Annex 2:

Integration and Better Care Fund

Better Care Fund 2025-26 HWB submission

Narrative plan template

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

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

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

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

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

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

Section 1: Overview of BCF Plan

This should include:

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

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

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

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

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

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

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

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

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

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

- Changes in eligibility criteria for intermediate care and reablement.

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

- Amalgamation of current intermediate care services.

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

- Review of the discharge hub to develop an integrated hub

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

- Intermediate care and reablement alignment

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

- Embed home first approaches across the discharge pathways

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

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

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

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

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

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

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

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

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

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

- Integrate a holistic mental health offer into our community services

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

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

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

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

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

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

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

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

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

Key ways the Frailty Hub is enhancing this partnership include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Rapid Assessment Team Service (RATS)

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

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

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

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

3. York Integrated Care Team

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

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

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

4. York Frailty Crisis Response Hub

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

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

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

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

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

5. York Integrated Care Team In-Reach Model.

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

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

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

The three scheme areas within the BCF are:

- Early Invention and Prevention

<u>Proactive anticipatory care</u>

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

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

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

Integrated Community Frailty Service MDT

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

Step Up / Step Down Bridging Care

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

Championing and Supporting the Role of the Voluntary Sector

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 3: Local priorities and duties

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

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

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

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

Population Health and Health Inequalities

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

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

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

Our approach across Humber and North Yorkshire

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

Our Strategic Priorities are -

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

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

Our approach in York

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

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

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

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

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

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

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

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

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

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

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

- Funding to support alcohol-related harm and misuse

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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