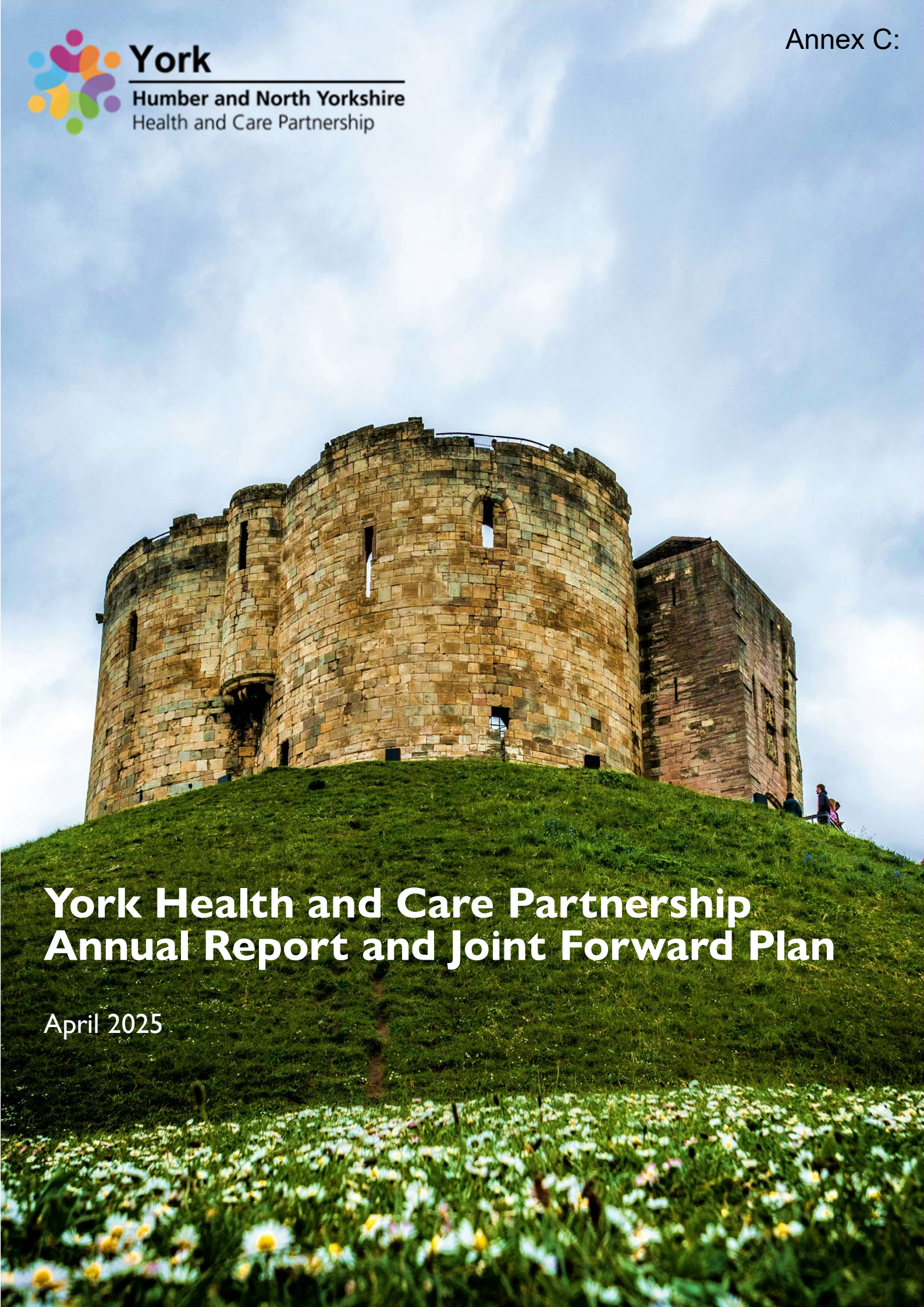
Annex C:

York
Humber and North Yorkshire
Health and Care Partnership



York Health and Care Partnership Annual Report and Joint Forward Plan

April 2025

1. Introduction

1.1 Context

2024-25 has been a year of significant development in our Health and Care Partnership. We have made substantial progress against the plans we set out this time last year and are now in a position to further focus our plans and priorities for 2025-26. We've strengthened our partnership working, with a joint committee between Humber and North Yorkshire Integrated Care Board (ICB) and City of York Council (CYC) set to be established for 2025-26. As a place partnership, we are committed to improving health and wellbeing outcomes for the people of York. We will make York a healthier and fairer city to live and work in, for current and future generations.

This report serves two purposes – a look back at our achievements and progress against our 2024-25 plans, and a forward plan of what we will prioritise and act on in 2025-26.

The government's 10 Year Health Plan, to be published in the spring 2025, will set out the three big shifts our NHS needs to be fit for the future:

- from hospital to community
- from analogue to digital
- from sickness to prevention.

Joint commissioning of effective and efficient out of hospital and prevention services is an important initial step in delivering these left shifts. We believe the plans and priorities that we have set for 2025-26 are well aligned with these three big shifts and will be the right ones to start delivering on the 10 Year Health Plan for York.

1.2 York Health and Care Partnership (YHCP)

The Humber and North Yorkshire Health and Care Partnership (HNY) is the Integrated Care System (ICS) which plans healthcare in our region. Within this partnership, York sits as one of six 'Places'. You can find out more about the Humber and North Yorkshire Partnership here. In York, our Place Partnership is called the York Health and Care Partnership (YHCP). The YHCP brings together a collection of partner organisations to collaboratively improve health and care outcomes and service provision in York.

2025-26 will mark a new era in partnership working as we formalise our collaboration under a revised Partnership Agreement. The agreement sets out the Partnership's objectives and priorities and the role and responsibility of senior leaders to work with and on behalf of the wider health and care partnership in addition to their organisational responsibilities.

Locally, the ICB's operating model of six places recognises delegation to place as key to planning and commissioning on a local footprint, informed by the needs of our local population. The development of a joint committee in York from 2025 will allow us to set out how we will plan and commission services together.

This sets the foundation for integration and transformation of health and social care to reduce health inequalities and improve the health of York's population. However, we recognise that this is a step in a longer-term journey towards partnership working and integration of services to ensure an effective and

sustainable health and care system for future generations. There is much further to go, and our 2025-26 plans in this document are part of that journey.

2024-25 has been a busy, challenging, and exciting year for the YHCP. Health and Care organisations in York are continuing to develop strong, multi-agency system teams to meet the health and social needs of our residents and, whilst we always strive for continuous improvement, significant progress has been made towards delivering our priorities in 2024-25.

1.3 Our purpose and priorities

The purpose of the YHCP is to reduce health inequalities and increase healthy years lived for people in York, by working together to address the wider determinants of health. We want to improve people's lives by providing the right support at the right time, to ensure everyone can have a happy and healthy life in York. We share the ambitions highlighted in the Joint Local Health and Wellbeing Strategy and are working in partnership to deliver the six big ambitions and ten big goals for York.

In 2023, YHCP identified six priorities to be delivered collaboratively, focused on strengthening integration, reducing health inequalities, and improving population health for people who live in York. The priorities support delivery of the Joint Health and Wellbeing Strategy for York, as well as contributing to the delivery of the Humber and North Yorkshire Health and Care Partnership Strategy.

