young people's experiences of accessing health and care services, and our Care Home Assessors supporting our care home visits, we would not be able to continue without you.

I hope you enjoy reading about all the work Healthwatch York have undertaken in the last year.

"It is always inspiring to see how many people in York take time to support us in our work. Together we can make sure York voices influence the planning and delivery of our city's services and support."

Janet Wright, Chair of Healthwatch York

About us

Healthwatch York is your local health and social care champion.

We make sure that the NHS hear your voice and use your feedback to improve care. We can also help you find reliable and trustworthy information and advice.

Our vision

Together we can make York better.

Our mission

Healthwatch York puts people at the heart of health and care services, enabling you to be heard. We believe that together we can help make York better for everyone.

Our values are:

Accessible : Empowering : Informative : Flexible

Participative : Valuing Diversity : Responsive

Inclusive : Supporting Choice : Accountable

"Healthwatch York demonstrate professionalism with a personable side. They are a joy to work with. They have a can-do attitude in a very challenging resource environment"

Dr Jed Meers
York Law School, University of York

Our year in numbers

We supported more than 2,700 people to have their say and get information about their care. We currently employ 4 staff and, our work is supported by 30 volunteers.

Reaching out to hear more

1,792 people shared their experiences of health and social care services with us, helping to raise awareness of issues and improve care.

4,745 people received clear information and the latest advice on topics such as finding an NHS dentist and getting help after a dementia diagnosis.

Making a difference through your experiences

We published 13 reports about local experiences of health and care services.

Our most popular report was **Exploring access to GP services** which celebrated what people value about local services, as well as highlighting areas where people want to see change.

Our team

We're lucky to have **30** outstanding volunteers who gifted us **620** hours of support to improve health and care services in York.

We're funded by our local authority. In 2024/25 our core contract was for £115,610 which is the same as the previous year.

We currently employ **4** staff who help us carry out our work.

A year of making a difference

Over the year we've been out and about in the community listening to your stories, engaging with partners and working to improve care in York. Here are a few highlights.

Spring

We closed our GP survey and began working through the data, having received over 1,300 responses!

We began recruiting Core Connector volunteers – young people aged 16-25 who gather the views of other young people.

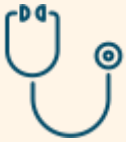
Summer

We celebrated our Making a Difference Award winners – 36 people and 15 organisations that people in York say provide excellent care.

Following a visit to the Land in Haxby, we began plans for a report about the experiences of neurodivergent families.

Autumn

We published our report on Access to GP services, highlighting what people value about their GP and what needs to improve.



We worked with Healthwatch North Yorkshire on relaunching our volunteer-led care home visiting programme.

Winter

We published the report of our Core Connectors, sharing the health and care experiences of over 150 young people in York.

We met local information and signposting needs by publishing a guide to essential services open over the Christmas period.

Working together for change

We work with neighbouring Healthwatch to make sure people's experiences of care across Humber and North Yorkshire are heard at the Integrated Care System (ICS) level, and they influence decisions made about services at Humber and North Yorkshire Integrated Care Board (ICB).

This year, we've worked together to achieve the following:

Amplifying young people's voices in healthcare

Young people often feel overlooked when it comes to health and care services. That's why we supported a team of young volunteers (aged 14-25) to speak with their peers about what's working, and what isn't, in local healthcare. The project was supported by NHS England funding.

Over the course of the project, we heard from 887 young people across Humber and North Yorkshire. Their honest feedback is already helping to shape services. Findings have been shared both locally and with the wider NHS through the Children and Young People's Transformation Programme.

This work means decision makers are hearing directly from young people.

Listening to communities to improve cancer care

Early diagnosis saves lives. But not everyone has the same awareness or access to cancer information. That's why we worked with Humber and North Yorkshire Cancer Alliance to find out what people know, and what they don't.

We listened to people often left out, including those living in poverty, refugees, carers, people who are neurodivergent, people experiencing mental ill-health, gypsy and traveller communities, and those experiencing homelessness. We spoke to communities in urban, rural and coastal areas. We wanted to make sure more people had the chance to be heard than ever before.

Working together for change - continued

Here's more of the work we did with neighbouring Healthwatch.

Building strong relationships to achieve more

Primary care services are really important to people in York. These include dental care, GP services, opticians and pharmacy services. We meet regularly with the people who buy these NHS services across Humber and North Yorkshire.

Through us they hear about the challenges you experience in York in accessing these services. They also keep us up to date on changes to services so we can pass this information on.

These meetings have been especially useful relating to dental access. Through our relationship with the buyers at Humber and North Yorkshire ICB, we have been able to make sure people with the worst health problems are given priority access.

The Healthwatch York team work from a values and a strengths base. Their values really shine through...

They bring professional and personal experience as well as sharp, intelligent analysis, good intuition and a real ability to collaborate. They are able to deliver nuanced messages in a skilled and supportive way, with the end goal of influencing positive change for, and amplifying the voice of people in local communities.

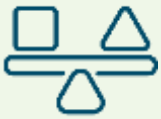
Abby Hands, Programme Director
Association of Directors of Adult Social Services (ADASS) Yorkshire and Humber

Making a difference in the community

We share all your feedback about your experiences with healthcare professionals and decision-makers. We make sure it is used to shape services and improve care over time.

Here are some examples of our work in York this year:

Finding out what life in local care homes is like



Speaking to residents and their families as well as care staff.
This year we relaunched our care home visiting programme. Our care home assessors meet residents, family members and staff, to get a flavour of life in our city's care homes. Everything they hear goes into our publicly available reports.

Working closely with our voluntary sector partners

Together, we can amplify the voices that most need to be heard.
This year we started our Voice and Representation meetings. We get together with local groups like York Carers Centre, Dementia Forward, Alzheimer's Society, Parent Carer Forum York, and Lived Insights to share what we are hearing, and plan how we might work together to address shared concerns.

Helping researchers hear more from people in York

We're working closely with the University of York and York St John, to make sure what matters to people in York helps shape national research.
This year we've been involved in research projects covering a wide range of health and care issues. This includes looking at people's experiences of waiting for social care, exploring awareness of cancer symptoms, and exploring how to keep GPs in the workforce.

Listening to your experiences

Services can't improve if they don't know what's wrong. Your experiences shine a light on issues that may otherwise go unnoticed.

This year, we've listened to feedback from all areas of our community. People's experiences of care help us know what's working and what isn't, so we can give feedback on services and help them improve.

Listening to your experiences

Access to GP services in York

Every year we receive lots of feedback about GP services. Many people tell us about kind, compassionate, excellent care. But we also hear lots of frustrations about online forms, struggling to get through on the phone, and long waits for routine appointments. We decided to explore this further.

What did we do?

We launched a short survey to better understand what is working well for people, and what they would like to see change. We received over 1,300 responses to our survey with our volunteers working hard to ensure we heard from people across the city.

Key things we heard:

People's positive and negative experiences were often opposite aspects of the same thing. So good and bad contact with staff, positive and negative communications and admin.

Access to appointments was a key issue with people particularly frustrated at waiting for up to 12 weeks for a routine appointment.

Many also highlighted problems with physical access and accessing information via websites.

Continuity of care was a real positive, but an issue when people couldn't see the same GP.

What difference did this make?

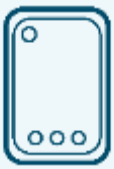
We sent individually tailored reports to all our GP practices. They were all receptive. A number committed to changes including reducing waiting times for routine appointments, improving support for people with long term conditions, using Pharmacy First to improve patient care and for all GP practices to work together to learn from good practice. We are starting to hear that some services are getting better.

Acting on your experiences

Taking action to improve access to GP services

Our report on access to GP services highlighted a theme around challenges with GP websites and physical access at surgeries.
We worked with York Disability Rights Forum to develop an access audit and built on Healthwatch North Yorkshire's GP website audit. Between November 2024 and February 2025 our volunteers visited every York GP surgery to assess accessibility and looked at all the GP practice websites to see how easy they were to use and if they could find key information.

Key things we learned:



Web: Everyone has a different website experience. Something simple for one person isn't always easy for everyone. Avoiding clutter and providing clear up to-date information is very important.
In surgeries: Clear information explaining how to seek help and where to find quiet waiting spaces is as important as automatic doors!

What difference did this make?

York's GP practices are working through their individual reports and working to improve signage and facilities at surgeries and tweaking their websites. One GP practice has invited us to work with them as a pilot accessible practice.

"Thank you so much for all your tremendous work on seeking the views of our patients and other service uses, both on the general quality of GP services, and more recently access and websites.

We were pleased with your report of 2024 and discussed this in our partners' meeting. We identified a few areas to improve which are a work in progress and include increasing use of the NHS App, for which there was recent staff training available.

The website is under review, and we will definitely have a closer look at our signage and door access."

Dr Fiona Lloyd
GP Partner Dalton Terrace

Hearing from all communities

We're here for everyone in York. That's why, over the past year, we've worked hard to reach out to those communities whose voices may go unheard.

Everybody should have the chance to share their story and help shape services to meet their needs.

This year, we have reached different communities by:

- Launching our Core Connector volunteer programme, where young people aged 16-25 reach out to their peers to find out about their experiences of health and social care in York.
- Working in partnership with local charities and voluntary groups to hear more from those they work with.
- Co-ordinating a report for Humber and North Yorkshire Integrated Care Board's Quality Committee about the healthcare experiences of migrants across the area.

Hearing from all communities

Core Connectors

The Core Connectors project seeks out the experiences of young people aged 14-25 in York when accessing health and care services.

Our Core Connectors found young people in the city want:

- Better support around the cost of living
- Shorter waiting times for mental health support
- Shorter waits for GP and dental appointments
- Affordable social and community spaces
- Better support for the transition to adult services
- Improvements to public transport to make sure young people can access everything York has to offer

Read the full report at https://bit.ly/CoreConnect25

> **"A lot of the time can't afford to eat – primary carer of mum and siblings and so there has been a lot of increased stress from trying to buy groceries. Also payments for apartments have massively gone up – really expensive."**

> **"I used to have an NHS dentist which was good, but he left and told me to find a new one. I've not been able to find one for 2 years now."**

What difference did this make?

In their Annual Report, York Health and Care Partnership note that the report "has provided valuable insights into young people's experiences of health and social care." York's Director for Public Health, Peter Roderick, also dedicated 2 pages of his annual report to the findings of the project. It is influencing children and young people's plans in the city.

Hearing from all communities

Listening to Neurodivergent Families

We were hearing about serious difficulties in getting the right help for neurodivergent (ND) children. We spoke to partners, and they confirmed they were hearing similar concerns.

We visited the Land in Haxby, a supportive space for neurodivergent families in the city. Alongside other partners and colleagues, we heard much more about people's experiences. Together with the Land, York Disability Rights Forum, York Carers Centre and Parent Carer Forum York, we agreed to share everything we were hearing in a report.

Our key findings were:

- Parent blame is still prevalent in services and wider society
- Experiences are worsened by poor admin and communication
- Services still work in silos, with families coordinating help
- Service capacity is limited with many looking for a reason to say 'no' to providing help
- School support varies significantly, and school behaviour codes can feel punitive to ND children and young people
- Significant overlap between children who are ND and who are gender questioning; services not geared up to support appropriately.

Read the full report at https://bit.ly/NDfamiliesJan25

What difference did this make?

We have shared the report with the City of York Council (CYC) Safeguarding Children Partnership. It has fed into CYC's Autism and ADHD needs assessment and strategy work. It is also shaping work across Humber and North Yorkshire on support for neurodivergent families. We also shared our work at Healthwatch England's national committee meeting to help inform their plans for further national work on neurodivergence.

