Annex A:

Humber and North Yorkshire
Health and Care Partnership

York Health and Care Partnership Annual Report and Joint Forward Plan

May 2024

Introduction

The Humber and North Yorkshire Health and Care Partnership 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 partners across health and care to deliver improvements in experience and outcomes for people living in York.

Welcome to the 2023/24 annual report for the YHCP. This report will capture some of the successes and achievements across the different priorities of the Partnership over the year. We are publishing this annual report at an important time for the YHCP as we continue to develop and strengthen integration across partners to reduce health inequalities and improve the health of York's population.

2023/24 has been a busy, challenging, and exciting year for the YHCP. Health and Care organisations in York are working towards developing 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 2023/24. This document provides a summary of this progress and outlines the YHCP's plans to continue improving health and care services for York in 2024/25.

Our purpose

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 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.

The YHCP has formed a number of system teams to support delivery of our priorities, which are evidence of the strong partnership culture the YHCP has developed over 2023/24. For example the York Population Health Hub (PHH) works across partners to oversee Population Health Management, Public Health Intelligence, and the Joint Strategic Needs Assessment, and to enable the healthcare system to make better use of data, insight, and population health approaches. By bringing together partners, the PHH enables the YHCP to focus on the wider determinants of health by using multi-agency data that can inform place-led approaches which respond to the specific needs and characteristics of the population of York. For example, in our Proactive Social Prescribing project delivered by York Centre for Voluntary Service (CVS), we are not only focussing on a single long-term condition, but the area that people live in and how their housing conditions may exacerbate their symptoms. This highlights the key role Place can play as a convener of all system partners to drive improvements in holistic, personalised care for people and implement the Joint Local Health and Wellbeing Strategies. As these system teams and 'Hubs' develop, the YHCP will play a key strategic role to ensure there is a consistent, effective, and holistic offer for people living in York where duplication and inefficiencies are minimised.

The YHCP has identified six long-term, transformational priorities to be delivered collaboratively over the next five years, focussed on strengthening integration, reducing health inequalities, and improving population health for people who live in York. The aim of these priorities is to deliver personalised care through integration, enabled by shared approaches to data and digital, workforce and estates, finance and quality, communication, and co-production. The priorities will support delivery of the Joint Health and Wellbeing Strategy for York and the '10 big ambitions' for our population, as well as contributing to the delivery of the Humber and North Yorkshire Health and Care Partnership Strategy. A detailed workplan sits behind each priority which is not included in this report. The YHCP monitors progress towards each priority through monthly meetings and progress is also reported to the Health and Wellbeing Board.

The six key priorities are:

1. Strengthen York's integrated community offer
2. Implement an integrated Urgent and Emergency Care (UEC) offer for York
3. Further develop Primary/Secondary shared-care models
4. Embed an integrated prevention and early intervention model
5. Develop a partnership based, inclusive model for children, young people, and families
6. Drive social and economic development

Key partnership achievements against these priorities in 2023/24 include:

- Implementation of the York Frailty Hub focusing on prevention and admission avoidance. We are strengthening the relationship with key partners to deliver collaborative, integrated care, making the best use of collective resource.
- York & Scarborough Hospitals Trust successfully led procurement for a new GP Out of Hours service with Nimbuscare due to deliver the service across the York & Scarborough Hospitals Trust footprint (Whitby, Scarborough, Malton, York, and Selby) from April 2024.
- The establishment of the York Place Primary/Secondary Care Interface Group with senior clinical representation from Primary Care and York & Scarborough Hospitals, which is leading practical, clinical pathway transformation projects in partnership with Hospital colleagues.
- We have accelerated our Long-Term Conditions Programme to strengthen secondary prevention care in York, including the launch of three static health kiosks placed in areas of deprivation to improve detection and treatment of hypertension and reduce health inequalities.
- For children and young people, the Early talk for York and More talk for York approach has been developed to identify speech language and communication needs.
- As part of our joint workforce plan, partnership recruitment activities and initiatives across health and care partners have commenced, including care leavers and the volunteer workforce, with a highlight being the joint recruitment fair between health and social care held in November 2023.

Engagement in 2023/24

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 as a whole when organisations share their findings and best practice around coproduction. As a key strategic partner of the YHCP, Healthwatch York have continued to lead engagement work across the YHCP, championing the voice of people in York and

ensuring that people's views are reflected in service transformation and delivery. Key highlights from Healthwatch York's work include:

- Publication of the Urgent Care report, engagement work funded by the YHCP to support the ongoing urgent care transformation work in York. This report ensured that the YHCP heard from people who live in York who told us that a disjointed UEC system was difficult to navigate. This helped the YHCP identify the next steps for transformation, reflective of what our residents had told us.
- Publication of the Independent Evaluation of the Pilot Pathway Adult ADHD and Autism report which is being used to inform improvements across ICB pathways across North Yorkshire and York.
- Publication of the Health and the Cost of Living May 2023 report highlighting the impact that the Cost of Living crisis is having on the health and wellbeing of people in York. This qualitative feedback was complimented by the York Population Health Hub's second Cost of Living Data Pack, which brought together multi-agency data to demonstrate the impacts observed in the city. Together, these two reports have been disseminated to inform leaders and practitioners about the health impacts of the financial situation and have formed the basis for a Population Health Hub Lunch and Learn to further educate the workforce about potential impacts and issues to be aware of for residents.
- Work to explore people's experiences of mental health crisis care
- Launch of the Core Connectors scheme working jointly with the ICB. Core Connectors are young people aged 16–25 who help other young people have their voices heard, they listen to people's experiences and capture what is working and where services could be improved to support service transformation. The Core Connectors will be focusing on engaging with people who experience health inequalities.

YHCP work to address Health Inequalities

Reducing health inequalities is a key role of Place Based Partnerships, and work to reduce health inequalities is a golden thread throughout each of the YHCP's priorities. The YHCP receives health inequalities funding from the Humber and North Yorkshire Integrated Care Board (ICB) to address local need in line with the Core20PLUS5 Framework. Throughout 22/23 and 23/24 the YHCP has been delivering a series of projects to utilise this funding, demonstrating the key partnership work happening in this area. These projects include:

- Bolstering the Ways to Wellbeing grant led by York CVS
- Supporting the York Ending Stigma campaign led by York CVS
- York's first ever Health Mela held in September 2023 with representation from all YHCP partners
- Increasing access to healthcare services for people who work in sex led by the ICB and Nimbuscare
- Placement of static health kiosks in areas of deprivation to support increased prevalence and subsequent treatment of hypertension, led by the ICB and Nimbuscare
- Roll out of the Asthma Friendly Schools Initiative and Speech and Language Training, led by the ICB and York & Scarborough Teaching Hospitals Foundation Trust (Y&SFT)
- Improvements in the school absence pathway led by CYC
- Launch of the Baby Friendly Initiative led by CYC Public Health

- Health and wellbeing support for York's asylum seeker and newly settled refugee communities in partnership with Refugee Action York
- Establishment of the primary and secondary care health inequalities training programme delivered in partnership by the ICB, CYC Public Health, Healthwatch York and York CVS

For more information on health inequalities in York, the York Population Health Hub has produced a Core20PLUS5 profile (expected to be published end of April 2024 – link to be added), outlining the groups who are most likely to experience health inequalities in the city.