The six key priorities for 2023 to 2025 were:

For 2025-26, we have refreshed our priorities and will focus on the following areas:

Accelerating Healthy Communities

Our overarching priority to transform how we operate together to deliver a new model of neighbourhood health, care and provision in the City for future generations.

Realising the benefits of Joint Commissioning for York's people

Including community equipment, Continuing Healthcare, Adult Social Care, addressing areas of duplication, a sustainable model for Community Mental Health, Better Care Fund.

Deliver our vision for an integrated neighbourhood model

Incorporating community, primary care, mental health and prevention, alongside an aligned partnership approach to workforce and estates.

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

Create capacity through a joint commissioning approach, including a sustainable model for family and Special Educational Needs and Disabilities hubs.

1.4 Key achievements in 2024-25

Achievements against our priorities in 2024-25 include:

- **Launch of the first Mental Health hub**: The Hub offers flexible mental health and wellbeing support tailored to the diverse challenges individuals face. It connects people to their local communities to support them to achieve the goals they identify to improve their mental health. This approach enables early intervention, preventing declines in mental health. The long-term goal is to establish three fully integrated Mental Health Hubs across the city, seamlessly linking with existing mental health services in York.
- **Expansion of the York Integrated Frailty Crisis Response Hub**: Now operating seven days a week, the hub allows multi-disciplinary teams to manage frail and vulnerable patients in their homes, reducing the need for hospital admissions. The hub, first introduced in November 2023, has expanded to support around 7,300 crisis cases per year. This has prevented 2,920 Emergency Department (ED) attendances. Case studies demonstrate improved outcomes for patients and their families and a significant time saving across local services.
- **Enhanced Health and Social Care Integration**: Our collaborative approach has streamlined hospital discharge processes and invested in "home first" care and support, leading to more patients who no longer require medical care being able to leave hospital much sooner compared to the previous year, and remain independent in their own homes.
- **Improved Support for Children and Young People**: Through the Asthma Friendly Schools project and establishment of a Reintegration Support Worker to improve school attendance for children and young people with autism and anxiety.
- **Addressing Health Inequities**: A range of initiatives have focused on supporting vulnerable populations in York, including social and wellbeing activities for asylum seekers and GP outreach services for women with urgent healthcare needs who struggle to access existing care.
- **Support for People with Cognitive Impairment and Dementia**: We've developed a more integrated Dementia Community Support model, combining resources across health and social care to offer comprehensive support both before and after diagnosis.
- **A second Brain Health Café** has been launched to assist individuals with mild cognitive impairment, offering a supportive space for those waiting for memory service assessments or those considering seeking a diagnosis.
- **Our Neighbourhood Model**: We've laid the groundwork for how services will look and feel in future for residents and practitioners, through co-creation of a set of guiding principles, shaped with over 200 front line leaders from across 30 local health, council, and partner organisations.

1.5 Engagement in 2024-25

The organisations that make up the YHCP all undertake their own engagement and coproduction exercises to ensure that services are developed alongside the people who will be using them, and the Partnership continues to benefit from this work when organisations share their findings and best practice around coproduction. As a key strategic partner of the YHCP, Healthwatch York (HWY) have continued

to champion the voice of people in York and ensure that people's views are captured to influence and shape local health and care services. Key highlights from Healthwatch York's work include:

Publication of the Core Connectors report which has provided valuable insights into young people's experiences of health and social care in York. Core Connectors are young people aged 16–25 who help other young people have their voices heard. The report highlighted many factors that are adversely impacting upon young people's physical and mental health including the cost of living, long waiting times, and challenges around social and family connections.

Publication of the Listening to Neurodivergent Families report in partnership with the Land, York Carers Centre, York Disability Rights Forum and Parent Carer Forum York in January 2025.

Publication of Exploring access to GP services in York - Interim report, in September 2024.

Publication of Migrant Healthcare Experiences in June 2024.

Enter and View Reports including Riverside Care Complex, Ebor and Birchlands Care Home reports. Themes include quality of life, quality of care and health checks.

Publication of What we are hearing April to June 2024, a quarterly report sharing what people have said from April to June 2024 across various areas of health services including hospital, GPs, mental health care and dentistry.

Wider engagement has taken place across the ICB called 'We Need To Talk.' Three priorities were published in the February 2025 report including (1) the need to improve access to services due to long waiting times; (2) develop a person centred approach including more integrated care delivery; and (3) having enough staff with the right skills and experience to support our population.

1.6 Reducing Health Inequalities

The YHCP has continued to deliver projects that target health inequalities, and they have been evaluated to inform plans in 2025-26. The York Population Health Hub has produced Core20PLUS5 profiles for Adults and Children and Young People, outlining the groups who are most likely to experience health inequalities in the city.

Case study

Inclusion Health Register Pilot in York - A Pioneering Approach to Equity in Healthcare

The Inclusion Health Register Pilot in York represents an innovative, data-driven approach to identifying some of the most vulnerable populations within the healthcare system. Designed to better recognise, track, and support Inclusion Health groups—including veterans, people experiencing homelessness, Gypsy, Roma and Traveller communities, potentially vulnerable migrants, and other at-risk populations—the pilot has demonstrated significant early benefits. The aim is to refine the model in York before scaling it across the wider Integrated Care Board (ICB) footprint.

The pilot is focusing on increasing the identification and coding of patients within Inclusion Health groups across participating practices. The initiative has driven a notable 32.18% increase in the total number of patients coded under these categories, equating to an additional 2,667 individuals now formally recognised

within the system. This progress is particularly encouraging as it lays the groundwork for better-targeted interventions and resource allocation.

Positive outcomes demonstrated by the pilot include:

- Increased Visibility of Vulnerable Groups: The growing number of patients coded within Inclusion Health categories ensures that these groups are no longer invisible within the healthcare system. This visibility allows for more tailored care pathways and targeted interventions.
- Data-Driven Decision Making: The insights gained from register trends help inform future healthcare planning, ensuring that resources are directed towards the populations with the greatest need.
- Gypsy, Roma and Traveller Communities: targeted work from January to March 2025 has led to more than a 200% increase in registrations amongst this population. Registrations rose from 103 to 313 between February and April 2025.

Case Study

Proactive Social Prescribing

The Proactive Social Prescriber (PSP) works across Primary Care Networks in York, contacting people directly, based on analysis and identification of people who might benefit from support. This analysis was developed through an algorithm in Year 1 and by individual Primary Care Networks in Year 2.

By proactively reaching out to individuals with respiratory conditions and tailoring support to their unique needs, the PSP bridges critical gaps between clinical services and social support networks. The initiative addresses challenges like social isolation and digital exclusion, which are often overlooked but can significantly impact health outcomes. The PSP connects people to support from established organisations as well as grassroots services that can offer a range of support for individuals.

Through an initial phone call, the PSP offers to meet people in a way that is accessible, familiar and safe for them, either over the phone or through face-to-face meetings (for example, in a local, familiar café or community centre). The PSP prioritises what matters to each person and what challenges they face and supports them to develop a mutually agreed personalised care plan, connecting each individual to a range of support, which could include mental health support, access to groups and activities, physiotherapy, occupational therapy, or services that can advise on benefits, housing, employment or smoking cessation.