Hearing from all communities

Listening to Neurodivergent Families – cont'd

> It has been a pleasure sitting down together and seeing the amazing report being prepared and produced. It has been such a positive experience.
>
> Vanessa
> The Land, York

Making space for more voices to be heard

Our partners have supported us to increase the range of our regular monthly outreach events. This means we hear from people whose voices are often missed in health and care conversations. This includes a monthly drop-in at York's Women's Centre

> "For the women who use our service, being able to feel listened to is a massive thing and Healthwatch has been brilliant in just giving the women space to talk about their experiences with health and social care because a lot of the time, women we support face a lot of stigma when they are accessing healthcare...
>
> "The Healthwatch staff member is really good at relating to the women and making them feel comfortable and she also offers that consistency- visiting every month. We couldn't ask for anything better, she is brilliant."
>
> Sofia
> Women's Centre Manager, Changing Lives

Information and signposting

Whether it's finding an NHS dentist, getting help after a dementia diagnosis, or choosing a good care home for a loved one – you can count on us. This year 4,745 people received clear information and the latest advice from our team.

This year, we've helped people by:

- Providing up-to-date information people can trust through our website, magazines and monthly email bulletins
- Supporting people to access the services they need
- Supporting people to look after their health
- Signposting people to additional support services

Information and signposting

Dental care for people in desperate need

Hearing your struggles to access dentistry in York, colleagues at Humber and North Yorkshire Integrated Care Board and a local practice arranged care for people in desperate need.

There simply isn't enough NHS dentistry in York. But we have managed to help people in desperate need:

- A woman in her 90s, seriously undernourished due to broken dentures.
- someone whose teeth were damaged by oesophageal cancer treatment.
- someone with a serious mental health issue whose mental health was declining due to lack of dental care.
- someone with sleep apnoea.

Our Manager meets regularly with ICB colleagues and sits on the Local Dental Network to make sure these challenges are heard and addressed. We continue to shout about your experiences, and demand better for our city.

> **"We are now NHS dental patients and would not have been without your help. Thank you."**

Addressing concerns about local care

A person contacted Healthwatch York with concerns about the care their mother had received in a local care home.

We shared these concerns with local colleagues. This led to an investigation into the concerns which were urgently acted upon. As a result, significant action was taken and standards quickly improved. The home continues to be closely monitored.

Individual feedback that we receive and information gathered during our care home visits help us give voice to the experiences and concerns raised. Recommendations that are made contribute to maintaining standards of care across the city.

> **"I believe that the recommendations will be useful, please thank your volunteers for their visit and assessment."**

Showcasing volunteer impact

Our fantastic volunteers have given 620 hours to support our work. Thanks to their dedication to improving care, we can better understand what is working and what needs improving in our community.

This year, our volunteers:

- Visited communities to promote our work
- Collected experiences and supported their communities to share their views
- Carried out enter and view visits to local services to help them improve

Showcasing volunteer impact

At the heart of what we do

From finding out what residents think to helping raise awareness, our volunteers have championed community concerns to improve care.

A particular highlight has been visiting the Over the Rainbow café near the Shambles. The café is a community space dedicated to supporting LGBTQ+, neurodivergent and disabled people. Its value cannot be overstated.... People were eager to share their experiences (which) was truly wonderful, and so constructive.... Elevating the voices of those previously ignored is a fundamental aspect of this project, providing a space for them to be heard."

Kiri
Core Connector

"I met someone from Healthwatch York at my local library, picked up a copy of the newsletter and found out about their readability volunteers. I'd been wanting to volunteer for a while. Having previously been a copywriter, I thought this might be ideal. However, I was apprehensive as I have a chronic illness - would they want someone with limited time, energy, and mobility? The answer was yes!

I joined the readability team. We look at patient leaflets to see if they're 'reader-friendly'. The flexibility means I can balance it with my health needs. It allows me to use my professional skills and personal experiences, too.

Earlier this year, I took part in auditing GP websites, which I thoroughly enjoyed. It's so important for patients to be able to access information and support easily (as well as making life easier for the practices), so it was a really interesting project to be a part of.

Another thing I love is how friendly and welcoming everyone is. It's easy to feel isolated when you have a chronic illness, but the team have made me feel valued and appreciated through regular emails, monthly e-newsletters, online meetings, event invites, training opportunities, and more. I would really recommend volunteering to anyone and everyone!"

Rachel
Readability Volunteer

Showcasing volunteer impact

At the heart of what we do

From finding out what residents think to helping raise awareness, our volunteers have championed community concerns to improve care.

"I do this voluntary work as a result of years of working in the field of adult social care, meeting people who received and provided health and social care services. This was valuable experience for this volunteer role.

I lead Enter and View visits to care homes, having helped develop Healthwatch York's new approach. There are many benefits to this work:

- Our visits contribute to the continuous enhancement of care standards.
- We voice people's experiences and concerns, fostering a sense of involvement and advocacy.
- The transparency of the process builds trust within the community, demonstrating a commitment to accountability and quality care."

Peter
Care Home Assessor

"I was one of a group of volunteers assessing the accessibility of GP surgeries. This involved visiting practices to visually assess them and ask questions to check facilities were available. We had a list to ensure all visits were assessed.

My experience was very positive. The visits were unannounced and I was easily able to assess things such as ramps, how doors opened, width of corridors for wheelchairs and buggies, lift availability etc. The staff were all lovely and helpful but couldn't always provide the required information.

It was a positive experience for me and a valuable one for Healthwatch as a large number of practices were assessed."

Kitty
Research Volunteer

Be part of the change.

If you've felt inspired by these stories, contact us today. Find out how you can be part of the change.

www.healthwatchyork.co.uk

01904 621133

healthwatch@yorkcvs.org.uk

Finance and future priorities

We receive funding from our local authority under the Health and Social Care Act 2012 to help us do our work.

Our income and expenditure:

Income		Expenditure	
Annual contract with City of York Council	£115,610	Expenditure on pay	£91,798
Additional income	£22,209	Non-pay expenditure	£17,357
		Office and management fee	£19,849
Total income	**£137,819**	**Total Expenditure**	**£129,004**

Additional income is broken down into:

- £10,278 from University of York, from the Administrative Fairness Lab work looking at social care waiting and from the Evidence Synthesis Group for Patient and Public Involvement support.
- £7,400 from York St John University for Cancer Awareness survey work.
- £3,278 from Purey Cust Trust for printing costs of our dementia guide.
- £1,253 from the Association of Directors of Adult Social Services Yorkshire & Humber for work relating to mystery shopping local authority care services.

"Healthwatch York provide a vital, valuable resource to the city that we cannot afford to lose. They are great value for money… their work is strategic rather than piecemeal; they produce insightful reports in areas where practice may need to be challenged.

They create a beautiful atmosphere around them in the way they do their work. They are very human and approachable.

Miles Goring and Astrid Hanlon
Lived Insights

Finance and future priorities

Next steps:

Over the next year, we will keep reaching out to every part of society so that those in power hear everyone's views and experiences.

Our top priorities for the next year are:

1. Working on gender health, covering women's health, men's health and trans and non-binary health
2. Refreshing our Dementia Guide, making sure people with dementia and their families can find all the support available in our city.
3. Continue our programme of Care Home visits, to highlight good practice in our city, and make recommendations to improve services further.
4. Revisit our Breaking Point report, and explore people's current experiences of mental health services in the city.
5. Begin developing plans to look at health inequalities across York.

Healthwatch York is an independent voice for patients, carers, communities. They can raise things through Healthwatch that they may not feel comfortable in raising with our organisation directly, and they often represent communities that we may struggle to reach....

They are very professional, and respectful. They listen to people, are realistic, pragmatic and enthusiastic about what they do.

Helen Embleton
Urgent Care Pathway Lead, Tees Esk and Wear Valleys NHS Foundation Trust

The legal bit – the contract for Healthwatch in York

**Healthwatch York is proud to be part of York CVS.
Our registered office is York CVS, 15 Priory Street, York, YO1 6ET. The Chair of Healthwatch York sits on the York CVS Board of Trustees, and a York CVS Trustee sits on the Healthwatch York steering group.**

Healthwatch York uses the Healthwatch Trademark when undertaking our statutory activities as covered by our licence agreement with Healthwatch England.

The way we work

How we involve others in our governance and decision making.

Our Healthwatch York Steering Group consists of 9 members. They work on a voluntary basis alongside our staff team to provide direction, oversight, and scrutiny of our activities. Our Steering Group makes sure that decisions about priority areas of work reflect the concerns and interests of our diverse local community.

Throughout 2024/25, the Steering Group met 4 times and provided advice and constructive challenge. This has informed our approach to all the work reported on this year.

Methods and systems used across the year to obtain people's experiences

We use a wide range of approaches to ensure that as many people as possible were able to share their insight and experience of using services. During 2024/25, we've been available by phone, email and social media we, provided a web form on our website. We also attended community group meetings and forums and hosted our own York volCeS meetings.

We make our publications available to as many people and partner organisations as possible. We publish them on our website, email them to our mailing list, and print and post copies too on request. We share our Annual Report with York's Health and Wellbeing Board and include highlights in our Summer magazine. We also provide libraries across the city with copies of our publications. Pop in an have a read at your convenience!

Statutory statements

Taking people's experiences to decision-makers

We make sure that people who can make decisions about services hear about your insights and experiences.

In York, we take information to sector representatives like York CVS, Community Pharmacy North Yorkshire, service providers like York Hospital, commissioners, council leaders, councillors, MPs, Humber and North Yorkshire Integrated Care Board and Health and Care Partnership. We also work with other local Healthwatch, Healthwatch England and the Care Quality Commission to address shared health and social care concerns. We share data with Healthwatch England to help address health and care issues at a national level.

We take insight and experiences to strategic meetings in the city including York's Health and Wellbeing Board, York Health and Care Partnership Executive Committee, York Health and Care Collaborative, York Mental Health Partnership, York Drug and Alcohol Partnership, York Safeguarding Adults Board and Raise York Partnership meetings.

Healthwatch York is a critical friend and is being seen as an equal partner within the statutory bodies. Healthwatch colleagues bring that direct connection into the community and they bring that into our conversations, giving us some real insight into population based need... Healthwatch York always brings additional value and a sense of realism into those conversations because their work is evidence based. They are advocating for the residents of York.

Shaun Macey
Assistant Director of Neighbourhoods
York Health and Care Partnership

Statutory statements

Healthwatch representatives

Healthwatch York is represented on the York Health and Wellbeing Board by Siân Balsom, Healthwatch York Manager. During 2024/25, Siân has effectively carried out this role by attending the meetings, sharing Healthwatch York reports, compiling updates at the Board's request, and taking an active role in all Board discussions.

Healthwatch York is represented on Humber and North Yorkshire Integrated Care Partnerships by Ashley Green, Chief Executive at Healthwatch North Yorkshire and on Humber and North Yorkshire Integrated Care Board by Helen Grimwood, Chief Executive at Hull CVS. Siân sits on the System Quality Group meeting which addresses concerns about the quality of care across Humber and North Yorkshire.

Healthwatch York are members of our Patient Experience Subcommittee as public representatives and they act as a critical friend...

We particularly value that they are connected across the system, they listen and seek to understand and represent the voice of patients and carers on all topics related to health and care.

Their research is high quality and they are skilled collaborators.