Case Study – Maternal and Child Nutrition Health Inequalities work

UNICEF Baby Friendly Initiative: There is strong evidence that adopting the UNICEF Baby Friendly Initiative standards and accreditation programme within a service act as a key intervention in improving infant feeding support for parents through ensuring that practitioners' knowledge and skills are developed and maintained at a high standard and that parents experiences of care are considered. York's Healthy Child Service has committed to implementing the UNICEF Baby Friendly Standards to improve infant feeding support for parents and families within the City and to provide targeted support to reduce inequality.

Food Insecurity – Infant Formula: Working in partnership with the Healthy Child Service, maternity and the Welfare and Benefits team, we have created a pathway for families which means that they will be able to access infant feeding support during financial hardship or food crisis (which conforms to the World Health Assembly International Code of Marketing of Breastmilk Substitutes and subsequent resolutions (the Code)) and receive wrap around care, enabling them to access additional support services to meet ongoing needs.

York Healthy Schools Programme: The Healthy Schools programme was launched by City of York Council in partnership with North Yorkshire County Council in March 2023. Funded and supported by the Public Health team, it is free for all publicly funded schools in York to join including academies. Since its launch in March last year, a quarter of schools in York have signed up to join the programme. The online programme supports schools to work towards improving the health and wellbeing of pupils and staff through an evidence-based 'whole school approach' across four key themes: personal, social, and health education (PSHE); emotional health and wellbeing; active lifestyles; and food in schools. Schools can work towards Bronze, Silver and Gold Healthy School awards.

York's Hungry Minds: In January 2024, City of York Council launched a universal free school meal pilot in Westfield Primary School and a free Breakfast club pilot in Burton Green Primary School, with the aim of reducing food insecurity and increasing nutritional status amongst children. There is some evidence of a beneficial impact of universal free school meal provision on pupil health and educational outcomes such as improved nutrition and academic performance. The pilot is due to be evaluated to demonstrate the impact that this has had on children.

Health Trainers: In early 2023, the Health Trainer service launched a useful guide called "Eating healthy on a budget". The guide gave practical support and advice to families around how to have healthy and nutritious meals while keeping costs to a minimum, tips on healthy swaps and a look at the cost of cooking appliances.

Home-Start Cookery Classes: Services from Home-Start have been commissioned by Public Health since 2023 and through contract monitoring arrangements it was identified that families needed further practical support around learning how to prepare healthy, budget-friendly meals at home.

Home-Start had an established relationship with a cookery school, who provide valuable resources and support to families in the city, particularly those with young children. This existing arrangement means that the service to reach families who may benefit from this initiative and volunteers are able to identify families in need and extend invitations to those who may benefit most.

Through this initiative families are able to participate in cooking demonstrations led by a skilled chef. Demonstrations not only showcase essential cooking techniques but also empower parents to take an active role in meal preparation. Participants of the course are also given printed menu cards and other 'take-home' resources in order to replicate the recipes and cooking methods learned during the sessions.

What does the work highlighted in this report mean for people and communities in York?

Working across partners to deliver our priorities will mean more joined up care, less duplication, and more effective, integrated health and care services for people living in York. We want to support people living in York to start well, live well, age well and end their lives well, and we intend to achieve this by delivering our six priorities which cover all ages, mental and physical health, and the wider determinants of health, to provide holistic and joined up health and care support to our population. The Joint Forward Plan section of this report includes more detail on what each priority will mean for people living in York. We are aligned with the Health and Wellbeing Strategy in our delivery of these priorities and share the ambition that **in 2032 York will be healthier, and that health will be fairer.**

Engagement and coproduction exercises are built into the workplan that sits behind each priority and are led by each organisation that forms the YHCP, to ensure that as a partnership we are continuously reflecting on what the public tell us and building this into service transformation where possible.

Delivery through the Charter of Behaviours

The work of the YHCP described in this document for 2023/24 and 2024/25 will continue to be delivered through the Charter of Behaviours, as outlined in our Prospectus:

- We are in it together
- We trust in people
- We are permission-giving and empower staff
- We are person-centred
- We commit to freeing the power of the community
- We commit to improving population health
- We connect clinicians and professionals
- Our finances will align

1. Delivery against our six priorities

This section of the document provides an update towards the delivery of our six priorities in 2023/24. We have taken a look back at what we said we would deliver in our joint workplan and provided an update against each of these actions.

Strengthen York's Integrated Community Offer

This priority includes our partnership 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 2023/24
Create an integrated frailty community hub.	Implemented a truly integrated frailty model which focuses on prevention, helping people in crisis to remain at home by reducing conveyance and admission to hospital, and supporting frail individuals to be discharged back to home safely and quickly. A Frailty Crisis Response Hub was launched in November 2023, part of which was a Frailty Advice and Guidance line ran by a GP with a specialist interest in Frailty. The line provides additional support to clinicians working with vulnerable and frail people, with the hope that with this additional support, these individuals can continue to be cared for at home. Paramedics making use of the Advice and Guidance line are actively promoting this service.
Health and social care service integration that supports end-to-end pathways (admission avoidance, in hospital, transfer, home) focused on improved outcomes that support the delivery of local and national plans, with personalised care at the centre of our approach.	Discharge Hubs at Scarborough and York have adopted new ways of working with extended multi-disciplinary team (MDT) membership which enables all partners to have oversight of cases. The MDT can escalate issues in real time to senior managers for speedy resolutions that support safe transfers of care for hospital inpatients. York introduced a new 'One Team' multi-provider daily call with a focus on collaboration in provision of packages of care, includes health and local authority, working in partnership. New processes have been established by City of York Council to facilitate earlier discharge and unblock issues which can lead to delays for patients waiting to leave hospital. Established a York and North Yorkshire ICB-led Discharge Quality Improvement Group to undertake system-based Quality improvement initiatives to improve the experience and overall quality of the discharge processes. Twinning of a Tees Esk and Wear Valleys NHS Foundation Trust (TEWV) Older People ward and a York Hospital Older People's ward to share skills and learning to improve pathways and overall experience of care for those patients living with dementia and experiencing physical ill health.
Understand where community integrated pathways work well e.g. heart failure and look where similar models of integrated care could be adopted locally.	Focus on Y&SFT Virtual Hospital Programme, linking multiple specialties that have cross cutting pathways such as Heart Failure/Respiratory.