The PSP uses a person-centred approach, giving choice and control back to people and attempting to educate and improve confidence in healthcare.

1.7 Delivery through the Charter of Behaviours

The Partnership has committed to a set of principles that will guide partners in our work.

We are in it together - We agree that we will have a robust airing of views, but that once our Partnership has reached a decision, we will all abide by that decision and support it publicly.

We will trust in people - We agree to openly discuss all matters that affect our ability to make firm decisions, including any conflicts of interest and any limits on our mandate (where we carry these from participant organisations), so that all members of our team are fully aware of any restrictions, caveats or further authority that may be required.

We will be permission-giving and empower staff - We will support our teams, and professional / clinically led service development. We will deliberately try to enable decisions to be made by 'front-line' staff by saying 'yes' to their solutions. We will promote an environment of high quality and low bureaucracy. We will recognise that Health and Care rises and falls on staff wellbeing.

We are person-centred - Recognising the diversity of our population we will develop solutions that are 'bespoke by default' focussing on understanding the needs of our residents. We will put people at the centre of decision making and be able to question where we think this is not the happening.

We will free the power of the community – People and patients will be actively involved in the system, providing feedback, supporting and leading change.

We are committed to improving population health - We recognise the significant health inequalities experienced across the city. We recognise the upmost importance of working to address these inequalities and support vulnerable individuals and populations when participating in our activities.

We will connect clinicians and professionals - We are committed to strengthening the connections between clinicians and professionals from primary and secondary care, nursing and social care, and the voluntary sector. Staff are empowered to make the right decisions without bureaucracy getting in the way and will understand the system as a whole.

Our finances will align - We will explore ways in which we can use our collective resources to the best possible effect for the population. We will strive to understand the consequences of our decisions on all partners and manage any repercussions so as not to destabilise any organisation and manage risk collectively.

We are open – We will operate with transparency, honesty, shared accountability and clear decision-making mechanisms.

2. Delivery against our six priorities in 2024-25

This section of the document provides an update towards the delivery of our six priorities in 2024-25. We have looked back at what we said we would deliver in our joint workplan and provided an update against each of these actions.

2.1 Strengthen York's Integrated Community Offer

This priority includes our ambitions to strengthen community integration across health and social care, and physical and mental health. The aim of this work is to improve models of community-based support which are preventative, so people do not need to seek professional help so often and can find mental wellness in connections and communities.

What we said we would deliver	What we have delivered in 2024-25
A new Reablement Contract, redesigned specification to ensure we are providing a sustainable, fit for purpose service, achieving best value	A revised reablement service specification was developed collaboratively by colleagues working across both the ICB and council, with a greater focus on integrated working, restoring patient independence, and a more seamless integrated discharge pathway. Since the new contract was implemented there has been a notable increase in service utilisation, with more individuals receiving reablement care upon discharge and as part of community step-up services.
Fully integrated Discharge to Assess Model	In June 2024, the Pathway 1 Bridging Service was commissioned, which employs a discharge care coordinator to carry out a short in-hospital assessment for immediate short-term needs and manage the rapid transfer to home. Initial results have been excellent, with most patients on this pathway being discharged within one day, and many patients seeing a reduction in the care needs previously identified whilst they were in hospital. Discharge to assess pathways were agreed in principle at a partner workshop in November, with implementation of integrated discharge hubs identified as key to implementing this model. Integrated discharge hubs are due to be implemented by September 2025 and the continued development of this model is a key priority for 2025-26.
Integration of Community Services	The York Integrated Community Model Joint Delivery Board was formed at the end of November to oversee the co-design and implementation of a new model for community health services that moves away from multiple, fragmented services and towards a more unified, system-wide approach.

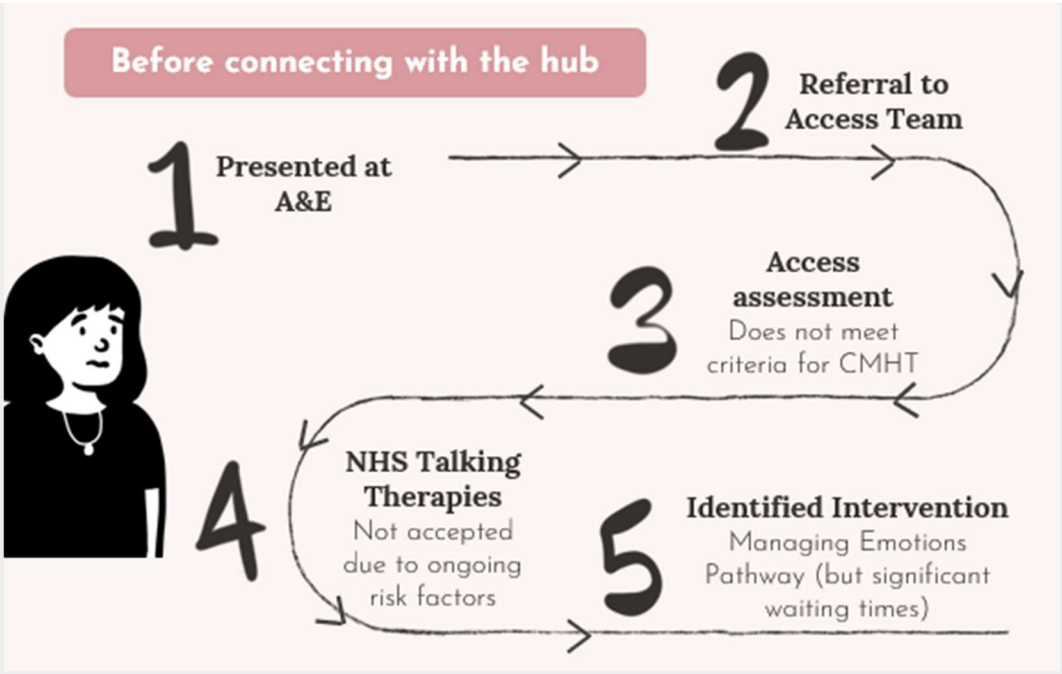
	The group has developed a proposal for York's future integrated community model which aims to reduce duplication, ensure care is delivered in the right place at the right time (with more care provided in the community and in patients' own homes), and deliver better patient outcomes while improving value for money. The next steps will be to finalise an action plan and timeline.
Realign existing resources to facilitate seamless support for people with dementia and their carers in the community	We have worked with Dementia Forward to combine the various health and social care funding streams to develop one joint agreement from 1st April 2025 that describes a complete wrap around support offer for people on the Dementia Pathway both pre and post diagnosis. The West Outer Primary Care Network (PCN) pilot for primary care diagnosis progressed well. Approximately 40 cases were redirected from the Tees Esk and Wear Valleys NHS Foundation Trust (TEWV) waiting list to the primary care Multi-Disciplinary Team (MDT). This is expected to have a further positive impact upon patient outcomes, reduced waiting times for memory clinic diagnosis, and an increase in the future overall diagnosis rate.
St Leonard's Hospice leading work to review end of life care pathways and processes	Progress to improve access has been made in a range of areas including: • As well as accepting referrals from the Specialist Palliative Care Team (SPCT) in the hospital, referrals are now taken directly from the hospital discharge liaison. • Improved communication with the hospital discharge team regarding capacity within the hospice at home (community care) team. • Co-location of hospice staff within the hospital discharge team to forge stronger connections and referral to hospice services when patients are imminently dying and would benefit from hospice care.