Krishna De
Head of Patient Experience and Involvement
York and Scarborough Teaching Hospital NHS Trust

Statutory statements

Enter and view

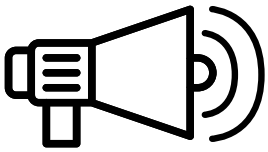
Location	Reason for visit	What you did as a result
Care home – Ebor Court	Routine care home assessor visit	Wrote a report with recommendations
Care home – Birchlands	Routine care home assessor visit	Wrote a report with recommendations
Care home – Riverside Care Complex	Routine care home assessor visit	Wrote a report with recommendations
Care home – Rawcliffe Manor	Routine care home assessor visit	Wrote a report with recommendations

2024 – 2025 Outcomes

Project/activity	Outcomes achieved
Reviewed mystery shopping materials for the Association of Directors of Adult Social Services Yorkshire and Humber.	Improved the quality of feedback for local authority colleagues about their information, advice and signposting support.
Joined University of York's Evidence Synthesis team to contribute to their patient and public involvement work.	Gave more local people and voluntary organisations opportunity to hear about, shape and inform research.
Co-ordinated a Migrant healthcare experiences report in partnership with Humber and North Yorkshire Healthwatch.	Provided insight about the healthcare experiences of migrants for Humber and North Yorkshire Quality Committee.
Gathered information about support services and shared this widely as our Winter services list.	Made sure people in York had vital information over the holiday period. Shared by many local partners.

Our call to action

We hope you have enjoyed reading this report. But more than that, we hope it inspires you to share your experiences of health and care with us.



You are Healthwatch York. Your voice matters.

We are your amplifier. We make sure those who need to hear you **really** hear you.

There are lots of ways to share your views or ask for information:

- Call **01904 621133** and choose option 3
- Email **healthwatch@yorkcvs.org.uk**
- Leave a WhatsApp message on **07512 342379**
- Visit our website and use our trip-advisor style feedback centre: **www.healthwatchyork.co.uk**
- To hear more from us, sign up to our monthly bulletins at **https://bit.ly/HWYbulletin**

Read our 2024/25 care home reports online;

Rawcliffe Manor: **https://bit.ly/RawcliffeM25**

Riverside Care Complex: **https://bit.ly/RiversideCC25**

Ebor Court: **https://bit.ly/EborCourt25**

Birchlands: **https://bit.ly/Birchlands25**

Read our GP reports online:

Exploring Access: **https://bit.ly/YorkGP24**

Website audits: **https://bit.ly/GPweb25**

Accessibility audits: **https://bit.ly/GPaccess25**

healthwatch York

Healthwatch York
Priory Street Centre
15 Priory Street
York
YO1 6ET

www healthwatchyork.co.uk

01904 621133

healthwatch@yorkcvs.org.uk

www.facebook.com/healthwatch.york

@hw_york

Linkedin.com/in/healthwatch-york-6912a4228

@healthwatchyork.bsky.social

Summary workplan for 2025/2026

healthwatch York

Priority Area	Description and activity
Exploring people's access to care	Gender health – Women's health. Starting with a report about what we have already heard, with HWNY.
Exploring people's access to care	Gender health – Men's health.
Exploring people's access to care	GP access – site visits and website reviews to help improve access for all.
Connecting with key initiatives	Gender health - Offering support for engagement around trans and non-binary healthcare to help shape local support.
Emerging issue	Health inequalities for those with multiple complex needs
Explaining the system	Using our magazines to provide insight into the shifting health and care landscape. E.g. Integrated Neighbourhood Teams work, abolition of NHSE, ICB changes.
IAS work	Signposting service – listening to people in York, understanding their experiences, connecting with advice and information services as required.
IAS work	Replacing our current website due to current provider withdrawing from the market.
Volunteer programme	Readability work – continuing to encourage local providers and commissioners to 'sense check' their information work through our panel of volunteers.
Volunteer programme	Delivering our Care Home visiting programme, linking in with key partners where possible.
Volunteer programme	Maintaining Core Connector volunteer programme with reduced funding through Public Health
Revisiting previous work	Mental health – considering what has improved since Breaking Point and what still needs to change.
Additional work	Understanding health comms and engagement in a post-NHSE, smaller ICB landscape.
Additional work	Working alongside the city's Universities to support opportunities for people in York to be involved in national research.
Additional work	Feeding into JSNA work especially around women's health and neurodiversity.

This page is intentionally left blank

Annex C:

An independent evaluation of the service provided by Healthwatch York from the stakeholders' perspective.

April 2024 to March 2025

Conducted by:
Michelle Smith
June 2025

Contents

1. Executive Summary

This evaluation demonstrates that the stakeholders interviewed regard Healthwatch York as an integral systems partner, gaining widespread recognition for its exceptional value and impact across York's health and social care landscape. Despite operating with limited resources, the organisation consistently delivers high-quality services that bridge gaps between communities and decision-makers.

Healthwatch York has made considerable progress in expanding collaborative partnerships over the past twelve months. Stakeholders describe working with them as a "privilege" and "joy," highlighting their transformation from being perceived as a service that mostly deals with complaints to becoming a valued research and improvement partner. They are embedded in professional networks, with healthcare commissioners seeking deeper involvement in neighbourhood team integration.

The team demonstrates exceptional effectiveness in reaching under-represented groups and vulnerable populations. Their work spans diverse communities including neurodivergent families, refugee groups, families struggling with gender care issues, and those facing healthcare stigma or literacy barriers.

Healthwatch York has gained recognition as a trusted research partner by stakeholders, including University of York, where their collaboration resulted in a successful funding application. Their evidence-based approach and ability to facilitate engagement with people with lived experience positions them as ideal partners for future research initiatives.

Stakeholders consistently praise Healthwatch York's reports as "very readable and impactful" and they are driving tangible service improvements. The neurodiversity work is shaping new strategies and feeding into national policy discussions. The team excels at explaining complex health information accessibly while maintaining professional standards. Their multi-channel approach includes face-to-face engagement, a digital presence, and traditional paper-based leaflets, ensuring inclusivity across the whole community.

The organisation brings "definite strategic focus" to decision-making forums, sitting on various Integrated Care Board (ICB) and partnership boards while maintaining strong links with local MPs and adult social care directors. The team does not merely identify problems; they offer collaborative solutions and alternative perspectives that help develop future service models and care strategies.

Healthwatch York provides meaningful volunteering opportunities that allow community members with professional and lived experience to contribute to systems change. Volunteers report feeling appreciated and supported, providing further evidence of the organisation's inclusive culture.

While widely regarded as providing exceptional "value for money," stakeholders consistently highlight the need for more realistic funding to increase capacity and expand its collaborative scope. The current funding model represents a barrier to achieving long-term sustainability.

Stakeholders have recommended specific development areas for the year ahead including:

- Embed Healthwatch York within the neighbourhood integration work.
- Investigate gaps in health and social care for people with multiple complex needs who avoid services until they reach crisis points.
- Diversify communication through podcasts, social media content, and accessible summaries, alongside traditional reports.
- Recruit volunteers with health conditions as "secret shoppers" to experience patient journeys.

Healthwatch York represents an exemplary service model that balances professional expertise with genuine human connection. Its unique position bridges professional, educational, political and community boundaries, enabling meaningful collaboration across the city.

2. Context

Healthwatch York helps local residents share their thoughts on health and social care services, such as hospitals, mental health services, community services, care homes, GP surgeries, dental care, pharmacies, opticians and home care services. Healthwatch York encourages everyone to get involved in improving these services. It provides information about what's available locally, makes it easier to access services, guides people to independent complaints advocacy, collects feedback on local services, and ensures this feedback is taken into account when planning and delivering services.

Healthwatch York has been in place since 2013. It is a project that sits within the independent charity York CVS, with a 'Steering Group' that acts as an advisory board. Ultimate accountability sits with the Trustees of York CVS.

Healthwatch York operates under a contract from City of York Council, with the equivalent of 2.7 full-time equivalent paid staff and 30 volunteers, who carry out roles as engagement volunteers, research volunteers, readability volunteers, representatives, communications volunteers, care home assessors, and members of the Steering Group.

Healthwatch York's Mission Statement:

"Healthwatch York puts people at the heart of health and social care services, enabling you to be heard. We believe that together we can help make York better for everyone".

Healthwatch York's aims:

- responsive to the needs of York residents.
- understands what is happening in relation to health and social services in York.
- speaks up about the provision of health and social care services in York.
- uses the reviews, words, and stories of service users to show the impact of health and social care services in York.
- involves the public in the work they do.
- advocates for people's active involvement in their health and social care.
- provides an effective service for the people of York using health and social care services.
- understands what is happening in relation to health and social services in York.
- reaches new people and partners.

The purpose of this evaluation is to explore:

- the value that stakeholders have placed on Healthwatch York's contribution to the local health and care system.
- how Healthwatch York has been able to meet its aims and outcomes.
- suggestions from stakeholders for Healthwatch York's focus in the coming year.

Healthwatch York provided a list of key stakeholders with whom they have worked during the past year. The sample came from statutory partners, voluntary and community sector organisations, and volunteers. Interviewees are listed in Appendix A.

Information has also been taken from this year's publications which are listed in Appendix B.

3. Reflections on progress: recommendations from last year's evaluation.

a) Advocate for sustainable funding

The majority of stakeholders interviewed highlighted the need for more realistic funding to increase Healthwatch York's capacity and broaden its scope for collaboration. Despite being widely regarded as providing "value for money" and delivering high-quality services on a limited budget, their current funding model could be seen as a barrier to achieving long-term sustainability. While they have successfully demonstrated their impact and built a strong case for increased funding, this has yet to result in the sustainable funding model that is needed.

"Healthwatch York provides a vital, valuable resource to the city that we cannot afford to lose. They are great value for money." (Miles Goring and Astrid Hanlon, Directors, Lived Insights.)

b) Expand collaborative partnerships

This area demonstrates Healthwatch York's greatest progress over the last twelve months. The organisation is now embedded in professional networks, with healthcare commissioners wanting deeper involvement in neighbourhood team integration. The evidence demonstrates that Healthwatch York has shifted from a community champion role, dealing mostly with complaints, to become active system partners. Comments like "privilege to work with them," "invaluable sounding board," and "joy to work with" show valued relationships. Stakeholders expressed an interest in joint research, shared improvement initiatives, and collaborative problem-solving.

"Healthwatch York is a critical friend and is being seen as an equal system partner within the statutory bodies. Healthwatch colleagues bring that direct connection into the community and they bring that into our conversations, giving us some real insight into population-based need. Having a neutral body in the room that can provide some checks and balances is helpful." (Shaun Macey, Assistant Director of Neighbourhoods, York Health and Care Partnership.)

c) Deepen engagement with under-represented groups

Healthwatch York is successfully reaching vulnerable populations, with particular strength in mental health service user engagement. The neurodiversity work highlights deep community connection with impactful, personal stories. This year the team engaged with 14 young people to research health and social care across their peers. Their report has highlighted key areas for focus in the future, an area of work that has rarely been carried out before.

"They have done a lot of work with the neurodivergent community in response to some big service challenges that we have had locally for that community in terms of access to assessments." (Shaun Macey, as before.)

"Their approach and techniques used often unearth findings that other research may not." (Miles Goring and Astrid Hanlon, as before.)

d) Explore long-term service provision studies

Healthwatch York is being recognised as a research partner by multiple stakeholders. Comments about being an "ideal partner for us to do more research" and their evidence-based approach suggest foundations are being developed for this work. Work with University of York resulted in a successful, significant funding application. It involved helping gain access to decision makers, reality checking research plans, having a good understanding of 'grey' literature and facilitating engagement with people who have lived experience.

"Their research is high quality and they are skilled collaborators." (Krishna De, Head of Patient Engagement, York and Scarborough Teaching Hospitals NHS Trust.)