	Benchmarking against local systems who excel in discharge planning and speedy transfers of care.
Continue to work in partnership to support implementation and expansion of Mental Health Community Hubs.	Following the prototype hub development and reviewing the lessons learned from the prototype partners are now in the process of implementing our first Mental Health Community Hub as part of the Community Mental Health Transformation. Accommodation: 30 Clarence Street has been confirmed as the location for the first hub and a weekly task and finish group is working to ensure that all of the operational requirements are in place for the opening of the hub. Initial discussions have taken place with primary care colleagues about potential locations for future hubs.

Case study: York's Integrated Frailty Hub

The York Frailty Hub is an integrated offering from all services commissioned to provide care and support for citizens in York that are Frail. The 3 different arms of the York Frailty Hub include:

- Anticipatory Care
- Crisis Response
- Discharge Support

This is a truly integrated frailty model which focuses on prevention, helping people in crisis to remain at home and avoid an admission whilst respecting their wishes, and supporting people to be discharge home from hospital safely and when they are ready. As part of this offering, a Frailty Crisis Response Hub has been in place since 1st November, which sees the collaboration of four providers working together at Acomb Garth Community Centre.

The model is comprised of:

- A GP with a Specialist Interest in Frailty running an Advice & Guidance phoneline Mon-Friday 9am – 8pm, available to Yorkshire Ambulance Service (YAS) and the wider local system – provided by Nimbuscare
- A Social Care Worker running the Duty Social Care Hotline, receiving urgent referrals for people experiencing a social care crisis – provided by City of York Council
- Y&SFT Urgent Community Response (UCR) / Community Response Team (CRT) Triage receiving calls for people requiring an urgent community response and linked to the wider UCR/CRT team based at the hospital – provided by Y&SFT.
- Social prescriber linked to CVS – connecting people with local community activities and services that can help improve their health and wellbeing, provided by York CVS
- People also receive support from a Frailty Nurse linked to York Integrated Care Team/Nimbuscare

The aim is to support and keep people that are vulnerable and frail safe in their homes whenever possible, whilst respecting people's wishes for care at home. Since its inception, the Frailty Advice & Guidance line has received over 800 calls to date and avoided over 320 ED admissions. The Extra Discharge Support Service is also a service that was set up this year and is provided by three voluntary sector organisations which support patients when they are discharged from hospital. The service has supported over 600 patients to be discharged home either more safely or quickly than they otherwise would have been.

Implement an integrated Urgent and Emergency Care Offer for York

The aim of this priority is to deliver safe, reliable, and resilient services providing the right care, right place, right time.

What we said we would deliver	What we have delivered in 2023/24
Urgent Care (Urgent Treatment Centre and Out of Hours). The strategic intention is to develop a prime provider 24/7 Integrated Urgent Care (IUC) service model across the York and Scarborough Teaching Hospitals Foundation Trust (Y&SFT) footprint which meets population need by delivering the right care, at the right time, in the right place, first time, in line with Fuller principles.	York place has seen real progress. Nimbuscare worked collaboratively with Totally PLC to operate the overnight GP Out of Hours (OOH) which improved resilience across all Totally PLC delivered urgent care services going into winter 2023/24. Y&SFT will be the lead provider of Urgent Care (GP OOH and Urgent Treatment Centres) from 1st April 2024 having already assumed lead provider for Selby UTC from Harrogate Hospitals Trust in 2023. Announced in December 2023, Y&SFT successfully led procurement for a new GP Out of Hours service with Nimbuscare due to deliver the service across the Y&SFT (Whitby, Scarborough, Malton, York, and Selby) from 2nd April 2024.
Clinical Assessment Service: support Healthcare Professionals through frail, elderly pathways as alternative to ED.	A Frailty Advice & Guidance (A&G) Line was established in 2023, primarily with a view to providing ambulance crews with support for clinical decision-making. While ambulance crew take up has been slower than anticipated, the A&G team provide a valuable service to a wide range of health and care providers and fully integrated within the Frailty Hub, itself increasingly integrated with the community services team. Funded by winter resilience monies, the GP in Yorkshire Ambulance Service Control Room (Nimbuscare) are also feeding into the A&G/Hub.
Development of additional direct access pathways to Same Day Emergency Care (SDEC) from community. Implementation of approach through redesign and integration of reablement and intermediate care. Fully embedded multi agency in reach team to support early discharge increasing flow.	Work is ongoing to build capacity to enable direct access to SDEC.

Further develop Primary/Secondary shared-care models

The aim of this priority is to develop shared care models between patients, GPs, and specialists, so patients receive a personalised, seamless, and holistic care experience.

What we said we would deliver	What we have delivered in 2023/24
Move away from referral-to-specialist towards a shared care model between patient, GP, and specialists.	Referral for Expert Input REI (Rapid Expert Input) has continued to develop across the 3 Specialties which are live – Neurology, Dermatology, Rheumatology – with good uptake and support from Primary and Secondary Care colleagues.
York has a referral platform in place which provides a platform for pathway standardisation, administrative and clinical review of Hospital referrals, and a support service for offering patients choice and booking them into Hospital clinics.	The Referral Support Service function continues to work across the Y&SFT footprint – providing the Gateway referral management system that improves the quality/completeness of referrals and compliance with commissioning policy to maximise workflow efficiencies across the Interface, and to help manage Hospital demand.
The Advice & Guidance platform is being developed between to include more specialties increasing integration between primary and secondary care.	Conversations continue via the Primary/Secondary Interface Group around bringing more specialties on board with our Advice & Guidance Platform, REI, which facilitates shared care between GP's and Hospital Specialists.
York and Scarborough areas are further developing forums for GP and Hospital clinicians to explore opportunities for creating shared care models, where care is managed collaboratively to best meet the patients' needs	The York Place Primary/Secondary Care interface Group meets monthly with a focus on pathway transformation and closer working between GP's and Hospital Specialists to support shared care. The group will expand to include Scarborough colleagues. We have started to develop the role that GPs with specialist interests play in these shared care models through a pilot in Gynaecology.
The Outpatient Transformation Programme will enable more patients to choose when and how they access Hospital Outpatient Clinics.	The Outpatient Transformation Programme is currently looking at new models of care (Referral for Expert Input and Connected Health Network, Patient Initiated… etc.), Patient Initiated Follow Up, and online/digital access to follow up appointments. We have used the national framework provided by the Getting It Right First Time (GIRFT) Programme to identify and act on opportunities to improve access to outpatient clinics.
Collaborative working will enable Primary Care direct booking into Hospital SDEC / speciality hot clinics – and Virtual Ward access for frailty, respiratory patients, bypassing the Emergency Department (ED).	Primary Care and Hospital colleagues have been working on these pathways during 2023/24. Pathways are becoming more connected through Respiratory/Frailty Hubs for example.

Embed an integrated prevention and early intervention model

The purpose of this priority is to enable a shift in all areas to prevention and early intervention models across the life course so that York's population can live healthier, longer lives.