Continue to work in partnership to support implementation and expansion of Mental Health Community Hubs	Our first Community Mental Health Hub opened in June 2024 and is now a fully established multidisciplinary team. The team is made up of social prescribers, peer support workers, mental health practitioners, carer support workers, a social care worker, recovery workers and volunteers. The hub provides mental health and wellbeing support to address the range of challenges people face, in a flexible manner to connect people with their local communities. Ongoing evaluation, led by a PhD student at York St John University and supported by external evaluators, is shaping the hub's development based on data-driven insights. Monthly Conversation Cafés also provide a platform for ongoing community feedback and engagement. Funding for a 24/7 Neighbourhood Community Mental Health Centre as part of a national pilot has been secured. A second codesign process has been complete for the development of the 24/7 hub which incorporates individuals with lived experience, practitioners and those from the local community. The Centre will open in Acomb in June 2025.

Case Study

York Community Mental Health Hubs

The Hub is a team made up of social prescribers, peer support workers, mental health practitioners, carer support workers, social care worker, recovery workers and volunteers. Hub users have told us that the hub has positively impacted upon their lives: *"You have opened your hands and your hearts"* and *"You've made a huge difference to my life."* Martha's journey further illustrates how the Hub provides mental health and wellbeing support in a flexible manner to connect people with their local communities.



* *Note CMHT – Community Mental Health Team*

2.2 Implement an integrated Urgent and Emergency Care Offer for York

What we said we would deliver	What we have delivered in 2024-25
With mobilisation of GP Out of Hours (OOH) and Urgent Treatment Centres (UTCs) at Scarborough, Malton, and York all partners expect to realise the ambition, transformation, and benefits of an integrated urgent care service ahead of winter 2024-25.	York and Scarborough Teaching Hospitals NHS Foundation Trust have worked closely with local GPs in Scarborough, Whitby, York, and Selby, as well as with Nimbuscare to implement a single joined up 24/7 urgent care service. The first year of the new GP Out of Hours contract has delivered clear and measurable improvements, including consistently improved shift fill rates, timely call-back performance, positive patient feedback, reductions in emergency department referrals and hospital admissions, and enhanced incident reporting.
Build on the momentum generated at the Urgent and Emergency Care Summit in February 2024, work with system partners to implement the agreed outputs, including a review of the pathways into and out of hospital-based services supporting ED, including the Urgent Treatment Centre, and Speciality-led Same Day Emergency Care services to support effective emergency flow, and build on the success of the GP in Yorkshire Ambulance Service Control Room pilot.	Across North Yorkshire and York, partners maintained an intense focus on urgent and emergency care resilience throughout winter 2024-25, taking forward 3 key system actions. • Piloted an Integrated Co-ordination Centre – a multi-disciplinary team, including GP and community services, which supports paramedics in determining whether a patient needs to attend hospital, with a focus on community alternatives where suitable. The 2024-25 pilot saw positive results - 716 cases were reviewed in 13 weeks, 68% of which were age 65 and over. Ambulance dispatch was avoided in 66% of cases. • Continued to review and improve flow on the hospital site, maximising the impact of optimal care services which diverts low acuity patients away from ED. • Commenced implementation of Discharge Command Centre, with 'Home First' principles fully embedded and agreed Discharge to Assess pathways.

Expand and enhance the Frailty Crisis Response Hub (part of which is the Frailty Advice & Guidance Line) to deliver a true 'call before convey' service for Yorkshire Ambulance Service and the wider system to support a tangible reduction in unnecessary ED attendances for frail and vulnerable people.	The Frailty Crisis Response Hub was expanded from 5 to 7 days per week in early 2024-25, and GP capacity in the hub was doubled on weekdays to provide greater support for frail patients, helping them to remain at home where in their best interests during a crisis. A "Call Before Convey" pilot was implemented, requiring frontline ambulance crews to contact the frailty hub before transporting a patient to the emergency department, unless it was a true emergency. This process has now been integrated into standard practice, significantly increasing the ambulance service's utilisation of the hub. The number of ED attendances avoided by this service each month in 2024-25 has more than doubled compared to 2023-24.

Case Study

Helping People Stay at Home with Dignity – How the Frailty Hub Made a Difference

'A 91-year-old gentleman had recently become much frailer. He had been to A&E several times and was struggling to eat and losing weight. His daughter was deeply worried. One day, when he became so weak he couldn't even stand, she was on the verge of calling an ambulance—but instead, she contacted the Frailty Hub.

A care navigator quickly assessed the situation and connected her to a specialist team. A GP spoke with the daughter and arranged for a rapid response team to visit the gentleman at home within two hours. This included both medical and support staff to carry out a full assessment. The GP also had a video call with the family to talk through the gentleman's wishes. It became clear that he needed end-of-life care, and most importantly, that he wanted to remain in his own home. Thanks to the Frailty Hub, the right support was put in place. The Hospice at Home team was arranged, and they provided care and comfort in his final days. He passed away peacefully at home, surrounded by family—just as he had wanted. This is just one example of how the Frailty Hub helps people avoid unnecessary hospital visits and receive compassionate care where they feel most comfortable: at home.'

2.3 Further develop Primary/Secondary shared-care models

What we said we would deliver	What we have delivered in 2024-25
There is an ambition to further develop shared care models between Primary and Secondary Care across the ICB, with a view to providing more integrated care closer to home.	The Primary/Secondary Care Interface Group has acted as a forum for discussion and resolution of issues that present through general practice collective action with on-going work to reduce GP workload regarding onward referrals where clinically appropriate, and to agree collaborative working principles. We continue to work with GP colleagues, the Local Medical Committee (LMC) and hospital colleagues to develop Shared Care Models and Integrated Working to benefit patients and the wider system.
Bring more pathways on board with Referral for Expert Input to facilitate shared care pathways.	Undertaken preparatory work with Paediatrics and Haematology. Both specialities will go live with Referral for Expert Input in early 2025-26, with further specialties to follow.
Continue to develop the Primary/Secondary Care Interface Group as a key forum for agreeing principles and culture around joint/collaborative working and sharing pathway development ideas/progress. Develop a Pathway Transformation Group to oversee and approve changes in clinical pathways with a focus on clinical governance and safety.	The Pathway Oversight Group was established in November 2024 with a focus on clinical pathway improvement and transformation. Work is in progress around Breathlessness and Hormone Replacement Therapy (HRT) pathways.