"Healthwatch York colleagues' local and national knowledge of critical issues is excellent. There's rarely a topic to which they don't make a contribution. They have become central to our processes for addressing national research priorities commissioned by our funder. Because of their local and national connections and networks, all projects have benefitted from engagement and input that have strengthened the outputs we produce. These have impact on health and social care policy and practice decision-makers nationally." (Professor Rachel Churchill, Professor of Evidence Synthesis, University of York.)

e) Expand regional influence

Healthwatch York has achieved influence beyond local boundaries. The neurodiversity work is described as feeding "into other work of national importance" including judicial reviews, indicating their local insights are contributing to national policy discussions and service development. The consistent quality and approach of their work, combined with stakeholder recognition of their expertise, positions them for broader influence.

4. Findings

4.1 The value that stakeholders have placed on Healthwatch York's contribution to the local health and care system

The public sector stakeholders interviewed regard Healthwatch York as an equal system partner, respected for its direct connection into local communities. Staff attend ICB-wide meetings, provide valuable scrutiny, hold executives accountable, and bridge the gap between leadership and the genuine experiences of service delivery.

The service demonstrates exceptional effectiveness in strengthening patient and community voices. They successfully reach communities that other organisations struggle to engage with directly, including women facing healthcare stigma, people with literacy barriers, and those unable to access traditional feedback mechanisms. This intermediary role enables more honest conversations and authentic feedback that would not otherwise reach decision-makers. Stakeholders interviewed highlighted that Healthwatch York's work helps them to understand their communities better. They create better communication between services and the public, making sure both sides are better informed, leading to service improvement.

Rather than simply identifying problems, Healthwatch York works collaboratively, offering alternative perspectives and potential solutions. They work closely with partners and can explain complex issues in ways that make sense. They are supportive rather than confrontational, which makes people more likely to listen and act. People regularly turn to Healthwatch York when they are not sure how something works or need advice. The staff help them understand the system, connect them with decision-makers, and provide useful resources such as the various publications they produce. They are often the first place people go for independent advice.

Healthwatch York offers meaningful volunteering roles, allowing people opportunities to improve services and contribute to systems change. Volunteers report that they feel appreciated, supported and fully involved in the tasks that they undertake.

Overall, Healthwatch York makes a real difference by ensuring that residents' voices are heard in health and care decisions, helping public sector organisations to understand their communities better, and working with everyone to find practical solutions to problems. They are trusted by both the public, and health and social care services, which makes them effective at bringing positive change.

"I think the officers of Healthwatch are very responsive, very keen to get our volunteer help and involve us in a number of ways and that feels positive... You can feel there is trust between the volunteers and the team." (Peter Smith, Volunteer, Healthwatch York.)

"For the women who use our service, being able to feel listened to is a massive thing and Healthwatch has been brilliant in just giving the women space to talk about their experiences with health and social care because a lot of the time, women we support face a lot of stigma when they are accessing healthcare." (Sofia, Women's Centre Manager, Changing Lives.)

"The Healthwatch York team work from a values and a strengths base. Their values really shine through, and they bring expert knowledge of health and social care." (Abby Hands, Programme Director, ADASS Yorkshire and Humber.)

4.2 How well does Healthwatch York represent public voices?

Stakeholders consistently report that Healthwatch York makes a real difference by listening to patients, carers and local residents. They bring valuable insights to meetings, asking important questions and sharing what they have learned from talking to the public. This feedback directly influences how services are planned and delivered. Healthwatch York does not just collect complaints, they work with services to learn from them and make things better. For example, one GP surgery installed a doorbell and ensured wheelchair space in waiting rooms. One stakeholder noted: "I could see things being changed even before the report was submitted."

Their reports have real impact. A mental health services report from 2023 was described as "very powerful" and still receiving publicity, leading to improvements in patient care. Healthwatch York's work on neurodiversity is helping to shape new strategies. These reports give communities a stronger voice when challenging services.

Healthwatch York has made notable contributions to work on emergency care following incidents of self-harm. One stakeholder explained that they were able to build on existing experience and local knowledge provided by Healthwatch York "to amplify patient and public voices and embed these in the ongoing work."

Over the last twelve months, Healthwatch York has reintroduced its volunteer-led visits to care homes. These inspection visits are helping care homes to improve, with managers viewing their feedback as positive and actionable.

Stakeholders praise Healthwatch York's careful consideration of equality, diversity and inclusion. Staff are described as using "caring and compassionate language" and making adjustments for people's individual needs. For example, by checking volunteers have what they need before meetings, providing information in different formats, and ensuring research includes people with lived experience from diverse backgrounds. They demonstrate real cultural awareness and sensitivity.

Staff think carefully about making scenarios and materials accessible to everyone. When asked to take on a piece of work, Healthwatch York actively considers who they might be missing. As one stakeholder noted: "They are constantly thinking about who they don't hear from and how they can hear from them more." They adapt their approach, formats, and locations to bring more people in. Over the last twelve months, they have done significant work with neurodivergent people, helped refugee groups connect to services, and supported families struggling with gender care and women's health issues. Staff are recognised for going out into communities rather than waiting for people to come to them.

The overall message from stakeholders is that Healthwatch York actively seeks out different voices and work hard to ensure everyone's voices can be heard.

"Healthwatch York is an independent voice for patients, carers, communities. They can raise things through Healthwatch that they may not feel comfortable in raising with our organisation directly, and they often represent communities that we may struggle to reach." (Helen Embleton,as before.)

"They bring professional and personal experience as well as sharp, intelligent analysis, good intuition and a real ability to collaborate. They are able to deliver nuanced messages in a skilled and supportive way, with the end goal of influencing positive change for, and amplifying the voice of people in local communities." (Abby Hands, as before.)

"We particularly value that they are connected across the system, they listen and seek to understand and represent the voice of patients and carers on all topics related to health and care." (Krishna De, as before.)

4.3 Information and support services - what stakeholders say

Stakeholders consistently praise Healthwatch York's reports as "very readable and impactful" and "fantastic for being able to see how things are going." The reports are described as accessible and well-presented, with people actively reading and sharing them. Complicated health information is shared in a way that's easy to understand. Stakeholders trust the information they provide.

Information is shared in a variety of ways:

a) Website with a range of information to help patients, carers and residents to navigate services.
b) Regular reports that are widely shared.
c) Face-to-face engagement with visits to public places such as libraries and community events.
d) Social media presence, including newer platforms like Bluesky.

Staff visit libraries and other public places on a regular basis to talk to people individually. People say they "leave feeling lighter" after these conversations. The staff listen to people's concerns and point them towards the right help.

Staff demonstrate a clear commitment to accessibility. They work hard to include people with different needs. Their website is easy to use, and staff are "very accommodating to service users' needs." They involve disabled volunteers and support people from different cultures and backgrounds.

Paper copies of information are still provided, which is hugely valued by people without computers or smartphones, or those who struggle to use them. Having real people to talk to makes a huge difference, especially for people who need extra support.

"If I am going to a meeting as a volunteer, they check that I have everything I need beforehand, and they check in. That has helped me massively because I'm not used to people making allowances for me. They consider any adjustments that I need." (Carrie Mitchell, Volunteer, Healthwatch York.)

"Their volunteer reading panel plays a key role in supporting the Trust reviewing our patient information leaflets and provide valuable feedback to ensure that our leaflets are accessible and able to be understood by patients and carers." (Krisha De, as before.)

"Not everything from Healthwatch is digital and that is good because a lot of our service users don't have access to technology. The fact that things are still provided on paper is helpful." (Sofia, as before.)

"Generally their website is easy to access and also when you are speaking to someone from Healthwatch, they are very accommodating to the service users' needs. They have pop ups all over the city, I think they are very accessible." (Bethany Thompson, Volunteer, Healthwatch York.)

4.4 How well does Healthwatch York work at a strategic level?

Stakeholders say that the organisation brings a "definite strategic focus" to meetings. They ask important questions and share what they've learned from talking to local people. This helps shape decisions about future services. Partners say that they "really do advocate for their residents" and "strive really hard to raise issues where things are not at an acceptable level."

Healthwatch York has "worked hard to become an active partner" in decision making forums. The local authority trusts them enough to rely on their contract visits to care homes. They have a strong presence at strategic level by sitting on various ICB and partnership boards, have good links with their local MPs and work directly with the organisation supporting directors of adult social care in this region.

Statutory stakeholders say the organisation helps shape:

- How people first access adult social care services.
- Future models of care across the region.
- Plans to move services from hospitals into neighbourhoods and communities.
- Strategies for supporting underrepresented groups.

Their reports don't just sit on shelves. The ADHD and autism work went to the ICB at the highest level, and some of their work has reached parliamentary committees. Their mental health report gained significant publicity and helped to focus on improving services.

Senior managers and decision-makers trust Healthwatch York because their feedback is direct evidence from local residents. They bring "a sense of realism" to strategic discussions, they are seen as professional and reliable, and they advocate strongly for residents while being realistic about what is possible.

"Healthwatch York has worked hard to become an active partner, and I would certainly reach out to them if there was something that I wanted to work with them on and gain further insights/feedback." (Helen Embleton, as before.)

"They strive for improvement and don't rest on their laurels. The work they have done with us has helped directors of adult social care to consider their strategic impact in supporting the wellbeing of local populations, specifically looking at the information and advice offer, and its success in preventing, reducing and delaying people needing social care involvement." (Abby Hands, as before.)

"Healthwatch York always brings additional value and a sense of realism into some of those conversations because their work is evidenced based. They are advocating for the residents of York." (Shaun Macey, as before.)

4.5 Overall organisational strengths- celebrating success

Healthwatch York is a great example of putting people first in service delivery. Feedback highlights how they treat everyone "like a human being" and create "a beautiful atmosphere around them," showing they have found the balance between being professional and genuinely caring. This approach is especially impressive in this area of work, where it's not easy to combine expertise with sincere connection.

They have built an impressive level of trust with a range of stakeholders. Whether it's vulnerable individuals or senior decision-makers, people feel heard and valued in their interactions. Their ability to connect with everyone is proof of their strong communication skills and emotional intelligence.

Rather than relying on assumptions or outdated information, they collect current, relevant data through direct community engagement. Facilitating meaningful participation from diverse community members as volunteers provides further evidence of their inclusive culture.

Stakeholders report that they are reliable and consistent - always there when needed, keeping the same familiar faces involved, and providing regular support to those dealing with challenging systems. The trust they've built across political, professional, and community boundaries positions them uniquely to bridge gaps and facilitate strong collaborative relationships.

Stakeholders send a clear message that Healthwatch York provides a valued, effective service that needs scaling up through sustainable funding.

"Healthwatch York demonstrate professionalism with a personable side. They are a joy to work with. They have a can-do attitude in a very challenging resource environment" (Jed Meers, York Law School, Administrative Fairness, University of York.)

"The Healthwatch staff member is really good at relating to the women and making them feel comfortable and she also offers that consistency- visiting every month. We couldn't ask for anything better, she is brilliant." (Sofia, as before.)

"They are very professional, and respectful. They listen to people, are realistic, pragmatic and enthusiastic about what they do." (Helen Embleton, as before.)