What we said we would deliver	What we have delivered in 2023/24
Tackle multi-morbidity through secondary prevention: strengthen and accelerate our secondary prevention programmes of work for Long Term Conditions (LTCs) and multiple LTCs, and the major conditions strategy.	Accelerated our secondary prevention programmes of work, including Cardio Vascular Disease (CVD) (hypertension treatment to target health inequalities programme and launch of static health kiosks in areas of deprivation), Diabetes (implementation of Locally Enhanced Service and embedding of specialist diabetes nurses), and Respiratory (Population Health Management approach to support Children and Young People (CYP) asthma nurse with spirometry uptake).
Improve prevention and early intervention pathways: inform modifications to services and pathways to strengthen secondary prevention services to increase early diagnoses and undertake more secondary prevention work.	As above, we have accelerated our secondary prevention programme working closely with partners to embed secondary prevention approaches and support Practices with COVID recovery. Work has begun in year to scope our integrated prevention approach for the city, including contract reviews and reviewing the prevention workforce across the YHCP. This will continue into 2024/25. A series of Population Health Management (PHM) projects are also being delivered by the York Place team to test and develop our approach to PHM, including Waiting Well (delivered jointly with Nimbuscare), the Brain Health Café (delivered jointly with Dementia Forward) and the Proactive Social Prescribing project (delivered jointly with York CVS).
Improve our PHM infrastructure and capabilities: York PHH will work with partners to develop our PHM infrastructure and capabilities to strengthen Information Governance (IG) and digital and data infrastructure.	Strengthened collaboration between PHH and GP Business Intelligence (BI) leads to embed PHM work in Practices. Developed information sharing charter, learning from the Humber, to be embedded across York Place.
Improve intelligence: York PHH will provide access to population health data to understand our population better (including the wider determinants of health), further defining York's CORE20Plus5 population.	The PHH has produced multi-agency analysis on the cost-of-living crisis to demonstrate the impact on our citizens and areas of focus for the city. The PHH has also updated the Core20PLUS5 profile for adults to provide a comprehensive overview of this population to be used in service planning and delivery.
Embed prevention and early intervention models through an integrated offer across the system: influence, secure and ringfence recurrent prevention budgets. Lead conversations for the strategic commissioning of services across sectors which tackle health inequalities.	As above, work has begun on scoping our integrated prevention offer for the city which will influence the delivery of prevention services in the future. We have commissioned and delivered a series of health inequalities projects across partners including Refugee Action York, Nimbuscare, York & Scarborough Teaching Hospitals Foundation Trust, Public Health, and York CVS.

	Designed a primary and secondary care health inequalities training programme to be delivered to health inequalities leaders in 2024/25.

Case study: Spotlight on proactive case management

York Centre for Voluntary Service, City of York Council Public Health, the ICB and general practice are working together to deliver a proactive social prescribing project, made possible through a bespoke pot of funding from the ICB's personalised care team. The project focusses on improving outcomes for people with respiratory conditions who are likely to be affected by the cost-of-living crisis through proactive case identification and management.

Using specialist clinical and public health advice, this group of individuals were chosen due to the impact that the cost-of-living crisis may have on their conditions, for example, through living in a cold home or not being able to afford a prescription. It was also identified that respiratory conditions can exacerbate over the winter period and often lead to A&E attendances and non-elective admissions when providers are experiencing significant pressures. Therefore it was agreed that the social prescriber would support these people to manage their conditions safely at home throughout the year to avoid exacerbations over the winter period.

People are proactively identified by primary care through a population health management approach using multi-agency data on respiratory conditions, risk of non-elective admission and postcode (to identify individuals living in areas of deprivation who may be impacted by the cost-of-living crisis). These individuals are then offered interventions from a social prescriber, such as support attending Long Term Condition Reviews, referrals to the CYC Health Trainer team, and empowering individuals to attend community groups for peer support.

The project has received positive feedback received from patients highlighting the impact of personalised social prescribing on their overall well-being. By addressing not only the medical aspects of respiratory health but also considering the wider social determinants, the project aims to enhance the holistic care experience for individuals facing respiratory challenges.

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

The aim of this priority is to ensure that children are at the centre of our city life, and work is done in partnership to raise a healthy generation of children.

What we said we would deliver	What we have delivered in 2023/24
Embed prevention and early intervention models through an integrated offer across the system for children and young people	Children and Young People (CYP) plan developed by City of York Council (CYC) with health input from CYP quality lead and CYP Mental Health commissioner. Family Hubs implementation commenced, and proposal being submitted for health inequalities funding to support a health practitioner role within family hubs. System wide communication and input into the ICB wide Healthier Together webpage/resources including locally produced resources. Integrated Bowel and Bladder workshops for CYP co-designed and co-delivered by Healthy child service and specialist Bowel and bladder nurses. Recommissioned initial health assessments (IHA) for CYP who are looked after to improve timeliness of assessments. Commissioned a second school Mental Health Support Team (Well-Being in Mind) delivered by TEWV. Jointly recommissioned the School Well-Being Service across all York state schools. Baby Friendly Initiative (BFI) funding from York's health inequalities funding led by Public Health – infant feeding lead appointed, and plan being developed to achieve BFI status in city. Early talk for York and More talk for York approach to identifying speech language and communication needs in children and young people. Developing resources to support 'Waiting Well' approach for CYP who are waiting on Speech and Language Therapy (SaLT) or Occupational Therapy (OT) waiting lists. Developed an integrated model of residential and edge of care support for young people who have or at risk of developing complex care and health needs. This 'Together We Can' service is based on a 'no wrong door approach' and benefits from jointly funded and commissioned clinical psychologist and speech and language therapist.

	Special educational needs and disability (SEND) operational plan coproduced and implemented by partners and stakeholders across the city.
Tackle health inequalities using the CORE20PLUS5 approach	CYP Health inequalities delivered to primary care protected learning time. Childrens Alliance and Transformation work: ➢ Asthma-Risk stratification undertaken by ICB CYP asthma team with primary care to identify those CYP locally who need review due to number of short acting beta-agonists, useful medications for supporting people with asthma. ➢ Primary care records and community diagnostics to be used to support diagnosis of CYP with likely asthma but no formal diagnosis yet. ➢ Asthma friendly schools post funded by York's health inequalities money- post currently out to advert with York & Scarborough Teaching Hospitals Foundation Trust. ➢ Epilepsy Mental health screening and psychology intervention pilot locally.
Work across the partnership on models of care, for example establishing a primary care led model for Children and Young People's Mental Health with Nimbuscare, Tees, Esk and Wear Valley and the York & Scarborough Teaching Hospitals Foundation Trust, and the development of family hubs.	School attendance support worker jointly commissioned by York Place and CYC. Family Support Worker jointly commissioned by York Place and CYC to work with children with most complex autism presentations and their families.