2.4 Embed an integrated prevention and early intervention model

What we said we would deliver	What we have delivered in 2024-25
Delivery of the Secondary Prevention Programme.	A key area of focus has been improving the management of diabetes in primary care. Working closely with colleagues from York and Scarborough Teaching Hospitals NHS Foundation Trust, we

	have delivered targeted upskilling for general practice teams, which has led to an increase in the number of diabetic patients receiving all NICE 9 care processes. In partnership with York CVS, social prescribing support has been provided to over 100 patients with uncontrolled Chronic Obstructive Pulmonary Disease (COPD). This intervention is already showing promising results, with increases in both annual reviews and medication adherence among this cohort. Collaboration with general practice has enhanced the management of patients diagnosed with hypertension. Insights from across these initiatives have informed ongoing service modifications, strengthening our secondary prevention offer and improving early identification and proactive care for long-term conditions.
Integrated Prevention Scoping Offer.	In 2024–25, we undertook a comprehensive scoping exercise to map the prevention workforce and services across York, identifying existing strengths and proposing areas for improvement. A number of positive themes were highlighted, demonstrating that several prevention services are already working effectively across the system. Opportunities for improvement include: • Provide greater stability to the current prevention workforce through recurrent funding • Support the emerging Integrated Neighbourhood Team model • Address the needs of High Intensity Users through a Population Health Management lens. As a key outcome of the scoping exercise, funding for the continuation and expansion of Proactive Social Prescribing project was secured from 2025–26 onwards.

Continue to strengthen the York Population Health Hub. Develop our Population Health Management (PHM) Infrastructure and Analysis.	The Population Health Hub has enabled teams across the system to adopt population health approaches through targeted support, including a series of 'lunch and learn' sessions and bespoke workshops. These have built confidence and understanding of PHM tools and methods, supporting teams to embed data-driven planning into their work. Significant progress has also been made in improving data sharing capabilities, laying the groundwork for more integrated analytics across sectors. This will provide a critical foundation for advancing our PHM ambitions and supporting more coordinated, person-centred care.
Accelerated delivery of the Health Inequalities Programme.	Completed a full evaluation of projects funded between 2022–2024, with the learning directly shaping our future strategy. This has led to the development of a new approach for health inequalities funding from 2025–26 onwards, aligned with our Partnership's strategic priorities. Delivery of the PCN and Trust Health Inequalities training programme which brought together colleagues from across the system to learn about health inequalities and population health management to translate into real life projects to support a reduction in inequality for our population.
Strengthen the city-wide Integrated Neighbourhood early intervention and prevention system.	A key priority has been fostering the development of locality-based working through the emerging Integrated Neighbourhood Teams model, with the aim of delivering more proactive, personalised care closer to where people live. Commenced the development of neighbourhood health profiles, which will provide essential insights into local population needs, enabling targeted action and resource allocation.

Case Study

Health Inequalities projects in 2024-25 – Focus on Children and Young People

Since 2023-24 the YHCP has received funding from Humber and North Yorkshire Integrated Care Board to deliver projects focused on health inequalities in the local population. Some of the projects that have had a positive impact for Children and Young People in York are:

Children and Young People (CYP) School Absences - This initiative directly supports children with autism and anxiety-related school absences, helping them reintegrate into education. A dedicated Reintegration Support Worker (RSW) works closely with families, schools, and support services to develop personalised plans. Since its launch, it has successfully reduced school absences for 72% of participating children, while others have accessed alternative education provision suited to their needs. Schools have praised the initiative, recognising its positive impact on tackling the barriers that neurodiverse CYP face in education.

Asthma Friendly Schools - This project aims to improve asthma care in schools across York Place, ensuring children and young people (CYP) have the necessary support to manage their condition. By training staff, appointing asthma champions, and improving policies around medication access, the initiative fosters a safer school environment.

Maternal and Child Nutrition - This project supports maternal and child health by promoting breastfeeding and improving infant feeding practices across York. With the goal of achieving UNICEF Baby Friendly Accreditation, it is driving change through training, community engagement, and the introduction of a city-wide "Feeding Friendly" scheme. Initial data shows that breastfeeding rates in York exceed the national average, and targeted interventions in areas with lower uptake are helping to address disparities.

Chronic Pain Clinic - A dedicated chronic pain clinic is being developed to improve care for children with chronic and functional pain conditions. The project includes clinician training, patient education resources, and new referral support materials to enhance understanding among families, healthcare providers, and schools. Though early in implementation, this initiative has the potential to reduce unnecessary medical referrals, improve symptom management, and provide CYP with better long-term health outcomes.

Training Package for Schools – This project is developing an improved online training and resource hub for speech, language, and occupational therapy support. Schools, parents, and professionals will have access to engaging, easy-to-understand resources to better support children with communication and developmental needs, increasing awareness and early intervention.

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

What we said we would deliver	What we have delivered in 2024-25
Support for our schools to support Children and Young People (CYP) with Asthma to fully participate in school life and manage symptoms to ensure they can achieve optimal outcomes.	By training staff, appointing asthma champions, and improving policies around medication access, the Asthma Friendly Schools initiative fosters a safer school environment and ensures CYP have the necessary support to manage their condition. This ongoing initiative aims to significantly reduce health inequalities by ensuring all asthmatic students receive consistent and high-quality care at school.
Continue to develop the integrated offer for support to children who experience difficulties with bowel and bladder function.	Additional workshops and targeted support were provided for CYP with additional needs or who are neurodiverse and required more bespoke advice and support. Face to Face individual appointments were introduced by the specialist team to ensure that additional needs were met. Integrated Bowel and Bladder workshops commenced in February 2025 whereby the healthy child service and specialist nurses deliver education and support on healthy bladder and bowels.
Review of commissioning arrangements for Speech and Language Therapy services (SaLT) and consideration of joint commissioning possibilities to ensure Speech, language and communication needs (SLCN) of CYP are supported throughout childhood.	Significant progress has been made in this area although concerns around SaLT waiting list times continue. Progress in 2024-25 includes: • Service improvement work including piloting group interventions to review some of longest waiters and a number of short term initiatives to address the increasing waiting list. • An increased training offer to schools and settings to improve universal and targeted offers. • The successful programme of Early Talk for York was widened to reach more areas with a focus on inequalities. The programme was expanded to include screening and intervention

	for older children to enable earlier identification of unmet SLCN needs.
Reduce barriers that CYP who are neurodiverse experience in relation to school attendance.	The primary focus of the Partnership for Inclusion of Neurodiversity in Schools (PINS) has been to equip schools with the knowledge, skills and resources to create more inclusive learning environments, strengthen partnerships between schools and families and improve whole-school Special Educational Needs and Disabilities provision. York schools have access to a wide range of offers and resources through PINS, which have been designed to enhance understanding, provide practical tools and create supportive environments for neurodiverse pupils. While these offers contribute to reducing barriers to school attendance, the primary focus has been on enhancing school environments and building staff capacity to better support neurodivergent learners.
Consider an improved integrated approach to SEND (special educational needs and disabilities) using a Family Hub approach and coproducing services with children and families.	A multi-professional hub to support children with SEND and their families will be launched at Clifton Children's Centre in Autumn 2025. A significant amount of planning has taken place through 2024-25 to enable this local offer from early help to specialist support, including securing a financial contribution from health partners.
Increase support for children and young people with autism with the most complex needs.	The ICB and CYC began to explore the possibility of capital funding for complex needs to create additional placements at the Beehive, for children with the most complex needs. Partners have agreed that this work will be progressed in 2025-26.