4.6 Suggestions for improved working between Healthwatch York and its partners

a) Evaluating new community services:

Partners have expressed a wish for Healthwatch York to help evaluate the new neighbourhood-based services. They are especially good at gathering patient stories, which show the real impact on people's lives rather than just data. One stakeholder said: "The high impact stuff is the stories and how their lives have been affected."

b) Improving complaints processes:

Stakeholders are keen to involve Healthwatch York in improving how complaints are handled, bringing an independent perspective to the process.

c) Expanding social care focus:

While Healthwatch York works in both health and social care, stakeholders suggest having more dedicated conversations about social care as "people sometimes think it's just about health."

d) Funding and resource sharing:

Stakeholders have spoken about submitting joint funding bids, sharing capacity, resources, knowledge, findings, and working together on specific issues.

e) Improved publicity of campaigns:

Councillors are keen to receive advance notice of future campaigns so they can input and support them.

f) Innovation showcase:

Healthwatch York's success stories deserve wider recognition. Systematically documenting and sharing the achievements could inspire similar approaches elsewhere while building a reputation as thought leaders in its practice. One stakeholder suggested an online hub for Healthwatch organisations in the region to share all their resources on a single site.

4.7 Reports produced

Healthwatch York produces excellent, clear reports that give their partners solid information to work with. They put real effort into their research, meeting people at different times and places to get a good mix of views. Their reports get outstanding response rates because of how much work they put in. People might not always like what the reports say, but they trust that the findings are accurate. A number of stakeholders highlighted that the reports could reach more people by using modern formats like podcasts and short videos. Significantly, the reports are connecting local experiences to national policy discussions, with one stakeholder noting they "feed into other work of national importance that has happened in this area".

- **GP access and primary care:**

The GP access report receives consistent praise from stakeholders for addressing a critical system pressure point. Many of those interviewed mention using this report to "correlate where there are wider issues" and support their own feedback patterns. For NHS managers removed from front-line delivery, these reports provide essential insight into "how service issues are affecting people across the city".

- **Listening to neurodivergent families**:

Multiple stakeholders highlight the outstanding value of this report. One manager noted how the stories "really stay with you," demonstrating the report's ability to create lasting emotional impact. It is described as providing "fascinating reading" and "really serious insight into the issues faced by families in the city".

- **Care Homes**:

Healthwatch York's inspection visits help care homes improve, with managers viewing their feedback as positive and actionable.

- **Core connectors**

Healthwatch York's Core Connectors program engaged 14 young people aged 16-25 to research health and social care experiences among their peers. The team surveyed 152 young people across various York locations, including colleges, community spaces, and LGBTQ+ venues, producing a comprehensive report on healthcare challenges facing young people in the city. The research stresses the need for systemic improvements in healthcare funding, communication, and youth-focused service delivery across York.

- **Migrant Healthcare experiences**:

The report highlights various challenges faced by migrants and stresses the need for improved access, language support, and culturally sensitive care for migrants.

"The report on mental health services was very powerful and it got a lot of publication and was widely publicised. It pushed a lot more people to look into it and it got me into volunteering for them." (Bethany Thompson, as before.)

"The "What we are hearing" reports give you a feel for what is coming through the front door and for what the public are prepared to share with Healthwatch... They are very good at bringing people together and explaining the sort of research that is being done and the findings from that research... Where we do make recommendations (arising from the Care Home visits), there is a real feeling that it is done professionally and that information is listened to by the organisation and so I think it has got a powerful role." (Peter Smith, as before).

5. Recommendations for 2025-2026

5.1 Transform reports into accessible formats to attract a wider audience

In addition to detailed, printed reports, a variety of content formats will meet the needs of wider audiences.

- Create summaries with key bullet points, using clear headings, easy to understand statistics, and formats that recognise time constraints and reading preferences.
- Create podcast-style audio summaries lasting 15-30 minutes to attract younger audiences and busy officers who can listen in the car or between meetings.
- Create bite-sized content for platforms where younger audiences are active such as TikTok-style videos highlighting key statistics, recommendations, and key messages.

This approach will ensure that the information reaches more people while maintaining the in-depth analysis of traditional reports intact.

5.2 Neighbourhood team integration

Healthcare commissioners want support "socialising changes to the way we are delivering care" and "reaching into communities to test out ideas for integrating neighbourhood teams." This represents an opportunity for Healthwatch York to support major system transformation initiatives. Rather than external oversight, stakeholders would like to involve Healthwatch York in supporting major system changes as neighbourhood teams and ICB structures develop. This represents an opportunity to influence system design from inception rather than responding to problems after implementation. It also raises the question of who will fund this work.

5.3 Investigate the population who present with complex and multiple needs/dual diagnosis

Healthwatch York to investigate how people with multiple complex needs can avoid “falling through the cracks”. Stakeholders consistently highlight that this group requires more holistic approaches. The feedback emphasises how a whole host of barriers to accessing care are faced, combined with funding reductions that limit accessible support. This group includes people who are "not coming onto anyone's radar" until crisis points, often presenting at A&E rather than engaging with primary care. The stigma and judgment they face when finally accessing healthcare compounds their vulnerability.

5.4 Recruit volunteers who are already accessing healthcare

Healthwatch York to recruit volunteers who are using healthcare services to report back on each stage of the process from making the first appointment through to treatment and beyond. It will be vital to consider and manage personal privacy throughout the process.

Suggestions include:

- Recruiting volunteer "secret shoppers" with health conditions to experience the full patient journey and identify accessibility barriers.
- Doing more work specifically around hearing or vision impairments.
- Conducting "spot checks" across different parts of the health system to assess accessibility.

Appendix A: <u>Participants</u>

Vanessa Beckett	The Land Haxby CIC	Parent and manager
Councillor Ben Burton	City of York Council	Councillor
Sarah Carter	Office of Luke Charters MP	Case worker
Professor Rachel Churchill	University of York	Professor of Evidence Synthesis
Krishna De	York & Scarborough Teaching Hospitals NHS Trust	Head of Patient Engagement
Helen Embleton	Tees Esk and Wear Valleys NHS Foundation Trust	Urgent Care Pathways Lead
Miles Goring and Astrid Hanlon	Lived Insights	Directors
Abby Hands	ADASS Yorkshire and Humber	Programme Director
Shaun Macey	York Health and Care Partnership	Assistant Director of Primary Care Transformation & Pathways
Dr Jed Meers	University of York	York Law School Administrative Fairness
Carrie Mitchell	Healthwatch York	Volunteer

Peter Roderick	York Health and Care Partnership / City of York Council	Director of Public Health
Alicia Rose	Healthwatch North Yorkshire	Research and Projects Coordinator
Peter Smith	Healthwatch York	Volunteer (care homes Enter and View)
Bethany Thompson	Healthwatch York	Volunteer
Sofia	Changing Lives	Women's Centre Manager

Appendix B: Reports

- Responses to recommendations July 2024
- Migrant Healthcare Experiences June 2024
- What we are hearing June 2024
- Exploring Access to GP services in York September 2024
- What we are hearing September 2024
- Services available over the festive period December 2024
- What we are hearing December 2024
- Listening to neurodivergent families January 2025
- Ebor Court Care Home visit February 2025
- Birchlands Care Home visit March 2025
- Core Connectors Report March 2025
- Riverside Care Complex visit March 2025

Health and Wellbeing Board **16 July 2025**

Report of the Director of Public Health

Progress Against Goals #3 and #4 in the Joint Local Health and Wellbeing Strategy 2022-2032

Summary

1. This paper provides the Health and Wellbeing Board (HWBB) with an update on the implementation and delivery of Goals 3 and 4 in the Joint Local Health and Wellbeing Strategy 2022-2032. It also includes information on performance monitoring.

2. The Board are asked to note the report.

Background

3. At their March 2023 meeting Health and Wellbeing Board members agreed an action plan and population health outcomes monitor to gauge delivery of the goals and priorities in the current Joint Local Health and Wellbeing Strategy. Progress reports on the action plan have been provided at HWBB meetings over the last two years.

4. At their meeting in March 2025 HWBB members agreed a revised action plan for the next two years. Progress reports on the actions within this will be presented to HWBB members over the course of the next 18 to 24 months.

5. The population health outcomes monitor agreed in 2023 remains the same and regular updates will be provided as annexes to these progress reports.

6. At the last meeting of the HWBB updates were given on **Goal 1** in the strategy, namely *'reduce the gap in healthy life expectancy between the richest and poorest communities'*

7. This report sets out updates on the eight actions associated with **Goals 3 and 4** in the current strategy**.**

8. **<u>Population Health Outcomes Monitor</u>**: this is linked to the ten big goals and is designed to provide board members with a holistic view of whether the strategy is making a difference to the health and wellbeing of York's population, using outcome data rather than data on what health and care services are 'doing'. Today's updates at **Annexes A** & **B** to this report provide information on the **two goals** that are set out in this report.

Progress Updates

9. **<u>Goal 3</u>: bring smoking rates down below 5% for all population groups**

10. Updates on these actions have been provided by the Public Health Team who are leading these 5 actions on behalf of the HWBB.

11. **Action A4:** continue joint working between Public Health and Public Protection to increase the amount of intelligence around illicit tobacco and utilise new legislation to support enforcement activity ('The Environmental Protection (Single-Use-Vapes) (England) Regulations 2024' and the proposed 'Tobacco and Vapes Bill')

    - Joint working continues between Public Health and Public Protection. A recent example of this is the work that was jointly coordinated between the two services, alongside the communications team. This work was in relation to the disposable vapes ban that came into force on 1 June 2024. The communications team produced a range of resources that the Public Protection team utilised to engage vape retailers in their obligations under the new legislation. There were also resources that were for residents, to ensure that the legislation changes were well communicated and understood by people who may be looking to buy disposable vapes. Additionally, Public Health are working with the ICB Centre for Excellence in Tobacco Control, who have commissioned market research into Illicit Tobacco. The output of the research is expected to be available in Q2 of 25/26.

12. **Action A5**: implement Tobacco Dependency Treatment service in York Hospital in both acute and maternity pathways

    - The Tobacco Dependency service has been implemented within the Acute pathway in York and Scarborough Trust. The service continues to develop and be further embedded into wards. The maternity pathway is not delivered within the trust, but via the local authority stop smoking services. Due to the trust geography this

covers the services provided by City of York Council, North Yorkshire Council and East Riding of Yorkshire Council. The trust has an ambition to bring the service in-house to within the maternity department, subject to a sufficiently funded internal business case.

13. **Action A6**: Implement the National Smoking in Pregnancy Incentive Scheme across York and Scarborough Trust

    - The National Smoking in Pregnancy Incentive Scheme (NSPIS) was available to be implemented from the latter half of 24/25, usually by NHS trusts as across England that is the usual place that maternity smoking cessation support is provided. However, as described above, the maternity pathway across York and Scarborough Trust sits with Local Authority stop smoking services. In order to onboard the NSPIS, a complex data sharing agreement needed to be drafted between the 3 local authority cases and the NHS trust. Changes to the national programme delivery from 25/26 have meant that new DSAs are required. In light of the trust's ambition to bring the maternity stop smoking service in-house, it may be that the NSPIS is not on-boarded while the service sits within Local Authority services. This constitutes a risk to achieving our objectives in this area.

14. **Action A7**: Increase the number of successful smoking quits through the York Health Trainer Service to 350 in 25/26

    - In 24/25, through the York Health Trainer service, 614 people set a quit date of which 381 were successfully quit at 4-weeks. This is an uplift from 23/24, where 300 people set a quit date and 220 were successfully quit at 4 weeks.

15. **Action A8**: Prioritise working with previously underserviced population groups, including Gypsy and Traveller, Homeless, Social Housing and IMD deciles 1 and 2

    - The York Health Trainer service, with the aid of Smokefree Generation funding, has adopted a new delivery model from May 2024. This has allowed the service to work directly with previously underserved communities. The service offer has been adapted to better suit the needs of those living and working in areas of deprivation and routine and manual occupations. The service is now available 5 days a week from 8am-7pm, at 14 locations across the city. The service is also adapting the delivery model to

work with specific population groups such as intensive work within the Gypsy and Traveller communities, a targeted offer for those living in Social Housing and a review of how the service can best support people with a Series Mental Illness (SMI).