Drive social and economic development

This priority will ensure that the YHCP works at the heart of our communities to use and grow the assets we have to improve population health and economic prosperity, maximising our collective capability, working in partnership taking a cradle to career approach. This will support the ICS to meet it's 'Fourth Purpose' to 'help the NHS to support broader social and economic development.' We know that effective action to tackle health issues requires not only a change in health and care services, but for health issues to run as a golden thread through local strategy to ensure all partners are aligned in their direction of travel for our population.

What we said we would deliver	What we have delivered in 2023/24
Infrastructure, Housing and Healthcare developments Work with Public Health colleagues to input into Local Development Plan to influence built environment and public realm as it impacts people's health, including new housing mapping exercise. Work with partners on more joined up, financially sustainable services. Look to invest in health provision in areas where economic regeneration will be supported by health access footfall.	Embedded a robust, consistent response process to new housing developments in order to request funding contributions to mitigate the impact of population increases on Primary Care. Strengthened close working with CYC colleagues to act as ambassadors for health input into the CYC Local Development Plan. Secured Section 106 contributions for a number of development schemes across the city which will be used to support practices either expand, reconfigure, or consolidate existing premises to meet the increased populations.
Workforce, training, and skills Contribute to a city-wide workforce plan, working with our universities and colleges to give us innovative solutions, as well as creating higher-paid research and teaching jobs to boost our economic and wage growth. Collaborate with partners to provide flexible offers for health and care training. Listen to our communities and find local solutions fill local workforce gaps	Local workforce priority actions have been developed around 5 key themes: Recruitment activities and initiatives across health and care partners including care leavers, and the volunteer workforce. Employee of the city – rotational programmes, harmonisation of terms and conditions, development of career pathways Student Placements – innovative ideas to expand placement capacity, retention, guaranteed offers, apprenticeships, and paid internships Understanding the workforce data across health and care partners Key Worker accommodation – exploring opportunities for increased key worker/affordable housing and exploring benefits mitigating affordability to work in York. Partnership Health and Care recruitment event held in West Offices in November 2023. Strengthened relationship with the North Yorkshire and York Workforce Group which has delivered on: • A pilot Legacy Mentoring programmes for all nurses and registered manager in social care. • The development of a platform to provide workforce support to Registered Managers and their management teams in social care.
Supporting social development for vulnerable groups	Continued delivery of health and care provision to support York's asylum seeker population through Refugee Action York and Nimbuscare, including delivery of vaccination programmes with support from Public Health.

Joint partner working on services and support to York Asylum Seekers. Continued delivery of the vaccination programmes to maintain protection in the most vulnerable communities. Work with the York Health and Care Collaborative to understand how we can work in partnership to strengthen our prevention approach and understand the impact of the wider determinants of health.	Delivery of the winter vaccination programme in line with guidance issued by NHS England. The York Health and Care collaborative continue to work across the partnership to identify how collaboration can be strengthened between services across all ages and physical and mental health.
Strengthening links to wider partnership strategy Plan for how Health and Care will contribute to the City's Economic and Climate Change Strategies, building on the work our organisations and HNY ICB are already doing and ensuring health is included in all policies (cleaner air, a cleaner NHS, net carbon zero by 2030, climate resilience, contribution to local skills and employment work)	Established a Health sub-group of the relaunched York Climate Commission Furthered involvement in the Greener General Practice Network Launched a consultation on Air Quality Management Plan 4 Gillygate Air Quality Action plan developed CYC Carbon Reduction Programme including 7x successful Net Zero projects funded 'Fuel for thought' campaign explaining health risks of indoor woodburning Commencement of several employments and health initiatives (WorkWell, IPS) Health and Wellbeing embedded in York and NY Mayoral Combined Authority framework, including pipeline projects for gainshare.

Case study: collaborative work to support asylum seekers with health and care needs

York continues to welcome asylum seekers to the city and as a partnership, the YHCP has been working collaboratively to support these people with their health and care needs.

The ICB and Nimbuscare have delivered bespoke primary care services to people arriving in the city to ensure their initial health and care requirements are met. This includes supporting people with complex issues and trauma through tailored, enhanced support to address their needs effectively, which may not be possible through other services. Translation services are also available to enable people to access care and develop and understanding of how to navigate the health and care system in York. Three of our City Practices have also been closely involved in this programme of work and register all new arrivals so that they are able to access wider health services across the system. Nimbuscare have also focused on young children MMR vaccinations, and Vaccination UK has supported with older groups.

Funded by the YHCP health inequalities budget, Refugee Action York are also working closely with asylum seekers to deliver a health and wellbeing support programme. This includes support for individuals to participate in exercise classes, group sessions on topics such as the menopause and mental health and hiring out community venues for group sport activities.

2. Conclusion

As this report has highlighted, there has been a significant amount of work undertaken by the YHCP and its system teams through 2023/24 to improve the health of people living in York and address health inequalities. The Partnership is strengthening through the integration of teams, and although great progress has been made, we always strive for continuous improvement and now is not a time to be complacent. There are a number of short-term projects outlined in this project which are testing approaches to new models of care as the YHCP goes through a period of growth and transformation. Over the coming years the YHCP will, where possible, look for longer term, sustainable opportunities for evidence-based care models that are effective following thorough evaluation and reduce duplication through consolidation. 2024/25 will see further advancement towards the achievement of our priorities and a continued dedication to improving the health and wellbeing of York's residents.

You may have noticed that there are quite a lot of references to the word **‘hub’** - 37 to be exact! This has developed organically as people come together from different parts of our system to create change to deliver better, more integrated care.

Development of 'Hubs' in York Place

Hubs are multi-agency ‘front doors’ which work together and anchor support to groups of our population with similar needs.

People may work from the same set of buildings and may have standard operating procedures.

There are emerging Hubs for families, mental health, and frailty.

Hubs help connect people to each other, and to the system, and build from the natural communities and capabilities.

3. Joint Forward Plan 2024/25

In 2023/24, with support from each Place and Collaborative the Humber and North Yorkshire Integrated Care Board published its Joint Forward Plan. The aim of the plan is to set out how the ICB, and its Provider Partners will contribute to and deliver the Humber and North Yorkshire Health and Care Partnership strategy and other local priorities over a five-year period.

The Joint Forward Plan includes detail about York's priorities (as outlined in this document). Each Place and Collaborative in the ICB is required to provide an annual update on their priorities and workplan as part of the Joint Forward Plan refresh. The remainder of this document outlines the YHCP's Joint Forward Plan refresh, including an update on our priorities and workplan for 2024/25.

The York Health and Care Partnership's Joint Forward Plan Refresh

Leaders across the YHCP have been working closely to identify a series of Place intentions for 2024/25 to realise our integration capabilities as a whole system. These intentions reflect our strategic plans for the YHCP and underpin the workplan included below.

YHCP strategic intentions for 2024/25: Signal our intentions to increase responsibility for services organised at Place level, taking a phased approach to deepen collaboration, build from experience, and embed learning.