An ICS approach to ensuring CYP have the best start in life and enable everyone to be safe, grow and learn as outlined in the HNY ICB Strategy.	The Director of Public Health Annual Report was published in March 2025 which provides an invaluable insight into the state of young people's health in York across a range of areas including physical health, mental health and wellbeing, SEND and neurodiversity and children with an experience of care. The newly established ICB CYP Integrated Start Well Board has membership across Executive Place Directors, Director of Children's Services and Public Health leads.

Case Study

Case Study - Raise York

Raise York brings together children; young people; families; communities and professionals so everyone can get the connections, help and support they want and need.

- **Raise York** - The network of people, places and online support for children, young people and families in York. It supports children, young people and families from pregnancy to adulthood.
- **Family Hubs** - The buildings where children, young people and families can access a wide range of Raise York services and support, all under one roof.

5,097 service users accessed services in Family Hubs (former children's centre) sites between Oct – Dec 2024 with 128 professionals involved in delivery of services in Family Hubs and the Raise York brand is starting to be recognised.

Co-production

Co-production has been at the heart of the development of Raise York throughout. 2,000+ families have been engaged in the development process and 325+ have been part of the co-production process.

Relationships and Integrated Working

- Partners are involved from a wide range of organisations including Local Authority, NHS / ICB, voluntary and community sector, and parents.
- Collaborative leadership and relational practice training has taken place, helping to place these at the centre of our Family Hubs model.
- Examples from pilot activity demonstrate how working in partnership has helped identify and address gaps in provision and use resource more efficiently.

To deliver Raise York's ambitions and achieve the outcomes families want and need, we have a range of tools and services available to us including information and support for families and tools, resources and support for professionals.

For the next 3 years, Raise York's priority areas of work are:

1. Infant feeding
2. Perinatal mental health and parent/carer-infant relationships
3. Healthy weight in under 5s
4. Communication and language skills
5. Children and young people's mental health
6. Cost of living

The Raise York Pledge

In order to achieve our outcomes for families, we are asking everyone that works with children, young people and families to make the Raise York Pledge.

Our pledge has three pillars, asking all partners to be:

Caring Together Trusted

2.6 Driving social and economic development

What we said we would deliver	What we have delivered in 2024-25
Infrastructure, Housing and Healthcare developments.	In 2024-25 YHCP developed proposals for establishment of the Accelerating Healthy Communities programme, our overarching vision for a new model of neighbourhood health. The proposal recognises the challenges we face – rising demand related to rising morbidity and population growth; the condition of the health and social care estate; funding deficits – and sets out the design principles for a neighbourhood health model. We've laid the groundwork for how services will look and feel in future for residents and practitioners, through co-creation of a set of guiding principles, shaped with over 200 front line leaders from across 30 local health, council, and partner organisations.
Workforce, training, and skills.	Student placements within the Frailty Hub have been progressed through the Nimbuscare Education Coordinator. Discussions are also progressing in relation to nursing staff from St Leonard's undertaking rotational placements within the Frailty Hub. Through the Care Connected Forum, engagement is underway to progress engagement with social care providers to understand and seek solutions to their workforce challenges, including issues and mitigations relating to sponsorship.
Supporting social development for vulnerable groups.	A key success from 2024–25 was the Inclusion Health Register Pilot, an innovative, data-driven approach to identifying and supporting some of the most vulnerable populations within the system. In 2024-25 we developed our health inequalities programme for implementation in 2025-26, a key

	element of which focuses on wider determinants of health in Children and Young People.
Strengthening links to wider partnership strategy.	We have contributed to the York and North Yorkshire Mayoral Combined Authority Local Growth Plan to build health and prosperity for the City's residents. Individualised Placement and Support is now up and running in mental health settings and through Drug and Alcohol services, supporting hundreds of people back to work. The Mayoral Combined Authority Economic Inactivity Trailblazer will shortly be launched, including a number of schemes which have health and work support at their heart. A wide range of partners have participated in the University of York's study focused on System Integration through Network Governance in NHS Place Committees. The outputs of this study, due in summer 2025, will illuminate our collaboration practices, successes, and challenges at these deeper levels, and strengthen awareness for Managers and Professionals leading system change to strengthen our future position as a Place and ultimately achieve better outcomes for our population.

Case Study

Joint Commissioning Lead for Health and Social Care

The ICB and City of York Council implemented a shared Head of / Assistant Director of Commissioning from July 2024. There are many working examples of how this role has successfully enabled delivery of our priorities and has moved us to a place of delivering better integration of care across our system. Some of the key successes of this role include reduced duplication, open and transparent conversations, alignment of working practices, boost in staff morale and empowerment to overcome specific challenges and barriers. As a result, the YHCP will consider more permanent and wide-ranging developments in the context of place delegation and integration, which can include joint posts alongside joint governance, budgets, and processes.

2.7 2024-25 Progress: Conclusion

As this report highlights, there has been a significant amount of work undertaken by the YHCP and its partnership teams through 2024-25 to improve health outcomes for people living in York and address health inequalities.

Now, we are re-focussing on three priorities for 2025-26 onwards which will build on the progress we have made so far and continue our dedication to improving the health and wellbeing of York's residents.

3. Joint Forward Plan 2025-26

Since we set our six priorities in 2023, the Partnership has evolved, the landscape has changed, and we have made significant progress against these priorities.

The YHCP has therefore produced a refresh of priorities for 2025-2028 to re-focus the Partnership on our 'must dos'. *Accelerating Healthy Communities* has been adopted as our unifying ambition, to provide clarity and constancy of purpose, and a guiding light for our Partnership's three 'must dos' over the coming years.

We will review our plans in response to the 10 Year Health Plan when published in Spring 2025 which will enable us to shift towards a medium-term approach to planning.

We must also recognise that 2025-26 will be a year of change and uncertainty in the health care sector, with fundamental alterations to the role and capacity of Integrated Care Boards underway and expected to take effect from Quarter 3. At the time of writing, it is unclear what this means for Place based capacity in the ICB and how this will apply to legislative functions, nor is it clear how or when providers will be expected to take on some of the duties of ICBs over time.

Although we will need to be mindful of these changes as we progress our delivery plans, commitment to our priorities and to delivering improved outcomes for our population will not waver.

3.1 York's Growing and Changing Population

In March 2025, we published a summary of the York Joint Strategic Needs Assessment (JSNA), Our City Health Narrative. Our Joint Forward Plan and priorities are adapting to meet the needs of our changing population and to mitigate the challenges these changes may bring.

3.1.1 Population growth

- The resident population of York is forecast to grow by approximately 35,000 between 2023 and 2033 with a projected 50% increase in the over 85 population by 2040.
- The proportion of adults with a major illness will grow by 38% by 2040.
- An extra 1,235 patients per year are seeking care in mental health services, an additional 52 patients are attending A&E each day, 60,000 more GP appointments take place per year and social care demand is rising by an extra 600 people per year.