16. **Goal 4:** Reduce from over 20% to 15% the proportion of York residents drinking above the Chief Medical Officer's alcohol guidelines

17. Updates on these actions have been provided by the Public Health Team who are leading these 3 actions on behalf of the HWBB.

18. **Action A9:** Continue making Alcohol Identification and Brief Advice (IBA) training available to organisations working with York residents to support conversations with individuals and enable signposting to appropriate services, and increase the number of staff who are trained to deliver IBA

    - IBA training continues to be made available to organisations. There were 15 sessions held over the last year, with 76 individuals from 8 organisations attending.

19. **Action A10**: Establish York Hospital Drug and Alcohol Care Programme for the identification of, and optimal treatment and effective discharge planning for all at risk of alcohol-related harm

    - The York Hospital Drug and Alcohol Care Programme has been commissioned by is taking longer than expected to be developed and implemented at the Hospital. This constitutes a risk to achieving our objectives in this area, and means that as well as a lost opportunity to get people into treatment and free of addiction, there is lost opportunity to prevent delayed transfers of care, reduce length of stay and reduce readmissions, positive impacts which have been seen in Alcohol Care Teams in other areas and in the national evaluation. We are working with York & Scarborough Teaching Hospitals NHS Foundation Trust to ensure delivery of the programme and are monitoring progress.

20. **Action A11**: Through the Drugs and Alcohol Partnership, take action to reduce alcohol harm, including using the levers which are available around the advertising, affordability and availability of alcohol in York, particularly for children and young people

    - It was agreed at the last meeting on 25th June that the board will take a public health approach across organisations through the

York Drugs and Alcohol Partnership Board to make York a place where people can be safe from the harms caused by alcohol; this will be achieved through influencing availability and affordability, shaping how York thinks about alcohol, reducing stigma and improving access to services. More detail can be found in the diagram at **Annex C** to this report.

- Priorities for 2025/26 will be decided at the September meeting of the Drugs and Alcohol Partnership.

Consultation and Engagement

21. As a high-level document setting out the strategic vision for health and wellbeing in the city, the current Joint Local Health and Wellbeing Strategy capitalised on existing consultation and engagement work undertaken on deeper and more specific projects in the city. Co-production is a principle that has been endorsed by the HWBB and will form a key part of the delivery, implementation, and evaluation of the strategy

22. The actions in the action plan have been identified in consultation with HWBB member organisations and those leading on specific workstreams that impact the ten big goals.

23. The performance management framework has been developed by public health experts in conjunction with the Business Intelligence Team within the City of York Council.

Options

24. There are no specific options for the HWBB in relation to this report. HWBB members are asked to note the update and provide comment on the progress made.

Implications

25. It is important that the priorities in relation to the current Joint Local Health and Wellbeing Strategy are delivered. Members need to be assured that appropriate mechanisms are in place for delivery.

Recommendations

26. Health and Wellbeing Board are asked to note and comment on the updates provided within this report and its associated annexes.

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

Contact Details

Author:	**Chief Officer Responsible for the report:**
Compiled by Tracy Wallis Health and Wellbeing Partnerships Co-ordinator	Peter Roderick Director of Public Health

Report Approved √ **Date** 04.07.2025

Specialist Implications Officer(s)
None

Wards Affected: **All** ✓

For further information please contact the author of the report

Annexes:

Annex A: HWBB Scorecard (for Goals 3 & 4)
Annex B: HWBB Trends (for Goals 3 & 4)
Annex C: Reducing Alcohol Related Harm

Health and Wellbeing 10 Year Strategy (2022-2032) 2023/2024

No of Indicators = 7 | Direction of Travel (DoT) shows the trend of how an indicator is performing against its Polarity over time.

Produced by the Business Intelligence Hub June 2025

				Previous Years								2023/2024		
			Collection Frequency	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	Year	Polarity	DOT
Goal 03: Reduce smoking rates	PHOF188	Smoking Prevalence in adults (18+) - current smokers (APS) (2020 definition)	Annual	14.60%	12.60%	9.00%	11.50%	11.90%	11.70%	9.20%	8.70%	8.10%	Up is Bad	▼ Green
		Benchmark - National Data	Annual	16.90%	15.50%	14.90%	14.40%	13.90%	13.80%	13.00%	12.70%	11.60%		
		Benchmark - Regional Data	Annual	18.60%	17.70%	17.00%	16.70%	15.70%	14.70%	14.10%	13.10%	12.70%		
		Regional Rank (Rank out of 15)	Annual	2	2	1	1	2	3	1	1	1		
	PHOF187	Smoking prevalence among adults aged 18-64 in routine and manual occupations (APS) (2020 definition)	Annual	28.10%	26.40%	24.60%	18.60%	26.90%	22.30%	20.90%	15.20%	18.80%	Up is Bad	◄► Neutral
		Benchmark - National Data	Annual	28.10%	26.50%	25.70%	25.40%	24.50%	24.50%	23.60%	22.50%	19.50%		
		Benchmark - Regional Data	Annual	30.00%	28.90%	28.20%	27.40%	27.60%	25.50%	24.20%	21.70%	21.60%		
		Regional Rank (Rank out of 15)	Annual	4	4	3	1	6	5	4	1	6		
	PHOF10	% of women who smoke at the time of delivery - (CYC)	Annual	12.30%	11.10%	10.40%	11.60%	10.40%	10.30%	8.00%	8.10%	6.20%	Up is Bad	◄► Neutral
		Benchmark - National Data	Annual	11.00%	10.70%	10.80%	10.60%	10.40%	9.60%	9.10%	8.80%	7.40%		
		Benchmark - Regional Data	Annual	14.60%	14.40%	14.20%	14.40%	14.00%	13.10%	12.00%	11.60%	9.30%		
		Regional Rank (Rank out of 15)	Annual	4	2	1	2	1	3	1	1	1		
	PHOF195	Smoking prevalence in adults with a long term mental health condition (18+) - current smokers (GPPS)	Annual	29.80%	28.50%	21.30%	30.30%	19.30%	26.30%	23.10%	20.90%	NA	Up is Bad	▼ Green
		Benchmark - National Data	Annual	33.00%	30.30%	27.80%	26.80%	25.80%	26.30%	25.20%	25.10%	NA		
		Benchmark - Regional Data	Annual	34.80%	31.60%	29.80%	28.20%	27.60%	27.50%	27.50%	25.40%	NA		
		Regional Rank (Rank out of 15)	Annual	3	5	2	10	1	4	4	3	NA		

			Collection Frequency	Previous Years								2023/2024		
				2015/2016	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	Year	Polarity	DOT
Goal 04: Reduce proportion of residents drinking over14 units of alcohol a week	LAPE12	Admitted to hospital with alcohol-related conditions (Broad): Males, all ages (per 100,000 population) - (New methodology)	Annual	-	2,411	2,912	3,103	3,057	2,468	2,913	2,976	3,401	Up is Bad	▲ Red
		Benchmark - National Data	Annual	-	2,534	2,585	2,752	2,826	2,309	2,682	2,646	2,837		
		Benchmark - Regional Data	Annual	-	2,718	2,731	2,812	2,800	2,300	2,678	2,727	2,870		
		Regional Rank (Rank out of 15)	Annual	-	7	10	11	11	9	10	10	13		
	LAPE13	Admitted to hospital with alcohol-related conditions (Broad): Females, all ages (per 100,000 population) - (New methodology)	Annual	-	978	968	1,084	1,118	942	1,075	1,001	1,063	Up is Bad	◀▶ Neutral
		Benchmark - National Data	Annual	-	837	855	911	938	801	906	881	935		
		Benchmark - Regional Data	Annual	-	932	941	986	991	831	955	943	1,010		
		Regional Rank (Rank out of 15)	Annual	-	10	9	10	12	11	12	8	10		
	PHOF191	Percentage of adults drinking over 14 units of alcohol a week - (4 year Aggregated)	Annual	29.40% (2014/15)	29.40% (2014/15)	29.40% (2014/15)	21.40%	21.40% (2018/19)	21.40% (2018/19)	21.40% (2018/19)	21.40% (2018/19)	21.40% (2018/19)	Up is Bad	◀▶ Neutr
		Benchmark - National Data	Annual	25.30% (2014/15)	25.30% (2014/15)	25.30% (2014/15)	22.80%	22.80% (2018/19)	22.80% (2018/19)	22.80% (2018/19)	22.80% (2018/19)	22.80% (2018/19)		
		Benchmark - Regional Data	Annual	25.80% (2014/15)	25.80% (2014/15)	25.80% (2014/15)	21.20%	21.20% (2018/19)	21.20% (2018/19)	21.20% (2018/19)	21.20% (2018/19)	21.20% (2018/19)		
		Regional Rank (Rank out of 15)	Annual	12 (2014/15)	12 (2014/15)	12 (2014/15)	9	9 (2018/19)	9 (2018/19)	9 (2018/19)	9 (2018/19)	9 (2018/19)		

Annex B:

Business Intelligence Hub

Joint Health and Wellbeing Strategy 2022-2032:

Performance Monitoring for July 2025 Board.

Indicator Trends

Author: CYC Business Intelligence Hub

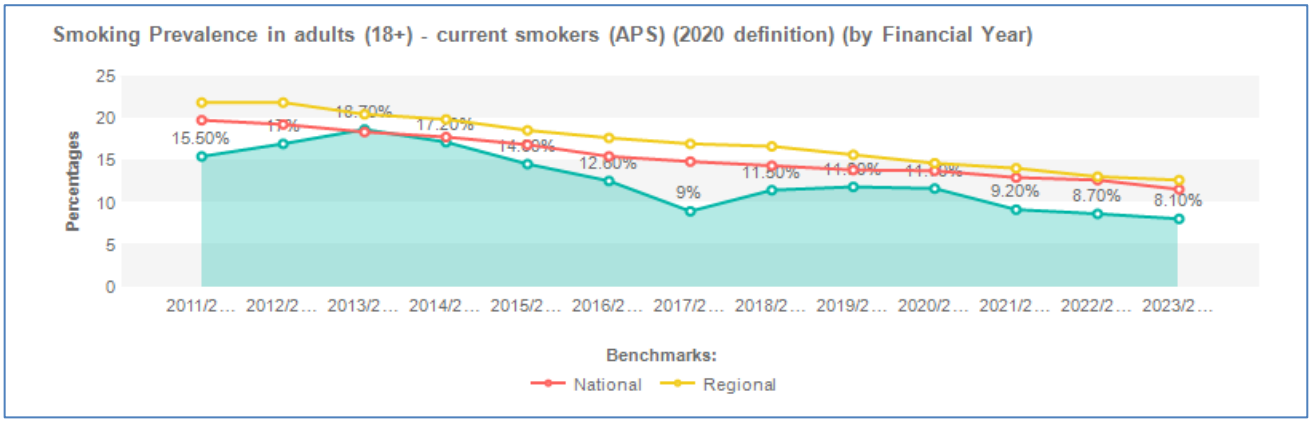
Date: July 2025

Contents

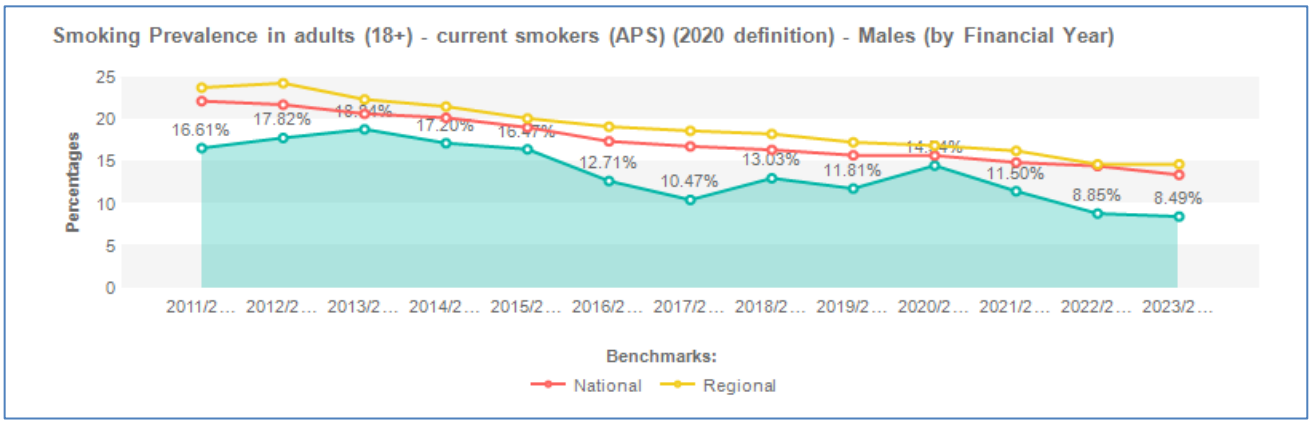
Goal 3: Bring smoking rates down below 5% for all population groups