- Take steps to accelerate delivery of shared objectives through joint planning and formalising integration arrangements that is financially better and leads to better outcomes.
- Enable our front-line teams to work to aligned budgets, plans and outcomes, particularly in services which target broadly the same population groups and outcomes.
- Harness the strength of our strong, independent organisations to pool and direct our collective capabilities to deliver for York and represent York in the wider system.
- Work with the other five Place health and care partnerships and ICB via a Strategic Framework.
- Develop a Service Offer which helps to overcome the unprecedented challenges we face and demonstrate the premium of place.
- Strengthen our governance arrangements to make it happen, building shared responsibility for delivery and accountability for outcomes, to shift decision-making to place.

York's Growing and Changing Population

Work undertaken by the York Population Health Hub in 2023/24 has revealed that our population is changing. 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.

Population growth

- The resident population of York is forecast to grow by approximately 35,000 between 2023 and 2033 with the largest percentage increases in the over 65's, an estimated additional 13,800 residents aged 65+ by 2033.
- The GP registered population is forecast to increase from 251,000 (currently) to 255,600 by 2033.

- All health and care services will be put under increasing pressure with an increased and ageing population.

Population health

- In 2022, life expectancy for males declined from a peak of 80.2 years (2019) to 79.2 (2022), and for females declined from a peak of 84.1 years (2019) to 83.3 (2022). Male life expectancy in York has now crept below the national average for the first time (York is 75th out of 148 LAs).
- The number of individuals living with multiple Long-Term Conditions is increasing in York, indicating increased and more complex health and care requirements for these individuals in future years.
- 1 in 9 children in York are living in poverty, and there was a 68% increase in average food bank voucher uptake per 1000 people between 2020/21 and 2022/23.
- As we welcome Refugee and Asylum seeker communities to York the YHCP is required to deliver and adapt services to meet the complex health and care needs of these individuals.

Estates challenges

- Rising demand for care from a growing and ageing population is expected to put pressure on the healthcare estate.
- The combined primary/community care space is estimated to already be approximately 2,500m2 short of current needs; forecasts indicate the overall shortfall in estate capacity will double to 5,500m2 by 2033 (approximately the size of a football pitch).

Engagement

As outlined above, 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. In 2024/25 the YHCP will work to strengthen the sharing of organisation led coproduction and engagement exercises, and organisations should look to work together where possible to undertake this work in partnership.

Healthwatch York will continue to lead on engagement activities across the YHCP in 2024/25 with a focus on access to Primary Care. The work will focus on what is working and where residents would like to see change. The Core Connectors scheme outlined on page 4 will also be a key area of focus for Healthwatch York.

The ICB will continue to undertake engagement activities in York Place, including a key piece of work on NHS 111 to increase awareness and understanding of NHS 111, and to gather greater insight into the local populations' views and experiences of using NHS 111.

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 2024/25. In 2024/25 the YHCP will receive health inequalities funding from the Humber and North Yorkshire ICB to address local need in line with the Core20PLUS5 Framework. Throughout 22/23 and 23/24 the YHCP has

been delivering a series of projects to utilise this funding, demonstrating the key partnership work happening in this area. This work will continue in 2024/25 through the following projects:

- **Maternal and child nutrition** to develop an Infant Feeding Strategy and delivery plan for the improvement of maternal and child health outcomes through better nutrition during preconception, pregnancy, and early childhood to achieve UNICEF Baby Friendly Accreditation for the Healthy Child Service and Primary Care settings across York.
- **Children and Young People's Asthma Friendly Schools project** to reduce health inequalities for CYP with Asthma by ensuring school staff have appropriate training, support, and awareness of CYP Asthma through the employment of a respiratory nurse to provide training across primary and secondary care with a focus on health inequalities.
- **Children and Young People's School Absence Project** supporting Children & Young People with anxiety related school absence, this project aims to reduce absences from school, improve educational outcomes and the social and emotional health and wellbeing of CYP.
- **Brain Health Café** to support individuals on the waiting list for the memory service to embed personalised care approaches for people with cognitive decline and provide support to carers. A population health management approach is planned in 24/25 to ensure those experiencing health inequalities are supported to attend the café.
- **York CVS Ways to Wellbeing Small Grants Programme** providing health inequalities funding into the Programme which funds projects which enhance community connections and improve health and address the causes of health inequalities, particularly in areas of deprivation or for those disadvantaged by inequality in the city.
- **York's second Health and Arts Mela** to support healthcare initiatives at York's second Health and Arts Mela, a multicultural festival bringing York's communities together to celebrate the arts and learn more about the health and care services available in the city.
- **GP outreach for vulnerable women p**roviding preventative health care and support with long term conditions.
- **Raise York Family Hubs health inequalities project,** lacing a paediatric advanced clinical practitioner role in the Family Hubs model that would deliver a range of interventions to build confidence and health literacy in families and help families access support to make best use of community assets.
- **Refugee Action York's** wellbeing and Recreational Activities for Asylum Seekers and newly settled refugees project, providing fortnightly health and wellbeing drop-in sessions, tailored sessions for individual groups, and a wellbeing fund for individuals to apply for to assist with their health and wellbeing.
- **Homelessness provision** providing primary care services to residents at Peasholme and Robinson Court, who are amongst the most deprived population often presenting with complex physical and mental health needs.

These are a series of short-term projects which do not currently have sustainable funding. For 25/26 onwards, the YHCP will explore a more strategic, sustainable approach to reducing health inequalities in York and will ensure this is in line with other policy developments happening in the city.

2024/25 priorities

The priorities set by the YHCP in 2023/24 are long term, transformational ambitions, and will therefore remain the same in 2024/25. The workplan has been updated below to outline our actions for each priority in 2024/25.

Strengthen York's Integrated Community Offer

This priority includes our partnership ambitions to strengthen community integration across health and social care, and physical and mental health.

What will we deliver?	How will we deliver this in 2024/25?
A new Reablement Contract, redesigned specification to ensure we are providing a sustainable, fit for purpose service, achieving best value.	Removing nonvalue added elements of previous contract and strengthening rapid response in reach to support earlier transfers of care for hospital inpatients. Working with providers to create a truly integrated model, making best use of collective resource across the system Reinvesting monies into other areas of the system to make the biggest impact.
Fully integrated Discharge to Assess Model	Work with local authority and YSFT colleagues to design and deliver a discharge to assess model that will redesign the way our community health and 'block booked' care beds operate to support the new model. This will have the biggest impact on reducing delays for hospital inpatients who are medically fit and ready to leave hospital.
Integration of Community Services	Co-design of community health 'non bedded' services led by voluntary sector, primary care, community health and York hospital. Providers will work together to design a model that delivers better outcomes for York's older population living with frailty and/or people of working age who are vulnerable or need time-limited extra support. Core functions will include anticipatory care, proactive admission avoidance, and pulling people out of hospital as soon as hospital teams give the green light to transfer.
Realign existing resources to facilitate seamless support for people with dementia and their carers in the community.	Work towards delivering a model that includes: • Memory Support Advisers- identification, and early intervention • Support for Carers • Mental health care and treatment • General health care and treatment, including a holistic annual review • Therapeutic interventions, for example cognitive rehabilitation • Dementia friendly environments