3.1.2 Population health

- Life expectancy for both males and females living in York is falling and is now below the national average for males. There is a gap in life expectancy of over 10 years for both males and females across our city.
- There are several distinctive demographics in York. We have the third lowest fertility rate in the country, 1 in 6 of our residents are students, we have the 14th most transient population in England and we have over 9 million tourists visit our city every year.
- An increasing number of children (0-11) are living with an unhealthy weight at reception and year 6. Children within this age group have good vaccination coverage but also experience inequalities in speech and language and school readiness and have poor oral health and access to dentistry.
- There are now more young people (11-25) with special educational needs and disabilities (SEND) and there are concerning trends around emotional and mental health and young people's experiences of relationships, with higher levels of school absence post COVID.
- 2 in 3 adults (18-64) living in York are overweight or obese with 20% living a sedentary lifestyle.
- Cost of living pressures are adversely affecting health outcomes and the average house in York is 9.3x average earnings.
- Our older population (64+) report higher than average levels of loneliness, and there is a raising demand for mental health services amongst our older population. There are 800 falls-related admissions per year and 25% of our over 65s experience digital exclusion.
- York also has many strengths to draw on, including a strong voluntary and community sector with over 350 charities; we have a growing and resilient economy with a strong local employment profile; we have the most highly educated population in the region; good access to green spaces and an increasingly diverse city with more residents from a minoritised ethnic background.

3.1.3 Estates challenges

Rising demand for care from a growing and ageing population will put pressure on the healthcare estate.

The combined primary and community care space is estimated to be approximately 2,500m^2 short of current needs; forecasts indicate the overall shortfall in estate capacity will double to 5,500m^2 by 2033 - approximately the size of a football pitch.

A Local Development Plan for York has now been ratified. Through our Accelerating Healthy Communities programme, we will consider our strategic estates needs and how we will plan to address these challenges.

3.2 Engagement

Each statutory member organisation of the Partnership will retain its own approach to public involvement for the services that they remain responsible for.

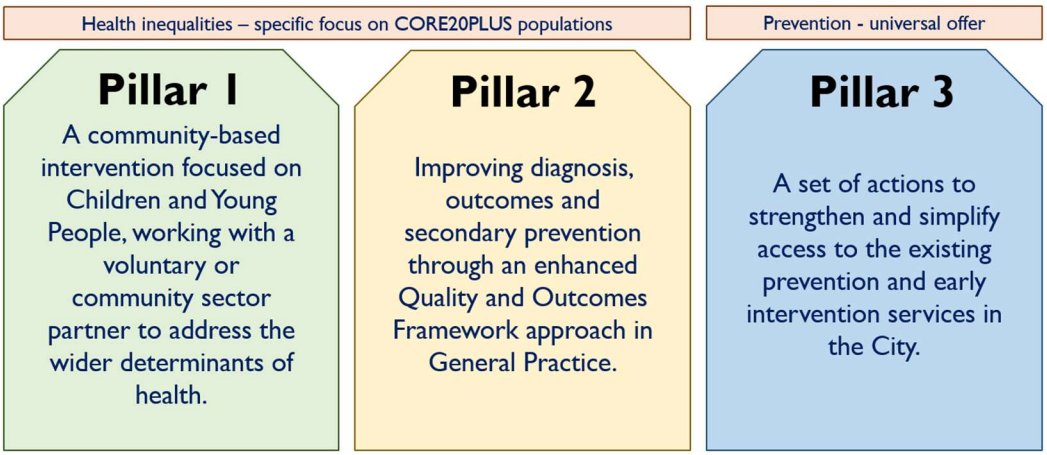
We intend for community engagement and co-production to happen extensively throughout our local integration journey, and in support of this the Partnership will:

- Continually consider how to engage members of the public so that their views can be reflected to YHCP Executive Committee and its sub groups, depending on the nature of the decisions to be taken.
- Utilise the involvement of patient engagement networks, carer networks, and other relevant organisations to ensure that there is public engagement and participation throughout the Partnership's work.
- Look to consolidate and where appropriate share resources across organisations for a common Partnership approach to communications and public involvement activities.

Healthwatch York will continue to work with people in York, giving individuals and communities a voice in what they want from local health and care services. Healthwatch's work in 2025-26 will include a continued focus on Core Connectors, Enter and View visits and a specific focus on Gender Health including women's health, men's health and the trans and non-binary community.

3.3 Health inequalities

Reducing health inequalities will continue to be a key role of Place Based Partnerships, and work to reduce health inequalities remains a golden thread throughout each of the YHCP's priorities for 2025-26. In 2025-26 the YHCP will receive health inequalities funding from the Humber and North Yorkshire ICB to address local need in line with the Core20PLUS5 Framework. This will be deployed through a two pillar approach, alongside a third pillar which will focus on prevention services.



3.4 Plans for delivery against the priorities in 2025-26

3.4.1 Delivering our vision for an integrated neighbourhood model

The development of a neighbourhood health model is a key national priority, articulated in the Fuller and Darzi reports and now confirmed in 2025-26 planning guidance with the requirement to –

Set the foundations of the neighbourhood health model by continuing to embed, standardise and scale core components of existing practice. This includes taking a consistent, system-wide population health management approach to patient segmentation and risk stratification.

Neighbourhood models are also expected to be a central development in the NHS 10 Year Health Plan, due in Spring 2025.

What are the benefits for our population?

Health and care services will feel joined up and will be provided in a convenient location – within the local community wherever possible.

People will be supported to stay healthy and well, maintaining independence and living at home as long as possible.

Care will focus on what matters to that person and their individual circumstances – and professionals will work behind the scenes to co-ordinate this.

People will know how to access the right support, advice and care at the right time.

People will be empowered to manage their own health through digital tools and technologies.

What will we do in 2025-26 to support this priority?

Deliver our vision for an integrated neighbourhood model	
What will we deliver?	**How will we deliver this in 2025-26?**
A co-ordinated approach to supporting High Intensity Users.	Identify a cohort of high intensity users of health care across our population. Design and implement a co-ordinated neighbourhood led approach to supporting the health and wellbeing of this cohort with general practice and wider partners, with the aim of improving outcomes and reducing healthcare resource use.
Complete development of Neighbourhood Health Profiles.	Complete our neighbourhood health profiles, which will provide essential insights into local population needs, enabling targeted action and resource allocation. These profiles will inform multi-agency discussions and decision-making at the neighbourhood level, allowing the system to better address health inequalities and increasing demand.
Mapping Neighbourhood services.	Identify the health and care staff, teams and assets in each neighbourhood and take steps to connect professionals who work in each locality to foster a culture of multi-disciplinary integrated working around a local population.
Establish Integrated Neighbourhood Teams in line with the agreed Neighbourhood Design Principles.	In partnership, we will develop and implement an operating model for our neighbourhood based teams. This will include confirming which services will operate 'in neighbourhoods' and which will relate 'to neighbourhoods' – operating on a different footprint but with strong links into each neighbourhood.
Build the revenue model based around the benefits of a neighbourhood health and care model for residents, practitioners and communities.	Appoint a health economics partner to work with our stakeholders and partner organisations to model the revenue impact of the neighbourhood model on NHS, social care and social housing.