Smoking prevalence in adults (18+)

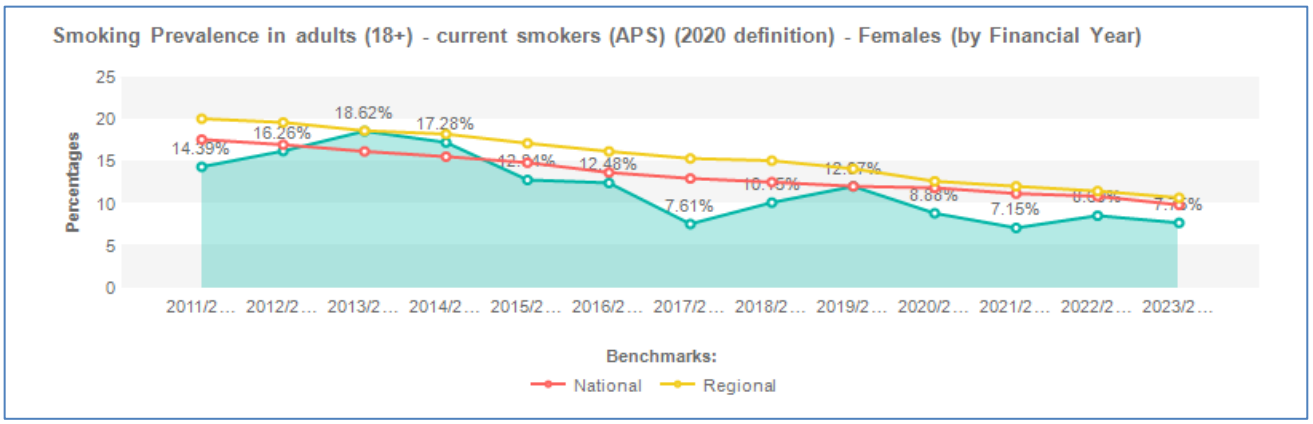
- Smoking prevalence in adults (18+) in York has fallen from **18.7%** in 2013/14 to **8.1%** in 2023/24



- Smoking prevalence in males (18+) in York has fallen from **18.8%** in 2013/14 to **8.5%** in 2023/24

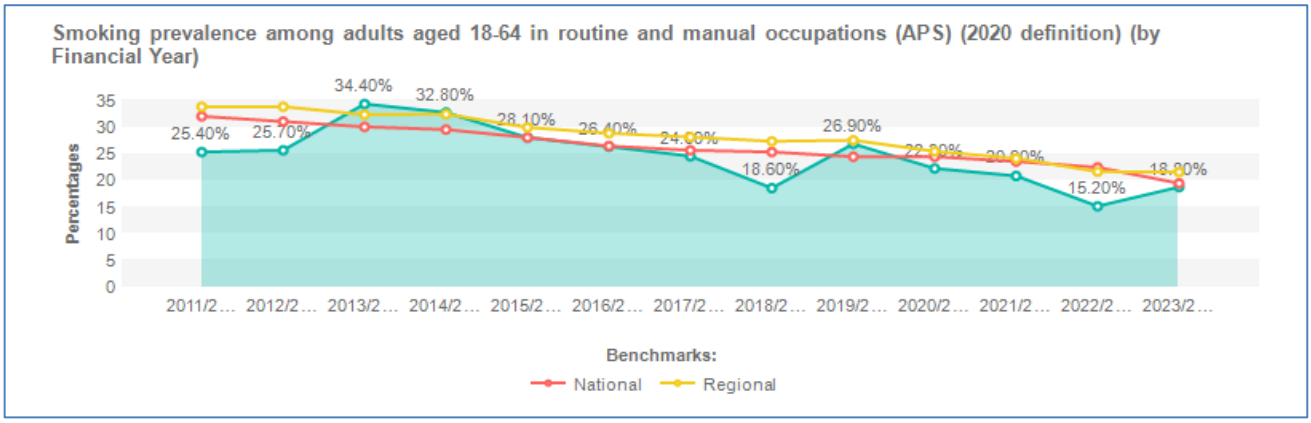


- Smoking prevalence in females (18+) in York has fallen from **18.6%** in 2013/14 to **7.8%** in 2023/24



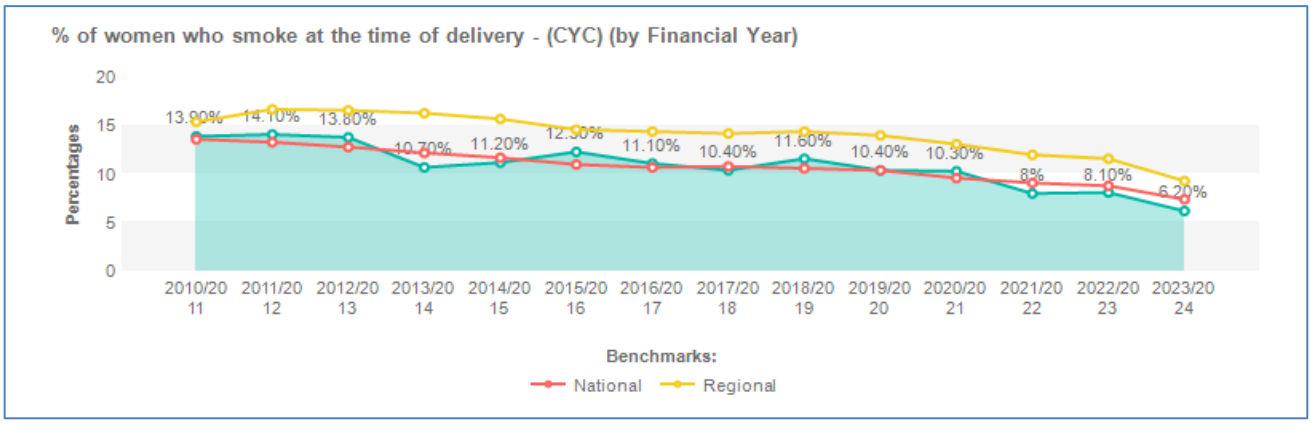
Smoking prevalence in adults aged 18-64 working in routine and manual occupations

- Smoking prevalence in adults aged 18-64 working in routine and manual occupations in York fell from **34.4%** in 2013/14 to **15.2%** in 2022/23 however it rose to **18.8%** in 2023/24.



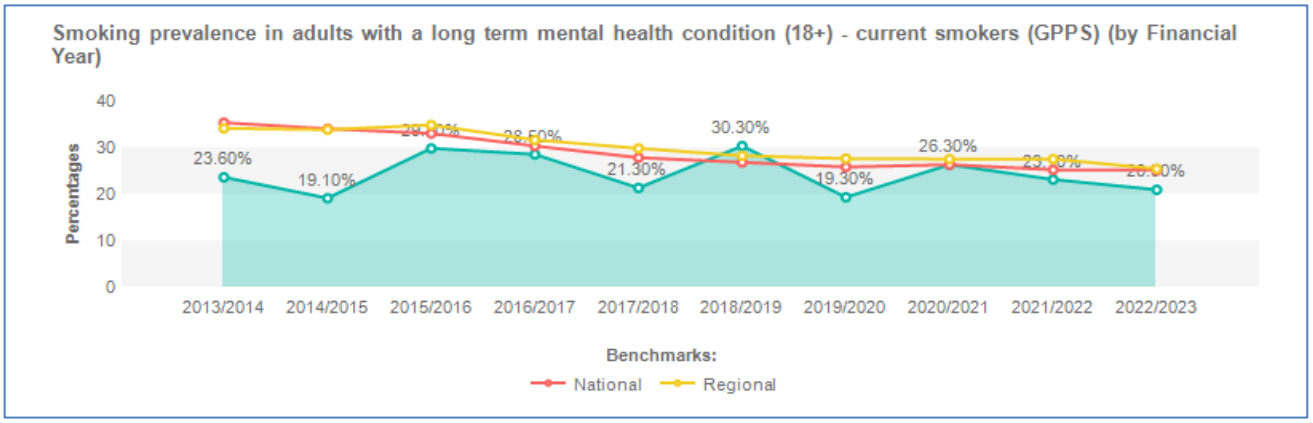
Smoking prevalence in mothers at the time of delivery

- Smoking prevalence in mothers at the time of delivery in York has fallen from **13.9%** in 2010-11 to **6.2%** in 2023/24.



Smoking rates in adults with a long-term mental health condition

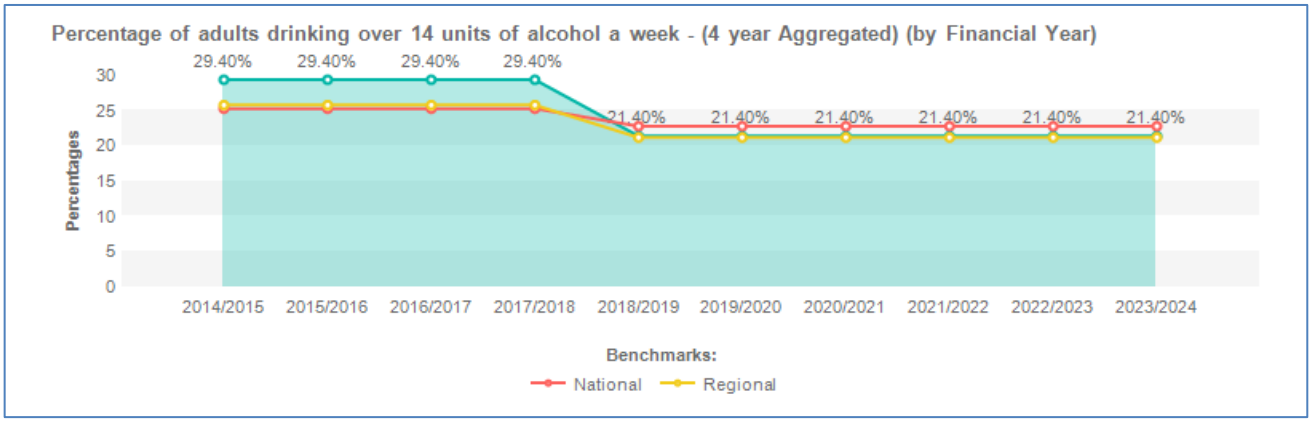
- Smoking rates in adults with a long-term mental health condition in York have not shown a clear trend over the last 10 years however the rate has fallen in the last two years from 26.3% in 2020/21 to 20.9% in 2022/23.