St Leonard's Hospice leading work to review end of life care pathways and processes	In 2024/25, YHCP will support St Leonard's hospice to continue to lead the review of pathways and processes and crucially, will ensure that integrated working between the trust and the hospice is central to everything we do. This will ensure that the appropriate people have access to hospice care when they need it on discharge from hospital. This integrated way of working has already commenced with hospice partners having active involvement in the MDT structure aligned to the new discharge improvement process.
Continue to work in partnership to support implementation and expansion of Mental Health Community Hubs.	Transfer learning from pilot into a permanent home. Recruitment is commencing for clinical, social worker and Voluntary, Community and Social Enterprise sector (VCSE) staff with the aim of the hub being opened in April 2024. Evaluating by use of outcome measures as well as service user feedback and continuing to use the model of co production and co design with involvement from the co design group in the evaluation.

What will this mean for our population over the next five years?

- Greater access to personalised support and integrated care outside of hospital care for physical and mental health
- Tailored support that helps people live well and independently at home for longer
- Timely support and follow-up from all sectors to reduce the risk of deterioration, embedding a preventative approach
- Increased rapid support to frailty clinicians.
- Greater education of individuals care needs and empowering/giving patients/carers opportunities to be actively involved in their own health management.

Implement an integrated Urgent and Emergency Care Offer for York

What will we deliver?	How will we deliver this in 2024/25?
With mobilisation of GP OOH and Urgent Treatment Centres at Scarborough, Malton, and York due to start 2nd April and an expectation that new providers will settle in from April – June 2024, all partners expect to realise the ambition, transformation, and benefits of an integrated urgent care service ahead of winter 2024/25.	York & Scarborough Hospitals Trust are now working closely with local GPs in Scarborough, Whitby, York, and Selby, as well as with Nimbuscare to understand how to join up the different contractual responsibilities into a single joined up 24/7 urgent care service. UEC Improvement Plan: Multi-Disciplinary work making incremental improvements to capacity, processes, and

	pathways, led by hospital clinical, professional, and operational leads.
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.	Following the success of the Frailty Crisis Response Hub in 2023/34, in 2024/25 we plan to integrate the service into a co designed community health model which meets future needs and benefits from the combined resources of the general practice, voluntary sector, social care and community health, ambulance, and hospital services. This will enable the Advice & Guidance Line to be included on the Yorkshire Ambulance Service Directory of Services. Continuing to enhance the service through the implementation of step-up pathways, improving links between the hub and other community-based services, and better resourcing the clinical visiting capacity of our Urgent Community Response Team, will ensure the hub is able to effectively and safely support frail and vulnerable people to remain at home and avoid unnecessary ED attendances, benefitting the local frail population and increasing confidence in the service and therefore utilisation.
Building 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.	Development of additional direct access pathways to SDEC from primary care and the Frailty Crisis Response Hub to reduce delays for patients and bypass busy ED departments. Work with system partners to explore opportunities to enhance clinical assessment in the Yorkshire Ambulance Service Control Room.

What will this mean for our population over the next five years?

- A safe, reliable, and resilient service where duplication is reduced, providing remote visits on a 24/7 basis, through a flexible workforce which maximises finite clinical skills and experience whilst also being cost effective.
- Right care, right place, right time: a better experience for patients and reducing pressure on inpatient beds
- Improving ambulance handovers will reduce time spent waiting at ED and support patients to remain, or return home sooner, and safely.

Further develop Primary/Secondary shared-care models

What will we deliver?	How will we deliver this 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 ICB is evaluating shared care models at Place with a view to scaling up these models where clinically appropriate.
Bring more pathways on board with Referral for Expert Input to facilitate shared care pathways.	Continue to explore options with York and Scarborough Hospitals clinicians and GPs to mobilise more pathways on REI. Potential expansion into cardiology, gastroenterology, respiratory, gynaecology, paediatrics, and Ear Nose Throat (ENT).
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.	Continue to develop our clinically led Interface Groups with senior leadership from partner organisations, plus engagement with Hospital Specialty leads and GP's.
As per the Delivery Plan for Recovering Access to Primary Care - cut bureaucracy and reduce the workload across the interface between primary and secondary care, and the burden of medical evidence requests so practices have more time to meet the clinical needs of their patients.	Key programme areas: • Onward referrals • Fit notes and discharge letters • Call and recall • Clear points of contact

What will this mean for our population over the next five years?

- Shared care models will significantly reduce hand-offs between primary and secondary care, increase agency for the patient/carer, and significantly reduce waiting times for non-admitted treatment.
- The development of more integrated Primary/Secondary Care services and pathways will mean that patients receive a more seamless and holistic care experience – with specialist advice/input where needed – with less need to attend Hospital Outpatient clinics.

Embed an integrated prevention and early intervention model

What will we deliver?	How will we deliver this in 2024/25?
Delivery of Secondary Prevention Programme	Continued delivery of the LTC programme with a specific focus on strengthening collaboration with primary care providers for streamlined disease management. Improve prevention and early intervention pathways: inform modifications to services and pathways to strengthen secondary prevention services to increase early diagnoses and undertake more secondary prevention work.
Delivery of Population Health Management Programme	Continue to develop and pilot a series of population health management projects to improve access and outcomes for targeted cohorts of our population, and to inform our future approach to population health management in future commissioning of services.
Integrated Prevention Scoping Offer	Scope what an integrated, multi-agency prevention offer should look like for York and make recommendations to the Place Board on future service provision. Influence and aim to preserve prevention budgets. Lead conversations for the strategic commissioning of services across sectors which focus on prevention and tackle health inequalities.
Continue to strengthen the York Population Health Hub PHM Infrastructure / Analysis	Support the development of PHM infrastructure and delivery across the partnership, with a specific focus on supporting secondary care and TEWV. Enable the system to undertake PHM approaches through lunch and learns and bespoke support to teams. Build our data sharing capabilities through finalization of the Information Sharing Charter.
Accelerated delivery of the Health Inequalities Programme	Delivery and evaluation of 2022-2024 projects. Inform longer term use of health inequalities funding from 25/26 in line with the partnerships' strategic ambitions and based on 2022-2024 project evaluation. Delivery of primary and secondary care health inequalities training Programme.

	Support development of Health Inequalities champions network in York with representation from all partners.
Strengthen the city-wide Integrated Neighbourhood early intervention and prevention system	A city-wide Integrated Neighbourhood early intervention and prevention system, aligned and joining up primary care, council, community, health, and care, with a single consistent and effective offer that shares culture, behaviours, is an easy-to-navigate/simple pathway from referral through signposting and/or interventions (including through council customer services), with commissioners, including PCNs, delivering within the same model, targeted towards areas of most need.