Undertake a feasibility review for our strategic approach to health and care estate.	Identify future estate needs based on the neighbourhood service delivery model, consider future strategic estate options and their feasibility.
Establish integrated workforce models to support the neighbourhood delivery model.	Involve our workforce through the design of neighbourhood models, engaging with all staff groups throughout the process to ensure that their perspectives are reflected and that they can see the benefits of the transformation for their individual roles and the care they give to patients. Identify gaps in the workforce, including skills, behaviours and ways of working to develop as well as gaps in specific roles and staff groups that we need to develop across the Partnership. This may include developing skills to cover multiple functions that traditionally may have been delivered separately so that staff are safely able to work in a more agile way and increase continuity for people and carers. Identify barriers and opportunities to better enable productive integrated working so that staff have the skills and tools to safely work across organisational boundaries and serve their local populations, while improving workforce interactions and experience.

3.4.2 Improving Outcomes for Children and Young People

We will develop a partnership based, inclusive model for children, young people and families. Create capacity through a joint commissioning approach, including a sustainable model for family and SEND hubs.

Children and Young People (CYP) are central to our Partnership's ambitions – getting it right earlier in life is crucial for the future health and wellbeing of our population. With an all-age approach, everything that the Partnership does will be with reference to children and young people.

Humber and North Yorkshire Health and Care Partnership's integrated strategy highlights radically improving the health and wellbeing of children and young people as our system's golden ambition. The Partnership is prioritising children and young people through its Start Well Board.

The Children's Wellbeing and Schools bill (currently at committee stage) will put in place a package of support to drive high and rising standards throughout our education and care systems so that every child can achieve and thrive. It will protect children at risk of abuse, stopping vulnerable children falling through

cracks in services, and deliver a core guarantee of high standards with space for innovation in every child's education.

What are the benefits for our population?

Families and carers will find it easier to access the support they need for their children and young people, and they will be able to access it at the earliest point that support is needed.

Children and Young People will feel safe, and when they go to an adult for support, they will receive the right help without multiple hand offs or having their needs 'lost' between services.

What will we do in 2025-26 to support this priority?

Develop a partnership based, inclusive model for children, young people and families	
What will we deliver?	**How will we deliver this in 2025-26?**
CYP York Place Priority Plan.	We will develop a CYP York Place Priority Plan that will be informed by the latest planning and best practice guidance, will be driven by local data about the needs and wants of families, children and young people in York, supported by an extensive engagement process. The plan will outline how the Partnership will deliver our CYP priorities in 2025-2028. The purpose of the plan is to explain: "how will health, council and schools work together to improve outcomes and experience for children?" We will not wait for the CYP Priority Plan to deliver on areas of improvement that we know we need to make now. This includes children with Speech, Language and Communication Needs (SLCN) for which detailed improvement projects are already underway. We will align delivery with our existing local plans and those which are in development.
Children's commissioning and integration approach.	We will progress delivery against the identified priorities and plans as set out in the CYP Place Priority Plan.

Integrated Neighbourhood Teams (INTs).	We will ensure that children and young people are at the centre of our integrated neighbourhood plans and that education partners are included as a key partner in the development of INTs in accordance with the national guidance.

3.4.3 Joint Commissioning

By realising the benefits of joint commissioning, we will reduce duplication and ensure we are delivering the best outcomes within the financial, workforce and estate constraints.

This makes sense for where services are targeting similar populations, where there is benefit in multi-agency working, and where an active focus on prevention can reduce costs to statutory services.

Joint commissioning arrangements will allow us to increasingly take account of interdependencies between health care services and the wider determinants of health.

What are the benefits for our population?

Jointly commissioned services will reduce the number of referrals and hand offs between providers.

This in turn will reduce administrative delays that patients often face when being transferred between health and social care.

Services will support patients with a wider range of needs, bringing a more personalised approach, because they will not be contracted as separate health, care and social provision with differing specifications and criteria.

Reducing duplication and ensuring most effective use of our resource will mean that more care and support can be delivered to people.

What will we do in 2025-26 to support this priority?

Realising the benefits of joint commissioning for York's people	
What will we deliver?	**How will we deliver this in 2025-26?**
Prevention and Health Inequalities – including services funded through prevention and health inequalities budgets, local GP enhanced services, budgets funding communities and housing support, and wider council budgets supporting prevention (all age).	Co-produce and commission our 'pillar 1' health inequalities intervention focused on Children and Young People. Implement the 'pillar 2' enhanced quality and outcomes framework (QOF), which will increase delivery of QOF secondary prevention interventions in our health inequalities cohorts. Build on the prevention proposals approved in 2024-25, including contracting for the ongoing

	proactive social prescribing service and developing supportive preventative interventions for high intensity users. Develop an integrated falls pathway, including universal assessment, strength and balance interventions, building on services already in place to ensure that people at risk of fall are identified at the earliest opportunity and preventative personalised support is in place.
Community Equipment Services.	Review the future of community equipment services, assessing the available options to align leadership, operational management, specifications and outcomes.
Integrate or align services in areas of likely duplication to maximise value for money and create flexibilities to reinvest.	Identify areas where CYC and ICB contract for similar outcomes and agree new options when contract periods are up.
York Integrated Community Model.	Work together to develop and deliver a joint model for non-bedded community health services that moves us away from multiple services, reduces hand offs, strips out waste, improves resilience and shares resources, and is established on neighbourhood health principles.
An integrated or common approach to working with the Voluntary, Community and Social Enterprise (VCSE) sector.	Establish and agree principles for commissioning and contracting with the VCSE Sector.
Assess and strengthen the alignment of pooled funds and the transparency of pooled funds.	Undertake a Better Care Fund best value scheme review. Build on our joint working arrangements, considering where there would be benefits of going further with the scope of joint commissioning approach.
Continuing Healthcare / Section 117 aftercare and jointly funded care packages	Work with other places in Humber and North Yorkshire to develop an approach to consistency of

	process for decisions, panels and disputes, with local variation where needed.
Establishing a path to a commissioned, integrated and de-medicalised 24/7 community mental health offer for York.	Support the Mental Health Partnership Sub Committee and Mental Health Hub Joint Delivery Board with integrated commissioning that helps providers work together to do the right thing and implement a sustainable model for Community Mental Health, building on the strengths of the hub approach, bringing community mental health teams, crisis services and other place-based mental health services into an integrated, recurrently funded model.
Identify opportunities for joint commissioning in the East Riding area of York Place.	Explore opportunities for joint commissioning between the ICB York Place and East Riding of York Council, including reducing duplication and streamlining of commissioning and contracting processes. Establish priority areas for joint working. Set up a sub-group to focus on the development of the neighbourhood working for this area, ensuring that governance aligns with INT developments across York Place and East Riding Council.

4. Conclusion

We believe that our plans for 2025-2028 are ambitious, while being clearly focused on our priority areas. 2025-2028 will be an exciting time for the YHCP, as we collaborate more closely with formal partnership arrangements in place and explore how we can further develop partnership working in future.

We look forward to the publication of the government's 10 Year Health Plan, which we expect to give further direction and significance to the way we work together across our local health and care system. We will focus on delivery of the three big shifts from hospital to community, from analogue to digital, and from sickness to prevention.

2025-26 is also set to be a challenging year, with substantial restructuring expected in the NHS and organisations continuing to manage significant financial and operational challenge. More than ever, this underlines the importance of working together, in partnership, and not losing sight of our vision - making York a healthier and fairer city to live and work in, for current and future generations.