Goal 4: Reduce from over 20% to 15% the proportion of York residents drinking above the Chief Medical Officer's alcohol guideline (no more than 14 units a week)

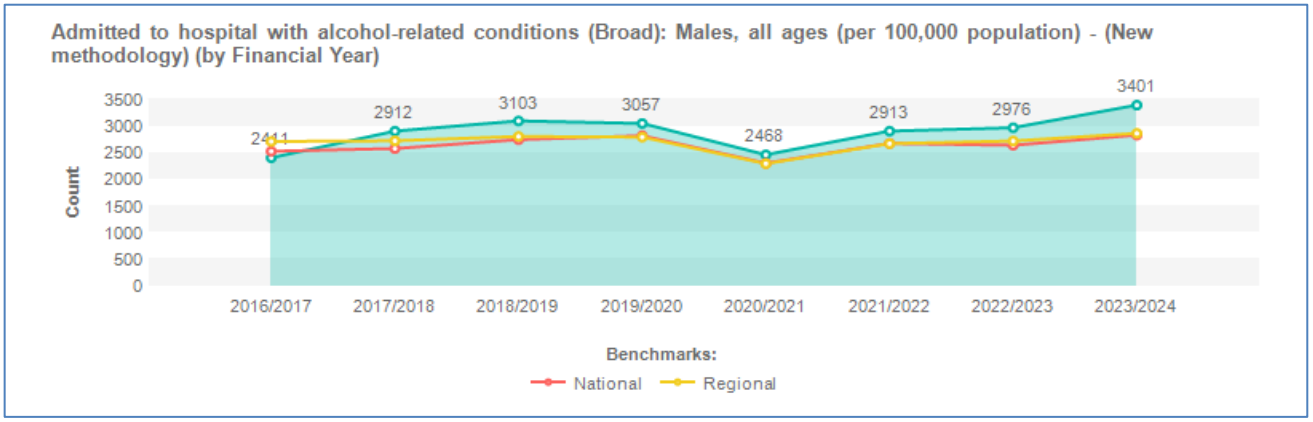
Percentage of people aged 18+ who reported that they usually drink more than 14 units of alcohol a week

- Data on the percentage of people aged 18+ who reported that they usually drink more than 14 units of alcohol a week is available from the Health Survey for England (HSE). In order to provide a robust sample, data is aggregated from 4 years of HSE data. The most recent figure is **21.4%** for York which is an improvement on the previous value of **29.4%.**

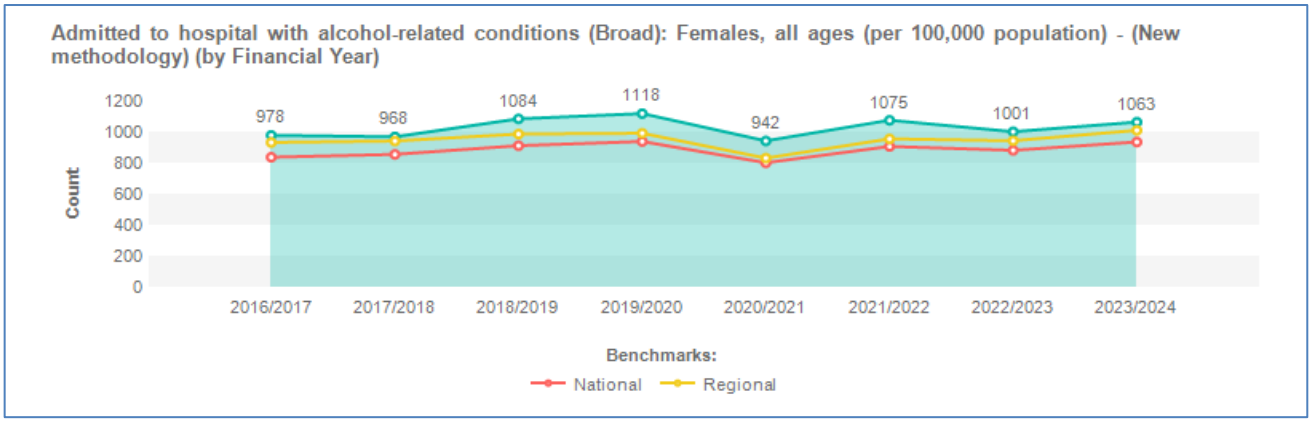


Admission rates to hospital for alcohol related conditions (broad)

- Eight years of trend data are available, showing admission rates to hospital for alcohol related conditions (broad) for males and females. The indicator is a measure of hospital admissions where either the primary diagnosis (main reason for admission) or one of the secondary (contributory) diagnoses is an alcohol-related condition.
- Admission rates are higher for males than for females, for example in 2023/24 in York there were 3,121 admissions for males (**3,401** per 100,000) and 1,081 admissions for females (**1,063** per 100,000).
- For males there was an increasing trend in admissions between 2016/17 and 2019/20. Admissions fell in 2020/21, presumably due to the national Covid-19 lockdowns. In 2021/22 rates went back up and have continued rising up to 2023/24.



- Admission rates for females have been fairly stable over the last 8 years.



- Admission rates for both males and females in York are above national and regional averages.

This page is intentionally left blank

Annex C:

Alcohol related harm:
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 alcohol

What are we going to do:

Influence Availability and Affordability

Partnership work to reduce alcohol harms through availability and affordability

Availability

Work with licensing team to:

- Support licensed premises to offer choice of no/low alcohol
- Have a CYC alcohol policy for events
- Restrictions on entrance/till placement in off-trade

Affordability

- Contribute to national consultations
- Consider Minimum Unit Pricing with support from national/regional teams
- Consider pricing of no/low alcohol alternatives– work with licencing team

Shape how York thinks about alcohol

Population-wide alcohol awareness information to be made accessible and available to all to prevent and reduce alcohol related harm

Brief Conversations

- Ensure training rolled out for professionals/volunteers

Children/Young People

- Ensure that HSP has appropriate resources
- FASD prevention awareness

Reduce stigma and improve access to services

Work across the city to challenge stigma and to enable the population of York to reach out for support. Ensure that those requiring access to services have the availability of a range of services to meet need

Inclusive Recovery City

- To agree a vision for York as an Inclusive Recovery City
- To have 'sign off' as a recovery city

Communication

- To have a code of best practice for producing communications, Press releases, social media ensuring appropriate language

Treatment service

- To ensure the service provider offers a range of services incl. for those wishing to reduce their alcohol use

Secondary Care

- York Hospital D&A care programme to identify people drinking above low risk levels and offer advice/referrals as required

Primary Care

- Provide primary care referral support

This page is intentionally left blank

Health and Wellbeing Board **16 July 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

Adult Social Care

2. CQC visited York as part of the local authority assessment during week commencing 16th June. We are now awaiting the report.

Update from the Ageing Well Partnership

3. The Ageing Well Partnership has continued to meet every other month with topics covered this year including:

   - Adult Social Care Strategy
   - Health self-monitoring
   - Dementia Strategy
   - Age Friendly York – Impact Report
   - Age Friendly York Handbook
   - AFY Getting Out And About Domain – progress update
   - Social Isolation

4. **Dementia Strategy** – Dementia Forward are the lead dementia provider in York. We have invited Jill Quinn CEO of Dementia Forward to be a member of the Ageing Well Partnership. We have agreed that Jill will lead on an update of the Dementia Strategy action plan with a theme for each meeting from the strategy, these include: preventing well; diagnosing well; living well; supporting well and dying well. The first agreed theme was diagnosing well with preventing well to follow in August.

5. **Age Friendly York** – is now on the second cycle of the Age Friendly York domains. This includes reviewing progress on the existing actions within each domain and refreshing the action points. The Your Home second cycle action points have been approved and the Getting Out and About action plan is progressing.

6. **Social Isolation** – We have had a presentation from Public Health on the recent social isolation figures. One of the priorities in the Health and Wellbeing Board's Joint Local Health and Wellbeing Strategy is to "Reduce the proportion of adults who report feeling lonely from 25% to 20% of our population". The data is now captured in a different way recording "adults that feel lonely often or always" rather than "adults that feel lonely often, always or some of the time". As feeling lonely some of the time is not always a bad thing as it can stimulate action to socialise, we support the new way of presenting this data. With this new data York is performing well both regionally and against comparable locations.

Area	Value
England	6.8
Yorkshire and the Humber region (statistical)	6.8
Kingston upon Hull	9.7
Doncaster	7.8
Wakefield	7.7
Leeds	7.6
Rotherham	7.4
North East Lincolnshire	7.4
Sheffield	7.2
North Lincolnshire	7.2
Bradford	6.8
Calderdale	6.4
Barnsley	6.3
Kirklees	6.2
York	5.3
East Riding of Yorkshire	5.2
North Yorkshire Cty	-

Specialist Implications Officers

Not applicable

Wards Affected: **All**

For further information please contact the author of the report

7. We have been working alongside universities within the Curiosity Partnership to better understand loneliness and social isolation and what this means in York. York University have been successful in attracting research receiving funding to take the next step which will explore the related concept of a Social Frailty. They plan to begin psychometric testing of a Social Frailty tool and measure in January across health and social care settings with older people. We are exploring the concept of linking in with the Frailty Hub as the primary group of residents in York

National and Local Updates

8. **NHS 10 year** plan: On 3rd July the NHS 10 year plan was published, setting out the government's strategy to shift care from hospital to community, from analogue to digital, and from sickness to prevention. The plan can be found here. At the Board meeting, members may wish to comment on the key aspects of the plan which are relevant for the York health and care system.

9. **Visit of Chief Medical Officer Chris** Whitty: On 1st July, the Chief Medical Officer (CMO) Chris Whitty visited York to hear about health in the city. His visit included presentations from the public health team on air quality, prevention and support in the first 1001 days, smoking cessation and the Health Trainer service. He walked the city walls and discussed with CYC officers and members the city's development plans and the York Central site, as well as our housing challenges and plans, and then visiting the Community Recovery Hub at Wellington Row, where he met members of the community to hear about their journey of recovery from drug and alcohol use, and the fantastic range of events and support that is available.

10. **ADHD/Autism strategy**: Partners, led by the Council and ICB, have been working on an all-age Autism and ADHD strategy for 9 months, and in May, the council's Scrutiny Committee had presented the Autism / ADHD Health Needs Assessment (here) and the draft Autism / ADHD Strategy (here). The strategy is subject to further co production and consultation over the summer and will be adopted by the Council's Executive in October, alongside the SEND and Alternative Provision Strategy.

11. **School age flu vaccine** uptake: York has seen a massive improvement in the uptake of the flu vaccine in school-aged children – from a lower than average uptake last year, we were among the top 4 local authorities for every age group and achieving 20% higher uptake than the England average in 2024/25.

12. **Suicide Prevention** Training: Death by suicide is the leading cause of death among young people aged 20 to 34 in the UK. We have an

established suicide prevention programme in York with a long history of partnership working, and suicide prevention training has been commissioned by ICB and public health, delivered by Papyrus.

13. **Smoking at Time of Delivery (SATOD)**: Data was released this week on Smoking at Time of Delivery for 2024/25, and shows that only 4.6% of women in York smoked at the time their baby was born – just 65 people. In 2020 this was 10.4% (167 people), and in the last 5 years we've focussed a lot of work on this area, introducing an incentive scheme, working closely with the hospital, training people on VBA, comms campaigns etc.

14. **Pharmaceutical Needs Assessment**: The Pharmaceutical Needs Assessment has been published for consultation ahead of full publication in the autumn.

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