What will this mean for our population over the next five years?

- We are making progress towards becoming a health generating city focussed on prevention, where people can find wellness and connection in their communities.
- We have developed a community of population health and health inequalities champions across the health and care system who are enabled to reduce health inequalities and improve population health both in their organisations and through integrated system working.
- Health inequalities are narrowing through the delivery of a series of projects that are improving health access and outcomes for individuals who experience health inequalities.

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

What will we deliver?	How will we deliver this in 2024/25?
Support for our schools to support CYP with Asthma to fully participate in school life and manage symptoms to ensure CYP can achieve optimal outcomes	Commissioned Asthma Friendly School (AFS) project nurse to work in partnership with CYC LA and Multi Academy Trusts to become accredited as AFS.
Continue to develop the integrated offer for support to children who experience difficulties with bowel and bladder function	Develop additional workshops and targeted support for CYP with additional needs or who are neurodiverse and need more bespoke advice and support. Continue to work with colleagues in primary care and healthy child service to ensure they have the right knowledge and support to deliver the Tier 1 level of advice and support in the community.

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 and assessment and intervention is undertaken using the iThrive approach – ensuring all workforce and community can support children with their SLCN Early Talk for York approach to reducing SLCN disadvantage that is experienced by children living in areas of deprivation. This could be upscaled and its reach extended if additional funding agreed by system partners.	Review current arrangements for SaLT commissioning which is majority NHS commissioned including service specification for NHS SaLT and consider potential for joint commissioning between education/settings and NHS. Work with partners to agree a model for joint commissioning of SaLT services that will meet local needs. Health inequalities funding being utilised to develop universal resources for speech and language support. NHS SaLT service transformation to continue including the introduction of a SaLT early help and support telephone line for parents/carers and education.
Reduce barriers that CYP who are neurodiverse experience in relation to school attendance	Roll out the Partnership for Inclusion of Neurodiversity (PINS) in selected York Schools alongside CYC commissioned Neurodiversity in Schools' support. Complete the transformation of Making Sense Together service (Occupational Therapy dept Y&SFT) which includes developing resources to support CYP with sensory processing difficulties. Health inequalities funding towards the joint commissioning of family and school link worker when CYP are experiencing school attendance issues (1 year proof of concept to be evaluated and jointly determined, if possible, to expand and continue joint commissioning).
Consider an improved integrated approach to SEND (special educational needs and disabilities) using a Family Hub approach and coproducing services with children and families Increase support for children and young people with autism with the most complex needs	Senior leaders across York Health and Care Partnership will work collaboratively to review current arrangements and consider joint commissioning possibilities to support CYP who have SEND using Childrens and Families Act and SEND Code of Practice to inform decisions. Autism Service Development Funding to pilot a family support worker based at the Beehive to work alongside the psychology- led FIRST: Family Intensive Rapid Intervention Service with the aim of improving participation at school and in community settings.
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.	Continue to build on the newly established ICB CYP Integrated Start Well Board, developing an operation model which clearly defines strategies across the ICB footprint with

	those which are best delivered at Place. A clear governance and meeting structure will be developed.

What will this mean for our population over the next five years?

- We are making progress towards becoming a health generating city focussed on prevention where children, young people and their families are supported, care is seamless and early intervention is prioritised.
- Children and young people are at the heart of our city life, where good health and wellbeing is priorities from birth.
- CYC Schools will be AFS accredited and CYP in York with diagnosis of asthma will have a Personalised Asthma Action Plan
- CYP will be supported throughout their developmental stages to develop SLC skills with a workforce that is skilled and trained in early intervention and assessment thus reducing need for individual specialist intervention.
- Parents/carers/education staff have timely access to specialist SaLT advice.
- CYP who are neurodiverse feel supported in education settings to thrive and achieve their desired outcomes and parents report that they are confident in schools/settings managing their child's needs.
- Increase in school attendance for CYP who are neurodiverse or experience anxiety in attending school.
- Education staff and parents/carers have training and resources to use to support CYP to improve school attendance.

Driving social and economic development

What will we deliver?	How will we deliver this in 2024/25?
Infrastructure, Housing and Healthcare developments	Partners to describe the City's future service delivery model for health, care, and prevention, and how estate/infrastructure might be shaped to enable this, to inform a tactical estates plan and delivery group. Ensuring responses to housing developments are timely, robust, and consistent in their approach. We will work with Public Health colleagues, CYC planning officers and local councillors to continue to identify housing development sites and ensure objections are raised.

	We will work more closely with local councillors to ensure good lines of communication, and clear expectations, are set at an early stage in matters that could affect Primary Care estates (e.g. branch closures or other changes to service). Through strong, ongoing communication and transparency with wider stakeholders, and further development of the relationship building, and closer ties forged within the York Health and Care Partnership in 2023.
Workforce, training, and skills	Progress the work on the workforce 5 priority actions (recruitment activities, Employee of the city, student placements, understanding workforce data and key worker accommodation) through the North Yorkshire and York Workforce Group: Launch of the Registered Managers workspace which will provide support to the sector across a range of workforce issues. Continue to engage with social care providers to understand and seek solutions to their workforce challenges. Support health and care organisations adopt the principles of the Care Leaver Covenant and/or the Care Leaver Friendly Employer Charter. Increase support to social care providers in the York Place area to recruit necessary workforce, working in partnership with Job Centre Plus. Actively participate in the ICB's Workforce Breakthrough programme for 2024/25. Build student provision into all commissioned services as part of workforce development.
Supporting social development for vulnerable groups	Continue to deliver health and social support to York's asylum seeker communities. Continue to deliver a series of health inequalities projects aimed at support social development for vulnerable groups, for example supporting the York CVS Ways to Wellbeing Grant Programme.
Strengthening links to wider partnership strategy	Develop approach to tackling issues with keyworker housing in the city, including developing a number of projects jointly between CYC and health partners to unlock accommodation / bridge affordability gaps for healthcare sector workers. Continue to work through the York Economic Strategy on inclusive economic growth, including promoting the Good Business Charter within health and care sectors.

	Contribute to the development of the Y+NY MCA economic framework, including shaping plans for investment of combined authority resource in a way which shapes community health. Take bold action to support the Council Plan on climate change, for example explore how joint solutions can be found to reduce the number of HGVs in the city centre to reduce emissions and therefore improve air quality. Successfully commence key work and health schemes, e.g. IPS in drugs/alcohol and mental health, and the WorkWell initiative. Participate in the University of York's study focussed on system Integration through Network Governance in NHS Place Committees. This research 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.

What will this mean for our population over the next five years?

- We are working towards better, joined up services for health and care with sustainable future provision of health and care.
- The holistic needs of patients are being considered through our understanding the wider determinants of health.
- Working towards improved population health through the YHCP using and growing its health assets and collective resources.